



Figure 1: Radiographs (anteroposterior view) of both knees showing bone fragmentation at the upper pole of the patella on both sides.

Pain in both knees

A 40-year-old woman presented with bilateral knee pain following a motorcycle collision. She had no prior history of pain in her knees. Physical examination revealed abrasions, swelling, ecchymosis and tenderness of both knees. There was no obvious limitation to range of motion, either active or passive, and she was able to actively extend her knees. Radiographs of the knees showed a smooth, regular, semilunar radiolucent defect at the superolateral pole of each patella (Figure 1).

Bipartite patella is a developmental variation in which the patella develops from 2 ossification centres.¹ It occurs in about 2%–6% of the population, with a male predominance (ratio 8:1). It is bilateral in 43% of patients.² In 1943 Saupé proposed the following radiological classification based on the position of the accessory ossification centre:³ type I (5% prevalence) involves the inferior pole of the patella and poses a high risk for fracture. Operative fixation may be required if there is disruption of the extensor mechanism. In type II (20% prevalence), the defect is located along the lateral patellar margin. The defect in the type III variant (75% prevalence), seen in our patient, is located at the superolateral pole of the patella. Most patients with bipartite patella have no symptoms and do not require treatment or referral. If there is no disruption to the extensor mechanism, symptomatic patients usually respond well to physiotherapy and analgesics. For a minority of patients for whom nonoperative treatment is ineffective, surgical excision of the bone fragment may be considered. Rarely, surgical repair is indicated when the synchondrosis has been fractured and there is loss of active extension. At last follow-up, our patient was doing well with physiotherapy and analgesics.

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