ORTHOPAEDIC

National Referral Guidelines

NATIONAL REFERRAL GUIDELINES : ORTHOPAEDIC			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Problems are categorised by the following anatomical headings: • neck • shoulder • elbow • wrist and hand • back • hip • knee • ankle and foot • paediatric • miscellaneous	A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Appropriate investigation by the referrer will facilitate the referral process.	Specific management depends upon the diagnosis	These guidelines are provided (below) to give greater clarity in the primary/secondary interface of patient care.

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NECK			
• Mechanical neck pain without arm pain • Neck pain associated with referred pain to the upper arm without neurological deficit.	**Key points**: • Duration of symptoms. • Presence of neurological symptoms and signs including evidence of lower limb spasticity. • Work status. • Weight loss, appetite loss and lethargy. • Fever and sweats. • Treatment to date. • Previous malignant disease. • General medical condition. **Investigations (only if indicated)**: • Xray • FBC & ESR • Biochemistry. (Consider calcium and phosphate, protein electrophoresis, immunoglobulins, PSA, Rheumatoid serology in specific cases).	Activity modification Analgesics NSAIDs Maybe physiotherapy Education Maybe trial of soft collar if severe spasm	If symptoms and signs persist despite adequate care.
• Neck pain associated with neurological deficit • Cervical myelopathy	Routine history and examination noting the key points as above.		Refer semi-urgent.
• Neck Pain secondary to malignant disease • Neck pain secondary to infection			Refer urgent
SHOULDERS			
Rotator Cuff Tendinitis/Tears Pain/stiffness in shoulder including frozen shoulder AC joint problems	Standard history and examination particularly neurological examination. Xrays (standard views) Consider FBC & ESR	Anti inflammatories Physiotherapy Consider Cortisone injections	Refer if patient fails to respond to treatment. Evidence of weakness suggestive of a rotator cuff tear is more urgent.
Recurrent dislocation shoulder Shoulder instability	Standard history and examination particularly neurological examination. Xrays (standard views)	Advice to avoid dislocation Shoulder rehabilitation programme (Physiotherapy)	Refer if recurrent functional instability and/or pain and has not responded to the rehab programme.

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ELBOWS			
Tennis/golfer's Elbow	Standard history and examination.	Bands Anti inflammatories Modify activity [eg patient with tennis elbow to use wrist in supination as much as possible] Physio Consider cortisone injection	Refer if fails to respond to treatment.
Painful/stiffness in elbow locking	Standard history and examination. Consider FBC & ESR.	Anti inflammatories physiotherapy	Refer if not responding to treatment.
WRIST & HAND			
Carpal Tunnel Syndrome	See under "miscellaneous section"		
Dupuytrens contracture	Key Points: • Duration and speed of progression. • Functional impairment. • Family history of Dupuytrens. • Smoking • Previous surgery • General medical conditions (especially diabetes, epilepsy, liver disease. • Medications (especially for epilepsy)		Refer if hand and fingers cannot be placed flat on table. Finger contractures more urgent.
Stenosing tenovaginitis (eg, Trigger fingers, de Quervains)	Standard history and examination.	Consider injection with steroids.	Refer if functional impairment or if unresponsive to treatment after injection.
Rheumatoid conditions (cf Rheumatology Recommendations)	Standard history and examination.	Usually refer to specialist rheumatologist/physician.	Refer to Rheumatology Recommendations
Basal Thumb Arthritis	Standard history and examination Xray	Anti inflammatories. Activity modification. Consider steroid injection.	Refer if fails to respond
Ganglia	Standard history and examination.	Consider aspiration (18g needle) and multiple puncture.	Refer if ganglia symptomatic. Cosmesis alone is not a reason for referral.
Painful/stiff Wrists	Standard history and examination. Xray	Anti inflammatories. Trial of wrist splint. Physio.	Refer if Xray abnormal or if does not respond to adequate conservative treatment.
Congenital upper limb abnormalities			Refer to local service as available.

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BACK			
• Mechanical low back pain without leg pain. • Back pain and sciatica without neurology. • Spinal stenosis with limitation of walking distance.	**Key Points**: • Duration of symptoms. • Presence of neurological symptoms and signs. • Functional impairment • Time off work • Weight loss, loss of appetite and lethargy • Fever and sweats • Treatment to date. • Previous spinal surgery • Previous malignant disease. • General medical condition and medication. **Investigations if symptoms persist**: • Xrays • FBC ESR Biochemistry. (Consider calcium and phosphate, electrophoresis, immunoglobulins, PSA, Rheumatoid serology in specific cases).	• Activity modification. • Analgesics and NSAIDs (see ACC Guidelines Booklet)	Significant symptoms persisting > 6/52 refer.
• Back pain and sciatica with neurological deficit.	As above.		Refer semi urgent
• Back pain secondary to neoplastic disease or infection.			Refer urgent
• Back pain with neurological bladder involvement (cauda equina syndrome)			Refer immediate

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HIPS			
Hip Arthritis • Osteoarthritis • Inflammatory Arthritis • Post Traumatic Arthritis • Avascular Necrosis • Previous Total Hip Replacement [THR]	Standard history and examination. **Key Points:** • Walking distance • Rest pain and disturbance of sleep • Ability to put on shoes • Use of walking aids. • Treatment including NSAIDs and analgesics • Previous joint surgery • General medical conditions and medication • History of recurrent infections and prostatism • Examination for range of movement **Investigations:** • Xray (AP pelvis, AP affected hip showing proximal 2/3 femur and lateral affected hip).	Anti-inflammatories / Analgesics / Physiotherapy. Activity modification including the use of a walking stick. Weight reduction	Refer if significant pain, disability, sleep disturbance and unresponsive to therapy. Pain in a previous arthroplasty should be referred fairly urgently. If infection suspected make acute referral (don't start antibiotics).
Paediatric Hip Conditions (Perthes, Slipped Upper Femoral Epiphysis [SUFE], Synovitis) Irritable hip	History, examination and Xray. Beware of pain in the knee as a symptom of hip disease.	Bed rest and simple analgesics.	Acute referral if systemically unwell, febrile, or on suspicion of SUFE. Otherwise reassess at 24 hours. Age ranges usually: 18 months to 6 years – irritable hip 4-10 years - Perthes 8-14 years – SUFE
KNEES			
Knee Arthritis: • Osteoarthritis • Inflammatory Arthritis • Post Traumatic Arthritis • Avascular Necrosis • Previous Total Knee Replacement [TKR]	**Key Points:** • Walking distance • Rest pain and sleep disturbance • Use of walking aids • Treatment including NSAIDs and analgesics • Previous joint surgery • General medical condition and medication • History of recurring infections and prostatism. • Examine for tenderness, swelling, range of movement and deformity. Investigations: • Xrays - routine knee Xrays including AP of both knees standing and lateral affected side.	• Anti-inflammatories/analgesics • Physiotherapy • Activity modification including the use of a walking stick • Weight reduction	Refer if significant pain, disability, sleep disturbance and unresponsive to therapy. Pain in a previous arthroplasty should be referred fairly urgently. If infection suspected make acute referral (don't start antibiotics).

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ANKLES & FEET			
Arthritis	Standard history and examination. • X-rays	Analgesics/anti-inflammatories Physiotherapy Activity modification Walking aids Consider steroid injection.	Refer if functional impairment despite conservative treatment.
Pain and deformity in forefoot (including bunions)	Standard history and examination. • X-rays • Check Tibialis Posterior	Modification footwear Orthoses Consider steroid injections for intermetatarsal bursa / neuroma	Refer if conservative treatment fails.
Pain and instability in hind foot.	Standard history and examination. • X-rays	Check Tibialis Posterior Modification footwear Orthoses Physiotherapy	Refer if conservative treatment fails.
Achilles tendon pathology	Standard history and examination. • X-rays	Physiotherapy Avoid steroid injections Heel cups/raise	Refer if conservative treatment fails.
Heel Pain	Standard history and examination. • X-rays Xrays allow exclusion of some diagnoses. NB : Plantar spur on an Xray does not imply plantar fascitis	Physiotherapy Steroid injections for plantar fascitis Heel cups/raise	Refer if conservative treatment fails.
PAEDIATRIC DEFORMITIES			
Club Foot	Features to be looked for are fixed equinus and varus.		Refer urgently.
Calcaneo valgus foot	Almost always correctable to neutral but check the hips for instability.	Reassurance.	Refer if not flexible/correctable.
Flat feet	Under the age of three years, flat feet are normal. Ask the child to stand on their tip toes - if the arch corrects, the foot is normal.	Reassurance	If painful or in spasm.
In toeing	Standard history and examination.	Reassurance	Refer for a second opinion if asymmetrical or significant deformity.

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MISCELLANEOUS			
Nerve entrapment syndromes, Carpal Tunnel Syndrome, ulnar neuritis, tarsal tunnel	Standard history and examination.	Consider one steriod injection for carpal tunnel. Splintage.	Refer urgently - if muscle wasting or associated with pregnancy. Otherwise if no improvement.
Bone and/or Joint Infection	Standard history and examination.	Don't start antibiotics.	Acute referral.
Bone and Soft Tissue Tumours	Standard history and examination. Do not needle biopsy		Refer urgently if tumour or suspicion of tumour.
Bursitis (pre-patellar, trochanteric, olecranon)	Standard history and examination. Acute/inflammatory consider aspirating for diagnosis. Will either be traumatic, gouty or infected	If acute consider aspirating for relief of symptoms. If chronic consider steroid injection.	Refer if non responsive to treatment.
Apophysitis eg. Osgood Schlatters, Sever's Disease	Standard history and examination. Consider Xray.	Activity modification, reassurance.	Refer if does not settle.
Gait	Standard history and examination. Up to two years bow legs are normal Knock knees from age 2-5 years are normal.	Reassurance.	Refer for second opinion or severe deformity outside the normal age range.
Sterno Mastoid Tumour (congenital muscular torticollis)	Standard history and examination.	Passive stretching by parent or physiotherapist.	Normally refer to exclude other abnormality.
Removal plates, screws and pins.	Pain Ulceration		Most metal implants are not removed. Consider referral if painful or risk of refracture.