RHEUMATOLOGY

National Referral Guidelines

SPECIFIC RHEUMATOLOGY REFERRAL LETTER GUIDELINES

The referral should include:

- Past History including details of previous treatment (eg, surgery), investigations including blood tests, bone density, etc.
- GP assessment of urgency, degree of loss of function, pain experience.

NATIONAL REFERRAL GUIDELINES : RHEUMATOLOGY

Diagnosis	Referral Guidelines
Patients referred to rheumatologists would normally have musculoskeletal complaints. This might include patients with inflammatory joint disease, connective tissue diseases, vasculitis and multisystem disorders, crystal arthropathies, degenerative joint disease, metabolic bone disease, soft tissue rheumatism and generalised painful disorders such as polymyalgia rheumatica, fibromyalgia.	Priority should be given to early referral of patients with inflammatory, destructive joint disease. Evidence increasingly shows that early intervention with disease modifying agents is required in order to get good outcomes. Patients with systemic inflammatory conditions and severe pain and dysfunction will also be given priority. Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on the size and staffing of the hospital department.

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Diagnosis	Evaluation	Management Options	Referral Guidelines
ACUTE SINGLE JOINT			
Important: Septic Arthritis	History Evaluation: Signs of infection? (Hot , red, swollen joint, presence of pyrexia).	Aspirate or refer?	If sepsis cannot be satisfactorily excluded refer urgently (orthopaedics) for aspiration and diagnosis - category 1.
Common: Gout, Pseudogout, reactive arthritis,	If no signs of infection, consider gout and joint aspiration. Diagnosis of gout is made by examination of joint fluid by polarised light microscopy.	Gout : initiate non steroidal inflammatories. Local steroid injection, short course high dose oral prednisone. Allopurinol is not appropriate for the treatment of single episodes of gout.	Refer patients with recurrent gout which is chronic, polyarticlar or if the diagnosis is uncertain - category 3.
Rare: Haemarthrosis, Psoriatic arthritis, Ankylosing Spondylitis, avascular necrosis	Consider pseudogout Blood : FBC, ESR, LFTS, UCES, uric acid	If confirmed pseudogout : treat with intra articular steroidal inflammatory injection.	Refer to specialist for aspiration and/or injection for difficult anatomical sites or problems requiring particular expertise - category 3.

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SUB-ACUTE SINGLE / FEW JOINT(S)			
Osteoarthritis **Oligoarticular synovitis** **Intercritical Gout** **Rare : Tumour (Primary or Secondary)**	History: - trauma - psoriasis - colitis/iritis - GU/GI infection Exam: - synovial swelling - joint tenderness - other joints XR: - affected joint Blood: - FBC, ESR, RhF, LFTs, uric acid	Simple analgesia (Paracetamol) NSAID Physiotherapy referral	Uncertain diagnosis - category 3. Local injection therapy - category 3.
MULTIPLE JOINT			
Rheumatoid Arthritis **SLE**	History: - as above - inc family history - systemic symptoms - pattern of joint involvement Exam: - rashes - anatomical swelling (cf oedema) - BP Blood: - FBC, ESR, RhF, ANF, U&Es, LFTs, CRP Invests: - urinalysis	Early referral to rheumatology service. Institute NSAID. Beware High Dose Prednisone (>10mg).	Most cases polyarticular synovitis should be assessed by the rheumatology service - category 2. Polyarthralgia with systemic symptoms or signs merits early discussion with rheumatologist.
Reactive Arthritis	History: - GU/GI infection - family history - back pain/stiffness		
Consider Polyarticular Gout	History: - previouse acute gout Invests - (aspirate joint for crystals)	NSAID/Colchicine consider Allopurinol	
PERIARTICULAR / SOFT TISSUE RHEUMATISM			
Shoulder/Rotator Cuff **Tennis Elbow** **Anserine Bursitis** **Trochanteric Bursitis** **Carpal tunnel syndrome** **Plantar Fascitis, etc**	History: - trauma - occupation - pain pattern Exam: - normal passive ROM - Clinical diagnosis Investig.- FBC/ESR - XR if fails to settle	Local injection therapy. NSAID Physio may be considered useful.	Uncertain diagnosis - category 3. L.I.T - category 3. Failure to settle - category 3.

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OSTEOPOROSIS / METABOLIC BONE DISEASE			
Post menopausal osteoporosis **Secondary Osteoporosis (inflammatory arthritis, steroid therapy)** **Osteomalacia**	History: - family history - age at menopause - fracture - dietary Ca^{II} - steroid therapy Exam: - vertebral deformity Investig.- BMD (dexa, CT) - XR - Ca^{II}, PO4, thyroid function - U&Es, creatinine, LFTS,vit.D - androgens in males	HRT for post menopausal osteoporosis Consider bisphosphonates/calcitriol. Dietary and exercise advice. Cessation of smoking, limiting alcohol.	Management of complicated or atypical presentations – category 3.
CHRONIC PAIN SYNDROME			
Fibromyalgia (FMS) **Complex regional pain syndromes (reflex sympathetic dystrophy, causalgia)** **Chronic low back trouble.**	Consider medical causes of fatigue, myalgia, eg hypothyroid, depression History: - trauma - sleep disturbance - psychosocial evaluation important Exam: - allodynia - tender points - pain behaviours Investig. - FBC / ESR / TFB / LFTs / U&Es / Ca $PO4^{2-}$ / CK *NB : FMS can exist with other conditions.*	Explore psychosocial issues. Lifestyle counselling. Emphasis on self management. Involve multidisciplinary approach. Downplay medical model. Low dose tricyclic antidepressants/ simple analgesia. Encourage maintenance at normal daily living activities including employment.	Uncertain diagnosis. Multi/interdisciplinary rehabilitation - category 3.
MULTISYSTEM / CONNECTIVE TISSUE DISEASE			
SLE (uncommon) Others are rare: Scleroderma Poly/Dermatomyositis Sjogrens **Vasculitis** Polymyalgia rheumatica **Others are rare:** Polyarteritis nodosa Wegener's granulomatosis	- False positive tests common - None of these conditions can be diagnosed by a single test. - Full history and physical exam. - Reasonable initial investigations: - FBC, ESR, CRP - U&Es, LFTs, CK - MSU - CXR	• Symptomatic treatment initially	• Referral to rheumatology service - category 2. • Early discussion with rheumatologist will aid prioritisation.

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Diagnosis	Evaluation	Management Options	Referral Guidelines
RHEUMATOLOGICAL REHABILITATION			
Chronic Arthritis - RA - multijoint OA - ankylosing spondylitis - psoriatic arthritis - polyarticular gout Recent onset Arthritis	Established diagnosis. Progressive worsening of disability. Threat to independence. Difficulty with primary economic activity. Need for help with self management.	Education (Arthritis Foundation). Physical therapy. Occupational Therapy Assessment (including work options). Self Management Skills. Lifestyles counselling. Orthotic Assessment.	Significant disease or disability - category 3. Lack of comprehensive local support systems – category 3.
MUSCULAR ACHES AND PAINS			
Polymyositis	Weakness (rising unassisted from chair?) Muscle tenderness Raised CK, ESR ?RASH		Refer to rheumatology service – category 2.
Polymyalgia Rheumatica/giant cell arteritis	Muscle pain and morning stiffness (marked) No true weakness Raised ESR Normal CK ?headaches, ?Amaurosis Fugax	Symptoms of giant cell arteritis mandate urgency. ?therapeutic trial of medium dose Prednisone (15-20mg daily)	Refer to rheumatology service – category 1.
Fibromyalgia syndrome	Morning stiffness/fatigue Widespread myalgias Tender points Disturbed sleep pattern Normal ESR.CK No clinical weakness	Patient education Low dose tricyclic antidepressants Simple analgesia Lifestyle counselling	Uncertain diagnosis - category 3. Multidisciplinary rehabilitation – category 4.

Further Information Required?
Access the Ministry of Health Resident Medical Officers guide @ http://axil.wave.co.nz/pages/jgill/moh/