Referral Guidelines: Rheumatology

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Arthritis
- Acute Single Joint Inflammation (Monoarthritis)

Inflammatory Arthritis
- Rheumatoid Arthritis
- Psoriatic Arthritis and Seronegative Spondyloarthropathy

Non-inflammatory bone and joint disease
- Osteoporosis / Metabolic Bone Disease
- Musculoskeletal Rheumatism
- Osteoarthritis
- Back Pain

Lupus, Scleroderma, Connective Tissue Diseases & Vasculitis
- Systemic Lupus Erythematosus
- Suspected Autoimmune Connective Tissue Disease & Vasculitis
- Polymyalgia and Giant Cell Arthritis

Musculoskeletal Pain Syndromes
- Fibromyalgia
- Complex Regional Pain Syndromes

Services not provided:
Management of cases with third-party payer involvement e.g. TAC, Workcover

PLEASE NOTE: All referrals received by Monash Health are triaged by clinicians to determine urgency of referral.

- Patients assessed as having an urgent need are offered an appointment within thirty days as assessed by the clinician.
- Patients assessed as having a non-urgent need for appointments in clinics where there is no waiting list, are offered an appointments within four months on a “treat in turn basis”.
- Patients assessed as having a non-urgent need for appointments in clinics that have a waiting list, referrers and patients will be notified of the expected wait times. Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at http://humanservicesdirectory.vic.gov.au/Search.aspx

IMPORTANT:
The following information is mandatory:

Demographic:
- Full name
- Date of birth
- Next of kin
- Postal address
- Landline & mobile number
- Medicare number
- Referring GP details
- Usual GP (if different)
- Interpreter requirements

Clinical:
- Reason for referral
- Duration of symptoms
- Management to date and response to treatment
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Family history
- Diagnostics as per referral guidelines

HEA D OF UNIT
Professor Eric Morand

DEPUTY HEAD OF UNIT
Professor Michelle Leech

PROGRAM MEDICAL DIRECTOR
Associate Professor Andrew Block

OUTPATIENT ENQUIRIES
(Access Unit)
P: 1300 342 273
F: (03) 9594 2273

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**Arthritis**

**Patient presentation**

**Acute single joint (Monoarthritis)**
- Gout, pseudo gout, septic arthritis, haemarthrosis,

- **Evaluation:** Hot, red swollen joint(s), presence of pyrexia or other signs of infection.
- **Aspiration mandatory**
- Diagnosis of gout and pseudogout is made by examination of joint fluid by polarised light microscopy
- Consider Blood tests: FBC, ESR, CRP, Uric acid, blood cultures
- Do not delay referral to await lab results if septic joint suspected

**WHEN TO REFER**
- All patients with acute inflammatory Monoarthritis require joint aspiration for exclusion of bacterial infection.
- Patients with gout should be referred if multiple attacks, especially if refractory to therapy

**Initial GP Work Up**

- Joint aspiration is mandatory
- Gout: initiate non steroidal inflammatories unless contraindicated; consider oral, IM or intra articular steroid
- Allopurinol is not appropriate for the treatment of initial episode of gout
- In general, do not stop allopurinol therapy during an acute attack once patient has commenced therapy

**Management Options For GP**
# Inflammatory Arthritis and Systemic Inflammatory Disease

## Patient Presentation

### Rheumatoid Arthritis
- Polyarticular
- Inflammatory (morning stiffness, relieved with use)
- Associated constitutional symptoms
- Family history, history of smoking

### Psoriatic Arthritis and Seronegative Spondyloarthropathies
- Can be mono, oligo, or polyarticular
- Inflammatory (morning stiffness, relieved with use)
- Associated constitutional symptoms
- Family history

## Initial GP Work Up

- Evaluation: symptoms and signs suggesting inflammatory arthritis: effusion/swelling, early morning stiffness, gel phenomenon.
- Consider Blood tests: FBC, ESR, CRP, ant-CCP (RhF is not needed in addition)
- Lab tests may be normal

## Management Options For GP

- Consider non-steroidal anti-inflammatory drugs for symptom relief unless contraindicated
- Disease-modifying anti-rheumatic drug therapy is generally recommended in all patients. Rheumatologist assessment is recommended prior to institution of such therapy
- Management of cardiovascular risk factors is essential

## When to Refer

All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies. If urgent review is required, please call the Rheumatology Registrar.

The Monash Psoriatic Arthritis Clinic runs in conjunction with the Dermatology Clinic, allowing a single point of care.
## Non-inflammatory bone and joint disease

### Patient Presentation

**Osteoporosis / Metabolic Bone Disease**
- Post menopausal osteoporosis
- Secondary osteoporosis (inflammatory arthritis, steroid therapy)
- Low impact fracture

**Initial GP Work Up**
- History: family history, age at menopause, fracture, dietary Ca2+, steroid therapy
- Exam: vertebral deformity
- Investigations: BMD (dxa), Vitamin D XR, Ca, PO4, thyroid, U&Es, LFT, androgens in males
- Consider pathological fracture

**Management Options For GP**
- Consider antiresorptive therapy if incident fracture.
- Dietary and exercise advice.
- Cessation of smoking, limiting alcohol.
- Optimise dietary Ca and consider supplementing Vit D 3

### WHEN TO REFER
- Management of complicated or atypical presentations

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**Musculoskeletal Rheumatism**
- Shoulder pain/Rotator cuff
- Adhesive capsulitis/Frozen Shoulder
- Epicondylitis
- Trochanteric bursitis
- Carpal tunnel syndrome
- Plantar Fascitis

**Initial GP Work Up**
- History: trauma, occupation, pain pattern
- Exam: normal, passive ROM
- Clinical diagnosis
- Investigations: FBC, ESR, XR if fails to settle

**Management Options For GP**
- Local injection therapy including imaging-guided if needed
- NSAID
- Physio of value especially ROM and strengthening exercises

### WHEN TO REFER
- Cases refractory to simple approaches including NSAID and steroid injection can be referred.

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**Osteoarthritis**
- Chronic joint pain
- Lack of inflammatory features

**Initial GP Work Up**
- Establish diagnosis
- Exclude inflammatory disease: CRP

**Management Options For GP**
- Education (Arthritis Foundation)
- Physical therapy
- Self management skills
- Orthotic assessment
- Simple analgesia

### WHEN TO REFER
- Osteoarthritis is usually best managed in the community. When pain and loss of function become limiting, surgery is usually required (Orthopaedic referral). Rheumatology can offer help if the differential diagnosis is uncertain (eg overlapping inflammatory symptoms) or if surgery is medically contraindicated
- Intra-articular steroid injections and arthroscopy have been demonstrated to be ineffective in osteoarthritis; patients should generally not be referred in expectation of such interventions

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Patient Presentation

Back pain
- Acute back pain after causative event, eg twisting injury
- Chronic back pain
- Radicular symptoms
- Limb motor or sensory findings
- Inflammatory back pain, eg spondyloarthropathy

Initial GP Work Up
- Are symptoms localised or is there referred pain?
- ‘Red flag’ symptoms: weight loss, PR bleeding, night pain, fevers/rigors, cough/haemoptysis, history of malignancy
- Consider Blood tests: FBC, ESR, CRP, LFT, Ca++
- Lab tests may be normal
- Plain radiographs of the spine are not indicated for most cases of back pain

Management Options For GP
- Consider simple analgesia or non steroidal inflammatories for symptom relief unless contraindicated
- Refer if significant referred pain or if any motor or sensory signs
- Most referrals for back pain require a physiotherapy/rehab approach, not medical therapy, unless there is diagnostic doubt. Consider a referral to a primary physiotherapy clinician instead of rheumatology.
- Monash Rheumatology does not have priority access to physiotherapy services.
- MRI scanning is not a routine part of the assessment of back pain at Monash Health

WHEN TO REFER
- Acute neurological signs (motor or sensory loss) should prompt early assessment, potentially via Emergency Department.
- Presence of ‘red flag’ symptoms should prompt early investigation and assessment.
# Lupus, Scleroderma, Connective Tissue Diseases and Vasculitis

## Patient Presentation

**Systemic Lupus Erythematosus**
- Systemic lupus erythematosis – multisystem inflammatory presentation often with arthritis, rash, anaemia
- Scleroderma (systemic sclerosis) – Raynaud’s, dysphagia, skin tightening, telangiectasia
- Autoimmune Connective tissue disease (e.g., Raynaud’s phenomenon, photosensitive rash, arthritis, serositis or proteinuria with positive ANA)

## Initial GP Work Up

- Always check the urine and BP
- Lab investigations which should be performed prior to referral include:
  - ANA
  - DsDNA
  - MSU (urinalysis, M&C)
  - FBE
  - ESR
  - U&E

## Management Options For GP

- Specific treatments depend on the specific problems identified; Immunosuppression is not required in all cases
- Correct early diagnosis is essential
- Life threatening complications include pulmonary arterial hypertension, interstitial lung disease, glomerulonephritis
- Scleroderma renal crisis presents with malignant hypertension and is an emergency

## WHEN TO REFER

- Monash Rheumatology provides a diagnostic service as well as management guidance. Patients with symptoms, or lab results, highly suggestive of SLE or a connective tissue disease, where a diagnostic opinion is required, may therefore also be referred
- If suspected pulmonary arterial hypertension, interstitial lung disease, or glomerulonephritis, please page Rheumatology Registrar to arrange early review.
- Scleroderma renal crisis presents with malignant hypertension and is an emergency. Patient should be urgently referred to the ED

**Monash Lupus and Vasculitis clinics run in conjunction with nephrology, allowing a single point of care**

## Suspected Autoimmune Connective Tissue Disease or Vasculitis

- SLE (uncommon)
- Others are rare:
  - Scleroderma
  - Polymyositis
  - Sjogren’s Syndrome
  - Vasculitis
  - Giant Cell Arteritis
  - 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. Visual fields in case of suspected GCA.
- Reasonable initial investigations:
  - FBC, ESR, CRP, U&Es, LFTs, CK, ANCA, ANA
  - MSU, CXR
- Chronic low grade autoimmune disease should receive specialist opinion prior to initiation of therapy
- Acute vasculitis syndromes may be life threatening. Telephone Rheumatology Registrar or refer to ED
- Giant cell Arteritis can result in blindness. If high index of suspicion, commence prednisolone 30-60 mg/day and arrange immediate transfer to ED

## WHEN TO REFER

- Acute vasculitis syndromes and suspected giant cell arteritis should be referred to ED or to Rheumatology Registrar immediately on suspicion
- Chronic or lower grade autoimmune diseases need careful diagnostic workup prior to initiation of therapy. Rapid referral to a Rheumatology clinic would be expedited by a call to the Rheumatology Registrar
- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease
### Patient Presentation

**Polymyalgia and Giant Cell Arthritis**
- Shoulder and hip girdle pain and stiffness
- Prominent early morning stiffness in the shoulder & hip girdle
- Headache with scalp tenderness, jaw claudication
- Visual loss (emergency)

### Initial GP Work Up
- Raised ESR/CRP, normal CK
- Exclude malignancy (clinical history and examination)

### Management Options For GP
- PMR: therapeutic trial of medium dose Prednisone (15-20mg daily) for PMR can be considered. Immediate and complete resolution of symptoms is expected in PMR.
- GCA: Symptoms of giant cell arteritis mandate urgency. Patient should be seen in Emergency Department for urgent biopsy and treatment

### WHEN TO REFER
- If GCA is suspected please page the on-call rheumatology registrar for immediate assessment. Referral for outpatient management is not appropriate.
- In suspected PMR, if symptoms are not immediately and completely relieved by low-dose prednisolone (15-20 mg/day), patient should be referred or diagnosis reconsidered.
## Musculoskeletal pain syndromes

### Patient Presentation

<table>
<thead>
<tr>
<th>Fibromyalgia and Chronic regional pain syndromes</th>
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<tbody>
<tr>
<td>- Fibromyalgia (FMS) – diffuse soft tissue pain and tenderness, often with fatigue</td>
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<tr>
<td>- Complex regional pain syndromes (reflex sympathetic dystrophy, causalgia) – similar but regional presentation e.g. one limb</td>
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</tbody>
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### Initial GP Work Up

| - Consider medical causes of fatigue, myalgia, eg hypothyroid, depression  |
| - Exclude statin myopathy and Vitamin D deficiency as reversible causes  |
| - History of trauma, sleep disturbance, psychosocial evaluation important.  |
| - Examination – tenderness to pressure in non-articular sites, tender points, pain behaviours  |
| - Investigations - FBC/ESR/U&Es/Vit D/CK  |
| - NB: FMS can exist with other conditions |

### Management Options For GP

| - Explore psychosocial issues  |
| - Increased aerobic fitness, especially with water-based exercise  |
| - Emphasis on self management  |
| - Involve multidisciplinary approach e.g. CBT via clinical psychologist  |
| - Low dose tricyclic antidepressants / gapapentin/simple analgesia  |
| - Avoid narcotic analgesia |

### WHEN TO REFER

- Monash Rheumatology does not offer a multidisciplinary team for the care of fibromyalgia. Expert rheumatologists with a research interest in fibromyalgia staff a weekly fibromyalgia clinic for medical advice. Community based care is emphasised and most patients are returned to the community.

- Fibromyalgia can be a chronic condition. If it has been diagnosed by a rheumatologist, management by that rheumatologist rather than by Monash Health is recommended. Monash fibromyalgia clinic has very long wait times for new patients.