South East London Integrated Care System

South East London Acute Provider Collaborative

South East London Integrated Care Board

Triage Guidelines for Orthopaedic optimisation pathway (based on Musculoskeletal (MSK) referral) V6.0

NHS Guy's and St Thomas' NHS Foundation Trust
NHS King's College Hospital NHS Foundation Trust
NHS Lewisham and Greenwich NHS Trust

Approved by: Acute Provider Collaborative (APC), South-East London ICB

Date approved: 11 October 2024

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Name of responsible committee/individual:
APC, South-East London ICB

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Description:
Clinical guidelines to support triage of referrals from primary care into the MSK pathway

Target audience:

- Stakeholders in the MSK Pathway
- Stakeholders engaged in development or review:
- Oxleas NHS Foundation Trust
- Guys and St Thomas NHS Foundation Trust
- Kings College NHS Foundation Trust
- Circle Health Group
- Lewisham and Greenwich NHS Trust
- Vita Health Group
- Dr Nuala Hale GP Clinical Lead

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Change/amendment: Adapted to suit the new orthopaedic optimisation pathway, does not include spines and chronic pain

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MSK clinical triage guidelines for south east London

- These MSK triage guidelines are for non-trauma benign MSK conditions excluding spines. Please note trauma is *"an identifiable acute event, resulting in pain, swelling and functional impairment, either as single component, or in combination"*
- These MSK triage guidelines have been produced to reduce unwarranted variation, to improve patient experience and clinical outcomes. They will support the orthopaedic GIRFT pathways to ensure all patients referred to orthopaedics have had evidence based first line treatments, appropriate imaging and Shared Decision Making.
- These MSK triage guidelines have been developed collaboratively with clinicians from across south-east London and are based upon the guidelines created by clinicians at Guy's and St Thomas NHS Foundation Trust. **They provide general advice and do not replace a clinician's responsibility to assess each clinical case and information provided on the referral form.**
- These MSK triage guidelines are also intended to guide the use of diagnostic imaging for primary care and support the clinically effective use of x-ray, MRI and ultrasound based on clinical need.

Training and Support

- All clinicians undertaking triage should receive training for their role and have access to regular supervision to discuss cases.
- All Physiotherapy teams should have access to discuss complex cases with an APP or senior clinical staff and access to MDTs. This removes the requirement for many service user conditions to be referred into APP or orthopaedic clinics directly and is reflected in these guidelines.
- (Access to MDT is not an alternative to referral for cases, but used to discuss cases that fall outside guidelines or please refer to your local MDM SOP)

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Acknowledgements

Thank you to the staff of Guys and St Thomas Orthopaedics and MSK team for sharing their vetting grid which formed the basis of this document.

Primary care imaging

Primary care referrers can refer to national guidance regarding appropriate use of diagnostic imaging.

Osteoarthritis

- Do not routinely use imaging to diagnose osteoarthritis unless there are atypical features that suggest an alternative or additional diagnosis (e.g. malignancy, fracture, or inflammatory arthritis).

Lower Limb

- Only consider MRI in specialist settings (e.g. APP or orthopaedics) for meniscal injuries if it is likely to change the management. MRI is considered on clinical need and local pathways. The threshold for MRIs can be a local consideration within APP clinics.
- Use Ottawa rules to identify those requiring imaging up to seven days following trauma to the knee, foot, or ankle.

Upper Limb

- Consider antero-posterior and lateral/axillary shoulder x-rays if:
  - There is a history of trauma.
  - The person is not improving with conservative treatment or symptoms are lasting more than 4 weeks (British Elbow and Shoulder Society).
  - Movement is severely restricted.
  - There is severe pain persisting for greater than 3 weeks and unresponsive to simple analgesia.
  - Any red flags are present.

Shared Decision Making

- Referrals made by primary care clinicians to MSK services should involve a shared decision-making process with service users to identify the most appropriate as well as clinically effective service for their needs.
- Service-users referred for elective surgical procedures should be assessed by primary care as fit enough and willing to consent to the procedure for which they are referred. Use NHSE decision aids or Versus Arthritis Decision tools
- Support for healthy lifestyle and behaviours should be discussed as part of a shared decision-making process with service users by Primary Care clinicians to facilitate successful navigation of the pathways. Such services may involve:
  - Weight-loss services
  - Smoking cessation services
  - Social Prescribing
  - IAPT referrals
  - Drug management services

Prioritisation

Urgent referral criteria

- patients who have had recent surgery/procedure requiring rehabilitation and/or
- patients who have had a recent injury, fracture or dislocation requiring rehabilitation and/or
- patients with acute and/or complex needs with high levels of pain leading to significant loss of function and/or disturbed sleep, and/or an inability to work or undertake care responsibilities.

Hip

Imaging in primary care

Do not routinely use imaging to diagnose osteoarthritis unless there are atypical features that suggest an alternative or additional diagnosis (e.g. malignancy, AVN, fracture or inflammatory arthritis) (NG226) (Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE)

Referral triaged to Physiotherapy

1. MSK hip complaint with no previous F2F Physiotherapy OR previous good response.
2. Soft tissue injury without significant weakness/ disability
3. Rehabilitation post fracture (If not appropriate to continue care under initial fracture provider)
4. Greater Trochanter Pain Syndrome

Referral triaged to Advanced Physiotherapy Practitioner (APP)

for consideration of imaging or injection

1. Musculoskeletal hip complaint and lack of response to a course of F2F physiotherapy
2. History of paediatric pathology - Perthes/ SUFE/ DDH
3. Soft tissue injury with suspicion of tear based on clinical symptoms from primary care and examination to give a more precise structural diagnosis +/- imaging.

Referral triaged to Orthopaedics

Elective surgery referrals should be assessed by MCATTs or clear indications from GP referral as fit and willing to undergo surgery.
All patients need X-rays prior to referral to orthopaedics for consideration of joint arthroplasty. X-ray should be no more than 12 months old

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Urgent

1. Known Avascular Necrosis (AVN) head of femur, X-ray or MRI proven.

Routine

1. Previous surgery
   a. Arthroplasty
   b. Other surgery such as pelvic or femoral surgery under orthopaedics within 1 year.
2. Severe OA confirmed on x-ray causing functional limitation and previous unsuccessful F2F physiotherapy patient keen to explore surgery & should be fit for surgery.
   Severe OA documented and not suitable for surgery (please see NICE NG56 for definition of comorbidities, see below or patient preference for nonsurgical management). Be aware that multimorbidity refers to the presence of two or more long-term health conditions, which can include:
   - defined physical and mental health conditions such as diabetes or schizophrenia
   - ongoing conditions such as learning disability
   - symptom complexes such as frailty or chronic pain
   - sensory impairment such as sight or hearing loss
   - alcohol and substance misuse.
3. History of THR and suspicion of loosening prosthesis
4. Confirmed Femoroacetabular impingement and no response to physiotherapy rehabilitation.

Referral triaged to Rheumatology

1. Known or suspected rheumatological disease e.g. RA/Spondyloarthritis as part of a multi-joint presentation
2. Suspected Polymyalgia Rheumatica with shoulder girdle involvement and bilateral presentation- advice referrer to use the rheumatology advice and guidance facility through e-RS or consultant connect' in the first instance and refer to the SE London guidance.

Knee

Imaging in primary care

- Do not routinely use imaging to diagnose osteoarthritis unless there are atypical features that suggest an alternative or additional diagnosis (e.g. malignancy, fracture or inflammatory arthritis).
- This is based on clinical judgement and will follow the guidelines if a different diagnosis apart from OA is considered.
- Only consider MRI in specialist settings (e.g. APP or orthopaedics) for meniscal injuries if it is likely to change the management such as meniscal root tears in younger and middle-aged individuals. Need for MRIs is based on clinical and physical assessment in APP clinics
- Use Ottawa rules to identify those requiring imaging up to seven days following trauma to the knee

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Referral triaged to Physiotherapy

1. Anterior knee pain if no previous physiotherapy input.
2. Suspected or imaging confirmed degenerate meniscal tear (horizontally oriented meniscal tear) with no locking and catching.
3. Non traumatic mechanical knee pain e.g. *tendinopathy, bursitis*
4. Early or moderate OA +/-previous injection.
5. Severe OA documented and not suitable for surgery (please see NICE NG56 for definition of comorbidities, see below or patient preference for nonsurgical management). Be aware that multimorbidity refers to the presence of two or more long-term health conditions, which can include:
   - defined physical and mental health conditions such as diabetes or schizophrenia
   - ongoing conditions such as learning disability
   - symptom complexes such as frailty or chronic pain
   - sensory impairment such as sight or hearing loss
   - alcohol and substance misuse.

Referral triaged to Advanced Physiotherapy Practitioner (APP)

1. Anterior Knee Pain / mechanical knee pain not responding to a course of physiotherapy.
2. Clinically suspected degenerate meniscal tear and no locking or giving way.
3. Early to moderate OA & unable to tolerate exercise due to pain - *possibly for injection*.
4. Persistent effusion with/without trauma (not imaged).
5. Soft tissue injury with suspicion of tear without significant instability or reduced activity from normal levels. Acute isolated ACL disruption in individuals over 45 can be referred to APP clinics for a trial of a 3 month ACL rehabilitation and refer to orthopaedics if dysfunction persistent.

Referral triaged to Orthopaedics

Elective surgery referrals should be assessed by MCATTs or clear indications from GP referral as fit and willing to undergo surgery.
Please ensure prior to referral to Orthopaedics patient will have had weight bearing x-rays for OA and MRI for soft tissue knee. X-ray should be no more than 12 months old

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Urgent via hot knee clinic - please check if this clinic is available to triage into.

1. Acute locked knee/ Confirmed meniscal tear in patients up to 45 years, in active individuals, or those who are involved in manual labour
2. New ACLD confirmed on MRI <45.
3. Combined ACL tears and meniscal tears
4. Confirmed AVN by X-ray and/or MRI scan
5. Confirmed osteochondral defect (OCD) causing severe disability - Xray or MRI scan.

Routine

1. 6 weeks MCL or LCL injury with instability. LCL disruption, with varus rotation laxity should be urgent referral, along similar lines to acute ACL disruption
2. Previous surgery with ongoing pain from arthroplasty or other surgery within 1 year.
3. Confirmed degenerate meniscal tear with mechanical symptoms (such as recurrent locking, giving way, or catching) not improved with F2F physiotherapy.
4. History of TKR over 1 year ago and suspicion of prosthetic loosening.
5. Known soft tissue injury with instability e.g. ACL/ PCL, collaterals.
6. Severe OA x-ray confirmed causing functional limitation and previous unsuccessful F2F physiotherapy, patient keen to explore surgery.

Referral triaged to Rheumatology

1. Known or suspected rheumatological disease e.g. Spondyloarthritis as part of a multi-joint presentation.
2. If a crystal arthritis such as CPPD or Gout is suspected advise referrer to use Rheumatology- refer to the SE London guidance in the first instance.
3. Confirmed knee synovitis with suspicion of underlying inflammatory condition such as RA, Psoriatic Arthritis, or autoimmune condition e.g. Lupus.

Foot and ankle

Imaging in primary care

- Do not routinely use imaging to diagnose OA unless there are atypical features that suggest an alternative or additional diagnosis (e.g. malignancy, fracture or inflammatory arthritis)
- Use Ottawa rules to identify those requiring imaging up to seven days following trauma to the ankle

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Referral triaged to Physiotherapy or MSK Podiatry

Soft tissue and no previous F2F MSK physiotherapy/podiatry OR previous good response.

1. Ankle instability –no previous F2F physiotherapy OR previous good response.
2. Acute soft tissue injuries e.g. *calf strain, ATFL sprain*.
3. Medial tibial stress syndrome.
4. Ankle impingement -no previous F2F physiotherapy OR previous good response.
5. Early/moderate OA ankle/foot.
6. Rehabilitation post fracture.

Referral triaged to MSK Podiatry or Foot Health Team where applicable

1. Morton's neuroma- no previous F2F MSK podiatry OR previous good response.
2. Metatarsalgia/bursitis/ capsulitis- no previous F2F MSK podiatry OR previous good response.
3. Peripheral neural entrapment /neuropathy- no previous F2F MSK podiatry OR previous good response.
4. Flat foot/ foot posture requiring orthotic assessment- no previous F2F MSK podiatry OR previous good response.
5. Tibialis Posterior dysfunction without deformity. Tib Post dysfunction should be referred to ortho F&A, prior to development of fixed deformity
6. Tendinopathies of the foot/ ankle.
7. OA – no previous F2F podiatry OR previous good response.
8. Plantar plate tear over 6 weeks duration.

Referral triaged to Advanced Physiotherapy Practitioner (APP)

1. Soft tissue pathology and unsuccessful F2F MSK physiotherapy/ podiatry.
2. Instability and unsuccessful F2F MSK physiotherapy/ podiatry.
3. Post traumatic ankle/ foot pain and unsuccessful F2F MSK physiotherapy/ podiatry.
4. Unspecified mechanical foot/shin/ankle pain and unsuccessful F2F MSK physiotherapy/ podiatry.
5. Degenerative tear -*e.g. tibialis posterior, plantar plate tear (no imaging).*
6. Tibialis Posterior dysfunction with deformity and no previous imaging or treatment.
7. Morton's neuroma- injection required and unsuccessful MSK F2F physiotherapy/ podiatry. (This is based on local service provision)
8. Metatarsalgia/bursitis/ capsulitis and unsuccessful F2F MSK physiotherapy/ podiatry.
9. Peripheral neural entrapment /neuropathy and unsuccessful F2F MSK physiotherapy/ podiatry. Peripheral neural entrapment confirmed by EMG should be considered for referral F&A for release.

Referral triaged to Fracture Clinic

1. Acute Plantar plate tear (<6 weeks).
2. Acute Stress fracture suspected or proven on MRI imaging.
3. AVN of foot/ ankle.
4. Acute tendon rupture.

Referral triaged to Specialist Foot Service/Podiatric Surgery- forefoot and midfoot only (where applicable)

1. Hallux valgus/tailor's bunion and unsuccessful F2F MSK podiatry.
2. Hallux Limitus/ rigidus and unsuccessful F2F MSK podiatry.
3. Toe deformities and unsuccessful F2F MSK podiatry/APP consultation.
4. Neuroma and unsuccessful F2F MSK podiatry / APP consultation.
5. Plantar plate disruption proven on imaging and unsuccessful podiatry.
6. Pain from osteophytes/ exostosis and unsuccessful podiatry / injection.
7. Ganglion/ bursa/ cyst and unsuccessful MSK podiatry / APP consultation.
8. Foot and ankle pain related to previous surgery (less than one year)

Referral triaged to Orthopaedics

Elective surgery referrals should be assessed by MCATTs or clear indications from GP referral as fit and willing to undergo surgery. X-ray should be no more than 12 months old

Urgent

1. Confirmed tendon tear post trauma *(e.g. peroneal split, tib post) – send to fracture clinic if acute.*

Routine

1. Foot and ankle pain related to previous surgery (less than one year).
2. Hallux valgus with significant pain/ functional disability and unsuccessful MSK podiatry.
3. Severe OA with functional limitation and unsuccessful MSK physiotherapy/ podiatry.
4. Known stage two, three and four Tibialis Posterior dysfunction and unsuccessful F2F physiotherapy/ podiatry.
5. Ongoing plantar plate disruption and unsuccessful with podiatry.

Referral triaged to Patient Appliances/Community foot health clinics

1. Leg length discrepancies requiring correction of over one 1cm.
2. Complex braces not provided within services.
3. Specific custom-made footwear or replacements/ adjustments.

Referral triaged to Rheumatology

1. Known or suspected rheumatological disease e.g. Spondyloarthritis and multi-joint presentation.
2. Suspected Polymyalgia Rheumatica and over the age of 50 years +/- hip girdle symptoms advice referrer to use the rheumatology advice and guidance facility through e-RS or consultant connect' in the first instance and refer to the SE London guidance.
3. Dactylitis.
4. Confirmed ankle/foot synovitis.

Referral triaged to High Risk foot service

1. Osteomyelitis (e.g. in diabetic foot).
2. Charcot foot.
3. Diabetic foot complications.

Shoulder and Elbow

Imaging in primary care

- Do not routinely use imaging to diagnose osteoarthritis unless there are atypical features that suggest an alternative or additional diagnosis
- Consider antero-posterior and lateral/axillary shoulder x-rays if:
  - There is a history of trauma
  - The person is not improving with conservative treatment or symptoms are lasting more than 4 weeks (BESS)
  - Movement is severely restricted
  - There is severe pain
  - Any red flags are present
- Ultrasound or MRI should only be requested by APPs or secondary care services if expected to change the management pathway (BESS)

Referral triaged to Physiotherapy

1. Mechanical shoulder pain without consistent night pain OR pain at rest.
2. Mechanical elbow pain *e.g. bursitis*.
3. 1st time shoulder dislocation (over 18 years old) –no trauma & no neurology OR post trauma and have been seen in A&E/MIU/fracture clinic.
4. Rehabilitation post fracture.
5. Rehabilitation of multidirectional dislocation.
6. Proven full thickness rotator cuff tear and not wanting/ not suitable surgery.

Referral triaged to Advanced Physiotherapy Practitioner (APP)

1. Shoulder capsulitis – unsuccessful previous F2F physiotherapy OR injection.
2. Mechanical shoulder or elbow pain & unsuccessful F2F physiotherapy and/or previous injection e.g. RC related shoulder pain, lateral epicondylitis.
3. Confirmed (MRI/US) partial thickness cuff tear with pain and disability.
4. Proven (MRI/US) full thickness rotator cuff tear and not wanting/ not suitable and requiring injection to aid progress.
5. Shoulder pain with:
   a. Pain at rest
   b. Night pain
6. Shoulder pain + unsuccessful injection (NOT capsulitis).
7. Suspected cuff tear.
8. Known OA/ tendinopathy and unsuccessful F2F physiotherapy- consider injection.

Referral triaged to Orthopaedics

Elective surgery referrals should be assessed by MCATTs or clear indications from GP referral as fit and willing to undergo surgery.

Urgent/Hot Clinic/Fracture Clinic

a. Shoulder dislocation with neurology.
b. Proven **acute** full thickness rotator cuff tear and considering/suitable for surgery.
c. Biceps tear

Routine

1. Previous surgery:
   a. Arthroplasty
   b. Other surgery within one year
2. Recurrent (more than 1) shoulder dislocations. Single dislocations with persisting subluxation/subclinical instability events.
3. Capsulitis – unsuccessful F2F physiotherapy and/or injection.
4. Known OA proven on x-ray GHJ or ACJ unsuccessful conservative Rx and injection.
5. Proven **chronic** full thickness rotator cuff tear and considering surgery (age<60 repair/arthroplasty).
6. Known AVN humeral head.
7. Failed Conservative management +/- injections lateral epicondylitis/medial epicondylitis/OA and willing to undergo and is fit for surgery.
8. Instability PLRI of the elbow.
9. Severe Elbow OA - and willing to undergo and is fit for surgery.
10. Ulnar neuropathy unresponsive to conservative requiring ulnar nerve release. Earlier referral, if progressive hand dysfunction such as clawing.

Referral triaged to Rheumatology

1. Known or suspected rheumatological disease e.g. Spondyloarthritis and multi-joint presentation.
2. Suspected Polymyalgia Rheumatica and over the age of 50 years +/- hip girdle symptoms advice referrer to use the rheumatology advice and guidance facility through e-RS or consultant connect' in the first instance and refer to the SE London guidance.
3. Confirmed shoulder synovitis.
4. Gout (Elbow olecranon bursitis/Tophus) - Advise referrer to use Rheumatology- refer to the SE London guidance in the first instance.

Wrist and hand

Imaging in primary care

- Do not routinely use imaging to diagnose osteoarthritis unless there are atypical features that suggest an alternative or additional diagnosis (e.g. malignancy, fracture or inflammatory arthritis)
- X-ray should be considered after trauma is there is pain or tenderness over the scaphoid bone.
- MRI and ultrasound imaging should only be considered by MCATTS or secondary care services.

Referral triaged to Hand Therapy/ Physiotherapy

1. OA MCP / IP / 1st CMC / ST joint / RC joint.
2. De Quervain's tenosynovitis -no previous treatment.
3. Soft tissue injury >6 weeks with normal X-ray.
4. Wrist tendinopathy.
5. Wrist pain atraumatic.
6. Carpal Tunnel Syndrome and patient wants conservative treatment and has trialled night splint for 8 weeks with following symptoms:
    a. Symptoms only at night OR (b) intermittent symptoms during the day
7. Ulnar neuropathy (elbow/wrist)
    a. Symptoms only at night OR (b) intermittent infrequent symptoms during the Day

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Referral triaged to Advanced Physiotherapy Practitioner (APP)/APP injection clinic

1. OA MCP/IP/ RC joint & unsuccessful F2F hand therapy/ physiotherapy.
2. Soft tissue injury and unsuccessful F2F hand therapy/ physiotherapy.
3. Wrist trauma > six weeks post injury & unsuccessful F2F hand therapy/ physiotherapy.
4. Wrist pain atraumatic and unsuccessful F2F hand therapy/ physiotherapy.
5. Ulnar neuropathy (elbow/hand) not responding to splinting.
6. Trigger finger/thumb.
7. De Quervain's and unsuccessful Hand Therapy/Physiotherapy OR requesting injection.
8. Mild/moderate OA 1st CMC.
9. OA MCP/DIPJ/PIPJ preferably USS guided if available.
10. Isolated mechanically induced Tenosynovitis of one flexor tendon or extensor compartment in the absence of broader inflammatory condition indicators and unsuccessful Hand Therapy/Physiotherapy OR requesting injection.
11. Degenerative TFCC (Triangular Fibro Cartilage Complex).
12. Carpal tunnel not responded to activity modification and splinting and does not want to pursue surgery following shared decision-making process:
    a. No wasting, no weakness
    b. Mildly +ve nerve conduction studies
    c. Frequent day symptoms

Referral triaged to Hands and Plastics/ Orthopaedics

Elective surgery referrals should be assessed by MCATTs or clear indications from GP referral as fit and willing to undergo surgery.

Urgent

1. Hand trauma <six weeks
2. Wrist trauma < six weeks to Orthopaedics only.
3. Carpal tunnel syndrome & any of the below with patient wanting surgical solution
    a. Moderate/severe on NCS
    b. Sensory loss
    c. Motor loss thumb abduction
    d. Mild to mod symptoms and unsuccessful conservative management with splints and injections

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Routine

1. Trigger finger/thumb & unsuccessful injections x2.
2. De Quervain's tenosynovitis and unsuccessful injections x2.
3. OA 1st CMC/RC/MCP/IP and unsuccessful conservative management including injection.
4. Ulnar neuropathy (elbow/wrist) & any of the following:
    a. Motor loss / clawing (b) Constant sensory loss (c) Significant wasting
5. Dupytren's Contracture impacting on function (greater than 30 degrees).
6. Seed ganglion and/or mucous cyst proven on MRI imaging if it meets the SEL Treatment Access Policy (July 2024)

Referral triaged to Rheumatology

1. Known rheumatological disease or suspected e.g. RA/ Psoriatic arthritis.
2. Suspected Polymyalgia Rheumatica and over the age of 50 years +/- hip girdle symptoms advice referrer to use the rheumatology advice and guidance facility through e-RS or consultant connect' in the first instance and refer to the SE London guidance.
3. New onset of symptoms in multiple small joints- refer to Urgent Early Arthritis Pathway.
4. Known or suspected connective tissue disease e.g. SLE.
5. Confirmed wrist / hand joint synovitis.
6. Dactylitis

Definitions Glossary

ACL	Anterior Cruciate Ligament
ACLD	Anterior Cruciate Ligament Distruption
ASAS	The Assessment of Spondyloarthritis International Society
ACJ	Acromio Clavicular Joint
APP	Advanced Practice Physiotherapist
AVN	Avascular Necrosis
CMC	Carpometacarpal
Cx	Cervical
DDH	Developmental Dysplasia of the Hip
F2F	Face-to-Face
GHJ	Gleno Humeral Joint
IP	Inter phalangeal
LCL	Lateral Collateral Ligament
Lx	Lumbar
MCL	Medial Collateral Ligament
MCP	Metacarpal phalangeal
NCS	Nerve Conduction Studies
OA	Osteoarthritis
OCD	Osteochondral Defect
PCL	Posterior Cruciate Ligament
RC	Radio carpal
SLE	Systemic Lupus Erythematosus
Sp	Spine
ST	Subtalar
SUFE	Slipped Upper Femoral Epiphysis
WAD	Whiplash Associated Disorder

Meniscal tear.pdf