South East London Integrated Care System

South East London Acute Provider Collaborative

Rheumatology Referral and Triage Guidance for South East London V8.0

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS Lewisham and Greenwich NHS Trust

Trusts included: Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust, King's College Hospital NHS Foundation Trust

Rheumatology is a specialty concerned with the management of multiple chronic complex rheumatic and musculoskeletal disorders requiring specialised medication regimes. Early treatment in these conditions helps prevent long term morbidity and mortality; they include inflammatory arthritis and spondyloarthritis, and the rarer autoimmune rheumatic diseases such as connective tissue diseases and vasculitis. For other non-inflammatory pain conditions including but not limited to osteoarthritis and fibromyalgia, we recommend care is better provided in primary care or may require the input of other services such as physiotherapy.

The COVID-19 pandemic has had in a short period an enormous impact on our healthcare services, including non-acute care services such as Rheumatology. Providing care through this period has highlighted the need for service redesign and streamlining the work stream, ensuring waiting times are kept at a minimum for the complex inflammatory conditions that require early definitive treatment. This guidance is in keeping with the British Society for Rheumatology recommendations for adult rheumatology referrals [(1)].

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Related documents

- South East London Rheumatology Guidance for the Diagnosis and Management of Fibromyalgia
- South East London Quick Guide to Rheumatology Referrals

Relevant external standards

- British Society for Rheumatology: Adult rheumatology referral guidance (2021)
- National Institute for Health and Care Excellence: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (2021)

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Information on making a rheumatology referral

All referrals made to rheumatology in South East London should be made via the electronic Referral System (eRS). A referral letter is required with an appropriate history, examination and background, information as to why the patient needs to be seen in rheumatology secondary care and an indication of urgency; this helps us to vet the patients into appropriate clinics. If there is no referral letter attached, the referral will be automatically rejected until such time that there is appropriate clinical information supplied.

The following investigations should be arranged, and the results must be sent with the original referral if relevant. Note, the results of these may influence urgency of appointment:

- Full blood count
- Renal function (urea, electrolytes and creatinine)
- Liver function tests
- Erythrocyte sedimentation rate (ESR) [within the last 3 months] or C-reactive protein (CRP) [within the last 3 months]

Other tests which may be relevant:

- Rheumatoid factor and anti-CCP antibody (if suspected inflammatory arthritis), Antinuclear antibody (if suspected Lupus), Creatine kinase (if suspected myositis), serum urate level (if suspected complex gout).

For referrals made to the metabolic bone service, a report for any previous DEXA scan(s) done would be helpful. The following investigations would also be helpful, but can be done in the metabolic bone clinic.

- Full blood count
- Renal function (urea, electrolytes and creatinine)
- Liver function tests
- Vitamin D level
- Bone profile
- Parathyroid hormone

Whether the patient requires transport and/or an interpreter for their hospital appointment should also be detailed.

For the following indications we recommend that referral should be made to the rheumatology service in the first instance:

Suspected rheumatoid arthritis

Refer if persistent symptoms for >4 weeks, even with normal ESR/CRP and negative CCP or rheumatoid factor:

- Small joints of the hands or feet
- More than one joint
- Delay of three months or longer between onset of symptoms and seeking medical advice

Suspected psoriatic arthritis and other peripheral spondyloarthritides

- Dactylitis
- Enthesitis without apparent mechanical cause, persistent or in multiple sites or with any of the following:
  - pain without apparent mechanical cause
  - current or past uveitis
  - current or past psoriasis
  - gastrointestinal or genitourinary infection
  - inflammatory bowel disease (Crohn's disease or ulcerative colitis)
  - first-degree relative with spondyloarthritis or psoriasis

Suspected axial spondyloarthritis (inflammatory back pain)

Low back pain that has lasted for >3 months and if four or more of the following additional criteria are also present:

- Low back pain that started before the age of 35 years
- Waking during the second half of the night because of symptoms
- Alternating buttock pain
- Improvement with movement
- Improvement within 48 hours of taking non-steroidal anti-inflammatory drugs
- A first-degree relative with spondyloarthritis
- Current or past arthritis
- Current or past history of enthesitis
- Current or past history of psoriasis

Persistent synovitis /arthralgia (monoarticular/polyarticular) of unknown cause

Suspected autoimmune rheumatic disease / connective tissue disease

Patients with positive antibody results in the absence of symptoms (utilise A&G for such queries):

- Atypical Raynaud's: late onset, digital ulceration
- SLE: rash, photosensitivity, oral ulcers, Raynaud's, joint pains, chest pain (pleuritic/pericarditis), fatigue, low white cells, low platelets, proteinuria, haematuria, raised creatinine, acute sensory or motor loss
- Systemic sclerosis: Raynaud's, puffy fingers, dyspnoea, indigestion, dysphagia

- Inflammatory myopathies: progressive muscle weakness (usually proximal) +/- rashes
- Sjogren's syndrome: dry mouth, dry eyes, parotid or submandibular swelling

Suspected vasculitis

Consider if systemically unwell with raised inflammatory markers in the absence of infection or other explanation. Be alert to evidence of end organ damage, e.g. skin infarction, visual loss, respiratory failure, cardiac failure, acute abdomen, acute kidney injury, acute sensory/motor loss

Other symptoms that might be present:

- Respiratory – haemoptysis, shortness of breath
- Oral health – mouth ulcers
- GUM – genital ulcers
- Renal – haematuria, elevated creatinine
- Ophthalmology – scleritis, visual loss
- ENT – hearing loss, nasal crusting, nosebleeds, sinus pain
- Other possible symptoms include rashes, weight loss, night sweats, fatigue, joint pain

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This is a clinical emergency and should be discussed urgently with the Rheumatologist on call for the trust – please do not refer this through eRS:

Suspected GCA (Giant cell arteritis)

- Age of onset >50 years
- New onset of headache (usually temporal)
- Scalp pain/tenderness/temporal artery abnormalities (reduced/absent pulsation)
- Jaw or tongue claudication
- Visual symptoms, e.g. diplopia, visual field defect, visual loss
- Symptoms of polymyalgia rheumatica (proximal muscle pain and stiffness)
- ESR/CRP typically raised but if clinical history is entirely typical and inflammatory markers are normal, GCA cannot be excluded.

For the following indications, we recommend that these cases are discussed prior to referral via the advice and guidance facility through e-RS or consultant connect:

Gout

(please use the advice and guidance facility through e-RS or consultant connect)

Gout is a condition that can be diagnosed and managed in primary care. Rheumatology input may be needed in the following circumstances:

- Symptomatic despite treatment
- Comorbidities limiting treatment options

Polymyalgia rheumatica

(please use the advice and guidance facility through e-RS or consultant connect)
PMR is a condition that can be diagnosed and managed in primary care. Rheumatology input may be needed in the following circumstances

Atypical features or features that increase likelihood of a non-PMR diagnosis:

- Age <60 years
- Chronic onset (>2 months)
- Lack of shoulder involvement
- Lack of inflammatory stiffness
- Prominent systemic features, weight loss, night pain, neurological signs
- Features of other rheumatic disease
- Normal or extremely high acute-phase response

Treatment dilemmas such as:

- Incomplete, poorly sustained or non-response to corticosteroids
- Inability to reduce corticosteroids
- Contraindications to corticosteroid therapy
- The need for prolonged corticosteroid therapy (>2 years).

Suspected fibromyalgia to confirm diagnosis where there is concern that other inflammatory conditions need to be excluded

(please use the advice and guidance facility through e-RS or consultant connect)

Osteoporosis

(please use the advice and guidance facility through e-RS or consultant connect)

Osteoporosis is a condition that can be diagnosed and managed in primary care. Rheumatology input may be needed in the following circumstances:

- Men aged <65 years
- Pre-menopausal women
- Patients requiring parenteral therapies
- Patients with multiple fractures despite treatment
- Patients with secondary causes.

Paget’s disease

(please use the advice and guidance facility through e-RS or consultant connect)

Conditions not for referral to rheumatology

Clinical Emergencies such as suspected cauda equina syndrome, metastatic cord compression, spinal infection or septic arthritis

Suspected cancers including bone malignancy

- For urgent referral as per local 2WW rule pathways

Patients with positive antibody results in the absence of symptoms

- Please use the advice and guidance facility through e-RS or consultant connect to support decision making

Osteoarthritis

Non-inflammatory back pain

- Refer to local MSK service

Soft tissue disorders

- Refer to local MSK service

Fibromyalgia

- Please follow: South East London Rheumatology Guidance for the Diagnosis and Management of Fibromyalgia

Chronic fatigue syndrome

Hypermobility

In cases of diagnostic uncertainty, please use the advice and guidance facility through e-RS or consultant connect, and we can advise further and assist with making a diagnosis. However, we do not provide long-term ongoing care for patients with fibromyalgia; if the patient has a known diagnosis of fibromyalgia, please do not re-refer to rheumatology for management of the same condition.

Summary of referrals process

All NHS GP referrals must be submitted using the NHS e-Referral Service (e-RS). Referrals sent by email or post from NHS GPs will not be processed. Once the referral is received, the consultant vetting the referral will then decide on whether the patient needs to be seen by Rheumatology in a new face to face appointment, a new virtual appointment [telephone or video] or if the referral is to be rejected with advice. Rejected referrals will give the GP or referrer some direction or advice on further information/investigations needed, or further management. Please note if referrals are rejected it is the GP's responsibility to inform the patient. The hospital does not contact the patient directly with clinical details, other than the administration team cancelling the appointment.

If a patient is already under the care of a Rheumatology service and it is felt a quicker review is needed, please contact the service directly to discuss the patient with the named consultant (via consultant connect, Advice and Guidance or directly via email). Please do not re-refer the patient as this creates confusion and the patient may end up in an incorrect clinic.

If there is a clinical query regarding a referral or advice is needed, then please use the advice and guidance facility through e-RS or consultant connect. Please note that should the advice indicate a patient will need to be seen by Rheumatology, a formal referral through e-RS will then be needed, as the patient cannot directly be booked in for an appointment through consultant connect or Advice and Guidance.

References

(1) Adult rheumatology referral guidance. British Society for Rheumatology. 2021. Available from: https://www.rheumatology.org.uk/Portals/0/Documents/Policy/Adult-rheumatology-referral-guidance.pdf?ver=2021-10-05-142645-127 [Accessed on 11 February 2022]