Rheumatology Referral Guidelines

Department of Health clinical urgency categories for specialist clinics
Urgent: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen within 30 days of referral receipt. For emergency cases, please send the patient to the Emergency department.
Semi Urgent: Referrals should be categorised as Semi Urgent where the patient has a condition that has the potential to deteriorate within 30-90 days.
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.

These guidelines have been set by DHHS: src.health.vic.gov.au

Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes
Ankylosing spondylitis (inflammatory back pain) Direct to an emergency department for: • **New neurological features in a patient with previously diagnosed ankylosing spondylitis** • **Patients with acutely painful, hot, swollen joint(s) especially if febrile** • **Suspected sepsis in a patient with previously diagnosed inflammatory back pain** • **Unexplained illness or fever in a patient being treated with biologic or immunosuppressant**	Inflammatory back pain with onset of symptoms before 45 years, with more than 3 months of symptoms. Patients may also have one or more of the following: 1. heel pain (enthesitis) 2. peripheral arthritis 3. dactylitis 4. iritis or anterior uveitis 5. psoriasis 6. inflammatory bowel disease 7. positive family history for axial spondyloarthritis, reactive arthritis, psoriasis, inflammatory bowel disease or anterior uveitis 8. previous good response to non-steroidal anti-inflammatory medicines 9. raised acute phase reactants (erythrocyte sedimentation rate (ESR) or	Must be provided: 1. Description of joints affected and onset, characteristics and duration of symptoms 2. Details of all sentinel findings 3. Report on x-ray that includes the sacroiliac joint 4. Details of previous medical management including the course of treatment and outcome of treatment 5. Full blood examination results 6. Erythrocyte sedimentation rate (ESR) 7. C-reactive protein (CRP) 8. Current and complete medication history (including non-prescription medicines, herbs and supplements) 9. If the patient is pregnant		Suggested notes on management: https://www.racgp.org.au/afp/2013/november/ankylosing-spondylitis/ for more details. Previous treatment already tried: NSAIDs, although response should not prevent referral (optional) physiotherapy referral

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medicines. Additional Comments: As inflammatory back pain is chronic or progressive condition that requires ongoing specialist advice, the referral should request partnership care between the patient, their general practitioner and the health service. The referral should note if the request is for a second or subsequent opinion as requests for a second opinion will usually not be accepted.	C-reactive protein (CRP) or both) 10. HLA-B27 positive 11. sacroiliitis shown on x-ray or MRI.	or planning a pregnancy. Provide if available: 1. Relevant x-rays 2. Liver function tests 3. Urea and electrolyte results 4. How symptoms are impacting on daily activities (e.g. work, study, or carer role) 5. Previous rheumatology assessments or opinions.		

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Crystal arthritis (gout) Direct to an emergency department for: • **Patients with acutely painful, hot, swollen joint(s) especially if febrile.** • **Suspected sepsis in a patient with previously diagnosed gout.**	1. Suspected gout in premenopausal women or men < 40 years 2. Tophaceous gout with progressive joint damage, active symptoms or growing tophi despite medical management 3. Gout that has previously been diagnosed with any of the following: • allopurinol intolerance (e.g. rash, hepatitis) • symptoms despite maximum tolerated allopurinol dosage • progressive joint damage despite medical management • compromised renal function: glomerular filtration rate (GFR) < 30 mL/min/1.73m2 • solid organ transplant • complex comorbidities. Referral not appropriate for: • Asymptomatic hyperuricaemia • A single attack of gout • Previously diagnosed gout that is adequately managed • Previously diagnosed gout without prophylactic treatment.	Must be provided: 1. Description of joints affected and onset, characteristics and duration of symptoms 2. Frequency of episodes and number of attacks that have occurred within the last 12 months 3. Inter-episode blood uric acid levels 4. Details of previous medical management including the course of treatment and outcome of treatment 5. Relevant medical history 6. Current and complete medication history (including non-prescription medicines, herbs and supplements) 7. Glomerular filtration rate (GFR). Provide if available: 1. How symptoms are impacting on daily activities (e.g. work, study, or carer role) 2. Full blood examination results 3. Relevant x-rays 4. Results of previous joint aspirations.		Suggested notes on management: https://www.nps.org.au/australian-prescriber/articles/the-management-of-gout Previous treatment already tried: recommended to have previously tried allopurinol

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Inflammatory arthritis Direct to an emergency department: • **Patients with acutely painful, hot, swollen joint(s) especially if febrile** • **Suspected sepsis in a patient with previously diagnosed rheumatoid arthritis** • **Unexplained illness or fever in a patient being treated with biologic or immunosuppressant medicines.** Additional Comments: • As inflammatory arthritis is chronic or progressive condition that requires ongoing specialist advice, the referral should request partnership care between the patient, their general practitioner and the health service. • The referral should note if the request is for a second or subsequent opinion as requests for a second opinion will usually not be accepted.	1. Suspected or diagnosed inflammatory arthritis with active symptoms 2. Previously diagnosed inflammatory arthritis for review of management plan, monitoring or management of toxicity associated with treatment.	Must be provided: 1. Description of joints affected and onset, characteristics and duration of symptoms 2. Details of previous medical management including the course of treatment and outcome of treatment 3. Full blood examination 4. Erythrocyte sedimentation rate (ESR) 5. C-reactive protein (CRP) 6. If the patient is pregnant or planning a pregnancy. Provide if available: 1. Rheumatoid factor (RhF) levels 2. Anti-cyclic citrullinated peptide (anti-CCP) antibody levels 3. Relevant x-rays 4. Liver function tests 5. Urea and electrolyte results 6. Current and complete medication history (including non-prescription medicines, herbs and supplements) 7. How symptoms are impacting on daily activities (e.g. work, study, or carer role) 8. Previous rheumatology assessments or opinions.		Suggested notes on management: https://www.nps.org.au/medical-info/clinical-topics/rheumatoid-arthritis Previous treatment already tried: (optional) can try: • NSAIDs, although response should not prevent referral • prednisolone up to 15mg daily, although response should not prevent referral

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Metabolic bone disease (rheumatology)
 	
Additional Comments:
Referrals to a rheumatology service are most appropriate for:
 	
• Metabolic bone disease associated with:
  ○ treatment with glucocorticoid medicines
  ○ inflammatory disorders
• Metabolic bone disease associated with complications of treatment:
  ○ atypical femoral fracture
  ○ osteonecrosis of the jaw.
 	
Other referrals are likely to be directed to an alternative specialist clinic or service.
	1. Suspected metabolic bone disease that is not osteoporosis (for example: Paget's disease, fibrous dysplasia, osteomalacia, osteogenesis imperfecta)
	2. Persistent osteoporosis despite maximum treatment
	3. Osteoporosis in women < 50 years or men < 60 years
	4. Intolerance to, or contraindication for, maximum treatment
	5. Metabolic bone disease associated with:
	  • treatment with glucocorticoid medicines
	  • inflammatory disorders
	  • chronic kidney disease
	  • post-transplant
	6. Metabolic bone disease associated with complications associated with treatment:
	  • atypical femoral fracture
	  • osteonecrosis of the jaw
	7. Advice on, or review of, management plan in patients with stable metabolic bone disease after 5 years of treatment.
	
	Referral not appropriate for:
		Must be provided:
		1. Details of all fractures, including location
		2. Details of previous medical management including the course of treatment and outcome of treatment
		3. Current and complete medication history (including non-prescription medicines, herbs and supplements)
		4. Recent (in last 3 months)
		  • serum calcium result
		  • serum 25-hydroxy vitamin D (25(OH)D)
		  • phosphate blood test result
		  • creatinine and electrolytes result
		  • albumin blood test result
		  • alkaline phosphate (ALP) blood test result
		5. Relevant comorbidities.
		
		Provide if available
		1. Current or previous bone densitometry results
		2. Current or previous radiological reports of any fractures
		3. Parathyroid (PTH) blood test result.
				When non-surgical therapies are preferred – otherwise consider referral to orthopaedic surgery
				https://www.nps.org.au/medical-info/clinical-topics/knee-and-hip-osteoarthritis

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	• Osteoporosis that has not been treated • Age appropriate osteopenia without fracture(s) • When the person's life expectancy is < 6 months.			

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Psoriatic arthritis Direct to an emergency department for: • **Patients with acutely painful, hot, swollen joint(s) especially if febrile** • **Suspected sepsis in a patient with previously diagnosed psoriatic arthritis** • **Unexplained illness or fever in a patient being treated with biologic or immunosuppressant medicines.** Additional Comments: • As psoriatic arthritis is chronic or progressive condition that requires ongoing specialist advice the referral should request partnership care between the patient, their general practitioner and the health service. • The referral should note if the request is for a second or subsequent opinion as requests for a second opinion will usually not be accepted.	Suspected psoriatic arthritis and may also cause one or more of the following: 1. inflammatory back pain 2. heel pain (enthesitis) 3. uveitis 4. dactylitis 5. psoriasis 6. inflammatory bowel disease 7. positive family history of spondyloarthritis 8. HLA-B27 positive.	Must be provided: 1. Description of joints affected and onset, characteristics and duration of symptoms 2. Details of skin conditions 3. Details of all sentinel findings 4. Details of previous medical management including the course of treatment and outcome of treatment 5. Full blood examination results 6. Erythrocyte sedimentation rate (ESR) 7. C-reactive protein (CRP) 8. Current and complete medication history (including non-prescription medicines, herbs and supplements) 9. If the patient is pregnant or planning a pregnancy. Provide if available 1. Relevant x-rays 2. Liver function tests 3. Urea and electrolyte results 4. How symptoms are impacting on daily activities (e.g. work, study, or carer role) 5. Previous rheumatology and dermatology assessments or opinions.		

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Inflammatory arthritis of peripheral joints	When to refer: • If clinical suspicion, after at least four weeks of symptoms. • If previous diagnosis by specialist, and ongoing provision of specialised medication/reassessment required. • See https://www.nps.org.au/medical-info/clinical-topics/rheumatoid-arthritis for more details.	1. Clinical history and examination • Duration of symptoms • Presence of early morning stiffness, and duration of stiffness • Joints involved (if small joints, please specify MCP/PIP/DIP/MTP) • Presence of swelling, and type (eg boggy, bony) • Any medications already tried (eg NSAID, prednisolone), dose and response • Any history of psoriasis (duration, location eg elbows, nails, scalp) • Any history of uveitis, plantar fasciitis, Achilles' tendonitis, nail disease, dactylitis 2. Any previous/current assessment by another rheumatologist (and if so, what diagnosis and treatment) 3. Imaging 4. Diagnostics • FBE UEC LFTs CRP ESR • Rh Factor, Anti-CCP • ANA uric acid • Parvovirus (if relevant symptoms)		

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Autoimmune:
-Lupus
-Scleroderma
-Myositis
-Vasculitis
	When to refer:
	
	• If clinical suspicion.
	• Clinical suspicion of a multisystem autoimmune disease may arise from findings of an inflammatory arthritis, typical rash, or unexplained haematological manifestations, which can be waxing and waning in nature, in conjunction with high inflammatory markers (ESR/CRP) with or without supportive serological testing (ANA, ANCA, complements). Please contact the rheumatology registrar to discuss other potentially less common manifestations.
	• For further information on SLE: https://www.racgp.org.au/afp/2013/october/systemic-lupus-erythmatosus/
		1. Clinical history and examination
		• Specific clinical features under suspicion, for example
		  ○ rash, mouth ulcers, joint pain, pleurisy, anaemia, leucopenia, thrombocytopenia, active urine sediment or proteinuria if lupus suspected
		  ○ Raynaud's phenomenon or skin thickening if scleroderma suspected
		  ○ muscle weakness and elevated CK if myositis suspected
		• Any previous history of specialist therapy, including previous organ involvement, investigations, medications
		2. Diagnostics
		• FBE UEC LFTs CRP ESR
		• ANA
		• (if ANA positive, please provide results of ENA, dsDNA, complements C3 C4, anti-cardiolipin Ab, anti-beta-glycoprotein I Ab, lupus anticoagulant, direct Coombs test)
		• urine microscopy, urine protein:creatinine ratio
		• ANCA
		• Rh Factor, Anti-CCP if predominantly joint involvement
		• CK if myositis suspected
				Suggested notes on management:
				
				Previous treatment already tried:
				Nil specific, but call for advice if concerned. Organ based treatment eg NSAID or topical steroid can be initiated.

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Back Pain /Neck Pain	When to refer: • If further advice required, and non-surgical options desired. • https://www2.health.vic.gov.au/Api/downloadmedia/%7BE39CADF7-A680-450E-A675-311992CBE8BD%7D • https://www.nps.org.au/australian-prescriber/articles/managing-low-back-pain-in-primary-care	1. Clinical history and examination • Duration of symptoms • Functional disability • Neurological examination findings 2. Imaging		Suggested notes on management: Previous treatment already tried: physiotherapy program focusing on core strengthening and muscle
Fibromyalgia	When to refer: • When patient not improving after previous treatment, and patient amenable to further discussion of non-pharmacological therapies • https://www.nps.org.au/australian-prescriber/articles/treatment-of-fibromyalgia • https://www.nps.org.au/medical-info/clinical-topics/chronic-pain	1. Clinical history and examination • Relevant symptoms • Previous therapies tried • List of co-morbidities • Conditions excluded 2. Diagnostics • FBE UEC LFTs CRP ESR • TSH iron studies vitamin D B12		Suggested notes on management: Previous treatment already tried: physiotherapy program focusing on core strengthening and muscle

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Polymyalgia rheumatica	When to refer: • Clinical suspicion. • https://www.nps.org.au/australian-prescriber/articles/prescribing-for-polymyalgia-rheumatica • https://medicinetoday.com.au/sites/default/files/cpd/MT2014-09-47-OWEN.pdf	1. Clinical history and examination • Duration of symptoms • Presence of early morning stiffness, and duration of stiffness • Locations involved (eg shoulders, hips, knees) including which side • Presence of any joint swelling (if small joints, please specify MCP/PIP/DIP/MTP) • Presence of features potentially suggestive of giant cell arteritis: visual changes, headache (and characteristics), scalp tenderness, jaw claudication (worsens on chewing rather than on opening jaw), limb claudication • Any medications already tried (eg NSAID, prednisolone), duration, dose and response 2. Imaging 3. Diagnostics • FBE UEC LFTs CRP ESR • Rh Factor, Anti-CCP • ANA ANCA CK TSH		