Monash Health Referral Guidelines
RHEUMATOLOGY

EXCLUSIONS

Services not offered by Monash Health

Management of cases with third-party payer involvement e.g. TAC, Workcover.
Patients under 18: Click here for Monash Children's Paediatric Rheumatology guidelines

CONDITIONS

INFLAMMATORY ARTHRITIS
- Rheumatoid Arthritis
- Suspected Inflammatory Arthritis
- Psoriatic Arthritis and Seronegative Spondyloarthropathy
- Acute Single Joint inflammation (Monoarthritis)

CONNECTIVE TISSUE DISEASES & VASCULITIS
- Systemic Lupus Erythematosus
- Scleroderma
- Vasculitis
- Other connective tissue disease
- Polymyalgia and Giant Cell Arthritis

NON-INFLAMMATORY BONE AND JOINT DISEASE
- Back & Neck Pain
- Soft tissue rheumatism (tendinitis, etc)
- Osteoarthritis
- Osteoporosis / Metabolic Bone Disease

MUSCULSKELETAL PAIN SYNDROMES
- Fibromyalgia
- Complex Regional Pain Syndromes

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

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.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit: Prof. Eric Morand

Program Director: Prof. William Sievert

Last updated: 23/5/2018

Monash Health Referral Guidelines
RHEUMATOLOGY

REFERRAL

How to refer to Monash Health

Mandatory referral content

Demographic:
Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details
including **provider number**
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
Dietary status
Family history
Diagnostics as per referral guidelines

Click here to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals, contact on call registrar via Main Switchboard 9594 6666

General enquiries

Phone: 1300 342 273

Submit a fax referral

Fax referral form to Specialist Consulting Services: 9594 2273

INFLAMMATORY ARTHRITIS

RHEUMATOID ARTHRITIS and SUSPECTED INFLAMMATORY ARTHRITIS

Initial GP Work Up

- Presentation: Polyarticular, inflammatory (morning stiffness, relieved with use), associated constitutional symptoms, family history, history of smoking
- Evaluation: symptoms and signs suggesting inflammatory arthritis: effusion/swelling, early morning stiffness, gel phenomenon
- Consider Blood tests: FBE, ESR, CRP, anti-CCP (RhF is not needed in addition)
- Lab tests may be normal

Management Options for GP

- Consider non steroidal inflammatories 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?

Urgent

Early institution of highly effective therapies is needed if high inflammatory burden evidenced by swollen joint count, CRP/ESR

Routine

- All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies
- Monash has a dedicated RA clinic offering advanced therapies

BACK

PSORIATIC ARTHRITIS AND SERONEGATIVE SPONDYLOARTHROPATHIES

Initial GP Work Up

- Presentation: Can be mono, oligo, or polyarticular, inflammatory (morning stiffness, relieved with use), associated constitutional symptoms, family history
- Evaluation: symptoms and signs suggesting inflammatory arthritis: effusion/swelling, early morning stiffness, gel phenomenon
- Presence of associated features eg psoriasis, colitis, eye inflammation
- Inflammatory back pain – early morning stiffness, relief with use
- Consider Blood tests: FBC, ESR, CRP, ant-CCP (RhF is not needed in addition), HLA-B27
- Lab tests may be normal
- Plain radiographs of sacroiliac joints

Management Options for GP

- Consider non steroidal inflammatories for symptom relief unless contraindicated
- Disease modifying anti-rheumatic drug therapy is generally recommended in all patients. Rheumatologist assessment is recommended prior to such therapy

WHEN TO REFER?

Urgent

Early institution of highly effective therapies is needed if high inflammatory burden evidenced by swollen joint count, CRP/ESR

Routine

- All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies
- Monash Psoriatic arthritis clinic runs in conjunction with dermatology clinic, allowing a single point of care

BACK

INFLAMMATORY ARTHRITIS (cont'd)

ACUTE SINGLE JOINT INFLAMMATION (MONOARTHRITIS)

Initial GP Work Up

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

Management Options for GP

- Gout: initiate non steroidal inflammatories unless contraindicated; consider oral, IM or intra articular steroid
- Do not stop allopurinol therapy during an acute attack
- Target allopurinol dose to uric acid in lower half of normal range

WHEN TO REFER?

Emergency

Patients with acute inflammatory Monoarthritis require joint aspiration for exclusion of bacterial infection

Routine

Patients with gout should be referred if multiple attacks, especially if refractory to therapy

BACK

CONNECTIVE TISSUE DISEASES & VASCULITIS

CONNECTIVE TISSUE DISEASES

- **Systemic lupus erythematosus** - multisystem inflammatory presentation often with arthritis, rash, anaemia, serositis, nephritis, CNS involvement
- **Scleroderma** (systemic sclerosis) - Raynaud's, dysphagia, skin tightening, telangiectasia
- **Vasculitis** - purpuric rash, nephritis, lung or ENT involvement, fever, constitutional features
- **Other Connective tissue disease** - features include Raynaud's phenomenon, rash, arthritis, serositis, myositis, proteinuria, sicca - with positive ANA

Initial GP Work Up

- Always check the urine and BP
- Nephritis can be rapidly progressive and requires urgent assessment
- Temporal arteritis can lead to blindness and must be assessed as an emergency
- Lab investigations which should be performed prior to referral include:
- ANA, DsDNA, ANCA
- MSU (urinalysis, M&C)
- FBE, ESR, U&E, CK, CXR

Management Options for GP

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

WHEN TO REFER?

Emergency

- Acute vasculitis syndromes should be referred to ED or to Rheumatology Registrar immediately on suspicion
- If GCA is suspected please page the on-call rheumatology registrar for immediate assessment. Referral for outpatient management is not appropriate
- Scleroderma renal crisis presents with malignant hypertension and is an emergency. Patient should be urgently referred to the ED

Urgent

- Autoimmune diseases need careful diagnostic workup prior to initiation of therapy. Rapid assessment would be expedited by a call to the Rheumatology Registrar
- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review
- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review

Routine

- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease and such referrals will be rejected
- 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
- Monash Lupus and Vasculitis clinics run in conjunction with nephrology, allowing a single point of care for each
- 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

BACK

CONNECTIVE TISSUE DISEASES & VASCULITIS (cont'd)

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

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
- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease

WHEN TO REFER?

Emergency

- Acute vasculitis syndromes should be referred to ED or to Rheumatology Registrar immediately on suspicion
- If GCA is suspected please page the on-call rheumatology registrar for immediate assessment. Referral for outpatient management is not appropriate
- Scleroderma renal crisis presents with malignant hypertension and is an emergency. Patient should be urgently referred to the ED

Urgent

- Autoimmune diseases need careful diagnostic workup prior to initiation of therapy. Rapid assessment would be expedited by a call to the Rheumatology Registrar
- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review

Routine

- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease and such referrals will be rejected
- 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
- Monash Lupus and Vasculitis clinics run in conjunction with nephrology, allowing a single point of care for each
- 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

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE

BACK AND NECK PAIN

- Acute back pain after causative event E.g. twisting injury
- Chronic back pain
- Radicular symptoms
- Limb motor or sensory findings
- Inflammatory back pain e.g. Spondyloarthropathy

Initial GP Work Up

- Are symptoms localised or is there referred pain?
- Neurological examination findings are required in the referral
- MRI scanning is not a routine part of the assessment of back pain at Monash Health
- 'Red flag' symptoms: weight loss, PR bleeding, night pain, fever/rigors, cough/haemoptysis, haematuria, history of or suggestive of malignancy
- Consider Blood tests: FBC, ESR, CRP, LFT, Ca++, myeloma screen
- 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.

WHEN TO REFER?

Emergency

Acute neurological signs (motor or sensory loss) should prompt early assessment, potentially via Emergency Department. If in doubt, please contact the Rheumatology Registrar for advice

Urgent

Presence of 'red flag' symptoms or nerve root symptoms should prompt early investigation and assessment.

Routine

- Monash Health has a dedicated Back and Neck clinic run on a physiotherapist clinical lead basis and staffed by rheumatologist with access to opinion by a neurosurgeon.
- Referrals to neurosurgery for back pain are triaged to the Back and Neck clinic
- Few patients with back pain or sciatica need surgery
- Do not refer unless treatment by a physiotherapist has been unsuccessful as this is always the first line of therapy (excluding emergency and urgent cases as above)
- Wait times for non-urgent assessment are long; consider management in the community

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE (cont'd)

SOFT TISSUE RHEUMATISM

- Shoulder pain/Rotator cuff/Adhesive capsulitis
- Epicondylitis
- Trochanteric bursitis
- Carpal tunnel syndrome
- Plantar Fasciitis

Initial GP Work Up

- History: trauma, occupation, pain pattern
- Exam: swelling, crepitus, range of motion
- Investigations: FBC, ESR, XR, US (see below)

Management Options for GP

- Local injection therapy including imaging-guided if needed
- NSAID
- Physiotherapy of value especially ROM and strengthening exercises
- Shoulder US usually shows cuff degeneration in older people

WHEN TO REFER?

Urgent

Cases where life is severely impacted upon, eg work ability, may be seen more urgently if specified

Routine

Cases refractory to simple approaches including NSAID and steroid injection can be referred

BACK

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?

Urgent

Cases where life is severely impacted upon, eg work ability, may be seen more urgently if specified

Routine

- 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

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE (cont'd)

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 (DEXA), Vitamin D, XR, Ca, PO4, thryroid, 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

WHEN TO REFER?

Routine

- Osteoporosis is usually best managed in the community. Management of complicated or atypical presentations, where conventional treatments are contraindicated or ineffective, can prompt referral.
- Monash Health also has dedicated Osteoporosis and Metabolic Bone Disease clinics

BACK

MUSCULOSKELETAL PAIN SYNDROMES

FIBROMYALGIA AND COMPLEX REGIONAL PAIN SYNDROMES

Initial GP Work Up

- Consider medical causes of fatigue, myalgia, e.g. 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?

Routine

- 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
- All rheumatologists can manage fibromyalgia. If fibromyalgia 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 and does not offer 'second opinion' consultations

BACK