East Sussex MSK Community Partnership

Hand & Wrist Triage Guidelines

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OA 1st CMCJ **Known as: OA thumb,** **Thumb arthritis, Thumb base pain**	**Assessment:** • Establish symptom longevity and severity • Assess for limitations in activities of daily living (ADL's) • Consider co-morbidities • Consider rheumatological presentation • Identify patients' beliefs and needs, include psychosocial issues and chroniciy **Diagnostics:Please be clear on your radiology request as to why you are requesting an xray** **Xray required for suspicion of base of thumb OA and** to inform a change in management eg intervention / surgery. Please be explicit in describing: 1. Significant change in pain levels 2. A reduction in previous levels of function eg gripping/strength 3. A reduction in range of motion / increased swelling • If the presentation meets this criteria, please request a X-ray (thumb base AP / oblique of CMCJ +/- wrist) • Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms • No x-rays required if referring only to Physiotherapy • Blood tests if suspecting rheumatological presentation **Management (including condition-specific self-care options):** • Explanation of cause and natural history • Condition specific advice and guidance: ➢ Managing early Osteoarthritis of the thumb – East Sussex Healthcare NHS Trust (esht.nhs.uk) ➢ What is joint protection? 5 ways you can look after your joints (versusarthritis.org) • Pain relief in line with agreed formularies / guidance - for a minimum of 6 weeks • Discuss activity modification and thumb splinting • Consider CMC joint injection • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Hand Therapy or Physiotherapy if:** • Mild / Mod symptoms • Joint protection advice • ADL assessment • Splints • Exercise • Adaptations **Refer to Advanced practitioner if:** • Severe symptoms • Not responding to physiotherapy / hand therapy • Diagnostically uncertain • Course of NSAIDs and / or analgesia has been trialled (except where contra-indicated) and symptoms severe • To discuss surgical / management options • For consideration of intra-articular steroid injection (if cannot be administered in primary care) **Refer urgently to Rheumatology if:** • Suspected inflammatory condition (Rheumatology blood tests required)	**Assessment:** **Diagnostics:** • X-ray (thumb base AP / oblique of CMCJ +/- wrist) if clinically indicated • Blood tests if suspecting rheumatological presentation **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Intra-articular steroid Injection **Refer to Advanced Practitioner (from Hand Therapy or Physiotherapy) if:** • No or limited response to physiotherapy and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • All conservative management options have been tried AND Surgery is indicated and SDM conversation with patient has taken place **Refer to Hand Therapy or Physiotherapy (from Advanced Practitioner / Orthopaedics) if** • Provided steroid injection for pain relief and needs further rehabilitation. • Patient declined surgery or not appropriate for surgery • Patient choice **Refer to Rheumatology if:** • Suspected inflammatory condition (Rheumatology blood tests required)

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Carpal Tunnel Syndrome **(Condition falls under Clinical effective Commiss-ioning (CEC) policy 2024)**	**Assessment:** • Establish symptom longevity and severity • Distribution/ behaviour of symptoms • Assess for sensory loss defined as 'objective evidence of reduced sensation' - more likely to be permanent or fixed in severe and late presentation • Assess for thenar wasting – test thumb abduction power • Tinel's/ Phalen's / Durkan's tests • Consider differential diagnoses including radiculopathy, diabetic neuropathy, vascular pathology, thyroid • Assess for limitations in activities of daily living (ADL's) • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Neurological examination if neck symptoms coexist – refer Spine pathways if presenting with atypical CTS symptoms or non-localised symptoms with neck pain • **NOTE: Consider Cervical Spine cord compression signs, bilateral clumsiness, problems with dexterity, balance disturbance and UMN screen.** **Diagnostics:** • **NONE -** nerve conduction studies **<u>are not</u>** indicated in primary care **Management (including condition-specific self-care options):** • Mild cases with intermittent symptoms causing little or no interference with sleep or activities **require no treatment (CEC 2024)** • Explanation of cause and natural history • Explanation of approaches to treatment • Pain relief in line with agreed formularies / guidance • Night straight (neutral) splint for 8 -12 weeks if available in primary care and / or Steroid injection • Advice on mobilisation, and tendon and nerve glides: Carpal Tunnel Syndrome – East Sussex Healthcare NHS Trust (esht.nhs.uk) • Occupation ergonomics advice • Consider the use of Fit notes if patient is working • Review and monitor for resolution of symptoms for up to 3 months • Check thyroid and diabetes screen status if bilateral • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service)	**Refer to Physiotherapy if:** • Mild symptoms and GP has no access to splints. **Refer to Advanced practitioner if:** • Moderate symptoms including pain or sensory loss • Symptoms persist for at least 3 months despite conservative therapy • Trial of local Corticosteroid injection (if available in primary care) • Trial of nocturnal splinting (used for at least 8-12 weeks) • Pregnancy related symptoms (consider need for urgent referral in these cases) **Refer to Orthopaedics:** **Urgently if:** • Severe symptoms ➢ Thenar wasting (URGENT) ➢ Muscle weakness (URGENT) ➢ Persistent paraesthesia **Routinely if:** • Above 'Severe' symptoms absent • Persistent symptoms not responding to night splint and / or steroid injection • Positive nerve conduction studies NHS_Carpal_Tunnel_decision_tool (england.nhs.uk)	**Assessment:** **Diagnostics:** • Nerve conduction studies if diagnostic uncertainty **Management:** • Comprehensive Physiotherapy where appropriate • Patient education • Patient choice following SDM • Trial of nocturnal splinting **and / or** steroid Injection where appropriate **Refer to Advanced Practitioner (from Physiotherapy) if:** • Conservative management ineffective • For consideration of injection • For consideration of surgical intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** **Urgently if:** • Severe CTS identified and patient wants surgery **Routinely if:** • Conservative management options have been tried in line with CEC guidelines and Surgery is indicated and SDM conversation with patient has taken place **Refer to Physiotherapy (from Advanced Practitioner) if:** • Mild symptoms and wants conservative management • If mild neck referred symptoms and not trialled Physiotherapy.

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Trigger Finger/ Thumb **(Condition falls under Clinical effective Commiss-ioning (CEC) policy 2024)**	**Assessment:** • Establish Symptom longevity and severity • Assess for finger/Thumb triggering and impact activities of daily living (ADL's) • Co-morbidities - consider diabetic and thyroid screening if multiple fingers/ resistant to treatment • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Non operative management for up to 12 weeks • Mild cases – no interventional treatment required • Explanation of cause and natural history • Activity modification advice • Consider 1 or 2 steroid injections and / or splinting affected finger at night for 3-12 weeks • Condition specific advice and guidance: ➢ Trigger Finger – East Sussex Healthcare NHS Trust (esht.nhs.uk) ➢ Trigger finger/thumb | The British Society for Surgery of the Hand (bssh.ac.uk) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer to Advanced practitioner if:** • Diagnostically unclear • Failure to respond to conservative treatment (i.e. 1 or 2 steroid injections or splinting for 3-12 weeks) • Injection not available in primary care **Refer urgently to Orthopaedics:** **Urgently if:** • Digit locked to palm **Routinely if:** • All CEC guidelines met and • SDM conversation completed and • patient wants surgery	**Assessment:** **Diagnostics:** • NONE **Management:** • Conservative management trialled for 12 weeks (where appropriate) • Patient education • Patient choice following SDM • Steroid injection and / or splinting (where appropriate) **Refer to Orthopaedics (from Advanced Practitioner) if:** • Conservative management options have been tried in line with CEC guidelines and Surgery is indicated and SDM conversation with patient has taken place

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Dupuytren's Disease **(Condition falls under Clinical effective Commissio-ning (CEC) policy)**	**Assessment:** • Establish Symptom longevity and severity • Consider family history (prevalence) • Check for nodule, cord, and finger range of movement • Assess for limitations in activities of daily living (ADL's) • Establish if the movement restriction meets the requirement for surgical intervention under the CEC guidelines (see end column) • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Explanation of cause and natural history • Condition specific advice and guidance ➢ Treatment is not indicated: ○ In cases with no contracture ○ In patients with mild, (less than 20 degree) contracture ○ Or contractures which are not progressing and not impairing function • If not meeting CEC criteria, patients should be provided with the decision tool and asked to self-monitor the degree of contracture for any progression: NHS_Dupuytren's_contracture_decision_tool (england.nhs.uk) • Consider steroid injection if intolerably painful nodules • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **PLEASE NOTE:** • Collagenase not currently available in UK as of 9/2024 • Radiotherapy is not currently available within the MSK service as evidence of efficacy is inadequate and only supported for research and audit purposes (NICE IPG 575). For more information see British Dupuytren's society	**Refer to Advanced practitioner if:** • Diagnostically unclear or CEC criteria not met/ documented **Refer urgently to Rheumatology if:** • Clinical presentation fulfils the CEC criteria (see end column), and patient wants surgery • **The patient must be advised that rehabilitation can be lengthy and the recurrence rate is high** NHS_Dupuytren's_contracture_decision_tool (england.nhs.uk)	**Assessment:** **Diagnostics:** • NONE **Management:** • Patient education • Patient choice following SDM • Steroid injection for intolerably painful nodules • Clinical presentation meets CEC criteria **To Orthopaedics (from Advanced Practitioner) if:** • Dupuytren's contracture restriction meets CEC guidelines **and** surgery is indicated **and** SDM conversation with patient has taken place **Only refer to Secondary Care for opinion if (as in CCG 'Clinically Effective Commissioning Policy' 2024):** • A flexion contracture > 30 degrees at the metacarpo-phalangeal joint OR • Flexion contracture >20 proximal interphalangeal joint OR • Severe thumb contractures **And** • Interfere with function

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De Quervain's Tenosynovitis **Thumb tenosynovitis of extensor pollicis brevis and abductor pollicis longus within the 1st extensor compartment)**	**Assessment:** • Establish Symptom longevity and severity • Assess for pain over 1st extensor compartment and positive Finkelstein's / Eichoff's test • Assess for limitations in activities of daily living (ADL's) • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Avoid repetitive tasks • Advice on activity modification • Advice on the use of thumb splints • Course of analgesia and / or NSAIDs in line with agreed formularies / guidelines • Referral to physiotherapy/hand therapy • Consider injection if available in primary care • Condition specific advice and guidance: De Quervain's syndrome | The British Society for Surgery of the Hand (bssh.ac.uk) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer to Physiotherapy if:** • Persisting symptoms >6 weeks • Functionally impaired • Pregnancy related symptoms (consider need for urgent referral in these cases) **Refer urgently to Advanced Practitioner if:** • Diagnostically uncertain • Failed conservative management • For consideration of steroid injection if not available in primary care	**Assessment:** **Diagnostics:** • NONE **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Trial of steroid Injection **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • All conservative management options have been tried, and surgery is indicated and SDM conversation with patient has taken place **Refer to Physiotherapy (from Advanced Practitioner / Orthopaedics) If:** • **Provided steroid injection for pain relief and needs further rehabilitation** • **Patient declined or not fit for surgery** • **Patient choice**

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Wrist Pain	**Assessment:** • Establish symptom longevity and severity • Consider history of trauma • Assess for limitations in activities of daily living (ADL's) • Assess for signs of synovitis, heat swelling, stiffness • **NOTE: Suspected Inflammatory Arthritis should be referred to Rheumatology – see guidelines** • Consider Gout • Identify patients' beliefs and needs, include psychosocial issues and chronicity • **NOTE: New fractures need urgent referral to A&E or Fracture Clinic** **Diagnostics:** **Xrays are required for first line investigation with Wrist pain to** inform a change in management eg intervention / surgery. Please be explicit in describing: 1. Any history of trauma or likely joint pathology 2. Moderate to severe pain levels 3. A reduction in function eg gripping/strength/weightbearing 4. A reduction in range of motion / increased swelling • If the presentation meets these criteria please request AP and lateral views of the wrist. • Repeat X-ray not required within 18 months unless significant deterioration or change in symptoms • For suspected scaphoid fractures refer to fracture clinic see GIRFT algorithm Hand-surgery_Scaphoid-fractures_Pathway_FINAL_V1_April-2024.pdf (gettingitrightfirsttime.co.uk) • No X-ray required if referring onto only physiotherapy • Blood tests if suspecting inflammatory arthritis **Management (including condition-specific self-care options):** • Course of analgesia and / or NSAIDs in line with agreed formularies / guidance for a minimum of 6 weeks • Advice on activity modification • Initiate gentle exercise of the wrist • If history of trauma, but X-ray shows no fracture, arrange for 2-week symptom review (Consider scaphoid fracture or scaphoid lunate ligament injury that may need further imaging or specialist assessment) • Patient education • Condition specific advice and guidance • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • Persisting symptoms >6 weeks **Refer to Advanced practitioner if:** • Diagnostic uncertainty **Refer to Orthopaedics if:** • Kienbock's Disease identified radiologically • Acute symptomatic scapholunate ligament rupture suspected	**Assessment:** **Diagnostics:** • Xray (usually AP and lat of wrist) • Blood tests if suspected synovitis • Other diagnostics as appropriate, dependent upon clinical presentation ➢ MRI ➢ MRA is an invasive test, to be used only rarely (10%-20%) ➢ Ultrasound Scan **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • Acute scapho-lunate ligament rupture identified • All conservative management options have been tried, and Surgery is indicated and SDM conversation with patient has taken place **Refer to Hand Therapy or Physiotherapy (from Advanced Practitioner / Orthopaedics) if** • Provided steroid injection for pain relief and needs further rehabilitation • Patient declined or not fit for surgery • Patient choice

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Ganglion Wrist **(Condition falls under Clinical effective Commissio -ning (CEC) policy 2024)**	**Assessment:** • Establish longevity and severity of symptoms • Assess for limitations in activities of daily living (ADL's) • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • No treatment indicated if asymptomatic and not affecting function • Advise that these are best left without any intervention and chance of spontaneous resolution • Condition specific information leaflet should be provided: Ganglion cysts | The British Society for Surgery of the Hand (bssh.ac.uk) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **NOTE: If soft tissue sinister pathology suspected please referral to local soft tissue sarcoma service**	**Refer to Advanced practitioner if:** • Intermittent Pain or tingling / numbness present • Diagnostic uncertainty **Refer to Orthopaedics if:** • Previous aspiration fails to resolve pain or tingling and there is restricted hand function • Evidence of persisting nerve compression (sensory loss, weakness power loss)	**Assessment:** **Diagnostics:** • Consider X-ray if wrist pain • Consider Ultrasound or MR if diagnostic uncertainty **Management:** • Patient education • Patient choice following SDM **Refer to Orthopaedics (from Advanced Practitioner) if:** • Aspiration fails to resolve pain / tingling / numbness **and** there is restricted hand function **and** SDM with patient has taken place

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Lumps and Bumps	**Assessment:** • Establish symptom longevity and severity • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Assess for limitations in activities of daily living (ADL's) • Consider family history • Consider history of trauma • Assess pain level • Examine for signs of synovitis, heat swelling, stiffness, red flags **NOTE: Skin lesions such as BCC/SCC need Dermatology referral, see next column for thresholds to refer via Urgent Sarcoma 2WW pathway** **Diagnostics:** • Xray is not indicated unless there is consideration of an underlying bone or joint pathology. X-ray if this will change your decision to refer or not • Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms • Consider ultrasound scan if diagnostic uncertainty **Management (including condition-specific self-care options):** • If pain free and not affecting range of movement and ADLs advise: ➢ That these are best left without any intervention ➢ Patient to self-monitor for size and interference with function • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Refer if a diagnosis cannot be made	**Urgent Sarcoma 2WW referral form for suspected malignancy if the lump fulfils any of the following criteria:** • Growing or greater than 5cm • Painful • Feels deep to muscle • Has recurred following excision **Refer to Integrated MSK Service (Advanced Practitioner) if:** • Patient concerned • No suspicion of malignancy • Clinical presentation of: ➢ Garrods pads ➢ Heberdens nodes ➢ Mucous cysts ➢ Seed Ganglion (for US guided aspiration (CEC Criteria 2024) **Refer to Orthopaedics:** • Any lump that is likely to need excision • Mucous cyst if recurrent discharge or nail deformity • Giant Cell Tumour • Neurofibroma	**Assessment:** **Diagnostics:** • X-ray if indicated • Consider Ultrasound and MR if diagnostic uncertainty **Management:** • Dependent upon clinical presentation **Refer to Orthopaedics (from Advanced Practitioner) if:** • Any lump likely to need excision **and** is interfering with ADLs and function, following a SDM conversation

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Finger Pain	**Assessment:** • Establish Symptom longevity and severity. • Assess for limitations in activities of daily living (ADL's) • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Finger pain is commonly caused by osteoarthritis but can also be caused by inflammatory arthritis, strains and injury • Screen for systemic inflammatory features ➢ Adults with suspected persistent joint inflammation (synovitis) in more than 1 joint, or the small joints of the hands and feet, should be referred to rheumatology (Nice Guidelines QS33) ➢ Early morning stiffness for more than 30 minutes ➢ Obvious painful swollen joint / dactylitis ➢ Elevated temperature • Consider family history • Consider co-morbidities • Assess for injury/trauma : **May require referral to A&E** **Diagnostics:** **Xray required for first line investigation finger pain** to inform a change in management eg intervention / surgery. Please be explicit in describing: 1. Any recent trauma or suspicion of joint pathology 2. Moderate or severe pain levels 3. A reduction in level of function eg gripping/strength 4. A reduction in range of motion / increased swelling • If your patient meets these criteria please request an X-ray centred on the joint involved e.g. "AP and lateral of the left ring finger". • Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms • Xray not required if referring to only physiotherapy • Blood tests if suspecting inflammatory arthritis **Management (including condition-specific self-care options):** • Course of analgesia and / or NSAIDs in line with agreed formularies / guidance, including topical NSAIDs • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Condition specific patient Information leaflet: Terminal finger joint arthritis | The British Society for Surgery of the Hand (bssh.ac.uk) **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to A&E if:** • Penetrating injury in last 2 weeks and sepsis suspected • If any evidence of finger tendon rupture e.g. 'mallet finger' **Refer to Physiotherapy if:** • Mild to moderate symptoms and difficulty with ADLs/ function **Refer to Advanced Practitioner if:** • Diagnostically unclear • Moderate to severe symptoms and course of NSAIDs and / or analgesia has been trialled • If no signs of inflammatory arthritis • Injury greater than 6 weeks ago **Urgent referral to Orthopaedics if:** • Surgical intervention indicated and not responding to treatment. • Suspected Volar plate injury **Refer urgently to Rheumatology if:** • Suspected inflammatory condition	**Assessment:** **Diagnostics:** • X-ray • Blood tests if suspecting inflammatory arthritis **Management:** • Comprehensive Physiotherapy (where appropriate) • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • All conservative management options have been tried **and** surgery is indicated **and** SDM conversation with patient has taken place **Refer to Physiotherapy (from Advanced Practitioner/Orthopaedics) if:** • Provided steroid injection for pain relief and needs further rehabilitation. • Patient declined or not fit for surgery • Patient choice