East Sussex MSK Community Partnership

Spine & Neck Triage Guidelines

V3 July 2025

East Sussex MSK Community Partnership

Contents

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Axial Lumbar pain – Persistent / Chronic (>3 months) with/without acute flare up	**Assessment:** • History • Caution: Be alert for: ➢ New or changed symptoms ➢ Trauma • Examination • Screen for serious pathology • Identify patients' beliefs and needs, include psychosocial issues • Consider STarTBacK Tool (STarTBacK Online – STarT Back (keele.ac.uk)), comorbidities, and current stressors predisposing to chronicity • Consider inflammatory back pain **Diagnostics:** • Lumbar MRI & other imaging studies are not routinely required in primary care • X-rays are not indicated **NOTE: MRI can be requested from primary care to exclude red flags e.g. MRI exclude metastasis, X-ray for fractures.** **Management:** • Continue offering reassurance & encourage return to normal activities. • 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 **Analgesia:** • NSAID/Weak opioid +/- paracetamol (when acute) • Do not offer: ➢ Paracetamol alone ➢ Opioids ➢ SNRI / SSRI / TCA ➢ Gabapentinoids • Consider a different option from the list above if the response to the first-line therapy is not satisfactory. • See NICE: Recommendations | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Integrated MSK Service (General Physiotherapy) if:** • Previous positive response to physiotherapy • Functional goals identified **Refer to Integrated MSK Service (Advanced Practitioner) if:** • Significant functional impairment • Uncertainty regarding management / shared decision-making discussion required • Poor response to previous episode(s) of evidence-based physiotherapy • Significant psychosocial factors identified or high levels of pain-related distress impacting on rehabilitation • Significant debilitating pain (non-MSK causes excluded) • Consideration of targeted medial branch block/Rhizotomy **Refer to Multidisciplinary Pain Service / Pain Consultant if:** • Consideration of pain-management programme **Note: Invasive procedures are often in combination with an MDT approach and should be reviewed by Advanced Practitioner in the first instance**	**Assessment:** **Diagnostics:** • Consider imaging for people with low back pain without sciatica only if the result is likely to change management. **Management** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** • •Non-response to physiotherapy where patient remains unable to self-manage. This should aim to be 12 weeks of care including exercise, manual therapy, education • For shared-decision-making when considering further interventions **Refer to Multidisciplinary Pain Service/Pain Consultant (From physiotherapy or Advanced Practitioner) if:** • Significant psychosocial factors identified or high levels of pain-related distress impacting on rehabilitation where psychology would be beneficial • Consideration of pain-management programme • Consideration of targeted medial branch block/Rhizotomy, SIJ injection **Note: Invasive procedures are often in combination with an MDT approach**

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Mechanical lower back pain / Lumbar pain **Acute pain <12 weeks**	**Assessment:** • History – caution trauma • Examination and Assessment • Exclude non-MSK factors • Identify patients' beliefs and needs, including psychosocial issues • Consider STarTBacK Tool (STarTBacK Online – STarT Back (keele.ac.uk)), comorbidities, and current stressors predisposing to chronicity • Consider inflammatory back pain • Screen serious pathology **Diagnostics:** • Lumbar MRI & other imaging studies are not routinely required in primary care • Xray are not indicated **NOTE: MRI can be requested from primary care to exclude red flags e.g. MRI exclude metastasis, X-ray for fractures.** **Management:** • Primary care management for first 6-weeks • Advice / Reassurance; natural history in most cases approx. 6 weeks • Activity modification • 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 • Exercise: (Exercises for the back | Versus Arthritis) • Address psychosocial factors i.e.: ➢ Fear or avoidance beliefs ➢ Associated anxiety/depression ➢ Support early return to work – consider educational interventions ➢ options for a 'phased return' and fit notes where possible • Patients dealing with disability/loss of employment should be directed specific areas of support e.g. through an occupational health department and specially trained staff. **Analgesia:** • NSAID/Weak opioid +/- paracetamol (when acute) • Do not offer: ➢ Paracetamol alone ➢ Opioids ➢ SNRI / SSRI / TCA ➢ Gabapentinoids See NICE: Recommendations | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme. Please refer to physiotherapy in the first instance**.	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • MSK related LBP if; >6weeks in duration without improvement in primary care	**Assessment:** **Diagnostics:** • Consider imaging for people with low back pain without sciatica only if the result is likely to change management. **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (From Physiotherapy) if:** • Non-response to physiotherapy where patient remains unable to self-manage. This should aim to be 12 weeks of care including exercise, manual therapy, education • For shared-decision-making when considering further interventions **Refer to Multidisciplinary Pain Service / Pain Consultant (From AP clinic or physiotherapy) if:** • Significant psychosocial factors identified or high levels of pain-related distress impacting on rehabilitation • Consideration of pain-management programme • Consideration of targeted medial branch block/Rhizotomy Note: Invasive procedures are often in combination with an MDT approach **Refer to Orthopaedics (From AP clinic):** **Urgently if:** • MRI identifies incidental / asymptomatic cord lesion e.g. cauda equine compression (See cauda equina pathway. Patient to be given warning card and safety-netted / understand management should things deteriorate). **Routinely if:** • Complex presentation or where continued uncertainty and consultant opinion required regarding management • Imaging needed outside of scope of AP e.g. CT **NOTE: Surgery is not indicated for axial back pain. Consider discussing cases in spinal MDT before referring to spinal consultant.**

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Coccydynia (traumatic and acquired)	**Assessment:** • History – determine if traumatic or acquired • Examination and Assessment • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Ask about impact on bowel and sexual function • More prevalent in: ➢ Women (4 x more likely) ➢ Increased BMI (3 x more likely) **Diagnostics:** • Consider Bloods if needing to rule out possible infection aetiologies e.g. Pilonidal cyst) • No x-ray indicated in primary care **Management:** • Education • Reassurance; Conservative treatment successful in 90% cases • Self-help strategies / cushion • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Analgesia • Use of warm / cold therapy • Avoidance of prolonged sitting / ergonomic adaptations **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Referral to Integrated MSK service (General physiotherapy) if:** • >6 weeks in duration without improvement in primary care • Worsening pain with significant functional impairment • Unable to cope at work / home • Consider early referral if identifiable factors predisposing to chronicity **Refer to Integrated MSK service (Advanced Practitioner from physiotherapy) if:** • Persistent/chronic symptoms despite physiotherapy	**Assessment:** **Diagnostics:** • MRI (Sacrum)/Xray if considering a displaced fracture **Management:** • Patient education • Trial of self-help strategies • Comprehensive Physiotherapy programme where appropriate • Patient choice following SDM **Refer to Integrated MSK service (Advanced Practitioner from physiotherapy) if:** • Poor / no response to physiotherapy • For shared decision-making conversation **Refer to Multidisciplinary Pain Service (From AP clinic) where:** • Significant yellow flags identified or high levels of pain-related distress impacting on rehabilitation that may benefit from psychology • Contra-indications or precautions to invasive intervention (e.g. anti-coagulants, BMI >35 associated with poorer outcome) • Consideration of targeted injection **Refer to Orthopaedics (From AP clinic) for consideration:** • MUA and local injection • Coccygectomy **Note: Surgery should be considered once all other interventions have been exhausted**

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Nerve Root Pain (Radiculo-pathy) - Back and Leg Pain **Make distinction between nerve and somatic referred pain.**	**Assessment:** • History • Exclude hip joint/lateral hip pain • Neurological exam essential • Consider upper motor neurone signs • Consider STarTBacK Tool (STarTBacK Online – STarT Back (keele.ac.uk)), comorbidities, and current stressors predisposing to chronicity **Diagnostics:** • Lumbar MRI & other imaging studies are not routinely required in primary care • X-ray not indicated **NOTE: MRI can be requested from primary care to exclude red flags e.g. MRI exclude metastasis, X-ray for fractures.** **Management:** • Primary care management for first 6-weeks **NOTE: acute deteriorating myotomal weakness should be treated as an emergency and referred to A&E. Please reference these guidelines for support if required: Spinal – Suspected Cauda Equina Syndrome 1a - GIRFT – Pathways** • Advice / Reassurance; natural history in most cases approx. 6-12 weeks • Activity modification • Exercise (Exercises for the back | Versus Arthritis) • Address psychosocial factors: ➢ Fear or avoidance beliefs ➢ Associated anxiety/depression • Consider use of fit notes if patient is working • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) **Analgesia:** • NSAID / Weak opioid +/- paracetamol (when acute) • Do not offer: ➢ Paracetamol alone ➢ Opioids ➢ SNRI / SSRI / TCA ➢ Gabapentinoids See NICE: Recommendations | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE **Literature:** Cauda Equina Information Cards | MACP (macpweb.org) **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to A&E if:** • Cord symptoms/cauda equina syndrome • Deteriorating neurology/progression to include bilateral sciatica • Acute (<72 hours) or progressive motor deficit (e.g. foot drop) Spinal – Suspected Cauda Equina Syndrome 1a - GIRFT – Pathways Cauda Equina Information Cards | MACP (macpweb.org) **Refer to Integrated MSK Service (General Physiotherapy) if:** • >6 weeks in duration without improvement in primary care • No significant motor loss (Myotomal power 4-5/5) • Mild sensory loss/tingling with otherwise normal neurology • Where there is uncertainty between somatic/radicular presentations but no red flags. **Refer to Integrated MSK Service (Acute Sciatica Pathway) if:** • <3 months history • Severe unilateral leg pain • Causing significant distress and functional loss • Severe unremitting and uncontrolled leg pain • No significant neurological deficit (power loss lower than 4/5) **Refer to Integrated MSK Service (Advanced Practitioner) if:** • Myotomal weakness 3/5 or below (longer than 72 hours) • Evidence of progressive loss of sensation • Significant functional impairment • Severe unremitting and uncontrolled leg pain	**Assessment:** **Diagnostics:** • MRI • Where Imaging / investigations are needed that are outside of scope of AP e.g. CT, referral from physio can be triaged directly to orthopaedics **Management:** • Patient education • Comprehensive Physiotherapy programme where appropriate • Patient choice following SDM **Refer to Advanced Practitioner (From Physiotherapy) if:** • Non-response to comprehensive physiotherapy where patient remains unable to self-manage • Where patient is considering further intervention **Refer to Orthopaedics (From Advanced Practitioner or Physiotherapy Clinic):** • Where a surgical target is identified on MRI that correlates with clinical presentation • Pt wants surgery • Complex presentation or where continued uncertainty and consultant opinion required regarding appropriateness of surgery • Incidental MRI findings of cord compression/CES unrelated to current presentation • Where Imaging/investigations are needed that are outside of scope of Advanced Practitioner e.g. CT, referral from physio can be triaged directly to orthopaedics **Refer to Multidisciplinary Pain Service (From AP clinic):** • For MDT approach where: ➢ Significant yellow flags identified or high levels of pain-related distress impacting on rehabilitation ➢ Contra-indications or precautions to invasive intervention (e.g. anti-coagulants, BMI >35 associated with poorer outcome) • Consideration of targeted epidural injection or CT guided nerve root block where appropriate single level target is identified on MRI and shared decision making has taken place **NOTE: Invasive procedures are often undertaken in combination with an MDT approach**

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Nerve Root Pain (Radiculo-pathy) – Neck and Arm **(also known as Brachialgia)** **Make distinction between nerve and somatic referred pain.**	**Assessment:** • History • Neurological exam • Consider upper motor neurone signs • Identify patients' beliefs and needs, including psychosocial issues • Consider comorbidity / current stressors predisposing to chronicity • For neck pain without arm symptoms see axial neck pain pathway. **Diagnostics:** • Cervical X-ray, MRI & other imaging studies are not routinely required **NOTE: MRI can be requested from primary care to exclude red flags e.g. MRI exclude metastasis, X-ray for fractures.** **Management:** • Advice and reassurance that natural history in most cases is 6-12 weeks • Activity modification • Exercise (Exercises for the neck I Versus Arthritis) **Analgesia:** • NSAID / paracetamol / Codeine • See NICE: Clinical Knowledge Summary; Prescribing information, Neck Pain, Non-specific. **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme. Please refer to physiotherapy in the first instance.**	**Refer to A&E if:** • Displaying cord symptoms / myelopathy -see urgent pathways • Significant trauma Myelopathy Warning Card 2025. **Refer to Integrated MSK Service (General Physiotherapy) if:** • >6 weeks in duration without improvement in primary care • No significant motor loss (Power grade 4-5/5) • Mild sensory loss/tingling with otherwise normal neurology Where there is uncertainty between somatic / radicular presentations but no red flags. **Refer to Integrated MSK Service (Advanced Practitioner) if:** • Myotomal weakness 3/5 or below (longer than 72 hours) • Progressive loss of sensation • Significant functional impairment • Severe unremitting / uncontrolled arm pain • Failure to manage with comprehensive course or physiotherapy	**Assessment:** **Diagnostics:** • MRI • Where Imaging / investigations are needed that are outside of scope of AP e.g. CT, referral from physio can be triaged directly to orthopaedics **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (From Physiotherapy) if:** • Non-response to comprehensive physiotherapy programme where patient remains unable to self-manage • Where patient is considering further intervention **Refer to Neurosurgical team - Brighton (from Advanced Practitioner) if:** • Where a surgical target is identified on MRI (MRI <6months) that correlates with clinical presentation • Pt wants surgery Due to long waiting lists, patients should be given appropriate safety-netting advice, issued warning card (Myelopathy Warning Card 2025) where applicable and advised to attend A&E should they experience acute deterioration whilst on the waiting list. **Refer to Multidisciplinary Pain Service (From Advanced Practitioner) if:** • For MDT approach where: ➢ Significant yellow flags identified or high levels of pain-related distress impacting on rehabilitation ➢ Contra-indications or precautions to invasive intervention (e.g. anti-coagulants, BMI >35 associated with poorer outcome) • Consideration of targeted epidural injection or CT guided nerve root block where appropriate single level target is identified on MRI **NOTE: Invasive procedures are often undertaken in combination with an MDT approach** **NOTE: Epidurals carry additional risk when compared with lumbar procedures due to cervical spine anatomy. Consequently, targeted epidurals are not available within East Sussex and require consultant referral to Guys Hospital. Selective nerve root block are considered controversial due to clinical outcomes and may be liable to change in future pathway amendments.** **NOTE: There is no surgical provision for cervical procedures within East Sussex.** **Refer to Orthopaedics (from Advanced Practitioner) ONLY in the following situations:** **As Urgent if:** • MRI identifies incidental cord lesion where there is no deterioration in clinical signs or symptoms e.g. myelopathy (As per myelopathy pathway. Patient should be given warning card and safety-netted understanding management should things deteriorate). **As Routine if:** • Complex presentation or where continued uncertainty and consultant opinion required regarding appropriateness of surgery • MRI contra-indicated or Imaging needed outside of scope of AP e.g. CT

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Non-specific axial neck and mechanical thoracic back pain without arm symptoms. **Including** **Cervicogenic headaches and Whiplash**	**Assessment:** • History • Caution Trauma: ➢ Odontoid peg fracture in elderly populations ➢ Fracture/dislocation in whiplash (midline tenderness) ➢ Instability – risk in populations with Diabetes, Downs and RA • Consider Neurological/Upper motor neurone examination • Exclude non-MSK factors • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Cervical X-ray, MRI & other imaging studies are not routinely required • For thoracic symptoms consider appropriate investigations if suspecting: ➢ Acute osteoporotic/Insufficiency fracture ➢ Spinal Infection ➢ Inflammatory back pain ➢ Metastatic disease ➢ Myeloma ➢ Metastatic spinal cord compression (MSCC) ➢ Myelopathy **NOTE: MRI can be requested from primary care to exclude red flags e.g. MRI exclude metastasis, X-ray for fractures.** **Management:** • Primary care management for first 6-weeks • Advice / Reassurance; natural history in most cases approx. 6 weeks • Activity modification • Consider ergonomics and workspace set up • Exercise (Exercises for the neck | Versus Arthritis) • Address psychosocial factors i.e.: ➢ Fear or avoidance beliefs ➢ Associated anxiety/depression ➢ Medico-legal issues ➢ Family dynamics • Cervical collars are not recommended for the management of neck pain • Encourage early return to work and use of fit notes **Analgesia:** • NSAID / Paracetamol / Codeine • See NICE; Clinical knowledge summary: Prescribing information | Neck pain - non-specific | CKS | NICE **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to A&E if:** • Displaying cord symptoms / myelopathy – see urgent pathways • Significant trauma Myelopathy-Warning-Card-2024.pdf (sussexmskpartnershipeast.co.uk) **Refer to Integrated MSK Service (General Physiotherapy) if:** • Refer for all other MSK related LBP • >6weeks in duration without improvement in primary care	**Assessment:** **Diagnostics:** • Consider imaging for people with axial neck pain only if the result is likely to change management. **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (From Physiotherapy) if:** • Non-response to physiotherapy where patient remains unable to self-manage. This follows comprehensive course of treatment including, exercise, manual therapy and advice. **Refer to Multidisciplinary Pain Service (From Physiotherapy or Advanced Practitioner) if:** • Significant psychosocial factors identified or high levels of pain-related distress impacting on rehabilitation • Consideration of pain-management programme • Consideration of targeted medial branch block, CT guided nerve root block, occipital block **Note: Invasive procedures are often in combination with an MDT approach** **Refer to Orthopaedics (From Advanced Practitioner clinic):** **Urgently if:** • MRI identifies incidental/asymptomatic cord lesion e.g. myelopathy (As per myelopathy pathway. Patient should be given warning card and safety-netted understanding management should things deteriorate). **Routinely if:** • Complex presentation or where continued uncertainty and consultant opinion required regarding management • Imaging needed outside of scope of AP e.g. CT **NOTE: Surgery is not indicated for axial neck pain. Consider discussing in spinal MDT before referring to spinal consultant**

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Spine Insufficiency Fracture's **Exclues:** **- Red flags** **- Possible pathological fractures**	**Investigation:** **Diagnostics** • Consider urgent X-Ray if considering possible fracture Please be explicit in your request regarding any trauma, the date of the trauma and any previous fractures / osteoporotic risk factors. If an acute injury refer to A&E. • Please describe location of Axial pain or referral of symptoms? • If your patient meets these criteria please request X-ray: AP / Lateral lumbar spine and/or AP pelvis: (if radiologists suggests new fracture, refer to fracture clinic Fracture risk stratification (FRAX: consider BMD) Urgent referral to secondary care fracture clinic if X-ray confirms fracture and: • Under 6 weeks duration. • With associated neurological involvement acute or subacute. • If suspected cord compression follow urgent pathway. **Management of fractures in Primary care (with confirmed fragility fracture)** • More than 6 weeks duration • Pain resolving, no neurological deficit. • Reassure patient and provide educational material. • Self-management plan: early mobilisation, pacing, walking aid. Pain management: consider appropriate pain relief & **NSAIDS with caution** • Consider bone health screen. • Consider prescribing bone protection medication or supplements. • Consider falls prevention service. • Consider management of risk factors: ➢ See NICE guidance ➢ NICE impact falls and fragility fractures **Referral to Rheumatology** • Please see ESMSK osteoporosis guidelines **Referral to fracture liaison service** • Not accepting spinal fragility fractures from primary care at present.	**Urgent Referral To Fracture Clinic:** • <6 weeks with confirmed fracture • Symptoms suggestive of neurological involvement acute or subacute **Urgent referral to integrated MSK service AP / consultant if:** • >6/52in duration with confirmed XR finding • High pain levels or worsening pain levels, impacting on function and Qol • Failure to respond to conservative measures (including physiotherapy) **Referral to Physiotherapy if pain at acceptable limits (>6weeks)**	**Referral to Physiotherapy if pain at acceptable limits (>6weeks)** Reduce risks / incidence of fractures: • Weight bearing exercise, promote muscle strengthening, balance and falls re-education, cardiovascular fitness. • Advice on pain management, pacing and patient education • Consider signposting: weight management, alcohol / smoking cessation & psychological wellbeing. **Referral to AP if pain more severe and not responding to conservative measures (>6weeks)** **AP Clinic:** • Consider Investigation ➢ MRI ➢ If requiring CT scan (contraindicated to MRI) then refer directly to secondary care **Management** • If **bone oedema present >6 weeks** and pain not well controlled, consider onward referral to spinal consultant • If **no bone oedema** and no neural deficit, consider: ➢ Pain medication review with GP. ➢ Refer back to GP or Fracture Liaison Service for medical review and further investigations and they can consider onward referral to rheumatology if needed. ➢ Refer to pain management service. ➢ Consider physiotherapy and other self-management strategies if pain improving **If incidental finding of spinal fracture(s) with no known history of osteoporosis or osteopenia** • As above for AP management • Spine AP to refer patient to Fracture Liaison Service or GP - If no other intervention is being considered AND if management of bone health is the definitive management option. • Request GP input if nature of fracture is uncertain **If recurring fractures with / without history of osteoporosis or osteopenia** • As above

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Scoliosis >16 years old **Kyphosis** **Exclues:** **- Red flags** **- Possible pathological fractures**	**Scoliosis** New onset of scoliosis in teenager 16 or over (usual age 10-15 years) refer to MSK for triage to secondary care orthopaedics No xrays required in primary care. Adult degenerative scoliosis is usually secondary to a childhood scoliosis, developing symptoms in adulthood due to degenerative changes or primarily due to underlying degenerative changes Refer to MSK for further assessment. No xrays required in Primary care. Encourage patients to keep active and use analgesia as required. Physiotherapy can help to maintain strength and flexibility but won't change size of deformity. Braces are not indicated in spinal skeletally mature individuals usually >16 years old. **Kyphosis** Scheurmanns disease or Idiopathic juvenile kyphosis of the spine Usual age of onset 11-16 Often asymptomatic For mild to moderate kyphosis treatment should include analgesia as necessary, exercise and postural correction Bracing can be used in adolescents but is not recommended for adults. Surgery is only considered in rare cases where the benefits are considered to outweigh the risks. **Pes Excavatum/Carinatum** These are now treated as normal variants and no treatment / bracing offered. If those with excavatum are struggling with breathlessness then refer for lung function studies and refer to respiratory team. Sudden onset of kyphosis / scoliosis in skeletally mature adult, rule out underlying pathology eg discitis, TB, pathological fracture Thoracic xray / Blood tests/ CXR or referral to A&E if unwell DEXA scan if considering treatment associated with osteoporotic fractures	**Scoliosis** **Referral to Orthopaedics** New onset of scoliosis in a young adult. Any person presenting with new onset scoliosis not previously imaged, should be xrayed and cobb angle measured. **Referral to Physio / MSk services** Worsening pain associated with a longstanding scoliosis **Kyphosis** Referral to A&E with sudden onset kyphosis and patient systemically unwell or abnormal bloods and new onset kyphosis **Scheurmans disease** Suspicion of Scheurmanns in young adult with moderate kyphosis referral to Orthopaedics Longstanding kyphosis with worsening kyphosis refer to MSK Kyphosis associated with osteoporotic fractures see guidance **Spine InsufficiencyFracture's**	Scoliosis Those with a Cob Angle greater than 50 degrees should be referred to tertiary services In London

Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Isolated hip or knee pain >65 years, with diagnosed insufficiency fracture Including: • Pubic rami • Sacrum • Head of femur • Proximal tibia *No history of trauma* *Trivial Trauma*	**Assessment:** • Establish history • Exclude trauma • Typical presentation: ➢ Patient usually elderly with pain in hip, pelvis or knee, possible trivial or no trauma ➢ Onset can be spontaneous with end range or sustained hip flexion (hip) • Exam and assessment **Diagnostics:** • Urgent X-Ray if considering possible fracture Please be explicit in your request regarding any trauma, the date of the trauma and any previous fractures / osteoporotic risk factors. If an acute injury refer to A&E. **NOTE: NB. These are rarely identified in Primary care. Insufficiency fracture is usually identified on MRI scan.** **Management:** • if diagnosed on xray or MRI scan prior to referral in MSK, follow up appointment should be booked urgently with AP or ORTHO consultant • DEXA scan and appropriate medical management	**As per 'isolated knee pain > 45 years of age' or 'Hip Osteoarthritis (suspected or diagnosed) >45' pathways** **Refer to A&E if:** • Patient is immobile (unable to weight bear) **Urgent referral to Orthopaedics if:** • Insufficiency fracture identified from imaging undertaken in primary care **Urgent referral to Advanced Practitioner if:** • if X-Ray NAD but insufficiency fracture suspected from clinical assessment	**Assessment:** **Diagnostics:** • Plain X-Ray ➢ Hip: AP lying and lateral ➢ Knee: AP standing, lateral, skyline • MRI **Management:** • Protected WB with crutches/frame if suspected or diagnosed as pain allows for 6-12 weeks • AP to discuss case with ortho consultant to determine suitability for conservative management vs surgery when identified in MSK clinic (NOTE: Requirement for surgery is dependent upon several factors including evidence of collapse and size of the area affected. This is a surgical decision) • Patient SDM • Patient education **Referral to A&E (from AP) if:** • Patient is immobile (unable to weight bear) and insufficiency fracture is suspect or confirmed on diagnostics **NOTE: these cases may need admission and urgent surgical management** **Referral to ESHT Fracture Liaison Service (from AP) if patient meets the following criteria:** • Slip trip or fall from standing height resulting in a fragility fracture • Age over 50yrs • Not peri prosthetic fracture • Further support can be sought from the Fracture Liaison Service via: ESHT.fractureliaisonservice@nhs.net