East Sussex MSK Community Partnership

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## Rheumatology Triage Guidelines

August 2025

East Sussex MSK Community Partnership

**Contents**

# 1. Axial Spondyloarthropathy

| Referral reason | Primary Care Management | Integrated MSK Service |
|---|---|---|
| | **Clinical presentation:**<br><br>Refer to MSK Rheum if: Low back pain > 3 months with onset before 45 years of age AND if 4 or more additional features below:<br><br>• Low back pain that started before the age of 35 years<br>• Waking during the second half of the night because of symptoms<br>• Buttock pain<br>• Improvement with movement<br>• Improvement within 48 hours of taking non-steroidal anti-inflammatory drugs (NSAIDs)<br>• A first-degree relative with spondylarthritis<br>• Current or past arthritis,<br>• Enthesitis (esp. non mechanical heel pain), or pain or swelling in tendon or joints not due to injury<br>• Current or past psoriasis,<br>• Family history Inflammatory bowel disease<br>• Uveitis: ask people with back pain > 3mths with onset before 45yrs if history of uveitis,<br>• Is the person HLA B27 positive or has a history of psoriasis<br><br>**Investigations:**<br><br>FBC, TFT, U&E, LFT, CRP, ESR, Glucose, Bone profile, Vitamin D, CK and HLA B27<br><br>No imaging required<br><br>**Management:**<br><br>• Patient education/information https://www.versusarthritis.org/ankylosing-spondylitis/ https://nass.co.uk/<br><br>• Medication management with NSAID. Consider switching to another NSAID if maximum tolerated dose for 2-4 weeks does not provide adequate pain relief Consider PPI cover | **Referral to Rheumatology:**<br><br>• For diagnosis if criteria met and after investigations have been completed<br><br>**Management following Assessment:**<br><br>If diagnosed with Axial spa:<br><br>• Medication management<br><br>• Review in rheumatology<br><br>• Early diagnosis support through Physiotherapy<br><br>If diagnosis ruled out refer back to GP |

# 2. Established Inflammatory Arthritis

| Referral reason | Primary Care Management | Integrated MSK Service |
|---|---|---|
| | **Guidance:**<br>• Review diagnosis and existing care plan<br>• Two or more painful and swollen joints<br>• Early morning stiffness for 30 minutes (often diurnal)<br>• Duration is more than 6 weeks<br>• Fatigue,<br>• Visual Analogue Scale pain score may be helpful,<br>• sleep pattern<br>• History of previous and current management<br>• Check patient knowledge of disease<br>• Check for cardiovascular risk factors (including HbA1C/lipids) and treat accordingly<br>• Patient education and advice Shared Care Protocol<br>• DMARD management Review analgesia<br>• Consider IM Depomedrone for flares<br><br>**Investigations:**<br>FBC, TFT, U&E, LFT, CRP, ESR,<br>Do not repeat ANA, RhF, ACCP, HLAB27 if previously done.<br>No imaging required | **Referral to Rheumatology:**<br>• For all follow-ups<br>• For flares or review of DMARDS following results of primary care investigations |

# 3. Fibromyalgia – a Primary Care Diagnosis

| Primary Care Management | Integrated MSK Service |
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**Guidance:**
Fibromyalgia is a syndrome characterised by widespread pain in the body present for at least 3 months and is thought to be related to amplified pain signals in the spinal cord and brain.

**Symptoms:**
- Chronic, waxing and waning, widespread body pain.
- Comorbid symptoms such as fatigue, memory difficulties, and sleep and mood difficulties, 'brain fog' are common.
- Physical examination is typically normal but there is often diffuse tenderness, which may be assessed by counting the number of tender points or by palpating several areas of the body.
- Allodynia
- Headaches
- Sensitivity to sensory Stimuli
- Numbness tingling

**Predisposing factors:**
- Previous psychological trauma
- Previous infection
- Family History
- Female
- Age 20-60 at outset

**Diagnosis:**
History and Clinical examination and exclusion of other differential diagnoses eg Inflammatory conditions

**Investigations:**
ESR, Thyroid function, FBC., Vit D, CK, Ferritin
Rh F, CCP and ANA should only be requested if there is a high clinical suspicion.

**Management:**
Fibromyalgia (FM) can be managed but not cured. The goals of treatment are to manage the core symptoms of FM by reducing pain levels, improving the quality of life and function, improving sleep quality and reducing fatigue, improving physical and mental health, and improving cognitive function. Treatment should include both non-pharmacological and pharmacological therapies, alone or in combination, which is individualised to the patient and involves a multidisciplinary team.

**Non-Pharmaceutical Management:**
- Patient education
- Pain management MDT programmes
- Low grade exercise and activity pacing
- CBT / ACT / Mindfulness

**Pharmaceutical management:**
Pharmacological therapy is, at best, modestly effective in a minority of patients - Fibromyalgia - Management Approach | BMJ Best Practice

**Onward Referral:**

- Physiotherapy - to guide low grade exercise programmes
- Pain clinic - For access to MDT Pain management programmes and psychological therapy
- No indication for rheumatology referral unless suspecting another rheumatological condition

# 4. Generalised Osteoarthritis

| Referral reason | Primary Care Management | Integrated MSK Service |
|---|---|---|
| | **Clinical presentation:**<br><br>• Symptom sites, severity and frequency<br>• History of fatigue, sleep, low mood<br>• Function: ADL's PMH/Co-morbidities/Peri-menopausal<br>• Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking<br>• Organ specific symptoms to exclude: systemic disease, depression, anxiety<br>• Yellow flags (psycho-social): Work, relationships, leisure, QOL<br>• Joint examination<br>• Attitudes to exercise<br>• Consider differential diagnoses such as gout, other inflammatory arthritis, septic arthritis and malignancy<br><br>**Assessment:**<br><br>Clinically diagnose without investigation if patient:<br><br>• Is 45 or over AND<br>• Has activity-related joint pain AND<br>• Has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.<br><br>Primary care further investigation:<br><br>• FBC, ESR/CRP, U&E, LFT, Bone profile, CK, TFT, eGFR, Vitamin D<br>• Urine dipstick<br>• Weight and BMI<br>• Auto-antibodies blood tests are unlikely to be helpful and should not be requested routinely (because there are frequent false positives), unless specific indications of connective tissue disorder such as: Dry eyes / Dry mouth / Photo-sensitive rash / Significant alopecia / Recurrent miscarriage<br><br>**Management:**<br><br>• Patient education/information https://www.versusarthritis.org/osteoarthritis/<br>• Advice on use of heat or cold<br>• Advice on pacing Advice on appropriate exercise to include local muscle strengthening and general aerobic fitness<br>• Advice on appropriate footwear, including shock absorbing properties, for people with lower limb osteoarthritis<br>• Advice on TENS machine<br>• Analgesia Consider topical capsaicin for knee or hand osteoarthritis Offer interventions to help weight loss for people who are obese or overweight | **Onward Referral:**<br><br>• Advise patient to self-refer to NHS Physiotherapy via; eastsussexmsk.nhs.uk/gethelp<br><br>• Referral on to East Sussex Community MSK Partnership through ERS.<br><br>• Do not refer to rheumatology unless suspecting inflammatory presentation |

# 5. Gout

| Primary Care Management | Integrated MSK Service |
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**Symptoms:**
- Severe, rapid onset joint pain; often at night or early morning
- Usually mono-arthritis generally 1st MTP but commonly ankles, knees, elbows, wrists and fingers.
- Swelling and erythema
- Tophi
- Risk factors: drugs: diuretics, low dose aspirin, renal disease, metabolic syndrome; ageing, male gender
- Consider differential diagnosis such as septic arthritis and other forms of inflammatory arthritis

**Investigations:**
- FBC, Urate, U&E, LFT, Bone profile, ESR, CRP, Blood cultures as appropriate
- Patient temperature
- No imaging necessary (acute onset)
- Aspirate for crystal examination, if diagnosis is uncertain or unconfirmed
- Note: A urate level within the normal range does not exclude a diagnosis of gout

**Management:**
- Patient education, lifestyle moderation
- Use of ice packs (PRICE)
- Stop or change precipitating drug where appropriate to do so
- Acute: (1) Full dose NSAID until 1-2 days after attack has resolved or (2)Colchicine 1g stat and then 500mcg 2 -3 times or (3) Steroid (IA, IM, PO)
- Review at 4 - 6 weeks to assess lifestyle factors, BP, serum urate, renal function, blood glucose and cholesterol
- Monitor response: Pain level- Visual Analogue Score

**Chronic Disease Management:**
- Lifestyle factors
- Agree management plan with patient
- Caution with renal impairment

**Decision to Treat:**

Offer Urate Lowering therapy using a treat to target strategy for people with gout who have:

1. Multiple troublesome flares
2. CKD 3-5y
3. Diuretic therapy
4. Tophi
5. Chronic Gouty arthritis with bony changes

First line treatment with allopurinol 1-2 weeks after inflammation has settled, and up-titration **– *"treat to target"*** Can be started earlier as appropriate

Suppress urate <0.36mmol/L

NSAID or colchicine prophylaxis for at least three months of starting urate lowering therapy and patient should have SOS pack at home in case of future flares

Treat any acute attacks as above and DO NOT STOP urate lowering drug

**Onward Referral to Rheumatology:**
- Unresponsive or toxicity to allopurinol and / or febuxostat
- Uncertainty about diagnosis
- Patient is under 30 years of age
- They have had an organ transplant
- They have CKD stages 3b to 5
- Patient is pregnant

# 6. Ehlers–Danlos syndrome (EDS) and hypermobility spectrum disorder (HSD)

| Referral reason | Primary Care Management | Integrated MSK Service |
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| | The Ehlers-Danlos syndromes (EDS) GP Toolkit<br><br>**(This advice applies to those 16 and over)**<br><br>**Clinical presentation:**<br><br>• Joint / tissue hypermobility<br>• Fatigue<br>• Neurodiversity<br>• Autoimmune disorders eg PoTS, allergies<br>• Gastric and gynae issues associated with connective tissue changes<br>• **Mast Cell Activation Syndrome (**MCAS)<br>• Family history<br><br>**Just GAPE** acronym below:<br><br>• Joints and (U)other Soft Tissues<br>• Gut<br>• Allergy / Atophy / Auto-immune<br>• Postural Symptoms (PoTS)<br>• Exhaustion<br><br>**Diagnosis:**<br><br>• Use of the Beighton score Beighton Score<br>• The patient's story<br>• Exclusion of other conditions eg inflammatory arthritis<br>• FBC, ESR/CRP, U&E, LFT, and Vitamin D | **Onward Referral:**<br>Many hypermobile patients will be managed, for the majority of their lives, solely within Primary Care.<br><br>Referral to physiotherapy, occupational therapy or podiatry for advice on self-management and to manage specific presentations may be helpful.<br><br>For those patients whose pain cannot be managed through primary care then referral onto pain services for medication review and/or a MDT biopsychosocial approach to manage their pain, fatigue and mood levels.<br><br>**Rheumatology Referral**<br><br>Formal genetic testing is rare and only considered in very specific presentations.<br><br>Referral for rheumatology review is indicated only if more than one of the following features is seen.<br><br>**Clinical signs:**<br>• Skin features – classical (Abnormal scars, very elastic skin) or vascular (translucent skin, skin which tears easily, abnormal bruises – very large or in unusual sites)<br>• Unusual facial features (thin lips, prominent eyes, narrow nose) in addition to skin fragility<br>• Severe scoliosis<br>• Marfanoid body habitus associated with an abnormal echocardiogram or lens dislocation<br><br>Personal or family history of any of the following should lead to the consideration of Vascular EDS<br>• Vascular events (aneurysms, subarachnoid haemorrhage, recurrent severe post-operative haemorrhage, arterial dissection)<br>• Recurrent spontaneous pneumothorax<br>• Bowel perforation uterine rupture<br>• Very severe peripartum perineal tear |

# 7. Osteoporosis Guidelines

| Referral reason | Primary Care Management | | Integrated MSK Service: |
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| | **Presentation:**<br>Fractures associated with osteoporosis, are often described as 'fragility' fractures. They are typically caused by low impact injuries that would not normally cause a fracture (such as a fall from standing height). Fragility fractures can occur spontaneously, in people with no history of injury. Most vertebral fragility fractures are not caused by falls, instead happening after activities involving lifting, twisting or bending. Fragility fractures most commonly affect the vertebral body, hip, proximal humerus and distal forearm. However, fragility fractures can happen in any bone, and some fractures (for example pelvis and rib fractures) are just associated with reduced bone strength as the most common fragility fractures.<br>• Consider PMH and Co-morbidities<br>• Consider impact on function and ADLs<br>• Yellow flags (psycho-social): Work, relationships, leisure, QOL<br>• Exclude secondary causes of Osteoporosis<br>• Consider risk factors for osteoporosis<br><br>**Risk Factors:**<br>Post menopausal women and men>50.<br>Parental history of previous hip fracture<br>Use of corticosteroids >7.5mg> 3 months<br>Smoking > 3 units/day/ alcohol<br>Low BMI<br><br>Calculate FRAX - https://www.sheffield.ac.uk/FRAX/<br>Consider NOGG guidelines - https://www.sheffield.ac.uk/NOGG/ | **Investigations:**<br>• DEXA if indicated following FRAX.<br>• Thoracic and lumbar spine (lateral) X-ray if indicated suspicious of vertebral fracture.<br>• BMI<br>• If low bone density consider: FBC, ESR, U&E, LFT, TSH, CRP, bone profile, Vitamin D<br>• All patients with new vertebral fractures to have serum electrophoresis and serum free light chains<br>• Consider coeliac, PTH, serum testosterone, sex hormone binding globulin, follicle stimulating hormone, luteinizing hormone, serum prolactin, 24-hour urinary free cortisol, 24-hour urinary calcium depending on clinical picture and as appropriate<br>• Investigate for renal disease and urinary calcium (urinalysis)<br>• Testosterone level is also recommended for men under 65yrs of age.<br>• If no obvious reason for a low bone density (especially in men) consider further investigations or referral to secondary care<br><br>**Education and Management:**<br>• Royal Osteoporosis Society \| Support for you<br>• Encourage exercise to improve bone health, muscle strength and balance - reducing the risk of falls.<br>• Muscle strengthening – weights / resisted work<br>• Weight bearing exercise / impact exercise<br>• Wellbeing / flexibility<br>➢ Offer dietary advice with food high in vit D, calcium and protein. https://cks.nice.org.uk/vitamin-d...<br>➢ Simple analgesics in line with agreed formularies<br>➢ Psycho-social support / support groups<br>➢ Consider treatment with 1st line bone protection/oral bisphosphonate https:/www.nice.org.uk/guidance/Bisphosphonates<br>➢ Consider HRT treatment.<br>➢ If intolerant to first oral Bisphosphonate trial a second oral bisphosphonate may be considered.<br>**Ongoing Management:**<br>• Do not repeat DEXA for 2-3 years and then only if likely to affect management.<br>• Reassess FRAX after 5 years, or before if patient fractures on treatment.<br>• Assess patients who fracture and > 2 years on treatment:<br>• Check compliance with medications<br>• Re-evaluate treatment choice | **Onward Referral:**<br><br>**Community MSK service:**<br>For consideration of assessment and management of specific MSK presentations.<br>Consider referral to falls prevention services<br><br>**Rheumatology:**<br>• For patients where oral bisphosphonate is not tolerated or contraindicated<br>• For patients who continue to fracture despite adherence to oral bone medication, having ruled out secondary causes of Osteoporosis |

# 8. Peripheral Spondyloarthropathy

| Referral reason | Primary Care Management | Integrated MSK Service |
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| | **Refer to Rheumatology if:**<br><br>Dactylitis (whole swollen digit- 'sausage' finger or toe)<br><br>**And / Or**<br><br>Persistent or multiple-site enthesitis without apparent mechanical cause and/or with other features, including:<br>• Back pain without apparent mechanical cause<br>• Current /past psoriasis, inflammatory bowel disease, (Crohn's disease / ulcerative colitis) or uveitis<br>• Close relative (parent, brother, sister, son or daughter) with Spondylarthritis or psoriasis<br>• Symptom onset following GIT or genitourinary infection<br>• Early morning stiffness >30 mins<br><br>**Investigations in primary care to be completed prior to referral:**<br><br>FBC, TFT, U&E, LFT, CRP, ESR,<br><br>**Primary Care management:**<br><br>Patient information / education<br><br>https://www.versusarthritis.org/psoriatic-arthritis/<br><br>https://www.papaa.org/<br><br>Medication management with NSAID. Consider switching to another NSAID if maximum tolerated dose for 2-4 weeks does not provide adequate pain relief<br>Consider PPI cover | Refer to MSK service for patients with a confirmed diagnosis for physiotherapy, podiatry, occupational therapy for specific presentations and interventions or for advice on supported self management |

# 9. Polymyalgia Rheumatica PMR

| Referral reason | Primary Care Management | Integrated MSK Service |
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| | **Symptoms:**<br>• Symmetrical shoulder and/or pelvic girdle proximal muscle stiffness and aching (if predominant feature pain and weakness consider polymyositis)<br>• Age >50 years<br>• Duration > 2 weeks<br>• Early morning stiffness >45minutes<br>• Previous medical history<br>• Poor sleep, concentration, mood<br>• Headaches or visual disturbance – see urgent GCA Pathway<br><br>**Assessment:**<br>• Assess shoulder, neck and hip range of movement<br>• Assess peripheral joints for synovitis<br>• Blood tests: Initially ESR, CRP, FBC, U&E, LFT, ESR, CRP, TFT, CK, Bone profile<br><br>**Diagnosis**<br>• Presence of core features of the condition<br>• Raised inflammatory markers<br>• Exclusion of differential diagnoses such as RA and Fibromyalgia<br>• The response to systemic steroids is usually rapid and dramatic with many symptoms resolving after a few days of treatment.<br>• Normalisation of inflammatory markers within 4 weeks<br><br>**Primary Care Management:**<br>• Patient education and information<br>• Use clinical judgement - prescribe 15mg of prednisolone daily for 2-3 weeks then review:<br>• Bone protection needs to be considered in all patients on long term prednisolone<br>• Gradually reducing the dose of corticosteroids<br>• Assessing and managing the symptoms of relapse, onset of GCA and steroid associated adverse effects | **Refer to Rheumatology:**<br><br>• Age <60 years<br>• Atypical presentation / features<br>• Prominent systemic features, weight loss, night pain, neurological signs<br>• Features of other rheumatic disease<br>• Resistant to corticosteroid therapy or repeated flare ups on dose reduction<br>• Steroids required >2 years<br>• CK significantly elevated (considering polymyositis) |

# 10. Septic Arthritis

| Referral reason | Primary Care Management | Integrated MSK Service |
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| | **Clinical presentation:**<br>• Short history of a hot, swollen and tender joint (or joints)<br>• Restriction of movement<br>• Feeling generally unwell with a high temperature<br>• Rule out systemic symptoms i.e rashes, malaise<br>• Risk factors; family history, smoking<br><br>**Management:**<br>• Consider differentials: Crystal arthritis, Osteoarthritis, Inflammatory arthritis, Haemarthrosis.<br>• **Refer as emergency to Secondary Care if Septic Arthritis is suspected** | |

# 11. Suspected Connective Tissue Disorder

| Referral reason | Primary Care Management | Integrated MSK Service |
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| | **Clinical presentation:**<br><br>• Symptoms suggestive of CTD can include:<br>• Arthralgia/Myalgia  Inflammatory muscle pain / weakness<br>• Telangiectasia (broken capillaries)<br>• Possible vasculitic rashes with joint pains<br>• Calcium deposits in the skin and other areas<br>• Raynaud's Phenomenon (secondary) – especially middle age onset<br>• Skin changes to include: thickening, swelling, tightening and colour changes<br>• Sun sensitive rash<br>• Malar or discoid rash<br>• Dry eye / dry mouth with joint symptoms Ulcers<br>• Hair loss<br>• High blood pressure Respiratory problems (pleuritis or pericarditis) Shortness of breath<br>• Heartburn Digestive tract problems such as: difficulty swallowing food, bloating and/or constipation, or problems absorbing food leading to weight loss<br>• Fever, malaise, fatigue and weight loss<br>• Multi-system/organ involvement<br>• Family history of CTD<br><br>**Primary Care Investigations prior to referral:**<br><br>FBC, ESR/CRP, U&E, LFT, CK, TFT  and ANA as appropriate.<br><br>Urine dipstick Urine PCR<br><br>**Management:**<br><br>• Patient education/information<br><br>• Analgesia<br><br>• Manage cardiovascular risk factors | **Rheumatology Referral:**<br><br>If CTD is suspected<br><br>And/or positive inflammatory markers<br><br>Any onwards referrals required will be managed through rheumatology |