British Society for Rheumatology

Adult rheumatology referral guidance

This guidance serves to support adult rheumatology departments and primary care colleagues. It provides information on symptoms and signs that might suggest an underlying rheumatological diagnosis and is helpful to include in referrals. It also provides information on when advice and guidance might be a more appropriate means to seek a rheumatology specialist opinion. We haven't included specifics as to what should be seen as routine vs urgent and recognise that most departments will have a specific urgent giant cell arteritis referral pathway.

The guidance is in line with the **GIRFT recommendations** (recommendations 1, 2 and 9) and related actions.

Importantly this is guidance and we recognise the following caveats:

- Primary care colleagues are not always certain as to the differential diagnosis and will refer on the basis of symptoms of concern.
- What is referred to a rheumatology clinic is influenced by local musculoskeletal, orthopaedic and pain services.
- There's variation between rheumatology departments and for some conditions referrals may be directed to a different speciality, e.g. osteoporosis.
- Rheumatology departments are at different stages of the journey with advice and guidance.

This guidance was drafted by the British Society for Rheumatology's Clinical Affairs Committee (14 September 2021).

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Refer to rheumatology

Suspected rheumatoid arthritis

Refer if persistent symptoms for >four weeks, even with normal ESR/CRP and negative CCP or rheumatoid factor:

- Small joints of the hands or feet
- More than one joint
- Delay of three months or longer between onset of symptoms and seeking medical advice.

Suspected axial spondyloarthritis (inflammatory back pain)

Low back pain that has lasted for >3 months and if **four or more** *of the following additional criteria are also present:*

- Low back pain that started before the age of 35 years
- Waking during the second half of the night because of symptoms
- Alternating buttock pain
- Improvement with movement
- Improvement within 48 hours of taking non-steroidal anti-inflammatory drugs
- A first-degree relative with spondyloarthritis
- Current or past arthritis
- Current or past history of enthesitis
- Current or past history of psoriasis.

Suspected psoriatic arthritis and other peripheral spondyloarthritides

- Dactylitis
- Enthesitis without apparent mechanical cause, persistent or in multiple sites or with any of the following:
  - pain without apparent mechanical cause
  - current or past uveitis
  - current or past psoriasis
  - gastrointestinal or genitourinary infection
  - inflammatory bowel disease (Crohn's disease or ulcerative colitis)
  - first-degree relative with spondyloarthritis or psoriasis.

Persistent synovitis/arthralgia (monoarticular/polyarticular) of unknown cause

Suspected autoimmune connective tissue disease

Patients with positive antibody results in the absence of symptoms (utilise A&G for such queries):

- Atypical Raynaud's: late onset, digital ulceration
- **SLE**: rash, photosensitivity, oral ulcers, Raynaud's, joint pains, chest pain (pleuritic/pericarditis), fatigue, low white cells, low platelets, proteinuria, haematuria, raised creatinine, acute sensory or motor loss
- **Systemic sclerosis**: Raynaud's, puffy fingers, dyspnoea, indigestion, dysphagia
- **Inflammatory myopathies**: progressive muscle weakness (usually proximal) +/- rashes
- **Sjögren's syndrome**: dry mouth, dry eyes, parotid or submandibular swelling.

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Suspected GCA (please refer to local emergency referral pathway, which may have access via an alternative specialty)

- Age of onset >50 years
- New onset of headache (usually temporal)
- Scalp pain/tenderness/temporal artery abnormalities (reduced/absent pulsation)
- Jaw or tongue claudication
- Visual symptoms, e.g. diplopia, visual field defect, visual loss
- Symptoms of polymyalgia rheumatica (proximal muscle pain and stiffness)
- ESR/CRP typically raised but if clinical history is entirely typical and inflammatory markers are normal, GCA cannot be excluded.

Suspected vasculitis

Consider if systemically unwell with raised inflammatory markers in the absence of infection or other explanation. Be alert to evidence of end organ damage, e.g. skin infarction, visual loss, respiratory failure, cardiac failure, acute abdomen, acute kidney injury, acute sensory/motor loss

Other symptoms that might be present:

- Respiratory – haemoptysis, shortness of breath
- Oral health – mouth ulcers
- GUM – genital ulcers
- Renal – haematuria, elevated creatinine
- Ophthalmology – scleritis, visual loss
- ENT – hearing loss, nasal crusting, nosebleeds, sinus pain
- Other possible symptoms include rashes, weight loss, night sweats, fatigue, joint pain.

Gout (consider the option of A&G for gout-related queries)

Gout is a condition that can be diagnosed and managed in primary care.
Rheumatology input may be needed in the following circumstances:

- Symptomatic despite treatment
- Comorbidities limiting treatment options.

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Polymyalgia rheumatica (consider the option of A&G for PMR-related queries)

PMR is a condition that can be diagnosed and managed in primary care.
If there is diagnostic uncertainty then please refer or consider A&G
Rheumatology input may be needed in the following circumstances
Atypical features or features that increase likelihood of a non-PMR diagnosis:

- Age <60 years
- Chronic onset (>2 months)
- Lack of shoulder involvement
- Lack of inflammatory stiffness
- Prominent systemic features, weight loss, night pain, neurological signs
- Features of other rheumatic disease
- Normal or extremely high acute-phase response

Treatment dilemmas such as:

- Incomplete, poorly sustained or non-response to corticosteroids
- Inability to reduce corticosteroids
- Contraindications to corticosteroid therapy
- The need for prolonged corticosteroid therapy (>2 years).

Suspected fibromyalgia to confirm diagnosis where there is concern that other inflammatory conditions need to be excluded

Osteoporosis (consider the option of A&G for osteoporosis-related queries)

Osteoporosis is a condition that can be diagnosed and managed in primary care
Rheumatology input may be needed in the following circumstances:

- Men aged <65 years
- Pre-menopausal women
- Patients requiring parenteral therapies
- Patients with multiple fractures despite treatment
- Patients with secondary causes.

Paget's disease

Do not refer to rheumatology (this will depend on local services and pathways)	
Clinical Emergencies such as suspected cauda equina syndrome, metastatic cord compression, spinal infection, septic arthritis or GCA (unless rheumatology is the point of access for your local emergency referral pathway for this condition)	Must be dealt with on the day as an emergency. Please keep updated about local pathways to manage
Suspected cancers including bone malignancy	Urgent referral as per local 2WW rule pathways
Patients with positive antibody results in the absence of symptoms	Utilise advice and guidance with local rheumatology service to support decision making
Osteoarthritis	Refer to local pathways, making the best use of MSK expertise in Primary and Community Care. This will include use of clinical pharmacists, social prescribers, First Contact Practitioners, Advanced Practitioners as well as MSK interface services and local orthopaedic, spinal and pain management services. Consider the use of Specialist Advice (A&G) for any diagnostic/ management uncertainty
Non-inflammatory back pain	
Soft tissue disorders	
Fibromyalgia	
Chronic fatigue syndrome	
Hypermobility	