**SELF-CARE AND SELF-MANAGEMENT**

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

**OUTCOME MEASURES**

- MSK-HQ
- Oxford Hip Score

| **Referral reason / Patient presentation** | **Osteoarthritis Hip – Established**<br>The term 'low back pain' is used to include any non-specific low back pain which is not due to cancer, fracture, infection or an inflammatory disease process |
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| **Primary Care Management** | **Examination, History & Assessment**<br>• Age<br>• History<br>• Co-morbidities<br>• Joint examination<br>• Signpost patient to Hip Decision Aid<br>•<br>**Investigation:**<br>AP & Lateral Hip X-Ray<br>**Management (including condition-specific self-care options):**<br>• Patient education<br>• ADL modifications<br>• Step-wise approach to analgesia – follow the analgesic ladder<br><br>**NICE OA Advice - Core**<br>**Access to appropriate information:**<br>Offer accurate verbal and written information to enhance understanding of osteoarthritis and management of the condition<br><br>Information leaflet:<br>http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/OA-Hip-1.pdf<br><br>Offer advice on appropriate footwear (including shock-absorbing properties)<br><br>**Activity and Exercise:**<br>Exercise should include local muscle strengthening and general aerobic fitness.<br>Interventions to help weight loss: Offer Sign Posting to people with osteoarthritis who are overweight or obese: Health Trainers or specific referral onto weight loss programmes |

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| **Thresholds for Primary Care to initiate a referral** | **Refer to General Physiotherapy if:**<br>flare ups are not settling<br><br>**Refer to Advanced Practitioner (ICATS) if:**<br>• Patient wants surgery e.g. night pain / reduced ADLs / failure to respond to analgesia & therapy / tried appropriate exercise programme for more than 3 months<br>• If severe OA on X-Ray<br>Comment: if severe pain consider AVN – see relevant pathway<br><br>**Refer to Orthopaedic Consultant if:**<br>• Second opinion advised by another orthopaedic surgeon. |
| **Management Pathway for the Integrated MSK Service** | • Patient information<br>• Assessment and Examination:<br>• Clinical examination and history<br>• Consider use of Hip Decision Aid<br>• Consider use of Oxford Score if patient wishes to pursue surgical opinion<br>• Patient education and information<br>• Discuss medication<br>• Consider intraarticular steroid joint injection in mild-moderate disease<br>• Consider Health Trainers support regarding lifestyle changes and weight-loss<br><br>Comment: consider signposting |
| **Thresholds for referral for Intervention**<br><br>Offer patient choice of provider | **If consideration of arthroplasty compliance with CEC guidelines:**<br>• Established OA on X-Ray<br>• Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of conservative treatment or management<br>• Physiotherapy, patient education, orthosis, lifestyle improvements management framework<br>• BMI > 35 offer weight loss management services<br>• BMI > 40 will **not** routinely be listed for arthroplasty |
| **Management pathway for Specialist In-patient care** | |

| Referral reason / Patient presentation | AVN |
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| **Primary Care Management** | **History**<br>• Previous history of long-term steroids<br>• Smoking<br>• HIV<br>• Sickle cell<br><br>**Assessment**<br>• Atraumatic<br>• Sudden onset<br>• Unrelenting<br>• Night pain<br><br>**Diagnostics**<br>X-Ray |
| **Thresholds for Primary Care to initiate a referral** | **Referral to ICATS – Urgent if:**<br>severe pain but no AVN on X-Ray<br><br>**Urgent referral to Orthopaedic Consultant if:**<br>AVN without OA<br><br>**Routine referral to Orthopaedic Consultant if:**<br>AVN in the presence of OA |
| **Management Pathway for the Integrated MSK Service** | • MRI<br>• Protected weight bearing if evidence of AVN |
| **Thresholds for referral for Intervention**<br><br>Offer patient choice of provider | **Urgent referral to orthopaedic consultant if:** AVN in the absence of OA for consideration of hip salvage surgery<br><br>**Routine referral to orthopaedic consultant if:**<br>AVN in the presence of OA |
| **Management pathway for Specialist In-patient care** | |

| Referral reason / Patient presentation | Anterior hip pain / Femoroacetabular impingement syndrome |
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| **Primary Care Management** | **Assessment:**<br>• History – young adult with hip pain in prolonged sitting or hip flexion, no trauma<br>• Examination – Pain and limitation into flexion or flexion / internal rotation<br><br>**Investigation:**<br>X-RAY AP and lateral hip<br><br>**Management (including condition-specific self-care options):**<br>• Patient education<br>• Activity modification<br>• Pain relief in line with agreed formularies / guidance – follow the analgesic ladder<br>• History<br>• Consider integrated service<br><br>Information leaflet<br>http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/04/Femoroacetabular-impingement-5.pdf |
| **Thresholds for Primary Care to initiate a referral** | **Refer to General Physiotherapy if:**<br>Symptoms persist for more than 6 weeks<br><br>**Refer to Advanced Practitioner (ICATS) if**<br>Previous poor response to physiotherapy |
| **Management Pathway for the Integrated MSK Service** | **Assessment and examination (General Physiotherapist / Advanced Practitioner)**<br><br>**Diagnostics:**<br>• Review X-Ray (in first instance)<br>• Consider MRI<br><br>**Management**<br>• Consider conservative measures, physio, lifestyle, weight loss<br>• If confirmed CAM or pincer deformity on imaging with signs or impingement or–<br>• Consider guided intraarticular steroid injection |
| **Thresholds for referral for Intervention**<br>Offer patient choice of provider<br><br>Griffin (2018)<br>Arthroscopy vs Conse | Consider secondary care referral if failed to respond to 6-8 weeks of physiotherapy<br><br>Offer choice of referral to specialist hip surgeon who can provide procedure if patient needs and wants surgery and is fit for surgery.<br>**Must have no evidence of Osteoarthritis**<br><br>If patient needs and wants surgery but is not fit for surgery, refer to GP for further management |
| **Management pathway for Specialist In-patient care** | Consider surgical intervention<br>• Arthroscopy Femoroacetabular surgery<br>https://www.nice.org.uk/guidance/ipg408<br><br>• Open Femoroacetabular surgery<br>https://www.nice.org.uk/guidance/ipg403/ |

| Referral reason / Patient presentation | Lateral hip pain / GTPS / gluteal tendinopathy |
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| **Primary Care Management** | **Assessment**<br>• History – trauma / trigger / insidious / red flags<br>• Examination – Pain local to lateral hip +/- referral<br>• +ve pain provocation tests<br><br>**Management**<br>• Consider US<br>- Pain relief in line with agreed formularies / guidance<br>• Patient education / exercise sheet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/03/Greater-Trochanteric-Pain-Syndrome.pdf<br>• Reassurance<br>• Activity modification<br>• If LBP is the primary pain suggest spine pathway / physiotherapy<br>• Advise to self-refer to physiotherapy if not<br>• improved within 6/52 |
| **Thresholds for Primary Care to initiate a referral** | **Urgent Referral to Physiotherapy if:**<br>If no obvious tear suspected but high pain levels / significant loss of function / disturbed sleep / work<br><br>**Referral to Physiotherapy if:**<br>No improvement at 6/52 OR ADLS affected OR in severe pain<br><br>**Urgent Referral to Advanced Practitioner (ICATS) if:**<br>• If suspect gluteal tear (+ve Trendelenburg) refer urgently to AP clinic<br><br>**Referral to Advanced Practitioner (ICATS) if:**<br>• No improvement with 3/12 physiotherapy<br>• +ve Trendelenburg / history of trauma suggesting gluteal tear<br>• Diagnostic uncertainty |
| **Management Pathway for the Integrated MSK Service** | **Assessment**<br>• History – trauma / trigger / insidious / red flags<br>• Examination<br>• +ve pain provocation tests<br><br>**Diagnostics**<br>If suspected gluteal tear/severe pain/significant functional loss consider urgent: MRI (better defn) / US (dynamic ax)<br>XR if limited hip ROM consistent with OA<br>Suspected fracture XR<br><br>**Management** (including condition specific self-care options). E.g.:<br>• Weight loss<br>• Activity modification<br>• Sign post to relevant self-management services<br>• Consider further physiotherapy<br>• Consider steroid injection (initial injection guided)<br>• Consider surgical opinion if diagnostics +ve for tear |

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| **Thresholds for referral for Intervention**<br><br>Offer patient choice of provider | **Secondary care**<br>• Acute Gluteal tendon tear needing surgical repair-patient fit for surgery<br>• Chronic tear not responded to conservative management / severe pain / loss of function<br>• Intractable tendinopathy unresponsive to conservative management<br>• If diagnosis uncertain in patient with previous THR consider Consultant opinion |
| **Management pathway for Specialist In-patient care** | |

| **Referral reason / Patient presentation** | **Hip fracture** |
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| **Primary Care Management** | **Assessment**<br>• History<br>• Mechanism of injury or trauma<br>• Range of movement, weight bearing and load<br><br>Diagnostics essential, urgent referral to A&E for X ray<br><br>**Management**<br>**NWB,** analgesia and immobilisation.<br>• Pain relief in line with agreed formularies / guidance<br>• Patient education / exercise sheet (link to leaflet<br>• Reassurance<br>• Activity modification, PWB or FWB / immobilisation<br>• Advise if pain increases, re-present to GP |
| **Thresholds for Primary Care to initiate a referral** | **Urgent referral to secondary care if**:<br>• Patient suffering constant pain<br>• Ascending pain<br>• Instability<br>AND / OR<br>• Immobilisation failed |
| **Management Pathway for the Integrated MSK Service** | Diagnostic date, method of current management (FWB, PWB, NWB), immobilisation.<br><br>**Urgent referral to A&E if:** Symptoms worsening<br><br>**Referral to Physiotherapy if:**<br>Symptoms improving but pain and stiffness from immobilisation or weight bearing status |
| **Thresholds for referral for Intervention**<br><br>Offer patient choice of provider | Risk of infection, non-union of fracture or patient not adhering to protocol. Refer to A&E<br>Examination of patient, history and recent investigations<br>Attending physiotherapy, poor compliance to exercises/protocol |
| **Management pathway for Specialist In-patient care** | |

| Referral reason / Patient presentation | Muscle strain |
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| **Primary Care Management** | **Assessment**<br>• History<br>• Examination – pain on activity, stretching, palpation<br><br>**No Diagnostics**<br><br>**Management**<br>If tendon rupture, complete tear or > ½ mm belly refer A&E<br><br>If no significant loss of function or strength<br>• Pain relief in line with agreed formularies / guidance<br>• Patient advice and education: PRICE and HARM<br>• Activity modification, consider immobilisation for a few days or use of crutches<br>• Review after 5-7 days if lack of improvement, difficulty walking or unable to weight-bear. |
| **Thresholds for Primary Care to initiate a referral** | **Refer to Physiotherapy if:**<br>Symptoms not showing signs of improvement, symptoms deteriorating or new symptoms develop or are disproportionate to degree of trauma.<br><br>**Refer to ICATS if:**<br>Not responding to physiotherapy |
| **Management Pathway for the Integrated MSK Service** | Diagnostics: US or MRI to exclude any other cause of symptoms |
| **Thresholds for referral for Intervention**<br><br>Offer patient choice of provider | Confirmation of muscle tear on imaging |
| **Management pathway for Specialist In-patient care** | Surgery for muscle repair taking into consideration<br>• Pain<br>• Functional limitations<br>• Quality of tissue<br>• Patient wants and is fit for surgery |

**Hip group 10th December 2013**
Peter Devlin (GP, BICS)
Matthew Prout (ESP Physiotherapist, SCT)
Ian Francis (Consultant Radiologist, MIP)
Johan Holte (Consultant Physiotherapist, BICS)
Chris Mercer (Consultant Physiotherapist, WSHT)
Samantha Hook (Orthopaedic Consultant, WSHT)
Ruy Dassuncao (Orthopaedic Consultant, WSHT)
Guy Slater (Orthopaedic Consultant, Horder Healthcare)
Matthew Carr (Service Manager, Horder Healthcare)

Nick Patton (GP)
Andrew Kemp (ESP Physiotherapist, MTW)
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Helen Harper-Smith (ESP Physiotherapist, ESHT)

**Hip group 2nd July 2014**
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Peter Devlin (BICS, Clinical Director)
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Ben Hodgson (BICS, ESP)
Mary McAllister (SCT, ESP)
Iben Altman (SCT, Chief Pharmacist)
John Bush (BSUH, Consultant Radiologist)
Anita Vincent (SASH, Service Manager)
Rachel Dixon (Horder Healthcare, Clinical Director)

**Hip group 20th November 2018**
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Alex Kyriacou (SCFT, Advanced Practitioner)
Mary McAllister (SCFT, Advanced Practitioner)
Stuart Osborne (HERE, Advanced Practitioner)
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*(total email distribution list: Anita Vincent, Blunt Natalie, Peter Devlin, Ben Hodgson, Johan Holte, Ian Francis, Iben Altman, Bush, Khalid Drabu , Laura Finucane, Mary McAllister, Matthew Prout, Stuart Osborne, Phil Stott, Dixon, Richard Bell, Sally Dando, Ciara Jones, Kasia Kaczmarek, Natasha Cracknell, Penny Bolton, Simon Oates)*