SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website:
Information on common MSK conditions
Local condition-specific clinical pathways covering best practice assessment, diagnostics, management and outcome tools and referral thresholds
Lifestyle choices and MSK wellbeing information
Self-care advice, information, resources, tools, videos, Apps
Sign-posting to local and national organisations and resources
Secure messaging function to seek advice from MSK expert clinicians
MSK Advice Line contact details
Patient Decision Aids and shared decision making resources / tools
Pre-Appointment Packs for patients who have been referred to the Integrated MSK Service

Nationally accredited structure self-care programmes provided by Versus Arthritis and National Rheumatoid Arthritis Society (NRAS):
http://www.arthritiscare.org.uk/, http://www.versusarthritis.org and **http://www.nras.org.uk/**

MSK Helplines – Versus Arthritis 0800 5200 520 and NRAS 0800 2987650
MSK Condition Information Packs for newly diagnosed patients
MSK Library of Conditions and Factsheets
MSK Risk Calculator
Tailored self-management programmes provided by Arthritis Care and NRAS including:
- Chat for Change telephone education and support groups
- Online Community Forum
- NRAS and Expert Patient Programme Rheumatoid Arthritis Self-management Programme
- Joint Approaches modular self-management workshops
- Challenging Pain Programme
- On-line self-management course
- Arthritis Champions providing 1-2-1 and community support

Other self-care support:
Integrated MSK Service Leaflet and information on common MSK conditions in local Pharmacies

Possability People – **http://possabilitypeople.org.uk** and telephone **01273 894040**
- advice, information and support; sign-posting; social prescribing; Direct Payments and Personal Budgets support; peer support; Get Involved Group

The Carers Centre - **http://www.thecarerscentre.org/** and telephone **01273 746222**
- carers support packages i.e. Advice Phone Line; support, advocacy and information; Carer Support Groups

Carers Support West Sussex - **https://www.carerssupport.org.uk/** and telephone 0300 028 8888
- Run Support Groups, a Carer Response Line, help carers access equipment to assist them in their caring role or provide funds so that carers can do something for themselves. Also help carers access counselling, call back services and wellbeing support

Local Authority initiatives – i.e. Health Champions / Trainers, Alcohol Reduction Programmes, Exercise Referral Schemes, Weight Management, Social Services, Falls Prevention Service

Action in Rural Sussex - **http://www.ruralsussex.org.uk/** and telephone **01273 473422**
- provides sign-posting, advice and information

Sport & Physical Activity Team - **http://www.brighton-hove.gov.uk/content/leisure-and-libraries/sports-and-activity** and telephone **01273 294589**
- provides advice on leading a healthy active lifestyle and information on local opportunities

West Sussex Wellbeing - **https://www.westsussexwellbeing.org.uk/**
- Help to find local wellbeing information and services

Table of Contents

Referral reason / Patient presentation	**Connective Tissue Disease (CTD)** A group of rare disorders but potentially life threatening. Requires high level of awareness and clinical suspicion. Occurs in all ages but higher prevalence in young–middle aged females.	
Back to Table of Contents	**Scleroderma** https://BSR-Scleroderma-guideline	**Raynaud's Phenomenon** https://cks.nice.org.uk/raynauds-phenomenon
Primary Care Management	**Assessment** Family history of CTD Arthralgia/myalgia Heartburn Telangiectasia – hand, face and around nail beds Raynaud's phenomenon (secondary) – especially middle age onset Skin changes to include: thickening, swelling, tightening and colour changes Calcium deposits in the skin and other areas High blood pressure Shortness of breath Digestive tract problems such as: difficulty swallowing food, bloating and/or constipation, or problems absorbing food leading to weight loss Multi-system/organ involvement Consider red flags **Investigations** FBC, ESR / CRP, RhF, ANA, Anti CCP, U&E, LFT, Bone profile, CK, TFT, lipid profile, HbA1c Urine dipstick Chest X-ray Blood pressure, Weight and BMI **Management** Patient education/information https://www.sruk.co.uk/ http://www.scleroderma.org/ https://www.versusarthritis.org/about-arthritis/conditions/systemic-sclerosis-scleroderma/ Analgesia Manage cardiovascular risk factors	**Assessment** Family history of CTD Consider causal factors such as: ○ Drugs ○ Occupation/Environmental ○ Haematological ○ Endocrine ○ Infections ○ Anatomical History of clearly demarcated pallor of the digit(s) followed by at least one other colour change (cyanosis and/or erythema) usually precipitated by cold Secondary Raynaud's should be suspected if: Onset at more than 30 years of age. Intensely painful, or asymmetrical episodes Clinical features suggestive of an underlying disease. Positive anti-nuclear antibody tests Abnormal nail-fold capillaries (although this may be difficult to determine). Digital ulcers present **Investigations** FBC, ESR / CRP, RhF, ANA, Anti CCP, U&E, LFT, Bone profile, CK, TFT Urine dipstick **Management** Patient education/information https://www.sruk.co.uk/ https://www.versusarthritis.org/about-arthritis/conditions/raynauds-phenomenon/ Analgesia Lifestyle advice for all types of Raynaud's: Keep the *whole* body (including the hands and feet) warm. Wear gloves and warm footwear in cold environments. Avoid or stop smoking Minimize stress if this is a trigger. Exercise regularly If medication may be causing or exacerbating the Raynaud's phenomenon, review the need for it and, if possible, stop it. If an occupational cause is suspected, refer to occupational health if available.

		Consider medication options – see guideline https://cks.nice.org.uk/raynauds-phenomenon/management In people with primary Raynaud's phenomenon, consider periodically stopping treatment as the disease may go into remission
Thresholds for Primary Care to initiate a referral	**Refer to Consultant Rheumatologist** If Scleroderma is suspected **Refer to appropriate speciality** For all other abnormal investigations	**Refer as emergency to Secondary Care for severe ischaemia of one or more digits** **Refer to Consultant Rheumatologist** If Raynaud's phenomenon is suspected – not necessary to refer all patients with suspected Raynaud's if the patient is typical young female with no concerns about systemic CTD; GP's can treat this primary uncomplicated group in the community If not responding to Primary Care Management All people with secondary Raynaud's phenomenon **Refer to appropriate speciality** For all other abnormal investigations
Management Pathway for the Rheumatology Service	**Assessment and examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging and request as needed **Management** Patient education/information Medication management Ongoing monitoring as needed Consider referral to MSK service with management plan which may include: ➢ Specialist Physiotherapy for specific MSK condition ➢ Specialist Occupational Therapy for hand function and/or ADL advice ➢ Pain Management ➢ Signposting for self-management advice	**Assessment and examination** Review holistic assessment Consider causal factors such as: ➢ Drugs ➢ Occupation/Environmental ➢ Haematological ➢ Endocrine ➢ Infections ➢ Anatomical ➢ Vascular Occlusive Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and request as needed **Management** Patient education/information Medication management Ongoing monitoring as needed Consider referral to MSK service with management plan which may include: ➢ Pain Management ➢ Signposting for self-management advice
Thresholds for referral for Intervention	**Referral to Specialist Tertiary Provider** For Scleroderma and Raynaud's phenomenon management. Royal Free Hospital – GP or consultant referral https://www.royalfree.nhs.uk/services/services-a-z/rheumatology/scleroderma/	

Back to Table of contents	**Systemic Lupus Erythematosus (SLE)** https://BSR-lupus-guidelines
Primary Care Management	**Assessment** Family history of CTD Arthralgia plus sun-sensitive rash Dry eye / dry mouth with joint symptoms Joint hypermobility (including subluxations and dislocations) Raynaud's phenomenon (secondary) – especially middle age onset Inflammatory muscle pain / weakness Possible vasculitic rashes with joint pains Respiratory problems (pleuritis or pericarditis) Fever, malaise, fatigue and weight loss Malar or discoid rash Ulcers Hair loss Multi-system/organ involvement Consider red flags **Investigations** FBC, ESR / CRP, RhF, ANA/ENA, Anti CCP, U&E, LFT, Bone profile, CK, TFT Urine dipstick Chest X-ray Blood pressure, Heart rate, Weight and BMI **Management** Patient education/information Analgesia Manage cardiovascular risk factors
Thresholds for Primary Care to initiate a referral	**Refer to Consultant Rheumatologist** If SLE is suspected and/or positive inflammatory markers **Refer to appropriate speciality** For all other abnormal investigations
Management Pathway for the Rheumatology Service	**Assessment and examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging and request as needed including: ➢ Tests for anaemia ➢ Vitamin D ➢ aPL ➢ Immunoglobulins ➢ Direct Coombs test

	Management Patient education/information Medication management including topical medication as appropriate Advice regarding sunscreen Ongoing monitoring as needed Consider referral to MSK service with management plan which may include: ➢ General Physiotherapy for specific MSK condition ➢ Pain Management ➢ Signposting for self-management advice	
Thresholds for referral for Intervention	**Referral to Specialist Tertiary Provider** For SLE Management. Guys and St Thomas' - GP or consultant rheumatologist referral UCLH – GP or consultant rheumatologist referral UCLH - http://www.uclh.nhs.uk/OurServices/Rheumatology RNOH - https://www.guysandstthomas.nhs.uk/our-services/lupus/overview.aspx	
Referral reason / Patient presentation	**General aches and pains (No evidence of Inflammatory Arthritis)**	
Back to Table of contents	**Undiagnosed**	**Persistent Pain/Fibromyalgia**
Primary Care Management	**Examination, History & Assessment** Symptoms: Duration, sites, severity and frequency History of fatigue, poor sleep, poor concentration, low mood Function: ADLs PMH/Co-morbidities/Peri-menopausal The patient does not have a disorder that would otherwise explain pain Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking Organ specific symptoms to exclude: systemic disease, depression, anxiety. PHQ9 and GAD7 may be helpful Yellow flags (psycho-social): Work, relationships, leisure, QOL Requires full examination including lymph nodes, breasts and thyroid **Investigations** FBC, U&E, LFT, TFT, ESR, CRP, Glucose, Bone profile and Vitamin D, CK PSA in men with bony pain and clinical correlation of symptoms: Urinary problems – weak urine stream, difficulty initiating urination, stopping and starting during urination; urinating frequently, especially at night, pain or burning with urination Blood – in the urine and semen. Pain – in the hips, pelvis, spine or upper legs. Pain or discomfort – during ejaculation. Difficulty – getting an erection.	**Examination, History & Assessment** Symptoms: Duration, sites, severity and frequency History of fatigue, poor sleep, poor concentration, low mood Function: ADL's PMH/Co-morbidities/Peri-menopausal The patient does not have a disorder that would otherwise explain pain Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking Organ specific symptoms to exclude: systemic disease, depression, anxiety. PHQ9 and GAD7 may be helpful Yellow flags (psycho-social): Work, relationships, leisure, QOL **Investigations** Consider if not already completed or symptoms have changed **Diagnosis** This should be made in Primary care following these diagnostic criteria: FMN72_New (umanitoba.ca) Consider a diagnosis of Persistent Pain syndrome in patients who do not quite meet the criteria for a diagnosis of Fibromyalgia

	Urine dipstick Consider CXR in smoker Auto-antibodies blood tests are unlikely to be helpful (frequent false positives), unless specific indications of connective tissue disorder such as: Dry eyes / Dry mouth / Photosensitive rash / Significant alopecia / Recurrent miscarriage Consider myeloma screen **Diagnosis of Fibromyalgia** This should be made in Primary care following these diagnostic criteria: FMN72_New (umanitoba.ca) **Management** Patient education/information Supported self-management and review as necessary Psycho-social support Simple analgesics in line with agreed formularies/NICE guidance (avoid opioids) https://www.brightonandhove/non-malignant-chronic-pain-prescribing https://www.nice.org.uk/advice/ktt21 (Medicines optimisation in long-term pain) Vitamin D supplementation as necessary https://www.brightonandhove/Vitamin-d-prescribing (Prevention, Investigation and Treatment of Vitamin D Deficiency and Insufficiency in Adults) Treat abnormal investigations as appropriate At each review, check for inflammatory joint pain (new): ➢ More than 30 minutes stiffness in early morning ➢ Signs of synovitis in hands, wrists or other painful joints ➢ Consider the Squeeze Test	**Management** Patient education/information Supported self-management and review as necessary Psycho-social support Simple analgesics in line with agreed formularies/NICE guidance (avoid opioids) https://www.brightonandhove/non-malignant-chronic-pain-prescribing https://www.nice.org.uk/advice/ktt21 (Medicines optimisation in long-term pain) Vitamin D supplementation as necessary https://www.brightonandhove/Vitamin-d-prescribing (Prevention, Investigation and Treatment of Vitamin D Deficiency and Insufficiency in Adults) Treat abnormal investigations as appropriate At each review, check for inflammatory joint pain (new): ➢ More than 30 minutes stiffness in early morning ➢ Signs of synovitis in hands, wrists or other painful joints ➢ Consider the Squeeze Test
Thresholds for Primary Care to initiate a referral	**Refer to Consultant Rheumatologist** Evidence of synovitis Investigations abnormal Suspected inflammatory process **Refer to pain management service** If not responding to Primary Care management **Refer to appropriate speciality** For all other abnormal investigations **Refer to Chronic Fatigue Syndrome Service** If appropriate. www.sussexcommunity.nhs.uk/CFS	**Refer to Pain Management Service following diagnosis** If not responding to Primary Care Management Marked deterioration in ADLs **Refer to Consultant Rheumatologist** Evidence of synovitis Investigations abnormal Suspected inflammatory process **Refer to appropriate speciality** For all other abnormal investigations

Management Pathway for the Rheumatology Service	**Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging & request as needed **Management** Patient education/information Signposting for self-management advice Medication management Consider emotional wellbeing support Consider Self-management programmes **Chronic Wide Spread Pain / Fibromyalgia** Refer to Pain Management **Polymyalgia** See Polymyalgia pathway **Hypermobility Spectrum Disorder** See Hypermobility Spectrum Disorder pathway	**Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging & request as needed **Management** Patient education/information Signposting for self-management advice Medication management Consider emotional wellbeing support Consider Self-management programmes Refer to Consultant Rheumatologist if diagnostic uncertainty
Referral reason / Patient presentation **Back to Table of contents**	**Generalised Osteoarthritis** NICE Guidance Osteoarthritis 2014 https://www.nice.org.uk/guidance/cg177	
Primary Care Management	**Examination, History & Assessment** Symptoms: Duration, sites, severity and frequency History of fatigue, sleep, low mood Function: ADL's PMH/Co-morbidities/Peri-menopausal Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking Organ specific symptoms to exclude: systemic disease, depression, anxiety Yellow flags (psycho-social): Work, relationships, leisure, QOL Joint examination Attitudes to exercise Consider differential diagnoses such as gout, other inflammatory arthritis, septic arthritis and malignancy Clinically diagnose without investigation if patient: ➢ Is 45 or over AND ➢ Has activity-related joint pain AND ➢ Has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.	

	Investigations FBC, ESR / CRP, U&E, LFT, Bone profile, CK, TFT, eGFR, Vitamin D Urine dipstick Chest X-ray Weight and BMI Auto-antibodies blood tests are unlikely to be helpful (because there are frequent false positives), unless specific indications of connective tissue disorder such as: Dry eyes / Dry mouth / Photosensitive rash / Significant alopecia / Recurrent miscarriage **Management** Patient education/information https://www.versusarthritis.org/osteoarthritis/ Advice on use of heat or cold Advice on pacing Advice on appropriate exercise to include local muscle strengthening and general aerobic fitness Advice on appropriate footwear, including shock absorbing properties, for people with lower limb osteoarthritis Advice on TENS machine Analgesia Consider topical capsaicin for knee or hand osteoarthritis Offer interventions to help weight loss for people who are obese or overweight
Thresholds for Primary Care to initiate a referral	**Refer to Consultant Rheumatologist** If flare ups are not settling or failing to respond to analgesia If patient does not want surgical intervention **Consider referral to specific orthopaedic pathways** If appropriate and surgery is being considered **Consider referral to occupational therapy** For bracing/ADL modifications/hand function **Consider referral to physiotherapy** For joint supports/walking aids and support with exercise
Management Pathway for the Rheumatology Service	**Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging & request as needed **Management** Patient education/information https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis/ Signposting for self-management advice Medications management Consider podiatry for foot problems and advice Consider community occupational therapy Consider physiotherapy for joint supports/walking aids and support with exercise Self-management programmes http://www.escape-pain.org/ or https://www.sussexcommunity.nhs.uk/EPP Joint injection as indicated

	Ongoing monitoring if required
Referral reason / Patient presentation **Back to Table of Contents**	**Giant Cell Arteritis** BSR Guidelines https://academic.oup.com/rheumatology/giant-cell-arteritis
Primary Care Management	**Examination, History & Assessment** Age >50 years Abrupt onset headache (usually unilateral in the temporal area) Scalp tenderness Jaw and tongue claudication Visual symptoms (including diplopia) Constitutional symptoms Polymyalgic symptoms Limb claudication Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking Abnormal superficial temporal artery (tender, thickened with reduced or absent pulsation) Transient or permanent visual loss Visual field defect Relative afferent pupillary defect Anterior ischaemic optic neuritis Upper cranial nerve palsies Features of large vessel GCA (vascular bruits and asymmetry of pulses or blood pressure) **Investigations (Prior to commencing steroid therapy)** Initially FBC, U&E, LFT, ESR, CRP, CK, TFT, RhF, Protein electrophoresis, Bone profile CXR may be required Urine dipstick **Management** Patient education and information Uncomplicated GCA (no jaw claudication or visual disturbance): 40mg prednisolone daily. This should be weaned as per BSR guidelines. https://academic.oup.com/rheumatology/article/49/8/1594/1789465 If there is jaw claudication: 60mg daily. Evolving visual loss or amaurosis fugax (complicated GCA): 500 mg to 1 g of i.v. methylprednisolone for 3 days before oral glucocorticosteroids. Established visual loss: 60 mg prednisolone daily to protect the contralateral eye. Patients should also receive bone protection. Proton pump inhibitors for gastrointestinal protection should be considered. Consider Aspirin if not already on an anti-coagulant or Clopidogrel and no contraindications **Bone protection needs to be considered in all patients on long term prednisolone**
Thresholds for Primary Care to initiate a referral	**Refer as emergency to secondary care if Giant Cell Arteritis is suspected** Acute onset temporal headache (uni or bilateral); jaw/tongue claudication; temporal artery and/or scalp tenderness: Contact duty Consultant in Acute Medical Unit If visual problems, contact duty Ophthalmology Team
Management Pathway for the Rheumatology Service	**Consultant Rheumatologist** **Patient education and information**

	Assessment and Examination Consider: Osteoporotic risk factors and fractures Other glucocorticosteroid-related complications Other symptoms that may suggest an alternative diagnosis Patients should be monitored for evidence of relapse **Investigations** Temporal artery biopsy Review previous bloods and imaging & request as needed **Management** Review drug management & optimise as appropriate Monitoring blood tests – FBC, ESR, CRP, U&E, glucose Chest radiograph to monitor for aortic aneurysm every 2 years Bone density may be required Routine follow up should be planned regularly in the first year Disease relapse should be suspected in patients with a return of symptoms of GCA, ischaemic complications, unexplained fever or polymyalgic symptoms. (A rise in ESR/CRP is usually seen with relapse, but relapse can be seen with normal inflammatory markers)
Referral reason / Patient presentation **Back to Table of Contents**	**Gout** **https://academic.oup.com/rheumatology/BSR-guideline-for-management-of-gout** **https://cks.nice.org.uk/gout**
Primary Care Management	**Examination, History and assessment** Severe, rapid onset joint pain; often at night or early morning Usually mono-arthritis Swelling and erythema Risk factors: drugs: diuretics, low dose aspirin, renal disease, metabolic syndrome; ageing, male gender Consider differential diagnosis such as septic arthritis, osteoarthritis **Investigations** FBC, urate, U&E, LFT, Bone profile, CRP, Blood cultures, ESR, Patient temperature **No imaging necessary** (acute onset) Aspirate for crystal examination, if possible: culture and gram stain **Note: A urate level within the normal range does not exclude a diagnosis of gout** **Management** Patient education, lifestyle moderation **Gout information booklet (versusarthritis.org)** The UK Gout Society: Gout - Arthritis. Symptoms, treatment and diet. - UK Gout Society 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 -4 times a day 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 – Advise that treatment may be needed for at least 12 months before flares may stop Caution with renal impairment First line treatment with allopurinol 1-2 weeks after inflammation has settled, and up-titration – ***"treat to target"*** Suppress urate <0.36mmol/L. **Recheck at 4-6 weeks and annually once target achieved** NSAID or colchicine prophylaxis for at least one month 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
Thresholds for Primary Care to initiate a referral	**Refer to A&E if septic arthritis suspected** **Refer to Consultant Rheumatologist** if: ➢ unresponsive or toxicity to allopurinol and/or febuxostat ➢ uncertainty about diagnosis ➢ patient is under 30 years of age ➢ patient is pregnant **Refer to a Consultant Urologist** If patient has urolothiasis
Management Pathway for the Rheumatology Service	**Refer to A&E if septic arthritis suspected** **Consultant Rheumatologist** **Patient education and information** Lifestyle factors Medication **Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods & request as necessary. Aspirate for crystal examination: culture and gram stain Xray if long term symptoms to assess erosive damage **Management** Agree management plan with patient as per medicines management guideline http://sussexmskpartnershipcentral.co.uk/for-health-professionals/medicines-management/ If chronic gout refer to Podiatry if indicated Consultant review if intolerant of GP prescription medication and if diagnostic uncertainty **Refer to a Consultant Urologist** If patient has urolothiasis

Hypermobility Spectrum Disorders (HSD) with Persistent MSK Pain

Referral reason / Patient presentation **Back to Table of Contents**	Hypermobility is very common affecting a significant proportion of the population Hypermobility Spectrum disorder encompasses those patients who have joint hypermobility and other symptoms such as persistent pain, gut issues, postural issues, fatigue etc. Ehlers-Danlos Syndrome is diagnosed according to the EDS Society 2017 classification criteria hEDS Diagnostic Checklist | The Ehlers Danlos Society : The Ehlers Danlos Society (ehlers-danlos.com) Many patients will not fulfil this criteria and will therefore be given a diagnosis of HSD Treatment for these conditions is the same http://hypermobility.org/ https://www.versusarthritis.org/about-arthritis/conditions/joint-hypermobility/ https://www.ehlers-danlos.org/ http://www.rcgp.org.uk/eds
Primary Care Management	**Assessment** Family history of HSD/EDS (diagnosed by professional not self-reported) Symptoms suggestive of HSD/EDS can include: ○ Joint hypermobility (including subluxations and dislocations) ○ Skin hyper-extensibility ○ Tissue fragility (easy bruising and scarring) ○ History of ocular problems, flat feet, tender trigger points ○ Chronic pain ○ Fatigue and poor sleep ○ Dysautonomia ○ GI issues ○ TMJ and dental problems ○ Spine problems ○ Reduced muscle tone and weakness ○ Lack of effectiveness of local anaesthetics ○ Psychiatric symptoms ○ Family history of HSD/EDS (Not genetic but familial) ○ Consider red flags ○ Inflammatory arthritis ruled out **Examination and History** Functional assessment, Pain Visual Analogue Score may be helpful Systemic symptoms using Just GAPE acronym below: ○ Joints and (U)other Soft Tissues ○ Gut ○ Allergy/Atophy/Auto-immune ○ Postural Symptoms ○ Exhaustion http://www.rcgp.org.uk/eds

	Check for connective tissue disease, recurrent miscarriage Check for mitral regurgitation: listen to heart Undertake Beighton score http://hypermobility.org/help-advice/hypermobility-syndromes/beighton-score/ Consider hEDS checklist hEDS Diagnostic Checklist | The Ehlers Danlos Society : The Ehlers Danlos Society (ehlers-danlos.com) Consider Persistent pain/Fibromyalgia in patients who do not meet the HSD criteria **Investigations** ESR, CRP, FBC, RhF, ANA, Anti CCP, U&E, LFT, Glucose, TFT, Bone profile and Vitamin D, CK Bone density Urine dipstick Chest X-ray Blood pressure, Heart rate, Weight and BMI **Management** Patient education/information www.sussexeds.com https://www.versusarthritis.org/about-arthritis/conditions/joint-hypermobility/ Analgesia as per guidance http://sussexmskpartnershipcentral.co.uk/for-health-professionals/medicines-management/ https://www.nice.org.uk/advice/ktt21 Management of multi system issues, i.e. Gut issues, Cardiovascular Autonomic Dysfunction, Musculoskeletal issues http://www.rcgp.org.uk/management of HSD Manage cardiovascular risk factors
Thresholds for Primary Care to initiate a referral	**Referral to occupational therapy** For bracing/ADL modifications/hand therapy **Referral to physiotherapy** For support with exercise and joint supports/walking aids **Refer to pain management service** If not responding to Primary Care management **Refer to Consultant Rheumatologist** If diagnosis is uncertain If investigations suggest an inflammatory/auto-immune cause If any hypermobile condition other than hEDS/HSD is suspected http://www.rcgp.org.uk/eds - Indications for referral in EDS **Refer to Orthopaedics** For recurrent joint subluxations/dislocations despite specific specialist physio input and patient adhering to exercise programme

	Refer to appropriate speciality For all other abnormal investigations	
Management Pathway for the Rheumatology Service	**Patient education and information** www.sussexeds.com https://www.versusarthritis.org/about-arthritis/conditions/joint-hypermobility/ **Assessment and examination** Review holistic assessment Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and imaging & request as needed **Management** Patient Education Group – EPP, BIC or PMP Medication management Lifestyle modification – Health Trainers, Wellbeing Services Exercise advice – The Right Track Programme Referral to physiotherapy/occupational therapy: ➢ For joint protection advice ➢ Strengthening ➢ Balance and proprioception training	**Management** Patient education/information Consider referral to MSK service with management plan which may include: ➢ General Physiotherapy for specific MSK condition ➢ Pain Management ➢ Signposting for self-management advice
Thresholds for referral for Intervention	**Referral to Specialist Tertiary Provider** For EDS management and Hypermobile patients with severe and complex problems. (most local service is UCL but patient choice must apply) Must have seen local Rheumatology consultant within 18 months UCLH - https://www.uclh.nhs.uk/OurServices/HypermobilityService - Hypermobility service is currently closed RNOH - https://www.rnoh.nhs.uk/our-services/rheumatology	
Referral reason / Patient presentation **Back to Table of Contents**	**Inflammatory mono-arthritis** https://academic.oup.com/rheumatology/article/management-of-the-hot-swollen-joint-in-adults	
Primary Care Management	**Examination, History & Assessment** Acute phase: rapid onset; often at night or early morning EMS > 30 minutes Obvious painful swollen joint, may be red and/or hot Rule out red flags and systemic symptoms i.e rashes, fever, risk factors family history, smoking Consider differentials: Crystal arthritis, Septic arthritis, osteoarthritis, Inflammatory arthritis, haemarthrosis Ask about enthesitis, STI, IBD, Uveitis, psoriasis, family history **If gout suspected follow gout pathway**	

	Investigations FBC, urate, U&E,LFT, Bone profile, CRP, Blood cultures, ESR, RhF, HLA B27 Patient temperature **No imaging necessary** (acute onset) **Management** Patient education, lifestyle moderation Use of ice packs (PRICE) Stop or change precipitating drug if appropriate NSAID risk assessment GI / CV / Renal Use high dose NSAID + gastro-protection if appropriate or step-wise analgesia
Thresholds for Primary Care to initiate a referral	**Refer to A&E if septic arthritis suspected** **Refer to Consultant Rheumatologist** **Urgent referral** for monoarthritis if first episode **and** symptoms are not responding to primary care intervention
Management Pathway for the Rheumatology Service	**Refer to A&E if septic arthritis suspected** **Consultant rheumatologist** **Patient education and information** **Assessment and Examination** Review referral information including history, examination and investigation results Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods and & request as needed. Consider imaging (X-ray, ultrasound or MRI with contrast) **Management** Discuss management plan options with patient Patient information Medication management including analgesia and DMARD if required Joint aspiration/Joint injection/Image guided injection as required Symptom management provided by MDT as appropriate
Referral reason / Patient presentation **Back to Table of Contents**	**Inflammatory Polyarthritis** NICE RA Guidelines 2018 https://www.nice.org.uk/guidance/ng100
Primary Care Management	**Examination, History & Assessment** Two or more painful, swollen joints; maybe red and/or hot EMS > 30 minutes Systemic symptoms including fatigue Consider differential diagnoses: Inflammatory arthritis, Crystal arthritis, Connective Tissue Disease/Vasculitis, Septic arthritis, Osteoarthritis Ask about enthesitis, STI, IBD, Uveitis, psoriasis, family history

	Investigations FBC, TFT, U&E, LFT, Bone profile, Immunoglobulins and strip, Urate, CRP, ESR, RhF, HLA B27, Anti CCP, ANA Consider X-ray hands and feet of patients with suspected RA and persistent synovitis (NICE guidelines) **Management** Patient education and advice Medication management including analgesia and steroid (IM, PO) if appropriate
Thresholds for Primary Care to initiate a referral	**Urgent referral to Rheumatology Service within 3 days**
Management Pathway for the Rheumatology Service	**Consultant Rheumatologist** **Assessment and Examination** Review referral information including history and investigation results Consider differential diagnoses Rule out red flags **Investigations** Review previous bloods & request as needed. Consider imaging (X-ray, ultrasound or MRI with contrast) **Management** Discuss management options with patient Dependent upon diagnosis consider: Patient information Peer support groups Psychological support Analgesia Joint aspiration +/- injection Symptom management provided by the MDT Initiate DMARDS if required and review monthly; escalate treatment according to clinical response After 3 months of DMARD initiate shared care with GP After 12 months move to established inflammatory arthritis pathway Infusions undertaken as day case **MSK AP service will review stable, follow up patients once diagnosis and treatment established** **Assessment and Examination** Review referral information including history and investigation results Rule out red flags **Investigations** Review previous bloods & request as needed. Consider imaging **Management** Discuss management options with patient Patient information Peer support groups Psychological support Advice on medication (verbal and written)

	Joint aspiration +/- injection Initiate DMARDS if required and review After 3 months of DMARD initiate shared care with GP After 12 months move to established inflammatory arthritis pathway
Referral reason / Patient presentation **Back to Table of Contents**	**Established Inflammatory Arthritis (Long-Term Conditions Strategy)** **Patients with an established Inflammatory Arthritis diagnosis, chronic flare-ups** After initial assessment and treatment in secondary care, suitable patients on disease modifying anti rheumatic drugs (DMARDS) will be monitored in the MSK ICATS, utilising a shared care approach to treatment with GPs and Secondary care in partnership Patients will be provided with education, rapid access and MDT intervention as needed NICE RA Guidelines 2018 https://www.nice.org.uk/guidance/ng100
Primary Care Management	**Examination, History and assessment** Review diagnosis and existing care plan Two or more painful joints Early morning stiffness for 30 minutes (often diurnal) Duration is more than 6 weeks Single or several joint pain small / large joints involved and swelling in hands and feet Fatigue, Visual Analogue Scale pain score may be helpful, sleep pattern Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking History of previous and current management Check patient knowledge of disease Check for cardiovascular risk factors (including HbA1C/lipids) and treat accordingly **Management (including condition-specific self-care options)** Patient education and advice Shared Care Protocol DMARD management Review analgesia Consider IM Depomedrone for flares but also alert Integrated MSK Service
Thresholds for Primary Care to initiate a referral	**Refer to MSK Rheumatology Nursing Service** For all follow-ups For flares (rapid access) or review of DMARDS For assessment for self-management programme
Management Pathway for the Rheumatology Service	**Rheumatology Nurse/AP/Consultant** **Patient education and information** 1:1 clinic follow up Education groups – including self-management strategies Advice line information Resource materials **Assessment and Examination** Disease activity monitoring Musculoskeletal assessment Holistic assessment including co-morbidities, functional ability and mood Medication review Anti TNF checklist (if required)

	Investigations As needed for routine monitoring or investigations as required LFTs, U&E, FBC, TFT, ESR, CRP, Anti CCP and Rheumatoid Factor, GGT, PSA X-rays as indicated Ultrasound scan – hands, feet and spine MRI CT (for patients with metal work) DEXA scan **Management** Agree management plan with patient Ongoing review frequency according to need Medication escalation and adjustment Medication changes Soft tissue and joint injection Specialist OT / Physiotherapist review if ADLs or hand functions are affected Patient review by Consultant Rheumatologist: ➢ For Biologic therapy ➢ New systemic features of disease ➢ Named consultant for annual review appointment in place Shared Care Protocol with GP Monitoring of established Biologic drug
Referral reason / Patient presentation **Back to Table of Contents**	**Osteoporosis** A fragility fracture is a fracture occurring from a fall from standing height or less or a vertebral fracture during normal daily activities NICE Osteoporosis: assessing the risk of fragility fracture CG146 **https://www.nice.org.uk/guidance/cg146** NICE Osteoporosis – prevention of fragility fractures **https://cks.nice.org.uk/osteoporosis-prevention-of-fragility-fractures** NOGG 2017: Clinical guideline for the prevention and treatment of osteoporosis **https://www.sheffield.ac.uk/NOGG/NOGG%20Guideline%202017.pdf**
Primary Care Management	**Examination, History and Assessment:** Rule out red flags and systemic symptoms PMH/Co-morbidities Function: ADLs Yellow flags (psycho-social): Work, relationships, leisure, QOL Assess for fragility fracture Exclude secondary causes of Osteoporosis Calculate FRAX https://www.sheffield.ac.uk/FRAX/ https://www.sheffield.ac.uk/NOGG/ **Investigations** DEXA if indicated following FRAX. Thoracic and lumbar spine (lateral) X-ray if indicated. BMI If low bone density consider: FBC, ESR, U&E, LFT, TSH, CRP, bone profile, Vitamin D All patients with new vertebral fractures to have serum electrophoresis and serum free light chains Consider coeliac, PTH, serum testosterone, sex hormone binding globulin, follicle stimulating hormone, lutenizing hormone, serum prolactin, 24 hour urinary free cortisol, 24 hour urinary calcium depending on clinical picture

	Investigate for renal disease and urinary calcium (urinalysis) Testosterone level is also recommended for men under 65yrs of age. If no obvious reason for a low bone density (especially in men) consider further investigations or referral to secondary care. **Management** Patient education and advice (lifestyle and dietary) Simple analgesics in line with agreed formularies Psycho-social support Consider treatment with 1st line bone protection/oral bisphosphonate https:/www.nice.org.uk/guidance/Bisphosphonates If intolerant to first oral Bisphosphonate trial a second oral bisphosphonate Vitamin D supplementation as per guidelines https://cks.nice.org.uk/vitamin-d-deficiency-in-adults-treatment-and-prevention#!scenario Do not repeat DEXA for 2-3 years and then only if likely to affect management. Reassess FRAX after 5 years, or before if patient fractures on treatment. Assess patients who fracture and > 2 years on treatment: Check compliance with medications Re-evaluate treatment choice
Thresholds for Primary Care to initiate a referral	**Referral to Integrated MSK Service (FLS)** For further support regarding Osteoporosis For patients who need consideration for alternative medications **Referral to Rheumatology** For patients where oral bisphosphonate is not tolerated or contraindicated For patients who continue to fracture despite adherence to oral bone medication, having ruled out secondary causes of Osteoporosis **Refer to Integrated MSK Service (General Physiotherapy)** For specific MSK reasons **Refer to Integrated MSK Service (Pain)** For pain management **Referral to falls intervention** https://www.sussexcommunity.nhs.uk/services/falls-and-fracture-prevention
Management Pathway for the Rheumatology Service	**Assessment and Examination** Rule out red flags and systemic symptoms PMH/Co-morbidities Function: ADLs Yellow flags (psycho-social): Work, relationships, leisure, QOL Calculate FRAX https://www.sheffield.ac.uk/FRAX/ https://www.sheffield.ac.uk/NOGG/ **Investigations** Review previous bloods & request as needed. Consider imaging FRAX or Q fracture plus FRAX

	Management Patient education and information Medication advice and prescribing Falls prevention Exercise advice and signposting Lifestyle advice and signposting
Referral reason / Patient presentation **Back to Table of Contents**	**Polymyalgia Rheumatica (NOT Giant Cell Arteritis)** BSR Guidelines https://academic.oup.com/rheumatology/management-of-polymyalgia-rheumatica
Primary Care Management	**Examination, History & Assessment** Symmetrical shoulder and/or pelvic girdle proximal muscle stiffness and aching (if predominant feature pain and weakness ?polymyositis) Age >50 years Duration > 2 weeks Early morning stiffness >45minutes Previous medical history Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking Poor sleep, concentration, mood Headaches or visual disturbance Assess shoulder, neck and hip range of movement Assess peripheral joints for synovitis **Investigations (Prior to commencing steroid therapy)** Initially FBC, U&E, LFT, ESR, CK, CRP, TFT, RhF, Protein electrophoresis, Bone profile CXR may be required Urine dipstick **Management** Patient education and information Use clinical judgement - prescribe 15mg of prednisolone daily for 2-3 weeks then review: **Bone protection needs to be considered in all patients on long term prednisolone**
Thresholds for Primary Care to initiate a referral	**Refer as emergency to secondary care if Giant Cell Arteritis is suspected:** Acute onset temporal headache (uni or bilateral); jaw/tongue claudication; temporal artery and/or scalp tenderness: Contact duty Consultant in Acute Medical Unit If visual problems, contact duty Ophthalmology Team **Refer to Consultant Rheumatologist** 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 Resistant to prednisolone therapy CK significantly elevated (considering polymyositis)

Management Pathway for the Rheumatology Service	**Patient education and information** **Assessment and Examination** **Investigations** Review previous bloods and imaging & request as needed **Management** Review drug management & optimise as appropriate Monitoring blood tests – ESR & CRP monthly for 3 months and then each 3 months; 6 monthly glucose/HbA1c Consider Physiotherapy and/or OT for adaptations via access point. For more complex needs/ongoing ADL difficulties refer specialist Rheumatology OT Review 3-6 monthly depending on response and assess for signs of synovitis at each visit
Referral reason / Patient presentation **Back to Table of Contents**	**Septic Arthritis** **https://academic.oup.com/rheumatology/septic-arthritis** **https://patient.info/health/arthritis/septic-arthritis**
Primary Care Management	**Examination, History & Assessment** Short history of a hot, swollen and tender joint (or joints) Restriction of movement Feeling generally unwell with a high temperature Rule out red flags and systemic symptoms i.e rashes, risk factors family history, smoking Consider differentials: Crystal arthritis, Osteoarthritis, Inflammatory arthritis, Haemarthrosis. Investigate and refer appropriately Pain (can be severe) **Management** Patient education
Thresholds for Primary Care to initiate a referral	**Refer as emergency to A&E if Septic Arthritis is suspected**
Management Pathway for the Rheumatology Service	**Refer as emergency to A&E if Septic Arthritis is suspected** **Consultant Rheumatologist** **Examination, History & Assessment** Short history of a hot, swollen and tender joint (or joints) Restriction of movement Feeling generally unwell with a high temperature Rule out red flags and systemic symptoms i.e rashes, risk factors family history, smoking Consider differentials: Crystal arthritis, Osteoarthritis, Inflammatory arthritis, Haemarthrosis. Investigate and refer appropriately Pain (can be severe) **Management** Patient education

Referral reason / Patient presentation	**Spondyloarthritis** Spondyloarthritis in over 16s Guidelines 2017 https://www.nice.org.uk/guidance/ng65	
Back to Table of Contents	**Axial Spondyloarthritis** https://nass.co.uk/	**Peripheral Spondyloarthritis**
Primary Care Management	**Examination, History & Assessment** Low back pain > 3 months with onset before 45 years of age And if 4 or more additional features below: Low back pain that started before the age of 35 years Waking during the second half of the night because of symptoms Buttock pain Improvement with movement Improvement within 48 hours of taking non-steroidal anti-inflammatory drugs (NSAIDs) A first-degree relative with spondyloarthritis Current or past arthritis, enthesitis, or pain or swelling in tendon or joints not due to injury Current or past psoriasis, or family history Uveitis: ask people with back pain > 3mths with onset before 45yrs if history of uveitis, and if the person is HLA B27 positive or has a history of psoriasis **Investigations** FBC, TFT, U&E, LFT, CRP, ESR, Glucose, Bone profile and Vitamin D, CK PSA in men over 50 and symptomatic with bony pain and clinical correlation of symptoms: Urinary problems – weak urine stream, difficulty initiating urination, stopping and starting during urination; urinating frequently, especially at night, pain or burning with urination Blood – in the urine and semen. Pain – in the hips, pelvis, spine or upper legs. Pain or discomfort – during ejaculation. Difficulty – getting an erection. If only 3 additional features, NICE recommends testing for HLA B27 **Management** Patient education/information https://www.versusarthritis.org/ankylosing-spondylitis/ 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	**Examination, History & Assessment** Dactylitis (whole swollen digit- ‘sausage’ finger or toe) or persistent or multiple-site enthesitis without apparent mechanical cause and with other features, including: Back pain without apparent mechanical cause Current/past psoriasis, inflammatory bowel disease, (Crohn’s disease/ ulcerative colitis) or uveitis Close relative (parent, brother, sister, son or daughter) with Spondyloarthritis or psoriasis Symptom onset following GIT or genitourinary infection **Investigations** FBC, TFT, U&E, LFT, CRP, ESR, Glucose, Bone profile and Vitamin D, CK PSA in men with bony pain and clinical correlation of symptoms: Urinary problems – weak urine stream, difficulty initiating urination, stopping and starting during urination; urinating frequently, especially at night, pain or burning with urination Blood – in the urine and semen. Pain – in the hips, pelvis, spine or upper legs. Pain or discomfort – during ejaculation. Difficulty – getting an erection. **Management** Patient education/information https://www.versusarthritis.org/psoriatic-arthritis/ 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
Thresholds for Primary Care to initiate a referral	**Refer to Spine Pathway** For investigations prior to referral to Consultant Rheumatologist if indicated	**Refer to Consultant Rheumatologist** For diagnosis
Management Pathway for the Rheumatology Service	**Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags	**Assessment and Examination** Review holistic assessment Consider differential diagnoses Rule out red flags

	Disease specific outcome measures to guide treatment (BATH indices**)** **Investigations** Review previous bloods and imaging and request as needed including HLA B27 if not done MRI (STIR protocol) If previous MRI normal, consider a follow up MRI Consider Plain film X-ray of the sacroiliac joints **Management** Patient education/information Provide Advice line number Ongoing monitoring as needed For patient information and medicines management please see https://www.nice.org.uk/guidance/ng65 Consider physiotherapy as appropriate. Specialist physiotherapy where available Signpost to Occupational therapy home assessment if required. Patient self-referral. https://www.brighton-hove.gov.uk/OT https://www.westsussexconnecttosupport.org/OT Signpost to NASS self-management group https://nass.co.uk/in-your-area/nass-horsham/ https://nass.co.uk/in-your-area/nass-brighton/ https://nass.co.uk/in-your-area/nass-haywards-heath/ https://nass.co.uk/in-your-area/nass-redhill/ Regular review to include: ➢ Re-assessment of symptoms and disease activity (uveitis, hip pain, rib pain, breathing difficulties, enthesitis, peripheral joints, bowel problems, skin rashes, sleep, fatigue, pain, EMS, flares), BP both arms ➢ Review medicine management & optimise as appropriate, review against NICE guidance ➢ Review blood tests and other investigations. Request as needed ➢ Assess impact on QOL (self-management skills and activation, psychological and general wellbeing, work, activity levels) ➢ Assess non-pharmacological management (stretching, strengthening and postural exercises, deep breathing, spinal extension, range of motion exercises for the lumbar, thoracic and cervical sections of the spine and aerobic exercise) ➢ Consider hydrotherapy	Disease specific outcome measures to guide treatment (PsARC) **Investigations** Review previous bloods and imaging and request as needed including HLA B27 if not done Plain film X-ray of symptomatic hands and feet Consider ultrasound of the hands and feet and suspected enthesitis sites Consider plain film X-rays, ultrasound and/or MRI of other peripheral and axial symptomatic sites If a diagnosis of peripheral spondyloarthritis is confirmed, offer plain film X-ray of the sacroiliac joints to assess for axial involvement, even if the person does not have any symptoms **Management** Patient education/information Provide Advice line number Ongoing monitoring as needed For patient information and medicines management please see https://www.nice.org.uk/guidance/ng65 Consider physiotherapy as appropriate. Specialist physiotherapy where available Signpost to Occupational therapy home assessment if required. Patient self-referral. https://www.brighton-hove.gov.uk/OT https://www.westsussexconnecttosupport.org/OT Regular review to include: ➢ Re-assessment of symptoms and disease activity (uveitis, joint pain, synovitis, enthesitis, bowel problems, skin rashes, sleep, fatigue, pain, EMS, flares), BP both arms ➢ Review medicine management & optimise as appropriate, review against NICE guidance ➢ Review blood tests and other investigations. Request as needed ➢ Assess impact on QOL (self-management skills and activation, psychological and general wellbeing, work, activity levels) ➢ Consider referral to Specialist Rheumatology OT for hand function