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| **Presentation** | **Differential diagnosis** | **Comments** | **Action** |
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| **Acute Single Joint** |  | | |
| **Septic arthritis** | Acute hot red joint. Usually very painful. Patient generally unwell, usually with fever. Septic prosthesis may be clinically silent (ref orthopedics). Immunosuppression will mask some signs. Need urgent aspiration of the joint for microscopy | *Urgent referral to ER within 24 hrs. Please phone if patient needs to be seen in clinic* |
| **Gout, pseudogout** | Difficult to distinguish from sepsis if no previous history of gout. Aspiration to show crystals is the definitive diagnostic test.The “typical” pseudogout patient would be an elderly woman with a hot red wrist or knee. After diagnosis rest, NSAIDs (if justified by GI risk) and joint injection are options. Colchicine works for gout but is poorly tolerated by many patients.Remember a normal uric acid does not exclude gout and a raised uric acid is very common.Remember that with allopurinol you aim to get the uric acid below 350, but even when you achieve this the patient may have further attacks for a year or two | *Urgent referral if possibility of sepsis.*If you are sure this is not sepsis please all me and I will see urgently |
| **Reactive arthritis psoriatic arthritis** | These patients may have a monoarthritis or oligoarthritis. Joints show clinical signs of inflammation, but redness is uncommon.Ask about inflammatory bowel disease, iritis, psoriasis and sexual history. Ask if they have had a tick bite | *Semi urgent referral for actively inflamed joints Investigations prior to referral;CBC, creatinine, LFT, CRP, ESR* |
| **Rarely; haemarthrosis, avascular necrosis sarcoidosis** | Sarcoid may be associated with erythema nodosum | *Ix as above: CXR if sarcoid suspected* |
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| **Sub-Acute Single/Few Joints** | **Osteoarthritis;** | This is a clinical diagnosis which is based on the history and examination.Generally these patients need education and encouragement towards self management.Referral is rarely useful in terms of improving patient outcome, though physiotherapy and occupational therapy assessment can help greatly. | *Only refer patients where there is diagnostic doubt, or where intra articular injection might help.* |
| **Gout** | Acute gout is discussed above. Chronic gout e.g. recurrent acute attacks, tophaceous gout may be an indication for allopurinol.Patients will continue to get attacks of acute gout for several months after starting allopurinol and may abandon therapy if not warned.There is evidence that close support results in better outcomes, and we are offering nurse led support clinics for chronic gout | *Refer patients where there is difficulty controlling the disease or diagnostic uncertainty. Patients with renal disease may be difficult to manage and I am happy to see this group CBC, ESR, CRP, creatinine, LFTs, uric acid* |

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| **Inflammatory Polyarthritis** |  | | |
| **Rheumatoid arthritis** | This is a predominantly clinical diagnosis based on the present of persistent (i.e. >6 weeks) symmetrical synovitis , morning stiffness, malaise. Rheumatoid factor is **not** a helpful diagnostic test and should only be used to assess prognosis. False positives are common. Anti CCP antibodies are highly specific (95-98%) for RA. We will be reserving clinic slots every week for assessment of patients with possible early RA and if the referral is clearly marked they will be seen quickly.**It is generally helpful not to start steroids before discussion with the rheumatologist** | *All potential new RA cases should be referred***urgently***for assessment Investigations helpful prior to referral include;CBC, creatinine, LFTCRP, ESR, lfts, creatinine Anti CCP, Rh f CXR XR hands and feet* |
| **Flare of RA** | Patients with active RA may flare following infections or without an obvious trigger. Generally it is reasonable to wait a few weeks to see if thing return to normal rather than rushing to change the DMARD dose etc. | *For persistent flares depomedrol 80 mg im may settle things down prior to referral for urgent review Please phone or fax specifying urgent review* |
| **Reactive arthritis** | See comments above | *Investigations as for inflammatory polyarthritis (see above) May be worth having a low threshold for suspecting Chlamydia and appropriate referral* |
| **SLE / CT diseases** | Please contact me for patients with CT diseases for advice on where they are best referred, and investigations which would guide triage and diagnosis | *Contact me if you need to discuss. ANA, ENA, CBC, renal, lfts, ESR, CRP, Urinalysis*CXR |
| **Post viral** | A history of infection is not always obvious, and distinguishing from rheumatoid arthritis is notoriously unreliable.It is reasonable to treat a patient with an inflammatory arthritis symptomatically with NSAIDs for a few weeks to see if it is self-limiting. Steroids can confuse the diagnostic picture and are usually best avoided. | *Phone to discuss this group if worried, or refer to EARLY RA clinic for us to decide* |

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| **Other rheumatology** |  | | |
| **Polymyalgia** | This | *All potential new RA cases should be referred***urgently***for assessment Investigations helpful prior to referral include;CBC, creatinine, LFTCRP, ESR, lfts, creatinine Anti CCP, Rh f CXR XR hands and feet* |
| **GCA** | These patients are very challenging. If you have a patient with features of systemic illness suggestive of GCA then contact ophthalmology. We do offer temporal artery ultrasound though at present OHIP is opaque on how we can bill for this so we are only able to offer this as part of a complete consultation and not a stand alone service.  I am also happy to communicate via OTN | *Please phone or fax specifying urgent review* |