

## Orthopaedic Referral Threshold Guidelines

### **Hips: Osteoarthritis**

Primary care management: Analgesics  
Weight reduction.  
Walking aid  
Activity modification

Consider referral for surgery if: Possible infection (urgent)  
Sudden deterioration in symptoms (soon)  
Symptoms affecting activities of daily living and conservative measures failed (routine)

### **Knee: Osteoarthritis:**

Primary care management: Physiotherapy  
Analgesics  
Weight reduction  
Activity modification  
Consider intra-articular injection but no more than 3 cortisone injections and one month between each.  
Do not inject if referring for surgery (contraindicated within 6 months of cortisone injection as increased infection risk).

Consider referral for surgery if: Possible infection/ acute inflammatory change(urgent)  
Sudden deterioration in symptoms (soon)  
Symptoms affecting daily activities and primary care management has failed (routine)

**Knee pain:**

Consider direct orthopaedic referral if suspicious of a Meniscal tear; history of injury, locking, giving way and patient under 40.

Signs: True joint line tenderness and positive tests e.g McMurray. If knee locked needs urgent referral.

**Back pain with or without sciatica:**

Follow primary care management : Rest for no more than 48 hours with adequate analgesia, gentle mobilisation after that. Physiotherapy referral if not settling within 6 weeks.

Consider orthopaedic referral if sciatica is not improving at 6 weeks and the patient is significantly disabled by leg pain and not settling with analgesia, if there are progressive motor symptoms. A scan will not alter management in the acute phase. It is only useful if considering surgery.

Refer urgently for red flag symptoms

- There is difficulty with micturition.
- There is loss of anal sphincter tone and faecal incontinence.
- Saddle anaesthesia by the anus perineum or genitals.
- Widespread or progressive motor weakness in the legs or gait disturbance.
- Pain is constant, progressive and non-mechanical in nature.
- Sciatic symptoms are not resolving after four to six weeks of conservative treatment.
- The patient is systemically unwell, unexplained weight loss.
- There is widespread neurology.
- There is structural deformity.
- ESR is abnormal.
- Age <20 or onset >55 years
- Thoracic pain
- Past history of carcinoma, long course of steroids, HIV

### **Shoulder - Atraumatic shoulder pain:**

Common diagnoses are impingement (cuff may be intact or torn), frozen shoulder, and osteoarthritis of glenohumeral or acromioclavicular joints. Initial management is the same –

1. Analgesics and physiotherapy
2. If fail to settle at 6 weeks consider cortisone injection (sub-acromial for impingement, glenohumeral for frozen shoulder and osteoarthritis, directly into acromioclavicular joint if this is the site of pain). Arrange plain radiograph.
3. If fail to settle after above, pain bad enough to consider surgery, and at least 3 months of symptoms, then refer (if injections and physiotherapy have not both been trialled, then referral will be returned).

### **Shoulder - Pain post trauma:**

Acute dislocations – will be managed in A&E/orthopaedic service.

Significant trauma, followed by bruising, inability to lift arm and weakness of external rotation – exclude fracture with radiograph, consider rotator cuff tear. Worth trial of 4 weeks non operative treatment, and if fails to improve refer to orthopaedic surgeon.

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