Waikato DHB Referral Criteria: Orthopaedics

Diagnosis	Evaluation	Management Options	Referral Guidelines
NECK • Mechanical neck pain without arm pain • Neck pain associated with referred pain to the upper arm without neurological deficit	**Key points:** • Duration of symptoms • Presence of neurological symptoms and signs including evidence of lower limb spasticity • Work status • Weight loss, appetite loss and lethargy • Fever and sweats • Treatment to date • Previous malignant disease • General medical condition **Investigations (only if indicated):** • X-ray • FBC & ESR • Biochemistry (Consider calcium and phosphate, protein electrophoresis, immunoglobulins, PSA, rheumatoid serology in specific cases)	• Activity modification • Analgesics • NSAIDs • Physiotherapy • Education • Maybe trial of soft collar if severe spasm	If symptoms and signs persist despite adequate care with allied Health treatment report.
• Neck pain associated with neurological deficit • Cervical myelopathy	Routine history and examination noting the key points as above		Refer
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
• Neck pain			Refer

secondary to malignant disease • Neck pain secondary to infection			
SHOULDER Rotator cuff tendinitis/tears Pain/stiffness in shoulder including frozen shoulder AC joint problems	Standard history and examination particularly neurological examination X-rays (scapular AP, infra-auxiliary lateral, supraspinatus outlet) CBC & ESR	Anti inflammatories Physiotherapy Consider cortisone injections	Refer if patient fails to respond to treatment with allied health treatment report
Recurrent dislocated shoulder/ Shoulder instability	Standard history and examination particularly neurological examination X-rays (scapular AP, infra-auxiliary lateral, supra-spinatus outlet)	Advice to avoid dislocation Shoulder rehabilitation programme (physiotherapy)	Refer if has not responded to the rehab programme with allied health treatment report.
Tennis/Golfer's Elbow	Standard History and Examination X-ray of the elbow	Bands Anti inflammatories Modify activity [e g patient with tennis elbow to use wrist in supination as much as possible] Physiotherapy Consider cortisone injection	Refer if fails to respond to adequate conservative treatment with copy of allied health treatment report
Painful/stiffness in elbow locking	Standard history and examination. CBC & ESR	Anti-inflammatories Physiotherapy	Refer if not responding to treatment with allied health treatment report

Diagnosis	Evaluation	Management Options	Referral Guidelines
WRIST & HAND	See under Miscellaneous		

Carpal Tunnel Syndrome	section		
Dupuytrens contracture	**Key Points:** • duration and speed of progression • functional impairment • family history of dupuytrens • smoking • previous surgery • general medical conditions (especially diabetes, epilepsy, liver disease) • medications (especially for epilepsy)		Refer, more particularly if PIPJ involved
Stenosing tenovaginitis (e.g. trigger fingers, de Quervains)	Standard history and examination	Refer Primary Health Care plan Consider injection with steroids	Refer if unresponsive to treatment after injection
Rheumatoid conditions	Standard history and examination	Usually refer to specialist rheumatologist / physician	Refer to Rheumatology
Basal thumb arthritis	Standard history and examination X-ray	Anti inflammatories Activity modification Consider steroid injection	Refer if fails to respond to treatment, with outline of treatment
Ganglia	Standard history and examination	Consider aspiration (18g needle) and multiple puncture	Refer if fails to respond to treatment, with outline of treatment
Painful/stiff wrists	Standard history and examination X-ray (wrist and carpal)	Anti inflammatories Trial of wrist splint Physiotherapy	Refer if X-ray abnormal or if does not respond to adequate conservative treatment with copy of allied health treatment report
Congenital upper limb abnormalities			Refer to local service as available

Diagnosis	Evaluation	Management Options	Referral Guidelines
BACK • Mechanical low back pain without leg pain • Back pain and sciatica without neurology • Spinal stenosis with limitation of walking distance	**Key Points:** • duration of symptoms • presence of neurological symptoms and signs • functional impairment • time off work • weight loss, loss of appetite and lethargy • fever and sweats • treatment to date • previous spinal surgery • previous malignant disease • general medical condition and medication **Investigations if symptoms persist:** • X-rays (lumber spine, AP pelvis) • FBC, ESR, biochemistry (Consider calcium and phosphate, electrophoresis, immunoglobulins, PSA, rheumatoid serology in specific cases)	• Activity modification • Analgesics and NSAIDs (see ACC Guidelines Booklet) • Physiotherapy	Significant symptoms persisting after 6 months with copy of allied health treatment report.
• Back pain and sciatica with neurological deficit	X-ray (lumber spine, AP pelvis) CBC, ESR		Refer with relevant information
• Back pain secondary to neoplastic disease or infection			Refer with relevant information
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
• Back pain with			Ring Orthopaedic Registrar on call

neurological bladder involvement (cauda equina syndrome)			
HIPS **Hip Arthritis** • Osteoarthritis • Inflammatory arthritis • Post traumatic arthritis • Avascular necrosis • Previous total hip replacement (THR)	Standard history and examination **Key Points:** • walking distance • rest pain and disturbance of sleep • ability to put on shoes • use of walking aids • treatment including NSAIDs and analgesics • previous joint surgery • general medical conditions and medication • history of recurrent infections and prostatism • examination for range of movement **Investigations:** • X-ray (AP pelvis, AP affected hip showing proximal 2/3 femur and lateral affected hip)	Anti-inflammatories / analgesics / physiotherapy Activity modification including the use of a walking stick Weight reduction	***Please note: A benchmark exists of 110kg and the BMI must be less than 35 for joint replacements. Please discuss this with your patient and refer when weight and BMI goals are reached.*** Refer if significant pain, disability, sleep disturbance, and unresponsive to therapy with outline of treatment carried out and any allied health treatment report If infection suspected make acute referral (don't start antibiotics)
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Paediatric Hip Conditions (perthes, slipped upper femoral epiphysis [SUFE], synovitis) Irritable hip	History, examination and x-ray. Beware of pain in the knee as a symptom of hip disease	Bed rest and simple analgesics	Ring Orthopaedic registrar on call for admission if systemically unwell, febrile, or on suspicion of SUFE Otherwise reassess at 48 hours

			Usual age ranges: 18 months to 6 years: irritable hip Perthers 4-10 years SUFEs usually 8-14 years
KNEE **Knee Arthritis** • Osteoarthritis • Inflammatory arthritis • Post traumatic arthritis • Avascular necrosis • Previous total knee replacement (TKR) • Bakers cyst	**Key Points:** • Walking distance • Rest pain and sleep disturbance • Use of walking aids • Treatment including NSAIDs and analgesics • Previous joint surgery • General medical condition and medication • History of recurring infections and prostatism • Examine for tenderness, swelling, range of movement **Investigations:** • X-rays - routine knee x-rays including AP of both knees <u>standing</u> and lateral affected side	• Anti-inflammatories / analgesics • Physiotherapy • Activity modification including the use of a walking stick • Weight reduction	***Please note: A benchmark exists of 110kg and the BMI <u>must</u> be less than 35 for joint replacements. Please discuss this with your patient and refer when weight and BMI goals are reached.*** Refer if significant pain, disability, sleep disturbance and unresponsive to therapy with outline of treatment carried out And any allied health treatment report If infection suspected make acute referral (don't start antibiotics)
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
ANKLES & FEET **Arthritis**	Standard history and examination • X-rays (standing)	Analgesics / anti-inflammatories Physiotherapy Activity modification Walking aids Consider steroid injection	Refer if functional impairment despite adequate conservative treatment, with copies of Allied health treatment report

Pain and deformity in forefoot (including bunions)	Standard history and examination • X-rays (standing) • check tibialis posterior	Modification footwear Orthoses Consider steroid injections for intermetatarsal bursa / neuroma	Refer if adequate conservative treatment fails, with copies of Allied health treatment report
Pain and instability in hind foot	Standard history and examination • X-rays (standing) • check tibialis posterior	Modification footwear Orthoses Physiotherapy	Refer if adequate conservative treatment fails, with copies of Allied health treatment report
Achilles tendon pathology	Standard history and examination • X-rays	Physiotherapy Avoid steroid injections Heel cups / raise	Refer if adequate conservative treatment fails, with copies of Allied health treatment report
Heel pain	Standard history and examination • X-rays X-rays allow exclusion of some diagnoses NB: Plantar spurs on an x-ray does not imply plantar fascitis	Physiotherapy Heel cups / raise via orthotics	Refer if adequate conservative treatment fails, with copies of Allied health treatment report
PAEDIATRIC DEFORMATIES **Club Foot**	Features to be looked for are fixed equinus and varus		Refer
Calcaneo valgus foot	Almost always correctable to neutral but check the hips for instability	Reassurance	Refer if not flexible / correctable
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Flat feet	Under the age of three years, flat feet are normal Ask the child to stand on his/her tip toes - if the arch corrects, the foot is normal	Reassurance	Refer if painful or in spasm
In toeing	Standard history and examination	Reassurance	Refer for a second opinion if asymmetrical or significant deformity
MISCELLANEOUS **Nerve entrapment syndromes, Carpal Tunnel**	Standard history and	If symptoms not	Refer if no response to

Syndrome, ulnar neuritis, tarsal tunnel	examination	responding, if recurrent after surgery or patient diabetic refer to neurology for Nerve conduction studies. Consider one steriod injection for carpal tunnel Splintage	adequate conservative treatment, with copies of Nerve conduction dtudy report if appropriate.
Bone and/or joint Infection	Standard history and examination	Don't start antibiotics	Ring orthopaedic Registrar on call
Bone and soft tissue tumours	Standard history and examination Do not needle biopsy		Refer urgently if tumour or suspicion of tumour
Bursitis (pre-patella, trochanteric, olecranon)	Standard history and examination X-ray CBC, ESR, Uric acid If acute / inflammatory consider aspirating for diagnosis. Will either be traumatic, gouty or infected.	If acute consider aspirating for relief of symptoms. If chronic consider steroid injection.	Refer if non responsive to adequate conservative treatment.
Apophysitis (e.g. Osgood Schlatters, Severs disease)	Standard history and examination Consider x-ray	Activity modification, reassurance	Refer if does not settle after adequate conservative treatment
Gait	Standard history and examination Up to two years bow legs are normal Knock knees from age 2-5 years are normal	Reassurance	Refer for second opinion or severe deformity outside the normal age range
Sterno mastoid tumour (congenital muscular torticollis)	Standard history and examination	Passive stretching by parent or physiotherapist	Normally refer to exclude other abnormality
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Removal plates, screws and pins	Pain Ulceration X-ray		Most metal implants are not removed. Consider referral if painful or risk of re-fracture, and not ACC.