HPH Bone and Joint Referral Guidelines for Primary Care Physicians

Effective December 21, 2017

This document is designed to help the primary care physicians determine when to refer patients for outpatient Bone and Joint consultation. They should only be used as a tool and not as exclusive indicators for referral.

These guidelines are designed to help the primary care physician determine when to refer patients with some of the more commonly seen musculoskeletal complaints for outpatient bone and joint consultation. They should only be used as a general guide to the initial evaluation and treatment of patients and indicators for referral to the Bone and Joint Center.

1. **Atraumatic Lower Back Pain without sciatica and no red flags (Systemic or neurological):**
    a. Initiate treatment with short term analgesia and if no contraindications short term NSAIDs.
    b. Start PT twice per week for 1 month to help patient understand inciting factors of the back pain and to work on preventive techniques.
    c. IF no better after 6 weeks of this treatment, then consider lumbar spine x-ray including AP, lateral and oblique views (lumbar spine series) and consider referring to physiatry medicine.

2. **Traumatic or Injury Induced Lower Back Pain with focal area of tenderness, but no sciatica and no red flags:**
    a. Lumbar spine x-rays as above and if no fracture then treatment as above. If fracture and no neurological findings then prescription to physiatry medicine for back brace (TLSO) for fractures L2 and higher and lumbar (LSO) corset for L3 and lower) and initiate treatment as above, refer to physiatry medicine. Review bone density status with patient.
    b. If neurological findings then order MRI and refer to orthopedic spine specialist.

3. **Atraumatic Mild/Moderate Lower back pain with sciatica without neurological defects:**
    a. Initial treatment as above as long as patient's condition does not worsen, if no change in two to four weeks then lumbar spine x-rays as above and referral to physiatry medicine.

4. **Atraumatic Severe Lower Back Pain with sciatica with neurological defects:**
    a. Initiate treatment as above, lumbar spine x-ray, MRI of the lumbar spine and referral to neurosurgery, orthopedic spine surgery (see above) or if only minimal and no progressive neurological deficits to physiatry Medicine.

5. **Severe Lower Back Pain with Red Flags:**
    a. Pharma therapy, lumbar spine x-ray, MRI, possible labs (ESR, CRP, CBC) and referral to neurosurgery or orthopedic spine surgery if neurological deficits are present or appropriate specialist depending on working diagnosis (infection to ID, cancer to oncology).

6. **Chronic Lower Back Pain duration greater than six months, patient on long term narcotic medication, evaluation completed at Straub or elsewhere with infection, malignancy and neurological etiology ruled out:**
    a. Referral to pain management network of providers.

7. **Atraumatic Neck Pain with no red flags:**
    a. Initiate treatment including short term analgesics, NSAIDs, PT twice per week for 1 month. If not better after six weeks obtain standard x-rays cervical spine pain series (AP, lateral, two oblique and open mouth views) then referral to physiatry medicine.

8. **Atraumatic Neck Pain with radiculopathy and no red flags:**
    a. Cervical spine x-rays as above and if neurological deficit, obtain MRI of the cervical spine and refer to neurosurgery. If no neurological deficits, then initiate treatment as above with the consideration of a tapering dose of oral corticosteroids and refer to physiatry medicine.

9. **Mild to Moderate atraumatic Shoulder Pain:**
    a. Initiate treatment with RICE, NSAIDs, Rehabilitation (PT, OT), if no better after six weeks then obtain standard x-rays shoulder pain series (four views) and refer to physiatry medicine/orthopedic surgery.

10. **Severe Shoulder Pain:**
    a. Initiate pharma therapy, four view shoulder x-rays. If fractures/dislocations then refer to orthopedic surgery. If degenerative changes or normal x-rays then initiate treatment as above, and if not better in two to four weeks or if PCP is concerned about the clinical presentation then referral to physiatry medicine/orthopedic surgery.

11. **Atraumatic Mild Knee Pain:**
    a. Initiate treatment with RICE, NSAIDs, decrease weight bearing activities, possibly PT twice per week for 1 month. If not better in six weeks then obtain x-rays (standing AP, standing Rosenberg at 45 degrees of flexion, Sunrise view of patellae, lateral views). and refer to physiatry medicine/orthopedic surgery.

12. **Atraumatic Moderate to Severe Knee Pain:**
    a. In adults older than 30 years obtain standard weight-bearing x-ray series (standing AP, standing Rosenberg at 45 degrees of flexion, Sunrise view of patellae, lateral views). Initiate treatment with RICE, NSAIDs, decrease weight bearing activities, possibly PT twice per week for 1 month. If there is a fracture then refer to orthopedic surgery. If osteoarthritis or normal x-rays and the patient does not improve with initial treatment in two to four weeks then refer to physiatry medicine/orthopedic surgery.

13. **Traumatic Mild to Moderate Knee Pain:**
    a. As noted above for severe traumatic knee pain; however, if no signs of an internal knee derangement then initiate treatment including pharma and PT twice per week for 1 month, and refer patient to physiatry medicine if no significant improvement in four to four to six weeks.

14. **Traumatic Severe Knee Pain:**
    a. Obtain x-rays as noted above unless the patent is not able to weight bear, then non-weight bearing views. If fracture, refer to orthopedic surgery. If no fracture; however, there is clinical evidence (large effusion, ligamentous laxity, lack of full ROM, positive McMurray's sign) of a

significant internal knee derangement (ACL tear, meniscal tear), obtain MRI of the knee and refer to physiatry medicine/orthopedic surgery. If no x-ray abnormalities or clinical evidence of an internal knee derangement then initiate pharma treatment and refer to physiatry medicine/orthopedic surgery.

15. **Atraumatic Mild to Moderate Hip Pain:**
    a. Initiate treatment, if no better after six weeks then obtain x-rays and refer to physiatry medicine/orthopedic surgery.

16. **Atraumatic Severe Hip Pain:**
    a. X-rays, standard hip series (2 view of hip in Epic: AP, frog leg lateral), initiate treatments as above. Refer to orthopedic surgery for fractures. Refer to physiatry medicine/orthopedic surgery for all others.

17. **Suspected Carpal Tunnel Syndrome:**
    a. If no weakness in the abductor pollicis brevis, then initiate treatment with NSAIDs, splinting and/or analgesics as needed and consider nerve conduction testing prior to referral to physiatry medicine. If weakness is present then refer to an orthopedic hand specialist.

18. **Scoliosis:**
    a. Obtain standing scoliosis views, refer to a pediatric orthopedic spine specialist with idiopathic scoliosis that is at high risk for progression.