

Specialty guides for patient management during the coronavirus pandemic

Urgent and Emergency Musculoskeletal Conditions Requiring Onward Referral

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As clinicians we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. We have a responsibility that essential musculoskeletal care continues with minimal burden on the NHS. This guidance is to help primary or community care practitioners recognise serious pathology which requires emergency or urgent referral to secondary care in patients who present with new or worsening musculoskeletal (MSK) symptoms.

Serious pathology as a cause of MSK conditions is considered rare, but it needs to be managed either as an emergency or as urgent onward referral as directed by local pathways.

Any part of the MSK system can be affected.

Consider serious pathology as a differential diagnosis if a person presents:

- **with escalating pain and progressively worsening symptoms that do not respond to conservative management or medication as expected**
- **systemically unwell (fever, weight loss)**
- **with night pain that prevents sleep due to escalating pain and/or difficulty lying flat.**

Emergency conditions

The following serious pathologies must be dealt with on the day as an emergency. Pathways for emergency referral have changed in many areas: please keep updated about changes in the local system.

- **Cauda equina syndrome (CES):** People presenting with spinal and leg pain, with neurological symptoms and any suggestion of changes in bladder or bowel function or saddle sensory disturbance, should be suspected of having CES. The link below

outlines the symptoms to be concerned about and these cards can be used to facilitate communication about sensitive symptoms. They can also be given to people who are at risk of CES and need to be warned about what to look out for and the action to take should they develop symptoms.

<https://www.eoemskservice.nhs.uk/advice-and-leaflets/lower-back/cauda-equina>

- **Metastatic spinal cord compression (MSCC):** MSCC occurs as a consequence of metastatic bone disease in the spine. It can lead to irreversible neurological damage. Symptoms can include spine pain with band-like referral, escalating pain and gait disturbance. This link outlines the symptoms to look out for: https://www.christie.nhs.uk/media/1125/legacymedia-1201-mscc-service_education_msc-cc-resources_red-flag-card.pdf
- **Spinal Infection:** May present with spinal pain, fever and worsening neurological symptoms. Consider risk factors (eg immunosuppressed, primary source of infection, personal or family history of tuberculosis).
- **Septic arthritis:** If the person presents unwell, with or without a temperature, with a sudden onset of a hot swollen painful joint and multidirectional restriction in movement, septic arthritis should be expected until proven otherwise. This is particularly important in children, who may present with a painful limp or loss of function in the upper limb, and not as a hot, swollen, painful joint.

Urgent conditions

The following require an onward urgent referral:

- **Primary or secondary cancers:** Primary cancers such as breast, prostate and lung can metastasise to the spine. May present with escalating pain and night pain; people may describe symptoms as being unfamiliar and eventually become systemically unwell. **If a person does become systemically unwell, they need to be escalated to the local emergency pathway.**
- **Insufficiency fracture:** Commonly presents with sudden onset of pain, mostly located in the thoraco-lumbar region following low impact trauma. The pain varies in presentation, but is often severe and mostly localised to the area of the fracture. Consider risk factors associated with osteoporosis; however, exclusion of a more serious pathological cause may be indicated.
- **Major spinal-related neurological deficit:** Commonly presents with spinal pain and associated limb symptoms. A person may present with new-onset or progressively worsening limb weakness, present for days/weeks, less than grade 4 on the Oxford muscle grading scale, associated with one or more myotome. See the following link for information on the Oxford scale: <https://www.csp.org.uk/documents/appendix-5-oxford-muscle-grading-scale>.

- **Cervical spondylotic myelopathy (CSM):** In rare cases cervical spondylosis can progress to this condition. Consider CSM if people present with worsening pain, lack of co-ordination (eg trouble with tasks like buttoning a shirt), heaviness or weakness in arms or legs, pins and needles and pain in arms, problems walking, loss of bladder or bowel control.
- **Acute inflammatory arthritis and suspected rheumatological conditions:** Refer any person to rheumatology with:
 - **persistent synovitis** (ie hot swollen joints), particularly if the small joints of the hands (metacarpophalangeal or proximal interphalangeal) and/or feet are affected, and person reports early morning joint stiffness lasting more than 30 minutes, even if the acute phase response (C-reactive protein – CRP or erythrocyte sedimentation ratio – ESR) is normal and cyclic citrullinated peptide antibody (anti-CCP) or rheumatoid factor (RF) are negative. The person may have rheumatoid arthritis or psoriatic arthritis
 - **a suspected new-onset autoimmune connective tissue disease (eg lupus, scleroderma) or vasculitis.** Symptoms include extra-articular manifestations such as a rash, Raynaud’s (colour change, with hands and/or feet turning white–blue and/or red in the cold), mouth ulcers and/or sicca symptoms (dry eyes/mouth) in association with their new inflammatory arthritis
 - **myalgia** which is not secondary to a viral infection or fibromyalgia but worsens proximally, ie affects the shoulder and pelvic girdles in a symmetrical pattern, is worse in the morning and associated with more than 30 minutes of stiffness, and accompanied by a raised acute phase response (ESR or CRP). They could have:
 - polymyalgia rheumatica (PMR): person usually aged over 50; **refer urgently to GP**, or
 - myositis: any age, usually accompanied by some weakness and raised creatine kinase (CK); **refer urgently to rheumatology service**
 - **new-onset headache** predominantly in temples with or without associated symptoms such as jaw claudication, proximal girdle pain, visual symptoms **and** accompanied by a raised acute phase response (ESR or CRP) in people usually aged over 50. They may have giant cell arteritis
 - **suspected inflammatory spinal pain:** person may report prolonged early morning stiffness, pain radiating to buttocks and/or night pain. They may or may not have associated psoriasis, inflammatory eye disease (uveitis, iritis) and/or inflammatory bowel disease. For further information see the link: <https://www.esht.nhs.uk/wp-content/uploads/2018/07/Msk-Think-SpA-NICE-guidance-on-recognition-and-referral-of-Spondyloarthritis.pdf>