Naval Medical Center Portsmouth
Rheumatology Referral Guidelines

Diagnosis:	**Osteoarthritis**

Clinic Name	Rheumatology
Clinic Phone Number	757-953-2160 or 2161
On Call Numbers	Duty Pager: 757-860-5702

1. Indications for Specialty Care:

- **If the diagnosis is unclear or if there is concern for the possibility of an inflammatory arthritis.** Inflammatory arthritis will generally manifest as prolonged morning stiffness (>60 minutes) and visible swelling of the joints and additionally warmth and redness. Please see inflammatory arthritis referral guidelines for further laboratory and radiographic evaluation prior to referral.

- A peripheral joint injection for symptomatic treatment is needed. This is also based on availability. Please note Rheumatology does not perform cervical/lumbar spine or intraarticular hip injections.

- Urgent evaluation for monoarthritis (one swollen joint). **Consideration needs to be first for an orthopedic evaluation if septic arthritis is in the differential diagnosis**. If other inflammatory arthritides such as crystalline arthritis (gout) needs to be considered then this should be arranged by a phone call to the duty Rheumatologist.

2. Quality Consult Criteria

When referring a patient, please include as much of the following information as possible (OK to cut and paste this into consult request)

1. Provisional diagnosis
2. Duration of Problem
3. Prior treatments
4. Current treatments/medications
5. Diagnostic studies obtained (imaging, labs, other tests, etc.)
6. Primary reason for consult
7. Use of referral guidelines

3. Diagnosis Definitions

- **Osteoarthritis (OA) is the most common cause of arthritis.** OA is a slowly progressive, non-inflammatory arthritis that typically affects the joints of the hands: 1st carpometacarpal (CMC) joint/ proximal interphalangeal (PIP) joint PIP/ distal interphalangeal (DIP) joint. It also affects the entire spine, and weight-bearing joints (hips, knees, first metatarsophalangeal joint) of the lower extremity.

- It is characterized by joint pain, particularly after activity, crepitus, stiffness as immobility and limitation of motion.

- It results from degenerative changes in the joint due to chronic use. The clinical joint symptoms are pathologically associated with defects in articular cartilage, osteophytes and subchondral sclerosis.

- There are NO systemic symptoms, and joint inflammation, when present, is mild. Patients can have cool effusions in the knee for example.

- OA is more common in men than women age 45 years; more common in women than men age > 45 years (related to estrogen).
  - It is estimated to be 12% of the adult population (> 25 years) overall and the percent is increasing.
  - **OA increases with age and is the strongest risk factor**. Radiographic OA is twice more common than symptomatic OA.
  - **Obesity is a clear risk factor for the development of OA,** especially the knee and, to a lesser degree, of the hand and hip.

4. Initial Diagnosis and Management

- The diagnosis is made by history and physical examination. Historical features will include morning stiffness lasting less than 30 minutes and chronic pain with exercise that typically improves with rest. Joint tenderness, crepitus, swelling, and deformity may be present on physical exam. Warmth, erythema, acute loss of mobility, and pain with passive and active range of motion should be absent. Physical examination may reveal bony articular nodules (osteophytes or "spurs) located at the DIP joints called **Heberden's nodes** and at the PIP joints **Bouchard nodes**.

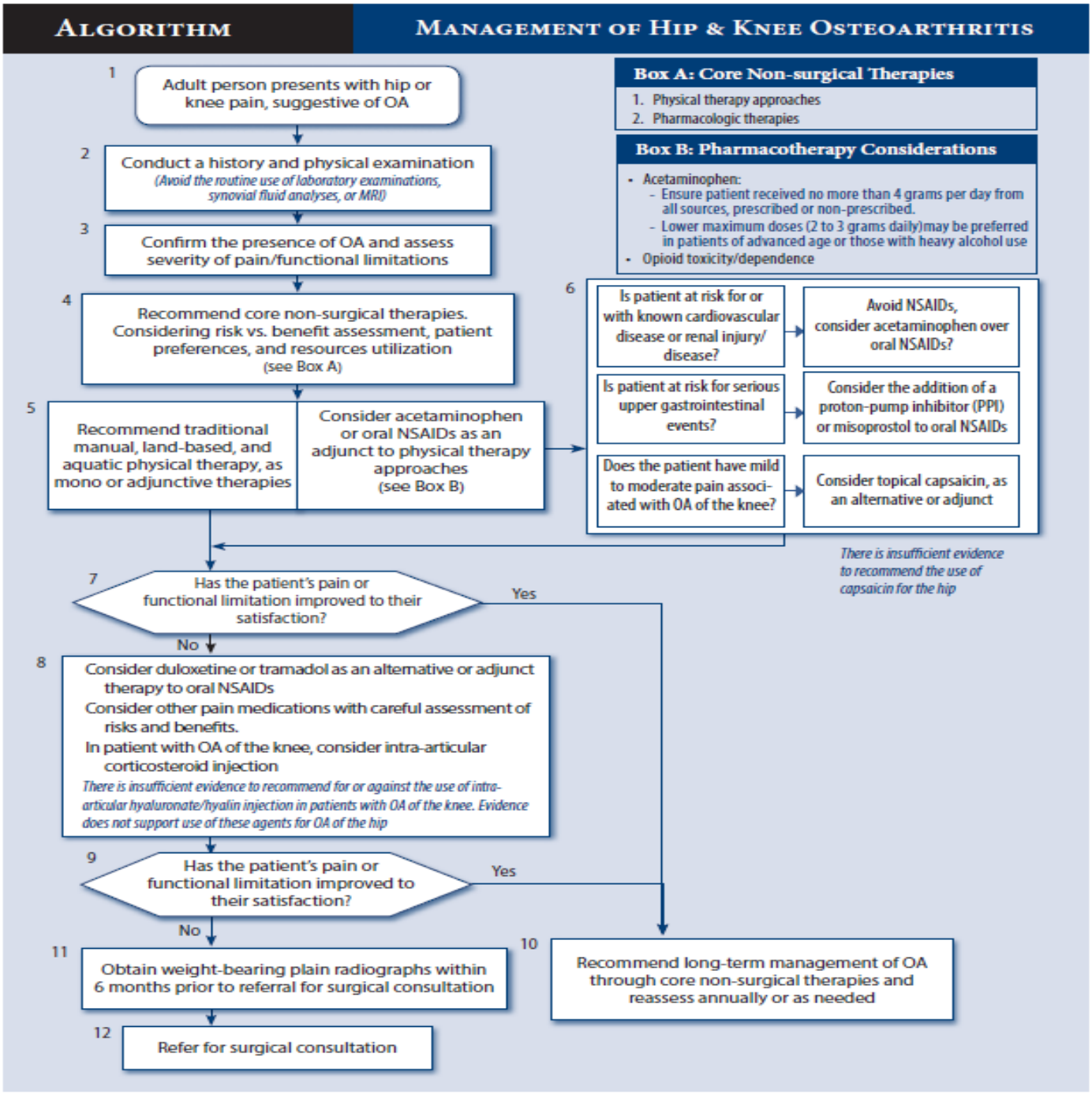
- **Radiographs and labs are not needed for the routine diagnosis of OA.** Radiographs may be normal early in the disease but will eventually show asymmetric loss of joint space, sclerosis, subchondral cysts and osteophytes of involved joints. Synovial aspiration of joint should have a cell count less than 2,000.

5. Ongoing Management and Objectives

- **Primary treatment goal is to alleviate pain and improve quality of life. There is no treatment that alters the disease course at this time. All non-invasive options can appropriately be managed in primary care.**
  - Patient education is key!
  - Weight loss: every 1 pound results in a fourfold reduction in load per step on the knee. Weight loss of 5% results in 18-24% improvement in function in patients with knee OA.
  - Occupational therapy assistant aids/devices, joint protection and modification of activities of daily living.
  - Exercise for muscle strengthening/flexibility surrounding the affected joint and aerobic conditioning.
  - Physical therapy referral may be considered
  - Optimal footwear and other ambulatory aids such as unloader/off-load knee brace, splinting and taping.
  - Paraffin baths for hands can be used at home.

- **Medications:** Medications are used to alleviate symptoms and increase function with the least toxicity.
  - Tylenol can be used to decrease OA pain.
  - NSAIDs such as ibuprofen or naproxen can be tried for symptom relief if there are no contraindications.
  - Topical NSAIDs such as diclofenac gel can be tried if there are contraindications to systemic NSAIDs.
  - Capsaicin cream and lidocaine patches may be tried.
  - Duloxetine (Cymbalta) or tramadol can also be used for OA pain. Tramadol is a scheduled IV narcotic and would require an opioid use agreement and urine drug screens.
  - Intraarticular corticosteroid or hyaluronic acid injections.

- **Other:**
  - Joint replacement. This should be considered when there is severe pain unresponsive to medical therapy and severe loss of joint function. This would require a referral to orthopedics.



The Non-Surgical Management Of Hip & Knee Osteoarthritis | ALGORITHMS | 5

https://www.healthquality.va.gov/guidelines/CD/OA/OASUM6FIA.pdf

6. Criteria for Return to Primary Care
• Diagnosis of Osteoarthritis established and patient not requiring or has failed intraarticular injections.

Date Adopted or Last Reviewed:	01 Feb 2018	By	CDR Shauna O'Sullivan LCDR Jeffrey Eickhoff LCDR Terrence Kilfoil LCDR Jason Weiner
Referral Guidelines require review every three years.			

7. Resources/References
• VA/DOD Clinical Guidelines: The non-surgical management of hip and knee OA (2014) • VA/DOD guidelines on the management of OA: https://www.healthquality.va.gov/guidelines/cd/oa/index.asp • Please see VA/DOD pocket card: https://www.healthquality.va.gov/guidelines/CD/OA/OAPocketv9FCROPPED.pdf • American College of Rheumatology: https://www.rheumatology.org/I-Am-A/Patient-Caregiver/Diseases-Conditions/Osteoarthritis • Orthopedic clinical practice guidelines on OA: http://www.orthoguidelines.org/topic?id=1005