# Orthopaedic Choice Referral Guidance – Upper Limb

Please include the following **MINIMUM CLINICAL DATA SET FOR ALL REFERRALS**. Referrals that do not contain this information are likely to be returned for completion:

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| BMI within 6/12 | Effect on function | Current analgesia |
| Duration | Effect on sleep | Occupational factors |
| Severity | Previous x-ray/imaging | PMH |
| Site (Laterality) | Previous treatment (injections, physio, podiatry etc. with details) | DH |

\*Covered by Prior Approval process – criteria are in ***bold italics***

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| HAND | Condition | Possible Primary Care treatments prior to referral | ESSENTIAL referral Information required from GP *plus* MINIMUM DATA SET |
| Carpal Tunnel – mild-moderate | Splint 6/52, Inject and splint 6/52. Qualifies for surgery if this done and >6 month history | Duration, symptoms (?permanent), thenar wasting?, prior treatments, relevant tests (NCS only if diagnostic doubt, blood tests only if indicated) |
| Carpal Tunnel – severe | Surgery indicated if severe – thenar wasting, permanent sensory loss etc.  | As above. State expectation surgery for DCC. |
| Dupuytren’s\* | Conservative management is advised if there is: • no contracture OR • only mild (less than 20 degrees) contracture OR • contracture that is not progressing and does not impair function | Record of degrees of contracture and description of functional impairment, refer only if fulfils funding criteria:• Finger contractures causing loss of finger extension of 30 degrees or more at the metacarpophalangeal joint (MCPJ) or 20 degrees at the proximal interphalangeal joint (PIPJ) resulting in functional loss OR • Severe thumb contractures which interfere with function |
| Trigger finger\* | Mild cases which cause no loss of function require no treatment or simple splinting. Recommend avoidance of activities which precipitate triggering and may resolve spontaneously | Surgery should only be considered if: • The triggering persists or recurs after one of the above measures (particularly steroid injections); or • The finger is permanently locked in the palm; or • The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods; or • The patient has diabetes. |
| OA base of thumb  | No requirement for diagnostic X-ray unless considering CSI.Offer advice education splinting pain relief.  | X-ray required Prior to referral if failed primary care. |
| OA fingers | No requirement for diagnostic X-ray unless considering CSI.Offer advice education splinting pain relief. | X-ray required Prior to referral if failed primary care. |
| De Quervains | Offer thumb splint, activity mods and could offer CSI. | If failed primary care. USS if diagnostic uncertainty. |
| Ganglion***\*(causes persistent pain or reduced function or sudden enlargement)*** | Most ganglia get better on their own. Interventions for ganglia are considered to be of limited clinical value and are not commissioned.Offer;Splint, anti-inflammatory measures. Aspirate if can (not digital mucus) | If persistent. Duration, location, effects of ganglion, unusual features, ultrasound if diagnostic doubt or digital. Imaging not required for dorsal wrist ganglion. |

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| ELBOW | Condition | Possible Primary Care treatments prior to referral | ESSENTIAL referral Information required from GP *plus* MINIMUM DATA SET |
| Tennis/Golfer’s Elbow | Activity modification. Brace. Physio if struggling. Avoid initial care with CSI due to deleterious effects.  | Prior treatments – must have physio first.  |
| Ulnar nerve entrapment | Advice not to lean on elbow sleep with elbow brace. Physiotherapy if persisting.If hypothenar wasting or weakness refer quickly. | Occupational factors, prior treatments. Note any muscle wasting weakness permanent numbness order NCS. |
| Suspected OA or loose body |  | X-ray required |

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| SHOULDER | Condition | Possible Primary Care treatments prior to referral | ESSENTIAL referral Information required from GP *plus* MINIMUM DATA SET |
| Subacromial pain\* (includes, impingement, supraspinatus, rotator cuff syndrome etc) | Conservative initially. Physiotherapy pain management. ***\*(eligible for surgery if >6m history + intrusive and debilitating + 6weeks physio + positive response to steroid injection)*** | X-ray required if >50.Ultrasound not helpful unless younger with traumatic presentation or severe functional disability. |
| Adhesive capsulitis (Frozen shoulder) | Advice re natural history. X-ray prior to offering CSI.NB Key diagnostic test is loss of passive range of external rotation | X-ray required if not done. Ultrasound not useful  |
| ACJ pain | Pain relief +/- Physiotherapy  | X-ray required if >50If failing initial management. |
| OA Glenohumeral joint | Pain relief +/- Physiotherapy | X-ray required if suspecting O.A. or > 50. If failing initial mangement. |

**General Guidance for all Upper Limb Orthopaedic Choice referrals**

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| Location of the Service | * Romsey
* Hythe
* Lymington
* Fordingbridge
* Avalon House, Winchester
* Andover
* Mooregreen
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| Exclusions | High index of suspicion for malignancy – primary or secondaryAcute injuriesPaediatrics <=16 yrs |
| Suggested Investigations | X-Ray/Scan investigations prior to referral as per guidance by condition |
| Administration Requirements | To Complete the referral proforma including all the minimum data set and refer on Choose and Book **Contact details for the booking office are:** 0300 003 0806**outpatients@southernhealth.nhs.uk****Address:**Lymington New Forest Hospital, Winchester Hill, Hampshire, SO51 7ZA |