Ambulatory referral guide Rheumatology

Updated January 2022

Pediatric patients: Please refer pediatric patients to the Stanford Pediatric Rheumatology Clinic.

Osteoporosis: Please refer patients with osteoporosis to endocrine clinic

Laboratory Testing:

ANA: The ANA test is not specific for any autoimmune disease, especially if it is low titer or transient. Depending on the technique used up to 15-30% of healthy people may have a positive titer. The prevalence increases in women and older people. Here is a breakdown of the prevalence of + ANA per titer:

ANA 1:40 present in 20-30% of healthy people. It is present in 70% of healthy people at age 70 or older.

ANA 1:80 is present in 10-15% of healthy people.

ANA 1:160 is present in 5% of healthy people.

- It is appropriate to order an ANA test if there is a suspicion for SLE, scleroderma, Sjogren's, myositis, mixed connective tissue disease but please do NOT order ANA if patient has a regional overuse soft tissue problem, neck or low back pain or joint pain from osteoarthritis.
- Please note that a positive ANA is also found in autoimmune diseases that are not rheumatologic (for example endocrine, neurologic, gastrointestinal, infectious disease, malignancies).
- When referring to rheumatology for a + ANA please make sure to state the reason the test was ordered, the ordering provider and specialty (if different from the ordering physician) and the month/year the test was ordered. We are receiving a high volume of consult requests for + ANA when the reason for ordering the test is not clear.
- When the referral is placed for a + ANA test please make sure that basic labs (CBC with differential, creatinine, urine analysis) are done within the last 3 months.

ANCA: There are two general staining patterns by immunofluorescence, C-ANCA and P-ANCA. ELISA testing reflects corresponding lysosomal enzymes, PR3 and MPO respectively. ANCA can be positive in cases of ANCA vasculitis but also in other diseases. Here are commonly seen associations:

- Granulomatous Polyangiitis (GPA), also known as Wegener's: C-ANCA +, PR3+
- Microscopic Polyangiitis (MPA): P-ANCA+, MPO+
- Eosinophilic Polyangiitis (EGPA): P-ANCA+, MPO+

Other autoimmune diseases (SLE, IBD, AIH), infections, drugs (PTU): often ANCA+ on immunofluorescence but ELISA does not show PR3 or MPO.

Asymptomatic CK elevation (asymptomatic hyperCKemia):
- CK levels 1.5 times upper level of normal should be considered abnormal: >1200 for black men, >650 for black women, >500 for white men, >325 for white women.

- Repeat the CK after the patient has refrained from intense exercise for >3 days if there is any question that the elevation could be due to overexertion.
- Exclude recent intramuscular injections.
- Review the medication list and inquire about recent drug exposures that could lead to a drug-induced CK elevation, particularly if the patient is treated with a statin.
- make sure that the thyroid function is normal.

If patient is asymptomatic, there is no muscle weakness on exam and CK level is less than 500, monitor periodically after drugs, toxins and other endocrine related etiologies have been ruled out.
If patient has a rash, proximal muscle weakness, inflammatory arthritis and/or concern for ILD, CK > normal level (as above) then please refer to rheumatology.

Autoimmune diseases:

Rheumatoid Arthritis: Symmetric inflammatory polyarthritis, often with + RF and/or + CCP. Treated with NSAIDs, DMARDs, Biologic medications and small molecule drugs (JAK inhibitors).

Seronegative Spondyloarthritis: A group of autoimmune diseases that are seronegative (RF-) and include psoriatic arthritis, ankylosing spondylitis, enteropathic arthritis and reactive arthritis. The spine is often involved. Treatment includes NSAIDs, DMARDs, biologics and small molecule inhibitors depending on the subgroup.

Systemic Lupus Erythematosus: Systemic autoimmune disease which can affect the skin, joint and internal organs. Peak incidence is between the ages of 15-40, more common in females. Almost always ANA+. Other serologies that are commonly positive are anti-dsDNA, anti-Smith, Anti-RNP, low C3 and low C4. Treated with immunosuppressive medications.

Scleroderma: systemic autoimmune disease, which is characterized by skin thickening, tightness, Raynaud's and can involve internal organs. Nearly all patients are ANA+. Patients with diffuse systemic sclerosis are usually Scl70+ and those with limited systemic sclerosis are anti-centromere +. Treatment is tailored to the organs involved and includes vasodilators for Raynaud's as well as immunosuppressor medications.

Sjogren's Syndrome: Systemic autoimmune disease with progressive lacrimal and salivary dysfunction in addition to extra-glandular disease. Some patients are ANA+. Typically, SSA+ and/or SSB+. Therapy is supportive for sicca symptoms. For extra-glandular disease immunosuppressive agents are used.

Myositis: Polymyositis and Dermatomyositis are idiopathic inflammatory myopathies characterized by symmetric proximal muscle weakness and elevated muscle enzymes. Most patients are ANA+. Additionally, myositis specific autoantibodies and myositis associated antibodies may be present. Therapy is immunosuppression with a variety of agents. Malignancy screening and surveillance is indicated.

Large vessel vasculitis:

- Takayasu's Arteritis: idiopathic vasculitis of the aorta and its main branches. Most common is women < 40 years old. Treatment is steroids and steroid-sparing disease modifying agents.
- Giant cell arteritis (GCA), also referred to as temporal arteritis (TA): Large vessel vasculitis affecting the extracranial branches of the carotid artery and/or the major arteries arising from

the aortic arch. May result in vision loss if untreated. ESR and CRP are usually elevated. Patients are usually 50 years old or older. Temporal artery biopsy is needed for diagnosis which should be requested from a surgical specialty as soon as possible. Immediate therapy is prednisone 1 mg/kg/day up to 60 mg daily. Temporal artery biopsy should be obtained within 2 weeks of starting steroid.

- Polymyalgia Rheumatica: shoulder and pelvic girdle stiffness and pain for at least 4 weeks combined with elevated ESE/CRP. Patients must be carefully evaluated for GCA. Treatment is prednisone starting with 20 mg daily dose and slow taper.

Medium vessel vasculitis:

- Polyarteritis Nodosa (PAN): medium vessel vasculitis with predilection to the skin, GI tract, nerve and kidney. ANCA negative. Therapy is steroids and steroid sparing disease modifying agents.
- ANCA-associated Vasculitis: GPA, MPA, EGPA. See ANCA associations above under laboratory testing.

Small vessel vasculitis:

- Immune-complex mediated vasculitis, hypersensitivity vasculitis, cryoglobulinemic vasculitis, HSP, hypocomplementemic urticarial vasculitis. The skin, kidneys, lungs may be affected. Therapy depends on etiology. Often steroids are required. Steroid sparing immunosuppressive agents may be needed.

Raynaud's: Vasospasm of the small vessels in the hands upon cold exposure. Results in blanching, cyanosis and then hyperemia. 5-10% of healthy adults have Raynaud's (primary). This does not result in ulcers or gangrenes. Secondary Raynaud's due to scleroderma or other connective tissue disease can on the other hand result in tissue damage to the fingertips. Initial treatment is avoiding cold exposure. Calcium channel blockers have vasodilator effect on the small finger arteries.

Crystal Arthritis:

Gout: The rheumatology clinic will see patients with hyperuricemia and suspected gout to establish the diagnosis and to give advice on management. Patients on stable medication regimen and no flares will be discharged back to primary care.

- Please do not stop urate lowering therapy (allopurinol, febuxostat, probenecid) if patient has an acute flare. Continue urate lowering therapy and treat the flare with colchicine, NSAIDs, steroids as possible considering the patient's comorbid conditions.

CPPD deposition disease:

- Radiographic chondrocalcinosis and CPPD crystals in synovial fluid are not uncommon in osteoarthritic joints. Treatment is the same as for osteoarthritis unless patient has a pseudogout flare which is managed with colchicine, NSAIDs, steroids.

Osteoarthritis:

Osteoarthritis of the hands:

- Analgesics (Tylenol, NSAIDs)

- Hand therapy (PT)
- Injections for the first CMC joints or if one joint is particularly tender/swollen. In general, the ACR does not recommend injection of the PIP and DIP joints

Osteoarthritis of the knees:

- Physical therapy
- Occupational therapy referral when needed
- Analgesics (Tylenol, NSAIDs)
- Nutrition consultation if patient is overweight or obese
- Bike, stationary bike, water exercise or swimming
- Knee injections. The rheumatology clinic provides knee injections to patients with autoimmune arthritis and coexisting osteoarthritis of the knees. Please refer patients who only have osteoarthritis to the orthopedic clinic.
- Knee replacement surgery for severe or refractory cases. Please refer to orthopedic clinic with this need.

Osteoarthritis of the hips:

- Physical therapy
- Occupational therapy referral when needed
- Analgesics (Tylenol, NSAIDs)
- Nutrition consultation if patient is overweight or obese
- Bike, stationary bike, water exercise or swimming
- Hip injections can be done under imaging but are not recommended by the orthopedic clinic.
- Please refer patients who need injection or surgical evaluation to orthopedic clinic

Osteoarthritis of the spine:

- Physical therapy
- Analgesics per primary care provider
- Nutrition consultation if patient is overweight or obese
- The rheumatology clinic does not provide injections for spine disease. For injections, please consult the interventional pain clinic. For surgical evaluation please consult the neurosurgery clinic.

Fibromyalgia:

- 1. DAILY aerobic exercise (can be a few minutes) initially and should be increased gradually over time.
- 2. SLEEP HYGIENE
- 3. Medications: start with trial of amitriptyline 25mg QHS (can take smaller dose but take nightly). If this fails, can add gabapentin (titrate dose). If these fails, then try Lyrica (would need to stop gabapentin) OR try Savella or Cymbalta (would need to stop amitriptyline).

Regional Rheumatic Pain Syndromes:

Shoulder:

Rotator cuff tendonitis, subacromial bursitis, adhesive capsulitis.

- Please refer patient to physical therapy
- Rest, ice, NSAIDs
- Injection

Elbow:

Lateral epicondylitis, medial epicondylitis:

- Please refer patient to PT for isometric strengthening
- Rest, ice, NSAIDs
- Epicondyle band over the counter
- Print exercise handout for patient in HeathlLink

Olecranon bursitis:

- Avoid pressure over the olecranon
- ACE bandage
- Aspiration is only recommended if there is a concern for infection (warm, erythematous, tender)

Wrist:

De Quervain's Tenosynovitis:

- Wrist splint with thumb spika
- Rest, NSAIDs
- Physical therapy
- Injection

Carpal tunnel syndrome: paresthesia of the volar hand (primarily the 1-3 fingers), worse at night.

- Wrist splint (specifically for CTS), patient should wear it night
- Rest, NSAIDs
- Physical therapy
- Refer for a nerve conduction study (NCS) if symptoms do not improve after 6 weeks of splinting, rest and NSAIDs
- Injection if conservative therapy above fails and if NCS shows mild to moderate median nerve compression
- Refer to hand surgery for carpal tunnel release if severe MN neuropathy on NCS. Also refer t hand surgery if failed conservative therapy and injection.

Trigger finger:

- Physical therapy
- NSAIDs, Rest
- Injection if refractory to the above
- Surgical release if refractory to injections

Hip:

Trochanteric bursitis:

- Physical therapy referral for strengthening of the gluteus medius muscle and the iliotibial band and stretching
- NSAIDs
- Injections

Knee:

Patellofemoral pain syndrome, patellar tendonitis, anserine bursitis:

- Physical therapy
- NSAIDs
- Injection (for anserine bursitis)

Popliteal (Baker's) cyst:

- Only requires therapy if it is symptomatic and or large
- Physical therapy
- NSAIDs
- Injection of the knee joint
- Aspiration and injection of the cyst is rarely needed and would be done under imaging guidance

Ankle:

Achilles tendonitis:

- Rest
- NSAIDs
- Physical therapy
- Please print exercise handout from Healthlink for patient
- Shoe insole

Plantar fasciitis:

- Rest
- NSAIDs
- Physical therapy
- Please print exercise handout from Healthlink for patient
- Shoe insole
- Injection in refractory cases. Rheumatology does not perform injections. Refer to podiatry asking for this consideration.