

# Monash Children's Hospital

## Referral Guidelines

### PAEDIATRIC RHEUMATOLOGY

#### EXCLUSIONS

Services not offered by Monash Children's Hospital

Patients over 18 years of age: [Click here](#) for adult Monash Health Rheumatology guidelines

#### CONDITIONS

##### INFLAMMATORY ARTHRITIS

[Juvenile Idiopathic Arthritis](#)  
[Reactive Arthritis and other forms of inflammatory arthritis](#)

##### AUTOINFLAMMATORY DISEASE

[Periodic fever syndromes](#)

##### MUSCULOSKELETAL PAIN SYNDROMES

[Amplified musculoskeletal Pain syndrome/Fibromyalgia](#)  
[Complex Regional Pain Syndrome](#)

##### CONNECTIVE TISSUE DISEASES & VASCULITIS

[Systemic Lupus Erythematosus](#)  
[Inflammatory myositis \(juvenile dermatomyositis\)](#)  
[Other connective tissue disease](#)  
[Localised Scleroderma \(Morphoea\)](#)  
[Vasculitis](#)  
[Behcet's disease](#)

##### NON-INFLAMMATORY BONE AND JOINT DISEASE

[Back Pain](#)  
[Benign Hypermobility and hypermobility syndromes](#)  
[Non-inflammatory bone and joint disease](#)

#### PRIORITY

All referrals received are triaged by **Monash Children's Hospital clinicians** to determine **urgency of referral**.

##### EMERGENCY

For emergency cases please do any of the following:

- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

##### URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

##### ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit:  
Dr Peter Gowdie

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Prof Nick Freezer

Last updated:  
04/01/2024

# Monash Children's Hospital

## Referral Guidelines

### PAEDIATRIC RHEUMATOLOGY

#### REFERRAL

How to refer to  
Monash Children's  
Hospital

#### Mandatory referral content

##### Demographic:

Full name  
Date of birth  
Next of kin  
Postal address  
Contact number(s)  
Email address  
Medicare number  
Referring GP details  
including **provider number**  
Usual GP (if different)  
Interpreter requirements

##### Clinical:

Reason for referral  
Duration of symptoms  
Management to date and response to treatment  
Past medical history  
Current medications and medication history if relevant  
Functional status  
Psychosocial history  
Family history  
Diagnostics as per referral guidelines



[Click here](#) to download the outpatient referral form

#### CONTACT US

##### Medical practitioners

To discuss complex & urgent referrals  
contact: On-call Paediatric Rheumatology  
Registrar via Monash Health Switchboard  
**9594 6666**

##### General enquiries

Phone: 8572 3004

##### Submit a referral

Fax referral form to Monash Children's  
Hospital Specialist Consulting Services:

Fax: 8572 3007

Email: [scmonashchildrens@monashhealth.org](mailto:scmonashchildrens@monashhealth.org)

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# INFLAMMATORY ARTHRITIS

## JUVENILE IDIOPATHIC ARTHRITIS (JIA)

## WHEN TO REFER?

### Presentation

- Oligoarticular JIA
- Polyarticular JIA
- Systemic JIA
- Enthesitis-related Arthritis (Juvenile Spondyloarthritis)
- Psoriatic JIA

### Initial GP Assessment

- Can be oligo or polyarticular inflammatory symptoms with morning stiffness, gelling and joint swelling.
- May be accompanying symptoms such as: rash, fever, growth abnormalities, functional decline, developmental regression, eye inflammation, psoriasis.
- Pain may not be a significant feature of JIA.
- Inflammatory back pain may be a feature in some subtypes of JIA – early morning stiffness, relief with use.
- Buttock pain can be suggestive of sacroiliitis.
- There may be a family history of inflammatory joint disease.
- Signs on evaluation may suggest inflammatory arthritis: effusion/swelling, reduced range of movement. Muscle atrophy, limp, leg length discrepancy may be features.
- If joint symptoms are undifferentiated without a clear inflammatory pattern, then it may be appropriate to withhold investigations until patient reviewed in Rheumatology clinic

### Investigations

- Consider blood tests if clear history of inflammatory arthritis: FBE, ESR, CRP, ANA, RF and HLA B27.
- Lab tests may be normal in JIA.

### Management Options for GP

- Consider non steroidal anti-inflammatories for symptom relief unless contraindicated.
- Generally no other specific management is required prior to assessment in Rheumatology clinic.

### Emergency

Suspect septic arthritis in unwell patients with acute inflammatory monoarthritis. Patients should be assessed in Emergency Department and may require joint aspiration to exclude bacterial infection.

### Urgent

- Patients with suspected systemic JIA require prompt review. Systemic JIA is a more severe subtype of JIA with patients presenting unwell with prolonged history of fever, rash, arthritis, lymphadenopathy, serositis and hepatosplenomegaly.
- Early outpatient assessment for patients with suspected systemic JIA can be expedited by a call to the Paediatric Rheumatology Registrar.
- Patients with severe polyarthritis with high inflammatory burden evidenced by multiple active joint count and high CRP/ESR, or with significant functional limitation will be assessed as a priority.
- All patients with chronic inflammatory arthritis require early specialist assessment and management. Early diagnosis allows optimal institution of effective therapies.

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# AUTOINFLAMMATORY DISEASE

## PERIODIC FEVER SYNDROMES

## WHEN TO REFER?

### Initial GP Assessment

- Recurrent unexplained episodes of fever.
- Associated symptoms may include: joint pain and swelling, abdominal or chest pain, diarrhoea or constipation, rash, mouth ulcers, pharyngitis.
- Absence of infective symptoms to explain fever
- Family history of periodic fever.
- Fever diary documenting duration of fever and associated symptoms
- Family are encouraged to take photos of any rashes

### Investigations

- Consider blood tests during febrile episode and after episode when well
- FBE, UEC, LFTs, CRP, ESR

### Management Options for GP

- Symptomatic management of febrile episodes with simple analgesia. Generally no other specific management is required prior to review in Rheumatology clinic.
- Discuss as required with on-call rheumatologist / immunologist
- If there is concern about possible immunodeficiency or recurrent infection, refer to [Immunology clinic](#).

### Urgent

Patients with increasing frequency of episodes, escalating symptoms or significant effect on quality of life.

### Routine

- Children with Periodic fever syndromes require specialist assessment and management to optimise disease control and prevent complications.
- Children with stable symptoms thought to be related to periodic fever syndrome will be seen on a routine basis

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# MUSCULOSKELETAL PAIN SYNDROMES

## AMPLIFIED MUSCULOSKELETAL PAIN SYNDROME (FIBROMYALGIA) and COMPLEX REGIONAL PAIN SYNDROME

## WHEN TO REFER?

### Initial GP Assessment:

- Consider medical causes of fatigue and myalgia e.g. hypothyroidism, anaemia
- History of sleep disturbance
- Psychosocial evaluation
- Examination – exclusion of inflammatory or mechanical causes of pain.
- Examination features of complex regional pain syndrome include: localised swelling, colour and temp change, allodynia and hypersensitivity.

### Investigations

- Consider investigations to rule out other causes of musculoskeletal pain – FBE, CRP, ESR, UEC, LFT, CK
- Imaging may not be required as part of assessment.

### Management Options for GP

- Joint hypermobility is normal in many children.
- Explore psychosocial issues
- Assessment by Paediatric Pain Specialist or Paediatric Rheumatologist is frequently required to rule out alternative diagnoses.
- Many patients require initiation of physiotherapy with a rehabilitation approach.
- Generally no other specific medical therapy is required prior to review.
- For referral to Paediatric Pain [click here](#)

### Urgent

- Patients with complex regional pain syndrome require early review for prompt diagnosis and early initiation of appropriate therapy. At times inpatient admission is considered.
- Early outpatient assessment for patients with suspected complex regional pain syndrome can be expedited by a call to the Paediatric Rheumatology Registrar (via Monash Health Switchboard **9594 6666**)

### Routine

Patients with suspected amplified musculoskeletal pain syndrome will be reviewed on routine basis.

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# CONNECTIVE TISSUE DISEASES & VASCULITIS

## CONNECTIVE TISSUE DISEASES & VASCULITIS

## WHEN TO REFER?

### Presentation

- **Systemic lupus erythematosus (SLE)** - multisystem inflammatory presentation often with arthritis, rash, anaemia, serositis, nephritis, CNS involvement, positive ANA.
- **Juvenile dermatomyositis (JDM)** – inflammatory myopathy with proximal weakness, typical skin rash, arthritis.
- **Vasculitis** - purpuric rash, nephritis, lung or ent involvement, fever, constitutional features
- **Other connective tissue disease** - features include raynaud's phenomenon, rash, arthritis, serositis, myositis, proteinuria, positive ANA.
- **Localised scleroderma** (morphoea) – discrete areas of skin inflammation and fibrosis.
- **Behcet's disease** – recurrent oral or genital ulcers, rash, arthritis, uveitis

### Initial GP Assessment

- Broad range of presenting features may include any of the aforementioned systems.
- Always check the urine and BP in suspected SLE.
- Nephritis can be rapidly progressive and requires urgent assessment.

### Initial GP Assessment

Initial investigations to consider prior to referral include:

- FBE, ESR, UEC, LFT, CK, CRP
- urinalysis and urine protein:creatinine ratio
- ANA, dsDNA, ENA, C3/C4, ANCA
- A positive ANA in the absence of clinical features is unlikely to represent a significant autoimmune disease.
- If nonspecific symptoms and diagnosis unclear, then it may be appropriate to withhold investigations until patient reviewed in Rheumatology clinic

### Management Options for GP

- Early consideration of connective tissue disease is essential to allow prompt diagnosis and management.
- Generally no other specific management is required prior to assessment in Rheumatology clinic.

### Emergency

Acute vasculitis syndromes should be referred to Emergency Department or to Paediatric Rheumatology Registrar (via Monash Health Switchboard **9594 6666**) immediately on suspicion.

### Urgent

- All patients with suspected SLE, JDM, vasculitis or other connective tissue disease need prompt diagnostic workup prior to initiation of therapy.
- Outpatient assessment can be expedited by a call to the Paediatric Rheumatology Registrar or on-call Paediatric Rheumatologist (via Monash Health Switchboard **9594 6666**).
- If suspected glomerulonephritis, pericarditis/pleuritis, severe polyarthritis or severe weakness secondary to myositis please page Rheumatology Registrar to arrange early review.

### Routine

- Patients with positive ANA and nonspecific clinical features will be seen on a routine basis.
- Patients with morphoea will be seen routinely.

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# NON-INFLAMMATORY BONE AND JOINT DISEASE

## NON-INFLAMMATORY BONE AND JOINT DISEASE

## WHEN TO REFER?

### Presentation

- Chronic back pain
- Benign hypermobility syndrome
- Overuse injuries including osteochondroses, apophysitis and patellofemoral syndrome
- Connective tissue disorders (eg Ehlers Danlos Syndrome)

### Initial GP Assessment

- Consider duration and frequency of symptoms, pattern of pain (eg overnight waking with pain, morning pain, pain with exercise), aggravating and relieving factors.
- Consider inflammatory symptoms suggestive of arthritis ([see inflammatory arthritis](#))
- Examine for signs of arthritis and hypermobility.
- Document neurological examination findings.
- Examine for bony tenderness or swelling at common sites of osteochondroses such as tibial tuberosity in Osgood-Schlatter disease.

### Investigations

- Blood tests are frequently not required in the initial assessment.
- Plain X-ray may be a consideration to rule out bone or joint abnormality.
- Consider hip X-ray (AP and frog-leg) in children presenting with hip pain and limp to rule out slipped upper femoral epiphysis (SUFE) and Perthes disease.
- Plain radiographs of the spine are not indicated for most cases of back pain.
- MRI scanning is not a routine part of the assessment of back pain or other non-inflammatory bone and joint disease.

### Management Options for GP

- Consider simple analgesia or non steroidal anti-inflammatories for symptom relief unless contraindicated.
- Many patients with non-inflammatory back pain require a physiotherapy and rehabilitation approach to management. Consider a referral to a appropriate paediatric physiotherapist.

### Emergency

Acute neurological signs (motor or sensory loss) associated with back pain should prompt early assessment, potentially via Emergency Department.

### Urgent

- Patients with inflammatory back pain or accompanying peripheral joint inflammatory disease require early diagnostic workup prior to initiation of therapy.
- Patients with Perthes disease or SUFE require URGENT [Orthopaedic review](#) not Rheumatology.

### Routine

- Patients with chronic back pain, hypermobility and connective tissues disorders will be reviewed on routine basis.
- Patients with scoliosis should be referred to [Orthopaedic clinic](#) not Rheumatology.

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