



E-consult response templates

Structured replies for common questions. Each ends with a clear decision about whether the patient needs to be seen.

RheumReferral

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E-consults help decide whether a patient needs to be seen, how soon, and what to send first. They don't replace an in-person examination when one is needed; when the answer depends on an examination, the right reply is a visit. Edit the bracketed text for each patient.

Positive ANA, few or no symptoms

Answer	The ANA of [titer, pattern] is common in healthy people (about 1 in 3 at 1:40, and about 1 in 20 at 1:160), and on its own it doesn't diagnose a connective tissue disease.
Needs to be seen?	No, if the tests below are normal and there are no new symptoms. Yes (within 2–4 weeks) if any disease-specific antibody is positive or the basic tests are abnormal.
Before the visit	CBC, metabolic panel, urinalysis with microscopy; if the titer is 1:160 or higher, an ENA panel, anti-dsDNA and C3/C4.
Meanwhile	Reassure the patient. Please don't repeat the ANA; the titer doesn't track disease activity.
Call or re-refer if	Rash, mouth ulcers, joint swelling, Raynaud's with puffy fingers or ulcers, weakness, cytopenias, proteinuria or hematuria develop, or a specific antibody is positive.

Gout: starting urate-lowering therapy

Answer	Urate-lowering therapy is indicated [strongly with tophi, radiographic damage or 2 or more flares a year / conditionally after a first flare with CKD stage 3 or worse, a urate above 9 mg/dL or kidney stones].
Needs to be seen?	No, this can usually be managed locally. Yes (4–8 weeks) for tophi, urate not at target despite titration, allopurinol intolerance, CKD stage 4–5, or diagnostic doubt.
Before the visit	Serum urate (2 or more weeks after a flare), eGFR, liver tests, CBC; HLA-B*58:01 for patients of Southeast Asian descent and African American patients before allopurinol.
Meanwhile	Allopurinol 100 mg daily or less (lower in CKD 3 or worse), increasing every few weeks (often every 2–5 weeks), with a urate check after each increase, to below 6 mg/dL. Colchicine 0.6 mg once or twice daily (adjusted for kidney function) for 3–6 months as flare prophylaxis. Continue ULT during flares.
Call or re-refer if	Rash or other signs of allopurinol hypersensitivity (stop it and seek advice), flares continuing despite a urate at target, or tophi.

Raised CK without weakness

Answer	A CK of [value] without weakness is often due to exercise, injury, hypothyroidism, medicines (especially statins), or a higher normal range in people of African ancestry or with high muscle mass.
Needs to be seen?	Not at this stage, if strength is normal and the rise is modest and stable. Yes (urgently) with proximal weakness, a dermatomyositis rash, dysphagia, or a CK that stays high after stopping a statin.
Before the visit	Repeat CK after a week without strenuous exercise; TSH, metabolic panel with potassium, AST/ALT, medication review.
Meanwhile	If on a statin and CK is above 10 times normal or symptoms are intolerable, stop it and recheck.
Call or re-refer if	Weakness, trouble swallowing or breathing (same day), rash, or a rising CK.

Joint pain with a positive RF or anti-CCP, no swelling found

Answer	Anti-CCP is highly specific for RA and can precede arthritis; RF alone is much less specific. Without synovitis, this is not yet inflammatory arthritis.
Needs to be seen?	Yes (routine) for high-titer anti-CCP with joint symptoms, especially with morning stiffness or a positive squeeze test. Yes (urgently, 2–4 weeks) as soon as any joint swelling is found. Low-titer RF alone with a negative anti-CCP usually doesn't need a visit.
Before the visit	ESR, CRP, CBC, metabolic panel, hepatitis B and C, and X-rays of both hands and feet.
Meanwhile	An NSAID if safe. Please avoid starting glucocorticoids before assessment; they can mask synovitis.
Call or re-refer if	Joints become swollen, or morning stiffness lengthens.

Isolated raised ESR or CRP

Answer	A mildly raised ESR or CRP without symptoms is rarely due to rheumatic disease; infection, obesity, anemia, kidney disease, age and malignancy are common causes.
Needs to be seen?	No, unless the features below appear.
Before the visit	Repeat ESR with CRP in a few weeks; CBC, metabolic panel with liver tests, urinalysis; serum protein electrophoresis if the ESR is high and the CRP normal.
Meanwhile	Keep age-appropriate cancer screening up to date.
Call or re-refer if	Features of PMR or GCA (same day for headache, jaw claudication or visual symptoms over 50), joint swelling, or a persistently very high ESR without explanation.

Possible polymyalgia rheumatica

Answer	The picture of [bilateral shoulder and hip girdle pain and stiffness, age 50 or older, raised ESR/CRP], without features of GCA, is consistent with possible PMR.
Needs to be seen?	Not necessarily: PMR without GCA features is semi-urgent and can often be managed in primary care. If you're not comfortable with the diagnosis or treatment, or features are atypical, we're happy to see the patient (within 4–8 weeks); sooner is better than later.
Before the visit	ESR, CRP, CBC, metabolic panel, CK, TSH, RF/anti-CCP, serum protein electrophoresis.
Meanwhile	Once the workup is back and mimics are excluded: prednisone 15–25 mg daily, tapering to 10 mg daily within about 2 months, with bone protection. Please avoid a 'trial of steroids' as a diagnostic test.
Call or re-refer if	New headache, scalp tenderness, jaw claudication, visual symptoms or limb claudication: same day, and start glucocorticoids for possible GCA. Also call for a poor response to glucocorticoids or relapse on taper.

HLA-B27 positive, or possible inflammatory back pain

Answer	HLA-B27 is present in roughly 6% of people, and most carriers never develop spondyloarthritis; it supports the diagnosis only when the symptoms fit.
Needs to be seen?	Yes (4–8 weeks) if back pain began before 45, has lasted 3 months or more, and there is at least one spondyloarthritis feature. No for HLA-B27 without symptoms.
Before the visit	CRP, ESR, and an AP pelvis radiograph (the preferred first imaging test).
Meanwhile	A continuous full-dose NSAID trial if safe, and physical therapy.
Call or re-refer if	A painful red eye with light sensitivity (same-day eye care), or new joint swelling.

Abnormal monitoring result on a DMARD

Answer	The [result] on [drug] is [below / above] the commonly used action threshold of [threshold]. Trends matter; many isolated abnormalities are transient.
Needs to be seen?	Not usually; this can be managed with advice. Same day for fever with neutropenia, bleeding with low platelets, or new cough or breathlessness on methotrexate.
Before the visit	Repeat the test within [1–2 weeks]; check for infection, alcohol, new interacting drugs (trimethoprim with methotrexate; allopurinol with azathioprine), and B12, folate and TSH for a high MCV.
Meanwhile	[Hold / reduce / continue] [drug] until the repeat result.
Call or re-refer if	The repeat result is worse, or symptoms develop.

Osteoporosis: choosing or changing treatment

Answer	For a patient with [T-score, FRAX, fracture history], first-line treatment is usually an oral bisphosphonate, or IV zoledronic acid if oral treatment isn't suitable.
Needs to be seen?	No for most. Yes (routine) for a fracture on treatment, very high risk where anabolic therapy may be needed, intolerance of standard options, or suspected secondary causes.
Before the visit	Calcium, 25-OH vitamin D, creatinine/eGFR, alkaline phosphatase; PTH and TSH if indicated; a dental check before starting antiresorptive therapy.
Meanwhile	Never stop denosumab without a plan: transition to a bisphosphonate to prevent rebound vertebral fractures. In advanced CKD or on dialysis, decide on denosumab with nephrology (FDA boxed warning: severe hypocalcemia).
Call or re-refer if	A new fragility fracture, or a denosumab dose missed by several months.

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