



Rheumatology referral quick card

Adults: how urgently to refer, and what needs a call today

RheumReferral

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Call rheumatology today, or send to the emergency department

- **Giant cell arteritis (GCA):** New headache, jaw claudication or visual symptoms in someone 50 or older. Start glucocorticoids the same day and call rheumatology.
- **ANCA-associated vasculitis with organ threat:** Rising creatinine with active urine sediment, lung hemorrhage or mononeuritis multiplex. Same-day contact; often admission.
- **Connective tissue disease with organ-threatening features:** Lupus, scleroderma, myositis or APS with a dangerous complication: kidney, lung, brain, blood or muscle failure.
- **Macrophage activation syndrome / HLH (adult):** Persistent fever with cytopenias and a very high or rising ferritin in Still's disease, lupus, infection or cancer.
- **A hot, swollen joint with fever** is septic arthritis until proven otherwise: same-day aspiration, usually in the ED or by orthopedics.

URGENT Urgent Within 2–4 weeks

New inflammatory arthritis (suspected RA). Joint swelling with prolonged morning stiffness.

Psoriatic arthritis (suspected). Joint swelling, dactylitis or enthesitis with current or past psoriasis, or a family history of psoriasis.

Suspected systemic lupus erythematosus (SLE). Positive ANA with lupus-type clinical features or lupus-specific antibodies.

Suspected inflammatory myopathy (myositis). Symmetric proximal weakness with a raised CK, or dermatomyositis rash.

Suspected systemic sclerosis (scleroderma). Raynaud's with puffy fingers, skin thickening, digital ulcers or scleroderma antibodies.

Sjögren's disease with systemic features. Dry eyes and mouth plus parotid swelling, purpura, neuropathy, cytopenias, kidney or lung involvement.

Mixed connective tissue disease (MCTD). Overlap of lupus, scleroderma and myositis features with a high-titer anti-U1 RNP.

Antiphospholipid syndrome (APS). Unexplained thrombosis or pregnancy morbidity with antiphospholipid antibodies that persist for at least 12 weeks.

Adult-onset Still's disease (AOSD). Daily spiking fevers, evanescent salmon rash, sore throat, arthritis and a very high ferritin.

Behçet's syndrome. Recurrent oral ulcers with genital ulcers, eye inflammation, skin lesions, or vascular or neurologic events.

Takayasu arteritis / large-vessel vasculitis. Limb claudication, absent or unequal pulses and bruits, usually in a younger patient.

Polyarteritis nodosa (PAN). Medium-vessel vasculitis with tender nodules, livedo, mononeuritis multiplex or testicular or abdominal pain.

Palpable purpura / small-vessel vasculitis (adult). Palpable purpura, especially with joint, gut, kidney or nerve involvement.

Checkpoint inhibitor rheumatic adverse events (irAEs). Inflammatory arthritis, PMR-like illness, myositis or sicca during or after anti-PD-1/PD-L1/CTLA-4 therapy.

Interstitial lung disease in autoimmune disease. New or worsening cough or dyspnea in someone with SSc, myositis, RA, Sjögren's or MCTD, or a falling FVC or DLCO.

SEMI-URGENT Semi-urgent Within 4–8 weeks

Suspected axial spondyloarthritis (axSpA). Chronic back pain beginning before age 45 with inflammatory features.

Polymyalgia rheumatica (PMR). Age 50 or older with bilateral shoulder and hip girdle pain and stiffness and raised inflammatory markers.

Gout: complex or refractory. Tophi, frequent flares despite urate-lowering therapy, failure to reach target, intolerance, advanced CKD or diagnostic doubt.

Calcium pyrophosphate deposition (CPPD). Recurrent pseudogout, chronic CPP arthritis that mimics RA or OA, or onset before 60.

Raynaud's phenomenon with secondary features. Raynaud's with digital ulcers or pitting, abnormal nailfold capillaries, a positive ANA with specific antibodies, or late onset.

Reactive arthritis (persistent or recurrent). Asymmetric lower-limb arthritis 1–4 weeks after a GI or GU infection that persists beyond about 6 weeks or keeps recurring.

IgG4-related disease. Swelling of glands or organs (salivary, lacrimal, pancreas, retroperitoneum, aorta) that can mimic cancer.

Sarcoidosis with rheumatologic features. Hilar lymphadenopathy with arthritis or erythema nodosum (Löfgren), uveitis, skin or multi-organ disease.

Drug-induced rheumatic disease. Drug-induced lupus, statin myopathy, retinoid sacroiliitis, or vasculitis linked to a medication.

VEXAS syndrome. A man over 50 with recurrent inflammation (fever, chondritis, rash), macrocytic anemia or other cytopenias, and thrombosis.

Relapsing polychondritis. Recurrent painful red swelling of the ear (sparing the lobe), nasal bridge or airway cartilage.

ROUTINE Routine referral Standard scheduling (about 8–12 weeks)

Established RA: treatment change or review. Known RA needing escalation, a switch, a biologic, a taper discussion or a second opinion.

Gout: new, uncomplicated. Classic or crystal-proven gout without tophi or CKD 4–5.

Osteoporosis: complex or refractory. Fracture on treatment, very high fracture risk needing anabolic therapy, glucocorticoid-induced osteoporosis, or intolerance.

Undifferentiated connective tissue disease (UCTD). Positive ANA with a feature or two (Raynaud's, arthralgia, rash, sicca) that doesn't meet criteria for a defined disease.

Sjögren's disease: sicca-predominant. Dry eyes and mouth with anti-SSA/Ro, without systemic features.

Positive anti-CCP or high-titer RF with joint pain, no swelling. Arthralgia without synovitis but with autoantibodies.

MAY NOT NEED REFERRAL May not require referral

Positive ANA without symptoms. The most common source of unnecessary referrals.

Osteoarthritis. Use-related pain, brief stiffness and bony enlargement with normal inflammatory markers.

Fibromyalgia. Chronic widespread pain with fatigue, unrefreshing sleep and cognitive symptoms.

Mechanical (non-inflammatory) back pain. Back pain that worsens with activity and eases with rest, without inflammatory features or red flags.

Often managed in primary care

Regional soft-tissue problems. Rotator cuff disease, epicondylitis, trigger finger, de Quervain's, plantar fasciitis, carpal tunnel, bursitis.

Asymptomatic hyperuricemia. High serum urate without gout.

Primary Raynaud's phenomenon. Symmetric color change of the fingers starting in youth, with no tissue injury, a negative ANA and normal nailfold capillaries.

Joint hypermobility without complications. Generalized hypermobility (common, about 10–30% of people) with pain but no recurrent dislocation or skin and vascular features.

REDIRECT Usually referred elsewhere first

Suspected septic arthritis → Emergency department / orthopedics

Suspected bone or joint malignancy, or metastases → Oncology / orthopedic surgery

Cauda equina syndrome or spinal cord compression → Emergency department / spine surgery

Isolated mechanical or soft-tissue problems → MSK pathway (PT, orthopedics, sports medicine)

Every referral: the details triage needs most

Your question · working diagnosis · onset date and duration · which joints are swollen · morning stiffness in minutes · red flags present or absent · results with dates · treatments tried (especially glucocorticoids) · pregnancy plans · how to reach you.

A guide to common presentations, not a complete list. Timeframes are typical targets; local pathways and clinical judgment come first. Children: see the pediatric red flags card. Full details and sources for every condition: rheumreferral.com/refer/when-to-refer/

Sources

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