

P019 RHEUMATOLOGY REFERRALS TO TERTIARY CARE HOSPITAL OVER A THREE MONTH PERIOD DURING COVID-19 PANDEMIC: A QUALITY IMPROVEMENT PROJECT

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Background/Aims

During the COVID-19 pandemic, waiting times for routine new referrals to our tertiary rheumatology department was >20 weeks. Therefore, a quality improvement project (QIP) was undertaken to understand the nature of these referrals and develop an alternative option to rheumatology review. Our aim was to reduce waiting times and improve patient experience by better integrating primary, secondary and therapy services, as well as provide additional triage options.

Methods

We conducted a retrospective analysis of all routine referrals over a 3-month period (1st April to 30th June 2020). Urgent referrals including GCA, CTD and EIA were excluded.

Results

A total of 92/143 (64%) patients were referred, a more significant reduction than normal due to the pandemic. Median age [IQR] was 39.5 [28-66.25] years and most referrals (79%) were from primary care. Table 1 represents information included in the referrals. Thirty-one patients had previously undergone a rheumatology review, of which 11 (35%) were seen in our department. Of these, 18/31 (58%) patients had a diagnosis of Hypermobility Spectrum Disorder (HSD) or fibromyalgia. The commonest reason for re-referral was worsening of existing symptoms (n = 11, 35%), with no suggestive of an alternative diagnosis.

P019 TABLE 1 Information included in new routine referrals to rheumatology

	Total n=92
Commonest presenting complaints (n, %)	
• Polyarthralgia	51 (55)
• Connective tissue disease/vasculitis symptoms	13 (14)
• Myalgia	12 (13)
Number of referrals stating joint swelling	4 (4%)
Working diagnosis	
• Hypermobility spectrum disorder	26 (28)
• Fibromyalgia	23 (25)
• Connective tissue disease	21 (23)
• Inflammatory arthritis	21 (23)
• Osteoarthritis	1 (1)
Laboratory tests performed (n = 62, %)	
• Inflammatory markers checked	49 (79)
o Patients with raised inflammatory markers	19 (39)
• Antibodies (RhF, Anti-CCP, ANA/ENA)	36 (58)
o ANA/ENA in conjunction with RhF	25 (69)
o Anti-CCP in conjunction with RhF	5 (14)
Patients with polyarthralgia and/or myalgia (n = 62, %)	
• Inflammatory markers checked	28 (45)
• RhF +/- Anti-CCP antibody	21 (33)
• ANA/ENA	12 (19)
Imaging (n = 13, %)	
• X-ray	7 (54)
• MRI	3 (23)
• CT	3 (23)
Treatment documented (n = 37, %)	
• Paracetamol	9 (24)
• Non-steroidal anti-inflammatory therapies	10 (27)
• Opiates	17 (46)
• Neuropathic agents	11 (30)
• Combination of opiates and neuropathic agents	5 (14)
• Immunosuppression (including steroids)	6 (7)
MDT input (n = 20, %)	
• Physiotherapy	19 (95)
• Occupational therapy	1 (5)
• Mental health services	1 (5)

Conclusion

Our QIP identified a variation in the quality of referrals and that a high proportion of referrals concerned HSD and fibromyalgia, with many re-referred due to exacerbation of their existing disease. Based on this, we conducted a regional GP trainee educational session and highlighted: i) key features in investigation and management of common rheumatological conditions ii) vital information to include in referrals based on presenting complaint(s) and working diagnosis. We developed a pathway for patients previously diagnosed with fibromyalgia or HSD in our department and re-referred with worsening symptoms, to be triaged into a newly set up weekly specialist MSK physiotherapy-led clinic with rheumatology supervision. Future work will involve re-assessing routine new-referral waiting times and evaluating pre- and post-physiotherapy intervention MSK and quality of life scores, with the aim of formulating a business case to conduct this clinic on a permanent basis. We hope incorporating this pathway will lead to improved patient outcomes and ease some departmental management decisions.

Disclosure

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