NICE referral advice summarised

The starring system developed by NICE to identify referral priorities.

Arrangements should be made so that the patient:

✪✪✪✪ is seen immediately 1

✪✪✪ is seen urgently 2

✪✪ is seen soon 2

✪ has a routine appointment 2

▲ is seen within an appropriate time depending on his or her clinical circumstances (discretionary)

1 - Within a day

2 - Health authorities, trusts and primary care organisations should work to local definitions of maximum waiting times in each of these categories.
The multidisciplinary advisory groups considered a maximum waiting time of 2 weeks to be appropriate for the urgent category.

Acne

Referral advice

Most patients with acne can be managed in primary care.

However, referral to a specialist service is advised if they:

✪✪✪ have a very severe variant such as fulminating acne with systemic symptoms (acne fulminans)

✪✪ have severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin

✪✪ have severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)

✪ are at risk of, or are developing, scarring despite primary care therapies

✪ have moderate acne that has failed to respond to treatment which should generally include several courses of both topical and systemic treatment over a period of at least 6 months. Failure is probably best based upon a subjective assessment by the patient

✪ are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment

Acute low back pain

Referral advice

The majority of patients with acute low back pain can be managed in primary care.

They should, however, be referred to a specialist service if:

✪✪✪✪ they have neurological features of cauda equina syndrome (sphincter disturbance, progressive motor weakness, perineal anaesthesia, or evidence of bilateral nerve root involvement)

✪✪✪ serious spinal pathology is suspected (preferably seen within 1 week)

✪✪✪ they develop progressive neurological deficit (weakness, anaesthesia) (preferably seen within 1 week)

✪✪✪ they have nerve root pain that is not resolving after 6 weeks (preferably seen within 3 weeks)

✪✪ an underlying inflammatory disorder such as ankylosing spondylitis is suspected

✪✪ they have simple back pain and have not resumed their normal activities in 3 months. The effects of pain will vary and could include reduced quality of life, functional capacity, independence or psychological wellbeing. Where possible, referral should be to a multidisciplinary back pain team

Atopic eczema in children

Referral advice

Most children with atopic eczema can be managed in primary care.

Referral to a specialist service, which may be prompted by features such as sleep disturbance and school absenteeism, is advised if:

✪✪✪✪ infection with disseminated herpes simplex (eczema herpeticum) is suspected

✪✪✪ the disease is severe and has not responded to appropriate therapy in primary care

✪✪✪ the rash becomes infected with bacteria (manifest as weeping, crusting, or the development of pustules), and treatment with an oral antibiotic plus a topical corticosteroid has failed

✪✪ the rash is giving rise to severe social or psychological problems

✪✪ treatment requires the use of excessive amounts of potent topical corticosteroids

✪ management in primary care has not controlled the rash satisfactorily. Ultimately, failure to improve is probably best based upon a subjective assessment by the child or parent

✪ the patient or family might benefit from additional advice on application of treatments (e.g. bandaging techniques)

✪ contact dermatitis is suspected and confirmation requires patch-testing (this is rarely needed)

✪ the child has uncontrolled eczema and dietary factors are suspected (refer directly to a dietician)

Menorrhagia

Referral advice

Many women with menorrhagia can be managed successfully in primary care.

However, referral to a specialist service is advised if:

✪✪✪ there is a suspicion of underlying cancer. For detailed advice on cancer referral see the Department of Health *Referral Guidelines for Suspected Cancer* (www.doh.gov.uk/cancer)

✪✪ they also have persistent intermenstrual or post-coital bleeding

✪ despite 3 months of drug treatment, the heavy bleeding persists and is interfering with quality of life. Failure is best based upon the woman's own assessment

✪ they wish to explore the possibility of surgical intervention rather than persist with drug treatment

▲ they have severe anaemia that has failed to respond to treatment

Osteoarthritis of the hip

Referral advice

The majority of the management of patients with osteoarthritis of the hip can be undertaken in primary care.

However, referral to a specialist service is advised if:

✪✪✪✪ there is evidence of infection in the joint

✪✪✪ symptoms rapidly deteriorate and are causing severe disability

✪ the symptoms impair quality of life. Referral should be based on an explicit scoring system that should be developed locally in a partnership involving patients together with healthcare professionals in primary and secondary care. Referral criteria should take into account the extent to which the condition is causing pain, disability, sleeplessness, loss of independence, inability to undertake normal activities, reduced functional capacity or psychiatric illness

Osteoarthritis of the knee

Referral advice

The majority of the management of patients with osteoarthritis of the knee is undertaken in primary care.

However, referral to a specialist service is advised if:

✪✪✪✪ there is evidence of infection in the joint

✪✪✪ there is evidence of acute inflammation caused by, for example, haemarthrosis, gout or pseudo-gout

✪✪ giving way is a problem despite therapy

✪✪ symptoms rapidly deteriorate and are causing severe disability

✪ the symptoms impair quality of life. Referral should be based on an explicit scoring system that should be developed locally in a partnership involving patients together with healthcare professionals in primary and secondary care. Referral criteria should take into account the extent to which the condition is causing pain, disability, sleeplessness, loss of independence, inability to undertake normal activities, reduced functional capacity or psychiatric illness

Persistent otitis media with effusion [glue ear] in children

Referral advice

In the majority of children, the effusion and hearing loss will resolve spontaneously and management will remain within primary care.

Specialist services (e.g. hearing assessment, tympanometry) may be required to clarify the diagnosis. Referral for an ENT opinion should take into account concerns raised by the child's parent, school or health visitor.

Children awaiting a routine outpatient appointment may need to be reassessed to check for clinical changes, and so the possible revision of the referral time.

For those with persistent effusion, referral for an ENT opinion is advised if:

✪✪✪ the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma

✪✪✪ they have excessive hearing loss suggestive of additional sensori-neural deafness

✪✪ they have proven hearing loss plus difficulties with speech, language, cognition or behaviour

✪✪ they have proven hearing loss plus a second disability, such as Down's syndrome

✪✪ they have proven hearing loss together with frequent episodes of acute otitis media

✪ they have proven persistent hearing loss detected on two occasions separated by 3 months or more (results of formal testing should be included in the referral letter)

Psoriasis

Referral advice

Most patients with psoriasis can be managed in primary care.

Referral to specialist services, which may be prompted by features such as sleep disturbance, social exclusion, reduced quality of life or reduced self-esteem, is advised if:

✪✪✪✪ the patient has generalised pustular or erythrodermic psoriasis

✪✪✪ the patient's psoriasis is acutely unstable

✪✪✪ the patient has widespread guttate psoriasis (so that he/she can benefit from early phototherapy)

✪✪ the condition is causing severe social or psychological problems

✪✪ the rash is sufficiently extensive to make self-management impractical

✪✪ the rash is in a sensitive area (such as face, hands, feet, genitalia) and the symptoms particularly troublesome

✪✪ the rash is leading to time off work or school which is interfering with employment or education

✪✪ the patient requires assessment for the management of associated arthropathy

✪ the rash fails to respond to management in general practice. Failure is probably best based on the subjective assessment of the patient. Sometimes failure occurs when patients are unable to apply the treatment themselves

Recurrent acute sore throat in children up to 15 years

Referral advice

Almost all children with recurrent sore throat can be managed in primary care. However, children should be referred to a specialist service if:

✪✪✪✪ they have, or are suspected of having, a quinsy

✪✪✪✪ the swelling is causing acute upper airways obstruction

✪✪✪✪ the swelling is interfering with swallowing, causing dehydration and marked systemic upset

✪✪ they have a history of sleep apnoea, daytime somnolence and failure to thrive

✪ they have had five or more episodes of acute sore throat in the preceding 12 months documented by the parent or clinician, and these episodes have been severe enough to disrupt the child's normal behaviour or dayto-day activity

✪ they have guttate psoriasis which is exacerbated by recurrent tonsillitis

▲ there is suspicion of a serious underlying disorder such as leukaemia

Urinary tract 'outflow' symptoms [prostatism] in men

Referral advice

Most men with evidence of urinary tract ‘outflow’ symptoms can be managed in primary care.

However, referral to a specialist service is advised if:

✪✪✪✪ they develop acute urinary retention

✪✪✪✪ they have evidence of acute renal failure

✪✪✪ they have visible haematuria

✪✪✪ there is a suspicion of prostate cancer based on the finding of a nodular or firm prostate, and/or a raised PSA

✪✪✪ they have culture-negative dysuria

✪✪✪ they develop chronic urinary retention with overflow or night-time incontinence

✪✪ they have a recurrent urinary tract infection

✪✪ they develop microscopic haematuria

▲ the symptoms have failed to respond to treatment in primary care and are severe enough to affect quality of life. This is best assessed by the patient using a symptom scoring system such as WHO’s International Prostate Symptom Score

▲ they have evidence of chronic renal failure or renal damage

Varicose veins

Referral advice

Most patients with varicose veins can be managed in primary care.

In patients in whom varicosities are present or suspected, referral to a specialist service is advised if:

✪✪✪✪ they are bleeding from a varicosity that has eroded the skin

✪✪✪ they have bled from a varicosity and are at risk of bleeding again

✪✪ they have an ulcer which is progressive and/or painful despite treatment

✪ they have an active or healed ulcer and/or progressive skin changes that may benefit from surgery

✪ they have recurrent superficial thrombophlebitis

✪ they have troublesome symptoms attributable to their varicose veins, and/or they and their GP feel that the extent, site and size of the varicosities are having a severe impact on quality of life