The FCP team is aware of messaging from LCH MSK triage and you may find that some of the typical presentations you have referred into MSK over the years are now being rejected. This may include **routine steroid injection therapy patients and the following email will hopefully help.** The FCP team are happy to see patients who you think may benefit from a joint injection. Injecting clinicians include Angie Reilly (Bellbrooke and Ashton View), Caroline Tobin (Harehills) and Stephen Morrissey (Conway and Bellbrooke)

Injections performed by FCP's in the PCN include
Knee joint
Ankle joint
1 st MTP
Troch bursa
Shoulder joint
Subacromial space /Impingement
1 st CMCJ
de Quervains
Wrist joint
Trigger digits
Carpal tunnel syndrome

Injections not performed
Hip joint
Elbow joint
Small hand joints ie MCPJ's DIP's and PIP's
Spinal injections

Contraindications to injection therapy

With regards to injection delivery in primary care - ***we cannot inject unstable diabetic patients and we also need an up to date INR reading for any warfarinised patients, we can inject DOAC patient, we cannot inject patients with significant immunosuppression, in cases of severe OA injections are likely to be ineffective. We cannot inject patients on Antibiotics and they need to be 2 weeks clear of ABxs at time of injection***

If you send patients with regards to an injection, explain to the patient that it is an assessment with regards to whether this is the most appropriate treatment for them. We need to assess the condition for ourselves and discuss with the patient whether an injection is appropriate, discuss all potential pros, cons and risks for injection therapy
eg sometimes we may not inject as injection may not be the best treatment option/1 st line care or we may deem that an injection will not be effective and the risk outbalances the likely benefits. So please do say its an assessment for suitability rather than a guarantee as otherwise patients can get somewhat annoyed with us when it turns out we can t do the injection/its inappropriate to do at that stage etc

It is a SDM process and a decision to be made between the patient and the injecting clinician as the inject9ing clinician will obviously take the clinical responsibility for the injections.

I think typically GP's/ANP's will refer *de quervains, Carpal tunnels , 1 st cmcj trigger digits* for injection into LCH MSK - send these our way now.

If you're thinking about *Knee injection* - we would always encourage 1 st line mgt of quads exs - LHP, VERSUS arthritis website,, reduce BMI footwear advice, and inject if presenting as an inflamm pain pattern swelling present. We can inject patients with gout once infection ruled out. Pls consider the age of the patient, those younger patients with no sig OA on xrays are not ideal for injections as we think that steroid may damage cartilage, (I always would question myself if I considered injected a patient under 50, In patients with established OA changes then injection is a reasonable offer

***Troch bursa* - the evidence of management does sway towards exercise more than injection however we can consider this option as there is still some evidence to support its use in some cases.**

***Hip joint* injs are now not done in FCP or in MSK - this all falls with orthopaedics now. I know GPs have direct access to hip orthopaedics which should work well for the OA- hip replacement referrals - if you have a patient and they are not at the stage of needing a new hip joint, pls feel free to have a chat with us or consider LCH MSK as triage at CAH/Ortho is pretty stringent into Hip Ortho**

***Plantar fasciitis* - we don t inject these now either in primary care MSK or podiatry - it is considered harmful and sig risk for rupture**

***Shoulders* - *frozen shoulder stage 1, acute calcific tendonopathy, shoulder OA* are all ideal presentations for potential injection. *Impingements* - I would encourage always a conservative approach in the 1 st instance - LHP pathways - cuff strengthening exercises - British elbow and shoulder surgical society (BESS) do a great free online video exercise programme for impingement - patients can access from "BESS shoulder exercises" . If you think its more bursitis ie constant pain with inflammatory pattern then we can consider injection**