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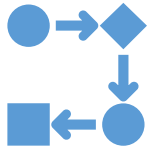
Implementing the new British Society for Rheumatology (BSR) guideline for the management of foot health in inflammatory arthritis

Robert Field, Aimie Patience and Christopher Joyce

Royal College of Podiatry Annual Conference – Glasgow, 2025

Concurrent Session – D3 Friday 21st November 2025

Session outline



Overview of the new BSR guidelines and its clinical implications for practice (Christopher Joyce)

How the guidelines can improve specialist rheumatology foot services in Dorset:
Do referrals into specialist rheumatology service meet current BSR guidelines? (Robert Field)

How the use of the BSR guidelines for the management of foot health in inflammatory arthritis can improve independent practice (Aimie Patience)

Questions

Nothing valuable can be lost by taking time

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ARMA inflammatory arthritis standards (ARMA, 2004)

Musculoskeletal Foot Health Standards (PRCA, 2008)

SIGN management of early rheumatoid arthritis (SIGN, 2011)

NWCEG Rheumatology podiatry guidelines (Williams *et al*, 2011)

NICE NG100 - Rheumatoid arthritis in adults: management (NICE, 2018)

BSR guideline for the management of foot health in patients with inflammatory arthritis (Chapman *et al.* 2025)

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What does the guideline cover

Foot problems in adults, children and young people with:

Rheumatoid arthritis (RA)

Spondyloarthropathies (SpA)

Juvenile idiopathic arthritis (JIA)

Areas not covered:
Details of surgical management, treatment of traumatic foot injuries, systemic drug therapies, connective tissue diseases

Overview of the BSR guidelines

Purpose:

•Standardize foot health care in people with IA via evidence-based practice

•Ensure early interventions and multidisciplinary care with podiatrists being a **core member of the MDT**

•Implementation improves **mobility, quality of life**, and **disease self-management**.

Key Updates / Changes:

•Stronger emphasis on **early podiatric involvement** post-diagnosis (Williams *et al.* 2011; De Souza *et al.* 2016)
•Inclusion of **structured foot assessments** (Vascular and neurological)

•Updated guidance on **orthotic management, footwear advice, and referral timing**.

What areas are covered?

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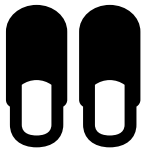
Assessment

Imaging

Referring to foot services

Footwear



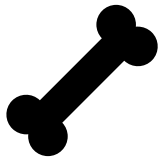
Orthoses

Targeted exercises

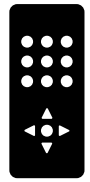
Skin and nail care

Wound management

Targeted injection therapy



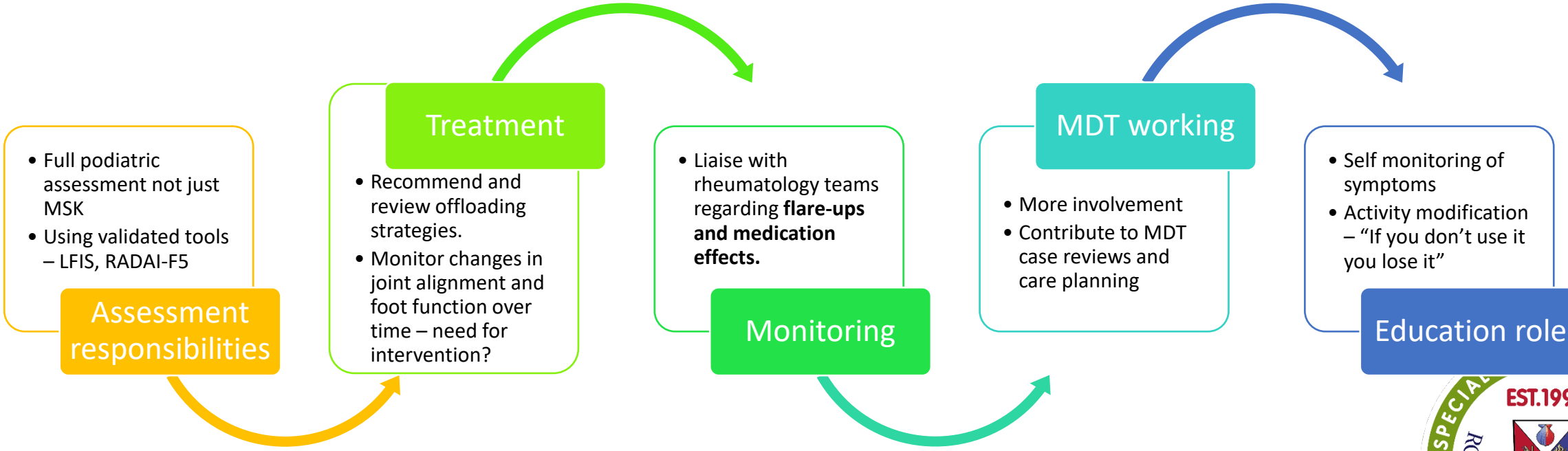
Surgery



Systemic disease control

Follow-up and monitoring

What do we NOW change in our practice?



Bringing the Guideline to Life : Implementation into practice

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Practical steps

Use of BSR audit tool against guidelines

Change the way we approach rheumatology foot assessment

Speak with rheumatology teams to create pathways/referring

Overcoming barriers

Address access issues for these patients through comms and education days

Advocate for better podiatry inclusion into MDT

Enablers for success

Let's create clinical champions to drive change

Better access to training and awareness sessions

Track outcomes with validated tools

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BSR IA foot audit tool

Purpose: Ensure that patients with an IA attending your service are getting correct assessment/treatment advice as per BSR guidelines

Content: 19 Q's (not all relevant to patients and/or setting)

Scan me for the audit tool

Dorset HealthCare University NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust

How the guidelines can improve specialist rheumatology foot services in Dorset: Do referrals into specialist rheumatology service meet current BSR guidelines?

Robert Field, Co-Lead Podiatrist - Rheumatology Services, Dorset HealthCare

Lucy Sanders, Lead Practitioner for Rheumatology, University Hospitals Dorset

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OUTLINE

- Background information about MDT rheumatology in Dorset
- How we applied the BSR audit tool
- A summary of findings
- Comments about completing the questionnaires
- Discussion
- Going forward


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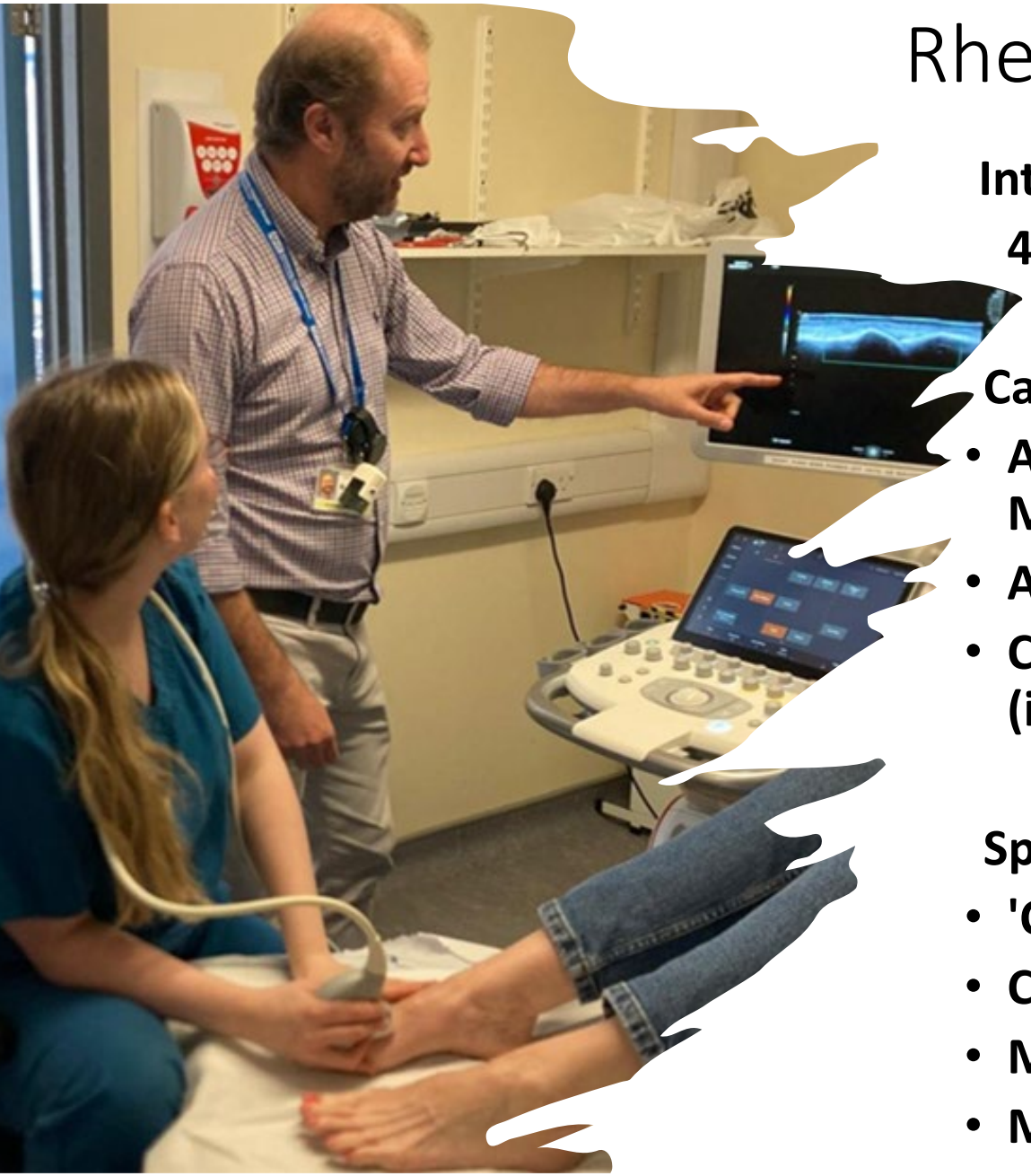


Rheumatology based Podiatry Service

Integrated podiatry team within Rheumatology Service

4.5 FTE podiatrists - 7 clinicians: Mix B7,B6, B5

Caseload: Mixed – mostly IA and CTDs

- **Approx 1100 caseload all referred via Rheumatology MDT only**
- **Around 200+ new referrals per year**
- **Covering 3 hospital sites & 4 community sites (intermediate clinics)**

Specialist clinics include:

- **'Complex foot' clinics including ulceration**
- **Complex CTD – mainly tissue viability upper limb**
- **MSK focused clinic – hospital & community**
- **MSK ultrasound**
- **Rheumatology dedicated footwear clinic**

Rheumatology Podiatry 'new' & 'existing' Caseload Prioritisation V4: 25-4-24

Dorset HealthCare NHS University NHS Foundation Trust

URGENT

Foot related Red Flags	&/OR	Foot related Presenting Condition	Upper Limb Condition
Infection Peripheral arterial disease Altered Neurology (sensory / motor) Tissue viability changes Tendon pathology (new episode / acute) Flare / hot joint Unexplained inflammation eg flare excluded 'New' change in structure / function / appearance Unremitting pain		Foot ulcer below ankle ⓘ Bacterial infection / Cellulitis in foot ⓘ Chronic Charcot arthropathy ⓘ Onychocryptosis ⓘ Tissue breakdown / uncomplicated wound ⓘ History of ulceration /Amputation ⓘ Extravasation (blood stained callous) ⓘ Inflammation ⓘ	Pre digital ulcer / Digital ulcer Including: Firm & liquid calcinosis; infection; necrosis Other wound / pressure sites at & distal to the elbow.

SOON

1c) All patients receiving biologic therapy should be referred for baseline assessment in terms of tissue viability risk factors. Appropriate management of identified risk factors will be provided.

1d) patients with disease flare, unstable disease reflected in a high DAS, or on prolonged higher dose prednisolone (5mgs & above) should be referred for baseline assessment in terms of tissue viability risk factors. Appropriate management of identified risk factors will be provided.

2a) Foot and ankle pain limiting ADLs (as demonstrated on HAQ / Foot Function Index/ Swindon Foot & Ankle questionnaire).
2b) Key Worker with Foot and ankle pain limiting ADLs (as demonstrated on HAQ / Foot Function Index/ Swindon Foot & Ankle questionnaire).

ROUTINE

3a) All patients with early inflammatory arthritis ie 0-2 years duration for screening, education and interventions as indicated (see early IA protocol) within 3 months of diagnosis.

3b) All patients with SLE, SSc or other CDT with lower limb signs / symptoms for screening, education and interventions as indicated within 3 months of diagnosis.

4) Patients with deformity/pain associated with foot and ankle

5) patient presenting with lower limb problem not included above for which podiatry opinion required as detailed in referral

Do referrals into specialist rheumatology service meet current BSR guidelines?

- Established triage process
- Reliant on information within the referral

- Better understanding of foot problems presenting and then identified within the Rheumatology Practitioner Service (RPS) clinics
- Our first use of the BSR audit tool

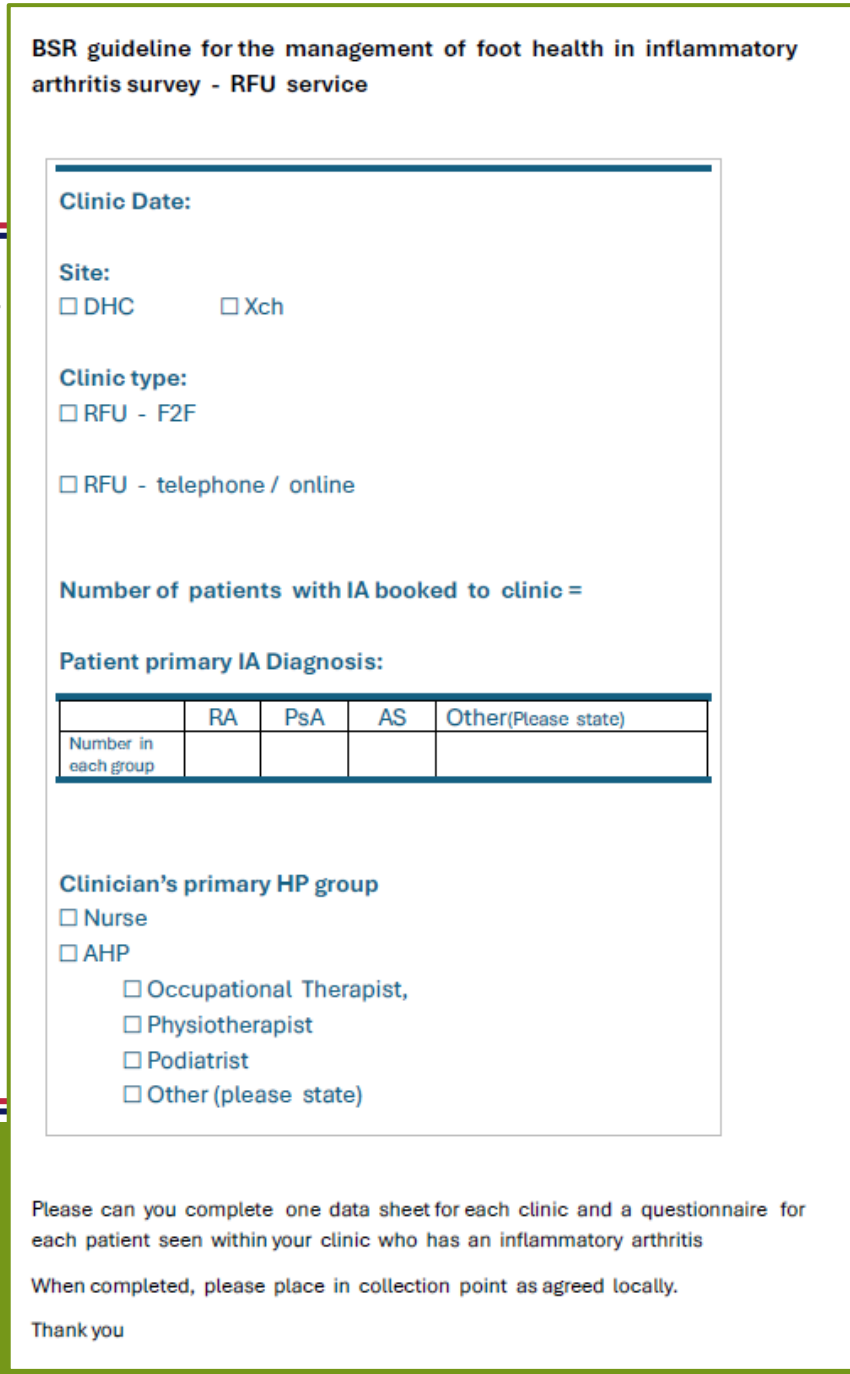
What did we do?

We asked Rheumatology Practitioner (RP) colleagues to complete:

- a clinic data sheet for each clinic
- BSR Foot Health in IA questionnaire for each patient with an IA attending clinic

Data collated into 2 groups based on Q2 'foot symptoms' – Y (group A) & N (group B)

Talked to 2 RPs about experience using the tool



BSR guideline for the management of foot health in inflammatory arthritis survey - RFU service

Clinic Date:

Site:
☐ DHC ☐ Xch

Clinic type:
☐ RFU - F2F

☐ RFU - telephone / online

Number of patients with IA booked to clinic =

Patient primary IA Diagnosis:

	RA	PsA	AS	Other(Please state)
Number in each group				

Clinician's primary HP group
☐ Nurse
☐ AHP
☐ Occupational Therapist,
☐ Physiotherapist
☐ Podiatrist
☐ Other (please state)

Please can you complete one data sheet for each clinic and a questionnaire for each patient seen within your clinic who has an inflammatory arthritis

When completed, please place in collection point as agreed locally.

Thank you

Clinics related data

Clinic Type:

- F2F = 39 patients seen
- Telephone = 2 patients

N=41

Number of clinics reported by RP professional group :

Nurse	9
OT	1
Physiother	0
Podiatrist	1
	n=11

Patient Diagnosis:

- RA = 27
- PsA = 10
- AS = 1
- Other: biologics screening = 2; MTX switch =1

N=41

Questionnaires (27 completed from 41 patients attending)

Q1. Was the patient asked whether they had any foot symptoms? Y= 26 N=1

Q2. Were foot symptoms present? Y = 8 N=19

Headlines – Foot symptoms present (8) Q3-14

Q3. Were the patient's foot symptoms impacting on activities of daily living, participation, and quality of life? Y=6 N=2

Q3a. If yes, was a prompt referral to specialist foot services considered? Y=6

Q4. Did the patient have access to customised orthoses, potentially through an additional referral? Y=4 N=2 N/A=2

Q5. Was therapeutic footwear provided, potentially through an onwards referral, or general footwear advice given? Y=3 N=5

Q6. Were individually tailored exercises offered, or was an onwards referral made? Y=2 N=2 N/A=4

Headlines – Foot symptoms present (8) Q3-14 continued

Q7. Did the patient have symptomatic callus affecting the feet? Y=1 N=7

Q10. Did the patient have a wound/ulcer? Y=0 N=8

Q11. Were local corticosteroid injections offered, potentially through an onwards referral? Y=0 N=1 N/A=7

Q12. Was inflammatory foot pain, new or increasing early morning stiffness, and/or suspected joint/tendon swelling present? Y=2 N=6

Q12a. If yes to Q12, was a review of systemic disease control undertaken, or an onwards referral made? Y=3 N= not reported

Q15-19 Groups A & B questionnaires combined

Q15. Was nail care advice issued? Y=0 N=7

Q16. Was the patient provided with individually tailored, culturally sensitive foot health education and support for self-management? Y=0 N=8

Q17. Was the patient encouraged and supported to meet physical activity guidelines for people with IA? Y=8 N=0

Q18. Does the patient smoke? Y=1 N=7

Q18a. If yes to Q18, was the patient encouraged and/or supported to stop smoking?

Q19. Was the patient encouraged and/or supported to maintain/reduce weight? Y=4 N=4

Some Thoughts

- Small numbers of completed questionnaires reflecting RP work load
- Not achieve consecutive sample of patients attending RP clinics
- Some gaps in completed questionnaires

- Whilst the number of completed questionnaires small
  - 30% active foot symptoms (8/27);
  - Foot symptoms impacted on ADLs (6/8) > podiatry referral considered.
  - No wounds present in group.

Some Thoughts

Questions related to Symptom (Q2), impact on ADLs (Q3), lifestyle related questions (Q17-19) more consistently completed by RPs.

Foot health advice was limited or not offered (Q6,15,16)

RPs reported:

- tool time consuming & could not be completed retrospectively
- some questions difficult to answer – too long / complex eg Q12, Q13
- Foot specific questions more relevant to a foot specialist
- some questions would benefit from a free text box.
- questionnaire acted as a prompt as to what to ask / do

Going Forward

- Adapt the BSR tool depending standard/s that apply to part of patient pathway being reviewed
- Develop prompt sheet to support RPS identify foot problems and promote timely referral
- Review the podiatry referral form / guide against the BSR standard

How the use of the British Society of Rheumatology (BSR) guidelines for the management of foot health in inflammatory arthritis can improve independent practice

Dr Aimie Patience

PhD, BSc Hons (Podiatry), PgCert

The Highland Foot Clinic

My rheumatology background

2016
Graduated from Queen Margaret University

2017
University of Leeds, Clinical Trials Associate

2018
Glasgow Caledonian University, Research Fellow and PhD student

2022
NHS Ayrshire and Arran, Advanced Practice Podiatrist

2024
Opened The Highland Foot Clinic, Inverness

Changing landscape

Establishing pathways

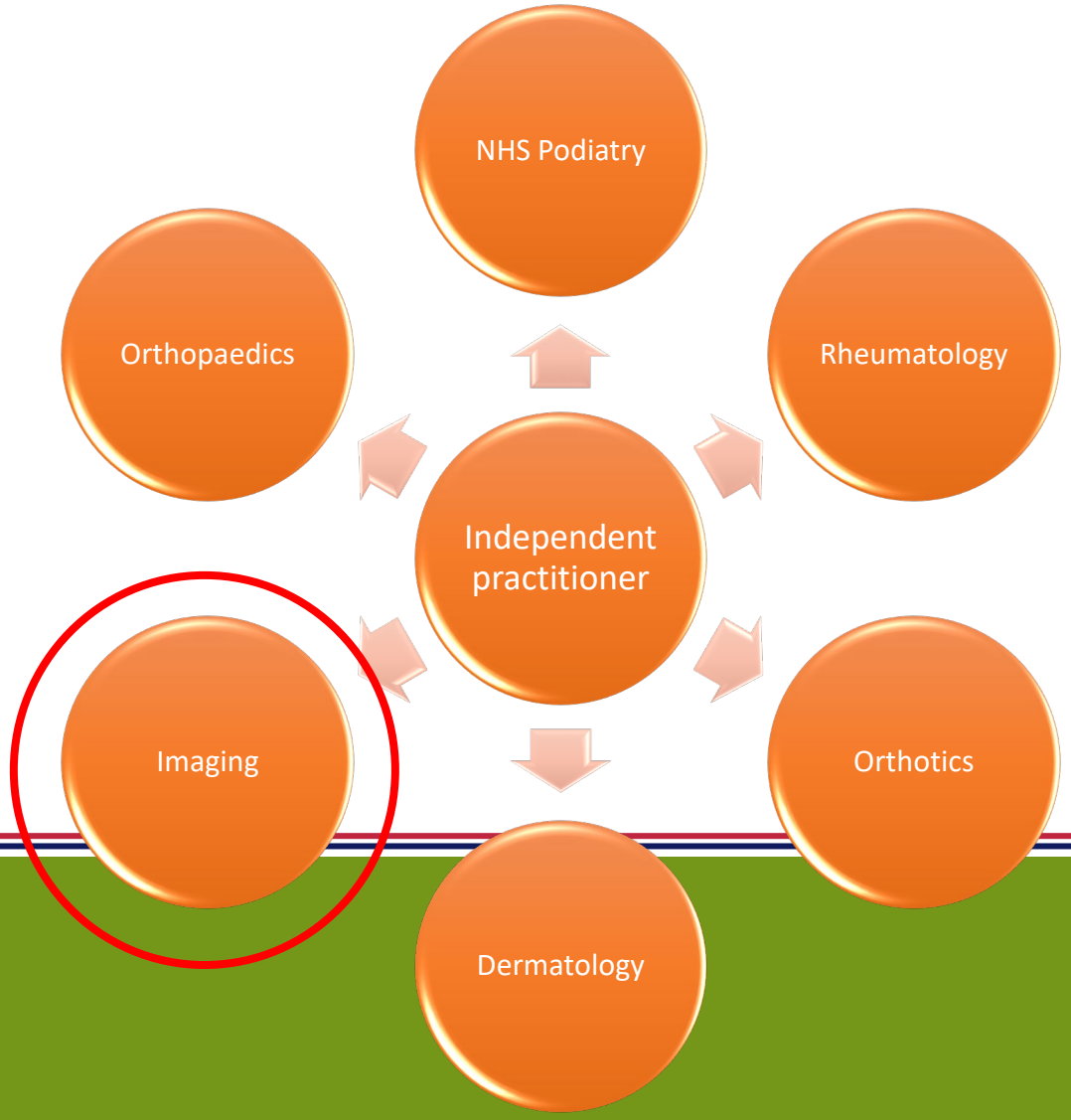
(2) Health professionals managing adults, children and young people with suspected or confirmed IA should have access to appropriate imaging (including X-ray, ultrasound (US), computed tomography (CT) and magnetic resonance imaging (MRI)) to assess foot health, to inform clinical management. SOR: 1; LOE: B/C; SOA: 99.

(3) In adults, children and young people with foot problems in IA, prompt referral to specialist foot services, e.g. podiatry, should be considered at any stage of the disease course where they impact on activities of daily living, participation and quality of life. Foot problems include but are not limited to pain, joint damage, deformity, risk of ulceration and/or footwear difficulties. SOR: 1; LOE: C; SOA: 98.

(23) In adults or children and young people with foot problems in IA, prompt surgical referral should be considered where there is pain, risk of ulceration, joint damage and/or deformity at the forefoot, midfoot or hindfoot, and usually when multidisciplinary non-operative care has failed or is considered unlikely to be successful. SOR: 2; LOE: C; SOA: 99.

Chapman et al, 2025

Establishing pathways



Imaging

(2) Health professionals managing adults, children and young people with suspected or confirmed IA should have access to appropriate imaging (including X-ray, ultrasound (US), computed tomography (CT) and magnetic resonance imaging (MRI)) to assess foot health, to inform clinical management. SOR: 1; LOE: B/C; SOA: 99.

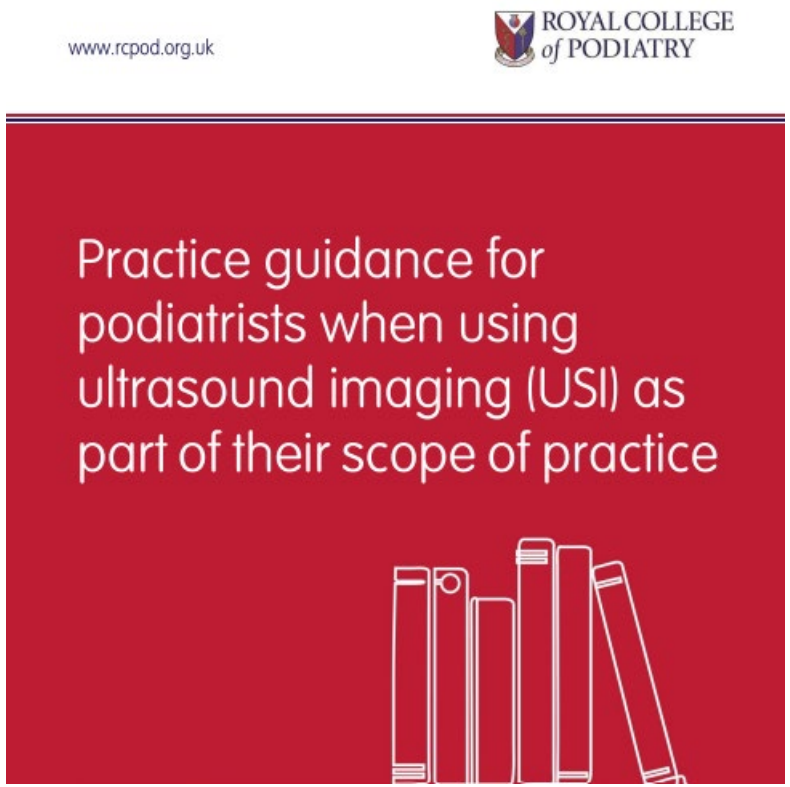
Imaging

TABLE 1: Comparison of Modalities

Ultrasound		MRI	
Strengths	Weaknesses	Strengths	Weaknesses
Real-time and dynamic imaging	Unable to image within bone	Ability to image deep within the joint and bone (e.g., marrow edema)	Contraindications (e.g., pacemaker)
Immediately accessible	Difficulties with temporal comparison	More complete assessment of whole joint including all articular surfaces	Time and patient tolerance
Allows operator to undertake clinical assessment	Poor depth penetration for larger joints and difficulty accessing parts of some joints	Proven correlation of synovitis and histopathology	Limited to one body region
Power Doppler imaging correlates well with disease activity	Specialist training not always available	Quantitative measurement of synovium	Ideally IV contrast administration needed for synovitis assessment
Relatively easy to examine multiple body regions	Operator dependent	Readily reproducible	Potential for motion artifact

Rowbotham et al, 2012

Use of US in independent practice



Rheumatology

- Monitoring disease activity
- Identification of soft tissue pathology
- Targeted injection therapy
  - <3–4 corticosteroid injections in the same joint per year[1]

1. Uson J et al, 2021

Assessment

Rheumatology foot proforma

Patient consented to physical examination and assessment: Yes / No			
Rheumatology information			
Diagnosis			
Date of diagnosis			
Current medication			
Previous medication			
Recent DAS-28 score	/9.4		
Remission 0-2.6, Mild >2.6-3.2, Moderate >3.2-5.1, High >5.1			
Foot pain/pathology			
RADAI-F5 score	/10		
Remission 0-1, mild >1 - 3.6, moderate >3.6 – 5.7, high >5.7 - 10			
RADAI-F5 improvement since last visit	Yes / No		
Deformity	Yes / No	Details:	
Bursa	Yes / No	Details:	
Nodules	Yes / No	Details:	
Subluxed MTPJ(s)	Yes / No	Details:	

Neurological assessment	**Right**	**Left**
Monofilament (10g)	Pass / Fail	Pass / Fail

Vascular assessment		**Right**	**Left**
Pulses:	Dorsalis Pedis	(Non)-Palpable	(Non)-Palpable
	Posterior Tibial	(Non)-Palpable	(Non)-Palpable
Doppler:		Mono / Bi / Tri Strong / Mod / Weak	Mono / Bi / Tri Strong / Mod / Weak
ABPI			
Severe disease <0.5, 0.5-0.8 presence of disease, 0.8-1.3 no disease, >1.3 calcification?			
CVD risk factors			

Skin assessment		
Ulceration	Past / Present / No	Past / Present / No
Details of previous ulcer(s)		

Podiatry treatment		
Footwear		Size:
Orthoses		
Mobility	Falls risk: Yes / No Mobility aids:	
Referrals		
Advice	Red flags Footwear Nail care Callous Pain	

Personalised care

- Custom foot orthoses
  - Reduce foot pain, improve foot function and alter plantar pressures[1-3]
  - Earning potential
  - Education gap – low confidence[4]
- Therapeutic footwear
  - Acceptability
- Physical activity
- Smoking cessation


ORIGINAL RESEARCH

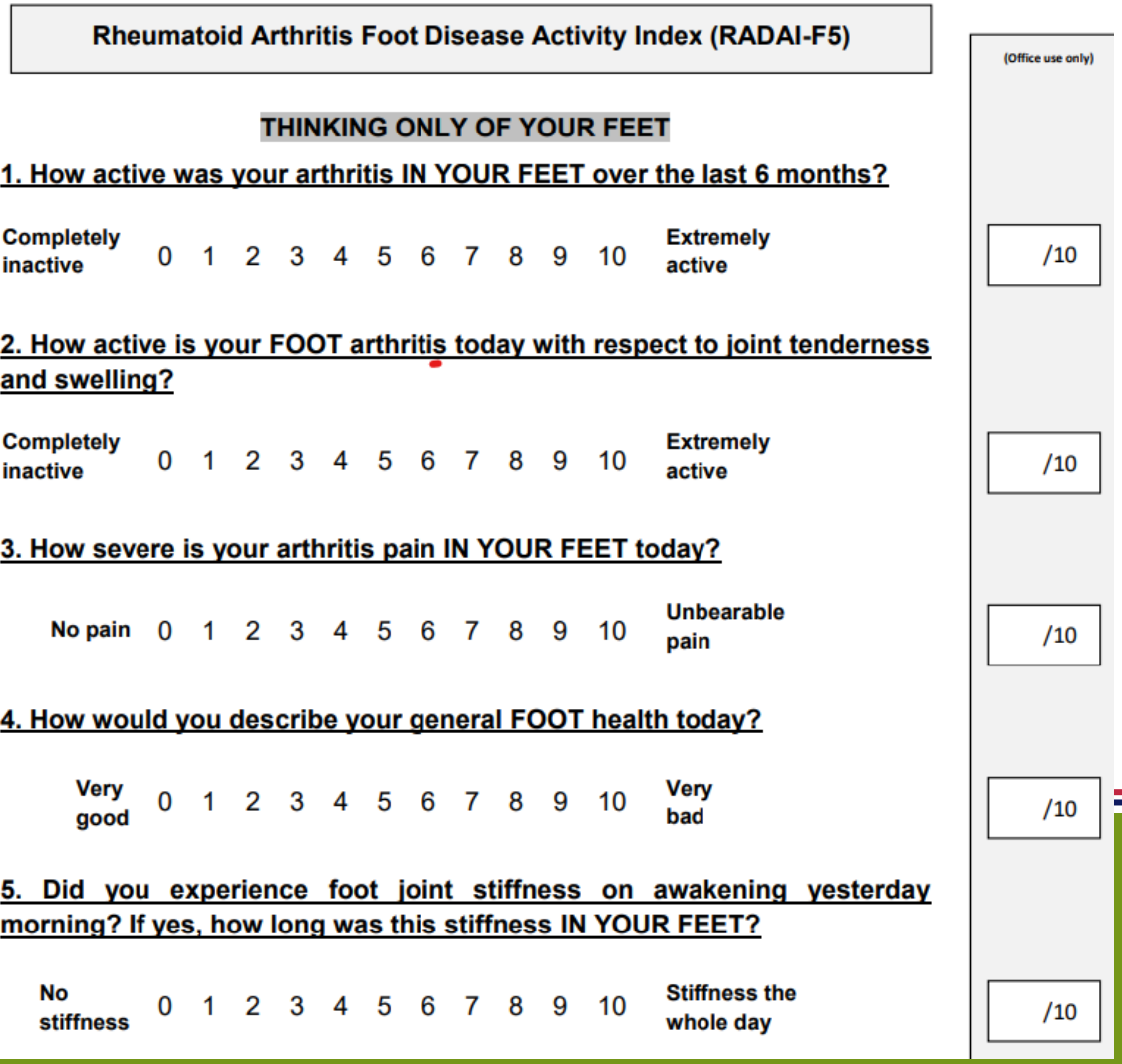
JOURNAL OF FOOT AND ANKLE RESEARCH

The experiences of podiatrists prescribing custom foot orthoses and patients using custom foot orthoses for foot pain management in the United Kingdom: A focus group study

Emily Leach[1,2] | Emma Cowley[1] | Catherine Bowen[1,3]

1. Gijon-Nogueron et al, 2018 2. Tenten-Diepenmaat et al, 2019 3. Arias-Martín et al, 2018
4. Leach et al, 2019

Disease monitoring



Rheumatoid Arthritis Foot Disease Activity Index (RADAI-F5)

(Office use only)

THINKING ONLY OF YOUR FEET

1. How active was your arthritis IN YOUR FEET over the last 6 months?

Completely inactive 0 1 2 3 4 5 6 7 8 9 10 Extremely active — /10

2. How active is your FOOT arthritis today with respect to joint tenderness and swelling?

Completely inactive 0 1 2 3 4 5 6 7 8 9 10 Extremely active — /10

3. How severe is your arthritis pain IN YOUR FEET today?

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain — /10

4. How would you describe your general FOOT health today?

Very good 0 1 2 3 4 5 6 7 8 9 10 Very bad — /10

5. Did you experience foot joint stiffness on awakening yesterday morning? If yes, how long was this stiffness IN YOUR FEET?

No stiffness 0 1 2 3 4 5 6 7 8 9 10 Stiffness the whole day — /10

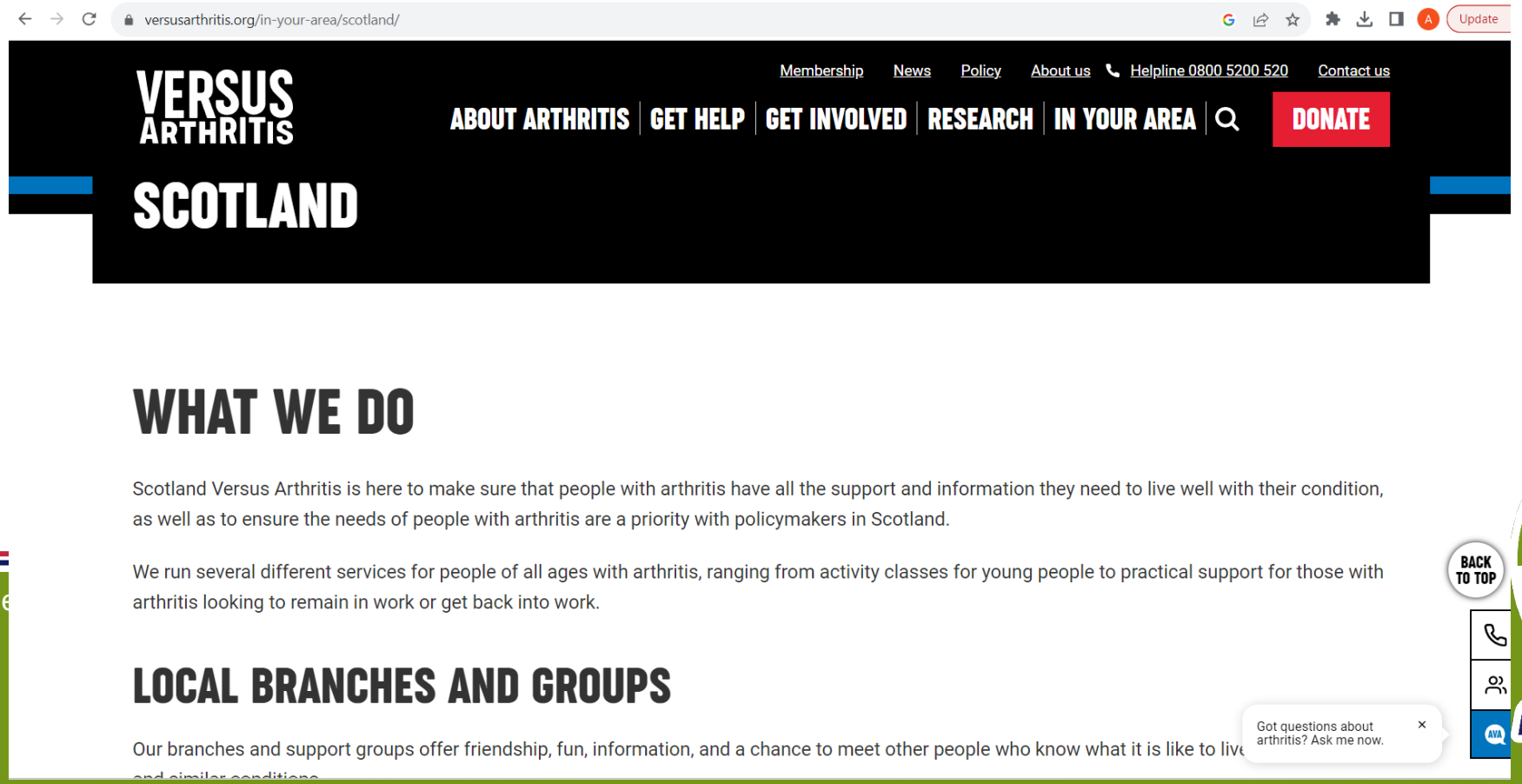
RADAI-F5

- First PROM designed to measure localised foot disease activity in RA
- Valid, reliable, and responsive to change, and is feasible for use in clinical practice
- Takes <1 min to complete

Hoque et al, 2021

Secondary prevention

"continuity has also been shown to bring about change to improve safety, efficiency and effectiveness of the services offered"[1]



1. NICE (2012) Patient expe

Further education

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British Society for Rheumatology

- Core Skills in Rheumatology
- Online, 2 days (27-28 November 2025)
- For full MDT (AHPs £165+VAT, bursaries available
- Webinars, podcasts and e-Learning

British Society for Rheumatology

EULAR eLearning Course for Health Professionals in Rheumatology

- 8 modules, fully online (starts in October)
- Exam and certification (March)

eular | EUROPEAN ALLIANCE OF ASSOCIATIONS FOR RHEUMATOLOGY

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Conclusion

- Changing landscape – seek community
- Early identification
- Embracing technology
- Advancing podiatry scope and skills
- Holistic, shared decision making

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Questions?