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Referral priority guide

Immediate	Phone the Gastroenterology Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.
Urgent <ul style="list-style-type: none"> • Strong suspicion of cancer • Impending liver failure (e.g. severe and progressive jaundice) • Progressive dysphagia • Subacute GI bleeding • Severe inflammatory bowel disease • Significant lower GI bleeding • Suspected oesophageal foreign body 	Urgent cases must be discussed with the Gastroenterology Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938. Likely to receive an appointment within 1-2 weeks.
Soon - Intermediate <ul style="list-style-type: none"> • Altered bowel habit: • Person > 40 years and/or alarm symptoms/abnormal baseline lab investigations and/or family history of cancer/inflammatory bowel disease • Alarm symptoms (any of the following): • Anaemia • Significant weight loss • Significant anorexia • Significant vomiting • GI bleeding • Undiagnosed significant diarrhoea in the absence of macro PR blood loss • Significant abdominal pain of short duration considered to be non-surgical • Suspected malabsorption • Iron deficiency anaemia • Occult GI bleeding • Decompensating liver disease: • Viral hepatitis • Drugs/alcohol • Visible rectal bleeding • Significant dyspepsia with alarm symptoms (as above including dysphagia or a person >50 years, unresponsive to empirical acid suppressant treatment) • Dysphagia • Abnormal Barium meal/enema findings • Suspicion or review of previously diagnosed IBD 	Likely to receive an appointment within 2-12 weeks, depending on severity.
Non-urgent <ul style="list-style-type: none"> • Altered bowel habit (person <40 years and/or no alarm symptoms/normal lab results) • IBS • Constipation • Hepatitis B and C • Haemochromatosis • Dyspepsia in the young with no alarm symptoms • Abnormal liver function tests • Non-cardiac chest pain • Strong family history bowel cancer/screening • Chronic abdominal pain 	Appointment may be delayed.
Not seen	Children under 16 years of age are not seen at the Alfred.

Please note: The times to assessment may vary depending on size and staffing of the hospital department.
 For The Alfred Endoscopy Booking office phone 9076 0358 or fax referral to 9076 0393

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Evaluation	Management	Referral Guidelines
Upper gastrointestinal tract		
Dysphagia		
		Refer to The Alfred Endoscopy service - phone 9076 0358 or fax referral to 9076 0393 Return to contents page
Pharyngeal		
<ul style="list-style-type: none"> • FBE + ESR • History of stroke/neurological conditions • Smoking and alcohol history 	Management may include: <ul style="list-style-type: none"> - Anti-reflux management - Speech language therapy assessment 	Obstructive dysphagia should be referred urgently to Gastroenterology or ENT service: PRIORITY 1 Return to contents page
Oesophageal		
<ul style="list-style-type: none"> • Diagnostic studies may include: <ul style="list-style-type: none"> - Soft tissue studies of the neck - CXR - Barium swallow The Alfred Radiology request form		Dysmotility dysphagia problems should be referred to Gastroenterology service routinely: PRIORITY 4 Return to contents page
Dyspepsia		
Alarm Symptoms: <ul style="list-style-type: none"> - Anaemia - Weight loss - Anorexia - Vomiting - GI bleeding - Dysphagia <ul style="list-style-type: none"> • Symptom duration • Age • Treatment (empirical non-response) • Current drug regimen (NSAIDs, alcohol, etc) • FBE + ESR • LFTs and/or amylase • Serological testing - to confirm presence of <i>H. pylori</i> 		Should be referred semi-urgently to Gastroenterology/ Endoscopy service: PRIORITY 2. Return to contents page
No alarm symptoms: <ul style="list-style-type: none"> - Age <40 years - Intermittent - Treatment responsive 	<ul style="list-style-type: none"> • Lifestyle changes (weight loss, cease smoking, limit alcohol, etc) • Antacids PRN • Intermittent H2 receptor antagonists 	Only refer if alarm symptoms or complications develop or become treatment non-responsive: PRIORITY 3 – 4 Return to contents page
Weight loss		
<ul style="list-style-type: none"> • Consider both GI and non-GI causes • Definitely document reported weight loss • Age and gender • Associated symptoms • Smoking and alcohol • FBE + ESR • CXR The Alfred Radiology request form <ul style="list-style-type: none"> • TFTs • Creatinine • Electrolytes • LFTs • Fasting glucose • Urinalysis 	<ul style="list-style-type: none"> • Lifestyle changes if appropriate 	Refer to appropriate speciality service depending on results Return to contents page

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Evaluation	Management	Referral Guidelines
Vomiting and nausea (> 2 weeks duration)		
<ul style="list-style-type: none"> Consider both GI and non-GI causes Age and gender Associated symptoms Smoking and alcohol Drugs FBE + ESR Creatinine U + Es LFTs Fasting glucose Urinalysis Urine HCG 	<ul style="list-style-type: none"> Symptomatic management with standard anti-emetics, etc Stop potential emetogenic drug/s if appropriate Lifestyle modifications if indicated 	Refer to appropriate speciality service depending on results and assessment Return to contents page
Upper gastrointestinal tract haemorrhage (haematemesis and/or melaena)		
ACUTE (haemodynamically unstable): <ul style="list-style-type: none"> Elderly patients (>60) and those with significant co-morbid disease are at very high risk 	Resuscitation and ambulance transfer	Immediate inpatient hospital referral – phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. Return to contents page
NON-ACUTE (haemodynamically stable): <ul style="list-style-type: none"> Check FBE Elderly patient (>60) and those with significant co-morbid disease are at very high risk <p>NOTE: Blood pressure, particularly in response to postural changes, is a good indicator of haemodynamic stability in these situations</p>	Cease ulcerogenic drugs	<ul style="list-style-type: none"> If definite melaena - for immediate hospital admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. If Hb >100gm/1 and asymptomatic refer urgent to gastro/endoscopy service – PRIORITY 1. If Hb <100gm/1 and symptomatic refer for immediate hospital admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. If on anticoagulants refer for immediate admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre Return to contents page
CHRONIC (iron deficiency anaemia): <ul style="list-style-type: none"> GI or non-GI causes Age and Gender Diet Drugs Previous endoscopy/GI surgery Check FBE and ESR Iron studies and Ferritin <p>NOTE: FOBs have limited sensitivity for occult GI bleeding</p>	<ul style="list-style-type: none"> Oral iron supplements if confirmed iron deficient and refer Cease potential ulcerogenic drugs and refer Dietary management if indicated 	Refer gastro/endoscopy service: PRIORITY 1 –2 Return to contents page
Upper abdominal pain		
<ul style="list-style-type: none"> Chronic vs acute Associated symptoms Drugs Smoking and alcohol Age, gender, ethnicity Overseas travel/immigration <p>INVESTIGATIONS:</p> <ul style="list-style-type: none"> FBE and ESR LFTs Amylase MSU AXR - supine Abdominal ultrasound The Alfred Radiology request form	Treat symptomatically as clinically appropriate. Consider non-GI causes, e.g. myocardial infarction, lower respiratory tract infection etc.	Refer to appropriate speciality service depending on results or clinical response Return to contents page

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Evaluation	Management	Referral Guidelines
Lower gastrointestinal tract		
Lower abdominal pain		
<ul style="list-style-type: none"> • Consider non-GI causes, e.g. urological, gynaecology, etc. • Chronic vs acute • Duration • Associated symptoms • Drugs • Family history Colorectal cancer/polyps • Age and gender • Overseas travel/immigration • FBE + ESR • LFTs • MSU • AXR - supine • Rigid sigmoidoscopy (if skilled) • Abdominal and/or pelvic ultrasound • Rectal and bimanual examinations • Barium enema <p>The Alfred Radiology request form</p>	<p>Treat symptomatically as clinically appropriate</p>	<p>Refer if significantly dehydrated, septic or an abdominal complication suspected</p> <p style="text-align: right;">Return to contents page</p>
Diarrhoea – acute (duration less than 6 weeks)		
<ul style="list-style-type: none"> • Increased frequency and/or abnormal stool consistency • Overseas travel • Drugs • Antibiotics (? In recent weeks) • Dietary indiscretion • Diarrhoeal contacts • Associated symptoms • Vascular diseases • Family history inflammatory bowel disease • Non-colonic symptoms suggestive of inflammatory bowel disease, e.g. uveitis, synovitis, erythema nodosum, anal fissure, etc • FBE + ESR • Rectal examination • Stools M, C and S + parasites • Consider <i>Clostridium difficile</i> toxin (antibiotics) • Rigid sigmoidoscopy and rectal swab (if skilled) 	<p>Seek specialist advice</p>	<p>In cases of clinically suspected inflammatory bowel disease refer to Gastroenterology service: PRIORITY 1.</p> <p style="text-align: right;">Return to contents page</p>

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Evaluation	Management	Referral Guidelines
Diarrhoea – chronic (duration longer than 6 weeks)		
<ul style="list-style-type: none"> • Increased frequency and/or abnormal stool consistency • Overseas travel • Drugs • Antibiotics • Dietary indiscretion • Diarrhoeal contacts • Associated symptoms • Vascular diseases • Known colonic disease • Family history colonic/coeliac disease • Weight loss/nutrition • History of GI surgery • Family history Inflammatory Bowel Disease • Non-colonic symptoms suggestive of IBD e.g. uveitis, synovitis, erythema nodosum, anal fissure, etc • Rectal examination • Stools M, C and S + parasites • <i>Clostridium difficile</i> toxin (antibiotics) • FBE + ESR • TFTs • Folate and B12 • Iron studies and Ferritin • Rigid sigmoidoscopy and rectal swab (if skilled) • Rectal biopsy (if skilled) 		<p>Refer to specialist service (e.g. Gastroenterology) for further investigation and management: PRIORITY 2. or PRIORITY 1 if warning symptoms present (eg. Anemia, weight loss, PR bleeding)</p> <p style="text-align: right;">Return to contents page</p>
Altered bowel habit		
<p>If:</p> <ul style="list-style-type: none"> ➢ Age >40 and/or ➢ alarm symptoms and/or ➢ family history of colorectal cancer or ➢ inflammatory bowel disease: • Recent antibiotic usage • FBE and ESR • Urinalysis • Stools M, C and S + parasites • FOBs (see previous comments) • Rigid sigmoidoscopy (if skilled) • Rectal examination • Bimanual examination if indicated 		<p>Refer for colonoscopy and sigmoidoscopy: PRIORITY 2.</p> <p style="text-align: right;">Return to contents page</p>
<p>If:</p> <ul style="list-style-type: none"> ➢ Age <40 and/or ➢ No alarm symptoms ➢ Normal lab tests ➢ No family history of colorectal cancer, inflammatory bowel disease or polyps: • Recent antibiotic usage • FBE and ESR • Urinalysis • Stools M, C and S + parasites • FOBs (see previous comments) • Rigid sigmoidoscopy (if skilled) • Rectal examination • Bimanual examination if indicated • Barium enema (after sigmoidoscopy) <p>The Alfred Radiology request form</p>	<p>Manage symptomatically if results suggest functional large bowel disorder (irritable bowel) e.g. bulking agents, antispasmodics, antidiarrhoeals, lifestyle advice, etc (slow introduction of fibre - 3 months)</p>	<ul style="list-style-type: none"> • Refer only patients who have functional bowel disorder with persistent or refractory symptoms greater than 6 months: PRIORITY 3 - 4 • If results abnormal and/or clinical suspicion of organic large bowel disease refer to Gastroenterology / Endoscopy service: PRIORITY 1 – 2. <p style="text-align: right;">Return to contents page</p>

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Evaluation

Management

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Rectal bleeding

- Nature - fresh or dark
- Quantity
- Painful vs painless
- Mixed or non-mixed with stools
- Age and gender
- Chronic vs acute
- Tenesmus
- Family history
- CRC/polyps/IBD
- FBE
- Proctoscopy
- Rectal examination
- Rigid sigmoidoscopy (if skilled)
- Barium enema (after sigmoidoscopy)

- If clinically benign anorectal bleeding (age <40 and unchanged bowel habit) e.g. anal fissure or haemorrhoids
- Treat symptomatically with bulking agents, lifestyle advice and proprietary anal creams and suppositories (see General Surgery referral recommendations)

Unexplained or recurrent bleeding should be referred to Gastroenterology / [Endoscopy](#) / [General Surgery](#): PRIORITY 1 – 2

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Liver

Jaundice

- Acute vs chronic
- Occupation
- Overseas travel
- Sexual history
- Drug history (pharmacological and recreational)
- Associated symptoms (pruritus, steatorrhoea, bruising, dark urine, etc)
- Alcohol consumption
- Possible hepatitis contracts
- Family history liver disease or blood disorder
- Needle stick injury (if at risk occupation)
- Liver functions tests:
 - Hepatocellular (elevated transaminases) - EBV, CMV, HAV, HBV, HCV testing
 - Cholestatic (elevated ALP and GGT) – ultrasound
- [The Alfred Radiology request form](#)
- FBE, platelets and if isolated elevated bilirubin a haemolysis screen
- Prothrombin time
- Immunoglobulins
- Autoantibodies (SMA, AMA)

Hepatocellular jaundice (viral or drug hepatitis):

- Rest
- No alcohol
- Good diet
- Stop potential hepatotoxic drugs
- Regular laboratory and clinical review

Cholestatic jaundice:

- Low fat diet and no alcohol
- Stop potential cholestatic drugs
- Vitamin K if prolonged prothrombin time
- Dilated ducts on ultrasound - refer
- Undilated ducts on ultrasound - check IgM, AMA

Refer to Gastroenterology:

- Suspected acute, severe or fulminant hepatic failure – Refer immediately - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre.
- Severe clinical or biochemical hepatocellular jaundice: IMMEDIATE or PRIORITY 1, depending on severity.
- Obstructive jaundice (dilated ducts): PRIORITY 1.
- Unexplained non-obstructive cholestatic jaundice: PRIORITY 1 - 2

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Abnormal liver function tests

Acute (<6/52) vs chronic (6/12):

- History as for jaundice
- Gender
- History of autoimmune disease
- Concurrent obesity, hyperlipidemia
- Menstrual history
- Signs of chronic liver disease
- As above for jaundice
- Additional investigations:
 - ANF, autoantibody screen (SMA and AMA)
 - Ferritin and iron studies
 - Immunoglobulins
 - IgM and AMA
 - Lipid profile, blood glucose

Suspected fatty liver:

- Lifestyle: weight loss, low fat diet, alcohol abstinence, stop drug(s) where applicable and monitor LFTs

Non-fatty liver:

- Satisfactory diet, alcohol reduction or abstinence where applicable and monitor LFTs

Refer to Gastroenterology:

- Cause undetermined after previous investigation negative: PRIORITY 2.
- LFTs remain abnormal despite lifestyle measures: PRIORITY 2.
- Clinical concern that there is significant chronic liver disease: PRIORITY 2.
- Probable requirement for liver biopsy: PRIORITY 2

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Evaluation	Management	Referral Guidelines
Pancreaticobiliary		
Pancreatic and biliary disorders		
<ul style="list-style-type: none"> • Pain suggestive (non-dyspeptic) - site character duration radiation etc. • Charcot's triad (jaundice, pain, fever = cholangitis) • Steatorrhoea or malabsorption • Dark urine • Alcohol consumption • Known gallstones or previous cholecystectomy? • Preceding trauma? • Drugs causing pancreatitis? • Family history of hyperlipidemia? • Jaundice: epigastric/RUQ tenderness or mass; peritonism fever • LFTs • FBE and platelets • Amylase • Blood cultures • Ultrasound • AXRs (sentinel loop; calcification) <p>The Alfred Radiology request form</p>	<p>Uncomplicated gallstones</p> <ul style="list-style-type: none"> • Observe <p>Mild pancreatitis</p> <ul style="list-style-type: none"> • Low fat diet • Analgesia PRN • Alcohol abstention <p>Chronic pancreatitis</p> <ul style="list-style-type: none"> • Low fat diet • Pancreatic enzyme supplements • Non-narcotic analgesia • Alcohol abstention 	<p>Refer to Gastroenterology or General Surgery:</p> <p>Admit acutely – IMMEDIATE referral - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre:</p> <ul style="list-style-type: none"> • Cholangitis • Moderate/severe pancreatitis • Complicated CBD stones • Cholecystitis <p>Elective referral to Gastroenterology or General Surgery:</p> <ul style="list-style-type: none"> • Uncomplicated gallstones or CBD stones: • Chronic relapsing pancreatitis • Chronic pancreatitis PRIORITY 1 - 2 <p style="text-align: right;">Return to contents page</p>