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REFERRAL GUIDELINES: GASTROENTEROLOGY

Essential Referral Content

Demographic

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements
- Medicare number

Clinical

- Reason for referral
- Duration of symptoms
- Relevant pathology & imaging reports
- Past medical history
- Current medications

The Alfred Outpatient Referral Form is available to print and fax to the Outpatient Department on 9076 2194.

Exclusion Criteria

The following conditions are not routinely seen at the Alfred:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen at The Alfred

REFERRAL PROCESS: GASTROENTEROLOGY

STEP 1

You will be notified when your referral is received by outpatients.

Essential referral content will be checked and you may be contacted if further information is required.

STEP 2

The referral is triaged by the specialist unit according to clinical urgency.

This determines how long the patient will have to wait for an appointment.

STEP 3

Patients with **urgent** conditions are scheduled to be seen within 30 days.
Patients with **routine** conditions are given the next available appointment according to clinical need.

Both the referrer and patient are notified.

Some clinics offer an MBS-billed service. **There is no out of pocket expense to the patient.** MBS-billed services require a current referral to a named specialist– please provide your patient with a **12 month referral addressed to the specialist of your choice.** Please note that your patient may be seen by another specialist in that clinic, in order to expedite their treatment.

Please note: The times to assessment may vary depending on size and staffing of the hospital department.

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Gastroenterology Registrar on call on 9076 2000.

For the Alfred Endoscopy Booking office phone 9076 0211 or fax referral to 9076 2194.

The Alfred gratefully acknowledges the assistance of the Canterbury and District Health Board in New Zealand in developing these guidelines.
They are intended as a guide only and have been developed in conjunction with the Heads of Unit of The Alfred.

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REFERRAL PRIORITY: GASTROENTEROLOGY

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

IMMEDIATE **Direct to the Emergency & Trauma Centre**	**URGENT** **Appointment timeframe within 30 days**	**ROUTINE** **Appointment timeframe greater than 30 days depending on clinical need**
• Acute (haemodynamically unstable) gastrointestinal tract haemorrhage (haematemesis and/or melaena and/or haematochezia) • GI tract bleeding with Hb <100g/1 and symptomatic, or if patient is anticoagulated. • Bloody diarrhoea with signs of dehydration • Abdominal pain if acute onset of severe pain, if patient is significantly dehydrated, septic, or there is suspicion of gastrointestinal haemorrhage. • Suspected acute, severe or fulminant hepatic failure. • Symptomatic marked ascites or new onset of ascites. • Severe hepatitis with jaundice • Cholangitis • Moderate/severe pancreatitis • Complicated CBD stones • Cholecystitis	• Strong suspicion of cancer • Obstructive or unexplained non-obstructive cholestatic jaundice • Progressive or obstructive dysphagia • Subacute (chronic) GI bleeding • Severe inflammatory bowel disease • Significant lower GI bleeding • Suspected oesophageal foreign body • Altered bowel habit if: ⇒ >40 years ⇒ Anaemia ⇒ Significant weight loss ⇒ Significant anorexia or vomiting ⇒ GI bleeding ⇒ Family history ⇒ Inflammatory bowel disease • 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, suspected chronic liver disease or moderate to severe abnormal LFTs • Unexplained or recurrent rectal bleeding • Significant dyspepsia with alarm symptoms (as above including dysphagia or a person >50 years, unresponsive to empirical acid suppressant treatment)	• Altered bowel habit if: ⇒ <40 years and/or ⇒ no alarm symptoms ⇒ normal lab results • Irritable bowel syndrome • Constipation • Hepatitis B and C • Haemochromatosis • Dyspepsia in the young with no alarm symptoms • Mild abnormal liver function tests • Non-cardiac chest pain • Strong family history bowel cancer/screening • Chronic abdominal pain
Phone the Gastroenterology Registrar on call on 9076 2000 and /or send to The Alfred Emergency & Trauma Centre.	Urgent cases must be discussed with the Gastroenterology Registrar on call to obtain appropriate prioritisation and a referral letter faxed to 9076 2194.	Fax referral to 9076 2194.

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Referral Guideline Contents

Upper gastrointestinal tract:
- Dysphagia
- Pharyngeal
- Oesophageal
- Dyspepsia
- Weight loss
- Vomiting and nausea
- Upper gastrointestinal haemorrhage (haematemesis and/or melaena and/or haematochezia)
  - Acute (haemodynamically unstable)
  - Non-acute (haemodynamically stable)
  - Chronic (iron deficiency anaemia)
- Upper abdominal pain

Lower gastrointestinal tract:
- Lower abdominal pain
- Diarrhoea
  - Acute (duration less than 6 weeks)
  - Chronic (duration longer than 6 weeks)

Lower gastrointestinal tract:
- Altered bowel habit including worsening constipation
- Rectal bleeding

Liver:
- Jaundice
- Ascites
- Abnormal liver function tests and Hepatitis

Pancreaticobiliary:
- Pancreatic and biliary disorders

Endoscopy guidelines

Functional GI disorders
- Suspected Irritable Bowel Syndrome/ functional diarrhoea
- Suspected functional dyspepsia
- Chronic constipation
- Functional chronic abdominal pain

Upper Gastrointestinal Tract:

DYSPHAGIA

Evaluation	Management	Referral Guidelines
		Refer to The Alfred Endoscopy service

PHARYNGEAL

Evaluation	Management	Referral Guidelines
• History of stroke/neurological conditions • Smoking and alcohol history	Management may include: • Anti-reflux management • Speech language therapy assessment	Obstructive dysphagia should be referred urgently to Gastroenterology or ENT service, refer - Urgent

OESOPHAGEAL

Evaluation	Management	Referral Guidelines
Diagnostic studies may include: • CXR • Barium swallow • Gastroscopy • Oesophageal manometry • 24 hour pH studies The Alfred Radiology request form	• Anti-reflux management • Specific management of an underlying oesophageal motility problem.	Standard referral pathways are appropriate in most situations. In the situation of significant clinical concern regarding dysphagia discuss with the gastroenterology registrar to arrange an urgent referral.

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DYSPEPSIA

Evaluation	Management	Referral Guidelines
Alarm Symptoms: – **Anaemia** – **Weight loss** – **Vomiting** – **GI bleeding** – **Dysphagia** • 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 *H. pylori* • Gastric emptying study if nausea or	• Consider gastroscopy if alarm symptoms are present or if over 55 years of age • Trial PPI • Eradicate *H. Pylori* if present • Trial Promotility agent • Trial IBERGAST • Consider Gut Focussed Hypnotherapy	Should be referred semi-urgently to Gastroenterology/ Endoscopy service, refer - Urgent

WEIGHT LOSS

Evaluation	Management	Referral Guidelines
• Consider both GI and non-GI causes • Definitely document reported weight loss • Dietary history including any change in amount or type of diet • Age and gender • Associated symptoms • Smoking and alcohol • FBE + ESR • CXR + CT abdo / pelvis (where appropriate) • TFTs • Creatinine • Electrolytes • LFTs • Fasting glucose • Urinalysis	Lifestyle changes if appropriate	Refer to appropriate speciality service depending on results

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VOMITING AND NAUSEA (>2 weeks duration)

Evaluation	Management	Referral Guidelines
• 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	• 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

GASTROINTESTINAL TRACT HAEMORRHAGE
(Haematemesis and/or Melaena and/or Haematochezia)

Evaluation	Management	Referral Guidelines
ACUTE (haemodynamically unstable): Older 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.
NON-ACUTE (haemodynamically stable): Check FBE Older patients (>60) and those with significant co-morbid disease are at very high risk **NOTE:** Blood pressure, particularly in response to postural changes, is a good indicator of haemodynamic stability in these situations	Cease ulcerogenic drugs	• If definite melaena - for IMMEDIATE hospital admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. • If Hb >100g/1 and asymptomatic refer - Urgent to gastro/endoscopy service • If Hb <100g/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
CHRONIC (iron deficiency anaemia): • GI or non-GI causes • Age and Gender • Diet • Drugs • Previous endoscopy/GI surgery • Check FBE and ESR • Iron studies and Ferritin **NOTE:** Faecal Occult Blood test is not useful	• Oral iron supplements if confirmed iron deficient and refer • Cease potential ulcerogenic drugs and refer • Dietary management if indicated	Refer gastro/endoscopy service, refer - Urgent

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UPPER ABDOMINAL PAIN

Evaluation

Alarm Symptoms:

- **Weight loss**
- **Dysphagia**
- **Age >50**
- **Smoker**
- **Obesity (particularly intra-abdominal distribution)**
- **Past history of Barrett's**
- **Family history of Barrett's, oesophageal or gastric cancer**
- **Anaemia or iron deficiency**
- **Abdominal mass**

ASSESSMENT:

- Acute vs chronic
- Associated symptoms
  - Jaundice
  - Nausea/vomiting
  - Change in bowel habit
  - GI bleeding
- Risk factors
  - Recent overseas travel
  - Drug or excessive alcohol use
  - Ethnicity
- Consider non GI causes—particularly IHD, basal pneumonia

INVESTIGATIONS:

- FBE
- LFTs
- U&Es
- Lipase
- Iron studies
- Inflammatory markers
- Abdominal ultrasound
- *H.Pylori* breath test
- MSU
- ECG

Management

- Treat as appropriate based on clinical assessment and investigations.
- If no alarm features and symptoms of dyspepsia are present a trial of PPI is appropriate before referral.
- Consider non-gastrointestinal causes, particularly ischaemic heart disease.

Referral Guidelines

- If no response to initial therapy refer to general gastroenterology clinic for ongoing investigation and management.
- If NO alarm features, negative investigations and chronic history (>3months), consider direct referral to the Functional Gastrointestinal Disorders clinic.
- If acute onset severe pain, if patient is significantly dehydrated, septic or there is suspicion of gastrointestinal haemorrhage refer for IMMEDIATE hospital admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre.

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Lower Gastrointestinal Tract:

LOWER ABDOMINAL PAIN

Evaluation

Alarm Symptoms:

- **Age >50**
- **Weight loss**
- **PR bleeding**
- **New onset**
- **Anaemia or iron deficiency**
- **Change in diameter of stools**
- **Abdominal mass**
- **Rectal prolapse**
- **Past history of polyps / cancer**
- **Family history of bowel cancer**

ASSESSMENT:

- Acute vs chronic
- Associated symptoms
  - Change in bowel habit
  - PR bleeding
  - Abdominal distension
  - Bloating
  - Vomiting
- Gender
- Age
- Risk factors
  - Recent overseas travel
  - History of diverticular disease
  - Previous abdominal surgery

INVESTIGATIONS:

- FBE
- U&Es
- LFTs
- Inflammatory markers
- Iron studies
- Pregnancy test in women of childbearing age
- MSU
- Faecal microscopy and culture
- Rectal exam
- Bimanual exam in females with pelvic pain
- AXR
- If female consider pelvic ultrasound
- Depending on location/quality of pain consider abdominal ultrasound, CT scan to exclude diverticulitis or CTU to exclude nephrolithiasis.

Management

- Treat as appropriate depending on clinical assessment and investigation results.

Referral Guidelines

- If no response to initial therapy refer to general gastroenterology clinic for ongoing investigation and management.
- If chronic history, NO alarm features, negative investigations and patient meets ROME III for irritable bowel syndrome (see below) consider referring directly to the Functional Gastrointestinal Disorders clinic.

ROME III criteria for Irritable Bowel Syndrome:

At least 12 weeks, which need not be consecutive, in the preceding 12 months of abdominal discomfort or pain that has two of three features:

1. Relieved with defecation; and /or
2. Onset associated with a change in frequency of stool; and/or
3. Onset associated with a change in form (appearance) of stool

- If acute onset severe pain, if patient is significantly dehydrated, septic or likely gastrointestinal haemorrhage refer for IMMEDIATE hospital admission - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre.

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DIARRHOEA

Evaluation	Management	Referral Guidelines
HISTORY: • Frequency, duration, nocturnal symptoms • Presence of blood, mucous or steatorrhoea • Weight loss, fever or severe abdominal pain • Family history (IBD, CD) • Travel • Recent antibiotic use / medication changes • Non-colonic features of IBD (arthritis, uveitis, erythema nodosum, fissure etc) **INVESTIGATIONS**: • Stools MC& S + parasites • CDT (if recent antibiotic use) • CRP • ESR • FBE • Iron studies • B12 • TSH • Coeliac serology **CONSIDER**: • Faecal calprotectin if suspicion for IBD persists • Faecal elastase if symptoms suggest steatorrhoea (Note: the above two tests may incur costs as they are not Medicare rebateable) • AXR - to rule out constipation with overflow	Seek specialist advice	If bloody diarrhoea is present with signs of dehydration, refer IMMEDIATELY - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. **Urgent referral** for: • Weight loss • Bloody diarrhoea • Severe acute diarrhoea Refer to either a specialised private dietician for education in dietary management of IBS, or directly to the Functional Gut Disorders Clinic

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ALTERED BOWEL HABIT INCLUDING WORSENING CONSTIPATION

Evaluation	Management	Referral Guidelines
If: – **Age >40 and/or** – **alarm symptoms and/or** – **family history of colorectal cancer or** – **inflammatory bowel disease:** • Recent antibiotic usage • FBE, CRP, Iron studies • Stools M, C and S, ova & parasites, *C. difficile* toxin (CDT) • FOBs • Rectal examination		Refer for colonoscopy and sigmoidoscopy, refer - Urgent
If: – **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, CRP, Iron studies • Stools M, C and S + parasites, *C. difficile* toxin (CDT) • FOBs • Rectal examination	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)	• Refer only patients who have functional bowel disorder with persistent or refractory symptoms greater than 6 months. (Routine referral to Functional Gut Disorders Clinic) • If results abnormal and/or clinical suspicion of organic large bowel disease refer to Gastroenterology / Endoscopy service, refer - Urgent

RECTAL BLEEDING

Evaluation	Management	Referral Guidelines
• 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, CRP, Iron studies • Rectal examination	• 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 / Colorectal Surgery, refer - Urgent

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Liver:

JAUNDICE

Evaluation	Management	Referral Guidelines
• Acute vs chronic • Complete drug and alcohol history (including paracetamol, recreational drugs, natural therapies) • Overseas travel • Risk factors for hepatitis virus (IDU, tattoos, sexual history, hepatitis contacts, needle stick) • Family history liver disease • Symptoms: pruritus, dark urine, pale stools, abdominal pain • Liver functions tests: - Hepatitic (high AST, ALT), HAV, HBV, HCV, EBV, CMV tests and consider IgG and ANA and SMA - Cholestatic (high ALP and GGT) ultrasound to exclude obstruction • FBE, INR, U&E (renal function)	• Avoid alcohol • Rest • Stop hepatotoxic drugs • Regular clinical and laboratory review • Balanced healthy diet	**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 hepatitis with jaundice— Refer IMMEDIATELY or Urgent depending on severity and patient's condition. • Obstructive jaundice (dilated ducts on imaging) Refer - Urgent • Unexplained non-obstructive cholestatic jaundice Refer - Urgent

ASCITES

Evaluation	Management	Referral Guidelines
• Acute onset or chronic • History of cirrhosis, chronic liver diseases, ascites, hepatitis, jaundice • Risk factors for liver diease as above including alcohol use, overseas travel, viral hepatitis • Drug history: oral contraceptive pill (women) • Symptoms: fever, abdominal pain, weight gain, jaundice • Liver functions tests (as above) • Liver ultrasound with Doppler - Features of cirrhosis, portal hypertension (dilated portal vein, varices, splenomegaly) - Hepatic vein thrombosis (Budd Chiari) - Portal vein thrombosis • FBE, INR, U&E (renal function)	• Avoid alcohol • Rest • Stop hepatotoxic drugs • Dietary salt restriction • Fluid restriction <1.5 l/d	**Refer to Gastroenterology:** • Symptomatic marked ascites or new onset of ascites - Refer IMMEDIATELY - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre. • Mild-moderate ascites: Refer— Urgent to The Alfred Liver Clinic and/ or send to The Alfred Emergency and Trauma Centre if other features of liver failure.

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ABNORMAL LIVER FUNCTION TESTS AND HEPATITIS

Evaluation	Management	Referral Guidelines
Acute (<6 weeks) vs chronic • History as for jaundice including age, sex • History of autoimmune disease, altered menstruation - ? Autoimmune hepatitis • Features of metabolic syndrome: obesity, diabetes, HT, hyperlipidaemia • Family history: coeliac disease, cirrhosis • Signs of chronic liver disease Additional investigations to above: • ANA, SMA, AMA • Ferritin, iron studies • Coeliac screen • IgG, IgM • Serum lipids, glucose	**Suspected fatty liver:** • Address obesity, diabetes hypercholesterolaemia • Lifestyle changes: low fat diet, exercise program • Avoid alcohol • Avoid hepatotoxic drugs • Monitor LFTs • Fibroscan to assess severity **Non-fatty liver:** • Healthy diet, modify or abstain from alcohol	**Refer to Gastroenterology:** • Suspected chronic liver disease: Refer - Urgent • Moderate to severe abnormal LFTs or cause uncertain: Refer - Urgent • Abnormal or mild LFTs persist despite appropriate lifestyle changes: Refer - Routine • Suspected need for liver biopsy: Refer - Urgent

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Pancreaticobiliary:

PANCREATIC AND BILIARY DISORDERS

Evaluation

- Pain (biliary - RUQ/epigastric; pancreatic - central radiating to back)
- Jaundice: painless with bilirubin above 200 suggests malignancy. Epigastric/ RUQ tenderness +/- fever, with bilirubin below 200 suggests stone disease
- Charcot's triad (jaundice, pain, fever = cholangitis)
- Steatorrhoea or malabsorption suggests exocrine pancreatic insufficiency
- Risk factors for pancreatitis
  - Alcohol consumption
  - Known gallstones or previous cholecystectomy?
  - Preceding trauma?
  - Drugs causing pancreatitis?
  - Hypertriglyceridaemia/ hypercalcaemia?
- Bloods
  - LFTs, FBEs, U&Es, clotting
  - Lipase, lipids, calcium, CRP
- Abdominal Ultrasound should be the initial investigation for jaundice or RUQ pain
- Subsequent imaging may include
  - CT scan, MRCP, endoscopic ultrasound
  - ERCP almost never used as a diagnostic procedure

The Alfred Radiology request form

Management

Uncomplicated gallstones

- Observe

Acutely complicated gallstones (cholangitis, biliary colic, cholecystitis)

- Refer to The Alfred Emergency and Trauma Centre

Acute pancreatitis

- Refer to The Alfred Emergency and Trauma Centre

Chronic pancreatitis

- Low fat diet
- Pancreatic enzyme supplements
- Non-narcotic analgesia
- Alcohol abstention
- Check for secondary diabetes

Referral Guidelines

Refer to Gastroenterology or General Surgery:

Admit acutely – IMMEDIATE referral - phone Gastroenterology Registrar on 9076 2000 and send to The Alfred Emergency and Trauma Centre:

- Cholangitis
- Moderate/severe pancreatitis
- Complicated CBD stones
- Cholecystitis

Discussion with Gastroenterology registrar re early review or admission:

- Jaundice thought to be obstructive
- CBD stones
- Biliary/pancreatic neoplasm

Elective referral to Gastroenterology or General Surgery:

- Uncomplicated gallstones
- Chronic pancreatitis
- Abnormal LFTs
- Biliary/pancreatic imaging abnormalities

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FUNCTIONAL GASTROINTESTINAL DISORDERS

Suspected Irritable Bowel Syndrome / functional diarrhoea

Evaluation	Referral Guidelines
Please include: • FBE • Iron studies • Liver function tests • CRP • Coeliac serology Please also include if previously performed: • Results of prior endoscopy • Faecal calprotectin • Thyroid function tests • Stool microscopy and culture	Refer to Functional Gut Clinic. Resources are available at the Gastroenterology Society of Australia IBS4GPs website.

Suspected functional dyspepsia

Evaluation	Referral Guidelines
Please include: • FBE • Iron studies • Liver function tests • H. Pylori status Please also include if previously performed: • Results of prior upper GI endoscopy • Abdominal USS	Refer to Functional Gut Clinic. Resources are available at the Gastroenterology Society of Australia IBS4GPs website.

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FUNCTIONAL GASTROINTESTINAL DISORDERS

Chronic constipation

Evaluation	Referral Guidelines
Please include: • FBE • Iron studies Please also include if previously performed: • Results of prior endoscopy • Calcuim • Thyroid function tests	Refer to Functional Gut Clinic. Resources are available at the Gastroenterology Society of Australia IBS4GPs website.

Functional chronic abdominal pain (>6 months duration) without alteration in bowel habit

Evaluation	Referral Guidelines
Please include: • FBE • Iron studies • CRP Please also include if previously performed: • Results of any prior GI endoscopy • Any imaging studies eg Abdominal USS, CT, MRE	Refer to Functional Gut Clinic. Resources are available at the Gastroenterology Society of Australia IBS4GPs website.