### Referral Guidelines: General Surgery

#### Essential Referral Content

- 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 6938

#### Exclusion Criteria

- 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
- Cosmetic breast surgery is not offered at The Alfred - see: “Guidelines for Aesthetic Surgery on the Public Hospital Waiting List”

### Referral Process: General Surgery

**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 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.**

Further information regarding the specialists attending the General Surgery clinics are available here: Breast Endocrine & General Surgery, Colorectal Surgery, HepatoPancreatoBiliary Surgery & Oesophago-Gastric & Bariatric Surgery. 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 Surgical Registrar on call on 9076 2000.

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.

Date Issued: March 2006  
Last Reviewed: September 2018
### Immediate
**Direct to the Emergency & Trauma Centre**

- Threatened cervical airway obstruction
- Incarcerated hernia and/or symptoms of bowel obstruction, local tenderness or erythema.
- Diverticulitis with systemic sepsis
- Large bowel obstruction
- Severe PR bleeding
- Perianal abscess
- Obstructive jaundice
- Haematemesis
- Melaena
- Acute pancreatitis
- Acute cholecystitis
- Acute, severe biliary pain
- Cachexia
- Acute dysphagia with intolerance of fluids
- Severe abdominal pain or intolerance of fluids after bariatric surgery
- Fever or shortness of breath after bariatric surgery

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### Urgent
**Appointment timeframe within 30 days**

- Diagnosed breast malignancy - will be seen within 1 week of referral. Please contact Surgical Registrar on 9076 2000.
- Diagnosed or suspected upper GI tract malignancy—contact Oesophago-Gastric/Bariatric Surgical Registrar or OG Cancer nurse coordinator (Cate Milnes) via switchboard on 9076 2000.
- Diagnosed liver, pancreas, biliary or duodenal malignancy—contact the HepatoPancreatoBiliary Fellow via switchboard on 9076 2000.
- Breast lumps
- Pigmented skin lesions
- Head and neck masses
- Thyroid masses
- Adrenal masses
- Hernias that have required acute reduction
- Acute painful leg ulcers
- Uncomplicated hernia
- Benign lumps
- Inguinal hernia (for exceptions refer to notes)
- Parathyroid disease
- Adrenal abnormalities
- Confirmed or suspected colorectal cancer
- Suspected liver, pancreas, biliary or duodenal malignancy
- Dyspepsia and/or dysphagia to solids associated with weight loss and/or anaemia
- Known gallstones with ongoing biliary colic
- Gall-bladder mass or polyp >10mm
- Vomiting and/or severe reflux following bariatric surgery

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### Routine
**Appointment timeframe greater than 30 days depending on clinical need**

- Lipomas
- Breast screening (unless significant family history and refer to guidelines)
- Carpal tunnel
- Gastroesophageal reflux
- Hiatus hernia without pain or dysphagia
- Asymptomatic gallstones
- Recurrent cholecystitis
- Chronic pancreatitis
- Small gallbladder polyps
- Asymptomatic common bile duct stones
- Non-suspicious pancreatic cystic lesions
- Biliary dilatation without stone or mass

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Phone the Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.

Urgent cases must be discussed with the Surgical Registrar on call to obtain appropriate prioritisation and a referral faxed to 9076 6938.

Fax referral to 9076 6938

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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 Surgical Registrar on call on 9076 2000.
GENERAL SURGERY

Referral Guideline Contents

General referral guidelines

Miscellaneous General Surgery
- Hernia
- Skin (See also Plastic Surgery Guidelines)
- Venous (See Vascular Surgery Guidelines)

Breast, Endocrine & General Surgery (BES)
- Thyroid masses
- Parathyroid disease
- Neck masses
  - Painless masses
  - Painful masses
- Adrenal mass

Breast Disease
- Family history of breast disease
- Breast lump
- Breast pain
- Nipple discharge
- Nipple retraction
- Change in skin contour

Guide for investigation of a breast lump

Colorectal and General Surgery (CRS)

Diseases of the Colon
- Colorectal Cancer:
  - Confirmed Colorectal Cancer
  - Suspected Colorectal Cancer
- Ano-rectal Disease:
  - Haemorrhoids
  - Anal fistula
  - Anal fissure

Oesophago-Gastric & Bariatric Surgery (OGB)

Disorders of the oesophagus
- Dysphagia
- Reflux symptoms

Disorders of the stomach and duodenum

Bariatric surgery

HepatoPancreatoBiliary Surgery (HPB)

Symptomatic disorders of the pancreas, biliary tree and liver
- Gallbladder pain
  - Biliary colic
  - Cholecystitis
- Pancreatic/common bile duct pain
  - Pancreatitis
- Obstructive jaundice
  - Cholangitis
  - Pancreatic cancer
<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems are categorised under the following groupings, and managed by the corresponding service:</td>
<td>A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Some appropriate investigation by the referrer will facilitate the referral process.</td>
<td>Most general surgical diagnoses require referral to specialist management. However, these guidelines are provided to give greater clarity in situations of the primary/secondary interface of care. Clearly telephone/fax communication would enhance appropriate treatment.</td>
</tr>
<tr>
<td><strong>BREAST, ENDOCRINE AND GENERAL SURGERY UNIT (BES):</strong></td>
<td></td>
<td>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 General Surgery registrar on call on 9076 2000.</td>
</tr>
<tr>
<td>• Neck masses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Thyroid masses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adrenal masses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parathyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Breast disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COLORECTAL AND GENERAL SURGERY UNIT (CRS):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inflammatory bowel disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diseases of the colon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anorectal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OESOPHAGO-GASTRIC AND BARIATRIC SURGERY UNIT (OGB):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disorders of the oesophagus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disorders of the stomach and duodenum</td>
<td></td>
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<tr>
<td>• Bariatric surgery</td>
<td></td>
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</tr>
<tr>
<td><strong>HEPATOPANCREATOBILIARY SURGERY UNIT (HPB):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disorders of the pancreas</td>
<td></td>
<td></td>
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<tr>
<td>• Disorders of the biliary tree &amp; liver</td>
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</tr>
<tr>
<td><strong>MISCELLANEOUS GENERAL SURGERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Venous</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HERNIA

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incisional hernia</td>
<td>Pain in groin sometimes precedes lump. Pain may be colicky and associated with vomiting (intestinal obstruction)</td>
<td>Refer for IMMEDIATE admission via The Alfred Emergency &amp; Trauma Centre if incarcerated and symptoms of bowel obstruction, local tenderness or erythema. If uncomplicated, refer to any General Surgery clinic - urgent or routine according to clinical indication.</td>
</tr>
<tr>
<td>Femoral hernia</td>
<td>Lump in groin - may be intermittent / reducible but is usually most obvious when patient is standing</td>
<td></td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>Diagnostic studies may include Ultrasound (only required if hernia can not be felt on examination.)</td>
<td></td>
</tr>
<tr>
<td>Umbilical hernia</td>
<td>The Alfred Radiology request form</td>
<td></td>
</tr>
</tbody>
</table>

### SKIN

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ganglia</td>
<td>USS of lesion +/- CT scan if malignancy suspected</td>
<td>Refer urgently if malignancy suspected, otherwise routine, depending on functional difficulties.</td>
</tr>
<tr>
<td>Lipomas</td>
<td>Include details of functional impairment in referral.</td>
<td></td>
</tr>
<tr>
<td>Sebaceous cysts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor skin lesions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VENOUS

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Refer to Vascular Surgery Guidelines:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vascular Surgery Referral and Management Guidelines</td>
</tr>
</tbody>
</table>
## Thyroid Masses

### Evaluation
- Solitary vs multi-nodular
- Euthyroid vs hypo/hyper thyroid
- Compression symptoms
- Risk factors
- Current medical treatment

### Management
- Hyper- or hypo-thyroid patients should be treated to render euthyroid
- Steroids for subacute thyroiditis

### Referral Guidelines
Refer urgently to Breast and Endocrine clinic any suspicious lesions, disease refractory to medical management or causing compression symptoms.

### Investigations
- FBE
- TFTs/Antibodies
- Ultrasound or CT thyroid
- FNA solitary nodule after imaging
- Nuclear Scan (Hyperthyroid only)

The Alfred Radiology request form

## Parathyroid Disease

### Evaluation
May be in conjunction with renal disease or part of a familiar syndrome such as MEN-1 (Multiple Endocrine Neoplasia type 1)

### Management

### Referral Guidelines
Refer urgently to Breast and Endocrine clinic for management

### Investigations
- PTH/Ca$^{2+}$

## Neck Masses - Painless

### Evaluation
Complete head and neck exam indicated for site of primary:
- TFTs
- Open biopsy is contraindicated
- CT or ultrasound

### Management

### Referral Guidelines
Referral to BES Clinic indicated if mass persists for two weeks without improvement.

Urgent referral if painless, progressive enlargement or if suspicion of metastatic carcinoma.

The Alfred Radiology request form
# NECK MASSES - PAINFUL

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete head and neck exam indicated for site of infection:</td>
<td>Appropriate antibiotic trial</td>
<td>Referral to BES Clinic indicated if mass persists for two weeks without improvement. Urgent referral if painless, progressive enlargement or if suspicion of metastatic carcinoma.</td>
</tr>
<tr>
<td>• FBE</td>
<td>- see <a href="#">ENT Otoaryngology Referral and Management Guidelines</a></td>
<td></td>
</tr>
<tr>
<td>• Cultures, when indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider HIV/intradermal TB/Paul Bunnell (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consider possible cat scratch disease (toxoplasmosis titres)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# ADRENAL MASS

**Evaluation**

Often incidentally found on CT. May be associated with hypertension (Conn’s syndrome or phaeochromocytoma)

**Investigations**

- Fine cut CT

[The Alfred Radiology request form](#)

- Serum K+
- Urinary catecholamines

**Management**

- Refer urgently all functioning lesions to BES
- Refer urgently non-functioning adenomas for review by BES for ongoing surveillance
- Refer urgently all adrenal masses >2cm
### Breast Disease

*Queries by phone to breast surgeons are welcome*

#### FAMILY HISTORY

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
</table>
| Request for assessment by a woman with a strong family history of breast cancer. | • For women with a positive family history, it is recommended that their baseline mammography is carried out 10 years before the age at which the mother was diagnosed.  
• Women who have a high risk, e.g. family or past history will require more active management. | Referral to a family cancer genetics clinic where possible. |

#### BREAST LUMP

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
</table>
| Triple assessment:  
• Clinical examination  
• Imaging (mammography and/or ultrasound)  
**The Alfred Radiology request form**  
• Fine needle aspiration cytology (± core biopsy)  
NB: If any of the investigations are inconclusive or don't correlate with the other results, then a benign result should not be accepted.  
• A fine needle aspiration (FNA) alone is an incomplete investigation. FNA may preclude effective mammography/clinical exam for up to 6 weeks. FNA should be after the radiological investigation to reduce the discomfort for the patient.  
• Surgeons prefer to see patient before FNA - especially if patient has a suspected small carcinoma, as it is difficult to assess a patient with bruising. | • General practitioner management initially for young women with tender, lumpy breasts and older women with symmetrical nodality, provided that they have no localised abnormality  
• Any lump that increases in size should be reviewed/referred  
• The BreastScreen program - 50 to 65 years - is funded to investigate asymptomatic patients only to the point of clear diagnosis. | Conditions that require referral to BES clinic – contact Surgical registrar and refer urgently:  
• Any new discrete lump  
• New lump in pre-existing nodality  
• Asymmetrically nodality that persists at review after menstruation  
• Abscess  
• Cyst persistently refilling or recurrent cyst |

#### BREAST PAIN

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
</table>
| Unilateral persistent mastalgia:  
• Mammography or breast USS  
**The Alfred Radiology request form**  
Localised areas of painful nodality:  
• Mammography or breast USS  
**The Alfred Radiology request form**  
Focal lesions:  
• Fine needle aspiration cytology | GP management initially for women with minor/moderate degrees of breast pain who do not have a discrete palpable lesion. | Refer to BES clinic:  
• If associated with a lump  
• Intractable pain not responding to reassurance, simple measures such as wearing a well-supporting bra, and common drugs  
• Unilateral, persistent pain in post-menopausal women |
### NIPPLE DISCHARGE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical examination</td>
<td></td>
<td>Refer to BES clinic:</td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td>All women aged 50 and over</td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td>Women under 50 with:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Bilateral discharge sufficient to stain clothes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Blood stained</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Persistent single duct</td>
</tr>
</tbody>
</table>

*The Alfred Radiology request form*

### NIPPLE RETRACTION

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical examination</td>
<td></td>
<td>Refer to BES clinic - nipple retraction or distortion, nipple eczema</td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Alfred Radiology request form*

### CHANGE IN SKIN CONTOUR

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Evaluation</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical examination</td>
<td></td>
<td>Refer to BES clinic if change in skin contour</td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Alfred Radiology request form*
Guide for Investigation of a Breast Lump
- Triage process for first presentation with no family or past history
(Adapted from General Surgery Review process, CDHB. 2001)

1. **<25 years**
   - Thickening
     - Concern
     - Observe
     - Reassure
   - Breast Lump
     - Concern
     - Ultrasound & FNA

2. **25-30 years**
   - Thickening
     - Concern
     - Observe
   - Breast Lump
     - Concern
     - Ultrasound ± Mammogram & FNA

3. **>30 years**
   - Thickening
     - Concern
     - Observe
   - Breast Lump
     - Concern
     - Mammogram Ultrasound & FNA

**NOTE:** The initial investigation of choice for symptomatic women are mammograms for women >30 years and ultrasound for women <30 years. (For women 30-35 years some radiologists recommend ultrasound)

Women who have a high risk eg family or past history will require more active management.
# DISEASES OF THE COLON

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History including:</strong></td>
<td>Acute mild diverticulitis: antibiotics.</td>
<td>Patients with:</td>
</tr>
<tr>
<td>• Family history</td>
<td></td>
<td>• diverticulitis with systemic sepsis</td>
</tr>
<tr>
<td>• Altered bowel habit</td>
<td></td>
<td>• large bowel obstruction</td>
</tr>
<tr>
<td>• Tenesmus</td>
<td></td>
<td>• severe PR bleeding</td>
</tr>
<tr>
<td>• Mass</td>
<td></td>
<td>should be referred immediately to the Alfred Emergency and Trauma Centre.</td>
</tr>
<tr>
<td>• Incomplete rectal emptying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Also refer to the <strong>Gastroenterology Referral Guidelines</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patients with: **diverticulitis** should be referred to the Colorectal Clinic for specialist opinion.

Patients with suspected or proven **inflammatory bowel disease** should be referred to the Gastroenterology Inflammatory Bowel Disease Clinic (Wednesday mornings).

---

## CONFIRMED COLORECTAL CANCER

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History including:</strong></td>
<td>Consider iron replacement while awaiting investigations</td>
<td>Patients with <strong>confirmed colorectal cancer</strong> refer urgently to the Colorectal Outpatient Clinic: contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice.</td>
</tr>
<tr>
<td>• Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ascites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tenesmus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• History of Malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PR blood, pus, or mucus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Altered bowel habit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Flatus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incomplete rectal emptying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family history of inflammatory bowel disease, polyposis or cancer</td>
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<td></td>
</tr>
</tbody>
</table>

**Investigations**

- FBE
- LFTs
- CEA
- CT Scan of chest, abdomen and pelvis
- Biopsy result
- Colonoscopy or Barium enema result

*The Alfred Radiology request form*
## SUSPECTED COLORECTAL CANCER

**Evaluation**
- History including:
  - Weight loss
  - Medications
  - Ascites
  - Tenesmus
  - History of Malignancy
  - PR blood, pus, or mucus
  - Altered bowel habit
  - Flatus
  - Incomplete rectal emptying
  - Family history of inflammatory bowel disease, polyposis or cancer

**Investigations**
- FBE
- LFTs
- Colonoscopy

**Management**
- Patients who have signs or symptoms suggestive of colorectal cancer should be referred for urgent outpatient appointment for colonoscopy.
- Patients with suspicious bleeding or definite change in bowel habit should be referred to the Colorectal Outpatient clinic for colonoscopy.
- Patients who have vague lower abdominal or change in bowel habits (to constipation) should be referred for Open Access Endoscopy clinic:
  - The Alfred Gastrointestinal Endoscopy Service request form
  - Endoscopy Referral Guidelines
  - Gastroenterology Service

**Referral Guidelines**
- Contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice.
- Guidelines for screening colonoscopy – refer to NH&MRC Colorectal cancer guidelines

## HAEMORRHOIDS

**Evaluation**
- History of ano-rectal bleeding
- Prolapse and thrombosis
- Evaluation:
  - PR
  - Proctoscopy
  - Sigmoidoscopy

**Management**
- Lifestyle/dietary advice/ modification
- Proprietary creams/ suppositories

**Referral Guidelines**
- Refer for colonoscopy if underlying disease suspected
- Points for concern:
  - An associated change in bowel habit
  - Blood mixed with stool
  - Associated pain and discomfort in the absence of thrombosis or other pathology such as a fissure
  - Palpable mass on rectal examination
  - Copious bleeding with associated anaemia

## ANAL FISTULA

**Evaluation**
- History of recurrent perianal abscesses, discharge sinus, and pervious drainage operation
- Evaluation:
  - PR
  - Proctoscopy
  - Sigmoidoscopy

**Referral Guidelines**
- Refer to CRS clinic for management and exclusion of associated disease.
# ANAL FISSURE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History of pain with and after defecation.</td>
<td>Rectogesic/faecal softeners</td>
<td>Refer to CRS clinic for management and exclusion of associated disease.</td>
</tr>
<tr>
<td>• Attacks may be intermittent or prolonged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation may be difficult due to spasm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Note anal tag</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Oesophago-Gastric Surgery

### DISORDERS OF THE OESOPHAGUS

#### Dysphagia

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Particularly important is any history of:</td>
<td>Diagnostic studies may include (depending on history):</td>
<td>• Refer to Oesophago-Gastric/Bariatric Surgery if oesophageal aetiology suspected or hiatus hernia</td>
</tr>
<tr>
<td>• Loss of weight</td>
<td>• Gastroscopy</td>
<td>If malignancy suspected, refer - urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.</td>
</tr>
<tr>
<td>• Anaemia</td>
<td>• Barium swallow/meal</td>
<td></td>
</tr>
<tr>
<td>• Progressive Dysphagia</td>
<td></td>
<td></td>
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<tr>
<td>• Liquids Vs solids</td>
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</tr>
<tr>
<td>May include history or findings of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Foreign body ingestion</td>
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<td></td>
</tr>
<tr>
<td>• Gastro-oesophageal motility disorder</td>
<td></td>
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<tr>
<td>• Neoplasm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nocturnal choking or coughing attacks</td>
<td></td>
<td></td>
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<tr>
<td>• Scleroderma</td>
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### Reflux Symptoms

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>May include history of findings of:</td>
<td>Lifestyle modification (weight loss, smaller meals, smoking cessation, bed head raise, etc.)</td>
<td>Refer to Oesophago-Gastric/Bariatric Surgery if medication is required for 6 weeks or more, or if symptoms of weight loss, anaemia or dysphagia are evident. The patient should attend with results of a recent gastroscopy.</td>
</tr>
<tr>
<td>• Heartburn</td>
<td>A trial of PPI therapy may be appropriate:</td>
<td></td>
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<tr>
<td>• Water brash</td>
<td>• Should have gastroscopy if symptoms don’t resolve after 6 week trial of PPIs OR if there is weight loss, haematemesis, iron deficiency anaemia, age &gt;45, dysphagia etc.</td>
<td>If severe reflux symptoms following bariatric surgery refer - urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.</td>
</tr>
<tr>
<td>• Volume reflux / regurgitation</td>
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<tr>
<td>• Nocturnal choking or coughing attacks</td>
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<tr>
<td>• Odynophagia</td>
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<tr>
<td>• Atypical symptoms include cough, and asthma, best initially screened via respiratory clinic</td>
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## DISORDERS OF THE STOMACH AND DUODENUM

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
<th>Referral Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pain:</td>
<td>Non-Acute</td>
<td>Acute</td>
</tr>
<tr>
<td>- Site</td>
<td>• Review other medications eg NSAID’s, prednisone</td>
<td>Refer to The Alfred Emergency &amp; Trauma Centre for IMMEDIATE admission (suspected perforation, haematemesis or malaena)</td>
</tr>
<tr>
<td>- Acute or chronic</td>
<td>• Lifestyle modifications</td>
<td>If malignancy suspected, refer - urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.</td>
</tr>
<tr>
<td>- Continuous or episodic</td>
<td></td>
<td><strong>Non-Acute</strong></td>
</tr>
<tr>
<td>• Nausea and vomiting</td>
<td></td>
<td>• If inadequate response to treatment after two months, refer for endoscopy</td>
</tr>
<tr>
<td>• Weight loss</td>
<td></td>
<td>• Pain with weight loss or pain with anaemia</td>
</tr>
<tr>
<td>• Haematemesis and/or malaena</td>
<td></td>
<td>• Post-prandial vomiting: refer for endoscopy.</td>
</tr>
<tr>
<td>• Anaemia</td>
<td></td>
<td>• If specialist follow up required after endoscopy refer to Oesophago-Gastric/Bariatric Surgery</td>
</tr>
<tr>
<td>• Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Post prandial fullness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Alcohol intake</td>
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</tbody>
</table>

Breath testing may be useful to confirm presence of *H. pylori*. 
BARIATRIC SURGERY

Alfred Health has introduced a Health Improvement and Weight Management Program for patients to complete prior to receiving an outpatient appointment in the Bariatric Surgery Clinic. Patients will receive and invitation to participate in the program within 6 months of being referred to the service.

The aim of the Health Improvement and Weight Management Program is to support patients to lead a healthy lifestyle and improve their wellbeing. If patients do proceed to undergo bariatric surgery, the aim is to reduce surgical risk by improving general health.

The program includes a number of steps the patient is required to complete, and it is compulsory to complete all steps prior to receiving an outpatient appointment.

On completion of the program, an outpatient appointment is scheduled in the Bariatric Surgery multidisciplinary clinic where patients are assessed by a specialist bariatric consultant, and if required a Respiratory and/or General physician specialising in management of obesity.

Is my patient suitable?

In accordance with the Department of Health and Human Services Framework for Bariatric Surgery, candidates for the program should:

- Have a BMI >40; or BMI>35 with two or more significant obesity related co-morbidities, such as:
  - Hypertension requiring medication
  - Obstructive sleep apnoea
  - Obesity hypoventilation syndrome
  - Dyslipidaemia
  - Type 2 diabetes mellitus
  - Pulmonary hypertension
  - Non-alcoholic steatohepatitis (fatty liver)

- Be over 18 years of age at time of referral.
- Be under 65 years of age at time of surgery. (Please note wait time for surgery may be lengthy)
- Have attempted but failed to achieve or maintain clinically beneficial weight loss using non-surgical measures.

How do I make a referral?

1. Complete a patient referral, Bariatric Clinic Screening Assessment form. Please note referrals will not be accepted if the completed assessment form is not included.

2. Fax the referral and completed assessment forms to 9076 0113.

What happens if the referral is accepted?

- Patients will be required to complete a Bariatric Health questionnaire which will be sent on acceptance of referral.
- Patients are required to attend an information session (1.5 hours duration) to learn more about obesity and the available treatment options.
- Patients are required to actively participate in an 8 week online Health Improvement and Weight Management program.

On completion of these requirements, patients will then receive an appointment to attend the multidisciplinary Bariatric Surgery clinic and discuss the options for management.
GALLBLADDER PAIN

**Evaluation**
- Epigastric, radiating around the costal margin to the scapula region
- Frequently post-prandial
  ⇒ Biliary colic
  ⇒ Persistent gallbladder/right upper quadrant pain and sepsis consider cholecystitis

**Management**
- Pre-referral investigations to consider if appropriate:
  - FBE, U&E, LFT, lipase
  - Hepatitis serology
  - Ca 19.9 for suspected pancreas or biliary malignancy
  - AFP for suspected hepatocellular carcinoma
  - Biliary ultrasound
  - CT liver – Quad Phase for newly diagnosed liver lesions
  - CT pancreas protocol for pancreatic lesions

**Referral Guidelines**
- If cholecystitis is suspected, cholecystectomy is usually indicated—refer IMMEDIATELY - phone the HepatoPancreaticoBiliary Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre.
- Biliary colic—consider outpatient referral as cholecystectomy may be indicated.

PANCREATIC/COMMON BILE DUCT PAIN

**Evaluation**
- Sharper epigastric pain radiating through to the back
  ⇒ Pancreatic pain +/- sepsis and nausea/vomiting—consider pancreatitis

**Management**
- Pre-referral investigations to consider if appropriate:
  - FBE, U&E, LFT, lipase
  - Hepatitis serology
  - Ca 19.9 for suspected pancreas or biliary malignancy
  - AFP for suspected hepatocellular carcinoma
  - Biliary ultrasound
  - CT liver – Quad Phase for newly diagnosed liver lesions
  - CT pancreas protocol for pancreatic lesions

**Referral Guidelines**
- If pancreatitis is suspected, inpatient management is usually indicated—refer IMMEDIATELY - phone the HepatoPancreatoBiliary Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre.
## OBSTRUCTIVE JAUNDICE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obstructive jaundice:</strong></td>
<td>Pre-referral investigations to consider if appropriate:</td>
</tr>
<tr>
<td>• Associated with obstructive LFTs</td>
<td>• FBE, U&amp;E, LFT, lipase</td>
</tr>
<tr>
<td>• Mixed conjugated/unconjugated bilirubin</td>
<td>• Hepatitis serology</td>
</tr>
<tr>
<td>• Biliary dilatation on imaging</td>
<td>• Ca 19.9 for suspected pancreas or biliary malignancy</td>
</tr>
<tr>
<td>⇒ Pain, sepsis and jaundice—consider cholangitis</td>
<td>• AFP for suspected hepatocellular carcinoma</td>
</tr>
<tr>
<td>⇒ Painless jaundice—consider pancreas cancer</td>
<td>• Biliary ultrasound</td>
</tr>
<tr>
<td></td>
<td>• CT liver – Quad Phase for newly diagnosed liver lesions</td>
</tr>
<tr>
<td></td>
<td>• CT pancreas protocol for pancreatic lesions</td>
</tr>
</tbody>
</table>

| Referral Guidelines                             | If jaundice/cholangitis/suspected pancreas cancer—refer IMMEDIATELY for acute and definitive management - phone the HepatoPancreatoBiliary Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre. |