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
- Gastro-oesophageal reflux in pregnancy

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 Oesophago-Gastric/Bariatric Surgical Registrar on call on 9076 2000.**
REFERRAL PRIORITY: OESOPHAGO-GASTRIC SURGERY

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.

<table>
<thead>
<tr>
<th>IMMEDIATE</th>
<th>URGENT</th>
<th>ROUTINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct to the Emergency &amp; Trauma Centre</td>
<td>Appointment timeframe within 30 days</td>
<td>Appointment timeframe greater than 30 days depending on clinical need</td>
</tr>
</tbody>
</table>

- Haematemesis
- Melaena
- 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
- 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.
- Dyspepsia and/or dysphagia to solids associated with weight loss and/or anaemia
- Vomiting and/or severe reflux following bariatric surgery
- Gastroesophageal reflux
- Hiatus hernia without pain or dysphagia

Phone the Oesophago-Gastric/Bariatric Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre. Urgent cases must be discussed with the Oesophago-Gastric/Bariatric Surgical Registrar on call to obtain appropriate prioritisation and a referral faxed to 9076 6938. Fax referral to 9076 6938

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 Oesophago-Gastric Surgical Registrar on call on 9076 2000.
## 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>
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<td></td>
</tr>
<tr>
<td>• Liquids Vs solids</td>
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<td></td>
</tr>
<tr>
<td>May include history or findings of:</td>
<td></td>
<td></td>
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<tr>
<td>• Foreign body ingestion</td>
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<td></td>
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<tr>
<td>• Gastro-oesophageal motility disorder</td>
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<td></td>
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<tr>
<td>• Neoplasm</td>
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<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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</tbody>
</table>

## Referral Guideline Contents

### Disorders of the oesophagus
- **Dysphagia**
- **Reflux symptoms**

### Disorders of the stomach and duodenum
**Gallbladder pain**

### 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>If severe reflux symptoms following bariatric surgery refer - urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.</td>
</tr>
<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>
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<tr>
<td>• Volume reflux / regurgitation</td>
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<td></td>
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<tr>
<td>• Nocturnal choking or coughing attacks</td>
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<td></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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</tbody>
</table>
## DISORDERS OF THE STOMACH AND DUODENUM

### Evaluation
- Pain:
  - Site
  - Acute or chronic
  - Continuous or episodic
- Nausea and vomiting
- Weight loss
- Haematemesis and/or malaena
- Anaemia
- Medications
- Post prandial fullness
- Alcohol intake

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

### Management

#### Non-Acute
- Review other medications eg NSAID’s, prednisone
- Lifestyle modifications

#### Acute
- Refer to The Alfred Emergency & Trauma Centre for IMMEDIATE admission (suspected perforation, haematemesis or malaena)
- If malignancy suspected, refer -- urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.

### Referral Guidelines

#### Non-Acute
- If inadequate response to treatment after two months, refer for endoscopy
- Pain with weight loss or pain with anaemia
- Post-prandial vomiting: refer for endoscopy.
- If specialist follow up required after endoscopy refer to Oesophago-Gastric/Bariatric Surgery

#### Acute
- Refer to The Alfred Emergency & Trauma Centre for IMMEDIATE admission (suspected perforation, haematemesis or malaena)
- If malignancy suspected, refer -- urgent, and contact the Oesophago-Gastric/Bariatric Surgery registrar.

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## GALLBLADDER PAIN

### Evaluation
**Gallbladder pain:**
- 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.