

# Monash Health Referral Guidelines

## UPPER GI / HEPATOBILLARY

### EXCLUSIONS

Services not offered by Monash Health

- Liver Transplant
- Patients under 18 years of age: [Click here](#) for Monash Children's Gastroenterology guidelines

### CONDITIONS

#### UPPER GASTRO-INTESTINAL

[Oesophageal Cancer](#)

[Peptic Ulcer Disease](#)

[Gastro-Oesophageal Reflux Disease \(GORD\)](#)

[Hiatus Hernias](#)

[Achalasia](#)

[Hyperplenism](#)

#### HEPATICO-BILARY

[Liver Cancer](#)

[Jaundice / Obstructed Jaundice](#)

[Gallstones](#)

[Gallbladder Polyps](#)

### PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral**.

#### EMERGENCY

For emergency cases please do any of the following:

- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

#### URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

#### ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit:  
Dr Liang Low

Program Director:  
A/Prof. Alan Saunder

Last updated:  
24/08/2020

# Monash Health Referral Guidelines

## UPPER GI / HEPATOBILLARY

### REFERRAL

How to refer to  
Monash Health

#### Mandatory referral content

##### Demographic:

Full name  
Date of birth  
Next of kin  
Postal address  
Contact number(s)  
Email address  
Medicare number  
Referring GP details  
including **provider number**  
Usual GP (if different)  
Interpreter requirements

##### Clinical:

Reason for referral  
Duration of symptoms  
Management to date and response to  
treatment  
Past medical history  
Current medications and medication  
history if relevant  
Functional status  
Psychosocial history  
Dietary status  
Family history  
Diagnostics as per referral guidelines



[Click here](#) to download the outpatient referral form

### CONTACT US

#### Medical practitioners

To discuss complex & urgent referrals  
contact on call Upper GI / Hepatobiliary  
registrar via main switchboard: **9594 6666**

#### Submit a fax referral

Fax referral form to Specialist Consulting  
Services: 9594 2273

#### General enquiries

Phone: 1300 342 273

Head of unit:  
Dr Liang Low

Program Director:  
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Last updated:  
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## UPPER GASTRO-INTESTINAL

### OESOPHAGEAL CANCER



#### WHEN TO REFER?

#### Presentation

- Dysphagia, odynophagia
- Loss of weight
- Anaemia
- Haematemesis or melaena

#### Urgent

Refer after initial work-up

#### Initial GP Work Up

- FBE, iron studies
- Gastroscopy & biopsy

#### Management Options for GP

- Commence PPI
- Ensure adequate nutrition (supplements)

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### PEPTIC ULCER DISEASE



#### WHEN TO REFER?

#### Presentation

- Dyspepsia not relieved after commencing PPI
- Alarm symptoms
  - Dysphagia
  - Loss of weight
  - Anaemia
  - Palpable mass
  - Haematemesis or melaena

#### Urgent

Proven gastric/ duodenal ulcer on gastroscopy where alarm symptoms are present

#### Initial GP Work Up

- Gastroscopy & biopsy
- H. Pylori breath test

#### Management Options for GP

- Commence PPI
- Eradication therapy for H. Pylori if present

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## UPPER GASTRO-INTESTINAL (cont'd)

### GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)

### WHEN TO REFER?

#### Presentation

- Heartburn/ dyspepsia not relieved by PPI
- Atypical symptoms; cough, asthma, recurrent chest infections, halitosis, hoarse voice, poor dental hygiene
- Alarm symptoms
  - Dysphagia
  - Loss of weight
  - Anaemia
  - Mass
  - Haematemesis or melaena

#### Initial GP Work Up

- Consider gastroscopy if:
  - Typical symptoms not relieved with PPI
  - Atypical symptoms
  - Alarm symptoms (above)
  - >50years with long history of GORD

#### Management Options for GP

- Commence PPI
- Eradication therapy if H. pylori present

#### Urgent

- Evidence of complications:
  - Oesophagitis, Barretts, Strictures, Cancer
- Atypical Symptoms
- Alarm Symptoms
  - Young <40 years

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## UPPER GASTRO-INTESTINAL (cont'd)

### HIATUS HERNIA

### WHEN TO REFER?

#### Presentation

- PPI
- Atypical symptoms; cough, asthma, recurrent chest infections, halitosis, hoarse voice, poor dental hygiene, sour taste in mouth
- Volume reflux symptoms:
  - Regurgitation (Solids and liquids)
  - Difficulty in swallowing (liquids and solids) More common in patients with para esophageal hiatus hernia
  - Night time symptoms of reflux/regurgitation/choking
- Complications:
  - Oesophagitis
  - Stricture
  - Barretts/Cancer
  - Strangulation/Gastric volvulus (more common with para esophageal hiatus hernias) presenting with vomiting and chest pain
  - Haematemesis

#### Urgent

- Severe symptoms for investigation (as above)
- Failure of medical therapy (PPI) in an individual with known hiatus hernia in consideration for surgery.
- Consideration for surgical repair of Large/Giant hiatus hernia, even if asymptomatic

#### Initial GP Work Up

- Barium swallow
- Gastroscopy

#### Management Options for GP

- Commence PPI
- Consider specialist referral if symptoms persist despite PPI therapy or investigations suggest a symptomatic or a large hiatus hernia

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### ACHALASIA

### WHEN TO REFER?

#### Presentation

- Atypical dysphagia.
- Worse with liquids
- Temperature related
- Regurgitation post-prandial and nocturnal.
- Weight loss

#### Urgent

When barium swallow or gastroscopy suggests achalasia

#### Initial GP Work Up

- Barium swallow
- Gastroscopy

#### Management Options for GP

- Consider the diagnosis in your patients with atypical GORD like symptoms.

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## UPPER GASTRO-INTESTINAL (cont'd)

### HYERSPLENISM

### WHEN TO REFER?

#### Presentation

- Pancytopenia in a patient with an enlarged spleen
- Anaemia
- Infection
- Bleeding

#### Initial GP Work Up

- FBE, Smear, White cell differential
- LFTs, Coag
- Ultrasound (for size, portal hypertension, discreet splenic lesions)

#### Management Options for GP

- Identify and treat cause
- Common causes include:
  - Liver disease
  - Haematological malignancy
  - Autoimmune
  - Infective (HIV, EBV, endocarditis)
  - Storage (Gaucher)

#### Urgent

- Refer all patients to Haematology Clinic primarily
- Splenectomy considered in
  - Second line treatment in immune thrombocytopenia including ITP
  - Splenomegaly in primary myelofibrosis
  - Hereditary spherocytosis
  - Painful splenomegaly
  - To allow adjuvant treatment when multiple cytopenias due to hypersplenism are present
  - For diagnosis in the case of splenomegaly of unknown cause

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# HEPATICO-BILARY

## LIVER CANCER

### WHEN TO REFER?

#### Presentation

- May have history or signs of cirrhosis or chronic liver disease (HCC)
- May has history of previous cancer eg colorectal cancer, gastric cancer
- May present as an incidental mass on CT or Ultrasound

#### Urgent

Refer all patients

#### Initial GP Work Up

- Tumour markers (AFP CEA Ca19-9)
- Hepatitis serology
- Routine bloods LFTs, U&Es, FBE, INR
- CT scan or Ultrasound

#### Management Options for GP

- Refer to liver surgery clinic or Hepatology clinic

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## JAUNDICE / OBSTRUCTED JAUNDICE

### WHEN TO REFER?

#### Presentation

- Clinical jaundice
- Dark urine +/- pale stools
- Pruritus

#### Initial GP Work Up

- FBE
- U&E
- LFTs
- Ultrasound

#### Management Options for GP

- Refer all patients to either hepaticobiliary surgical outpatients or the Emergency Department.

#### Emergency

Send to the Emergency department if:

- Features of cholangitis, fevers, chills, sweats, rigors, vomiting, tachycardia, hypotensive
- Pain not controlled by simple analgesia.
- Bilirubin >100
- Acute renal impairment
- Significant pruritus
- Gallstones on ultrasound
- Otherwise refer for urgent outpatient appointment if clinically well.

#### Urgent

Other conditions that should be referred to the hepaticobiliary surgical clinic:

- Biliary dilatation
- Choledochal cyst
- Liver lesion/mass (except cirrhotic patients with a liver mass who should be referred to [Gastroenterology](#))
- Pancreatic cyst or mass

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## HEPATICO-BILARY (cont'd)

### GALLSTONES

### WHEN TO REFER?

#### Presentation

- Right upper quadrant pain
- Epigastric upper abdominal pain
- Nausea
- Bloating
- Postprandial symptoms
- Incidental finding on imaging.

#### Initial GP Work Up

- LFTs, FBE, U&E
- Ultrasound

#### Management Options for GP

- Clinical observation if asymptomatic and none of the following.
- Refer for surgical opinion if:
  - Biliary pain
  - Weight loss
  - Jaundice
  - Abnormal LFTs
  - Imaging shows thick walled GB, wall calcification/porcelain GB, calculi, GB mass or polyp, biliary ductal dilation

#### Emergency

Send to Emergency department if features of:

- Acute cholecystitis
- Acute severe pain not settling
- Fevers
- Vomiting
- Tachycardia
- Febrile marked tenderness over the gallbladder
- Guarding
- Positive Murphy's test
- Elevated white cell count >14

#### Urgent

Refer all other patients requiring a surgical opinion

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### GALLBLADDER POLYP

### WHEN TO REFER?

#### Presentation

- Usually asymptomatic

#### Initial GP Work Up

- LFTs
- Ultrasound

#### Management Options for GP

- Clinical and ultrasound surveillance if asymptomatic and none of the below indications for referral if surveillance ultrasound in 6 months, then yearly if no change.
- Refer for surgical opinion if:
  - Upper abdominal pain, weight loss, post prandial symptoms
  - Jaundice
  - Family history of biliary malignancy
  - Abnormal LFTs
  - Imaging shows:
    - Irregular polyp, polyp and calculi, GB wall calcification, invasion or other features suspicious for malignancy, biliary ductal dilatation.
    - Size >7mm, increasing in size on surveillance.

#### Urgent

All patients requiring a surgical opinion

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