

Monash Health Referral Guidelines

ENDOCRINOLOGY

EXCLUSIONS

Services not offered by Monash Health

- Patients under 18 years of age: [Click here](#) for Monash Children's Endocrinology and Diabetes guidelines
- Patients presenting with Diabetes: refer to Monash Health [Diabetes Unit](#)

CONDITIONS

ADRENAL DISORDERS

- [Adrenal Insufficiency](#)
- [Adrenal Incidentaloma](#)
- [Glucocorticoid Excess \(Cushing's syndrome\)](#)
- [Hirsutism](#)
- [Hypertension \(excess Aldosterone\) or Pheochromocytoma](#)

ANDROLOGY

- [Klinefelter Syndrome](#)
- [Male Hypogonadism](#)

BONE AND MINERAL METABOLISM

- [Hypercalcaemia](#)
- [Hypocalcaemia](#)
- [Osteoporosis and metabolic bone disease](#)
- [Paget's disease](#)

PITUITARY DISORDERS

- [Pituitary Disorders](#)
- [Hyponatraemia](#)
- [Polydipsia/Polyuria](#)
- [Glucocorticoid Excess \(Cushings syndrome\)](#)

REPRODUCTIVE HEALTH

- [Amenorrhoea](#)

THYROID DISEASE

- [Hyperthyroidism](#)
- [Hypothyroidism](#)
- [Thyroid enlargement/Goitre](#)

OTHER

- [Hypoglycaemia \(Endocrine\)](#)

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:
Prof. Peter Fuller

Program Director:
Prof. William Sievert

Last updated:
08/05/2019

Monash Health Referral Guidelines

ENDOCRINOLOGY

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
Relevant pathology and
imaging reports (please refer
to specific guidelines)
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 Endocrinology on call 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

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ADRENAL DISORDERS

ADRENAL INSUFFICIENCY

Presentation

Acute:

- Cessation of glucocorticoid therapy
- Adrenal haemorrhage in severe illness

Chronic:

- Autoimmune, Tb, other adrenal disease
- Hypopituitarism

Initial GP Work Up

- Fatigue, weight loss,
- Pigmentation,
- Nausea/vomiting,
- Hypotension,
- Hyponatraemia/hyperkalaemia/hypoglycaemia

Investigations:

- Electrolytes, creatinine, glucose, cortisol, renin, aldosterone pituitary investigations if evidence of ACTH deficiency

Management Options for GP

Early discussion with Endocrinologist

WHEN TO REFER?

Emergency

If acute, call Endocrinologist on: 9594 6666 or refer to ED

Urgent

- Suspected or confirmed acute adrenal insufficiency
- Severe untreated chronic adrenal insufficiency

Routine

Established treated insufficiency

[BACK](#)

ADRENAL INCIDENTALOMA

Initial GP Work Up

- Establish whether the mass is either malignant and/or functional
- Dedicated adrenal CT scan with non-contrast images to establish density (Hounsfield Units)

To exclude a functional lesion:

- Blood pressure, electrolytes, renin,
- Aldosterone ratio
- 24 hr urinary catecholamines or plasma etanephrens
- Urinary free cortisol and overnight 1mg Dexamethasone
- Suppression test
- Testosterone
- DHEAS

Management Options for GP

N/A

WHEN TO REFER?

Urgent

Strong suspicion of malignancy or hypersecretion

Routine

Small low density lesion, no change over time, no features of hormonal excess.

[BACK](#)

ADRENAL DISORDERS (cont'd)

GLUCOCORTICOID EXCESS (Cushing's Syndrome)

WHEN TO REFER?

Presentation

- Exogenous glucocorticoids
- ACTH-secreting pituitary adenoma
- Ectopic ACTH secretion
- Adrenal adenoma, carcinoma

Initial GP Work Up

- Weight gain, fat distribution, hirsutism
- not specific; thin skin, bruising, striae
- more reliable indicators
- Measure 24 hour urine free cortisol and/or 0800-0900 plasma cortisol after 1 mg dexamethasone at 2300 to confirm or exclude cortisol excess.
- False positive results in obesity, polycystic ovary syndrome, depression, illness

Management Options for GP

Early discussion with Endocrinologist advised

Emergency

Patient decompensating eg marked myopathy, worsening diabetes etc, rapid onset.

Urgent

Significant burden of disease

Routine

All patients with suspected or confirmed endogenous Cushing's syndrome

[BACK](#)

HIRSUTISM

WHEN TO REFER?

Presentation

- Idiopathic/ familial increased androgen sensitivity
- Idiopathic ovarian androgen excess (polycystic ovary syndrome)

Rare causes:

- Late onset congenital adrenal hyperplasia
- Cushing's syndrome
- Functioning ovarian or adrenal tumour

Initial GP Work Up

- Teenage onset hirsutism with regular periods: idiopathic/ familial
- Teenage onset hirsutism with irregular periods: polycystic ovary syndrome
- Progressive hirsutism with masculinisation, plasma testosterone >5 nmol/L consider Cushing's syndrome, adrenal or ovarian tumour.

Investigations:

- Testosterone, SHBG, LH, FSH, prolactin, fasting glucose, lipids

Management Options for GP

N/A

Urgent

Progressive hirsutism, Cushingoid features, masculinisation, plasma testosterone >5 nmol/L

Routine

Significant hirsutism without evidence of severe androgen excess.

[BACK](#)

ADRENAL DISORDERS (cont'd)

HYPERTENSION

Presentation

- Pheochromocytoma
- Primary hyperaldosteronism (Conn's syndrome)
- Hyperaldosteronism: adrenal adenoma or bilateral hyperplasia
- Suppressed plasma renin, 'normal' or high aldosterone, high aldosterone: renin ratio

Initial GP Work Up

- Resistant, severe hypertension especially in younger adults
- Labile hypertension with adrenergic symptoms
- Unexplained hypokalaemia
- Adrenal mass
- Many drugs affect renin and aldosterone secretion: early discussion with Endocrinologist recommended

Investigations

- Electrolytes, creatinine, renin, aldosterone, 24 hour urine catecholamines

Management Options for GP

Early discussion with Endocrinologist advised

WHEN TO REFER?

Emergency

Malignant or poorly controlled hypertension; severe cardiovascular sequelae

Urgent

- Suspected pheochromocytoma
- Associated adrenal lesion with worrying CT characteristics
- Poorly controlled hypertension

Routine

- Suspected primary hyperaldosteronism
- Adrenal 'incidentaloma'

[BACK](#)

ANDROLOGY

KLINFELTER SYNDROME, MALE HYPOGONADISM



WHEN TO REFER?

Presentation

- Hypopituitarism
- Mumps orchitis, other testicular disease
- Significance of age related decline in total and free testosterone uncertain

Initial GP Work Up

- Low plasma total testosterone often due to low SHBG in overweight, insulin resistant men: normal free testosterone
- Calculated 'free androgen index' unreliable indicator of free testosterone in men

Investigations:

- Testosterone, SHBG
- LH, FSH, prolactin
- Bone densitometry
- Pituitary investigations as above if LH, FSH not elevated

Management Options for GP

Hypothyroidism can reasonably be managed in the GP setting

Urgent

- Recent onset
- Suspected hypopituitarism

Routine

- Confirmed hypogonadism

[BACK](#)

BONE AND MINERAL METABOLISM

HYPERCALCAEMIA

Presentation:

- Primary hyperparathyroidism
- Malignancy: solid tumours, myeloma,
- Other - sarcoidosis, other
- Elevated or high normal PTH: primary hyperparathyroidism
- Suppressed PTH: malignancy, other non-PTH mediated hypercalcaemia.

Initial GP Work Up

- Often asymptomatic
- Thirst, polyuria, renal colic
- Anorexia, constipation, nausea, vomiting
- Fatigue, confusion

Investigations

- Serum total calcium, albumin OR ionized calcium
- Electrolytes, creatinine, phosphate
- Parathyroid hormone
- Fasting AM urine calcium/creatinine
- Bone densitometry

Management Options for GP

N/A

WHEN TO REFER?

Urgent

Severely symptomatic hypercalcaemia

Routine

- All other symptomatic hypercalcaemia
- All non-PTH mediated hypercalcaemia.
- Mild asymptomatic hyperparathyroidism

[BACK](#)

HYPOCALCAEMIA

Presentation

- Hypocalcaemia
- Hypoparathyroidism
- Vitamin D deficiency; causes include:
 - Lack of sunlight exposure
 - Malabsorption
 - Renal failure

Initial GP Work Up

- Severe, symptomatic with elevated phosphate: hypoparathyroidism
- Mild, asymptomatic with normal or low phosphate (unless renal impairment)
- Vitamin D deficiency

Investigations

- Total or ionized calcium
- Phosphate, electrolytes, creatinine, ALP
- Parathyroid hormone
- 25-hydroxy-vitamin D

Management Options for GP

- Calcium supplement
- Cholecalciferol (Vit D3)

WHEN TO REFER?

Emergency

Symptomatic hypocalcaemia

Urgent

Mild and severe, symptomatic hypocalcaemia

Routine

Mild, asymptomatic

[BACK](#)

BONE AND MINERAL METABOLISM (cont'd)

OSTEOPOROSIS AND METABOLIC BONE DISEASE WHEN TO REFER?

Presentation

- Bone density
- Age
- Postural instability
- Previous fracture
- Causes:
 - Idiopathic, familial, aging
 - Alcohol, smoking
 - Male, female hypogonadism (including postmenopausal)
 - Primary hyperparathyroidism
 - Glucocorticoid excess
 - Coeliac disease
 - Myeloma

Initial GP Work Up

- Estimate fracture risk
- Exclude/ detect specific causes of osteoporosis

History

- Falls, fractures
- Smoking, alcohol
- Early menopause, hypogonadism
- Glucocorticoid therapy
- Weight loss, diarrhoea, iron deficiency
- Document height; kyphosis, postural stability

Investigations

- Lateral X-ray thoracic and lumbar spine
- Total or ionised calcium
- Electrolytes, creatinine, 25-OH Vit D, alkaline phosphatase, TSH, FBE, ESR
- FSH, oestradiol, testosterone
- Serum and urine protein electrophoresis
- Coeliac disease serology

Management Options for GP

- Calcium; Vit D3 if Vit D deficient
- Weight bearing exercise
- Oestrogen or testosterone if hypogonadal
- Bisphosphonates

Emergency

Atypical femoral fracture including early changes

Urgent

- Due for dose of Denosumab
- Severe previously unrecognised
- Associated co-morbidities or secondary cause

Routine

- Difficult patients can be referred to the menopause clinic
- Premenopausal
- Male
- Glucocorticoid associated
- Hyperparathyroidism
- Other (suspected) metabolic bone disease
- Unresponsive to or intolerant of therapy
- Non-PBS indications for bisphosphonate therapy

[BACK](#)

BONE AND MINERAL METABOLISM (cont'd)

PAGET'S DISEASE



WHEN TO REFER?

Presentation

- Most patients asymptomatic
- Expansion, deformity, stress fractures of Pagetic bone
- Articular surface involvement
- Mechanical effects of deformity on adjacent joints

Initial GP Work Up

- Bone pain
- Progressive deformity
- Impaired hearing, other neurological effects

Investigations

- X-ray, bone scan
- Alkaline phosphatase
- Calcium, electrolytes, creatinine

Management Options for GP

Oral or intravenous bisphosphonates for pain attributable to Pagetic bone involvement, as per PBS indications

Urgent

Fracture, neurological involvement, heart failure.
Pain attributable to Pagetic bone involvement

Routine

Asymptomatic

[BACK](#)

PITUITARY DISORDERS

PITUITARY DISORDERS

WHEN TO REFER?

Presentation

- Headache
- Bitemporal hemianopia
- Hyperprolactinaemia: galactorrhoea, amenorrhoea, erectile dysfunction
- Acromegaly and Cushing's syndrome
- Gonadotrophins, TSH, ACTH, growth hormone deficiency
- Diabetes insipidus

Initial GP Work Up

- Consider possible mass effects, hormone excess, hormone deficiency in all patients with suspected pituitary disease
- Hypopituitarism not excluded by 'normal' pituitary hormone levels.

Investigations

- Prolactin
- Suspected Cushing's syndrome: 24 hour urine free cortisol
- Suspected acromegaly: growth hormone and IGF-1
- Suspected hypopituitarism: FSH, LH and oestradiol or testosterone; TSH and thyroxine; cortisol
- Visual fields charting and MR pituitary imaging

Management Options for GP

N/A

Emergency

- Visual compromise/ impairment and/ or severe headache with pituitary mass
- Features of secondary hypoadrenalism or Diabetes insipidus

Urgent

- Features of hypersecretion or hypopituitarism
- Headache

Routine

All other cases of suspected pituitary disease

[BACK](#)

PITUITARY DISORDERS (cont'd)

HYPONATRAEMIA

WHEN TO REFER?

Presentation

- Inappropriate ADH secretion
- SSRI's, other drugs
- Hypothyroidism
- Intracranial pathology
- Chest pathology
- Abdominal malignancy
- Sodium depletion:
 - Diuretic therapy
 - Vomiting, diarrhoea
 - Adrenal insufficiency
- Oedematous states (cardiac failure, cirrhosis, nephrotic syndrome)

Initial GP Work Up

- Assess mental state
- Assess volume status:
 - Euvolaemic: inappropriate ADH secretion
 - Hypovolaemic: sodium depletion
 - Oedema: cardiac failure, cirrhosis, nephrotic syndrome

Investigations

- Electrolytes, creatinine • serum and urine osmolality
- Urine sodium

Management Options for GP

Water retention caused by inappropriate ADH secretion usually readily responsive to fluid restriction

Emergency

- Sodium <125mM
- Seizures, altered conscious state
- Acute onset
- Symptomatic
- Other significant co-morbidities and or causes

Routine

Mild, chronic asymptomatic hyponatraemia

[BACK](#)

PITUITARY DISORDERS (cont'd)

POLYDIPSIA AND POLYURIA

WHEN TO REFER?

Presentation

- Diabetes mellitus
- Hypercalcaemia
- Hypokalaemia
- Chronic renal failure
- Primary polydipsia
- Diabetes insipidus

Initial GP Work Up

If not diabetes mellitus:

- Is polydipsia the cause (primary polydipsia) or consequence (hypercalcaemia, hypokalaemia, renal failure, diabetes insipidus) of polyuria?
- Fluid restriction is hazardous in patients with diabetes insipidus.

Investigations

- Glucose, electrolytes, calcium, creatinine
- Serum and urine osmolality after supervised water deprivation

Management Options for GP

Discuss with Endocrinologist

Emergency

- Significant hypernatraemia, hyperglycaemia or hypercalcaemia
- Severely symptomatic patients

Urgent

Mild or no symptoms but significant electrolyte disturbances

Routine

Patients with less severe, long-standing symptoms

[BACK](#)

GLUCOCORTICOID EXCESS (Cushing's Syndrome)

WHEN TO REFER?

Presentation

- Exogenous glucocorticoids
- ACTH-secreting pituitary adenoma
- Ectopic ACTH secretion
- Adrenal adenoma, carcinoma

Initial GP Work Up

- Weight gain, fat distribution, hirsutism
- not specific; thin skin, bruising, striae
- more reliable indicators
- Measure 24 hour urine free cortisol and/or 0800-0900 plasma cortisol after 1 mg dexamethasone at 2300 to confirm or exclude cortisol excess.
- False positive results in obesity, polycystic ovary syndrome, depression, illness

Management Options for GP

Early discussion with Endocrinologist advised

Emergency

Patient decompensating eg marked myopathy, worsening diabetes etc, rapid onset.

Urgent

Significant burden of disease

Routine

All patients with suspected or confirmed endogenous Cushing's syndrome

[BACK](#)

REPRODUCTIVE HEALTH

AMENORRHOEA



WHEN TO REFER?

Presentation

- Pregnancy, lactation
- Weight loss, exercise, illness (hypothalamic amenorrhoea)
- Hyperprolactinaemia
- Ovarian androgen excess (polycystic ovary syndrome)
- Primary ovarian failure (premature menopause)
- Pituitary disease

Initial GP Work Up

- Beta-HCG
- Prolactin, FSH, LH, oestradiol
- Testosterone, SHBG

Management Options for GP

N/A

Urgent

- Associated galactorrhea
- Features consistent with hypopituitarism
- Acute virilisation

Routine

Amenorrhoea for investigation and management

[BACK](#)

THYROID DISEASE

HYPERTHYROIDISM

WHEN TO REFER?

Presentation

- Graves' disease (+ ophthalmopathy)
- Toxic multinodular goitre, adenoma
- Thyroiditis: including subacute, postpartum, amiodarone

Initial GP Work Up

- Is the thyroid gland enlarged? If so, is it diffuse or nodular, nontender or tender?
- Is there associated ophthalmopathy?
- Cardiac rhythm, evidence of cardiac failure?

Investigations

- TSH, free T4, free T3, FBE, ESR
- Consider isotope scan to determine cause if not clinically evident
- Ultrasound is not helpful in this regard

Management Options for GP

- If hyperthyroid with Graves' disease, consider starting carbimazole + beta blocker (after discussion with Endocrinologist) followed by semi-urgent clinic appointment
- FBE essential before starting carbimazole or propylthiouracil; all patients must be warned of risk of drug induced agranulocytosis
- Toxic multinodular goitre and adenoma usually best treated with iodine-131 without prior carbimazole therapy; beta blocker often indicated
- Hyperthyroidism caused by thyroiditis usually transient, unresponsive to carbimazole; beta blocker often indicated
- Consider anticoagulation if in atrial fibrillation

Emergency

Clinically severe hyperthyroidism complicated by cardiac, respiratory failure

Routine

- All hyperthyroid patients should be referred to an endocrinologist
- Neutropaenia in patients taking carbimazole or propylthiouracil
- All other newly diagnosed hyperthyroid patients
- Recurrent hyperthyroidism
- Inadequate or unstable response to medication
- Intolerance of medication

[BACK](#)

THYROID DISEASE (cont'd)

HYPOTHYROIDISM

Initial GP Work Up

Measure both TSH and thyroxine to exclude secondary hypothyroidism (eg. pituitary adenoma).

Management Options for GP

Hypothyroidism can reasonably be managed in the GP setting

WHEN TO REFER?

Emergency

Symptomatic, altered conscious state, decompensation

Urgent

- TSH > 20
- Mild symptomatic

Routine

- Suspected or confirmed secondary hypothyroidism
- Problems with management of primary or secondary hypothyroidism.

[BACK](#)

THYROID ENLARGEMENT, GOITRE

Presentation

- Colloid, multi-nodular goitre
- Hashimoto's thyroiditis
- Colloid cyst
- Adenoma (non- or hyper-functioning)
- Carcinoma
- Recent enlargement
- Pain, tenderness
- Hoarse voice, dyspnoea, dysphagia
- Diffuse goitre, multi-nodular goitre or solitary nodule
- Lymphadenopathy
- Stridor, venous congestion on elevation of upper limbs

Thyroid pain usually caused by:

- Sub-acute thyroiditis
- Haemorrhage into nodule

Initial GP Work Up

- TSH; T4, T3 if TSH low
- ESR
- Thyroid peroxidase antibodies
- Thyroid ultrasound
- Fine needle aspiration cytology for solitary nodules, except if suppressed TSH ie hyper-functioning (benign) adenoma
- Isotope scan for diagnosis of multinodular goitre, hyperfunctioning adenoma

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Thoracic inlet obstruction

Urgent

- Severe pain
- Malignancy
- Stridor

Routine

- Uncertain diagnosis
- Local symptoms
- Surgery or radioiodine required

[BACK](#)

OTHER

HYPOGLYCAEMIA - ENDOCRINE

WHEN TO REFER?

Presentation

- Reactive (post-prandial)
- Young, lean, fit adults
- Impaired glucose tolerance, early T2D
- Dumping syndrome

Fasting:

- Insulin excess especially insulinoma
- Liver failure
- Hypoadrenalism
- Growth hormone deficiency (esp children)
- Sulphonylureas, insulin

Initial GP Work Up

- Fasting or postprandial symptoms?
- Relieved by carbohydrate?
- Low blood glucose at time of symptoms?
- Previous abdominal surgery
- Access to hypoglycaemic medication?

Investigations

- Capillary, plasma glucose at time of symptoms
- Fasting plasma, glucose and insulin

Management Options for GP

- Avoid simple sugars; high complex carbohydrate diet
- Exercise, weight loss to reduce insulin resistance

Emergency

Associated with adverse sequelae eg seizures

Urgent

- Compelling clinical evidence
- Worsening or more frequent hypoglycaemia

Routine

- All patients with fasting hypoglycaemia
- Suspected fasting hypoglycaemia
- Reactive hypoglycaemia not responding to diet

[BACK](#)