Monash Health Referral Guidelines
GASTROENTEROLOGY

EXCLUSIONS

Services not offered by Monash Health

Refer to Monash Children's Hospital for patients under 18 years old

Gall stones within the gall bladder: refer to Upper Gastrointestinal Surgery
Haemorrhoids: refer to Colorectal Surgery
Anal fissures: refer to Colorectal Surgery
Alcohol abuse without liver disease or GI involvement: refer to Addiction Medicine Unit

CONDITIONS

GASTRO-INTESTINAL TRACT

Dysphagia
Dyspepsia
Haematemesis and / or melaena
Vomiting & nausea
Weight loss
Altered bowel habit
Rectal bleeding
Diarrhoea
Lower abdominal pain

LIVER

Abnormal liver function tests
Hepatitis B
Hepatitis D
Hepatitis C
Fatty Liver (NAFLD)
Hepatocellular Carcinoma, Benign Liver lesions

PANCREATICOBILLIARY

Biliary colic
Choledocholithiasis (bile duct stones)
Biliary obstruction and pancreatic mass

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: Associate Professor Sally Bell
Program Director: Alan Saunder
Last updated: 30/06/2021

Monash Health Referral Guidelines
GASTROENTEROLOGY

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
Height and weight
Diagnostics as per referral guidelines

Click here to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact: the on-call gastroenterology registrar on 9594 6666

General enquiries

Phone: 1300 342 273

Submit a fax referral

Fax referral form to Specialist Consulting Services: 9554 2273

FIBROSCAN

Fibroscan® (transient elastography) is a non-invasive method of assessing liver fibrosis based on the measurement of liver stiffness.
Click here for more information

Submit a fax referral

- Fax referral form to (03) 9594 6250
- Tick appropriate box to indicate reason for referral
- Add current LFT, FBC and INR results

Click here to download the fibroscan referral form

Head of unit: Associate Professor Sally Bell
Program Director: Alan Saunder
Last updated: 30/06/2021

MonashHealth

GASTROINTESTINAL TRACT

CONDITION: DYSPAGIA, PHARYNGEAL OR OESOPHAGEAL

Initial GP Work Up

- (cf ENT Referral Recommendation)
- FBE
- History of stroke/neurological conditions smoking and alcohol history
- History of gastro-oesophageal reflux disease
- Diagnostic studies may include:
- Soft tissue studies of the neck.
- CXR/CT of chest
- Barium swallow +/- video fluoroscopy

Management Options for GP.

- Anti-reflux treatment
- Speech/Language Therapy assessment

WHEN TO REFER?

Urgent

- Dysphagia with food bolus or with haematemesis: should be referred urgently to Gastroenterology service.
- Dysphagia with alarm symptoms (acute onset or progressive symptoms, dysphagia for solids greater than liquids, anaemia, weight loss): Should be referred urgently to Gastroenterology service

Routine

Dysphagia without alarm symptoms: should be referred electively to Gastroenterology service

BACK

CONDITION: DYSPEPSIA, UPPER ABDOMINAL PAIN,REFLUX

Initial GP Work Up

- No response to empirical treatment
- Current drug regiment (NSAIDs, alcohol)
- Investigations: FBE, LFT, lipase
- Imaging to be considered: US or CT

Management Options for GP.

- Antacids
- Trial of PPI

WHEN TO REFER?

Routine

Refer if alarm symptoms or complications develop or becomes treatment non-responsive

BACK

CONDITION: HAEMATEMESIS AND/OR MELAENA

Initial GP Work Up

- Blood pressure and pulse rate, particularly in response to postural changes, are good indicators of haemodynamic stability
- FBE, Iron studies & Ferritin
- Medication history, previous ulcer disease, endoscopy / GI surgery

Management Options for GP

- Cease drugs
- If on anticoagulants refer to ED
- If Hb > 100 g/l & asymptomatic discuss with Gastroenterology service
- Oral iron supplements if confirmed iron deficient and refer

WHEN TO REFER?

Emergency

Emergency Department referral: Elderly patients (>70 years) and those with significant co-morbid disease are at very high risk.
Emergency Department referral: If Hb < 100 g/L, symptomatic or on anti-coagulants, refer for immediate hospital admission.

Urgent

To Clinic: (Iron Deficiency Anaemia): if HB >100g/L and asymptomatic

BACK

GASTROINTESTINAL TRACT (cont'd)

CONDITION: VOMITING AND NAUSEA

Initial GP Work Up

- Consider both GI and non-GI causes
- Associated symptoms
- Alcohol, medications or other drugs, marijuana

Investigations

- FBE
- Creatinine
- U & Es
- Calcium / phosphate
- TSH
- LFT
- Fasting glucose.
- Urinalysis.
- Urine beta HCG

Management Options for GP

- Symptomatic management with standard anti-emetics, etc
- Stop potential emetogenic drug(s) if appropriate
- Life style medications if indicated

WHEN TO REFER?

Emergency

Refer to ED if significant dehydration/unable to maintain intake of fluids

Routine

Refer to appropriate specialty service depending on the results and assessments

BACK

CONDITION: WEIGHT LOSS (10% body weight or more)

Initial GP Work Up

- Consider both GI and non-GI causes
- Definitively document reported weight loss
- Associated Symptoms

Investigations

- Consider GI and non-GI causes
- Onset
- Duration
- Associated symptoms (weight loss, bleeding, nocturnal symptoms)
- Drugs
- Family history colorectal cancer or polyps
- Previous abdominal surgery

Management Options for GP.

- Treat symptomatically as clinically appropriate

WHEN TO REFER?

Routine

Refer if alarm symptoms or complications develop or becomes treatment non-responsive

BACK

GASTROINTESTINAL TRACT (cont'd)

CONDITION: ALTERED BOWEL HABIT

WHEN TO REFER?

Urgent

Refer for consultation:

- patients who have functional bowel disorders with persistent or refractory symptoms
- If investigations abnormal and or clinical suspicion of malignancy (age > 40 years and or PR bleeding and/or family history of colorectal cancer or inflammatory bowel disease)

.

Initial GP Work Up

- Recent antibiotic usage
- Alarm symptoms (weight loss, bleeding)
- Family history of colorectal cancer, inflammatory bowel disease
- Recent travel or other exposure history

Investigations

- FBE,UEC, LFT, TSH, CRP
- Urinalysis
- Stools M, C & S + parasites
- Rectal examination
- NB: faecal occult blood testing is a screening test for bowel cancer not a diagnostic test in patients with altered bowel habit

Management Options for GP.

- Manage symptomatically if results suggest functional large bowel disorder (Irritable Bowel syndrome)
- E.g. Bulking agents, antispasmodics, anti-diarrheal, lifestyle advice, etc.

BACK

CONDITION: RECTAL BLEEDING

WHEN TO REFER?

Emergency

If large volume significant bleeding may need urgent admission to hospital with resuscitation and transfusion

Urgent

Active bleeding with anaemia or haemodynamic compromise: urgent referral to Gastroenterology Service

Initial GP Work Up

- Nature Bright red or dark
- Quantity
- Pain or Tenesmus
- Mixed or unmixed with stools
- Age and gender
- Chronic vs acute
- Family Hx colorectal cancer /Inflammatory bowel disease / Polyps

Investigations

- FBE
- Rectal examination

Management Options for GP

- Bleeding age > 40 years or significant bleeding age < 40 years should be referred to Gastroenterology Service
- If anal fissure or haemorrhoids, Rx symptomatically with bulking agents, life style advice and proprietary anal creams and suppositories, Anal fissure or haemorrhoids - refer to Colorectal Surgery
- If in doubt, specialist referral

BACK

GASTROINTESTINAL TRACT (cont'd)

CONDITION: DIARRHOEA

WHEN TO REFER?

Routine
Refer if significantly dehydrated, septic or an abdominal complication suspected
In cases of clinically suspected IBD refer to Gastroenterology Service

Initial GP Work Up

- Increased frequency and/or abnormal stool consistency
- Overseas travel
- Drugs
- Antibiotics, other medications
- Contact with others who have diarrhoea
- Vascular diseases
- Family Hx IBD, coeliac disease
- Extra-intestinal symptoms suggestive of IBD eg. uveitis, synovitis, erythema nodosum
- Known Colonic Disease
- Weight loss
- Dietary history/nutrition
- History of GI surgery

Investigations

- FBE, UEC, LFT, CRP, TFT, Folate & B12, Iron Studies & Ferritin
- Rectal examination
- Stools M, C & S + parasites
- Consider Clostridium difficile toxin (antibiotics)
- Sigmoidoscopy +/- rectal biopsy (if skilled)

Management Options for GP

- If infectious treat as appropriate and report to Public Health Authority
- Food handling and hygiene advice
- Seek advice form specialist where indicated eg. Amoebic dysentery
- If non-infectious treat symptomatically with standard antidiarrheals eg. Bulking agents or loperamide
- Seek specialist advice

BACK

CONDITION: LOWER ABDOMINAL PAIN

WHEN TO REFER?

Routine
Refer to appropriate speciality service depending on results or clinical response

Initial GP Work Up

- Consider GI and non-GI causes
- Onset
- Duration
- Associated symptoms (weight loss, bleeding, nocturnal symptoms)
- Drugs
- Family history colorectal cancer or polyps
- Previous abdominal surgery

Management Options for GP

- Treat symptomatically as clinically appropriate

BACK

LIVER

CONDITION: ABNORMAL LIVER FUNCTIONS TESTS

Initial GP Work Up

- Onset/duration
- Exposure risks including occupation, Overseas Travel, Sexual history, Drug history (pharmacological and recreational), alcohol consumption, possible hepatitis contacts, Needle stick injury (if at risk, occupation)
- Obesity, hyerlipidemia, metabolic syndrome
- Family history of liver disease or blood disorders
- Associated symptoms (pruritus, steatorrhea, bruising, dark urine, etc.)
- Signs of chronic liver disease

Investigations:

- Liver function tests
- Serology for EBV, CMV, HAV, HBV, HCV
- Iron studies, caeruloplasmin, copper,alpha-1 antitrypsin
- ANA, Anti Smith Muscle Ab, Anti Mitochondrial Antibody, coeliac serology, ANCA
- Serum Immunoglobulins
- Ultrasound abdomen
- FBE, platelets, haemolysis screen if isolated bilirubin elevation
- Prothrombin time/INR
- HbA1c, alpha foeto protein, Ca19.9

Management Options for GP

- No alcohol
- Stop potential hepatotoxic drugs
- Regular laboratory and clinical review and refer if no improvement

WHEN TO REFER?

Urgent

- Suspected acute, severe or fulminant hepatic failure – jaundice, abnormal ALT, prolonged INR, encephalopathy
- Obstructive jaundice (dilated ducts)
- Unexplained non-obstructive cholestatic jaundice (elevated alkaline phosphatase, bilirubin)
- Persistently abnormal liver function tests with no cause found from initial evaluation
- Positive serology

BACK

LIVER (cont'd)

CONDITION: HEPATITIS B

Initial GP Work Up

- High prevalence population (Southern and Eastern Europe, Southeast Asia, Pacific Islands, Aboriginal or Torres Strait Islander)
- Men who have sex with men
- Had an occupational or environment exposure to HBV
- Abnormal LFTs or evidence of liver disease with no apparent cause
- Extra hepatic manifestations of hepatitis: (eg. Vasculitis, peripheral neuropathy)
- Renal dialysis patient

Investigations

- Counselling (natural history, transmission risk, treatment)
- ALT
- HBsAg, HBeAg
- HBV DNA

Recommended Referral tests

- HBsAg, HBeAg
- HBV DNA
- FBE
- INR
- Creatinine
- Urea & Electrolyte
- Bilirubin
- Albumin
- Alpha fetoprotein
- Liver ultrasound
- HCV/HAV serology
- Ferritin

Management Options for GP

- Screening of family members and sexual contacts
- Immunisation of household and sexual contacts
- Referral to Liver Clinics

HEPATITIS D

- Hepatitis D only exists in the setting of Hepatitis B
- Therefore If patient tests positive for Hepatitis B surface antigen, all patients need to be screened for Hepatitis D

WHEN TO REFER?

Urgent

- Markedly abnormal LFT
- Jaundice
- Cirrhosis
- Elevated AFP
- Hepatitis B in pregnancy

Routine

Patients with normal or mildly abnormal LFT

BACK

LIVER (cont'd)

CONDITION: HEPATITIS C

WHEN TO REFER?

Routine
Refer to liver clinic

Initial GP Work Up

Risk Assessment

- Injecting drug use (ever)
- Imprisonment
- Received blood or blood products before 1990
- Received blood or blood products overseas
- Country of Birth (High prevalence)
- Had an occupational or environment exposure to HCV (needle stick injury)
- Abnormal LFTs or evidence of liver disease with no apparent cause
- Extra hepatic manifestations of hepatitis: (eg. vasculitis, peripheral neuropathy)
- Renal dialysis patient

Investigations

- Counselling (natural history, transmission risk, treatment)
- ALT
- Anti HCV
- HCV RNA

Recommended Referral Tests

- Anti HCV
- HCV RNA and genotype
- FBE
- INR
- Creatinine
- Urea & Electrolytes
- Bilirubin
- Albumin
- Alpha fetoprotein
- Liver ultrasound
- HBV/HAV serology
- Ferritin

Management Options for GP

HCV RNA negative

- May have cleared virus
- Repeat PCR
- Check LFTs in 12 months
- Discuss prevention

HCV RNA positive

- Refer to liver clinic
- Discuss mode of transmission /prevention
- Alcohol reduction
- Hepatitis A and B immunisation

BACK

LIVER

CONDITION: FATTY LIVER (NAFLD)

WHEN TO REFER?

Routine
Refer to liver clinic

Initial GP Work Up

Risk Assessment

- Overweight/obesity
- T2DM and/or metabolic syndrome (Hypertension, dislipidaemia, T2DM)
- Abnormal LFTs or evidence of liver disease with no apparent cause
- Signs of chronic liver disease

Recommended Referral tests

- Liver function tests
- Serology for EBV, CMV, HAV, HBV, HCV
- Iron studies, caerloplasmin, alpha-1, antitrypsin
- ANA, Anti Smith Muscle Ab, Anti Mitochondrial Antibody, Coeliac Serology
- FBE, platelets, haemolysis screen if isolated bilirubin elevation
- Prothrombin time/INR
- HbA1c, Lipids (trigs, LDL HDL, Insulin Glucose) alpha foeto protein
- TSH
- Liver ultrasound

Management Options for GP

- No alcohol
- Stop potential hepatotoxic drugs
- Counselling re weight loss, T2DM control
- Regular laboratory and clinical review and refer if no improvement

BACK

LIVER LESIONS - Hepatocellular Carcinoma, Benign Liver Lesions

WHEN TO REFER?

Urgent
Refer to liver clinic if elevated AfP and CA 19.9

Initial GP Work Up

Risk Assessment

- Newly diagnosed liver lesion
- Raised tumour markers e.g. AfP, CA19.9
- Overweight/obesity
- Known or exposure to risks of Viral Hepatitis Excess Ethanol intake current or past
- Family history of Liver lesions
- Significant recent weight loss
- Signs of chronic liver disease

Recommended Referral tests

- Abdominal Ultrasound
- Liver function tests
- Serology for EBV, CMV, HAV, HBV, HCV
- FBE, platelets, haemolysis screen if isolated bilirubin elevation
- Prothrombin time/INR
- alpha foeto protein, Ca19.9
- CT Abdominal (Liver focused), Quad phase with contrast (if lesion greater than 1cm)

Management Options for GP.

Refer urgently to Specialist Consulting liver clinic

BACK

PANCREATICOBILIARY

BILIARY COLIC JAUNDICE AND/OR FEVER and PANCREATIC MASS and DILATED COMMON BILE DUCT AND/OR PANCREATIC DUCT

Initial GP Work Up

Risk Assessment

- jaundice, RUQ abdominal pain, fever = ascending cholangitis
- Dark urine
- Alcohol consumption
- Known gallstones or previous cholecystectomy
- Drugs causing pancreatitis
- Family history of hyerlipidemia

Investigations

- LFT
- FBE
- lipase
- UEC
- lipids
- Ultrasound
- AXR's (sentinel loop; calcification)
- Calcium and phosphate
- Tumour markers AfP and CA 19.9

Management Options for GP

- Uncomplicated gallstones (eg found incidentally on ultrasound without symptoms).
- Observe
- Chronic Pancreatitis.
- Low fat diet
- Pancreatic enzyme supplements
- Non-narcotic analgesia
- Alcohol abstention

WHEN TO REFER?

Emergency

Refer to ED acutely

- Cholangitis
- acute pancreatitis
- CBD stones
- Cholecystitis

Routine

- Elective referral
- Uncomplicated gallstones
- Chronic pancreatitis

Urgent

- Pancreatic mass
- Dilated common bile duct and/or pancreatic duct

BACK