Monash Health Referral Guidelines
COLORECTAL

EXCLUSIONS

Services not offered by Monash Health

Patients under 18 years of age: Click here for Monash Children's Paediatric Surgery guidelines

CONDITIONS

RECTAL BLEEDING
Rectal bleeding

RECTAL PROLAPSE
Rectal prolapse

ANAL PAIN
Anal pain

COLORECTAL CANCER
Colorectal cancer

ANORECTAL CONDITIONS
Haemorrhoids
Anal fissure
Pruritus ani

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: Mr William Teoh

Program Director: Mr Alan Saunder

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REFERRAL
How to refer to Monash Health

Secure eReferral by HealthLink is now our preferred method of referral.

Find up-to-date information about how to send a referral to Monash Health on the **eReferrals page on our website**.

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact on call Colorectal Fellow via switchboard: 9594 6666

For diagnosed Colorectal Cancers contact Colorectal Cancer Nurse Coordinator:

Email: bowelcancercoordinators@monashhealth.org

Phone: 0466 300 228

General enquiries

Phone: 1300 342 273

RECTAL BLEEDING

RECTAL BLEEDING

Presentation:
- Fresh or dark
- Painful vs painless
- On paper or mixed in stool
- Small or large volume
- Occult bleeding (FOBT+ve)

Initial GP Work Up
- Rectal examination
- Palpable suspicious mass (see Colorectal Cancer guideline)
- Haemorrhoid (see Haemorrhoid guideline)
- Fissure (see Anal Fissure guideline)
- Rigid sigmoidoscopy (if skilled)
- Full Blood Count

Red flags
- Dark blood or mixed in stool
- Altered bowel habit
- Weight loss
- Abdominal pain
- Anaemia
- Patients >40years with rectal bleeding should be referred for colonoscopy

Management Options for GP
See guidelines for specific conditions

WHEN TO REFER?

Emergency
Large volume bleeding should be referred to emergency department

Urgent
- Refer if unable to determine benign diagnosis.
- Refer if suspicious mass
- FOBT positive

Routine
Refer if failure of conservative treatment

BACK

ANAL PAIN

ANAL PAIN

Presentation

- Pain and bleeding with defecation (fissure)
- Painful swelling (thrombosed haemorrhoid, abscess, cancer)

Initial GP Work Up

Rectal examination

- Thrombosed Haemorrhoid – tender and swollen haemorrhoid (see Haemorrhoid guideline)
- Anal Fissure – usually marked anal spasm (see Anal Fissure guideline)
- Perianal abscess/ischiorectal abscess
- Mass (see Colorectal Cancer guideline)

Management Options for GP

- See guidelines for specific conditions

WHEN TO REFER?

Emergency

Perianal or ischiorectal abscesses should be referred for surgical drainage

Urgent

Refer if suspicious mass

Routine

Refer if failure of conservative treatment – see relevant guidelines

BACK

ANORECTAL CONDITIONS

HAEMORRHOIDS

Presentation

- Bright bleeding on defecation – on paper, drip or spray (Grade 1)
- Prolapsing lump, spontaneous reduction (Grade 2)
- Prolapsing lump, manual reduction (Grade 3)
- Painful tender lump (Grade 4, thrombosed external)
- Discomfort, Itch
- Mucus discharge

Initial GP Work Up

- Rectal examination
  - If thrombosed haemorrhoid, check for necrosis
  - Rule out cancerous mass
- Rigid sigmoidoscopy (if skilled)

Management Options for GP

- Dietary – increase fibre and fluid intake
- Topical – if small painful thrombosed haemorrhoid – e.g. proctosedyl or scheriproct

WHEN TO REFER?

Emergency

If thrombosed haemorrhoid is associated with necrosis, sepsis

Routine

If fails 4 weeks conservative management

BACK

ANAL FISSURE

Presentation

Pain and bleeding with defecation

- Pain typically sharp and ripping
- Itch

Initial GP Work Up

Rectal examination

- Fissure usually midline posterior or anterior
- Marked anal spasm may prevent DRE

Management Options for GP

- Dietary – increase fluid and fibre intake
- Stool softener – e.g. Coloxyl, macrogol
- Topical – Recto-gesic ointment 3x/day and lignocaine ointment

WHEN TO REFER?

Routine

If fails 4 weeks of conservative management

BACK

ANORECTAL CONDITIONS

PRURITUS ANI

Presentation

May be a symptom of haemorrhoids, anal fissure, mucus discharge, faecal incontinence, pin-worm/threadworm, allergies, eczema, dermatitis, fungal infection

Initial GP Work Up

Rectal examination

- Check perianal skin for dermatitis, dry skin or fine fissures
- Look for anal fissure, haemorrhoids, anal seepage

Management Options for GP

- Dietary – increase fluid and fibre intake
- Keep anus clean and dry – soft wipes, dabbing rather than wiping
- Topical barrier ointment – after cleansing
- Topical steroid with antifungal– short course for 2 weeks
- Check for pinworm/threadworm – sticky tape test – treat with anti-helminthic

WHEN TO REFER?

Routine

If fails 4 weeks of conservative management

BACK

RECTAL PROLAPSE

RECTAL PROLAPSE

Presentation

- Internal prolapse (rectal intussusception) – feeling of incomplete emptying
- Mucosal prolapse (inner lining)
- Complete prolapse (full thickness)
- Protrusion of rectum during defecation, incontinence, mucus discharge, feeling of incomplete emptying/constipation, rectal pressure sensation, bleeding

Initial GP Work Up

Rectal examination

- Visible prolapse of mucosa or full thickness of rectum during straining
- Weak anal tone commonly
- Mucus discharge

Management Options for GP

- Incomplete rectal prolapse or mucosal prolapse – manage with bulk laxatives to avoid excessive straining
- Complete rectal prolapse will need referral for surgical management

WHEN TO REFER?

Emergency

Irreducible rectal prolapse

Urgent

Refer if suspicious mass

Routine

- Incomplete rectal prolapse not responding to conservative management
- Complete rectal prolapse

BACK

COLORECTAL CANCER

COLORECTAL CANCER

Presentation

- Rectal bleeding
- Altered bowel habit
- Weight loss
- Rectal mass
- Colorectal cancer on colonoscopy or direct physical examination

Initial GP Work Up

- Colonoscopy (if not done)
- U&E, FBC, LFT, CEA
- CT chest, abdomen & pelvis
- Ferritin & CRP

Management Options for GP

N/A

WHEN TO REFER?

Emergency

If patient is in pain or obstructed then contact Colorectal Fellow via switchboard 9594 6666 and refer to Emergency Department

Urgent

Contact Colorectal Cancer Nurse Coordinator on 0466 300 228 or bowelcancercoordinators@monashhealth.org

BACK