Monash Health Referral Guidelines

Incorporating Statewide Referral Criteria

GASTROENTEROLOGY

EXCLUSIONS

Including 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 (gastroenterology)
Gastroesophageal reflux
Dyspepsia
Haematemesis and/or melaena
Vomiting & nausea
Weight loss
Altered bowel habit
Rectal bleeding
Diarrhoea with sentinel findings
Constipation with sentinel findings
Lower abdominal pain
Chronic refractory constipation
Chronic refractory diarrhoea
Coeliac disease
Inflammatory bowel disease
Persistent iron deficiency
FOBT

LIVER

Abnormal liver function tests
Hepatitis B
Hepatitis D
Hepatitis C
Cirrhosis
Fatty Liver (NAFLD)
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: 27/02/2024

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GASTROENTEROLOGY

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 the **on-call gastroenterology registrar** on 9594 6666

General enquiries

Phone: 1300 342 273

Urgent Endoscopy Enquiries

For in-hours discussion (0800-1800) regarding urgent endoscopy enquiries contact: on call Endoscopy Registrar on 0409 954 180

FIBROSCAN

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

GASTROINTESTINAL TRACT

DYSPHAGIA (GASTROENTEROLOGY)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Recent onset dysphagia with any of the following:
- Symptoms for less than 12 months
- Progressive symptoms
- Anaemia
- Haematemesis
- Weight loss (≥ 5% of body weight in previous 6 months)
- Painful swallowing
- Symptoms of aspiration
- Previously resolved bolus obstruction.

Information to be included in the referral

Information that **must** be provided

- History of dysphagia and other symptoms over time including whether dysphagia is for solids, liquids or both and whether it is progressive.
- History of GORD, regurgitation, painful swallowing,
- Weight loss, smoking and alcohol consumption
- Any previous gastroscopy or other relevant investigations.

Provide if available

- Barium swallow, relevant imaging or gastroscopy results.
- FBE and iron studies

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for oropharyngeal dysphagia (suggested by difficulty in initiation of swallow and recurrent aspiration, particularly in the setting of neurological disease) should be directed to an ENT service provided by the health service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Progressively worsening oropharyngeal or throat dysphagia
- Inability to swallow with drooling or pooling of saliva
- Unresolved food bolus obstruction

Urgent

- 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
- Submission of an urgent referral should also be accompanied by a telephone call to the Gastro Registrar
- Urgent endoscopy enquiries contact: Endoscopy Registrar on 0409 954 180

Routine

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

Referral to a public hospital is not appropriate for

- Dysphagia that has persisted for more than 12 months with none of the following:
  - Progressive symptoms
  - Anaemia
  - Weight loss
  - Painful swallowing
  - Aspiration
  - Previous resolved bolus obstruction.

GASTROINTESTINAL TRACT

GASTROESOPHAGEAL REFLUX

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Recent onset, persistent symptoms of gastroesophageal reflux with:
  - Unintended weight loss (≥ 5% of body weight in previous 6 months)
  - Dysphagia
  - Vomiting
  - Iron deficiency that persists despite correction of potential causative factors.

- Surveillance for previously diagnosed Barrett's oesophagus.

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of sentinel findings e.g. changes in weight, ferritin levels
- Previous endoscopy results
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available

- Previous histology confirming Barrett's oesophagus

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

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Emergency

Direct to an emergency department for:

- Potentially life-threatening symptoms suggestive of acute severe upper gastrointestinal tract bleeding

Referral to a public hospital is not appropriate for

- Patients with simple gastroesophageal reflux without associated symptoms (see above)
- Patients with controlled symptoms
- Patients that cease treatment and symptoms return
- Belching
- Halitosis
- Screening for Barrett's oesophagus in patients with gastroesophageal reflux without additional symptoms

BACK

GASTROINTESTINAL TRACT

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
- Dietary modifications
- Lifestyle modifications

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Dyspepsia and heartburn/GORD

WHEN TO REFER?

Routine

Refer if alarm symptoms, e.g. dysphagia, weight loss or complications develop or becomes treatment non-responsive

BACK

HAEMATEMESIS AND/OR MELAENA

Initial GP Work Up

- History of timing of haematemesis and melaena, history of vomiting prior to haematemesis.
- History of collapse or syncopal episode
- Medication history, particularly aspirin, antiplatelets agents, NSAIDS, oral anticoagulants, and PPI use.
- Previous ulcer disease, endoscopy / GI surgery
- Presence of risk factors for liver disease (e.g. alcohol, viral hepatitis), or history of cirrhosis
- History of factors that may affect anaesthetic risk e.g. IHD, COPD, aortic stenosis.
- Blood pressure and pulse rate, including postural changes
- Signs of liver disease: jaundice, ascites, spider naevi
- FBE, Iron studies & Ferritin
- LFTS, INR

Management Options for GP

- Refer to ED with above details
- If Hb > 100 g/l & asymptomatic discuss with Gastroenterology service
- Oral iron supplements or IV iron if confirmed iron deficient and refer

WHEN TO REFER?

Emergency

Direct to an emergency department for immediate hospital admission via ambulance:

- Elderly patients (>70 years), Hb < 100g/L, symptomatic, haemodynamically unstable or on anti-coagulants

Urgent

Refer to clinic for Iron Deficiency Anaemia if history of resolved malaena, HB > 100g/L and now asymptomatic

BACK

GASTROINTESTINAL TRACT

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

Direct to an emergency department for:

- Significant dehydration/unable to maintain intake of fluids

Routine

Refer to appropriate specialty service depending on the results and assessments

BACK

WEIGHT LOSS (10% body weight or more)

Initial GP Work Up

- Consider both GI and non-GI causes
- Definitively document reported weight loss
- Estimate whether oral intake adequate
- Associated symptoms (weight loss, bleeding, nocturnal symptoms)
- Onset
- Duration
- Medication
- Family history colorectal cancer or polyps
- Previous abdominal surgery
- Depression

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

GASTROINTESTINAL TRACT

ALTERED BOWEL HABIT

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, faecal PCR, C.Difficile toxin if recent antibiotic use
- Rectal examination
- NB: faecal occult blood testing is a screening test for bowel cancer not a diagnostic test in patients with altered bowel habit
- Faecal calprotectin if suspicion of IBD

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.

WHEN TO REFER?

Urgent

Refer for consultation:

- 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)

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BACK

GASTROINTESTINAL TRACT

RECTAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Rectal bleeding in patients with any of the following:
- 40 years or older
- Unintended weight loss (≥ 5% of body weight in previous 6 months)
- Abdominal or rectal mass
- Recent change in bowel habits
- Iron deficiency that persists despite correction of potential causative factors
- Patient or family history of bowel cancer (first degree relative < 55 years).

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of symptoms e.g. Colour: Bright red or dark, Mixed or unmixed with stools, Quantity, Presence of pain or Tenesmus
- Full blood examination
- Urea and electrolytes
- Iron studies
- Previous and current gastrointestinal investigations and results
- Patient age
- Details of relevant family history of gastrointestinal or colorectal cancers
- Rectal examination results must be included

Provide if available

- Current and previous colonoscopy results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for colonoscopy requested for a positive faecal occult blood test should be made using Victoria's colonoscopy referral information form.

Referrals for severe haemorrhoids should be directed to colorectal service provided by the health service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Potentially life-threatening symptoms suggestive of acute severe lower gastrointestinal tract bleeding
- Haemodynamic compromise

Urgent

- Presence of rectal mass on PR
- Possible colonic or rectal malignancy identified on imaging
- Please fax referral and call the Gastroenterology Registrar to arrange urgent endoscopy

Routine but Category 1

- FOBT + NBSCP
- PR bleeding, age > 40
- Anaemia with Hb < 80
- Please fax referral. These patients will be triaged for urgent review to arrange prompt endoscopy

Referral to a public hospital is not appropriate for

- Persistent but unchanged symptoms previously investigated
- If the patient has had a full colonoscopy in the last 2 years for the same symptoms
- Untreated anal fissures
- Bleeding is known to be coming from haemorrhoids

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Colorectal cancer symptoms – suspected colorectal cancer

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

GASTROINTESTINAL TRACT

DIARRHOEA WITH SENTINEL FINDINGS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Diarrhoea > 4 weeks duration, affecting activities of daily living, with one or more of the following:
- Bloody diarrhoea
- Nocturnal diarrhoea
- Weight loss (≥ 5% of body weight in previous 6 months)
- Abdominal or rectal mass
- Inflammatory markers in the blood or stool
- Iron deficiency that persists despite correction of potential causative factors.

Information to be included in the referral

Information that **must** be provided

- Frequency and duration of diarrhoea
- Onset, characteristics and duration of sentinel findings: urgency, incontinence, PR bleeding
- Risk factors; overseas travel, medications particularly antibiotics, contact with others who have diarrhoea
- Personal or family history of IBD, coeliac disease
- Associated symptoms; weight loss, fever, extra-intestinal manifestations of IBD
- History of GI surgery
- Investigations: faecal microscopy and culture, faecal PCR, Clostridium difficile toxin, FBE, C-reactive protein (CRP), LFTs, Coeliac serology

Provide if available

- Previous colonoscopy and histology results
- Details of any previous gastroenterology assessments or opinions
- Iron studies
- Thyroid stimulating hormone levels
- Faecal calprotectin
- Faecal occult blood test
- Recent travel history.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

See also: statewide referral criteria for inflammatory bowel disease.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Severe diarrhoea with dehydration or when the person is systemically unwell
- Patients with features of acute severe colitis: > 6 bloody bowel actions/day, abdominal pain, +/- fever, tachycardia and anaemia

Routine

- Cases of clinically suspected IBD

Referral to a public hospital is not appropriate for

- Diarrhoea < 4 weeks duration without sentinel findings

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Diarrhoea in Adults

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

GASTROINTESTINAL TRACT

CONSTIPATION WITH SENTINEL FINDINGS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Constipation in patients with a duration of more than 6 weeks but less than 12 months, with any of the following:
  - > 40 years of age
  - rectal bleeding
  - positive faecal occult blood test
  - weight loss (≥ 5% of body weight in previous 6 months)
  - abdominal or rectal mass
  - iron deficiency that persists despite correction of causative factors
  - patient or family history of bowel cancer (first degree relative < 55 years).

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of constipation and sentinel findings
- Current and previous colonoscopy results
- Full blood examination
- Iron studies.

Provide if available

- Current and previous histology results
- Details of any previous gastroenterology assessments or opinions
- Faecal occult blood test
- Thyroid stimulating hormone levels.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

As part of the referral assessment, patients may be triaged to colonoscopy prior to the appointment at a specialist clinic.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Constipation in adults

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Suspected large bowel obstruction
- Faecal impaction that has not responded to adequate medical management

Referral to a public hospital is not appropriate for

- Patients with more than 12 months of symptoms, with no sentinel findings, who have not had an adequate trial of treatment.

GASTROINTESTINAL TRACT

LOWER ABDOMINAL PAIN

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

WHEN TO REFER?

Routine

Refer to appropriate speciality service depending on results or clinical response

BACK

GASTROINTESTINAL TRACT

CHRONIC REFRACTORY CONSTIPATION

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Constipation lasting more than 12 months with refractory symptoms that affect the person's activities of daily living despite an adequate trial of treatment.

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of symptoms
- Details of previous medical management including the course of treatment and outcome of treatment
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Thyroid stimulating hormone levels
- Serum calcium.

Provide if available

- Current and previous colonoscopy results
- Details of any previous gastroenterology assessments or opinions.
- Current and previous imaging results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

The referral should note that the request is for advice on, or review of, the current management plan as requests for second opinion will usually not be accepted.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Constipation in adults

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Suspected large bowel obstruction
- Faecal impaction that has not responded to adequate medical management

Referral to a public hospital is not appropriate for

- Patients with no sentinel findings, who have not had an adequate trial of treatment (e.g. regular osmotic laxatives)
- Laxative dependence

BACK

GASTROINTESTINAL TRACT

CHRONIC REFRACTORY DIARRHOEA

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Chronic refractory diarrhoea lasting more than 4 weeks with refractory symptoms (following an adequate trial of treatment) that affect the person's activities of daily living.

Referral to a public hospital is not appropriate for

- Laxative dependence

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of symptoms
- Details of previous medical management including the course of treatment and outcome of treatment
- Details of any previous gastroenterology assessments or opinions
- Previous histopathology results.

Provide if available

- Full blood examination
- Iron studies
- Vitamin B12 and folate test results
- 25-OH vitamin D results
- Faecal calprotectin
- Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)
- Previous colonoscopy results
- If symptoms are thought to be linked to probable or confirmed SARS CoV-2 (COVID-19) infection or Long COVID.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

The referral should note that the request is for advice on, or review of, the current management plan as requests for a second opinion will usually not be accepted.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Diarrhoea in Adults

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

GASTROINTESTINAL TRACT

COELIAC DISEASE

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Positive coeliac serology
- Advice on, or review of, symptomatic coeliac disease (previous histological diagnosis) not responding to dietary and medical management.

Information to be included in the referral

Information that **must** be provided

- Coeliac serology results or previous histology results
- Full blood examination
- Iron studies.

Provide if available

- Gastrointestinal symptoms (e.g. diarrhoea, weight loss)
- Previous gastroscopy results
- Previous histology results
- Previous gastroenterology assessments or opinions
- Urea and electrolytes
- Liver function tests
- Details of previous medical management including the course of treatment and outcome of treatment
- Details of any other autoimmune conditions.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Coeliac disease in adults

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Referral to a public hospital is not appropriate for

- Positive coeliac gene test without positive coeliac serology

BACK

GASTROINTESTINAL TRACT

INFLAMMATORY BOWEL DISEASE

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Known inflammatory bowel disease.
- Strongly suspected inflammatory disease based on:
  - Recurrent perianal fistulas or abscesses
  - Imaging results that strongly suggest Crohn's disease or colitis
  - Endoscopy findings consistent with inflammatory bowel disease.

Information to be included in the referral

Information that **must** be provided

- Current and previous colonoscopy results.
- Current and previous imaging results.
- Inflammatory marker result (erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)).
- Full blood examination.
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available

- Faecal calprotectin.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

See also: statewide referral criteria for symptoms such as diarrhoea or abnormal imaging or colonoscopy results.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Inflammatory Bowel Disease (IBD)

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Acute severe colitis: patients with ≥ 6 bloody bowel motions per 24 hours plus at least one of the following:
  - Temperature > 37.8°C
  - Pulse rate > 90 bpm
  - Haemoglobin < 105 gm/L
  - Raised inflammatory markers (erythrocyte sedimentation rate (ESR) > 30 mm/hr or C-reactive protein (CRP) > 30 mg/L)
- Suspected or known Crohn's disease with acute complications:
  - Bowel obstruction
  - Sepsis or intra-abdominal, pelvic or perianal abscess.

BACK

GASTROINTESTINAL TRACT

PERSISTENT IRON DEFICIENCY

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Persistent iron deficiency in men and post-menopausal women with either:
  - Ferritin < 30 µg/L
  - Ferritin 30-100 µg/L in the presence of inflammation (e.g. C-reactive protein (CRP) ≥ 5 mg/L)
- Iron deficiency that persists despite correction of potential causative factors
- Iron deficiency in pre-menopausal women:
  - With positive coeliac serology
  - With positive faecal occult blood test
  - That persists despite treatment of menorrhagia, with good cycle control.

Information to be included in the referral

Information that **must** be provided:

- History of menorrhagia
- Dietary history, including red meat intake
- Iron studies or serum ferritin
- Full blood examination
- Coeliac serology results
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Faecal occult blood test
- Faecal calprotectin
- Any family history of gastrointestinal cancer.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for iron deficiency related to persistent, heavy menstrual bleeding should be made to suitable community-based services wherever possible (see 1800 My Options). Where this is not practicable, referrals should be directed to a gynaecology service provided by the health service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Iron Deficiency Anaemia

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Shortness of breath or chest pain, syncope or pre-syncope with iron deficiency (ferritin below the lower limit of normal)

Referral to a public hospital is not appropriate for

- Iron deficiency in pre-menopausal women with:
  - No positive coeliac serology
  - Negative faecal occult blood test
  - Managed menorrhagia and with good cycle control
- Isolated low serum iron
- Non-iron deficiency anaemia without evidence of blood loss
- Vegetarian diet without iron supplementation.

BACK

GASTROINTESTINAL TRACT

FAECAL OCCULT BLOOD TEST (FOBT)

Monash Health employs a Direct Access Colonoscopy, Nurse-led model for suitable patients referred with a positive FOBT.

Direct Access Colonoscopy utilises a digital care pathway, which provides patients with information about the procedure and bowel preparation, as well as other pre-admission requirements, prior to them being placed on the procedure wait list. Patients complete a comprehensive digital health questionnaire, which is reviewed by a clinician (Senior Endoscopy Nurse, with escalation to a Gastroenterologist as required) in order to determine the suitability of Direct Access Colonoscopy.

If Direct Access Colonoscopy is deemed inappropriate, the patient may be directed to a specialist clinic or service for assessment prior to the procedure.
All patients are reviewed by a Gastroenterology clinician on the day of Colonoscopy or as dictated by Monash Health policy. Where clinically appropriate the referral may be directed to a specialist clinic or service for assessment prior to the procedure.

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Positive immunochemical faecal occult blood test (iFOBT) within previous 12 months.
- Patient aged 75 years or less

Information to be included in the referral

Information that **must** be provided:

- Faecal occult blood test results and if the test result was or was not detected through the National Bowel Cancer Screening Program (NBCSP)
- Patient age
- Onset, characteristics and duration of symptoms
- Relevant medical history and comorbidities
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Confirmation that the patient has indicated interest in having a colonoscopy
- Confirmation that the patient understands the need for bowel preparation prior to colonoscopy

NBCSP details (mandatory requirement)

- Results of NSCP testing
- Participant ID

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Potentially life-threatening symptoms suggestive of acute severe lower gastrointestinal tract bleeding.

Referral to a public hospital is not appropriate for

- Patients requiring gastroscopy in addition to colonoscopy
- Already undergone colonoscopy with adequate examination following positive FOBT result
- Known inflammatory bowel disease
- Known polyp syndrome (Cancer Surveillance referral required)

BACK

GASTROINTESTINAL TRACT

FAECAL OCCULT BLOOD TEST (FOBT) - Continued

Information to be included in the referral

Anaesthetic risk

Indicate if the patient has any of the following:

- body mass index (BMI) > 40
- a permanent pacemaker
- any bleeding disorder
- any cognition issues or impairment
- any known or prior reaction to anaesthesia (malignant hyperthermia, suxamethonium apnoea, severe post-operative nausea or vomiting, known difficult airway)
- any neuromuscular condition (e.g. myasthenia gravis, muscular dystrophy, cerebral palsy)
- a respiratory disease that requires oxygen therapy or limits the patient's daily activities (New York Heart Association (NYHA) Functional Classification class 3)
- severe obstructive sleep apnoea
- stage 4 or 5 chronic kidney disease (pre-dialysis or requires dialysis)
- symptomatic ischaemic heart disease
- valvular heart disease or congestive heart failure

Anticoagulation or antiplatelet therapy

Indicate if the patient is taking any of the following medicines (or any other anticoagulant or antiplatelet therapy):

- apixaban
- aspirin
- clopidogrel
- dabigatran
- low molecular weight heparin
- prasugrel
- rivaroxaban
- ticagrelor
- warfarin

Risk factors for poor bowel preparation for colonoscopy

Indicate if the patient has any of the following:

- body mass index (BMI) > 30
- chronic opioid use
- constipation
- type 1 diabetes (management plan)
- type 2 diabetes (management plan)
- Parkinson's disease
- previous bowel resection
- stroke

BACK

GASTROINTESTINAL TRACT

FAECAL OCCULT BLOOD TEST (FOBT) - Continued

Provide if available:

- Previous and current gastrointestinal investigations and results, including when and where previous endoscopy procedures were performed.

Helpful resources links for GPs

NBCSP - GP Checklist for talking with your patients

NBCSP - GP assessment report form GP assessment report form

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals for rectal bleeding should be directed to Gastroenterology service provided by the health service.

Referrals for persistent iron deficiency should be directed to Gastroenterology service provided by the health service.

Referrals for severe haemorrhoids should be directed to Colorectal service provided by the health service.

Note: FOBT is not indicated in asymptomatic people aged > 80 years

BACK

LIVER

ABNORMAL LIVER FUNCTION TESTS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Abnormal liver function tests with:
  - Platelet count < 120 x 10^9 per litre
  - Splenomegaly
  - Ascites
  - Hepatic encephalopathy
  - Genetic haemochromatosis (C282Y homozygotes and C282Y/H63D compound heterozygotes only).
- Abnormal liver function test with aspartate transaminase (AST) or alanine aminotransferase (ALT) ≥ 5 times the upper level of the normal range
- Two abnormal liver function test results performed at least 3 months apart with aspartate transaminase (AST) or alanine aminotransferase (ALT) 2-5 times the upper level of the normal range.

Information to be included in the referral

Information that **must** be provided:

- Duration of abnormal LFTs
- Risk factors: History of alcohol intake
- History of injectable drug use
- Associated symptoms (pruritus, steatorrhea, bruising, dark urine etc)
- Family history of liver disease e.g. Hepatitis B
- Signs of chronic liver disease
- Current and historical liver function tests
- FBE, INR, UEC, Iron studies
- Upper abdominal ultrasound results
- Hepatitis B virus and Hepatitis C virus serology results
- History of diabetes
- Iron Studies
- Current and complete medication history (including non-prescription medicines, herbs and supplements)

Provide if available:

- Height, weight and body mass index
- Any relevant family history
- If symptoms are thought to be linked to probable or confirmed SARS CoV-2 (COVID-19) infection or Long COVID

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Acute liver failure: jaundice, elevated ALT/AST, prolonged INR, encephalopathy
- Severe hepatic encephalopathy
- Aspartate transaminase (AST) > 2,000 U/L

Urgent

- Obstructive jaundice (dilated ducts)
- Unexplained non-obstructive cholestatic jaundice (elevated alkaline phosphatase, bilirubin)
- ALT > x5 ULN
- New diagnosis of cirrhosis
- PSC with evidence of new dominant stricture or episode of cholangitis

Routine

- Hepatitis C for antiviral treatment https://www.gesa.org.au/resources/hepatitis-c-treatment/
- Hepatitis B for consideration of antivirals
- Isolated elevated GGT in presence of alcohol/fatty liver
- Fatty liver with abnormal LFTs
- Haemochromatosis
- Primary biliary cholangiopathy, primary sclerosing cholangitis

Referral to a public hospital is not appropriate for

- Fatty liver with normal liver function tests

Continued over page

BACK

LIVER

ABNORMAL LIVER FUNCTIONS TESTS (Continued)

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Abnormal Liver Function Tests

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Management Options for GP

- Cease alcohol
- Stop potential hepatotoxic drugs
- Regular laboratory and clinical review and refer if no improvement
- Treat for Hepatitis C according to guidelines https://www.gesa.org.au/resources/hepatitis-c-treatment/

BACK

LIVER

HEPATITIS B

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Patients who are hepatitis B surface antigen (HbsAg) positive
- Pregnant women who are hepatitis B surface antigen (HbsAg) positive
- Patients who are immunosuppressed or starting immunosuppressant medicines who are hepatitis B surface antigen (HbcAb) positive (e.g. transplant patients, starting chemotherapy).

Information to be included in the referral

Information that **must** be provided:

- Hepatitis B virus (HBV) serology results and viral load results: HBsAg, HBeAg, cAb, HBVDNA
- Hepatitis A, Hepatitis C virus and HIV serology
- Liver function tests
- Full blood examination and INR
- Upper abdominal ultrasound results
- If pregnant, gestational age
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Previous liver biopsy results
- Details of previous medical management including the course of treatment and outcome of treatment.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Who to test

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

Continued over page

Emergency

Direct to an emergency department for:

- Acute liver failure
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy
- Severe ascites restricting movement and breathing

Urgent

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

Routine

Patients who are hepatitis BsAg positive with:

- Normal or mildly abnormal LFTs
- Evidence of compensated cirrhosis
- Family history hepatocellular carcinoma
- Pre pregnancy

Referral to a public hospital is not appropriate for

- Patients who are hepatitis B surface antigen (HbsAg) negative, unless they are immunosuppressed or starting immunosuppressant medicines and are hepatitis B core antibody (HbcAb) positive.

BACK

LIVER (cont'd)

HEPATITIS B (Continued)

Investigations

- Counselling re sexual and blood borne transmission, natural history of Hepatitis B, and need for regular follow up
- Screening of family members and sexual contacts
- Annual LFTs and HBVDNA
- 6 monthly screening for hepatocellular carcinoma with liver ultrasound and AFP for all hepatitis B sAg positive men over 40, women over 50, all cirrhotics and all Africans irrespective of age

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 antibody

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Chronic Hepatitis B

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

LIVER (cont'd)

HEPATITIS C

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Patients who are hepatitis C (HCV) RNA positive unable to be managed and treated in community-based services.

Information to be included in the referral

Information that **must** be provided:

- Risk factors for acquisition including year (e.g. blood product transfusion pre 1990, IDU, incarceration, renal dialysis)
- Country of birth
- Current and complete medication history (including non-prescription medicines, herbs and supplements).
- History of alcohol intake
- History of injectable drug use including if the patient is still injecting
- If pregnant, gestational age
- Hepatitis C virus serology, and RNA (HCV PCR) results
- Hepatitis B virus
- HIV serology results
- Liver function tests including aspartate transaminase (AST)
- Full blood examination, INR
- Alphafoetoprotein (AFP)
- Upper abdominal ultrasound results

Provide if available:

- Previous liver biopsy results
- Details of previous medical management including the course of treatment and outcome of treatment

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Who to test

- 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: (e.g. vasculitis, peripheral neuropathy)
- Renal dialysis patient

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Acute liver failure
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy
- Severe ascites restricting movement and breathing

Routine

Refer to liver clinic
Upload referral through Healthlink

Referral to a public hospital is not appropriate for

- If Hepatitis C can be managed and treated through suitable community-based services wherever possible
- Patients who are hepatitis C (HCV) RNA negative who are not at ongoing risk of cirrhosis.

BACK

LIVER (cont'd)

HEPATITIS C (Continued)

Management Options for GP

- Counselling (natural history, transmission risk, treatment)
- If HCV RNA negative: may have cleared virus
- Repeat PCR
- Check LFTs in 12 months
- Discuss prevention
- If HCV RNA positive: treat
- Refer to liver clinic or community based treatment centre or treat using GESA guidelines: https://www.gesa.org.au/public/13/files/Hepatitis%20C/GP%20algorithm%20v11%20June%202020.pdf

Discuss harm reduction strategies:

- Refer to Addiction medicine services where appropriate
- Alcohol intake as per NHMRC Guidelines: https://www.nhmrc.gov.au/healthadvice/Alcohol
- Abstinence from alcohol is recommended for patients with cirrhosis
- Hepatitis A and B immunisation
- Annual influenza vaccine.
- Refer for fibroscan if duration of infection more than 20 years or significant concomitant alcohol
- **Click here** to download the fibroscan referral form

Patients with probable cirrhosis (fibroscan>12kPA, platelets<100,000 or features on imaging) should be referred to liver clinic.
These patients should receive annual influenza vaccine, pneumovax, a dietician review, and 6 monthly screening for hepatocellular carcinoma with liver ultrasound and AFP.

Resources: https://www.nps.org.au/australianprescriber/articles/managing-hepatitis-c-in-generalpractice

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Hepatitis C (HCV)

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

LIVER

CIRRHOSIS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Suspected cirrhosis suggested by one or more of the following:
  - Evidence of cirrhosis on imaging
  - platelet count < 120 x 10^9 per litre
  - Ascites
  - Hepatic encephalopathy
  - AST to platelet ratio index (APRI) > 2.0.

Information to be included in the referral

Information that **must** be provided:

- History of alcohol intake
- History of injectable drug use
- Current and historical liver function tests
- Full blood examination
- International normalised ratio (INR) result
- Urea and electrolytes
- Upper abdominal ultrasound results
- Hepatitis B virus and Hepatitis C virus serology results
- History of features of the metabolic syndrome such as diabetes, hypertension, obesity (BMI), dyslipidaemia
- Iron studies
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Examination findings suggestive of cirrhosis or portal hypertension: jaundice, dupyten's contracture, wasting, asterixis, easy bruising, spider naevi, ascites, splenomegaly, peripheral oedema

Provide if available:

- Height, weight and body mass index

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition: Cirrhosis

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Acute liver failure: jaundice, coagulopathy (INR > 1.5) and encephalopathy
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy with reduced GCS
- Severe ascites restricting movement and breathing.
- Haematemesis and malaena in a known cirrhotic

Urgent

- Mild - moderate ascites
- Mild hepatic encephalopathy

Routine

- Compensated cirrhosis (imaging features of cirrhosis or fibroscan > 12kPa, without ascites, encephalopathy or bleeding

Referral to a public hospital is not appropriate for

- Not applicable

BACK

LIVER (cont'd)

FATTY LIVER (NAFLD)

WHEN TO REFER?

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, caeruloplasmin, 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

Routine

- Refer to liver clinic according to NASH algorithm.

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
- Refer to Monash NASH guidelines

BACK

LIVER LESIONS

WHEN TO REFER?

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)

Urgent

- Refer to liver clinic if elevated AfP and CA 19.9

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 (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

Urgent

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

Routine

- Elective referral
- Uncomplicated gallstones
- Chronic pancreatitis

BACK