# Monash Health Referral Guidelines
## UPPER GI / HEPATOBILLARY

## EXCLUSIONS

Services not offered by Monash Health

- Liver Transplant
- Patients under 18 years of age: Click here for Monash Children's Gastroenterology guidelines

## CONDITIONS

**UPPER GASTRO-INTESTINAL**

Oesophageal Cancer

Peptic Ulcer Disease

Gastro-Oesophageal Reflux Disease (GORD)

Hiatus Hernias

Achalasia

Hyperplenism

**HEPATICO-BILARY**

Liver Cancer

Jaundice / Obstructed Jaundice

Gallstones

Gallbladder Polyps

## PRIORITY

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

| | |
|---|---|
| **EMERGENCY** | For emergency cases please do any of the following:<br>- send the patient to the Emergency department OR<br>- Contact the on call registrar OR<br>- 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 |


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MonashHealth

# Monash Health Referral Guidelines
## UPPER GI / HEPATOBILLARY

## REFERRAL
How to refer to Monash Health

### Mandatory referral content

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

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

Click here to download the outpatient referral form

**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 Upper GI / Hepatobiliary registrar via main switchboard: **9594 6666**

### General enquiries
Phone: 1300 342 273

# UPPER GASTRO-INTESTINAL

## OESOPHAGEAL CANCER

### WHEN TO REFER?

**Urgent**

Refer after initial work-up

### Presentation

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

### Initial GP Work Up

- FBE, iron studies
- Gastroscopy & biopsy

### Management Options for GP

- Commence PPI
- Ensure adequate nutrition (supplements)

BACK

## PEPTIC ULCER DISEASE

### WHEN TO REFER?

**Urgent**

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

### Presentation

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

### Initial GP Work Up

- Gastroscopy & biopsy
- H. Pylori breath test

### Management Options for GP

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

BACK

# UPPER GASTRO-INTESTINAL (cont'd)

## GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)

### Presentation

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

### Initial GP Work Up

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

### Management Options for GP

- Commence PPI
- Eradication therapy if H. pylori present

## WHEN TO REFER?

**Urgent**

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

BACK

# UPPER GASTRO-INTESTINAL (cont'd)

## HIATUS HERNIA

### Presentation

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

### Initial GP Work Up

- Barium swallow
- Gastroscopy

### Management Options for GP

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

## WHEN TO REFER?

**Urgent**

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

BACK

## ACHALASIA

### Presentation

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

### Initial GP Work Up

- Barium swallow
- Gastroscopy

### Management Options for GP

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

## WHEN TO REFER?

**Urgent**

When barium swallow or gastroscopy suggests achalasia

BACK

# UPPER GASTRO-INTESTINAL (cont'd)

## HYPERSPLENISM

## WHEN TO REFER?

### Presentation

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

### Initial GP Work Up

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

### Management Options for GP

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

**Urgent**

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

BACK

# HEPATICO-BILARY

## LIVER CANCER

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

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

### Management Options for GP
- Refer to liver surgery clinic or Hepatology clinic

## WHEN TO REFER?

**Urgent**

Refer all patients

BACK

## JAUNDICE / OBSTRUCTED JAUNDICE

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

### Initial GP Work Up
- FBE
- U&E
- LFTs
- Ultrasound

### Management Options for GP
- Refer all patients to either hepaticobilary surgical outpatients or the Emergency Department.

## WHEN TO REFER?

**Emergency**

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

**Urgent**

Other conditions that should be referred to the hepaticobilary surgical clinic:
- Biliary dilatation
- Choledochal cyst
- Liver lesion/mass (except cirrhotic patients with a liver mass who should be referred to Gastroenterology)
- Pancreatic cyst or mass

BACK

# HEPATICO-BILARY (cont'd)

## GALLSTONES

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

### Initial GP Work Up
- LFTs, FBE, U&E
- Ultrasound

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

## WHEN TO REFER?

**Emergency**

Send to Emergency department if features of:
- Acute cholecystitis
- Acute severe pain not settling
- Fevers
- Vomiting
- Tachycardia
- Febrile marked tenderness over the gallbladder
- Guarding
- Positive Murphy's test
- Elevated white cell count >14

**Urgent**

Refer all other patients requiring a surgical opinion

BACK

## GALLBLADDER POLYP

### Presentation
- Usually asymptomatic

### Initial GP Work Up
- LFTs
- Ultrasound

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

## WHEN TO REFER?

**Urgent**

All patients requiring a surgical opinion

BACK