Monash Health Referral Guidelines

Incorporating Statewide Referral Criteria

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 requiring Lipid Management
- Patients seeking Bariatric/ Obesity Management: refer to Clinical Nutrition
- 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
Metabolic bone disease (Endocrinology)
Paget's disease

PITUITARY DISORDERS

Pituitary Disorders
Hyponatraemia
Polydipsia/Polyuria
Glucocorticoid Excess (Cushings syndrome)

REPRODUCTIVE HEALTH

Amenorrhoea

THYROID DISEASE

Hyperthyroidism
Hypothyroidism
Thyroid mass (Endocrinology)

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

Last updated:
October 2024

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Endocrinology

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 Endocrinology on call registrar via Main Switchboard 9594 6666

General enquiries

Phone: 1300 342 273

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 etanephrins
- Urinary free cortisol and overnight 1mg
- Dexamethasone
- Suppression test
- Testosterone
- DHEAS

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

GLUCOCORTICOID EXCESS (Cushing's Syndrome)

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

WHEN TO REFER?

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

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

WHEN TO REFER?

Urgent

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

Routine

Significant hirsutism without evidence of severe androgen excess.

BACK

ADRENAL DISORDERS

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

KLINEFELTER SYNDROME, MALE HYPOGONADISM

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

WHEN TO REFER?

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

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

METABOLIC BONE DISEASE (ENDOCRINOLOGY) > WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Suspected metabolic bone disease that is not osteoporosis (for example: Paget's disease, fibrous dysplasia, osteomalacia, osteogenesis imperfecta)
- Persistent osteoporosis despite 3 years of maximum antiresorptive treatment
- Intolerance to, or contraindication for, maximum antiresorptive treatment
- Metabolic bone disease associated with:
  - Treatment with glucocorticoid medicines
  - Chronic kidney disease
  - Post-transplant.
- Osteoporosis in women < 50 years or men < 60 years
- Secondary osteoporosis due any of the following:
  - Hyperthyroidism
  - Primary hyperparathyroidism
  - Male hypogonadism
  - Amenorrhea in women < 40 years.
- Advice on, or review of, management plan in patients with stable metabolic bone disease after 5 years of treatment.

Information to be included in the referral

Information that **must** be provided

- Details of all fractures, including location
- 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)
- Recent (preferably in last 3 months):
  - Serum calcium result
  - Serum 25-hydroxy vitamin D (25(OH)D)
  - Phosphate blood test result
  - Creatinine and electrolytes result
  - Albumin blood test result
  - Alkaline phosphate (ALP) blood test result.
- Relevant comorbidities

Provide if available

- Current or previous bone densitometry results
- Current or previous radiological reports of any fractures
- Parathyroid (PTH) blood test result.

Continued over page

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

SEMPHN Pathways

The SEMPHN Pathways are not available for this condition at time of publishing

BACK

BONE AND MINERAL METABOLISM

METABOLIC BONE DISEASE (ENDOCRINOLOGY) Cont'd

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.

Referral to a public hospital is not appropriate for

- Osteoporosis that has not been treated
- Age appropriate osteopenia without fracture(s)
- When the person's life expectancy is < 6 months.

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

Management Options for GP

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

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

BACK

BONE AND MINERAL METABOLISM

PAGET'S DISEASE

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

WHEN TO REFER?

Urgent

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

Routine

Asymptomatic

BACK

PITUITARY DISORDERS

PITUITARY DISORDERS

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

WHEN TO REFER?

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

HYPONATRAEMIA

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

WHEN TO REFER?

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

POLYDIPSIA AND POLYURIA

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

WHEN TO REFER?

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)

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

WHEN TO REFER?

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

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

WHEN TO REFER?

Urgent

- Associated galactorrhea
- Features consistent with hypopituitarism
- Acute virilisation

Routine

Amenorrhoea for investigation and management

BACK

THYROID DISEASE

HYPERTHYROIDISM

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Assessment of newly identified or recurring hyperthyroidism (including Graves' disease)
- Advice on, or review of, management plan for stable hyperthyroidism.

Information to be included in the referral

Information that **must** be provided

- Onset, characteristics and duration of symptoms
- Current and complete medication history (including non-prescription medicines, herbs and supplements), particularly medicines such amiodarone, lithium, biotin and kelp products
- Recent free triiodothyronine (T3), free thyroxine (T4) and thyroid stimulating hormone level (TSH)
- If the patient is pregnant.

Provide if available

- Anti- thyroid peroxidase (TPO) antibodies results
- Thyroid stimulating hormone receptor antibody (TRAb) or thyroid stimulating immunoglobulin (TSI) results
- Current and previous scan results (e.g. nuclear thyroid scan).

Additional comments

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

Thyroid ultrasound is not useful in assessing hyperthyroidism.

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

Presentation

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

Emergency

Direct to an emergency department for:

• Hyperthyroidism complicated by cardiac, respiratory compromise or other indications of severe illness (fever, vomiting, labile blood pressure, altered mental state)

• Neutropenic sepsis in patient taking carbimazole or propylthiouracil

• Hyperthyroidism with hypokalaemia or paralysis.

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

SEMPHN Pathways

The SEMPHN Pathways are not available for this condition at time of publishing

HealthPathways

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

Continued over page

BACK

THYROID DISEASE

HYPERTHYROIDISM (Continued)

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

BACK

THYROID DISEASE

HYPOTHYROIDISM

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Persistent hypothyroidism despite adequate replacement treatment
- Pregnant women with thyroid stimulating hormone level (TSH) > 10 mU/L with a history of Graves' disease or treatment with radioactive iodine
- Suspected or confirmed secondary hypothyroidism (i.e. low thyroid stimulating hormone level (TSH) and low free thyroxine (T4))
- Persistent thyroiditis that has lasted for more than 6 months

Information to be included in the referral

Information that **must** be provided

- Free thyroxine (T4) results and thyroid stimulating hormone level (TSH). Please provide series of results over time if the referral is related to persistent thyroiditis
- Thyroid related history including any history of surgery or Graves' disease
- Details of previous medical management including the course of treatment and outcome of treatment

Provide if available

- Anti-thyroid peroxidase (TPO) antibodies results.

Additional comments

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

Do not delay treatment initiation or modification where a referral has been made for a pregnant woman with hypothyroidism.

Thyroid ultrasound is not useful in assessing hypothyroidism.

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

Referral to a public hospital is not appropriate for

• Clinically stable hypothyroidism
• Primary hypothyroidism (except in patients with cardiac disease, pregnancy or if thyroxine treatment is contraindicated) that has not been treated with replacement therapy

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Suspected myxoedema coma (impaired conscious state, hypothermia, bradycardia) with high thyroid stimulating hormone level.

Urgent

- TSH > 20
- Mild symptomatic

Routine

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

SEMPHN Pathways

The SEMPHN Pathways are not available for this condition at time of publishing.

HealthPathways

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

BACK

THYROID DISEASE

HYPOTHYROIDISM (Continued)

Initial GP Work Up

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

Management Options for GP

Hypothyroidism can reasonably be managed in the GP setting

SEMPHN Pathways

The SEMPHN Pathways are not available for this condition at time of publishing.

BACK

THYROID DISEASE

THYROID MASS (Endocrinology)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Assessment of suspected malignancy
- Thyroid mass associated with mild to moderate compressive symptoms
- Thyroid mass associated with hyperthyroidism.

Information to be included in the referral

Information that **must** be provided

- Ultrasound with, or without, fine needle aspiration results
- Thyroid stimulating hormone (TSH) and free thyroxine (T4) results.

Additional comments

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

Note: there are also ENT statewide referral criteria for *Thyroid mass*.

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

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

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Thyroid mass with difficulty in breathing

Urgent

- Severe pain
- Malignancy
- Stridor

Routine

- Uncertain diagnosis
- Local symptoms
- Surgery or radioiodine required

SEMPHN Pathways

The SEMPHN Pathways are not available for this condition at time of publishing.

HealthPathways

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

BACK

THYROID DISEASE

HYPOGLYCAEMIA - ENDOCRINE

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 i.e. hyper-functioning (benign) adenoma
- Isotope scan for diagnosis of multinodular goitre, hyperfunctioning adenoma

BACK

OTHER

HYPOGLYCAEMIA - ENDOCRINE

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

WHEN TO REFER?

Emergency

Associated with adverse sequalae 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