

# GENERAL SURGERY

## HOSPITAL REFERRAL AND MANAGEMENT GUIDELINES

### CONTENTS:

The Alfred Specialist Consulting Clinics Appointment Priority Guide .....	2
Referral & Management Guidelines	
Miscellaneous General Surgery:	
Hernia.....	3
Skin (See Plastic Surgery Guidelines).....	3
Venous (See Vascular Guidelines).....	3
Breast & Endocrine Clinic (BSS) .....	4
Neck.....	4
Thyroid Masses.....	4
Adrenal Masses .....	4
Parathyroid Disease.....	4
Breast Disease.....	4
Colo-Rectal Service (CRS).....	6
Inflammatory Bowel Disease.....	6
Diseases of the Colon .....	6
Ano-rectal Disease .....	6
Upper Gastrointestinal Services (UGIS).....	7
Disorders of the Oesophagus.....	7
Disorders of the Stomach and Duodenum .....	7
Disorders of the Pancreas, Liver and Biliary Tract .....	7
<b>APPENDIX</b>	
Guide for Investigation of a Breast Lump .....	8

## THE ALFRED SPECIALIST CONSULTING CLINICS PRIORITY GUIDE

General Surgery

New Appointment

<b>Priority Definitions:</b>	<p><b>Immediate</b> -phone Surgical registrar on call on 9076 2000 and/or send to The Alfred Emergency &amp; Trauma Centre.</p> <p>1. <b>Urgent</b> -likely to receive an appointment within 1-2 weeks</p> <p>2. <b>Soon</b> -likely to receive an appointment within 2-6 weeks</p> <p>3. <b>Intermediate</b> -likely to receive and appointment within 6-12 weeks</p> <p>4. <b>Non-urgent</b> -appointment may be delayed</p> <p><b>Not seen</b></p> <p><b>Please note:</b> The times to assessment may vary depending on size and staffing of the hospital department.</p> <p>Urgent cases must be discussed with the Surgical registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.</p>	
Priority	Criteria	Examples
<b>IMMEDIATE</b> (Contact Surgical registrar or send to Emergency Department)	Moderate risk of permanent damage if delay occurs	<ul style="list-style-type: none"> <li>▪ Threatened cervical airway obstruction</li> <li>▪ Diagnosed GI tract or breast malignancy</li> <li>▪ Obstructive jaundice</li> <li>▪ Haematemesis</li> <li>▪ Melaena</li> <li>▪ Acute pancreatitis</li> <li>▪ Acute , severe biliary pain</li> </ul>
	Major functional impairment	<ul style="list-style-type: none"> <li>▪ Severe uncontrolled diarrhoea</li> <li>▪ Cachexia</li> <li>▪ Ascites</li> </ul>
<b>1. URGENT</b>	Suspected malignancies	<ul style="list-style-type: none"> <li>▪ Breast lumps</li> <li>▪ Pigmented skin lesions</li> <li>▪ Change in bowel habits and /or PR bleeding suggestive of malignancy</li> <li>▪ Painful defecation</li> <li>▪ Head and neck masses</li> <li>▪ Diagnosed GI abnormality</li> <li>▪ Dyspepsia associated with weight loss and/or anaemia</li> <li>▪ Thyroid masses</li> <li>▪ Adrenal masses</li> </ul>
	Recurrent pain	<ul style="list-style-type: none"> <li>▪ Known gallstones with ongoing biliary colic</li> <li>▪ Hernia that have required acute reduction</li> <li>▪ Acute painful leg ulcers</li> <li>▪ Gall-bladder mass/Recurrent cholecystitis</li> <li>▪ Chronic pancreatitis</li> </ul>
<b>2. SOON</b>	Infective conditions	<ul style="list-style-type: none"> <li>▪ Active pilonidal disease</li> <li>▪ Infected ingrown toenails</li> </ul>
	Minimal on no functional impairment	<ul style="list-style-type: none"> <li>▪ Dyspepsia unassociated with weight loss or anaemia</li> <li>▪ Anal fistula or fissure</li> <li>▪ PR bleeding not suspicious of malignancy</li> <li>▪ Known gallstones with ongoing biliary colic</li> <li>▪ Uncomplicated hernia</li> <li>▪ Diagnosed GI abnormality</li> <li>▪ Benign lumps</li> <li>▪ Diverticular disease</li> <li>▪ Inguinal hernia (for exceptions refer to notes)</li> </ul>
	Family history	<ul style="list-style-type: none"> <li>▪ Routine screening for family history of Colorectal cancer</li> </ul>
	Endocrine Disease	<ul style="list-style-type: none"> <li>▪ Parathyroid disease</li> <li>▪ Adrenal abnormalities</li> </ul>
<b>3. INTERMEDIATE</b>		<ul style="list-style-type: none"> <li>▪ Haemorrhoids (for exceptions refer to notes)</li> <li>▪ Single episode cholecystitis</li> <li>▪ Lipomas</li> <li>▪ Pilonidal sinus</li> <li>▪ Bowel screening (refer to Gastroenterology only if significant family history with referral to guidelines)</li> <li>▪ Breast screening (unless significant family history and refer to guidelines)</li> <li>▪ Perianal skin tags</li> </ul>
<b>4. NON-URGENT</b>		<ul style="list-style-type: none"> <li>▪ Obesity management for consideration of laparoscopic gastric banding</li> <li>▪ Uncomplicated varicose veins see <a href="#">Vascular Surgery Referral and Management Guidelines</a></li> </ul>
<b>NOT SEEN</b>		Children under 16 years of age are not seen at the Alfred

## REFERRAL & MANAGEMENT GUIDELINES: GENERAL SURGERY

DIAGNOSIS	EVALUATION	MANAGEMENT
<p>Problems are categorised under the following groupings, and managed by the corresponding service:</p> <p><b>1. BREAST AND ENDOCRINE CLINIC (BES):</b></p> <ul style="list-style-type: none"> <li>▪ Neck</li> <li>▪ Thyroid masses</li> <li>▪ Adrenal masses</li> <li>▪ Parathyroid disease</li> <li>▪ Breast disease</li> </ul> <p><b>2. COLORECTAL SERVICE (CRS):</b></p> <ul style="list-style-type: none"> <li>▪ Inflammatory bowel disease</li> <li>▪ Diseases of the colon</li> <li>▪ Anorectal disease</li> </ul> <p><b>3. UPPER GASTROINTESTINAL SERVICE (UGIS):</b></p> <ul style="list-style-type: none"> <li>▪ Disorders of the oesophagus</li> <li>▪ Disorders of the stomach and duodenum</li> <li>▪ Disorders of the pancreas</li> <li>▪ Disorders of the biliary tree &amp; liver</li> </ul> <p><b>4. MISCELLANEOUS GENERAL SURGERY</b></p> <ul style="list-style-type: none"> <li>▪ Hernia</li> <li>▪ Skin</li> <li>▪ Venous</li> </ul>	<p>A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Some appropriate investigation by the referrer will facilitate the referral process.</p>	<p>Most general surgical diagnoses require referral to specialist management. However, these guidelines are provided to give greater clarity in situations of the primary/secondary interface of care. Clearly telephone/fax communication would enhance appropriate treatment.</p> <p><b>If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the General Surgery registrar on call on 9076 2000.</b></p>

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>MISCELLANEOUS GENERAL SURGERY</b>			
<p><b>HERNIA</b> Incisional/Femoral/ Inguinal hernia</p>	<ul style="list-style-type: none"> <li>▪ Pain in groin sometimes precedes lump. Pain may be colicky and associated with vomiting (intestinal obstruction)</li> <li>▪ Lump in groin - may be intermittent/reducible but is usually most obvious when patient is standing</li> </ul>	<ul style="list-style-type: none"> <li>▪ Diagnostic studies may include Ultrasound (only required if hernia can not be felt on examination <a href="#">The Alfred Radiology request form</a>)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to any UGIS clinic - PRIORITY 2-4</li> <li>▪ Refer for immediate admission via The Alfred Emergency &amp; Trauma Centre if incarcerated and symptoms of bowel obstruction, local tenderness or erythema</li> </ul>
<p><b>SKIN</b></p>	<ul style="list-style-type: none"> <li>▪ Cross refer to appropriate unit guidelines: <a href="#">Dermatology Referral and Management Guidelines</a> <a href="#">Plastic Surgery Referral and Management Guidelines</a></li> </ul>		
<p><b>VENOUS</b></p>	<ul style="list-style-type: none"> <li>▪ Refer to Vascular Surgery Guidelines: <a href="#">Vascular Surgery Referral and Management Guidelines</a></li> </ul>		

## REFERRAL & MANAGEMENT GUIDELINES: BREAST & ENDOCRINE (BES)

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>NECK</b>			
Painful Mass	<ul style="list-style-type: none"> <li>▪ Complete head and neck exam indicated for site of infection:                             <ul style="list-style-type: none"> <li>○ FBE</li> <li>○ Cultures, when indicated</li> <li>○ Consider HIV/intradermal TB/Paul Bunnell (if indicated)</li> <li>○ Consider possible cat scratch disease (toxoplasmosis titres)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Appropriate antibiotic trial see <a href="#">ENT Otolaryngology Referral and Management Guidelines</a></li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral to BES Clinic indicated if mass persists for two weeks without improvement. Urgent referral if painless, progressive, enlargement or if suspicion of metastatic carcinoma - PRIORITY 1</li> </ul>
Painless Mass	<ul style="list-style-type: none"> <li>▪ Complete head and neck exam indicated for site of primary:                             <ul style="list-style-type: none"> <li>○ TFTs</li> <li>○ Open biopsy is contraindicated</li> <li>○ CT or ultrasound</li> </ul> </li> <li>○ <a href="#">The Alfred Radiology request form</a></li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to BES (see above)</li> </ul>
<b>THYROID MASSES</b>			
	<ul style="list-style-type: none"> <li>▪ Solitary vs multi-nodular</li> <li>▪ Euthyroid vs hypo/hyper thyroid</li> <li>▪ Compression symptoms</li> <li>▪ Risk factors</li> <li>▪ Current medical treatment</li> <li><b>Investigations</b> <ul style="list-style-type: none"> <li>▪ FBE</li> <li>▪ TFTs/Antibodies</li> <li>▪ Ultrasound or CT thyroid</li> <li>▪ FNA solitary nodule after imaging</li> <li>▪ Nuclear Scan (<b>Hyperthyroid only</b>)</li> </ul> </li> <li>○ <a href="#">The Alfred Radiology request form</a></li> </ul>	<ul style="list-style-type: none"> <li>▪ Hyper or Hypo thyroid patients should be treated to render euthyroid</li> <li>▪ Steroids for thyroiditis</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to Breast and Endocrine clinic any suspicious lesions, disease refractory to medical management or causing compression symptoms - PRIORITY 2</li> </ul>
<b>ADRENAL MASS</b>			
	<ul style="list-style-type: none"> <li>▪ Often incidentally found on CT. May be associated with hypertension (Conn's syndrome or phaeochromocytoma)</li> <li><b>Investigations</b> <ul style="list-style-type: none"> <li>▪ Fine cut CT</li> <li>○ <a href="#">The Alfred Radiology request form</a></li> <li>▪ Serum K+</li> <li>▪ Urinary catecholamines</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer all functioning lesions to BES - PRIORITY 1</li> <li>▪ Refer non-functioning adenomas for review by BES - PRIORITY 2 and for ongoing surveillance</li> <li>▪ Refer all Adrenal Masses &gt;4cm</li> <li>▪ PRIORITY 1</li> </ul>
<b>PARATHYROID DISEASE</b>			
	<ul style="list-style-type: none"> <li>▪ May be in conjunction with renal disease</li> <li>▪ May be part of a familiar syndrome such as MENI</li> <li><b>Investigations</b> <ul style="list-style-type: none"> <li>▪ PTH/Ca<sup>2+</sup></li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to Breast and Endocrine clinic for management - PRIORITY 1-2</li> </ul>
<b>BREAST DISEASE</b>			
Queries by phone to breast surgeons are welcome			
<b>Family History</b>	Request for assessment by a woman with a strong family history of breast cancer	<ul style="list-style-type: none"> <li>▪ For women with a positive family history, it is recommended that their baseline mammography is carried out 10 years before the age at which the mother was diagnosed</li> <li>▪ Women who have a high risk, eg family or past history will require more active management</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral to a family cancer genetics clinic where possible</li> </ul>

## REFERRAL & MANAGEMENT GUIDELINES: BREAST & ENDOCRINE CLINIC (BES)

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>BREAST DISEASE CONT.</b>			
Queries by phone to breast surgeons are welcome			
<b>Breast Lump</b>	<ul style="list-style-type: none"> <li>▪ Triple assessment                             <ul style="list-style-type: none"> <li>○ Clinical examination</li> <li>○ Imaging (mammography and/or ultrasound)</li> </ul> </li> <li>▪ <a href="#">The Alfred Radiology request form</a> <ul style="list-style-type: none"> <li>○ Fine needle aspiration cytology (± core biopsy)</li> </ul> </li> <li>▪ If any of the investigations are inconclusive or don't correlate with the other results, then a benign result should not be accepted</li> <li>▪ A fine needle aspiration (FNA) alone is an incomplete investigation. FNA may preclude effective mammography/clinical exam for up to 6 weeks. FNA should be after the radiological investigation to reduce the discomfort for the patient</li> <li>▪ Surgeons prefer to see patient before FNA - especially if patient has a suspected small carcinoma, as it is difficult to assess a patient with bruising</li> </ul>	<ul style="list-style-type: none"> <li>▪ General practitioner management initially:                             <ul style="list-style-type: none"> <li>○ Young women with tender, lumpy breasts and older women with symmetrical nodality, provided that they have no localised abnormality</li> </ul> </li> <li>▪ Any lump that increases in size should be reviewed/referred</li> <li>▪ Breast screening programs                             <ul style="list-style-type: none"> <li>○ Breast screen program - 50 to 65 years - is funded to investigate asymptomatic patients only to the point of clear diagnosis</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Conditions that require referral to BES clinic – Contact Surgical registrar or PRIORITY 1                             <ul style="list-style-type: none"> <li>○ Any new discrete lump</li> <li>○ New lump in pre-existing nodality</li> <li>○ Asymmetrically nodality that persists at review after menstruation</li> <li>○ Abscess</li> <li>○ Cyst persistently refilling or recurrent cyst</li> </ul> </li> </ul>
<b>Breast Pain</b>	<ul style="list-style-type: none"> <li>▪ Unilateral persistent mastalgia</li> <li>▪ Mammography or ultra-sonograph</li> <li>▪ <a href="#">The Alfred Radiology request form</a></li> <li>▪ Localised areas of painful nodality</li> <li>▪ Mammography or ultra-sonograph</li> <li>▪ Focal lesions</li> <li>▪ Fine needle aspiration cytology</li> </ul>	<ul style="list-style-type: none"> <li>▪ Women with minor moderate degrees of breast pain who do not have a discrete palpable lesion</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to BES clinic</li> <li>▪ If associated with a lump</li> <li>▪ Intractable pain not responding to reassurance, simple measures such as wearing a well-supporting bra, and common drugs</li> <li>▪ Unilateral, persistent pain in post-menopausal women</li> </ul>
<b>Nipple Discharge</b>	<ul style="list-style-type: none"> <li>▪ Clinical examination</li> <li>▪ Mammography</li> <li>▪ Ultrasound</li> <li>▪ <a href="#">The Alfred Radiology request form</a></li> </ul>	<ul style="list-style-type: none"> <li>▪ Women aged under 50 who have nipple discharge that is from more than one duct or is intermittent and is neither bloodstained not troublesome</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to BES clinic</li> <li>▪ All women aged 50 and over</li> <li>▪ Women under 50 with:                             <ul style="list-style-type: none"> <li>▪ Bilateral discharge sufficient to stain clothes</li> <li>▪ Blood stained</li> <li>▪ Persistent single duct</li> </ul> </li> </ul>
<b>Nipple Retraction</b>	<ul style="list-style-type: none"> <li>▪ Clinical examination</li> <li>▪ Mammography</li> <li>▪ Ultrasound</li> <li>▪ <a href="#">The Alfred Radiology request form</a></li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to BES clinic</li> <li>▪ Nipple retraction or distortion, nipple eczema</li> </ul>
<b>Change in skin Contour</b>	<ul style="list-style-type: none"> <li>▪ Clinical examination</li> <li>▪ Mammography</li> <li>▪ Ultrasound</li> <li>▪ <a href="#">The Alfred Radiology request form</a></li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to BES clinic</li> <li>▪ Change in skin contour</li> </ul>

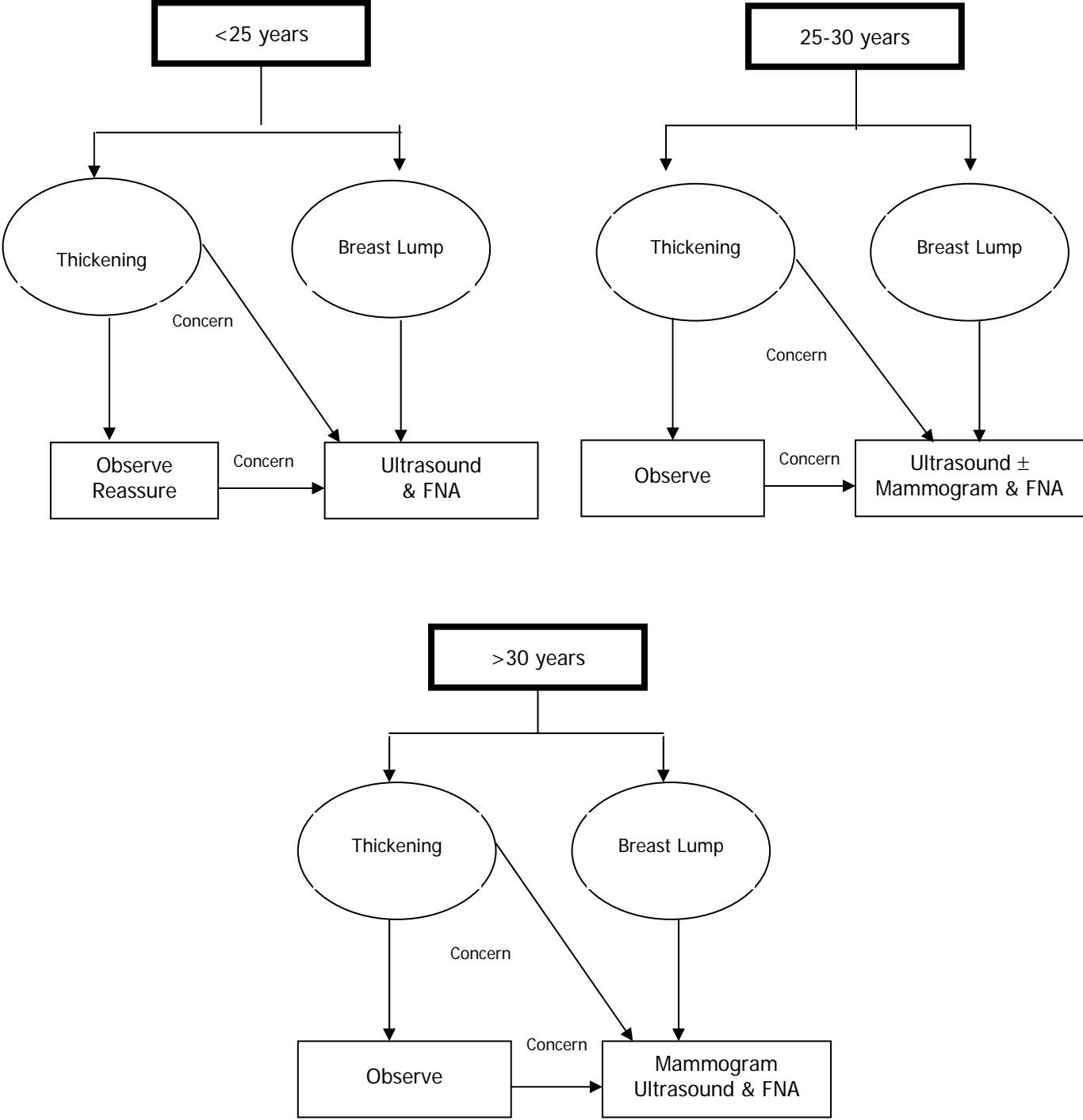
## REFERRAL & MANAGEMENT GUIDELINES: COLO-RECTAL SERVICE (CRS)

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>INFLAMMATORY BOWEL DISEASE</b>			
	<ul style="list-style-type: none"> <li>▪ Family/personal history of Crohn's Disease</li> <li>▪ Pain (site, acute/chronic, continuous/episodic)</li> <li>▪ Vomiting</li> <li>▪ Weight loss</li> <li>▪ Diarrhoea</li> <li>▪ Fever</li> <li>▪ Abdominal mass</li> <li>▪ History of previous surgery (adhesions or malignancy)</li> <li>▪ Anaemia and melaena</li> <li>▪ Steatorrhoea</li> <li>▪ Atrial fibrillation/recent MI</li> <li>▪ Previous arterial embolus</li> <li>▪ Last passed flatus?</li> <li>▪ FBE &amp; ESR/CRP</li> <li>▪ B12, folate and Fe studies</li> <li>▪</li> </ul>	<ul style="list-style-type: none"> <li>▪ Case of known Crohn's Disease can be managed by GPs in liaison with specialist</li> <li>▪ Attempted conservative management of recurrent incomplete small bowel obstruction, eg antispasmodics, clear fluids, simple analgesia</li> </ul>	<p><b>Acute Admission to The Alfred Emergency &amp; Trauma Centre</b></p> <ul style="list-style-type: none"> <li>▪ Complications of Crohn's</li> <li>▪ Intestinal obstructions with colic, vomiting, distension and no passage of flatus</li> <li>▪ Peritonitis</li> <li>▪ ? Ischaemia</li> </ul> <p><b>Referral:</b></p> <ul style="list-style-type: none"> <li>▪ Suspected Crohn's - PRIORITY 2</li> </ul>
<b>DISEASES OF THE COLON</b>			
<b>c.f. Gastroenterology referral recommendations</b>	<ul style="list-style-type: none"> <li>▪ Pain (site, acute/chronic, continuous/episodic)</li> <li>▪ Weight loss</li> <li>▪ Medications</li> <li>▪ Exaggerated gastro colic reflex</li> <li>▪ Ascites</li> <li>▪ Mass</li> <li>▪ Tenesmus</li> <li>▪ History of Malignancy</li> <li>▪ Blood, pus, mucus (PR)</li> <li>▪ Consider infectious/tropical diseases</li> <li>▪ Altered bowel habits</li> <li>▪ Fever</li> <li>▪ Flatus</li> <li>▪ Incomplete rectal emptying</li> <li>▪ Family history of inflammatory bowel disease, polyposis or cancer</li> </ul> <p><b>Investigations</b> (for confirmed Cancer)</p> <ul style="list-style-type: none"> <li>▪ CT Scan of Abdomen and Pelvis</li> </ul> <p><a href="#">The Alfred Radiology request form</a></p>	<ul style="list-style-type: none"> <li>▪ Cases with confirmed Cancer.</li> <li>▪ Patients who have vague lower abdominal pain or change in bowel habits (to constipation) Should be referred for colonoscopy</li> </ul> <p><b>**Refer to Open Access Endoscopy clinic (Phone 9076 0237 for referral form)</b></p> <ul style="list-style-type: none"> <li>▪ Consider iron replacement while awaiting investigations</li> <li>▪ Cases of known Inflammatory Bowel Disease can be managed by GPs in liaison with specialists</li> <li>▪ Acute mild diverticulitis: antibiotics, fibre, and antispasmodics.</li> <li>▪ Complex constipation: standard investigations and referral when normal medical therapy inadequate.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patients with confirmed Cancer- Contact Surgical Registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul> <p><b>Acute Admission to The Alfred Emergency &amp; Trauma Centre:</b></p> <ul style="list-style-type: none"> <li>▪ Large bowel obstruction</li> <li>▪ Diverticulitis with evidence of systemic sepsis</li> <li>▪ Severe bleeding</li> <li>▪ Suspected appendicitis</li> <li>▪ Fulminant colitis</li> </ul> <p><b>Other Referrals</b></p> <ul style="list-style-type: none"> <li>▪ Patients who have suspicious bleeding or change in bowel habit should be referred for colonoscopy - PRIORITY 1</li> <li>▪ Patients with diagnosed recurrent attacks of diverticulitis should be referred for specialist opinion - PRIORITY 2 (Colorectal Clinic)</li> </ul> <p>Guidelines for screening colonoscopy – refer to <a href="#">NH&amp;MRC Colorectal guidelines</a></p>
<b>ANO-RECTAL DISEASE</b>			
<b>Haemorrhoids</b>	<ul style="list-style-type: none"> <li>▪ History of ano-rectal bleeding</li> <li>▪ Prolapse and thrombosis</li> <li>▪ Evaluation:                             <ul style="list-style-type: none"> <li>○ PR</li> <li>○ Proctoscopy</li> <li>○ Sigmoidoscopy</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Lifestyle/dietary advice/ modification</li> <li>▪ Proprietary creams/ suppositories</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer for colonoscopy if underlying disease suspected – PRIORITY 1</li> <li>▪ Points for concern                             <ul style="list-style-type: none"> <li>○ An associated change in bowel habit</li> <li>○ Blood mixed with stool</li> <li>○ Associated pain and discomfort in the absence of thrombosis or other pathology such as a fissure</li> <li>○ Palpable mass on rectal examination</li> <li>○ Copious bleeding with associated anaemia</li> </ul> </li> </ul>
<b>Anal Fistula</b>	<ul style="list-style-type: none"> <li>▪ History of recurrent perianal abscesses, discharge sinus, and previous drainage operation</li> <li>▪ Evaluation:                             <ul style="list-style-type: none"> <li>○ PR</li> <li>○ Proctoscopy</li> <li>○ Sigmoidoscopy</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to CRS clinic for management and exclusion of associated disease - PRIORITY 2</li> </ul>
<b>Anal Fissure</b>	<ul style="list-style-type: none"> <li>▪ History of pain with and after defecation.</li> <li>▪ Attacks may be intermittent or prolonged</li> <li>▪ Evaluation may be difficult due to spasm</li> <li>▪ Note anal tag</li> </ul>	<ul style="list-style-type: none"> <li>▪ Proprietary creams/ suppositories</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to CRS clinic for management and exclusion of associated disease - PRIORITY 2</li> </ul>

## REFERRAL & MANAGEMENT GUIDELINES: UPPER GASTROINTESTINAL SERVICE (UGIS)

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>DISORDERS OF THE OESOPHAGUS</b>			
<b>Dysphagia</b>	<ul style="list-style-type: none"> <li>▪ Particularly important is any history of:                             <ul style="list-style-type: none"> <li>○ Loss of weight</li> <li>○ Anaemia</li> <li>○ Progressive Dysphagia</li> <li>○ Liquids Vs solids</li> </ul> </li> <li>▪ May include history or findings of:                             <ul style="list-style-type: none"> <li>○ Foreign body ingestion</li> <li>○ Gastro-oesophageal motility disorder</li> <li>○ Neoplasm</li> <li>○ Nocturnal choking or coughing attacks</li> </ul> </li> <li>▪ Scleroderma</li> </ul>	<ul style="list-style-type: none"> <li>▪ Diagnostic studies may include (depending on history):                             <ul style="list-style-type: none"> <li>○ Ba swallow/meal is the first investigation of choice</li> <li>○ Gastroscopy</li> <li>○ Soft tissue imaging studies of the neck</li> </ul> </li> </ul> <p style="text-align: center;"><a href="#">The Alfred Radiology request form</a></p>	<ul style="list-style-type: none"> <li>▪ Refer to UGIS Clinic</li> <li>▪ Refer to UGIS if oesophageal aetiology suspected</li> <li>▪ Refer to BES clinic if thyroid suspected</li> </ul>
<b>Reflux Symptoms</b>	<ul style="list-style-type: none"> <li>▪ May include history of findings of:                             <ul style="list-style-type: none"> <li>○ Heartburn</li> <li>○ Water brash</li> <li>○ Volume reflux / regurgitation</li> <li>○ Nocturnal choking or coughing attacks</li> <li>○ Odynophagia</li> <li>○ Atypical symptoms include cough, and asthma, best initially screened via respiratory clinic</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Lifestyle modification (weight loss, smaller meals, smoking cessation, bed head raise, etc.)</li> <li>▪ A trial of PPI therapy may be appropriate:                             <ul style="list-style-type: none"> <li>○ Should have gastroscopy if symptoms don't resolve after 6 week trial of PPIs OR if there is weight loss, haematemesis, iron deficiency anaemia, age &gt;45, dysphagia etc.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer to UGIS if medication is required for 6 weeks or more, or if symptoms of weight loss, anaemia or dysphagia are evident. The patient should attend with results of a recent gastroscopy</li> </ul>
<b>DISORDERS OF THE STOMACH AND DUODENUM</b>			
<b>Stomach - Duodenum</b>	<ul style="list-style-type: none"> <li>▪ Pain (site, acute/chronic, continuous/episodic)</li> <li>▪ Nausea and vomiting</li> <li>▪ Weight loss</li> <li>▪ Haematemesis and/or malaena</li> <li>▪ Anaemia</li> <li>▪ Medications</li> <li>▪ Post prandial fullness</li> <li>▪ Alcohol intake</li> <li>▪ Breath testing may be useful to confirm presence of <i>H.pylori</i>.</li> </ul>	<p><b>Non-Acute</b></p> <ul style="list-style-type: none"> <li>▪ Review other medications eg NSAID's, prednisone</li> <li>▪ Lifestyle modifications</li> <li>▪</li> </ul>	<p><b>Acute</b></p> <ul style="list-style-type: none"> <li>▪ Refer to The Alfred Emergency &amp; Trauma Centre for immediate admission (suspected perforation, haematemesis/malaena)</li> </ul> <p><b>Non- Acute</b></p> <ul style="list-style-type: none"> <li>▪ If inadequate response to treatment after two months, refer for endoscopy</li> <li>▪ Pain with weight loss or pain with anaemia</li> <li>▪ Post-prandial vomiting: refer for endoscopy.</li> <li>▪ If specialist follow up required after endoscopy refer to UGIS</li> </ul>
<b>PANCREAS, BILIARY TREE AND LIVER</b>			
	<ul style="list-style-type: none"> <li>▪ Charcot's Triad:                             <ul style="list-style-type: none"> <li>▪ Pain (site, acute/chronic, continuous/episodic)</li> <li>▪ Jaundice</li> <li>▪ Fever</li> <li>▪ = Cholangitis</li> </ul> </li> <li>▪ Courvoisier's Law:                             <ul style="list-style-type: none"> <li>▪ Painless, obstructive jaundice</li> <li>▪ Palpable Gallbladder</li> <li>▪ = Ca. Pancreas</li> </ul> </li> <li><b>Investigations:</b> <ul style="list-style-type: none"> <li>○ FBE</li> <li>○ Liver function tests</li> <li>○ Amylase</li> <li>○ Hepatitis serology, if indicated</li> <li>○ Ultrasound</li> </ul> </li> </ul> <p style="text-align: center;"><a href="#">The Alfred Radiology request form</a></p> <p><b>NB Obstructive Jaundice</b></p> <ul style="list-style-type: none"> <li>▪ Investigate initially with ultrasound.</li> <li>▪ If no gallstones, next order</li> <li>▪ 'CT upper abdomen with pancreas protocol'</li> </ul> <p style="text-align: center;"><a href="#">The Alfred Radiology request form</a></p>	<ul style="list-style-type: none"> <li>▪ Known gallstones                             <ul style="list-style-type: none"> <li>○ Low fat diet</li> <li>○ Short attacks of biliary colic can be managed symptomatically</li> <li>○ Known CBD stones - twice daily temperatures by patient &amp; present to The Alfred Emergency &amp; Trauma Centre if febrile &gt;38</li> </ul> </li> <li>▪ Gallstones, points for concern:                             <ul style="list-style-type: none"> <li>○ Increasing frequency and severity of pain</li> <li>○ Documented jaundice or deranged liver function tests</li> <li>○ Documented pancreatitis</li> <li>○ Ultrasound evidence of duct dilatation</li> </ul> </li> </ul> <p style="text-align: center;"><a href="#">The Alfred Radiology request form</a></p> <ul style="list-style-type: none"> <li>▪ Palpable gall-bladder</li> <li>▪ Proven pancreatitis                             <ul style="list-style-type: none"> <li>○ Avoid alcohol</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate admission – via The Alfred Emergency &amp; Trauma Centre for acute pancreatitis, or severe biliary pain unrelieved (or recurrent after) single dose opiate analgesia</li> <li>▪ Immediate referral (phone Surgical registrar or send to The Alfred Emergency &amp; Trauma Centre)                             <ul style="list-style-type: none"> <li>○ Obstructive jaundice</li> <li>○ CBD stones</li> <li>○ Pancreatic or liver mass</li> <li>○ Liver metastases</li> </ul> </li> <li>▪ Other referrals:                             <ul style="list-style-type: none"> <li>○ Symptomatic cholelithiasis - PRIORITY 1</li> <li>○ Ultrasound abnormalities requiring further elucidation - PRIORITY 1</li> </ul> </li> </ul> <p style="text-align: center;"><a href="#">The Alfred Radiology request form</a></p> <ul style="list-style-type: none"> <li>○ Chronic pancreatitis- PRIORITY 1</li> </ul>

**Guide for Investigation of a Breast Lump**  
 - Triage process for first presentation with no family or past history -  
 (Adapted from General Surgery Review process, CDHB. 2001)



**NOTE:** The initial investigation of choice for symptomatic women are mammograms for women >30 years and ultrasound for women <30 years. (For women 30-35 years some radiologists recommend ultrasound)

Women who have a high risk eg family or past history will require more active management.