### GASTROENTEROLOGY REFERRAL RECOMMENDATIONS

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<th>Diagnosis / Symptomatology</th>
<th>Evaluation</th>
<th>Management Options</th>
<th>Referral Guidelines</th>
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<tr>
<td>General problems include:</td>
<td>A thorough history and physical examination is required to determine the specific diagnosis. Key signs and symptoms, and pertinent investigations are indicated (see below).</td>
<td>Specific treatments depend on the specific problem.</td>
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<tr>
<td>• Upper GI tract</td>
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<tr>
<td>• Lower GI tract</td>
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<td>• Liver</td>
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<tr>
<td>• Pancreatoco-biliary</td>
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### Upper Gastro-Intestinal Tract

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<tr>
<th>Oesophageal manometry service</th>
<th>Statewide service provided at Royal Perth hospital. For patients with: • Difficulty in swallowing. • Gastric reflux. Patients may also require a 24 hour pH Study.</th>
<th>Refer patient to gastroenterologist for assessment.</th>
<th>Urgent-Routine based on clinical discretion.</th>
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**Dysphagia**

- pharyngeal
- or
- oesophageal

| (cf ENT Referral Recommendation) | FBC + ESR. History of stroke/neurological conditions. NB smoking and alcohol history. Diagnostic studies may include: • soft tissue studies of the neck. • CXR/CT of chest. • Barium swallow +/- videofluoroscopy. | Management may include: • Anti reflux management. • Speech Language Therapy assessment. • Endoscopic intervention. | Refer to Gastro/Endoscopy service. Obstructive dysphagia with food bolus or with haematemesis should be referred urgently to gastroenterology service – Urgent. Obstructive dysphagia with alarm symptoms (acute onset or progressive symptoms, anaemia, weight loss) – Urgent. Dysmotility dysphagia problems without alarm symptoms should be referred to gastroenterology service semi-urgently - Semi-urgent. |

*Updated December 2014*
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<tr>
<td><strong>Dyspepsia / upper abdominal pain</strong></td>
<td>Alarm symptoms: (anaemia, weight loss, anorexia and vomiting and GI bleeding and dysphagia). Symptom duration. Age. Treatment (empirical no response). Current drug regimen (NSAIDs, alcohol). Investigations: FBC &amp; ESR. LFTs &amp;/or Amylase? Helicobacter pylori antibody. Imaging to be considered: US or CT.</td>
<td>Life Style Changes (weight loss, cease smoking, limit alcohol etc). Trial of H2RAs or PPIs or Helicobacter pylori eradication therapy if +ve antibody.</td>
<td>Should be referred urgently to Gastroenterology/Endoscopy service Semi-urgent.</td>
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<tr>
<td><strong>Upper Gastro-Intestinal Tract Haemorrhage (Haematemesis and/or melaena)</strong></td>
<td><strong>Acute</strong> (Haemodynamically unstable). <strong>Sub-Acute</strong> (Haemodynamically stable). Check FBC. *Elderly patients (&gt; 60) and those with significant co-morbid disease are at very high risk. (Note: Blood pressure, particularly in response to postural changes, is a good indicator of haemodynamic stability in these situations). <strong>Chronic (Iron Deficiency Anaemia)</strong>  • GI or non-GI causes. • Age &amp; gender. • Diet. • Menstrual loss. • Blood donation.</td>
<td>Resuscitation &amp; Ambulance transfer. Cease Ulcerogenic drugs. Oral iron supplements if confirmed iron deficient and refer. Cease potentially ulcerogenic drugs and refer.</td>
<td>Immediate inpatient hospital referral – Urgent. If Hb &lt; 100gm/l and symptomatic refer for immediate hospital admission – Urgent. If on anticoagulants refer for immediate admission – Urgent. If Hb &gt; 100mg/l &amp; asymptomatic refer urgent to Gastro/Endoscopy service – Urgent. Refer Gastro/Endoscopy service. If Hb &lt; 90gms and symptomatic or on warfarin refer urgent to Gastro/Endoscopy service – Urgent. If Hb &gt; 90gms and asymptomatic refer urgent to Gastro/Endoscopy service.</td>
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<td>CPAC Gastroenterology</td>
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| **Drugs.**  
*Previous Endoscopy/GI surgery.*  
*Check FBC & ESR.*  
*Iron studies & Ferritin.*  
*Note: FOBs have no role in the investigation of iron deficiency anaemia.*  
*Note: 15-20% of premenopausal women are iron deficient.*  |
| **Dietary management if indicated.**  |
| **semi-urgent to Gastro/Endoscopy service**  
*Urgent.*  
*If Hb normal (iron deficiency without anaemia) and a) male or b) female with symptoms or age > 45 years refer semi-urgent to Gastro/Endoscopy service – Semi-urgent.*  |

| **Vomiting & Nausea**  
(*>2 week’s duration*)  |
|-----------------------|
| **Consider both GI and non-GI causes.**  
**Age & gender.**  
**Associated symptoms.**  
**Smoking & alcohol.**  
**Drugs.**  |
| **Symptomatic management with standard anti-emetics etc.**  |
| **Refer to appropriate specialty service depending on results and assessment.**  |

| **Investigations:**  
*FBC & ESR.*  
*Creatinine.*  
*U & Es.*  
*Calcium/phosphate.*  
*LFTs.*  
*Fasting Glucose.*  
*Dipstix Urinalysis.*  
*Urine HCG.*  |

| **Weight Loss**  
(*10% Body Weight or more*)  |
|-----------------------|
| **Consider both GI and non-GI causes.**  
**Definitively document reported weight loss.**  
**Age & gender.**  
**Associated symptoms.**  
**Smoking & alcohol.**  |
| **Life style changes if appropriate.**  |
| **Refer to appropriate speciality service depending on results.**  |

| **Investigations:**  
*FBC & ESR.*  
*CXR.*  
*TFTs.*  
*Creatinine.*  
*Electrolytes.*  
*LFTs.*  
*Fasting Glucose.*  
*Dipstix Urinalysis.*  |

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| Lower Gastro-Intestinal Tract | Consider non-GI causes eg. urological, gynaecology etc.  
• Chronic vs acute.  
• Duration.  
• Associated symptoms.  
• Drugs.  
• Family Hx CRC/Polyps.  
• Age & gender.  
• Overseas travel/immigration.  
Investigations:  
• FBC & ESR.  
• LFTs.  
• MSU.  
• AXR – supine.  
• Abdominal and/or Pelvis Ultrasound.  
• Rectal & Bimanual examinations | Treat symptomatically as clinically appropriate. | Refer to appropriate speciality service depending on results or clinical response. |
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<td>Altered Bowel Habit</td>
<td>Age (&gt; 40) and/or alarm symptoms* and/or family history CRC or IBD. Recent antibiotic usage see CPAC. Investigations: FBC &amp; ESR. Dipstix Urinalysis. Stools M, C &amp; S + parasites. Rectal examination. Age (&lt; 40) and no alarm symptoms/normal lab tests/no family hx CRC/IBD/Polyps recent antibiotic usage. Investigations: FBC &amp; ESR. Dipstix Urinalysis. Stools M, C &amp; S + parasites. Rectal examination.</td>
<td>Manage symptomatically if results suggest functional large bowel disorder (Irritable Bowel). Eg bulking agents, antispasmodics, anti-diarrheals, lifestyle advise etc.</td>
<td>Refer for colonoscopy or possibly Ba Enema in conjunction with Sigmoidoscopy (rigid or flexible) – Semi-urgent. NOTE: all functional bowel disorders should not be referred to tertiary hospital for assessment. Refer to general hospitals or where appropriate to the private sector. Refer only patients who have functional bowel disorder with persistent or refractory symptoms greater than six months – Routine. If results abnormal and or clinical suspicion of organic large bowel disease refer to gastroenterology/endoscopy service – Urgent-Routine depending on abnormality uncovered as specialist’s discretion.</td>
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## Diagnosis / Symptomatology

### Acute (<6 weeks)
- Increased frequency and/or abnormal stool consistency.
- Overseas travel.
- Drugs.
- Antibiotics.
- Dietary indiscretion.
- Diarrhoeal contacts.
- Associated symptoms.
- Vascular diseases.

- Family Hx IBD.
- Non-colonic symptoms suggestive of IBD eg Uveitis, synovitis, erythema nodosum anal fissure etc.

**Investigations:**
- FBC and ESR.
- Rectal examination.
- Stools M, C & S + parasites.
- Consider clostridium difficile toxin (antibiotics).
- Rigid Sigmoidoscopy +/- rectal biopsy (if skilled).

**Management Options:**
- If infectious treat as appropriate and report to Public Health Authority.
- Food handling and hygiene advice.
- Seek advice from specialist where indicated e.g. Amoebic dysentery.
- If non-infectious treat symptomatically with standard antidiarrhoels e.g. bulking agents or loperamide.
- Seek specialist advice.

**Referral Guidelines:**
- Refer if significantly dehydrated, septic or an abdominal complication suspected – Urgent.
- Mild – Moderate – refer if needed to Gastroenterology Service – Semi-urgent.

### Chronic (6 weeks)
- Increased frequency and/or abnormal stool consistency.
- Overseas travel.
- Drugs.
- Antibiotics.
- Dietary indiscretion.
- Diarrhoeal contacts.
- Associated symptoms.
- Vascular diseases.
- Known colonic disease.
- Family Hx colonic/coeliac disease.
- Weight Loss/Nutrition.
- History of GI surgery.

**Management Options:**
- Refer to specialist service (eg. Gastroenterology) for further investigation and management.
- Moderate and Severe diarrhoea – Semi-urgent.
- Mild diarrhoea – Routine.
- Family Hx IBD.
- Non-colonic symptoms suggestive of IBD eg. Uveitis, synovitis, erythema nodosum, anal fissure etc.

**Investigations:**
- Rectal examination.
- Stools M, C & S + parasites.
- Clostridium difficile toxin (antibiotics).
- FBC & ESR.
- TFTs.
- Folate & B12.
- Iron studies & ferritin.
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| Rectal Bleeding            | - Nature fresh or dark  
- Quantity  
- Painful vs painless  
- Mixed or non-mixed with stools  
- Age and gender  
- Chronic vs acute  
- Tenesmus  
- Family Hx CRC/PolyPS/IBD | If large volume significant bleeding may need urgent admission to hospital with resuscitation and transfusion.  
If clinically benign anorectal bleeding (age < 40 and unchanged bowel habit) eg anal fissure or haemorrhoids, Rx symptomatically with bulking agents, life style advice and proprietary anal creams and suppositories (see General Surgical referral recommendations). | Active bleeding with anaemia or haemodynamic compromise for referral to Gastroenterology/Endoscopy/General Surgery – Urgent.  
Bleeding age > 40 years or significant bleeding age<40 years should be referred to Gastroenterology/Endoscopy/General Surgery – Urgent-Semi-urgentfor outpatient assessment or colonoscopy. |
| Family History of Colon Cancer | One first degree relative with bowel cancer diagnosed under the age of 55 years, or two or more first degree relatives on the same side of the family with bowel cancer at any age (risk : three-six fold)  
One first degree relative (parent, sibling or child) with bowel cancer diagnosed at age 55 years or older.  
More complex family history of bowel cancer than above two scenarios. | Colonoscopy every five years starting at age 50 years, or at an age 10 years younger than the age of the earliest diagnosis of bowel cancer (whichever comes first) – Routine.  
FOBT every second year from age 50 years (up to 75 years). These patients receive screening as for asymptomatic and average risk individuals; referral to specialist generally not required.  
Referral to gastroenterology service for clinical review. Genetic testing may subsequently be arranged. |
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<tr>
<td>Liver</td>
<td>Clinical:</td>
<td>Hepatocellular jaundice (viral or drug hepatitis):</td>
<td>Refer to Gastroenterology or General Medicine service if:</td>
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<tr>
<td></td>
<td>• Acute vs chronic.</td>
<td>• Rest.</td>
<td>• Suspected acute, severe or fulminant hepatic failure – Urgent.</td>
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<td>• Occupation.</td>
<td>• No alcohol.</td>
<td>• Severe clinical or biochemical hepatocellular jaundice – Urgent.</td>
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<td>• Overseas travel.</td>
<td>• Good diet.</td>
<td>• Obstructive jaundice (dilated ducts) – Urgent.</td>
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<td>• Sexual history.</td>
<td>• Stop potential hepatotoxic drugs.</td>
<td>• Unexplained non-obstructive cholestatic jaundice – Urgent – Semi-urgent.</td>
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<td>• Drug history (pharmacological and recreational).</td>
<td>• Regular laboratory and clinical review.</td>
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<td>• Associated symptoms (pruritus, steatorrhoea, bruising, dark urine, etc).</td>
<td>Cholestatic jaundice</td>
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<td>• Alcohol consumption.</td>
<td>• Low fat diet and no alcohol.</td>
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<td>• Possible hepatitis contacts.</td>
<td>• Stop potential cholestatic drugs.</td>
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<td>• Family history of liver disease or blood disorders.</td>
<td>• Vitamin K if prolonged prothrombin time.</td>
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<td>• Needle stick injury (if at risk occupation).</td>
<td>• Dilated ducts on ultrasound; refer.</td>
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<td>Investigations:</td>
<td>• Undilated ducts on ultrasound; check IgM, AMA.</td>
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<td>• Liver function tests.</td>
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<td>• Hepatocellular (elevated Transaminases) – EBV, CMV, HAV, HBV HCV testing.</td>
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<td>• Cholestatic (elevated ALP and GGT).</td>
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<td>• Iron studies, caeruloplasmin, alpha-1.</td>
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<td>• Antitrypsin.</td>
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<td>• ANF, ASMA, AMA.</td>
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<td>• Ultrasound.</td>
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<td>• FBC, platelets and if isolated elevated bilirubin a haemolysis screen.</td>
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<td>• Prothrombin time.</td>
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</table>
| Abnormal liver function tests | Acute (<6/52) vs chronic (6/12)  
- History as for jaundice.  
- Gender.  
- History of autoimmune disease.  
- Concurrent obesity, hyperlipidemia, obesity?  
- Menstrual history.  
- Signs of chronic liver disease. |  
- Suspected fatty liver?  
Lifestyle – weight loss, low fat diet, alcohol abstention, stop drug(s) where applicable and monitor LFTs  
- Non-fatty liver?  
Satisfactory diet, alcohol reduction or abstention where applicable and monitor LFTs. | Refer to Gastroenterology service if:  
- Cause undetermined after previous investigation negative – Routine.  
- LFTs remain abnormal despite lifestyle measures – Routine.  
- Clinical concern that there is significant chronic liver disease – Routine.  
- Possible requirement for liver biopsy – Routine. |
| Investigations:  
- 1xs as above for jaundice  
- ANF and RF  
- Autoantibody screen  
- Ferritin and iron studies  
- IgM and AMA  
- Lipid profile  
- Blood glucose | | |
| Hepatitis C | Risk Assessment  
- Ever injected.  
- Ever been in prison.  
- Received blood or blood products before 1990.  
- Received blood or blood products overseas.  
- Had an occupational or environment exposure to HCV.  
- Abnormal Lfts or evidence of liver disease with no apparent cause.  
- Extra hepatic manifestations of hepatitis: (eg. Vasculitis, peripheral neuropathy).  
- Renal dialysis patient. | Anti HCV +ve /  
HCV RNA –ve  
- Natural history of Hep C.  
- Post test counselling.  
- May have cleared virus.  
- Repeat PCR.  
- Check LFTs in 12 months.  
- Discuss prevention.  
HCV RNA +ve/  
Normal ALT  
- Monitor Alts every six months.  
- Monitor signs & symptoms of liver disease.  
- Discuss mode of transmission/prevention.  
- Alcohol reduction. |  
- Refer to Hepatitis Service  
Categorisation will depend on the degree of decompensated liver disease – based on specialist’s assessment Urgent, Semi-urgent or Routine. |
| Investigations  
- Acute vs chronic.  
- Pre test counselling.  
- ALT.  
- Anti HCV.  
- HCV RNA | | |  
Include:  
- Likely date and mode of transmission.  
- Alcohol consumption (std drinks per week).  
- Current medications.  
- Other drugs (include IDU).  
- Symptoms and signs of Hepatitis including (Hx and jaundice). |
* Anti HCV +ve Legislation requirements in connection with notification.

**Recommended Pre Referral Tests**

- Anti HCV.
- HCV RNA and genotype.
- FBP.
- INR.
- Creatinine.
- Urea & electrolytes.
- Bilirubin.
- Albumin.
- Alpha – fetoprotein.
- Liver/Biliary tree u/sound.
- HBV/ HAV serology.
- Ferritin.

Consider Clinic Based Hepatitis C Shared Care.

**Contact Details:**

- Fremantle 08 9431 2913
- RPH 08 9224 2186
- SCGH 08 9346 3228

Refer to Hepatitis Service - HCV RNA +ve/ Abnormal Alt.
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<td>Pancreaticobiliary</td>
<td>Clinical:</td>
<td>Uncomplicated gallstones:</td>
<td>Refer to General Surgery or Gastroenterology.</td>
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<td>- Pain suggestive (non) dyspeptic site, character, duration, radiation, etc.</td>
<td>- Low fat diet.</td>
<td>- Admit acutely – Urgent.</td>
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<td>- Charcots triad (jaundice, pain, fever = Cholangitis.</td>
<td>- Antispasmodics.</td>
<td>- Cholangitis.</td>
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<td>- Steatorrhoea or malabsorption.</td>
<td>Mild Pancreatitis</td>
<td>- Moderate/severe pancreatitis.</td>
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<td>- Dark urine.</td>
<td>- Low fat diet.</td>
<td>- Complicated CBD stones.</td>
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<td>- Alcohol consumption.</td>
<td>- Analgesia PRN.</td>
<td>- Cholecystitis.</td>
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<td>- Known gallstones or previous cholecystectomy?</td>
<td>- Alcohol abstention.</td>
<td>- Elective referral/phone discussion Urgent – Semi-urgent.</td>
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<tr>
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<td>- Preceding trauma?</td>
<td>Chronic Pancreatitis:</td>
<td>- Uncomplicated gallstones or CBD stones.</td>
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<td>- Drugs causing pancreatitis?</td>
<td>- Low fat diet.</td>
<td>- Chronic relapsing pancreatitis.</td>
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<td>- Family history of hyperlipidemia?</td>
<td>- Pancreatic enzyme supplements.</td>
<td>- Chronic pancreatitis.</td>
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<td>- Jaundice; epigastric/RUQ tenderness or mass; peritonism; fever.</td>
<td>- Non-narcotic analgesia.</td>
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