Gastroenterology referral management guidelines:

Director of Department: Dr George Ostapowicz

Specialist advice service: Please contact the Gastroenterology advanced trainee on-call between 9am-4pm Monday- Friday if you need advice prior to referral via GCUH switchboard: 5687 0003

When considering a Gastroenterology referral, please consider these referral guidelines for management of your patient prior to referral.

Minimum information required in all Gastroenterology referrals

When making a referral please ensure the letter is addressed to the Director of the department: Dr George Ostapowicz.

The clinical information and pre-requisite investigations requirements are currently found on GP referral templates for GP software programs, the latest of which can be found at http://www.gpgc.com.au/cmsItem.aspx?CK=187.

If the clinical information or pre-requisite investigations are not clearly provided, your referral may be returned to you asking for more information.

Clinical information

To safely categorise/prioritise your patient, the Gastroenterology department need the following information as a minimum to be clearly provided in every referral:

- Patient details
- Reason for referral (If you want a colonoscopy or upper endoscopy only, clearly state in referral “Please perform Colonoscopy/Upper Endoscopy Only”)
- If you want advice only, clearly state “For Advice Only”
- Has the patient been seen by a GCHHS consultant in this specialty in the past?
  o If yes, provide GCHHS consultant’s name
- Duration of problem (e.g. days, weeks etc.)
- Examination findings – specifically PR findings
- Treatment to date
- Include any previous Gastroenterology reports or investigations eg colonoscopy (including those from Gold Coast Health)

Pre-requisite investigations required

Please only send investigations relevant to the treating clinician (as requested).
Services provided (click to navigate to area)

- **Bowel Cancer Screening**
- **Chronic Constipation**
- **Chronic Diarrhoea**
- **Coeliac Disease**
- **Dyspepsia**

- **Inflammatory Bowel Disease**
- **Iron Deficiency**
- **Irritable Bowel Syndrome**
- **Polyp Surveillance**
- **Rectal Bleeding**

Services not provided by Gastroenterology Department, Gold Coast Health

- Refer paediatric conditions to paediatric department

Current range of clinics available:

- General Gastroenterology Clinic
- Inflammatory Bowel Disease Clinic

## Condition specific guidelines

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| **Bowel cancer screening** | Please include information in when to refer in your referral documentation              | See when to refer and the following document: [Gold Coast Health Colorectal Cancer Prevention, early detection & management guidelines](#) | Colonoscopy is indicated in those with a family history of colorectal cancer in:
  - a first-degree relative ≤55 years OR
  - two, first- or second-degree relatives on the same side of the family diagnosed at any age

  For those who do not fulfil the above criteria, perform, faecal occult blood testing every 2 years from age 50.

  Consider colonoscopy every five years from age 50 following consultation with a specialist. |

  [Detailed guidelines can be found here:](#) [NHMRC Clinical Practice Guidelines for the Prevention, early detection & management of Colorectal Cancer](#)
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| Chronic constipation | • FBC  
• ELFTs  
• TSH  
• Iron studies | **Lifestyle changes:**  
• Increase dietary fibre if lacking and increase fluid intake.  
• Address inappropriate toileting habits.  
• Undertake regular exercise.  
• Review diet with a qualified dietitian.  

**Medical management:**  
• Cease any aggravating medications if possible eg. opioids, anticholinergics.  
• bulk-forming laxatives e.g. Metamucil (while maintaining adequate fluid intake)  
• osmotic laxatives e.g. Movicol, Lactulose  
• stimulant laxatives e.g. Coloxyl with senna or Bisacodyl (If above not effective)  

Consider pelvic floor dysfunction and physiotherapy management. | **Presence of any red flags (as below) requires immediate referral.**  
Patients without red flags can be referred and will be triaged appropriately.  

**Red flags**  
• unexplained weight loss of ≥5% of body weight in previous six months  
• new onset > age 50 years old  
• unexplained iron deficiency anaemia  
• Rectal Bleeding  
• abdominal mass |
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<td>Chronic diarrhoea</td>
<td>- History – frequency, duration, overseas travel&lt;br&gt;- medication history&lt;br&gt;- FBC&lt;br&gt;- ELFTs&lt;br&gt;- TSH&lt;br&gt;- ESR/CRP&lt;br&gt;- coeliac serology&lt;br&gt;Additional Information (if relevant):&lt;br&gt;- stool m/c/s + PCR&lt;br&gt;- clostridium difficile toxin (if recent antibiotics)&lt;br&gt;- family history of inflammatory bowel disease or colorectal cancer&lt;br&gt;- faecal calprotectin (will require funding by the patient)&lt;br&gt;- plain abdominal x-ray&lt;br&gt;- Iron studies, B12, Folate</td>
<td>Lifestyle changes:&lt;br&gt;- Review diet.&lt;br&gt;- Minimise alcohol intake.&lt;br&gt;Medical management:&lt;br&gt;- Consider constipation and overflow.&lt;br&gt;- Consider faecal incontinence.&lt;br&gt;- Consider trial of Loperamide – monitor, as it may be contraindicated if idiopathic IBD.</td>
<td>Presence of any red flags (as below) requires immediate referral.&lt;br&gt;Patients without red flags can be referred and will be triaged appropriately.&lt;br&gt;<strong>Red flags</strong>&lt;br&gt;- bloody or nocturnal diarrhea&lt;br&gt;- significant weight loss of ≥5% of body weight in previous six months</td>
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<td>Coeliac disease</td>
<td>- coeliac disease serology&lt;br&gt;- FBC&lt;br&gt;- ELFTs&lt;br&gt;- iron studies&lt;br&gt;- family history of coeliac disease&lt;br&gt;<strong>If patients are on a gluten-free diet, advise them to add gluten to their diet for</strong></td>
<td>Following diagnosis, a strict lifelong gluten-free diet must be maintained.&lt;br&gt;- Review diet with a qualified dietitian.&lt;br&gt;- Monitor for diet compliance with coeliac disease serology every six to 12 months.&lt;br&gt;- Screen family</td>
<td>if positive coeliac disease serology&lt;br&gt;if coeliac disease is strongly suspected, despite negative serology result</td>
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<td>Coeliac disease</td>
<td>four weeks before the above tests and diagnosis. If not viable to return gluten to the diet, arrange a HLA DQ2/DQ 8 gene test. Additional information (if relevant)</td>
<td>- Establish baseline bone mineral densitometry. - Monitor for other autoimmune disorders - Consider referral if symptoms persist despite following a gluten free diet for three months.</td>
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<td>Dyspepsia/heartburn/reflux</td>
<td>- TSH - red cell folate and vitamin B12 - 25-OH vitamin D</td>
<td>- FBC - ELFTs - iron studies Additional Information (if relevant)</td>
<td>Presence of any red flags (as below) requires immediate referral</td>
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<td>- Helicobacter pylori breath test or faecal antigen test (either test will require funding by patient) – must be off proton pump inhibitor (PPI) for two weeks - Upper abdominal ultrasound - Coeliac serology - Previous endoscopic procedures (date and report)</td>
<td>- Lifestyle changes: - cease smoking - avoid alcohol intake - avoid triggers e.g. caffeine, chocolate, spicy and fatty foods - reduce weight if overweight. Medical management:</td>
<td>Patients without red flags can be referred if symptoms are refractory to treatment</td>
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<td>- if H pylori is present, treat and check for eradication. - Cease any aggravating medications if possible e.g. NSAIDS, aspirin. - Trial proton pump inhibitor at full dose for at least four weeks.</td>
<td>Red flags</td>
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<td>- gastrointestinal bleeding - unexplained weight loss of ≥5% of body weight in previous six months - difficult or painful swallowing - persistent vomiting - unexplained iron deficiency anaemia - any patient &gt;55 years with unexplained or persistent recent onset dyspepsia</td>
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| Inflammatory bowel disease – suspected or established | - where and when diagnosed – if available  
- specific diagnosis – if available  
- family history of IBD  
- imaging, colonoscopy and histology reports if available  
- past surgery for IBD  
- medication history  
- FBC  
- ELFTs  
- ESR/CRP  
- iron studies, vitamin B12, 25-OH vitamin D  
- stool m/c/s including Clostridium difficile toxin  
- faecal calprotectin (will require funding by patient)- optional | Lifestyle changes:  
- smoking cessation for Crohn’s disease  
- review of diet by a qualified dietitian.  

Presence of any red flags (as below) requires immediate referral and/or phone call to IBD  
Helpline, Monday-Friday 9am-5.00pm on 1800 138 029  
Patients without red flags should be referred and will be triaged appropriately.  
**Red flags**  
- New or increased rectal bleeding  
- Symptoms of bowel obstruction  
- fever and abdominal / perineal mass  
- significant diarrhoea ≥6x/day  
- significant weight loss of ≥5% of body weight in previous six months  
- significant abnormalities in investigations i.e. Hb <100 g/l, CRP >45 or faecal calprotectin >200 mcg/g |
| Iron deficiency                              | - history of bleeding e.g. menorrhagia  
- family history of colorectal cancer  
- medication history (especially NSAIDS, aspirin and corticosteroids)  
- FBC  
- ELFTs  
- iron studies  
- coeliac disease serology | Lifestyle changes:  
- If there is a dietary cause, modify diet and/or refer to dietitian.  

Medical management:  
- Establish and treat the cause (e.g. menorrhagia, diet).  
- If appropriate, treat with iron supplements.  
  Cease any aggravating medications if possible (e.g. NSAIDS).  

Presence of any red flags (as below) requires immediate referral  
Patients without red flags can be referred and will be triaged appropriately  
**Red flags**  
- significant weight loss of ≥5% of body weight in previous six months  
- iron deficiency anaemia with no obvious cause  
- iron deficiency associated with any of the following:
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| Irritable bowel syndrome - suspected | • FBC  
• ELFTs  
• ESR/CRP  
• Coeliac disease serology  
• iron studies.  
Additional information (if relevant)  
• stool m/c/s + PCR  
• family history of inflammatory bowel disease or colorectal cancer  
• faecal calprotectin – will require funding by the patient | Lifestyle changes:  
• include regular exercise  
• address triggers (stress, food, medications e.g. NSAIDS, antibiotics)  
• review diet with a qualified dietitian (e.g. fermentable, oligo-, di-, mono-, saccharides and polyols (FODMAP) diet).  
Medical management:  
• cease any aggravating medications if possible  
• bulk-forming or osmotic laxatives for constipation  
• Loperamide for diarrhoea  
• peppermint oil or Mebeverine for crampy abdominal pain  
• consider tricyclic antidepressant (TCA) or selective serotonin reuptake inhibitors (SSRIs) if no contraindications  
• treat anxiety and/or depression if present. | o gastrointestinal bleeding  
• abdominal pain  
• new change in bowel habit |

Presence of any red flags (as below) requires immediate referral.

Patients without red flags can be referred and will be triaged appropriately.

- **Red flags**
  - change in bowel habits of >6 weeks in patients >40 years
  - significant weight loss of ≥5% of body weight in previous six months
  - unexplained iron deficiency anaemia
  - rectal bleeding
  - abdominal mass.
### Diagnosis

**Polyp surveillance**

- family or personal history of colorectal cancer OR cancer syndrome eg. Lynch, FAP.
- previous endoscopic procedures (date, report and histology).

### Evaluation Information

- Presence of any **red flags (as below)** requires immediate referral.

#### Red flags

- significant weight loss of ≥5% of body weight in previous six months
- unexplained iron deficiency anaemia

In the absence of any red flags, the following time frames are recommended for polyp surveillance:

- **five-yearly**: if <3 polyps (excluding diminutive rectosigmoid hyperplastic polyps) provided that all polyps are 'simple', as defined by dimensions (<10mm) and histopathology (no high-grade dysplasia or villous change)

- **three-yearly**: if three or four polyps (excluding diminutive rectosigmoid hyperplastic polyps) or if one or more polyps are ‘advanced’ as characterised by dimensions (≥10mm) and/or histopathology (presence of high-grade dysplasia or villous change)

- **annually**: if five to nine polyps (excluding diminutive rectosigmoid hyperplastic polyps)

- **<12 months**: if required, a baseline colonoscopy may need to be repeated in cases of poor bowel preparation (immediate rescheduling), possible incomplete excision of a large polyp (often at three months) or the presence of multiple adenomas (≥10) to ensure complete clearance.
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| Rectal bleeding   | ● Describe bleeding – distinguish between dark blood coating or mixed with stool; or bright red blood passed after the motion or on the paper.  
● previous endoscopic procedures (date, report and histology) if relevant  
● family or personal history of colorectal cancer or inflammatory bowel disease  
● FBC  
● ELFTs  
● iron studies  
● Faecal Occult Blood Test (FOBT) | Medical management:  
● treat constipation  
● perform PR examination, +/- proctoscopy.                                                                                                                                                                                    | Presence of any red flags (as below) requires immediate referral.  
All Rectal Bleeding will be considered URGENT but it is useful to provide the Red Flags below to provide maximal clinical information.                                                                                                                                 |
|                   |                                                                                                                                                                                                                        |                                                                                               | Red flags                                                                                                                                                                                                    |
|                   |                                                                                                                                                                                                                        |                                                                                               | ● change in bowel habits > 6 weeks in patients >40 years  
● significant weight loss of ≥5% of body weight in previous six months  
● unexplained iron deficiency anaemia.  
● abdominal or rectal mass.                                                                                                                                      |