



## Gastroenterology and Liver Clinic

### Gastroenterology Clinic

- 1 Abdominal Pain
- 1 Iron Deficiency Anaemia
- 2 Positive Coeliac Antibodies
- 2 Constipation & Fluctuating Bowel Habit (including suspected irritable bowel syndrome)
- 3 Diarrhoea
- 3 Dysphagia
- 3 Upper GI Tract Haemorrhage
- 4 Family History of Colorectal Cancer (CRC)
- 4 Established Inflammatory Bowel Disease (IBD)
- 5 Nausea and Vomiting
- 5 Follow up of previous Colonic Polyps
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- 6 Reflux

### Liver Clinic

- 7 Abnormal Liver Function Tests (LFTs)
- 7 Jaundice

#### Definitions

- EMERGENCY** Proceed to Emergency Department  
Please contact the senior clinician for medical advice  
**24hrs Direct Line 9288 4356** Fax 9288 4368
- URGENT** Appointment within **2 weeks** of receipt of the referral
- SEMI URGENT** Appointment within **8 weeks** of receipt of the referral
- ROUTINE** Next available appointment

*Unless otherwise stated on individual referral guidelines*



## Mandatory Referral Content

### Demographic:

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements

### Clinical:

- Reason for referral
- Duration of symptoms
- Management to date and response to treatment
- Relevant pathology and imaging reports (please refer to specific guidelines)
- Past medical history
- Current medications (and medication history if relevant)

## Preferred Referral Content

- Functional status
- Psychosocial history
- Dietary status
- Family history
- Usual GP



**St Vincent's**

*Continuing the Mission of the Sisters of Charity*

## Abdominal Pain

### Initial Work Up

- FBE
  - U & E
  - Ca
  - ESR & CRP
  - BSL
  - Abdominal x-ray (supine)
  - Abdominal ultrasound
- In selected cases:**
- LFTs (upper abdominal pain)
  - Amylase (upper abdominal pain)
  - Pelvic ultrasound (where appropriate)
  - MSU (where appropriate)

### When to Refer

#### EMERGENCY

- Severe acute pain
- Suspected surgical problem including bowel obstruction

Please contact the senior clinician for medical advice **24hrs Direct Line 9288 4356** Fax 9288 4368

#### URGENT

**When combined with at least one of the following alarm symptoms:**

- Progressive, unintentional weight loss
- Proven anaemia
- Persistent vomiting
- Anorexia

#### ROUTINE

- For all other presentations of abdominal pain

## Iron Deficiency Anaemia (IDA)

### Initial Work Up

- FBE
- Iron studies, B12, red cell folate
- U&E, LFTs
- CRP or ESR
- Coeliac antibodies

### GP Management

- Treatment with oral iron prior to clinic is desirable for severe or symptomatic anaemia
- Patients <40 years of age with no alarm symptoms:
  - Treat other likely causes before referral i.e.
    - Menorrhagia
    - Dietary deficiency
- All should have coeliac antibodies

### When to Refer

#### URGENT

- Severe symptomatic IDA with no obvious cause such as menorrhagia or dietary deficiency
- When combined with at least one of the following alarm symptoms
  - Overt GI bleeding
  - Abdominal pain
  - Change in bowel function

#### SEMI URGENT

- New onset of unexplained IDA
- Note: Early appointment for upper and lower endoscopy will be made but clinic attendance is required prior to scopes*

#### ROUTINE

- Long-standing IDA
    - < 40 years of age with other potential causes for IDA (such as menorrhagia or dietary deficiency)
    - Patients with obscure IDA (no cause on upper and lower endoscopy) are eligible for capsule endoscopy of the small intestine within 6 months of their scopes
- We may book these patients directly for capsule endoscopy prior to clinic appointment*

## Positive Coeliac Antibodies

### Initial Work Up

- FBE & ESR
- U&Es
- Calcium, PO<sub>4</sub>
- LFTs
- Anti-gliadin IgA and IgG
- Anti-endomysial IgA
- Anti-transglutaminase IgA, IgA level
- Iron studies
- B12
- Red cell folate
- Vitamin D
- Zinc

### When to Refer

#### SEMI URGENT

- Coeliac antibodies strongly suggestive of coeliac disease. *Patients with strongly positive endomysial or transglutaminase antibodies are highly likely to have coeliac disease and will be booked for gastroscopy prior to consultation in the Clinic.*
- When combined with at least one of the following symptoms:
  - Progressive weight loss
  - Abdominal pain
  - Severe diarrhoea

#### ROUTINE

- Clinical suspicion of coeliac disease and/ or equivocal antibody results

## Constipation & Fluctuating Bowel Habit (Including Suspected IBS)

### Initial Work Up

- FBE
  - ESR & CRP
  - TFTs
  - Folate, B12
  - Iron studies and ferritin
  - U&E
  - LFT
  - FOBs
  - Plain abdominal x-ray
- Consider**
- Stools M, C & S, parasites in patients with an element of diarrhoea
  - Ultrasound if prominent pain/bloating
  - Trial of laxatives, fibre supplement +/- lactulose or stimulant laxative *(whilst awaiting a Clinic appointment)*

### When to Refer

#### EMERGENCY

- Suspected bowel obstruction (Vomiting & distension with constipation)

Please contact the senior clinician for medical advice  
**24hrs Direct Line 9288 4356**  
 Fax 9288 4368

#### URGENT

**When combined with any of the following alarm symptoms:**

- Progressive, unintentional weight Loss
- Proven iron deficiency anaemia
- Vomiting

#### SEMI URGENT

- Positive FOBT
- Rectal bleeding
- Change in bowel function in recent months

#### ROUTINE

- Long-standing bowel disturbance or suspected Irritable Bowel Syndrome (IBS) without alarm symptoms

## Diarrhoea

### Initial Work Up

#### Acute persistent diarrhoea (<6 weeks) or Chronic diarrhoea (>6 weeks)

- Stools M, C and S, parasites
- Consider Clostridium difficile toxin (previous antibiotics)
- FBE & ESR
- CRP
- TFTs
- Folate and B12
- Iron studies and Ferritin
- U&E
- LFT

#### Note:

- Non-colonic symptoms suggestive of inflammatory bowel disease e.g.
  - Uveitis
  - Synovitis
  - Erythema nodosum
  - Anal fissure
- Family history of inflammatory bowel disease

### When to Refer

#### EMERGENCY

- Acute severe diarrhoea or bloody diarrhoea
- Please contact the senior clinician for medical advice  
**24hrs Direct Line 9288 4356** Fax 9288 4368

#### SEMI URGENT

- Less severe acute diarrhoea or chronic diarrhoea
- Clinically suspected inflammatory bowel disease

## Dysphagia

### Initial Work Up

- FBE & ESR

#### Consider:

- Soft tissue imaging of the neck
- CXR
- Barium swallow

### When to Refer

#### URGENT

- Recent onset dysphagia
- Progressive dysphagia
- Associated with weight loss

#### SEMI URGENT

- Long-standing, non-progressive dysphagia

## Upper GI Tract Haemorrhage (Haematemesis and/or Melaena)

#### EMERGENCY

- All patients should be referred directly to the Emergency Department
- Please contact the senior clinician for medical advice **24hrs Direct Line 9288 4356** Fax 9288 4368

## Family History of Colorectal Cancer (CRC)

### Initial Work Up

- Family history of cancer including:
  - Colorectal cancer (CRC)
  - Uterine cancer
  - Gastric cancer
  - Small intestinal tumour
- Family member's relationship to the patient
- Family member's age at diagnosis of colorectal cancer

### When to Refer

#### DO NOT REFER

- Asymptomatic people with no family history of colorectal cancer
- Yearly FOBT recommended in average risk patients over 50 years of age

#### ROUTINE

##### Suspicion of Hereditary Non-Polyposis Colon Cancer Syndrome

*Multiple relatives with colorectal cancer, other GI cancer or uterine cancer and at least one relative with age of onset of cancer <50 years of age*

- Refer at 25 years of age for consideration of screening

##### First degree relative with colorectal cancer

- Refer at 50 years of age or 10 years of age earlier than the age at which the youngest first degree relative was diagnosed with CRC, whichever comes first

## Established Inflammatory Bowel Disease

### History

- Crohn's
- Ulcerative colitis
- Indeterminate colitis
- Site
  - Proctitis
  - Left colon
  - Pancolitis
  - Small bowel
- Complications e.g.
  - Fistula
- Extra intestinal manifestations e.g.
  - Arthritis
  - Iritis
  - Erythema nodosum

### Initial Work Up

- FBE
- ESR & CRP
- Faecal specimen for M,C & S
- Iron studies

*Please send all prior endoscopy, histopathology and radiology reports*

### When to Refer

#### URGENT

**Admission or clinic appointment within 1 week**

**When patient presents with any of the following, contact Gastroenterology Registrar via Switch 9288 2211**

- >6 loose bowel actions per day
- Urgency
- PR bleeding
- Significant abdominal pain
- Significant weight loss
- Anaemia
- Previously severe disease

#### SEMI URGENT

**1-2 weeks**

- 4-6 loose bowel actions per day
- Occasional PR blood
- Mild abdominal pain
- Recurrent symptoms on reducing steroids
- Patients known to the IBD Clinic  
*Call Lead Nurse on 9288 3771*

#### ROUTINE

**Maintenance: At least 3 monthly review**

- If taking imuran, 6mp, MTX, infliximab
- Patients in remission**
- Colonoscopy screening for colorectal cancer

## Nausea & Vomiting

### Initial Work Up

- |              |           |                   |                           |                  |
|--------------|-----------|-------------------|---------------------------|------------------|
| - FBE        | - U + Es  | - TFTs            | - Pregnancy test          | <b>Consider:</b> |
| - ESR & CRP  | - Calcium | - Fasting glucose | - Plain x-ray             |                  |
| - Creatinine | - LFTs    | - Urinalysis      | - Neurological assessment |                  |
|              |           |                   |                           | - Faeces MC& S   |

### When to Refer

EMERGENCY	URGENT	SEMI URGENT
<ul style="list-style-type: none"> <li>- Suspicion of bowel obstruction</li> <li>- Dehydration</li> <li>- Acutely unwell</li> </ul> <p style="color: red; font-weight: bold;">Please contact the senior clinician for medical advice <b>24hrs Direct Line</b> <b>9288 4356</b> Fax 9288 4368</p>	<p><b>Presence of alarm symptoms:</b></p> <ul style="list-style-type: none"> <li>- Significant weight loss</li> <li>- Fever</li> </ul> <p><i>Otherwise referral is treated as semi urgent</i></p>	<ul style="list-style-type: none"> <li>- Other patients with ongoing nausea and vomiting</li> </ul>

*Appropriate patients will be booked for endoscopy at the time of referral to the Gastroenterology Clinic but prior attendance at the Clinic is required to proceed with the endoscopy booking.*

## Follow Up of Previous Colonic Polyps

*Based on the published NHMRC guidelines for polyp follow-up*

### Initial Work Up

**Provide details of:**

- Last colonoscopy report findings & histology
- Family history including:
  - Family member's relationship to patient
  - Family member's age at diagnosis of colorectal cancer (CRC) or polyps
  - Any family history of uterine, ovarian, gastric or small intestinal tumour

### When to Refer

DO NOT REFER	SEMI URGENT	ROUTINE
<ul style="list-style-type: none"> <li>- Asymptomatic people with a family history of bowel polyps</li> </ul>	<p><b>Refer for repeat colonoscopy 3 months after previous colonoscopy if:</b></p> <ul style="list-style-type: none"> <li>- Piecemeal removal, or excision of malignant adenoma OR</li> <li>- Incomplete excision of a large adenoma</li> </ul>	<p><b>Refer for repeat colonoscopy within a year if:</b></p> <ul style="list-style-type: none"> <li>- Incomplete or inadequate examination e.g.                             <ul style="list-style-type: none"> <li>• Multiple adenomas</li> </ul> </li> </ul> <p><b>Refer for repeat colonoscopy within 3 years for:</b></p> <ul style="list-style-type: none"> <li>- Large adenomas (&gt; 1 cm)</li> <li>- High-grade dysplasia</li> <li>- Villous change</li> <li>- Three or more adenomas OR</li> <li>- Aged 60 years or over with a first degree relative with colorectal cancer</li> </ul> <p><b>Refer for repeat colonoscopy within 4-6 years for:</b></p> <ul style="list-style-type: none"> <li>- Those without the preceding risk factors for colorectal cancer</li> </ul>

## Rectal Bleeding

### Initial Work Up

- FBE
- Rectal examination

### When to Refer

URGENT	SEMI URGENT	ROUTINE
<ul style="list-style-type: none"> <li>- Blood mixed in with stool</li> <li>- Anaemia</li> <li>- Pain</li> </ul>	<ul style="list-style-type: none"> <li>- Change in bowel habit (To looser stools and/or increased frequency of defecation persistent for 6 weeks)</li> <li>- High risk family history (1st degree relative &lt; 50 years of age at onset of colorectal cancer OR more than one 1st degree relative with colorectal cancer)</li> <li>- Unexplained or recurrent rectal bleeding</li> </ul>	<ul style="list-style-type: none"> <li>- &lt; 40 years of age with chronic haemorrhoidal type bleeding (no change in pattern)</li> </ul>

## Reflux

### Initial Work Up

- FBE & ESR
- Iron studies

#### Consider:

- Trial of proton pump inhibitor (PPI) therapy if onset in patients less than 50 years of age and no alarm symptoms as listed in the urgent category

### When to Refer

URGENT	SEMI URGENT	ROUTINE
<p><b>When combined with at least one of the following alarm symptoms:</b></p> <ul style="list-style-type: none"> <li>- Associated dysphagia</li> <li>- Haematemesis and/or melaena</li> </ul>	<ul style="list-style-type: none"> <li>- Onset of symptoms over 50 years of age</li> <li>- Failure to respond to PPI therapy</li> <li>- Worsening symptoms</li> <li>- Anaemia</li> <li>- Progressive, unintentional weight loss</li> <li>- Persistent vomiting</li> </ul>	<ul style="list-style-type: none"> <li>- Onset of symptoms under 50 years of age with no alarm symptoms as listed in 'urgent' category</li> </ul>

## Abnormal Liver Function Tests (LFTs)

### Initial Work Up

- Hepatitis serology
  - Hep A IgM, Hep B sAg, Hep B cAg, HCV Ab
- Immunoglobulins
- Autoantibodies (ANA, SMA, AMA)
- Iron studies
- Copper and caeruloplasmin
- Lipid profile
- Blood glucose
- BMI
- Ultrasound upper abdomen
- Alcohol history

#### For known Hepatitis C

- HCV genotype & viral load
- Psychiatric history

#### For known Hepatitis B

- Hep B eAg, Hep B eAb

Please include prior blood results if available

### When to Refer

#### URGENT

- Jaundice
- ALT > 400 or documented acute onset hep A, B or C
- Decompensated liver disease:
  - Ascites
  - Peripheral oedema
  - Wasting
- Suspected malignancy or liver mass on imaging

#### SEMI URGENT

- Hepatitis B with ALT > 100
- Clinical concern that there is significant chronic liver disease
- Abnormal LFTs with no cause found (BMI normal)
- Liver diagnosis for initial management e.g.
  - Suspected or proven primary biliary cirrhosis
  - Haemochromatosis
  - Alcoholic CLD
  - Autoimmune hepatitis

#### ROUTINE

- Hepatitis C for treatment
- Hepatitis B with ALT < 100
- Probable nonalcoholic steatohepatitis (NASH)
  - Abnormal LFTs despite lifestyle change & weight loss

## Jaundice

### Initial Work Up

- LFTs
- Hepatocellular (elevated transaminases):
  - EBV, CMV, HAV, HBV, HCV
- Cholestatic (elevated ALP & GGT)
  - Abdominal ultrasound
- FBE
- U&Es
- If isolated raised bilirubin: haemolysis screen
- Prothrombin time/INR
- Immunoglobulins
- Autoantibodies (SMA, AMA)
- Clinical evidence of encephalopathy
  - Abdominal ultrasound
  - CT where appropriate

### When to Refer

#### EMERGENCY

- Suspected acute, severe or fulminant hepatic failure
  - Direct referral to A&E

Please contact the senior clinician for medical advice **24hrs Direct Line 9288 4356** Fax 9288 4368

#### URGENT

**When patient presents with any of the following, contact Gastroenterology Registrar via Switch 9288 2211:**

- ALT > 1000, abnormal INR, encephalopathy
- Severe clinical or biochemical hepatocellular jaundice
  - Refer to A&E OR Liver Clinic (depending on severity)
- Obstructive jaundice (dilated ducts)

#### SEMI URGENT

- Unexplained non-obstructive cholestatic jaundice