THE ALFRED REFERRAL GUIDELINES: GENERAL SURGERY

Referral priority guide

General referral guidelines

Miscellaneous General Surgery

- Hernia
- Skin (see Plastic Surgery Referral and Management Guidelines)
- Venous (see Vascular Surgery Referral and Management Guidelines)

Breast, Endocrine and General Surgery (BES)

- Neck masses
  - Painful neck mass
  - Painless neck mass
- Thyroid masses
- Adrenal mass
- Parathyroid disease
- Breast disease
  - Family history of breast disease
  - Breast lump
  - Breast pain
  - Nipple discharge
  - Nipple retraction
  - Change in skin contour

Colorectal and General Surgery (CRS)

- Diseases of the Colon
- Colorectal cancer
  - Confirmed Colorectal Cancer
  - Suspected Colorectal Cancer
- Ano-rectal disease
  - Haemorrhoids
  - Anal Fistula
  - Anal fissure

Upper Gastrointestinal and General Surgery (UGIS)

- Disorders of the oesophagus
  - Dysphagia
  - Reflux symptoms
- Disorders of the stomach and duodenum
- Disorders of the pancreas, biliary tree and liver

Guide for investigation of a breast lump

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THE ALFRED REFERRAL GUIDELINES
GENERAL SURGERY

Referral priority guide

<table>
<tr><td>Immediate
• Threatened cervical airway obstruction
• Diagnosed GI tract or breast malignancy
• Obstructive jaundice
• Haematemesis
• Melaena
• Acute pancreatitis
• Acute , severe biliary pain
• Severe uncontrolled diarrhoea
• Cachexia
• Ascites</td><td>Phone the Surgical Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.</td></tr>
<tr><td>Urgent
• Breast lumps
• Pigmented skin lesions
• Change in bowel habits and /or PR bleeding suggestive of malignancy
• Painful defecation
• Head and neck masses
• Diagnosed GI abnormality
• Dyspepsia associated with weight loss and/or anaemia
• Thyroid masses
• Adrenal masses
• Known gallstones with ongoing biliary colic
• Hernias that have required acute reduction
• Acute painful leg ulcers
• Gall-bladder mass/recurrent cholecystitis
• Chronic pancreatitis</td><td>Urgent cases must be discussed with the Surgical Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.

Likely to receive an appointment within 1-2 weeks.</td></tr>
<tr><td>Soon
• Dyspepsia unassociated with weight loss or anaemia
• Anal fistula or fissure
• PR bleeding not suspicious of malignancy
• Known gallstones with ongoing biliary colic
• Uncomplicated hernia
• Diagnosed GI abnormality
• Benign lumps
• Diverticular disease
• Inguinal hernia (for exceptions refer to notes)
• Routine screening for family history of Colorectal cancer
• Parathyroid disease
• Adrenal abnormalities</td><td>Likely to receive an appointment within 2-6 weeks.</td></tr>
<tr><td>Intermediate
• Haemorrhoids (for exceptions refer to notes)
• Single episode cholecystitis
• Lipomas
• Pilonidal sinus
• Bowel screening (refer to Gastroenterology only if significant family history with referral to guidelines)
• Breast screening (unless significant family history and refer to guidelines)
• Perianal skin tags</td><td>Likely to receive and appointment within 6-12 weeks.</td></tr>
<tr><td>Non-urgent
• Obesity management for consideration of laparoscopic gastric banding
• Uncomplicated varicose veins see Vascular Surgery Referral and Management Guidelines</td><td>Appointment may be delayed.</td></tr>
<tr><td>Not seen</td><td>Children under 16 years of age are not seen at the Alfred.</td></tr>
</table>

Please note: The times to assessment may vary depending on size and staffing of the hospital department.
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 Surgical Registrar on call on 9076 2000.

Return to contents page

THE ALFRED REFERRAL GUIDELINES
GENERAL SURGERY

General referral guidelines

Diagnosis	Evaluation	Management
Problems are categorised under the following groupings, and managed by the corresponding service: BREAST, ENDOCRINE AND GENERAL SURGERY UNIT (BES): • Neck masses • Thyroid masses • Adrenal masses • Parathyroid disease • Breast disease COLORECTAL AND GENERAL SURGERY UNIT (CRS): • Inflammatory bowel disease • Diseases of the colon • Anorectal disease UPPER GASTROINTESTINAL AND GENERAL SURGERY UNIT (UGIS): • Disorders of the oesophagus • Disorders of the stomach and duodenum • Disorders of the pancreas • Disorders of the biliary tree & liver MISCELLANEOUS GENERAL SURGERY • Hernia • Skin	A through 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.	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. **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.** Return to contents page

THE ALFRED REFERRAL GUIDELINES
GENERAL SURGERY

Miscellaneous General Surgery

Diagnosis	Evaluation	Referral Guidelines
Hernia		
• **Incisional hernia** • **Femoral hernia** • **Inguinal hernia**	• Pain in groin sometimes precedes lump. Pain may be colicky and associated with vomiting (intestinal obstruction) • Lump in groin - may be intermittent/reducible but is usually most obvious when patient is standing • Diagnostic studies may include Ultrasound (only required if hernia can not be felt on examination The Alfred Radiology request form	• Refer for immediate admission via The Alfred Emergency & Trauma Centre if incarcerated and symptoms of bowel obstruction, local tenderness or erythema • If uncomplicated, refer to any General Surgery clinic - PRIORITY 2-4 **Return to contents page**
Skin		
		Refer to appropriate unit guidelines: Dermatology Referral and Management Guidelines Plastic Surgery Referral and Management Guidelines **Return to contents page**
Venous		
		Refer to Vascular Surgery Guidelines: Vascular Surgery Referral and Management Guidelines **Return to contents page**
Neck masses **Painful neck mass**		
Complete head and neck exam indicated for site of infection: • FBE • Cultures, when indicated • Consider HIV/intradermal TB/Paul Bunnell (if indicated) • Consider possible cat scratch disease (toxoplasmosis titres)	Appropriate antibiotic trial- see ENT Otolaryngology Referral and Management Guidelines	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 **Return to contents page**
Painless neck mass		
Complete head and neck exam indicated for site of primary: • TFTs • Open biopsy is contraindicated • CT or ultrasound The Alfred Radiology request form		Refer to BES (see above) **Return to contents page**

THE ALFRED REFERRAL GUIDELINES
BREAST, ENDOCRINE AND GENERAL SURGERY

Evaluation	Management	Referral Guidelines
Thyroid masses		
• Solitary vs multi-nodular • Euthyroid vs hypo/hyper thyroid • Compression symptoms • Risk factors • Current medical treatment Investigations • FBE • TFTs/Antibodies • Ultrasound or CT thyroid • FNA solitary nodule after imaging • Nuclear Scan (**Hyperthyroid only**) The Alfred Radiology request form	• Hyper or Hypo thyroid patients should be treated to render euthyroid • Steroids for subacute thyroiditis	Refer to Breast and Endocrine clinic any suspicious lesions, disease refractory to medical management or causing compression symptoms - PRIORITY 2 Return to contents page
Adrenal mass		
Often incidentally found on CT. May be associated with hypertension (Conn's syndrome or phaeochromocytoma) Investigations • Fine cut CT The Alfred Radiology request form • Serum K+ • Urinary catecholamines		• Refer all functioning lesions to BES - PRIORITY 1 • Refer non-functioning adenomas for review by BES - PRIORITY 2 and for ongoing surveillance • Refer all adrenal masses >2cm - PRIORITY 1 Return to contents page
Parathyroid disease		
May be in conjunction with renal disease May be part of a familiar syndrome such as MENI Investigations • PTH/Ca^{2+}		Refer to Breast and Endocrine clinic for management - PRIORITY 1-2 Return to contents page

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THE ALFRED REFERRAL GUIDELINES
BREAST, ENDOCRINE AND GENERAL SURGERY

Breast disease

*Queries by phone to breast surgeons are welcome

Family history

Evaluation	Management	Referral Guidelines
Request for assessment by a woman with a strong family history of breast cancer	• 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 • Women who have a high risk, eg family or past history will require more active management	Referral to a family cancer genetics clinic where possible Return to contents page

Breast lump

Evaluation	Management	Referral Guidelines
Triple assessment: o Clinical examination o Imaging (mammography and/or ultrasound) The Alfred Radiology request form o Fine needle aspiration cytology (± core biopsy) NB: If any of the investigations are inconclusive or don't correlate with the other results, then a benign result should not be accepted • 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 • 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	General practitioner management initially: • Young women with tender, lumpy breasts and older women with symmetrical nodality, provided that they have no localised abnormality • Any lump that increases in size should be reviewed/referred • The BreastScreen program - 50 to 65 years - is funded to investigate asymptomatic patients only to the point of clear diagnosis	Conditions that require referral to BES clinic – Contact Surgical registrar or PRIORITY 1: • Any new discrete lump • New lump in pre-existing nodality • Asymmetrically nodality that persists at review after menstruation • Abscess • Cyst persistently refilling or recurrent cyst Return to contents page

Breast pain

Evaluation	Management	Referral Guidelines
Unilateral persistent mastalgia: • Mammography or breast USS The Alfred Radiology request form Localised areas of painful nodality: • Mammography or breast USS The Alfred Radiology request form • Focal lesions • Fine needle aspiration cytology	Women with minor/ moderate degrees of breast pain who do not have a discrete palpable lesion	Refer to BES clinic: • If associated with a lump • Intractable pain not responding to reassurance, simple measures such as wearing a well -supporting bra, and common drugs • Unilateral, persistent pain in post-menopausal women Return to contents page

Nipple discharge

Evaluation	Management	Referral Guidelines
• Clinical examination • Mammography • Ultrasound The Alfred Radiology request form		Refer to BES clinic: • All women aged 50 and over • Women under 50 with: o Bilateral discharge sufficient to stain clothes o Blood stained o Persistent single duct Return to contents page

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THE ALFRED REFERRAL GUIDELINES
BREAST, ENDOCRINE AND GENERAL SURGERY

Breast disease

*Queries by phone to breast surgeons are welcome

Evaluation	Management	Referral Guidelines
Nipple retraction		
• Clinical examination • Mammography • Ultrasound The Alfred Radiology request form		Refer to BES clinic - nipple retraction or distortion, nipple eczema Return to contents page
Change in skin contour		
• Clinical examination • Mammography • Ultrasound The Alfred Radiology request form		Refer to BES clinic - change in skin contour Return to contents page

Evaluation	Management	Referral Guidelines
Diseases of the colon		
History including: ▪ Family history ▪ Altered bowel habit ▪ Tenesmus ▪ Mass ▪ Incomplete rectal emptying **Also refer to the** Gastroenterology Referral Guidelines	Acute mild diverticulitis: antibiotics, fibre, and antispasmodics.	Patients with: ➢ diverticulitis with systemic sepsis; ➢ large bowel obstruction; ➢ severe PR bleeding should be **referred immediately** to the Alfred Emergency and Trauma Centre. Patients with diagnosed recurrent attacks of **diverticulits** should be referred to the Colorectal Clinic for specialist opinion – Priority 2 Patients with suspected or proven **inflammatory bowel disease** should be referred to the Gastroenterology Inflammatory Bowel Disease Clinic (Wednesday mornings**)** Return to contents page

Return to contents page

Evaluation	Management	Referral Guidelines
Confirmed Colorectal cancer		
History including: ▪ Weight loss ▪ Medications ▪ Ascites ▪ Tenesmus ▪ History of Malignancy ▪ PR blood, pus, or mucus ▪ Altered bowel habit ▪ Flatus ▪ Incomplete rectal emptying ▪ Family history of inflammatory bowel disease, polyposis or cancer Investigations ▪ FBE ▪ LFTs ▪ CEA ▪ CT Scan of chest, abdomen and pelvis ▪ Biopsy result ▪ Colonoscopy or Barium enema result The Alfred Radiology request form	Consider iron replacement while awaiting investigations	▪ Patients with **confirmed colorectal cancer** refer to the Colorectal Outpatient Clinic – PRIORITY 1 ▪ Contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice. Return to contents page
Suspected Colorectal Cancer		
History including: ▪ Weight loss ▪ Medications ▪ Ascites ▪ Tenesmus ▪ History of Malignancy ▪ PR blood, pus, or mucus ▪ Altered bowel habit ▪ Flatus ▪ Incomplete rectal emptying ▪ Family history of inflammatory bowel disease, polyposis or cancer Investigations ▪ FBE ▪ LFTs ▪ Barium enema result if available		▪ Patients who have signs or symptoms **suggestive of colorectal cancer** should be referred for urgent outpatient appointment for colonoscopy - PRIORITY 1 ▪ Patients with **suspicious bleeding or definite change in bowel habit** should be referred to the Colorectal Outpatient clinic for colonoscopy ▪ Patients who **have vague lower abdominal or change in bowel habits** (to constipation) should be referred for **Open Access Endoscopy clinic:** The Alfred Gastrointestinal Endoscopy Service request form ▪ Contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice. Guidelines for screening colonoscopy – refer to NH&MRC Colorectal guidelines Return to contents page

Evaluation	Management	Referral Guidelines
Haemorrhoids		
▪ History of ano-rectal bleeding ▪ Prolapse and thrombosis ▪ Evaluation: o PR o Proctoscopy o Sigmoidoscopy	▪ Lifestyle/dietary advice/ modification Proprietary creams/ suppositories	▪ Refer for colonoscopy if underlying disease suspected – PRIORITY 1 ▪ Points for concern o An associated change in bowel habit o Blood mixed with stool o Associated pain and discomfort in the absence of thrombosis or other pathology such as a fissure o Palpable mass on rectal examination o Copious bleeding with associated anaemia Return to contents page
Anal Fistula		
▪ History of recurrent perianal abscesses, discharge sinus, and pervious drainage operation ▪ Evaluation: o PR o Proctoscopy o Sigmoidoscopy		▪ Refer to CRS clinic for management and exclusion of associated disease - PRIORITY 2 Return to contents page
Anal Fissure		
▪ History of pain with and after defecation. ▪ Attacks may be intermittent or prolonged ▪ Evaluation may be difficult due to spasm ▪ Note anal tag	Proprietary creams/ suppositories	Refer to CRS clinic for management and exclusion of associated disease - PRIORITY 2 Return to contents page

THE ALFRED REFERRAL GUIDELINES
UPPER GASTROINTESTINAL AND GENERAL SURGERY

Evaluation	Management	Referral Guidelines
Dysphagia		
Particularly important is any history of: o Loss of weight o Anaemia o Progressive Dysphagia o Liquids Vs solids May include history or findings of: o Foreign body ingestion o Gastro-oesophageal motility disorder o Neoplasm o Nocturnal choking or coughing attacks o Scleroderma	Diagnostic studies may include (depending on history): o Ba swallow/meal is the first investigation of choice o Gastroscopy o Soft tissue imaging studies of the neck The Alfred Radiology request form	• Refer to UGIS if oesophageal aetiology suspected • Refer to BES clinic if thyroid pathology suspected Return to contents page
Reflux symptoms		
May include history of findings of: o Heartburn o Water brash o Volume reflux / regurgitation o Nocturnal choking or coughing attacks o Odynophagia o Atypical symptoms include cough, and asthma, best initially screened via respiratory clinic	Lifestyle modification (weight loss, smaller meals, smoking cessation, bed head raise, etc.) A trial of PPI therapy may be appropriate: o 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 >45, dysphagia etc.	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. Return to contents page

Evaluation	Management	Referral Guidelines
Disorders of the stomach and duodenum		

• Pain
  ○ Site
  ○ Acute or chronic
  ○ Continuous or episodic
• Nausea and vomiting
• Weight loss
• Haematemesis and/or malaena
• Anaemia
• Medications
• Post prandial fullness
• Alcohol intake
 	
Breath testing may be useful to confirm presence of *H.pylori.*
	Non-Acute
	▪ Review other medications eg NSAID's, prednisone
	▪ Lifestyle modifications
		Acute
		• Refer to The Alfred Emergency & Trauma Centre for immediate admission (suspected perforation, haematemesis or malaena)
		
		Non- Acute
		• If inadequate response to treatment after two months, refer for endoscopy
		• Pain with weight loss or pain with anaemia
		• Post-prandial vomiting: refer for endoscopy.
		• If specialist follow up required after endoscopy refer to UGIS
		
		Return to contents page

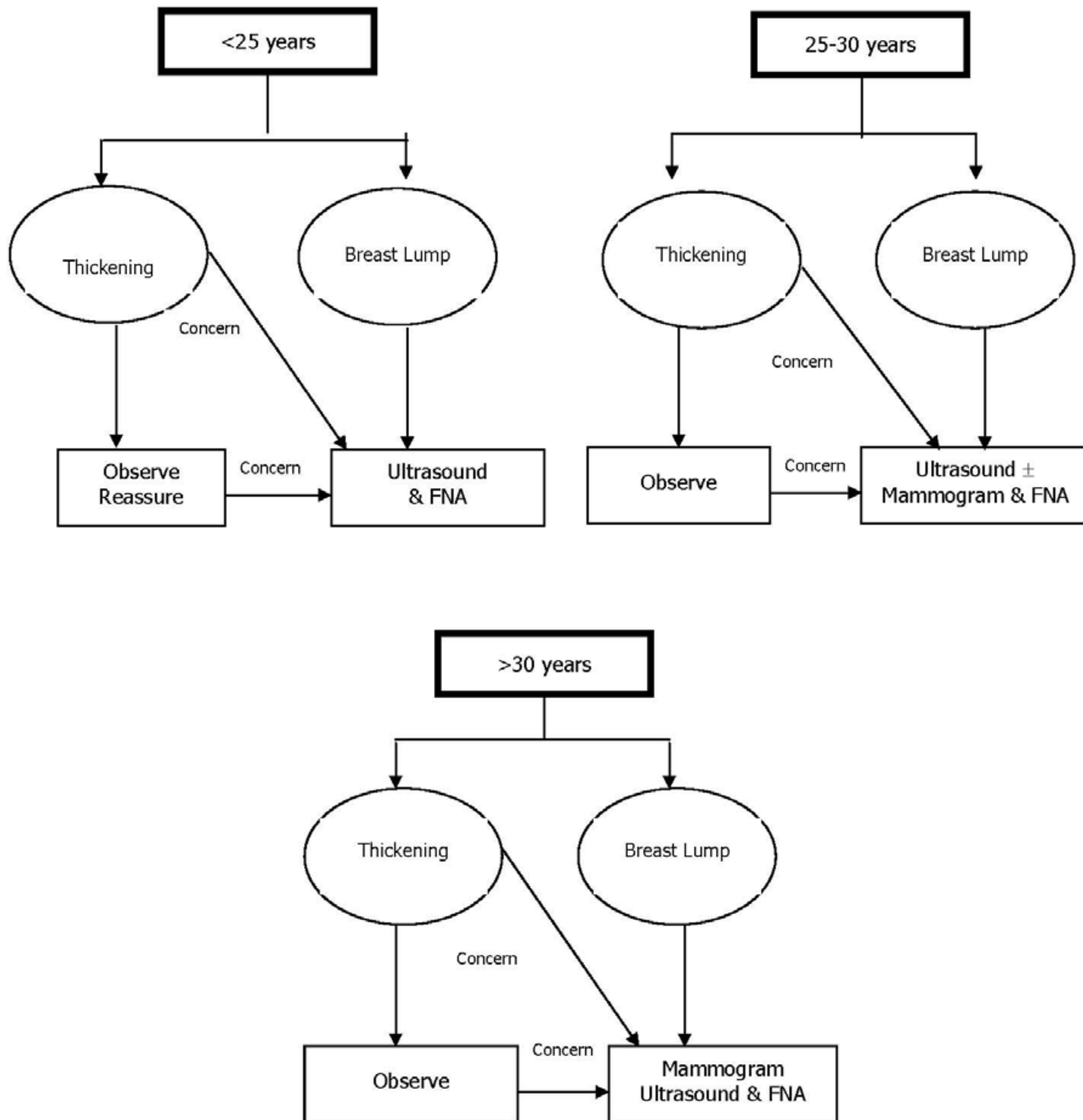
THE ALFRED REFERRAL GUIDELINES
UPPER GASTROINTESTINAL AND GENERAL SURGERY

Disorders of the pancreas, biliary tree and liver

Evaluation	Management	Referral Guidelines
Charcot's Triad: • Pain (site, acute/chronic, continuous/episodic) • Jaundice • Fever = Cholangitis Courvoisier's Law: • Painless, obstructive jaundice • Palpable Gallbladder = Ca. Pancreas **Investigations:** • FBE • Liver function tests • Lipase • Hepatitis serology, if indicated • Ultrasound The Alfred Radiology request form NB Obstructive Jaundice • Investigate initially with ultrasound. • If no gallstones, next order '*CT upper abdomen with pancreas protocol*' The Alfred Radiology request form	• Known gallstones: o Low fat diet o Short attacks of biliary colic can be managed symptomatically o Known CBD stones - twice daily temperatures by patient & present to The Alfred Emergency & Trauma Centre if febrile >38 • Gallstones, points for concern: o Increasing frequency and severity of pain o Documented jaundice or deranged liver function tests o Documented pancreatitis o Ultrasound evidence of duct dilatation The Alfred Radiology request form o Palpable gall-bladder • Proven pancreatitis: o Avoid alcohol	• Immediate admission – via The Alfred Emergency & Trauma Centre for acute pancreatitis, or severe biliary pain unrelieved (or recurrent after) single dose opiate analgesia • Immediate referral (phone Surgical registrar or send to The Alfred Emergency & Trauma Centre): o Obstructive jaundice o CBD stones o Pancreatic or liver mass o Liver metastases • Other referrals: o Symptomatic cholelithiasis - PRIORITY 1 o Ultrasound abnormalities requiring further elucidation - PRIORITY 1 The Alfred Radiology request form o Chronic pancreatitis- PRIORITY 1 Return to contents page

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.

Return to contents page