Monash Children's Hospital Referral Guidelines
GASTROENTEROLOGY

EXCLUSIONS

Gastrointestinal

- Failure to thrive – refer to general paediatrician prior to referring to MCH Gastroenterology
- Infant feeding problems – refer to general paediatrician prior to referring to MCH Gastroenterology
- Constipation – refer to general paediatrician prior to referring to MCH Gastroenterology **(**unless the child has failed a trial of disimpaction/maintenance with an osmotic laxative such as Movicol or Osmolax).
- Suspected IBD over the age of 17 years **- c**onsider referring to the young adult IBD clinic or an adult gastroenterologist

Liver

- Viral hepatitis
- Patients assessed for liver transplant

- Patients over 17 years of age who are not in high school – refer to Monash Health Gastroenterology service

CONDITIONS

Gastroesophageal Reflux (GORD)

Gastroesophageal Reflux not responding to first line treatment or persistent >6 months

Eosinophilic Oesophagitis

Functional GI disorders

- Chronic abdominal pain
- Chronic vomiting
- Cyclic vomiting syndrome

Coeliac Disease

Suspected IBD

- Crohn's disease
- Ulcerative Colitis
- Perianal Crohn's disease
- Very early onset IBD

Liver Disease and Pancreas

- Abnormal liver tests
- Jaundice with raised conjugated bilirubin
- Autoimmune hepatitis
- Primary sclerosing Cholangitis
- Chronic/ recurrent pancreatitis

Chronic Diarrhoea

GI Bleeding: haematemesis, haematochezia and/or melena

- Not resolved with the treatment of constipation
- Suspected IBD
- Polyp/ familial polyp syndromes
- Gastrointestinal food allergy presenting in infancy, not responding to maternal dietary exclusions or trial of hydrolysed formula

Head of unit:	Program Director:	Last updated:
Dr Rupert Hinds	Prof Nick Freezer	02/04/2019

Monash Children's Hospital

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GASTROENTEROLOGY

PRIORITY

All referrals received are triaged by **Monash Children's Hospital clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

How to refer to Monash Children's Hospital

Mandatory referral content

Demographic:
Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details
including **provider number**
Usual GP (if different)
Interpreter requirements

Clinical:
Reason for referral
Duration of symptoms
Management to date and response to treatment
Past medical history
Current medications and medication history if relevant
Functional status
Psychosocial history
Dietary status
Family history
Diagnostics as per referral guidelines

Click here to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact: paediatric gastroenterologist via Monash Health switchboard (03) 9594 6666

General enquiries

Phone: 8572 3004

Submit a referral

Fax referral form to Monash Children's Hospital Specialist Consulting Services:
Fax: 8572 3007
Email: scmonashchildrens@monashhealth.org

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Monash Children's Hospital

GASTROESOPHAGEAL REFLUX (GORD)

Initial GP Work Up

- History
- Physical examination
- Growth assessment

Management Options for GP

Lifestyle modifications:

- Infants:
  - Provide caregiver education
  - Smaller, more frequent feeds
  - Avoid overfeeding
  - Frequent burping
  - Keeping the infant upright after feeds
  - Avoiding vigorous handling after feeds
  - Thickeners

- Older children:
  - Head elevation
  - Avoiding tobacco smoke exposure.
  - Weight loss
  - Avoidance of meals 2-3h before sleep
  - Avoiding specific food triggers

Acid suppression trial 4-8 weeks

- In older children
- In infants - if referral to a paediatrician is not possible

WHEN TO REFER?

Emergency

- Haematemesis (see below)
- Apparent life-threatening events (ALTE)
- Brief Resolved Unexplained Event (BRUE)
- Suspected neurologic cause of vomiting: e.g. raised ICP

Urgent

- Poor weight gain
- Weight loss
- Failure to thrive

Routine

Refractory GORD

- not responding to optimal treatment after eight weeks of maximum pharmacologic and/or non-pharmacologic therapy based on the available health-care facilities with the following symptoms:
- Feeding refusal, prolonged feeding
- Post-prandial irritability
- Dysphagia, Odynophagia
- Heartburn, chest pain
- Epigastric pain
- Regurgitation/vomiting >18 mo of age
- Conditions that predispose for GORD: CF, neurodevelopmental disorders, prematurity, congenital oesophageal disorders.

BACK

EOSINOPHILIC OESOPHAGITIS (EoE)

Initial GP Work Up

- History: dysphagia, odynophagia, food refusal, food bolus obstruction, history of allergy, asthma, eczema
- Family history of EoE

Management Options for GP

- Refer to paediatric gastroenterology

WHEN TO REFER?

Emergency

Food bolus obstruction

Urgent

- Weight loss
- Severe dysphagia
- Significant symptoms

Routine

- Mild symptoms
- Suspected EoE

BACK

FUNCTIONAL GI DISORDERS

Initial GP Work Up

- Consider GI and non-GI causes
- History: onset, duration, location
- Associated symptoms (weight loss, rectal bleeding, nocturnal symptoms)
- Family history of IBD, coeliac disease, peptic ulcer disease, colorectal cancer or polyps
- Previous abdominal surgery
- Features of functional GI disorder
- Dietary history and response to diet changes

Management Options for GP

- If functional, treat symptomatically as clinically appropriate, e.g. constipation trial of treatment.

WHEN TO REFER?

Urgent

- Suspected IBD
- Positive coeliac serology in the symptomatic patient
- GI bleeding
- Suspected symptomaticpeptic ulcer

Routine

Refer to appropriate speciality service depending on results or clinical response

BACK

COELIAC DISEASE

Initial GP Work Up

- Coeliac serology: TTG IgA, DGP IgG
- FBE, LFTs, iron studies

Optional:

- Coeliac disease susceptibility genotype (DQ2 DQ8).
- Anti-endomesial antibodies

Management Options for GP

- Remain on a gluten containing diet until reviewed by gastro.

WHEN TO REFER?

Emergency

Severe malnutrition

Urgent

- Significant weight loss
- Severe iron deficiency anaemia

Routine

Positive coeliac serology

BACK

SUSPECTED INFLAMMATORY BOWEL DISEASE

Initial GP Work Up

- History: symptom duration, travel, drugs, family history of IBD .
- Suspected IBD: Chronic diarrhoea, PR bleeding, weight loss, chronic abdominal pain, family history of IBD elevated inflammatory markers,elevated calprotectin (not acute)
- Consider blood tests: FBE, ESR, CRP, LFTs, iron studies
- Consider a faecal calprotectin in children > 5-years of age

Management Options for GP

N/A

WHEN TO REFER?

Urgent

Children with evidence of anaemia, hypoalbuminemia or raised inflammatory markers on blood work or with significant weight loss or constitutional disturbance should be seen promptly.

Routine

All children with suspected inflammatory bowel disease require specialist assessment and management. Monash Children's has a dedicated Paediatric IBD clinic.

BACK

SUSPECTED LIVER DISEASE: ABNORMAL LFTs

Initial GP Work Up

- **History**: onset, duration, birth history, travel, drug history, alcohol consumption, possible hepatitis contacts, obesity, metabolic syndrome.
- Family history of liver disease or blood disorders
- **Associated symptoms**: Jaundice, pigmented stools, pruritus, steatorrhea, bruising, dark urine.
- Signs of chronic liver disease

Investigations:

- **All:** FBE, LFTs (including total and conjugated bilirubin) , Coagulation studies
- Ultrasound abdomen

Older child:

- Autoimmune markers ANA, Anti Smith Muscle Ab, LKM1 Ab
- Serology for EBV, CMV, HAV, HBV, HCV
- Iron studies, caeruloplasmin, copper,alpha-1 antitrypsin phenotyping
- Serum Immunoglobulins

Management Options for GP

- Referral to paediatric gastroenterology
- If positive viral hepatitis, refer to Infectious Diseases

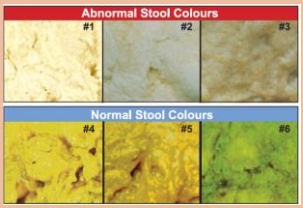
WHEN TO REFER?

Emergency

Suspected acute, severe or fulminant hepatic failure, jaundice, abnormal ALT, prolonged INR, encephalopathy

Urgent

- All infants under the age of 6 months with conjugated hyperbilirubinemia, and/or pale stools.



- Obstructive jaundice or unexplained non-obstructive cholestatic jaundice (elevated alkaline phosphatase, GGT, bilirubin)
- Persistently abnormal liver function tests with no cause found from initial evaluation

BACK

CHRONIC DIARRHOEA (OVER 4 WEEKS)

Initial GP Work Up

- History: duration, travel, drugs, family history of IBD or coeliac
- Dietary history: response to lactose elimination, sugar malabsorption (e.g. response to diet manipulation in a toddler).
- Consider blood tests: FBE, ESR, CRP, LFTs, iron studies, coeliac antibodies, immunoglobulins
- Consider a faecal calprotectin in children > 5-years of age

Management Options for GP

- Consider dietary advice
- In children less than 5 years of age with no constitutional symptoms, good growth and normal blood tests consider reassurance/explanation about Functional Diarrhoea of Infancy or Toddler's Diarrhoea.

WHEN TO REFER?

Urgent

Children with significant weight loss or constitutional disturbance should be seen promptly**.**

Routine

All children with unexplained chronic diarrhoea require specialist assessment and management.

BACK

GI BLEEDING: HAEMATEMESIS, HAEMATOCHEZIA AND/OR MELENA

Initial GP Work Up

Upper GI bleeding

- History of foreign body ingestion
- History of acute vomiting suggestive of Mallory–Weiss tear.
- History of GOR/GORD (see above)

Lower GI bleeding:

- Exclude constipation**:** history and physical examination (e.g. anal fissure)
- Symptoms and family history suggestive of IBD *
- Family history of polyps
- History of acute illness suggestive of infective colitis

Physical examination

- Exclude constipation: faecal mass, anal fissure
- Signs of IBD
- Signs of chronic liver disease

Management Options for GP

- Treat constipation according to available guidelines
- Consider referral to a general paediatrician of children with difficult to treat constipation and infants with suspected cow milk protein intolerance

WHEN TO REFER?

Emergency

- Significant bleeding with signs of haemodynamic compromise
- Fall of Hb level > 2g/dL
- Hb < 7 g/dL
- Known or suspected liver disease (e.g. varices)
- History of foreign body ingestion

Urgent

- Iron deficiency anaemia
- All upper GI bleeding
- Constitutional symptoms suggestive of IBD*
- Infant with suspected cow milk protein intolerance

Routine

Ongoing rectal bleeding without constipation or not responding to treatment of constipation

BACK