Monash Children's Hospital Referral Guidelines
HAEMATOLOGY AND ONCOLOGY

EXCLUSIONS

Services not offered by Monash Children's Hospital

- Haematology patients over 19 years of age: Click here for adult Monash Health Haematology Guidelines
- Oncology patients over 19 years of age: Click here for adult Monash Health Oncology Guidelines
- Patients with retinoblastoma – referred to RCH specialist ophthalmology service
- Sickle cell anaemia/ severe thalassaemia- refer to medical therapies (thal unit).
- Simple iron deficiency and iron infusions- refer to general paediatrics or adolescent medicine. .

CONDITIONS

HAEMATOLOGY

- Anaemia, neutropenia, thrombocytopenia and other blood film abnormalities; including Aplastic anaemia; Bone marrow failure syndromes
- Thrombotic and bleeding disorders
- Any other disorders of a haematological nature, including conditions such as hereditary spherocytosis
- Complicated iron deficiency.

ONCOLOGY DIAGNOSES

All childhood cancers except retinoblastoma, this includes:

- All types of leukaemia
- Non-Hodgkin lymphomas
- Hodgkin lymphoma
- All forms of childhood solid tumours
- Brain and spinal cord tumours
- Histiocytic diseases
- Hepatoblastomas and some sarcomas will be treated in conjunction with surgical teams at RCH.

ONCOLOGY DIAGNOSES

Signs and symptoms for childhood cancer are non-specific- see hyperlinks to more common symptoms or concerning features:

- Acute leukaemia
- Lymphadenopathy
- Mediastinal mass
- Abdominal mass
- Raised intracranial pressure
- Spinal cord compression
- Other masses, pain or suspected malignancy

- A specialist Late effects service for all children and adolescents who are survivors of childhood cancer
- Transfer of care from another centre

Monash Children's Hospital

Monash Children's Hospital Referral Guidelines
Haematology and Oncology

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:
- All cases of suspected paediatric cancer should be discussed immediately with the Paediatric Oncology Consultant on call with consideration of an emergency department presentation.
- For emergency cases please:
- Contact the call Paediatric Haematology/ Oncology fellow or consultant
- Send patient to Emergency Department
- Phone 000 to arrange immediate transfer to ED
- send the patient to the Emergency department OR
- During the day Contact the paediatric Oncology Fellow
- After hours contact the on-call paediatric 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

Head of unit: Dr Peter Downie

Program Director: Prof Nick Freezer

Last updated: 20/05/2021

Monash Children's Hospital

Monash Children's Hospital Referral Guidelines
Haematology and Oncology

CONTACT US

Medical practitioners
To discuss complex & urgent referrals contact: On-call (registrar or consultant) via 8572 3456 or the switchboard 8572 3000

General enquiries
weekdays 9am – 5pm
Phone: 8572 3456

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

OR
Refer via electronic referral using HealthLink. Details available at https://monashchildrenshospital.org/for-health-professionals/gp-ereferrals/

All cases of suspected paediatric cancer should be discussed immediately with the Paediatric Oncology Consultant on call with consideration of an emergency department presentation.

For emergency cases please:
Contact the call Paediatric Haematology/ Oncology fellow or consultant
Send patient to Emergency Department
Phone 000 to arrange immediate transfer to ED

References:
- **Vics.org.au (Paediatric integrated cancer services Victoria)**
- **Referral guidance for suspected cancer in children and young people- a supporting resource for NICE guideline NG12- CCLG eReferral guidelines April 2021)-cclg.org.au**
- **www.headsmart.org.uk for features of primary CNS tumours**

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HAEMATOLOGY

ANAEMIA, NEUTROPENIA, THROMBOCYTOPENIA AND OTHER BLOOD FILM ABNORMALITIES

Initial GP Work Up

- Full Blood Examination (FBE)
- Biochemistry including liver and renal function

Management Options for GP

- If haemolytic anaemia is suspected ~
- SBR – conjugated and unconjugated
- Reticulocyte count
- DAT
- Iron studies; make sure the serum iron is a morning sample

WHEN TO REFER?

Emergency

If pancytopenia is considered, refer to ED or Urgent clinic referral – do not wait for extensive blood work-up

Ongoing bleeding and severe anaemia – call Oncology Fellow or consultant on-call. Send to MCH ED

Urgent

Severe anaemia - Hb < 6 g/dL

Thrombocytopaenia plts < 20,000

Routine

All other haematological problems

BACK

THROMBOTIC AND BLEEDING DISORDERS

Initial GP Work Up (may need to be repeated due to different reference ranges)

- INR, APTT, Fibrinogen
- Full Blood Examination (FBE)
- Biochemistry including liver and renal function

WHEN TO REFER?

Emergency

If suspected bleeding or thrombophilia or concern re clotting is considered, refer into urgent clinic or ED. Do not wait for extensive blood work-up.

Contact Paediatric Oncology Fellow or Consultant to discuss

Urgent

Stable bleeding or coagulation concern.

Routine

More chronic haematological problems

BACK

HAEMATOLOGY - ONCOLOGY

OTHER DISORDERS OF A HAEMATOLOGICAL NATURE

If family history or strong concern re sickle cell disease, thalassaemia- refer to thalassaemia clinic.
Other concerns do minimal pre- investigations and refer in.

Initial GP Work Up

General

- Full Blood Examination (FBE)

Iron Overload – in children, this can be seen after treatment for leukaemia and other cancers

- Serum Fe
- Ferritin, transferrin saturation
- LFT's

Thrombocytosis & Lymphocytosis

- FBE, Iron Studies

Iron Deficiency

- FBE, iron studies, CRP, UEC, LFT, B12, folate, reticulocytes
- Coeliac serology if there is a history that warrants; slowing growth, abdominal pain, diarrhoea.

WHEN TO REFER?

Emergency

Unwell child with suspected haematological issue

Urgent

Abnormal blood test in relatively stable child.

Routine

Stable child, concern re haematological issue, family history or known condition.

BACK

HAEMATOLOGY - ONCOLOGY

IRON DEFICIENCY

Known iron deficiency of known aetiology- oral supplementation is the preferred option. If patient will not take oral supplementation, refer to general clinic for iron infusion.

Iron deficiency of unknown origin, or failure of appropriate oral or IV supplementation can be referred to paediatric haematology.

Initial GP Work Up

General

- Full Blood Examination (FBE)

Iron Deficiency

- FBE, iron studies, CRP, UEC, LFT, B12, folate, reticulocytes
- Coeliac serology if there is a history that warrants; slowing growth, abdominal pain, diarrhoea.

Management Options for GP

- Trial of oral iron
- Dietary history and guidance re appropriate iron intake
- Faecal occult blood screen

WHEN TO REFER?

Emergency

Unwell child, anaemic and symptomatic.

Urgent

Anaemic with minimal abnormal signs.

Routine

Stable child, known iron deficiency.

BACK

HAEMATOLOGY - ONCOLOGY

ACUTE LEUKAEMIA

If pancytopaenia or leukaemia is considered, refer into urgent clinic or ED.
Do not wait for or do extensive blood work-up

Initial GP Work Up may include but no tests required before referring for emergency assessment.

- Full Blood Examination (FBE)
- Biochemistry including liver and renal function
- Calcium, phosphate
- Uric acid
- LDH
- INR, APTT, fibrinogen

Management Options for GP

- Consider a new diagnosis of leukaemia in a child who has pancytopaenia or more than 2 cell lines down, such as aneamia, neutropaenia and thrombocytopaenia. Look for pallor, petechiae, bruising, bone pain, limp, hepatosplenomegaly.
- For known patients with leukaemia on treatment discuss new issues with the treating team.

WHEN TO REFER?

Emergency

All cases of suspected acute leukaemia should be discussed immediately with the Paediatric Oncology Consultant on call with consideration of an emergency department presentation.

Urgent

Review of a known patient with unexplained fever, exposure to chicken pox or measles, other viral exposures or a known patient with a new problem

Routine

Review of a known patient off treatment

BACK

HAEMATOLOGY-ONCOLOGY

CONCERN ABOUT LYMPHADENOPATHY

If lymphoma or other solid malignancy is considered, contact the on call Paediatric/ Oncology/ Haematology team for an urgent clinic review or refer to ED. Do not wait for or do extensive blood work-up or other imaging.

Initial GP Work Up

- Full Blood Examination (FBE)
- Biochemistry including liver and renal function
- ESR
- LDH
- CXR

Management Options for GP

- Enlarged lymph nodes (LN) are common and usually the result of inflammation or inflammatory processes.
- Concern regarding possible malignancy warrants careful assessment and referral.
- Lymph nodes < 2cm in diameter, reducing or fluctuating in size are unlikely to be associated with malignancy in the absence of other suspicious features.
- If an ultrasound or CXR has been done please include the report; and if possible a hard copy of the images
- Please DO NOT arrange for a fine needle aspirate of any paediatric lymph node.
- Please DO NOT commence steroids even if respiratory compromise, unless discussed with team prior. This can mask the diagnosis, lead to tumour lysis syndrome and compromise definitive diagnosis and treatment.

WHEN TO REFER?

Emergency

Unwell, acute breathlessness, rapidly enlarging abdominal distension, rapidly enlarging lymphadenopathy, distended veins/ venous congestion of upper chest or face suggestive of SVC obstruction.

Mediastinal mass.

Urgent

Progressive enlargement of lymph nodes over weeks or months with no obvious cause, night sweats, unexplained weight loss, fevers, pruritus or increasing breathlessness over time.
Supraclavicular LNs, associated splenomegaly, bone pain or limp.

Routine

Chronic lymphadenopathy of unknown cause.

BACK

HAEMATOLOGY-ONCOLOGY

MEDIASTINAL MASSES

If lymphoma or other solid malignancy is considered, contact the on call Paediatric/ Oncology/ Haematology team for an urgent clinic review. Or refer to ED
Do not wait for or do extensive blood work-up

Initial GP Work Up

- May present like asthma or croup- could be leukaemia, lymphoma or other solid cancers such as neuroblastoma, germ cell or sarcoma.
- CXR

Management Options for GP

- Consider a CXR for any patient presenting with new respiratory symptoms or signs, including wheeze if no previous history of asthma or known infection.
- If an ultrasound or CXR has been done please include the report; and if possible a hard copy of the images
- DO NOT arrange for CT scan
- Please DO NOT arrange for a fine needle aspirate of any paediatric lymph node.
- Please do not commence steroids even if respiratory compromise. This can mask the diagnosis, lead to tumur lysis syndrome and compromise definitive diagnosis and treatment.

WHEN TO REFER?

Emergency

Breathlessness suggestive of airway obstruction not explained by known respiratory illness, increased shortness of breath lying flat, distended veins/ venous congestion of upper chest, face, head suggestive of SVC obstruction.

Urgent

Progressive respiratory symptoms of unknown aetiology, with systemic symptoms such as fever, night sweats, loss of weight.

BACK

HAEMATOLOGY-ONCOLOGY

A CHILD WITH AN ABDOMINAL MASS

If lymphoma or other solid malignancy is considered, contact the on call Paediatric/ Oncology/ Haematology team for an urgent clinic review or refer to ED. Do not wait for, or do extensive blood work-up or other imaging

Initial GP Work Up

- Full Blood Examination (FBE)
- Biochemistry including liver and renal function
- Calcium, phosphate
- Uric acid
- LDH
- INR, APTT, fibrinogen
- Ultrasound

Management Options for GP

- Any relevant imaging; reports and hard copies (ultrasound, CT and MRI if done)
- if an abdominal mass is suspected, call for advice
- Paediatric Oncology Fellow
- Paediatric Oncology Consultant on-call

WHEN TO REFER?

Emergency

Mass with compressive symptoms, uncontrolled pain, irritability, unexplained neurological symptoms (Horner's in neuroblastoma), symptoms of bone marrow involvement such pallor, bruising, fever

Urgent

Palpable abdominal mass

Hepatomegaly otherwise unexplained

Systemic features of weight loss, fever, fatigue, loss of appetite.

Haematuria, hypertension, flank pain

Routine

Review of a known patient off treatment

BACK

HAEMATOLOGY-ONCOLOGY

INTRACRANIAL MASSES- RAISED INTRACRANIAL PRESSURE

If a CNS tumour is suspected, contact the on call Paediatric/ Oncology/ Haematology team and/ or neurosurgeons for an urgent clinic review or refer to ED. Do not wait for, or do extensive blood work-up or other imaging

Initial GP Work Up

- Concerns re persistent or recurrent vomiting, persistent or recurrent headaches, balance or coordination problems, loss of milestones, abnormal eye movements, squint or suspected loss of vision, behaviour change or lethargy, afebrile seizures, head tilt, increasing head circumference crossing centiles, failure to grow, diabetes insipidus (polyuria/ polydipsia), delayed or arrested puberty.
- MRI head if feasible in short time frame, else refer to ED

Management Options for GP

- Any relevant imaging; reports and hard copies (ultrasound, CT and MRI if done)
- if a CNS mass is suspected, call for advice
- Paediatric Oncology Fellow
- Paediatric Oncology Consultant on-call
- Neurosurgeon on call

WHEN TO REFER?

Emergency

Acute neurological symptoms or any deteriorating neurological state. Any concern about raised intracranial pressure including bradycardia and hypertension.

Urgent

Slowly progressive neurological signs, or symptoms and signs as listed.

Routine

Review of a known patient off treatment

BACK

HAEMATOLOGY-ONCOLOGY

SPINAL CORD COMPRESSION

Initial Work Up

Refer as soon as suspicion.
Spinal cord compression is a severe, often irreversible complication of intraspinal or paraspinal pathology.
It is rare in paediatrics, but NOT rare in children with cancer.
A patient presenting with symptoms or signs of SCC must be investigated and treated without delay.
There is no need for a tissue diagnosis or multiple investigations- we will arrange the appropriate investigations and biopsies
If tests have been ordered, please send ALL results with referral including histopathology and imaging.

Management Options for GP

Consider imaging if slowly progressive symptoms.

Any abnormal findings on imaging call the paediatric oncology Fellow or paediatric oncology consultant on-call.

WHEN TO REFER?

Emergency

Any acute neurological symptom or change, including weakness, change in sensation.

Back pain that is worsening or acute with no obvious other cause.

Bladder or bowel dysfunction.

All cases of suspected paediatric cancer should be discussed immediately with the Paediatric Oncology Consultant on call with consideration of an emergency department presentation.

Urgent

Sensory change in back, arms or legs, sensory loss

Slowly progressive motor loss

Scoliosis associated with pain.

Loss of or increase in reflexes.

Weakness, local tenderness along spine, altered gait or coordination.

Routine

Slow growing suspicious lesion

Continued care or review of a known patient on treatment

New non-urgent problem in known patient.

Scoliosis

BACK

HAEMATOLOGY-ONCOLOGY

MASSES, PAIN OR SUSPECTED MALIGNANCY OR KNOWN MALIGNANCY

Initial Work Up

Refer as soon as suspicion. This may include bony masses or lesions, enlarging supraclavicular masses, localised pain with no obvious diagnoses, recurrent presentations, a child who is not right.

There is no need for a tissue diagnosis or multiple investigations- we will arrange the appropriate investigations and biopsies

If tests have been ordered, please send ALL results with referral including histopathology and imaging.

General

- FBE and ESR
- LDH
- Calcium, phosphate
- Uric acid
- LFTs and renal function

Management Options for GP

Consider imaging;
ultrasound of the mass;
CXR

DO NOT ARRANGE FOR A FINE NEEDLE ASPIRATE

Any abnormal findings on imaging especially a mediastinal mass call the paediatric oncology Fellow or paediatric oncology consultant on-call

WHEN TO REFER?

Emergency

Any mass causing compressive symptoms, severe pain.

Urgent

Unexplained or enlarging mass
Scrotal swelling
Blood stained vaginal discharge
Back pain, bone pain, weakness, limp
Pain that wakes overnight
Urinary retention
Proptosis
Persistent/ recurrent bloody/ purulent discharge from ear/ nose.
Incidental lytic lesion on imaging

Review of a known patient with unexplained fever, exposure to chicken pox or measles, other viral exposures or a known patient with a new problem

Routine

Slow growing suspicious lesion

Continued care or review of a known patient on treatment

New non-urgent problem in known patient.

Patients whose care is being transferred from elsewhere.

BACK

HAEMATOLOGY-ONCOLOGY

CANCER SURVIVORSHIP- LONG TERM FOLLOW UP (LTFU)

WHEN TO REFER?

Routine

LTFU is a state-wide service coordinated via PICS-Paediatric integrated cancer services.

Please refer to their website for the appropriate forms and referral pathways. https://www.vics.org.au/pics-health-professionals

Initial GP/ provider Work Up

- Summary of all correspondence, treatment summaries, original histopathology report, all molecular testing, all imaging results, and date of completion of therapy.
- Patient's GP and all relevant providers

BACK

TRANSFER FROM ANOTHER CANCER SERVICE OR CARE PROVIDER

WHEN TO REFER?

Routine

Patients whose care is being fully transferred from an oncologist at another centre/healthcare service

Initial GP Work Up

- All correspondence, treatment summaries, original histopathology report, all molecular testing, all imaging results.
- Patient's GP and all relevant providers
- Reason for transfer needs to be clearly stated
- Time frame (note that new patients will be prioritised ahead of transferring patients)
- Patients who have received anti-cancer therapy need to have a clear treatment summary
- Transfer request to continue current therapy must include all details of treatment, eg chemotherapy chart/ plan.

BACK