Monash Children's Hospital Referral Guidelines
PAEDIATRIC GENERAL SURGERY

EXCLUSIONS

Services not offered by Monash Children's Hospital

[List exclusions]
Patients over 16 years of age: Please refer to relevant adult Monash Health Surgical specialty

CONDITIONS

FORESKIN

Phimosis (tight foreskin)

Recurrent balanitis

Balanitis xerotica obliterans

HERNIAS

Inguinal hernia

Umbilical hernia

Epigastric hernia

Femoral hernia

INTESTINAL CONDITIONS

Appendicitis

Pyloric Stenosis

Intussusception

Gastro-oesophageal Reflux Disease (GORD)

Malrotation

NEONATAL SURGERY

Necrotizing Enterocolitis

Gastroschisis

Omphalocele/Exomphalos

Diaphragmatic hernia

Intestinal/oesophageal atresia

Anorectal malformations

Hirschprung's disease

SKIN/SUBCUTANEOUS CONDITIONS

Vascular malformations

Skin lesions / cysts

Lymphadenopathy

TESTIS

Undescended testis

Retractile testis

Ectopic testis

Acute testicular pain

Head of unit: Dr Peter Ferguson

Program Director: A/Prof Alan Saunder

Last updated: 22/05/2019

Monash Children's Hospital

Monash Children's Hospital Referral Guidelines
PAEDIATRIC GENERAL SURGERY

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. For urgent inquiries outside office hours, please call switch on (03) 9594 6666 and page the on-call paediatric surgical registrar.

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: On-call Paediatric Surgery Registrar via switch: (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

Head of unit:
Dr Peter Ferguson

Program Director:
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Last updated:
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Monash Children's Hospital

FORESKIN

PHIMOSIS

Initial GP Work Up

Clinical history and physical examination

- History of progressive narrowing
- Pathological phimosis (BXO) - tight scarred foreskin opening
- Physiological phimosis with symptoms

Management Options for GP

- Physiological phimosis with symptoms - consider topical creams e.g.0.05% betnovate for 6 weeks
- Antibiotics for acute balanitis

WHEN TO REFER?

Emergency

Urinary retention secondary to phimosis requires immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

Urgent

- Pin hole prepucial orifice with poor urinary stream
- Severe pain with micturition (UTI excluded)
- Urgent referrals can be faxed to **(03) 9594 6008.** These referrals will be triaged within one business day.

Routine

- Recurrent balanitis
- Scarred foreskin
- Progressive narrowing of foreskin
- Assymptomatic phimosis in boys older than 13
- Symptomatic foreskin following trial of conservative management

BACK

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

HERNIAS

INGUINAL HERNIA

Initial GP Work Up

Clinical history and physical examination

Irreducible inguinal hernia

- Irreducible mass in inguinal region
- Lump may extend to the scrotum area in boys
- Possible complications:
  - Irreducible hernias - testicular or ovarian ischaemia,
  - Bowel obstruction
  - Bowel ischeamia

Indirect inguinal hernia

- Reducible inguinal swelling
- History of intermittent swelling
- Palpable "lymph node" size swelling at upper labia in females (ovary)

Management Options for GP

- Refer for surgical repair
- No imaging required

WHEN TO REFER?

Emergency

- Irreducible inguinal hernia
- Immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

Urgent

Indirect inguinal hernia

- < 6 months of age
- Difficult to reduce or painful hernia

Routine

Indirect inguinal hernia

- > 6 months of age

BACK

UMBILICAL HERNIA

Initial GP Work Up

Clinical history and physical examination

Infants

- Often increase in size in first 4 months

Management Options for GP

- Reassurance and await self resolution

WHEN TO REFER?

Emergency

- Irreducible umbilical hernia (very unusual)
- Immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

Routine

Refer if still present at 3 years old, or if painful

BACK

HERNIAS (cont'd)

EPIGASTRIC HERNIA

Initial GP Work Up

Clinical history and physical examination

- Midline swelling between umbilicus and xiphisternum
- Hernia contains pre-peritoneal fat
- Usually asymptomatic

Management Options for GP

- This is an elective surgical condition
- No investigations required

WHEN TO REFER?

Routine

If symptomatic or cosmetic concerns

BACK

INTESTINAL CONDITIONS

APPENDICITIS

Initial GP Work Up

- Clinical history and examination
- Significant pain with movement and particularly abdominal dysuria suggest surgical pathology and should be assessed in ED

Management Options for GP

- Bloods and community ultrasound not required but may help triaging whether attendance at ED is required

WHEN TO REFER?

Emergency

- This is a surgical condition requiring immediate specialist attention
- Immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

Urgent

Insert relevant information here

Routine

Insert relevant information here

BACK

PYLORIC STENOSIS

Initial GP Work Up

Clinical history

- 2-8 week old infants:
  - Foreceful non bile stained vomiting
  - Dehydration and poor weight gain if >48 hour history
  - Most babies will be 3-6 weeks old at onset

Management Options for GP

ultrasound may exclude diagnosis if normal but may not preclude hospital attendance

WHEN TO REFER?

Emergency

- This is a surgical condition requiring immediate specialist attention
- Immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

BACK

INTESTINAL CONDITIONS (cont'd)

INTUSSUSCEPTION

Initial GP Work Up

Clinical history / examination

Most will be 3 months – 1 year old

- Episodes of colicky abdominal pain / vomiting – Abdominal mass may be palpable
- Drawing legs up with associated pallor
- Redcurrant jelly stool may be present

Management Options for GP

- Differential diagnosis from viral colic or gastro may be difficult
- If patient is well a normal ultrasound should exclude intussusception
- Keep fasted

WHEN TO REFER?

Emergency

Immediate referral to emergency department and contact on-call Paediatric Surgery Registrar via main switchboard: **(03) 9594 6666**

BACK

INTESTINAL CONDITIONS (cont'd)

MALROTATION

Initial GP Work Up

- History of green vomiting
- Most symptomatic malrotation presents less than 3 months old but any age is possible

Management Options for GP

- Refer to emergency department if suspected

WHEN TO REFER?

Emergency
Acute bilious vomit with or without abdominal signs / pain or systemic effect

Urgent

Routine
Insert relevant information here

BACK

NEONATAL SURGERY

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

NEONATAL SURGERY (cont'd)

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

NEONATAL SURGERY (cont'd)

Emergency
Insert relevant information here

Urgent
Insert relevant information here

Routine
Insert relevant information here

ANORECTAL MALFORMATIONS

Initial GP Work Up

- Difficulty stooling < 2 years old mandates at least perineal inspection
- Majority of anorectal malformations missed at birth have a perineal opening but not a normal looking anus

Management Options for GP

- A normal rectal examination excludes the diagnosis but not other surgical causes of congenital obstruction eg Hirschsprung's Disease

WHEN TO REFER?

Emergency
Send to emergency dept if significant abdominal distension

Urgent
All other anorectal malformations will be seen urgently in clinic

Routine
Insert relevant information here

BACK

NEONATAL SURGERY (cont'd)

HIRSCHPRUNG'S DISEASE

Initial GP Work Up

- Abdominal distension / constipation
- Majority present as neonates – classically with failure to pass meconium
- Rare cause of chronic constipation
- Note: Approx 1/3 Hirschsprung's **will** pass meconium in first 24 hours

Management Options for GP

WHEN TO REFER?

Emergency
Send to emergency department any infant with suspected or confirmed Hirschsprung's who is unwell and distended

Urgent
Constipation and abdominal distension after neonatal period where Hirschsprung's suspected

Routine

BACK

SKIN/SUBCUTANEOUS CONDITIONS

VASCULAR MALFORMATIONS

Initial GP Work Up

- Subcutaneous malformations - soft swellings +/- purple discolouration / prominent superficial vessels – ultrasound
- May grow during first 1-2 years then often stabilise
- Risk of infection / bleeding causing size increase +/- pain

Management Options for GP

- Observation of capillary (strawberry)
- haemangiomas unless ulcerated / perorbital
- Asymptomatic cosmetically insignificant lesions can be observed

WHEN TO REFER?

Emergency
Acute painful size increase +/- compression symptoms

Urgent
Insert relevant information here

Routine
Cosmetic concern – refer to Paed plastics or general surgery depending on site (eg: face – plastics)

BACK

SKIN LESIONS / CYSTS

Initial GP Work Up

Management Options for GP

- Ultrasound may be indicated – depends on clinical impression

WHEN TO REFER?

Emergency
Acute abscess, pain

Urgent
Suspicion of malignancy or infected pre-existing lesions

Routine
Insert relevant information here

BACK

SKIN/SUBCUTANEOUS CONDITIONS (cont'd)

LYMPHADENOPATHY

Initial GP Work Up

- Insert relevant information here

Management Options for GP

- Insert relevant information here

WHEN TO REFER?

Emergency
Acute inflammatory lesions / abescess

Urgent

Routine
Insert relevant information here

BACK

TESTIS

UNDESCENDED TESTES

WHEN TO REFER?

Initial GP Work Up

Clinical history and physical examination

- Diagnostic imaging has very limited role in the management of undescended testes
- Diagnosis is clarified on clinical examination
- Cannot be manipulated into the scrotum by the age of 3 months

Routine

- Refer to be seen around 6 months of age if the testes are not fully descended by 3 months – will most likely require surgery

Management Options for GP

Risk of infertility if orchidopexy is delayed

BACK

RETRACTILE TESTES

WHEN TO REFER?

Initial GP Work Up

- Retractile testis are normal throughout childhood
- Testis normal in size that reach the scrotum on examintion

Management Options for GP

- Review testis position every 2-3 years then refer if concerns

Routine

If a testis are never seen in the scrotum and there is some tension on the cord when manipulated to a normal position

BACK

TESTIS (cont'd)

ACUTE TESTICULAR PAIN

Initial GP Work Up

- If testicular tenderness +/- irreducible acute swelling refer directly to ED at Monash Children's, Clayton

WHEN TO REFER?

Emergency
All acute testicular pain

BACK