# Monash Children’s Hospital
Referral Guidelines
## GASTROENTEROLOGY

### CONDITIONS

<table>
<thead>
<tr>
<th>Gastroesophageal Reflux (GORD)</th>
<th>Liver Disease and Pancreas</th>
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<tbody>
<tr>
<td>Gastroesophageal Reflux not responding to first line treatment or persistent &gt;6 months</td>
<td>Abnormal liver tests</td>
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<tr>
<td></td>
<td>Jaundice with raised conjugated bilirubin</td>
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<td></td>
<td>Autoimmune hepatitis</td>
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<tr>
<td></td>
<td>Primary sclerosing Cholangitis</td>
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<td></td>
<td>Chronic/ recurrent pancreatitis</td>
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<thead>
<tr>
<th>Eosinophilic Oesophagitis</th>
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<tr>
<th>Functional GI disorders</th>
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<tbody>
<tr>
<td>Chronic abdominal pain</td>
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<tr>
<td>Chronic vomiting</td>
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<tr>
<td>Cyclic vomiting syndrome</td>
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<thead>
<tr>
<th>Coeliac Disease</th>
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<tr>
<th>Suspected IBD</th>
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<tbody>
<tr>
<td>Crohn’s disease</td>
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<tr>
<td>Ulcerative Colitis</td>
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<tr>
<td>Perianal Crohn’s disease</td>
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<tr>
<td>Very early onset IBD</td>
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<tr>
<th>GI Bleeding: haematemesis, haematochezia and/or melena</th>
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<tbody>
<tr>
<td>Not resolved with the treatment of constipation</td>
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<tr>
<td>Suspected IBD</td>
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<tr>
<td>Polyp/ familial polyp syndromes</td>
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<tr>
<td>Gastrointestinal food allergy presenting in infancy, not responding to maternal dietary exclusions or trial of hydrolysed formula</td>
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</tbody>
</table>

### 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 - consider 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

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Head of unit: Dr Rupert Hinds  
Program Director: Prof Nick Freezer  
Last updated: 12/10/2023
Monash Children’s Hospital
Referral Guidelines
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

**Submit a referral**
Please use HealthLink to submit all referrals to Monash Children's hospital
Email: scmonashchildrens@monashhealth.org

**General enquiries**
Phone: 8572 3004

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**Head of unit:**
Dr Rupert Hinds

**Program Director:**
Prof Nick Freezer

**Last updated:**
02/04/2019
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.

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
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 symptomatic peptic ulcer

Routine
Refer to appropriate speciality service depending on results or clinical response

COELIAC DISEASE

Initial GP Work Up
- Coeliac serology: TTG IgA, DGP IgG
- FBE, LFTs, iron studies

Optional:
- Coeliac disease susceptibility genotype (DQ2 DQ8).
- Anti-endomysial 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
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

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 REFERR?

**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.

WHEN TO REFER?
GI BLEEDING: HAEMATEMESIS, HAEMATOchezia AND/OR MELENA

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

Monash Children’s Hospital Referral Guidelines | GASTROENTEROLOGY

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
- 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