

# 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 - 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

#### 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

Last updated:  
November 2024



# 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: [smonashchildrens@monashhealth.org](mailto:smonashchildrens@monashhealth.org)

##### General enquiries

Phone: 8572 3004



## 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.

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## 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

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## FUNCTIONAL GI DISORDERS

### WHEN TO REFER?

#### 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.

#### 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

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## COELIAC DISEASE

### WHEN TO REFER?

#### Initial GP Work Up

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

#### Management Options for GP

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

#### Emergency

Severe malnutrition

#### Urgent

- Significant weight loss
- Severe iron deficiency anaemia

#### Routine

Positive coeliac serology

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## SUSPECTED INFLAMMATORY BOWEL DISEASE

### WHEN TO REFER?

#### 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 faecal calprotectin (in the absence of acute GI infection)
- 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

#### 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.

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## SUSPECTED LIVER DISEASE: ABNORMAL LFTs

### WHEN TO REFER?

#### 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

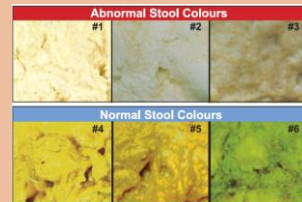
- Referral to paediatric gastroenterology
- If positive viral hepatitis, refer to Infectious Diseases

#### 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

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## CHRONIC DIARRHOEA (OVER 4 WEEKS)

### WHEN TO REFER?

#### 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

#### 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.

#### 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.

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## GI BLEEDING: HAEMATEMESIS, HAEMATOCHYZIA AND/OR MELENA

### WHEN TO REFER?

#### 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

#### 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

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