

## HPH Guidelines for Gastroenterology Referrals

Effective November 28, 2016

The following guidelines are designed to provide guidance to practicing clinicians regarding the transfer of patients for gastroenterology evaluation and treatment. These guidelines are not intended to supersede the medical judgment of the attending provider.

### 1. Colon cancer screening, colon cancer surveillance, colon polyp surveillance:

- The gastroenterology sections at HHP Gastroenterology sites use the 2008 US PTF guidelines for screening and surveillance colonoscopy. If a patient does not need GI consultation but only colon cancer screening or surveillance, Straub and several other HHP GI sites have a direct access process. The nurses that manage the direct access center will establish that the patient meets the appropriate guidelines before scheduling colonoscopy or any other colon cancer screening modality. If there is a question as to whether the patient fits the guidelines, or if a patient has questions or a desire to meet the physician prior to a procedure, an appointment will be made with a gastroenterologist. Recall that average risk colon cancer screening begins at age 50 and some guidelines suggest age 45 for African Americans; and at age 40 for high risk patients.

### 2. Inflammatory bowel disease:

- Consider referral for patients (18 years old or older) with inflammatory bowel disease (ulcerative colitis or Crohn's disease) or suspected inflammatory bowel disease. Consider the following evaluation prior to GI consultation: CBC, stool culture, stool for C. diff toxin, sedimentation rate, and C-reactive protein, liver panel, and metabolic panel.

### 3. Irritable bowel syndrome (IBS):

- Consider referral for patients whose diagnosis is uncertain.
- Consider referral for patients when there is suspicion of other pathology or when symptoms are not consistent with irritable bowel such as nocturnal diarrhea, anemia, weight loss.

### 4. Chronic diarrhea:

- Consider referral for patients who have diarrhea of greater than 2 weeks duration that is unexplained. Please perform stool cultures, c. difficile, hemoccult, CBC, TSH, and consider giardia antigen/ova and parasite examination.
- Consider referral for patients with diarrhea and associated weight loss, diarrhea that awakens from sleep, or diarrhea associated with joint pain, rash or fever.
- Consider referral for patients with suspected celiac disease and/or positive celiac serology.
- Consider referral for patients who are suspected of having malabsorption or mal-digestion of small bowel or pancreatic origin.

**5. Constipation:**

- Consider referral for patients with constipation that is refractory to usual cathartics or when the constipation represents a change in bowel habit.

**6. Gastroesophageal reflux disease:**

- Consider referral for patients who have alarm symptoms (dysphagia, odynophagia, anemia, melena, hematemesis, unexpected weight loss, or mass on abdominal exam).
- Consider referral for patients who are not responding well to standard anti-secretory medication (proton pump inhibitors and/or H2 blockers).
- Consider referral for patients who have had chronic GERD symptoms (greater than 5 years), particularly Caucasian men as they are at highest risk for Barrett's esophagus.
- Consider referral for patients, who are thought to have atypical GERD manifestations, such as cough, laryngitis, asthma, etc.

**7. Dysphagia:**

- Consider referral for patients who have dysphagia or odynophagia.

**8. Dyspepsia:**

- Consider referral for patients over the age of 40 who have dyspepsia.
- Consider referral for patients under the age of 40 who have dyspepsia and have undergone testing for *Helicobacter pylori* and treatment if positive, and who continue to have symptoms.
- Consider referral for patients with dyspepsia who have alarm symptoms (unexpected weight loss, evidence of GI blood loss such as guaiac positive stools, melena, or anemia).

**9. Anemia:**

- Consider referral for patients who have iron deficiency anemia documented by lab unless there is an obvious source other than the GI tract such as heavy menstrual flow.
- Consider referral for patients suspected of pernicious anemia or atrophic gastritis.

**10. GI bleeding:**

- Patients with active GI bleeding should be admitted to the hospital and inpatient gastroenterology consultation obtained.
- Consider referral for patients with hematochezia who do not have an identified source.
- Consider referral for patients with guaiac positive stools, melena or hematemesis.

**11. Abnormal liver tests:**

- Consider referral for patients with abnormal liver enzymes where there is no explanation or when there is a known liver disease which requires treatment or follow-up.

- Consider referral for patients who have a chronic liver disease such as autoimmune hepatitis, primary biliary cholangitis, alcoholic liver disease, metabolic liver disease (hemochromatosis) and nonalcoholic fatty liver disease (NAFLD).

**12. Biliary tract disease:**

- Consider referral for patients who have liver chemistries, signs, symptoms or imaging studies suggestive of bile duct obstruction such as choledocholithiasis, bile duct tumor or bile duct inflammation.

**13. Chronic hepatitis B and C:**

- Consider referral for patients who are found to have chronic Hepatitis B or C. For patients with hepatitis B, please obtain liver panel, CBC, hepatitis B viral load, hepatitis B antigen, and hepatitis B antibody. For patients with hepatitis C, please obtain liver panel, hepatitis C viral load, and hepatitis C genotype.

**14. Pancreatic Disease:**

- Consider referral for patients who are noted to have abnormal pancreatic imaging (IPMN, Cystic lesions, solid tumors, PNETs).
- Consider referral for patients who are thought to have chronic pancreatitis particularly when etiology is not clear.

**15. Suspected Cancer:**

- Consider referral for patients with suspected neoplastic disease (abnormal imaging, elevated serologic tumor markers) of liver, pancreas, biliary tract, esophagus, stomach, small intestine or Colon.