Health Services Programs
Outpatient Redesign Project

Gastroenterology (paediatric)
Clinical Prioritisation Criteria (CPC)
Outpatient Referral Criteria

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Contents

Summary

This document contains the Clinical Prioritisation Criteria (CPC) for frequently referred Gastroenterology (paediatric) conditions. It is a consultation drafting document only. The final format will be as indicated on the CPC website Clinical Prioritisation Criteria specialities | SA Health.

Gastroenterology (paediatric) conditions

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the exclusions section.

- Abdominal Pain
- Altered Bowel Habit
- Coeliac Disease
- Gastrointestinal Bleeding
- Inflammatory Bowel Disease
- Iron Deficiency Anaemia with Suspected Gastrointestinal Cause
- Liver Dysfunction
- Nutritional and Weight Concerns
- Upper Gastrointestinal Dysfunction

Out of scope

Not all conditions are covered by the CPC, as certain conditions may be considered out of scope or managed by other specialist services:

- nil

Exclusions for public specialist outpatient services

Not all conditions are appropriate for referral into the South Australian public health system. The following are not routinely provided in a public specialist outpatient service:

- second opinions in children where family or medical disagreement exists without consultation with treating paediatrician
- second opinions for conditions already seen by the same specialty
- refer to individual condition pages for more condition-specific exclusions

Emergency information

See the individual condition pages for more specific emergency information.

Feedback

We welcome your feedback on the Clinical Prioritisation Criteria and website, please email us any suggestions for improvement at Health.CPC@sa.gov.au.

Review

The Gastroenterology (paediatric) CPC is due for review within 5 years.

This document is for consultation only.

Abdominal Pain

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- acute, severe abdominal pain for surgical review:
  - peritonitis, infarction or obstruction – for example, rigid abdomen, guarding, pain out of proportion to clinical signs)
  - suspected bowel obstruction – bilious vomiting, significant distention, lack of passage of flatus
  - suspected ectopic pregnancy, ovarian torsion, or testicular torsion
  - suspected appendicitis
  - abdominal pain associated with acutely irreducible hernia
- shock or sepsis

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- non-tertiary referrals for chronic/recurrent abdominal pain without concerning features listed in the 'Emergency' and 'Triage categories' criteria – refer instead to Paediatric Medicine

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- recurrent abdominal pain with any of the following concerning features:
  - faltering growth (weight loss > 2 weight percentiles)
  - iron deficiency anaemia with haemoglobin (Hb) < 85g/L
  - significant abnormality in inflammatory markers – raised platelet count, C-reactive protein, erythrocyte sedimentation rate and/or reduced albumin; **and** infection excluded – stool MCS or PCR negative
  - tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
  - associated, persistent bloody diarrhoea > 2 weeks **and** infection excluded

Category 2 (appointment clinically indicated within 90 days)

- abdominal pain with iron deficiency anaemia – see also 'Iron Deficiency Anaemia CPC'
- abdominal pain with associated persistent non-bloody and non-infectious diarrhoea for > 4 weeks
- tertiary referrals for abdominal pain for > 8 weeks without concerning features: referral should be made from paediatrician or paediatric surgeon

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including onset and duration of symptoms
  - onset and duration of symptoms
  - frequency and severity of symptoms
  - current management regime
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations
- investigations including:
  - C-reactive protein (CRP)
  - erythrocyte sedimentation rate (ESR)
  - full blood count (FBC)
  - iron (Fe) studies
  - liver function test (LFT) results
  - coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA)
  - stool microculture and sensitivities (MCS)
  - faecal multiplex polymerase chain reaction (PCR) and microscopy

Additional information to assist triage categorisation

- paediatrician report, if available
- previous investigations and reports of presenting abdominal pain, e.g. endoscopy, radiological reports
- faecal calprotectin result if inflammatory bowel disease suspected, in children aged > 4 years

Clinical management advice and resources

Clinical management advice

In many cases, more serious causes of abdominal pain can be reasonably excluded by a thorough history and examination, without the need for extensive investigation.

Refer also to relevant CPCs for:

- Altered Bowel Habit
- Coeliac Disease
- Inflammatory Bowel Disease
- Iron Deficiency Anaemia with Suspected Gastrointestinal Cause

Clinical resources

- HealthPathways SA – Chronic recurrent abdominal pain in children, log in required
- Royal Children's Hospital Melbourne – Abdominal pain: chronic

Consumer resources

- Royal Children's Hospital Melbourne – Abdominal pain fact sheet

Key Words

abdominal pain, gastroenterology

Altered Bowel Habit

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- acute severe colitis (> 6 bloody bowel motions per 24 hours)
- dehydration unable to be managed at home
- suspected bowel obstruction – bilious vomiting, significant distention, lack of passage of flatus, obstipation

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- allergic colitis
- non-tertiary referrals for chronic constipation and encopresis – refer to Paediatric Medicine - Constipation/Encopresis
  Note: tertiary referral from paediatrician or paediatric surgeon accepted.
- positive stool multiplex PCR for infection
- self-limiting diarrhoea < 6 weeks

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- persistent diarrhoea (bloody or non-bloody) > 4 weeks with any of the following features:
  - negative stool multiplex PCR for infection
  - faltering growth (weight loss of > 2 weight percentiles)
  - significantly elevated inflammatory markers – raised platelet count, C-reactive protein, erythrocyte sedimentation rate, and/or reduced albumin
  - tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
  - elevated faecal calprotectin > 500 mcg/g

Category 2 (appointment clinically indicated within 90 days)

- persistent diarrhoea > 4 weeks without any of the above features

Category 3 (appointment clinically indicated within 365 days)

- tertiary referral (i.e. paediatrician or paediatric surgeon) for treatment resistant constipation or encopresis
  Note: non-tertiary referrals for constipation/encopresis should be directed in the first instance to Paediatric Medicine

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of the presenting condition including:
  - onset, duration, frequency and severity of symptoms
  - medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations
- investigations including:
  - c-reactive protein (CRP)
  - erythrocyte sedimentation rate (ESR)
  - faecal multiplex PCR result
  - faecal calprotectin result (in children aged > 4 years with diarrhoea > 4 weeks)
  - full blood count (FBC)
  - iron (Fe) studies
  - liver function test (LFT) results
  - coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA).

Additional information to assist triage categorisation

- any previous investigations and reports, e.g. endoscopy, radiological reports – including date and location of imaging

Clinical management advice and resources

Clinical management advice

Faecal calprotectin levels can be elevated in healthy, pre-school aged children and should be interpreted with caution.

Consumer resources

- Gastroenterological Society of Australia (GESA) – Information about constipation

Key Words

Altered bowel habit, persistent diarrhoea, constipation, encopresis, gastroenterology

Coeliac Disease

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- nil

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- normal coeliac serology regardless of HLA DQ2 or DQ8 typing, exception if IgA deficient
- positive HLA DQ2 or DQ8 typing and normal coeliac serology, exception if IgA deficient

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- suspected coeliac disease with any of the following:
  - tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
  - iron deficiency anaemia
  - faltering growth with weight loss of > 2 weight percentiles

Category 2 (appointment clinically indicated within 90 days)

- suspected coeliac disease with tissue transglutaminase IgA (TTG IgA) 2-10 x ULN
- suspected coeliac disease in the presence of IgA deficiency (< 0.2 g/L)

Category 3 (appointment clinically indicated within 365 days)

- known coeliac for routine follow-up

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least 2 weight measurements, with percentiles

    - any weight loss, including amount and timeframe
    - medical history, medications, allergies, immunisations
- investigations including:
    - tissue transglutaminase IgA (TTG IgA) on gluten-containing diet for > 6 weeks
    - total IgA

Additional information to assist triage categorisation

- family history of coeliac disease and/or autoimmune disease
- full blood count (FBC)
- iron studies
- endomysial antibodies IgA

Clinical management advice and resources

Clinical management advice

- Continue gluten-containing diet until initial review or withdraw gluten and advise patient that reintroduction of gluten may be required for further testing.
- All patients with suspected coeliac disease should be referred to a gastroenterologist for confirmation of diagnosis and counselling.

Clinical resources

- Coeliac Australia Health Professionals Hub

Consumer resources

- Coeliac Australia

Key Words

Coeliac disease, gastroenterology

Gastrointestinal Bleeding

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- acute haematemesis or melaena
- acute lower gastrointestinal bleeding in large volume or with haemodynamic compromise
- acute severe colitis (> 6 bloody bowel motions per 24 hours)

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- non-significant haematochezia (i.e. small, fresh rectal bleeding on wiping) responsive to trial of laxatives
- thriving infant with minor rectal bleeding (i.e. food protein-induced allergic proctocolitis)
  - for suspected FPIES refer to Allergy & Immunology Food Allergy CPC
- allergic proctocolitis
  Note: not out of scope if tertiary referral from paediatrician
- rectal bleeding (small volume) in the setting of formed stools – 6-week trial of appropriate stool softener
  Note: If bleeding persists despite this trial, referral should be made

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- persistent haematemesis, melaena or rectal bleeding with any of the following features:
  - faltering growth (weight loss of > 2 weight percentiles)
  - iron deficiency anaemia
  - persistent diarrhoea (bloody or non-bloody) > 6 weeks
  - significantly elevated inflammatory markers (raised platelet count, C-reactive protein, erythrocyte sedimentation rate and/or reduced albumin)

Category 2 (appointment clinically indicated within 90 days)

- persistent haematemesis, melaena or rectal bleeding without any of the above features

Category 3 (appointment clinically indicated within 365 days)

- suspected colonic polyp with minimal rectal bleeding

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations
- investigations including:
  - full blood count (FBC)
  - liver function test results (LFTs)
  - iron (Fe) studies
  - c-reactive protein (CRP)
  - erythrocyte sedimentation rate (ESR)
  - coagulation studies

Additional information to assist triage categorisation

- faecal multiplex PCR results
- faecal helicobacter pylori antigen
- faecal calprotectin result if diarrhoea > 6 weeks (in children aged ≥ 4 years)
- previous investigations and reports (e.g. endoscopy, radiological reports) if available

Clinical management advice and resources

Consumer resources

- Australasian Society of Clinical Immunology and Allergy (ASCIA) – Food Protein-Induced Allergic Proctocolitis

Key Words

Gastrointestinal bleeding, haematemesis, melaena, rectal bleeding, gastroenterology

Inflammatory Bowel Disease (suspected or known)

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- suspected or known inflammatory bowel disease with severe abdominal pain and/or bloody diarrhoea, and any of the following features:
    - fever
    - haemodynamic compromise
    - suspected megacolon
    - suspected bowel perforation
    - bowel obstruction
    - abscess (abdominal or perianal)
    - haemoglobin < 90 g/L

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
    - In hours: Gastroenterology registrar
    - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- bloody diarrhoea in the presence of bacterial infection found on stool multiplex PCR

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- suspected or known inflammatory bowel disease where chronic diarrhoea (bloody or non-bloody) or other symptoms > 4 weeks with elevated faecal calprotectin (> 250 mcg/g), **and** any of the following critical features are present:
    - new progressive gastrointestinal symptoms, e.g. abdominal pain, vomiting
    - faltering growth (weight loss of ≥ 2 weight percentiles)
    - perianal pain or fistulae suspected
    - significant abnormality to one or more of the following laboratory critical features:
        - anaemia
        - low albumin
        - elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)
        - iron deficiency
        - holotranscobalamin (active vitamin B12) deficiency
    - abnormal imaging suggesting inflammatory bowel disease

Category 2 (appointment clinically indicated within 90 days)

- suspected inflammatory bowel disease where chronic diarrhoea (non-bloody) or other symptoms > 6 weeks with elevated faecal calprotectin (> 100 mcg/g), and none of the above critical features are present
- known inflammatory bowel disease with a flare of symptoms, and none of the above critical factors are present

Category 3 (appointment clinically indicated within 365 days)

- known inflammatory bowel disease for routine follow-up

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, including percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations
- investigations including:
  - stool multiplex PCR negative and *Clostridium difficile* toxin
  - faecal calprotectin result (in children aged > 4 years)
  - full blood count (FBC)
  - liver function test result
  - electrolytes, urea and creatinine (EUC)
  - iron studies
  - holotranscobalamin (active vitamin B12)
  - c-reactive protein (CRP)
  - relevant imaging reports – including date and location of imaging
  - current and previous colonoscopy results, if available

Additional information to assist triage categorisation

- personal or family history of inflammatory bowel disease

Clinical management advice and resources

Clinical management advice

Faecal calprotectin levels can be elevated in healthy, pre-school aged children and should be interpreted with caution.

Clinical resources

- Crohn's and Colitis Australia

Consumer resources

- Crohn's and Colitis Australia
- Gastroenterological Society of Australia (GESA) – Inflammatory Bowel Disease
- Royal Children's Hospital – Inflammatory bowel disease (IBD)

Key Words

Inflammatory bowel disease, IBD, Crohn's disease, ulcerative colitis, gastroenterology

Iron Deficiency Anaemia with Suspected Gastrointestinal Cause

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- severe symptomatic anaemia with:
  - acute overt gastrointestinal (GI) bleeding
  - chest pain
  - dyspnoea
  - haemodynamic instability e.g., shock, hypotension, syncopal episodes

Please contact the gastroenterology on-call registrar (or relevant surgical or medical subspecialty) to discuss your concerns prior to referral.

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Inclusions, exclusions and triage categories

Inclusions

- iron deficiency anaemia with gastrointestinal symptoms and/or suspected gastrointestinal cause

Exclusions

- all other presentations of iron deficiency should be referred first to Paediatric Medicine
- iron deficiency without anaemia, in the absence of positive coeliac serology and/or elevated calprotectin > 500mcg/g

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- iron deficiency with positive coeliac serology
- iron deficiency with elevated calprotectin > 500mcg/g

Category 2 (appointment clinically indicated within 90 days)

- iron deficiency anaemia with epigastric discomfort and/or recurrent abdominal pain
- iron deficiency anaemia with family history of gastric cancer – these patients should be screened for Helicobacter pylori (H. pylori) – refer to 'Clinical Management Advice' and ESPGHAN/NASPGHAN Guidelines for management of Helicobacter pylori infection in children and adolescents (2023)

Category 3 (appointment clinically indicated within 365 days)

- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- past medical history – please provide any relevant features as relating triage categories
- family history including gastrointestinal/colorectal cancer, coeliac disease, inflammatory bowel disease (IBD)
- dietary history
- medications, allergies and immunisations
- details of presenting condition including:
    - symptoms, including frequency, severity and duration
    - sensory and texture issues with food, if any
    - food avoidance/restricted eating patterns, if any
    - associated symptoms, e.g. dysphagia, eczema, asthma, prolonged illness/infection
    - presence of concerning features
    - oral supplementation trialled, including doses and duration and response
- pathology:
    - complete blood examination (CBE)
    - urea, electrolytes, creatinine (UEC)
    - liver function tests (LFTs)
    - iron (Fe) studies
    - coeliac serology
    - thyroid function tests (TFTs)
    - c-reactive protein (CRP)
    - erythrocyte sedimentation rate (ESR)
    - faecal calprotectin
    - faecal multiplex polymerase chain reaction (PCR)
    - stool microculture and sensitivities (MCS)

Additional information to assist triage categorisation

- dietitian summary/report, if available
- 3-day food chart
- current weight and length or height, with percentiles
- growth chart trends including at least two weight measurements, with percentiles
- blood pressure (trends)
- abdominal examination (findings)
- relevant diagnostic/imaging reports – including date and location of imaging

Clinical management advice and resources

Clinical management advice

Helicobacter pylori is rarely a cause for recurrent abdominal pain or pathogenic in children and should not be screened for on a routine basis. It should only be screened for if there is concern about peptic ulcer disease or there is a family history of gastric cancer in a first degree relative.
In the case of a peptic ulcer this should warrant referral to Gastroenterology.

Refer also to Paediatric Medicine Iron Deficiency – Paediatric CPC.

Clinical resources

- European Society for Paediatric Gastroenterology, Hepatology, and Nutrition and North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN/NASPGHAN) – Guidelines for management of Helicobacter pylori infection in children and adolescents (2023)
- Perth Children's Hospital - Iron Deficiency and Iron Deficiency Anaemia
- Royal Children's Hospital Melbourne – Iron Deficiency

Consumer resources

- Better Health Victoria – Iron and Iron Deficiency
- Gastroenterological Society of Australia (GESA) – Information about Iron Deficiency
- Nutrition Australia – Fact Sheets (Iron)
- Perth Children's Hospital – Keeping Our Mob Healthy: Iron deficiency anaemia or low iron

Key Words

iron, deficiency, infusion, anaemia, low, haemoglobin, gastroenterology

Liver Dysfunction

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- acute liver failure – e.g. INR > 1.5 and encephalopathy or INR > 2 – in the absence of pre-existing liver disease
- acute paracetamol toxicity – referral is indicated to paediatrician if no liver synthetic dysfunction
- chronic liver failure with fever or sepsis
- jaundice with confusion
- newborn with persistent (> 6 weeks), severe, recurrent unconjugated hyperbilirubinemia despite phototherapy – phone on-call gastroenterologist for advice
- post-transplant jaundice with fever or sepsis
- sudden onset, obstructive jaundice

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- Hepatitis A with no coagulopathy that is able to have follow up in the community.
- Sonographic fatty liver with normal liver function tests and normal liver and spleen size, in a child who has a weight and BMI > 85th percentile as per age and sex appropriate percentile chart.
  Note: Child would benefit from dietitian or weight management referral in the first instance.

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- newborn with persistent jaundice (> 2 weeks) with a conjugated fraction > 20% (with or without pale stools and/or dark urine)
  Note: presence of pale stools warrants an immediate contact to on-call gastroenterologist for advice
- acute hepatitis with worsening liver function tests – contact on-call gastroenterologist for clinical advice while awaiting triage
- chronic hepatitis – triage category may vary depending on presenting symptoms and investigations and will be determined by triaging clinician based on clinical information provided in referral
- unexplained cirrhosis

Category 2 (appointment clinically indicated within 90 days)

- liver lesion on ultrasound with normal liver function tests
- liver disease treatment required that is outside the referrer's scope of practice, for example,

viral hepatitis, autoimmune liver disease, primary sclerosing cholangitis, Wilson's disease, metabolic diseases
- suspected steatotic liver disease or metabolic associated fatty liver disease (MAFLD)

Category 3 (appointment clinically indicated within 365 days)
- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, immunisations and allergies
- use of nutritional supplementation and/or over the counter and herbal medicines
- risk factors for viral hepatitis
- investigations including:
  - liver function test results (current and previous)
  - full blood count (FBC)
  - coagulation profile
  - hepatitis A serology (HAV IgG)
  - hepatitis B serology (HBV sAg, sAb, cAb)
  - hepatitis C serology (HCV Ab)
  - iron studies
  - Epstein-Barr virus (EBV) and cytomegalovirus (CMV) serology
  - upper abdomen ultrasound

Additional information to assist triage categorisation

- alcohol intake, including duration and quantity, if relevant
- vaccination history
- any relevant family history, including family history of hepatitis B carriage/treatment/hepatoma
- haemoglobin A1C (HbA1c)
- creatine kinase (in presence of elevated transaminases)
- any previous ultrasound, computed tomography (CT) scan or magnetic resonance imaging (MRI) reports – including location and date of imaging
- additional pathology tests, e.g. autoimmune hepatitis, Wilson's disease, genetic disorders

Clinical management advice and resources

Clinical resources

- Royal Children's Hospital Melbourne – Clinical Practice Guideline: Jaundice in early infancy

Consumer resources

- Childrens' Liver Disease Foundation

Key Words

Liver disease, hepatitis, liver lesion, jaundice, hepatosplenomegaly, cirrhosis, gastroenterology

Nutritional and Weight Concerns

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- acute onset vomiting and/or diarrhoea in the context of dehydration unable to be managed at home
- and/or electrolyte disturbances is present or suspected

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- anaemia or iron deficiency secondary to haematological, renal, dietary, physiological or gynaecological cause – refer to Paediatric Medicine
- intentional weight loss or body dysmorphia – consider referral to Statewide Paediatric Eating Disorder Service
- isolated low serum ferritin without anaemia, nutritional or weight concerns
  - 3-month trial of adequate iron supplementation – consider coeliac screening and holotranscobalamin if unresolved
- normochromic, normocytic anaemia with normal iron studies
- weight loss in the neonatal period – refer to Paediatric Medicine
- failure to thrive in the absence of specific gastrointestinal symptoms and positive coeliac serology – refer to Paediatric Medicine

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months with any of the following:
  - features of inflammatory bowel disease – see also Inflammatory Bowel Disease CPC
  - features of coeliac disease – see also Coeliac Disease CPC
  - > 4 weeks of vomiting and/or diarrhoea
  - evidence of fat malabsorption
  - low serum albumin
  - severe malnutrition (body mass index Z-score of -3) with underlying cause or contributing factors warranting specialist review
- severe, unexplained iron deficiency anaemia (Hb < 90g/L)

Category 2 (appointment clinically indicated within 90 days)

- rate of weight gain significantly below that expected for age and sex, or weight decreased ≥ 2 major percentile lines despite paediatric dietetic intervention for nutrition support, (referral should be made from paediatrician)
- recurrent, unexplained iron deficiency with or without anaemia, despite appropriate trial of

oral iron therapy. See Royal Children's Hospital Melbourne - Iron Deficiency Clinical Practice Guideline guidelines on oral iron replacement.
- recurrent vitamin B12 deficiency

Category 3 (appointment clinically indicated within 365 days)
- nil

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations
- investigations including:
  - full blood count (FBC)
  - haematinics (iron studies, red blood cell count, folate, active vitamin B12 – holotranscobalamin), if suspicious of malabsorption, child has a restricted dietary intake, vegan or vegetarian diet
  - coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA), if infant is on solids or feeds contain gluten
  - faecal multiplex PCR
  - stool MCS, ova cysts parasites (OCP)

Additional information to assist triage categorisation

- paediatrician report
- urinalysis, microscopy and culture (especially infants < 12 months of age, as occult urinary tract infection can present with slow weight gain)
- electrolytes, urea and creatinine (EUC)
- thyroid stimulating hormone (TSH)
- liver function test (LFTs) results
- random glucose
- presence of fat globules and/or fatty acid crystals on stool microscopy
- faecal elastase
- C-reactive protein (CRP)
- erythrocyte sedimentation rate (ESR)
- faecal calprotectin result (in children aged ≥ 4 years)

Clinical management advice and resources

Clinical resources

- Royal Children's Hospital Melbourne – Iron Deficiency Clinical Practice Guidelines

Key Words

Nutritional concerns, faltering growth, failure to thrive, weight loss, malnutrition, malabsorption, iron deficiency, anaemia, B12 deficiency, gastroenterology

Upper Gastrointestinal Dysfunction

Referral to emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek urgent medical advice if in a remote region.

- caustic ingestion
- dysphagia with obstruction from food
- suspected or known oesophageal foreign body (especially button battery or > 1 magnet)
- intractable vomiting leading to dehydration in infants less than 6 months of age

Contacts for clinical advice

For clinical advice, please telephone the relevant specialty service.

Women's and Children's Hospital Network

- Women's and Children's Hospital (08) 8161 7000
  and request to speak with:
  - In hours: Gastroenterology registrar
  - After hours: Gastroenterologist on call

Exclusions and triage categories

Exclusions

- < 4 weeks of vomiting
- infantile reflux or colic – refer to Paediatric Medicine

Triage categories

Category 1 (appointment clinically indicated within 30 days)

- recurrent dysphagia with previous food bolus obstruction and/or decrease of **>** 2 weight percentiles
- persistent or recurrent vomiting with small volume haematemesis

Category 2 (appointment clinically indicated within 90 days)

- aged > 2 years with reflux and recurrent or persistent dyspepsia despite 2-month trial of proton pump inhibitors
- failure to progress to solid foods (after speech pathology and/or dietetics review)
- lack of progression to harder food textures due to swallowing difficulties (after speech pathology and/or dietetics review)
- dysphagia without faltering growth and/or weight loss
- persistent or recurrent vomiting (**≥** 4 weeks) without small volume haematemesis
- positive Helicobacter pylori (H. pylori) testing (stool antigen or urea breath test) in the presence of refractory upper gastrointestinal symptoms and associated with iron deficiency anaemia and/or family history of gastrointestinal cancer. Helicobacter pylori testing not indicated in the absence of above features.

Category 3 (appointment clinically indicated within 365 days)

- nausea with associated weight loss **≥** 2 weight percentiles with or without vomiting.
- aged > 2 years with painless, effortless regurgitation.

Referral information

For information on referral forms and how to import them, please view general referral information.

Essential referral information

Completion required before first appointment to ensure patients are ready for care. Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

- details of presenting condition including:
  - onset and duration of symptoms
  - frequency and severity of symptoms
- medical management to date / treatment trialled and response, e.g proton pump inhibitors, Helicobacter pylori treatment
- clinical history including:
  - current weight and length or height, with percentiles
  - growth chart trends including at least two weight measurements, with percentiles
  - any weight loss, including amount and timeframe
  - medical history, medications, allergies, immunisations

Additional information to assist triage categorisation

- previous endoscopy or histopathology results, if available
- recent pathology reports
- Helicobacter pylori results, including urea breath tests
- relevant imaging reports – including date and location of imaging

Clinical management advice and resources

Clinical management advice

- Proton pump inhibitors are safe to use in children; if responsive to a trial for 6-8 weeks and able to be weaned off without a recurrence of symptoms, review by Gastroenterology is not required.

Key Words

Upper gastrointestinal dysfunction, recurrent vomiting, recurrent dysphagia, gastroenterology

Version Control

Version	Date	Author	Nature of Amendment
1.0	January 2025	CPC team (Angela Mignone, Principal Project Officer)	Initial development