GO PUBLIC!

Valley Specialty Center
751 South Bascom Avenue
San Jose, CA 95128
Tel: 408-885-5000
scvmc.org

General Surgery Referral Guidelines

General Surgery Clinic Location:	Valley Specialty Center 4th floor 751 S. Bascom Ave.
General Surgery Clinic Phone:	(408) 793-2524
General Surgery Clinic Fax:	(408) 885-6577

This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.

E-CONSULT DISCLAIMER:

E-consults are based on the clinical data available to the reviewing provider, and are furnished without benefit of a comprehensive evaluation or physical examination. All advice and recommendations must be interpreted in light of any clinical issues, or changes in patient status, not available to the reviewing provider. The ongoing management of clinical problems addressed by the e-consult is the responsibility of the referring provider. If you have further questions or would like clarifications regarding e-consult advice, please contact the reviewing provider. If needed, the patient will be scheduled for an in-office consultation.

All URGENT consultations require provider-to-provider communication. If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.

***For approval of Urgent referrals please contact the triage General Surgery Attending listed on call for “Urgent Outpatient Consults” listed each day on AMION or reached through the VMC Operator.

Referrals that have not been discussed with the triage “Urgent Outpatient Consult” attending (ie Speaking with resident housestaff) may result in delayed appointment/treatment for your patient**

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****REFERRALS TO BE DIRECTED TO VMC DEPARTMENTS OTHER THAN GENERAL SURGERY****

ACHALASIA/GERD-HIATAL HERNIA/PARAESOPHAGEAL HERNIA/IBD – Refer to GI

1. Refer to GI for work up and trial of medical therapy.

AORTIC AND PERIPHERAL VASCULAR DISEASE/SYMPTOMATIC VARICOSE VEINS/VASCULAR ACCESS FOR DIALYSIS – Refer to Vascular Surgery

1. Vascular access for dialysis requires conjunction with Vascular Surgery.

BURNS/COMPLICATIONS OF BREAST IMPLANTS/HANDS/SUBCUTANEOUS MASSES ON THE FACE – Refer to Plastics

CHEST WALL MASSES/EMPYEMA/LUNG-MEDIASTINAL TUMORS – Refer to Thoracic/Cardiothoracic Surgery

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POST-DISCHARGE MANAGEMENT OF DRAINS – Refer to IR

SURGICAL DISEASES IN CHILDREN (<18 years of age) – Refer to Pediatric Surgery

****REFERRALS TO BE DIRECTED TO STANFORD OR ANOTHER OUTSIDE TERTIARY REFERRAL CENTER****

BARIATRIC SURGERY – Refer to Stanford Bariatric Surgery

1. **Background**
   a. Visit Stanford website for referral guidelines: https://**stanford**healthcare.org/medical-clinics/**bariatric-surgery**.html
   b. Useful link: National Coverage Determination (NCD) for Bariatric surgery for Treatment of Morbid Obesity https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=57&bc=AgAAgAAAAAAA&ncdver=3

2. **Pre-referral evaluation and treatment**
   a. Testing
      i. Required psychiatric tests
      ii. Required preoperative tests and procedures

3. **Indications for referral**
   a. Bariatric surgery can only be considered in morbidly obese patients with a BMI of greater than or equal to 35 with at least one co-morbid condition related to obesity and have been previously unsuccessful with medical treatment alone.
   b. For Medicare/Medi-Cal and the majority of third party payers this procedure is only covered in facilities certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence.
      i. These patients should not be referred to General Surgery at SCVMC but should be directly referred to Stanford (or other covered facility in their insurance plan).

4. **Please include the following with your referral**
   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
      i. Please follow all referral guidelines and provide the downloadable referral request directly to Stanford

            1. Referral request form – may require copy into browser: https://stanfordhealthcare.org/content/dam/SHC/referralcomponent/shc-referral-request-form.pdf
    ii. A referral to one of the Stanford providers should be entered into HL for patients who are members of one of our own health plans.
        1. Names of Bariatric Surgeons at Stanford as of May 2017 are:
            a. Dan Elison Azagury, MD
            b. Homero Rivas, MD
            c. John Magana Morton, MD
            d. James Lau, MD
    iii. Please include all the information requested by the Bariatric Surgery Program
        1. Co-morbid conditions
        2. Dietary programs
        3. BMI
        4. Required psychiatric tests
        5. Required preoperative tests and procedures
        6. For patients who are members of one of our own health plans (VHP or VHP MCMC) the preoperative evaluations by GI, Pulmonology, nuclear Med are usually performed here after they have been evaluated by the surgeon and you will be called on to assist in arranging these or other studies.

CONGENITAL CARDIAC ANOMALIES IDENTIFIED IN CHILDREN (<18 years of age) – Refer to Stanford Pediatric (Congenital) Cardiac Surgery

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HIGH RESOLUTION ANOSCOPY FOR ANAL DYSPLASIA/ANAL SPHINCTER RECONSTRUCTION – Refer to Stanford Advanced Colo-Rectal Surgery

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****APPROPRIATE GENERAL SURGERY REFERRALS****

BREAST/ENDOCRINE

ADRENAL TUMORS

1. **Background**
   a. Adrenal masses are sometimes diagnosed due to recognition of over-production of hormones (aldosteronomas, Pheochromocytomas, Cushing's syndrome) or more commonly they are found incidentally on CT scans of the abdomen that are done for unrelated reasons.

2. **Pre-referral evaluation and treatment**
   a. Most investigations to allow diagnosis can be carried out in the Primary Care setting.
   b. Testing
      i. The evaluation of Adrenal Incidentaloma Syndromes is seen in the table below
      ii. FNA with CT guidance for tissue confirmation as well as a work-up for primary tumor if they do not have a pre-existing diagnosis should be done.

Table 2. Evaluation of AI Syndromes

Diagnosis	Features	Biochemical Tests
Pheochromocytoma	High blood pressure, catechol symptoms	Urine-free and plasma-free metanephrines
Primary aldosteronism	High blood pressure, low K^+, low PRA*	Plasma aldosterone-to-renin ratio
Adrenocortical carcinoma	Virilization or feminization	Urine 17-ketosteroids
Cushing or "silent" Cushing syndrome	Cushing symptoms or normal examination results	Overnight 1-mg dexamethasone test
*Plasma renin activity		

   c. Management
      i. Metastases to the adrenal are the 4th most common site of tumor spread and the treatment depends on the site of the primary tumor.

3. **Indications for referral**
   a. Benign adrenal masses
      i. Functional
         1. The treatment for a hormonally active (functional) adrenal tumor is surgery.
   b. Malignant adrenal masses
      i. The treatment for a malignancy depends on the cell type, spread, and location of the primary tumor.
      ii. Primary
      iii. Metastatic

c. Do not refer
    i. Benign nonfunctional adrenal masses
        1. Nonfunctional adrenal cortical adenomas are not premalignant, and surgical excision is not indicated unless they show a concerning size or growth pattern over time.
    ii. Conditions that do not warrant surgery include bilateral adrenal diseases such as corticotropin-dependent Cushing disease or bilateral hyperaldosteronism.
        1. Hyper-aldosteronism without a predominant mass should be referred to endocrinology to optimize and reduce end organ damage (renal) as well as for coordination of venous sampling to determine if surgical treatment will help resolve the syndrome.

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL (to allow accurate, timely categorization)
    1. Medical history
        a. Changes in weight, cold/heat intolerances, tremor, palpitations
        b. Uncontrollable hypertension
        c. Renal stones, abdominal pains, bone pains
    2. Family History of endocrine disorders or cancers if relevant
    3. Management to date
    4. Medications (including blood thinning medications and indication)
    5. Other medical conditions (ie obesity, NIDDM etc)
    6. Examination findings
        a. Nature and size of any lumps
        b. Any grossly involved lymph nodes
    7. Investigations
        a. Adrenal imaging as appropriate
        b. Consider referral to Endocrinology to attain adequate control of the systemic effects alpha blockade for suspected pheochromocytomas or for full studies to determine the functional status of “adrenal incidentalomas”

b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
    1. Surgical or medical history that may affect the safety of an operation or general anesthetic

BENIGN AND MALIGNANT BREAST CONDITIONS

1. **Background**
   a. One in 8 women (12%) will develop breast cancer in her lifetime. The underlying fear for women with breast symptoms as well as those who are their primary care medical providers is that they will miss that one woman. Risk assessment tools may help in opening the discussion of factors that may contribute to their increased risk. Some tools on line include.
      i. *Breast Cancer Risk Assessment Tool.* This is an interactive tool designed by the National Cancer Institute and the National Surgical Adjuvant Breast and Bowel Project (NSABP) to estimate a woman's risk of developing invasive breast cancer. This is available on the National Cancer Institute's Web site (http://www.cancer.gov/bcrisktool/).
      ii. *Claus Model.* The Claus model (http://www4.utsouthwestern.edu/breasthealth/cagene/default.asp) estimates the probability that a woman will develop breast cancer based on her family history of cancer; it incorporates more extensive family history but excludes other risk factors. Risk tables have been published by Claus et al and the risks can be calculated as lifetime probabilities of developing cancer or an estimated risk that a woman will develop cancer over 10-year intervals. It should be emphasized that the Claus model may be used only for women with at least one female first- or second-degree relative with breast cancer; this model does not take into account other risk factors that have been associated with breast cancer, such as age of menarche, age at first live birth, or a family history of ovarian cancer

2. **Pre-referral evaluation and treatment**
   a. Evaluation of every breast lump is important in determining the urgency of treatment. Most investigations to allow diagnosis can be performed in the Primary Care setting
      i. Basic investigations include:
         1. Screening and Diagnostic Mammography
         2. Breast Ultrasound
         3. Stereotactic Core needle biopsy
         4. Ultrasound guided Core needle biopsy
      ii. Advanced investigations include
         1. Breast MRI-recommended in only limited patient populations.

a. Screening MRI is not recommended for women with a lifetime risk of breast cancer below 15%
b. Patients with dense breast tissue noted by the breast radiologist on the screening mammogram. (provide the radiology reading in the documentation to the insurance carrier to prove the medical need)
c. Some high risk patients with a diagnosed cancer. (the surgeon will decide if this is needed before surgery so no need to order before referral)

3. Indications for referral

a. Immediate referral to Emergency-RED FLAG
    i. Breast abscess with systemic symptoms (fevers, chills, etc) or severe pain.
        1. Counsel patient that if any of these symptoms appear she should go directly to the ER.
b. Call the “Urgent Outpatient Consults” phone (through VMC Operator or AMION)
    i. If breast cancer is diagnosed or seriously suspected make sure that this information is made clear in the referral. Call attending to alert them to the case and to discuss.
c. Routine referral
    i. All breast biopsies with atypia should be referred to a surgeon for excisional biopsy
    ii. All patients with growth or change in character or appearance of a known mass
d. Do not refer common benign breast conditions
    i. Breast pain in the absence of predominant breast mass
        1. Change style or fit of bra
        2. Limit sodium intake
        3. Encourage avoidance of caffeine containing foods and drink
        4. Use of Vitamin C, E, B6, B1
        5. OTC NSAIDS for symptomatic relief
        6. Evening primrose oil
        7. Severe cyclic pain may be treated with OCP, danazol, or bromocriptine
            a. Danazol or bromocriptine prescription may require Gyn
        8. Counseling and reassurance that the overwhelming majority of breast pain in the absence of a breast

mass is benign. This is often the patient's primary concern about breast pain.

ii. Simple cysts less than 2 cm
    1. Consider US guided cyst aspiration if symptomatic
iii. Fibroadenomas that are biopsy proven benign and asymptomatic
    1. Follow the recommendations of the radiologist for follow up examinations
    2. Stereotactic or US guided core biopsy without atypia can be followed clinically

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN REFERRAL
    i. Medical history
    ii. Family history of breast cancer if relevant
    iii. Management to date
    iv. Examination findings
        1. Nature of the lump (size, firm, soft, cysted, fixed/mobile etc)
        2. Any grossly involved lymph nodes
    v. Investigations
        1. Breast imaging with BIRADS score (mammogram/ultrasound)
        2. Pathology report (for patients with stereotactic breast biopsy)
b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
    i. Imaging
        1. Bone scan, CT scan of chest/abdomen, or recent CXR if breast mass is biopsy-proven to be malignant.

BREAST ABSCESSES WITH NO SYSTEMIC SYMPTOMS

1. Background

a. Most primary breast abscesses are caused by *Staph aureus*.

2. Pre-referral evaluation and treatment

a. Testing
    i. Breast ultrasound
b. Treatment
    i. Initial antibiotic treatment should target *S aureus*. Consider patients at risk for MRSA
    ii. Order ultrasound guided abscess aspiration through radiology with instructions to send the fluid for culture. Do

not start antibiotics until after a sample has been aspirated for microbiology.

    iii. Patients may need more than one aspiration to resolve the abscess
    iv. Tailor antibiotics as gram stain and culture results become available

3. **Indications for referral**
    a. Overlying skin is compromised
    b. Cases where abscess is not responsive to needle aspiration and antibiotics

NIPPLE DISCHARGE

1. **Background**
    a. Majority associated with benign condition/normal findings

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. Send prolactin to rule out pituitary/hormonal etiology
        ii. Mammogram if age >40 years
        iii. Retro-areolar ultrasound

3. **Indications for referral**
    a. Recognize the signs of Paget's disease (refer General Surgery)
        i. Persistent crustiness, scaliness or redness of the nipple
        ii. Itching or burning of the nipple
        iii. Bleeding or oozing from the skin of the nipple
    b. Worrisome findings in nipple discharge (refer General Surgery)
        i. Bloody discharge
        ii. Persistent unilateral discharge
        iii. Spontaneous discharge that presents with red or brown "spotting" of bra or nightgown

4. **Please include the following with your referral**
    a. Results of prolactin

THYROID AND PARATHYROID TUMORS

1. **Background**

a. Early diagnosis of any thyroid lump is important in determining the urgency of treatment. Most investigations to allow diagnosis can be performed in the Primary Care setting.
b. If there is a malignancy or high risk lesion please use AMION to page the triage "Urgent Outpatient Consult" attending to discuss care and allow for the accurate categorization and timely care of the patient.

2. Pre-referral evaluation and treatment

a. Testing for thyroid nodules
    i. Laboratory
        1. Measure TSH
        2. T3 and T4 if TSH is suppressed
    ii. Imaging
        1. Radioisotope scan if TSH is suppressed
        2. Ultrasound with or without FNA
b. Management, initial
    i. If thyrotoxic start treatment with carbimazole and consider beta blockade if tachycardia is present before urgently referring to endocrine for optimization

3. Indications for referral

a. Immediate referral to Emergency-RED FLAGS
    i. Suspected thyroid storm
    ii. Chest pain
    iii. Marked respiratory difficulties due to tracheal compression
    iv. Malignant hypertensive crisis
    v. Severe end organ damage in the setting of an uncontrolled hormonal state
b. Urgent referral
    i. If there is no respiratory compromise but the trachea is deviated they should be referred to General Surgery or ENT for urgent evaluation
c. Routine referral to General Surgery
    i. Refer thyrotoxic/hypothyroid patients to endocrinology to optimize thyroid treatment and determine whether they require surgical treatment
    ii. Benign thyroid tumors
        1. Thyroid Goiter
        2. Adenoma
    iii. Malignant thyroid tumors
        1. Papillary carcinoma
        2. Follicular carcinoma
        3. Anaplastic

        4. Medullary carcinoma
   - iv. Other thyroid conditions that may require surgery
        1. Thyroiditis
        2. Hyperthyroidism
        3. Thyroglossal cyst (typically caught in childhood so <18 refer to Peds Surgery)
   - v. Parathyroid
        1. Refer scan positive parathyroid lesions to ENT
        2. Adenoma
        3. Hyperplasia

4. **Please include the following with your referral**
   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
      1. Medical history
         a. Changes in weight, cold/heat intolerances, tremor, palpitations
         b. Uncontrollable hypertension
         c. Renal stones, abdominal pains, bone pains
      2. Family History of endocrine disorders or cancers if relevant
      3. Management to date
      4. Medications (including blood thinning medications and indication)
      5. Other medical conditions (ie obesity, NIDDM etc)
      6. Examination findings
         a. Nature and size of any lumps
         b. Any grossly involved lymph nodes
         c. Thyroid eye disease
         d. Tremor
         e. Tachycardia
      7. Investigations
         a. P-10 (including Ca++) LFT’s
         b. TSH, T3 and T4, anti-thyroid antibodies (if thyroid disorder is suspected
         c. Serum Ca++ Vitamin D and PTH (if parathyroid disorder is suspected)
         d. Thyroid, Parathyroid imaging as appropriate
         e. Consider referral to Endocrinology to attain adequate control of the systemic effects of altered hormone production, euthyroid state
   b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
      1. Surgical or medical history that may affect the safety of an operation or general anesthetic

COLO-RECTAL

ANAL CONDITIONS (Tumors, hemorrhoids, fistulae/abscess)

1. **Background**
    a. Includes these conditions:
        i. Chronic symptomatic hemorrhoids
        ii. Fissure-in-ano
        iii. Fistula
        iv. Anal squamous cell cancer
        v. Rectal prolapse

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. FIT or Hemoccult, LFT's
    b. Management
        i. Lifestyle Changes
            1. Ensure adequate fiber intake, avoid constipation and straining. Start pharmacologic regimen if dietary changes are not effective
            2. Use topical preparations and Sitz baths initially to ensure that the condition will not heal with conservative measures (consider surgical referral to conditions that do not heal after a 4-6 week trial of conservative treatment).
            3. Reduce alcohol intake
            4. Avoid local scratching
            5. Remove reading material from the bathroom as sitting on the toilet for prolonged periods can make the issues worse

3. **Indications for referrals**
    a. Immediate referral to Emergency-RED FLAGS considered
        i. Severe rectal bleeding
        ii. Abscess
        iii. Severe rectal prolapse
    b. Urgent referral
        i. Biopsy proven anal cancer/high clinical suspicion of anal cancer.
            1. Please call the "Urgent Outpatient Referral" listed on AMION to discuss.
    c. Routine referral

        i. Chronic symptomatic hemorrhoids
        ii. Fissure-in-ano
        iii. Fistula
        iv. Anal squamous cell cancer
        v. Rectal prolapse
    d. Do not refer
        i. Fecal incontinence associated with Obstetric trauma should be Referred to OB.
        ii. Fecal incontinence not associated with obstetric trauma, and dysplasia or anal squamous cell cancer associated with HIV infection should be referred to Stanford Colo-Rectal group as they represent specialized care that is not provided at SCVMC

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN REFERRAL
        i. Medical History
            1. History of recurrent peri-anal conditions and previous anal operations
            2. Colonoscopy report for all patients over 50 being referred for hemorrhoids
        ii. Management to date including timeline, medications and lifestyle
        iii. All other medications (if they are not on HL)
        iv. Other medical conditions (if they are not on HL)
        v. Examination findings
        vi. Investigations
            1. FIT or Hemoccult, LFT's
    b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
        i. Biopsy reports (if done)
        ii. Barium enema report (if done)

COLON/RECTAL CANCER

1. **Background**
    a. Colon/Rectal cancer is usually diagnosed on colonoscopy. Surgery is appropriate for patients in whom the cancer has not spread (metastasized) to other organs or for those with impending or present obstruction due to the mass.
2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, LFTs, CEA
        ii. Iron studies

iii. CT scan chest, abdomen and pelvis
iv. Colonoscopy report with pathology

b. Management
   i. Optimize diet and nutrition
   ii. Correct iron deficiency and anemia if possible
   iii. Encourage smoking cessation and reduce alcohol intake in preparation for major surgery
   iv. Advise the patient to go immediately to Emergency if any of the above red flag symptoms occur

3. Indications for referral

a. Immediate referral to Emergency-RED FLAGS
   i. Severe rectal bleeding
   ii. Large bowel complete or near complete obstruction

b. All confirmed cancers that are not metastatic are appropriate for urgent referral. Please call the “Urgent Outpatient Referral” Attending listed on AMION to discuss care and arrange urgent appointment.

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
   i. Medical history
      1. Weight loss, altered bowel habit, tenesmus, PR bleeding
   ii. Management to date, medications and lifestyle
   iii. Family history of colon cancer polyps or IBD
   iv. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
   v. Examination
      1. Comment if obese or cachectic
   vi. Investigations
      1. CBC, P7, LFTs, CEA
      2. Iron studies
      3. CT scan chest, abdomen and pelvis
      4. Colonoscopy report with pathology

INFLAMMATORY BOWEL DISEASE COMPLICATIONS: Strictures/enteric fistulas, after treatment by GI to optimize control of IBD

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1. Background

2. Pre-referral evaluation and treatment

3. **Indications for referral**
4. **Please include the following with your referral**

RECURRENT DIVERTICULITIS/COMPLEX DIVERTICULITIS

1. **Background**
    a. Management of diverticulitis is usually medical, with attention to diet, probiotics, adequate fiber and early treatment of infective exacerbations. Surgical referral is reserved.
    b. Surgery for acute diverticulitis may require a staged procedure with a temporary colostomy. We try to perform the operation electively at least 12 weeks from the most recent exacerbation to give the patient the best chance of a single staged procedure or if appropriate a minimally invasive procedure.

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, LFTs
        ii. Iron studies
        iii. CT scan chest, abdomen and pelvis
        iv. Colonoscopy report with pathology (if done)
    b. Management
        i. Lifestyle changes
            1. Consider dietary review
            2. Monitor iron studies and correct iron deficiency if necessary
            3. Reduce alcohol intake
            4. Educate patient to monitor symptoms suggesting acute attack and seek primary care or Urgent care evaluation early for treatment
        ii. Medical Management
            1. Mild attacks may be managed at home with oral antibiotics, analgesics and low residue diet
            2. More severe attacks may need to be referred urgently to ED bowel rest IV fluids and antibiotics

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Severe rectal bleeding
        ii. Palpable mass and fever suggesting diverticular abscess
        iii. Fever and abdominal pain not responding to antibiotics and analgesia
        iv. Large bowel obstruction with nausea/vomiting

b. Referral to General Surgery
    i. Acute severe bleeding in which a bleeding source had been identified
    ii. Diverticular abscess requiring IR drainage
    iii. Recurrent severe diverticulitis not responding to conservative measures
        1. Current recommendations from the Society of Colo-rectal surgeons are that surgery should be considered for patients with greater than 3 documented episodes of recurrent diverticulitis.
    iv. Fistula to skin or other organs

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
    i. Medical history
        1. If previously seen by a gastroenterologist please include the information. All patients over 50 should have colonoscopy to rule out malignancy masquerading as diverticulitis
        2. Number of exacerbations in the last 12 months and severity
        3. Alteration in bowel habit, tenesmus, incomplete rectal emptying, fecaluria (fecal or food matter in the urine), or pneumaturia (flatus in the urine stream)
        4. History of frequent UTI
    ii. Management to date, medications and lifestyle
    iii. Family history of colon cancer polyps or IBD
    iv. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
    v. Examination
        1. Comment if obese
    vi. Investigations
        1. CBC, P7, LFTs
        2. Iron studies
        3. CT scan chest, abdomen and pelvis
        4. Colonoscopy report with pathology (if done)

b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
    i. CT abdomen/pelvis
    ii. CEA

HEPATOBILIARY

GALLBLADDER DISEASE AND SYMPTOMATIC CHOLELITHIASIS

1. **Background**
   a. Over 50% of patients with gallstones will have no symptoms in their lifetime
   b. Includes these conditions:
      i. Symptomatic gallstones
      ii. Acute/chronic cholecystitis
      iii. Gallstone-related cholangitis
      iv. Gallstone pancreatitis

2. **Pre-referral evaluation and treatment**
   a. Testing
      i. LFT's
      ii. Serum lipase/amylase (especially relevant if performed at the time of an attack of pain)
      iii. Upper abdominal ultrasound/CT scan documenting the presence of stones
      iv. *H. pylori* investigation and treatment to rule out gastritis or PUD.
   b. Management
      i. Lifestyle Changes
      ii. Optimize diet and nutrition to prepare for possible surgery
      iii. Low fat diet
      iv. Encourage smoking cessation
      v. Reduce/stop alcohol intake if excessive
      vi. If obese encourage healthy weight loss with fat reduced diet. Consider dietary review
   c. Medical Management of asymptomatic gallstones
      i. Educate patient about the symptoms to look for such as RUQ pain 1-3 hours after a fatty meal, jaundice, as well as education on the RED FLAG symptoms
      ii. Encourage patient to seek early medical care if they develop symptoms
      iii. Encourage a healthy low fat content diet to avoid progression or symptoms
      iv. Reduce/stop alcohol intake if excessive
      v. Encourage Smoking cessation

3. **Indications for referral**
   a. Consider immediate referral to Emergency-RED FLAGS
      i. Painless progressive jaundice

ii. Significantly elevated serum lipase associated with upper abdominal pain
iii. Upper abdominal pain with obstructive jaundice +/- fever and rigors
iv. Acute RUQ pain that does not respond to analgesics and lasts for longer than 30 minutes.

b. Documented common bile duct stones should prompt an urgent referral to Gastroenterology and will be referred to General Surgery after the duct has been cleared with ERCP if possible.

c. Do not refer
   i. Asymptomatic or incidentally discovered gallstones should not be referred to General Surgery

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
   i. Medical history
      1. Timeline of current symptoms and previous symptoms
      2. Any information from gastroenterologist
   ii. Management to date, medications and lifestyle
   iii. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
   iv. Examination
      1. Jaundice, anemia
      2. Abdominal masses, palpable gallbladder
   v. Investigations
      1. LFT's
      2. Serum lipase/amylase (especially relevant if performed at the time of an attack of pain)
      3. Upper abdominal ultrasound/CT scan documenting the presence of stones
      4. *H. pylori* investigation and treatment to rule out gastritis or PUD.

HEPATIC TUMORS, after screened by Liver tumor board

1. Background

a. Hepatic cancers associated with chronic hepatitis or cirrhosis should be reviewed in the Liver Tumor Board to determine the best course of treatment. Many are now treated in interventional radiology and some are appropriate for referral to consider liver transplantation. To have a patient reviewed please call Gastroenterology to arrange.

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, LFTs, PT/INR
        ii. Hepatitis serologies
        iii. Serum Alpha fetoprotein
        iv. Upper abdominal ultrasound/Triphasic liver CT scan
    b. Management
        i. Lifestyle changes
            1. Optimize diet and nutrition to prepare for possible surgery
            2. Encourage smoking cessation
            3. Assist to cease alcohol if necessary
        ii. Medical Management
            1. Correct iron and vitamin deficiencies if needed
            2. Advise patient to go to ED if any RED FLAG SYMPTOMS OCCUR
            3. If cirrhosis is present or suspected investigate cause
            4. Patients with chronic cirrhosis are followed with periodic alpha fetoprotein and imaging to monitor for the development of liver masses/malignancies as they have a lifetime high risk

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Obstructive jaundice
        ii. Large abdominal mass
        iii. Recent onset of ascites
        iv. Hematemesis

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. Jaundice
            2. Coagulopathy
            3. History of esophageal varices
            4. History of TIPS
        ii. Predisposing conditions
            1. Chronic hepatitis B or C
            2. Alcohol intake (please include if the patient is still drinking)
            3. IV drug use
            4. Diagnosed Cirrhosis
        iii. Management to date, medications and lifestyle

    iv. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
    v. Examination
        1. Liver enlargement
        2. Presence of ascites
        3. Stigmata of chronic liver disease
    vi. Investigations
        1. CBC, P7, LFTs, PT/INR
        2. Hepatitis serologies
        3. Serum Alpha fetoprotein
        4. Upper abdominal ultrasound/Triphasic liver CT scan

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PANCREATIC TUMOR

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1. **Background**
    a. If pancreatic cancer is suspected diagnostic tests should be ordered in the primary care setting in order that the patient can be referred with the diagnosis

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, LFTs, CEA, Ca 19.9
        ii. Serum lipase or amylase
        iii. CT scan pancreatic protocol (for suspected Pancreatic cancer)
        iv. Investigate changing symptoms with US or CT with pancreas protocol if appropriate
    b. Management
        i. Optimize diet and nutrition to prepare for possible surgery
        ii. Correct iron deficiency and anemia if possible
        iii. Encourage smoking cessation and reduce alcohol intake if excessive
        iv. Advise the patient to go immediately to Emergency if any of the above red flag symptoms occur
        v. Control pain
        vi. For urgent advice you may call the “Urgent Outpatient Referral” Attending listed on AMION

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Obstructive jaundice if unwell/fever/pain
        ii. Chronic severe pain
        iii. Weight loss

   b. Please call the “Urgent Outpatient Referral” Attending listed on AMION to discuss care and arrange urgent appointment.
      i. Confirmed cancers that are not metastatic
      ii. Patients with gastric outlet obstruction.

4. **Please include the following with your referral**
   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
      i. Medical history
         1. Timeline of symptoms
         2. Previous GI work ups
         3. Alcohol intake
      ii. Management to date, medications and lifestyle
      iii. Family history of colon cancer polyps or IBD
      iv. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
      v. Examination
         1. Jaundice, anemia, stigmata of liver disease
         2. Abdominal masses, palpable gallbladder
      vi. Investigations
         1. CBC, P7, LFTs, CEA, Ca 19.9
         2. Serum lipase or amylase
         3. CT scan pancreatic protocol (for suspected Pancreatic cancer)

PANCREATITIS/PANCREATIC PSEUDOCYST

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1. **Background**
2. **Pre-referral evaluation and treatment**
   a. Testing
      i. CBC, P7, LFTs
      ii. Serum lipase
      iii. Upper abdominal US documenting stones/CT abdomen for pseudocyst
   b. Management
      i. Optimize diet and nutrition to prepare for possible surgery
      ii. Correct iron deficiency and anemia if present
      iii. Encourage smoking cessation and reduce alcohol intake in preparation for major surgery
      iv. Advise the patient to go immediately to Emergency if any of the RED FLAG symptoms occur

3. **Indications for referral**
   a. Consider immediate referral to Emergency-RED FLAGS

i. Acute pancreatitis is a medical emergency. All patients should be sent to Emergency for assessment and treatment.
ii. Obstructive jaundice if unwell/fever/pain
iii. Mass in the abdomen with fever, elevated WBC, or air (pancreatic abscess)

b. Routine referral
   i. Patients that present after the resolution of the attack may be referred by the normal referral process
   ii. Non-gallstone pancreatitis should only be referred if there is a persistent pseudocyst.

4. **Please include the following with your referral**
   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
      i. Medical history
         1. Timeline of symptoms
         2. State if gallstones are present
      ii. Management to date, medications and lifestyle
      iii. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
      iv. Examination
         1. Jaundice, anemia, stigmata of liver disease
         2. Abdominal masses, palpable gallbladder
      v. Investigations
         1. CBC, P7, LFTs
         2. Serum lipase
         3. Upper abdominal US documenting stones/CT abdomen for pseudocyst
   b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
      i. Ca19.9

HERNIAS

INGUINAL HERNIA

1. **Background**
   a. Hernias will either worsen over time or stay the same and all symptomatic hernias in surgical candidates should be referred for assessment particularly for inguinal and femoral hernias. Paraumbilical hernias with minor symptoms can be observed as the potential for morbidity is much less

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. Current EKG for all patients over the age of 50 for males and 55 for females
    b. Management
        i. Lifestyle Changes
            1. Advise and support weight loss if obese
            2. Encourage smoking cessation
            3. Assist to cease alcohol if necessary
            4. Encourage use of a support belt with activities that may worsen the hernia such as lifting and athletic activity
        ii. Medical Management
            1. Give the patient advice and information regarding hernias (available on HL in multiple languages) and advise them to go to the Emergency Department for evaluation if any RED FLAG symptoms develop
            2. Treat Urinary hesitancy and signs of BPH prior to referral
            3. Treat constipation prior to referral

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Severe pain at the hernia site
        ii. Inflammation at the hernia site associated with fever
        iii. Any evidence of acute incarceration or bowel obstruction
    b. Please call the attending listed on AMION for “Urgent Outpatient Referrals” to discuss care and decide on the timing of the appointment
        i. Hernias that have been associated with episodes of intestinal obstruction or strangulation or acute incarceration.

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. History of hernia-position, duration, size, symptoms
            2. Previous attempts at repair
            3. Previous surgery on the abdominal cavity
        ii. Comorbidities-CAD,diabetes, obesity (note that we may consider elective repair of inguinal hernias on patients that exceed BMI 35)
        iii. Investigations
            1. Current EKG for all patients over the age of 50 for males and 55 for females
    b. ADDITIONAL INFORMATION THAT MAY BE USEFUL

   i. Ultrasound of the area
   ii. History of constipation or urinary hesitancy, frequent nocturia (these conditions should be optimized prior to referral as they impact the recurrence rate after surgery)

VENTRAL/UMBILICAL/INCISIONAL HERNIAS (patients BMI <35)

1. **Background**
   a. Hernias will either worsen over time or stay the same and all symptomatic hernias in surgical candidates should be referred for assessment particularly for inguinal and femoral hernias. Paraumbilical hernias with minor symptoms can be observed as the potential for morbidity is much less.

2. **Pre-referral evaluation and treatment**
   a. Testing
      i. Current EKG for all patients over the age of 50 for males and 55 for females
      ii. CT scan for incisional or special abdominal hernias (parastomal)
   b. Management
      i. Lifestyle Changes
         1. Advise and support weight loss if obese
         2. Encourage smoking cessation
         3. Assist to cease alcohol if necessary
         4. Encourage use of a support belt with activities that may worsen the hernia such as lifting and athletic activity
      ii. Medical Management
         1. Give the patient advice and information regarding hernias (available on HL in multiple languages) and advise them to go to the Emergency Department for evaluation if any RED FLAG symptoms develop
         2. Treat Urinary hesitancy and signs of BPH prior to referral
         3. Treat constipation prior to referral

3. **Indications for referral**
   a. Consider immediate referral to Emergency-RED FLAGS
      i. Severe pain at the hernia site
      ii. Inflammation at the hernia site associated with fever
      iii. Any evidence of acute incarceration or bowel obstruction

b. Please call the attending listed on AMION for "Urgent Outpatient Referrals" to discuss care and decide on the timing of the appointment
    i. Hernias that have been associated with episodes of intestinal obstruction or strangulation or acute incarceration
c. Routine referral
    i. Refer abdominal hernias for elective repair only if the BMI is below 35 or they have symptoms concerning for episodic obstruction or threatened strangulation

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. History of hernia-position, duration, size, symptoms
            2. Previous attempts at repair
            3. Previous surgery on the abdominal cavity
        ii. Comorbidities-CAD,diabetes, obesity (note that we do not do elective abdominal hernia repair in general on patients that exceed BMI 35)
        iii. Investigations
            1. Current EKG for all patients over the age of 50 for males and 55 for females
            2. CT scan for incisional or special abdominal hernias (parastomal)
    b. ADDITIONAL INFORMATION THAT MAY BE USEFUL
        i. Ultrasound of the area
        ii. History of constipation or urinary hesitancy, frequent nocturia (these conditions should be optimized prior to referral as they impact the recurrence rate after surgery)

UPPER GASTROINTESTINAL

ACHALASIA, after GI

1. **Background**
    a. Achalasia is a rare primary motility disorder of the esophagus that affects one person in 100,000 per year. It is characterized by the absence of esophageal peristalsis and incomplete relaxation of the lower esophageal sphincter.
    b. Useful links: http://www.sages.org/publications/guidelines/guidelines-for-the-surgical-treatment-of-esophageal-achalasia/

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, Albumin and Prealbumin to determine nutritional status
        ii. Barium swallow with smooth tapering of the lower esophagus “birds beak”
        iii. GI consultation with Manometry and endoscopy to rule out malignancy.
    b. Management
        i. Optimize diet and nutrition
        ii. Encourage smoking cessation and reduce alcohol intake in preparation for major surgery
        iii. Advise the patient to go immediately to Emergency if any of the above red flag symptoms occur

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Suspected esophageal leak or obstructing esophageal cancer
        ii. Pneumonia due to aspiration with or without sepsis
    b. The majority of these referrals should come from GI rather than primary as the symptoms overlap with other motility disorders such as Diffuse esophageal Spasm, and Nutcracker esophagus. There are procedures that they must complete before being considered for surgery that take time to schedule. Please refer the patient to GI for the initial workup in cases where Achalasia (or any motility disorder) is suspected. GI will then refer to surgery when those procedures are complete.

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. Weight loss, dysphagia with solids or liquids or both.
            2. Regurgitation of undigested foods
        ii. Management to date, medications and lifestyle
        iii. Family history esophageal cancer or other motility disorders
        iv. Other medical conditions that may affect the perioperative management (ie obesity, CAD, DM etc)
        v. Examination
            1. Comment if cachectic
        vi. Investigations
            1. CBC, P7, Albumin and Prealbumin to determine nutritional status

2. Barium swallow with smooth tapering of the lower esophagus “birds beak”
3. GI consultation with Manometry and endoscopy to rule out malignancy

ESOPHAGEAL CANCER

1. **Background**
   a. Esophageal cancer will usually have been diagnoses through EGD and therefore pathology should be available before referral to surgery. The condition may be highly suspected on Barium studies.

2. **Pre-referral evaluation and treatment**
   a. Testing
      i. CBC, LFT’s
      ii. Iron studies
      iii. EGD findings or barium swallow results
      iv. CT scans of chest/abd/pelvis
   b. Management
      i. Lifestyle changes
         1. Optimize diet and nutrition to prepare for possible surgery with liquid diet supplementation such as Boost, Glucerna, or Ensure if appropriate
         2. Encourage smoking cessation
         3. Assist to cease alcohol if necessary
      ii. Medical Management
         1. Correct iron and vitamin deficiencies if needed
         2. Advise patient to go to ED if any RED FLAG symptoms occur
         3. Start PPI
         4. Control pain if present

3. **Indications for referral**
   a. Consider immediate referral to Emergency-RED FLAGS
      i. Severe dysphagia with inability to swallow liquids
      ii. Signs of dehydration
      iii. Hematemesis/Melena
   b. Please call the “Urgent Outpatient Referral” Attending listed on AMION to discuss care and make clinical decisions on the best referral.

        i. Confirmed cancers that are not metastatic are appropriate for urgent referral however esophageal tumors in some locations will be more appropriate for Thoracic surgery.

   c. Treatment for Esophageal Cancer is multi-modal and involves treatment pathways involving Radiation Oncology, Medicine Oncology. Presentation of the patient at the SCVMC Tumor board may allow more efficient care of your patient by helping them get to the right specialty first.

4. **Please include the following with your referral**
   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. Timeline of symptoms, weight loss, anorexia, pain dysphagia (solids, liquids or both) anemia or history of clinically significant upper GI bleed.
            2. If previously seen by an outside Gastroenterologist please include the clinic and procedure notes and any available pathology
        ii. Management to date, medications and lifestyle
        iii. Family history
        iv. Alcohol intake
        v. Investigations
            1. CBC, LFT's
            2. Iron studies
            3. EGD findings or barium swallow results
            4. CT scans of chest/abd/pelvis
   b. ADDITIONAL INFORMATION THAT MAY BE HELPFUL
        i. PET scan indicating resectable disease (if CT is negative)

ESOPHAGEAL STRICTURE

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1. **Background**
   a. Benign esophageal stricture should be referred to Gastroenterology for diagnostic work up and potential treatment with endoscopic dilation. Surgical treatment may be appropriate in cases where non-operative therapy has failed.

2. **Pre-referral evaluation and treatment**
   a. Management
        i. Lifestyle changes
            1. Optimize diet and nutrition to prepare for possible surgery with liquid diet supplementation such as Boost, Glucerna, or Ensure if appropriate

2. Consider dietician referral for advice regarding food consistency
3. Encourage smoking cessation
4. Assist to cease alcohol if necessary

3. Indications for referral

a. Consider immediate referral to Emergency-RED FLAGS
   i. Severe dysphagia with inability to swallow liquids
   ii. Signs of dehydration
   iii. Signs of aspiration pneumonia or sepsis

b. Please call the “Urgent Outpatient Referral” Attending listed on AMION to discuss care and make clinical decisions on timing of the appointment.
   i. Progressive dysphagia with near obstruction
   ii. Anemia
   iii. Severe weight loss

c. Routine referral
   i. Cases of esophageal stricture which have failed endoscopic dilation, nonoperative treatment.

GASTRIC CANCER

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1. Background

a. Esophageal cancer will usually have been diagnosed through EGD and therefore pathology should be available before referral to surgery. The condition may be highly suspected on CT scans but should be confirmed prior to surgical referral.

2. Pre-referral evaluation and treatment

a. Testing
   i. CBC, LFT’s
   ii. Iron studies
   iii. EGD findings or barium swallow results
   iv. CT scans of chest/abd/pelvis
   v. Pathology of tumor

b. Management
   i. Lifestyle Changes
      1. Optimize diet and nutrition to prepare for possible surgery
      2. Encourage smoking cessation
      3. Assist to cease alcohol if necessary
   ii. Medical Treatment
      1. Correct iron and vitamin deficiencies if needed

            2. Advise patient to go to ED if any RED FLAG symptoms occur
            3. Start PPI
            4. Control pain if present
            5. Investigate for metastatic spread with CT chest/abdomen

3. Indications for referral

   a. Consider immediate referral to Emergency-RED FLAGS
      i. Severe dysphagia with gastric outlet obstruction
      ii. Signs of dehydration
      iii. Hematemesis/Melena
   b. Please call the “Urgent Outpatient Referral” Attending listed on AMION to discuss care and make clinical decisions on timing of the appointment.
      i. Confirmed cancers that are not metastatic are appropriate urgent referrals.
   c. Treatment for Gastric Cancer is multi-modal and involves treatment pathways involving Radiation Oncology, Medicine Oncology. Presentation of the patient at the SCVMC Tumor board may allow more efficient care of your patient by helping them get to the right specialty first.

4. Please include the following with your referral

   a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
      i. Medical history
         1. Timeline of symptoms, weight loss, anorexia, pain, anemia or history of clinically significant upper GI bleed.
         2. If previously seen by an outside Gastroenterologist please include the clinic and procedure notes and any available pathology
      ii. Management to date, medications and lifestyle
      iii. Family history
      iv. Investigations
         1. CBC, LFT’s
         2. Iron studies
         3. EGD findings or barium swallow results
         4. CT scans of chest/abd/pelvis
         5. Pathology of tumor
   b. ADDITIONAL INFORMATION THAT MAY BE HELPFUL
      i. *H. pylori* serologies
      ii. B12 and folate

GASTRIC OUTLET SYNDROME

1. **Background**
2. **Pre-referral evaluation and treatment**
3. **Indications for referral**
4. **Please include the following with your referral**

GERD UNRESPONSIVE TO MEDICAL THERAPY, after GI

1. **Background**
    a. Common Triggers for Heartburn and GERD
        i. Sedatives for anxiety or sleeplessness
        ii. Bronchodilators
        iii. Tricyclic antidepressants
        iv. Beta blockers for heart disease or hypertension
        v. Anticholinergics
        vi. Dopamine-active drugs for parkinson's disease
        vii. Calcium channel blockers
    b. Useful Links
        i. American College of Gastroenterology Heartburn and GERD: http://patients.gi.org/topics/acid-reflux/
        ii. Society of American Gastrointestinal and Endoscopic Surgeons SAGES http://www.sages.org/publications/guidelines/guidelines-for-surgical-treatment-of-gastroesophageal-reflux-disease-gerd/

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, P7, iron studies, *H. pylori*
    b. Management
        i. Lifestyle Changes
            1. Elevation of head of bed at night
            2. Cease smoking
            3. Reduce obesity/diet
                a. Spicy foods/fried foods
                b. Tomato based foods
                c. Caffeine
                d. Mint flavoring
                e. Alcohol
                f. Garlic and onion
            4. Attention to meal timing and size of meals
        ii. Medical Treatment

1. Proton pump inhibitor
2. Add in H2 blocker if symptoms persist
3. Consider motility agent
4. Refer to GI for pH studies, EGD
    a. Most if not all patients need GI procedure(s) to evaluate and determine the proper surgical procedure so refer to GI if they have not had EGD and/or 24 hour pH monitoring along with esophageal Manometry

3. Indications for referral

a. Consider immediate referral to Emergency-RED FLAGS
    i. Severe dysphagia
    ii. Severe stricture leading to complete dysphagia
    iii. Symptomatic food lodged in esophagus
    iv. Hematemesis/melena
b. Call the “Urgent Outpatient Consult” Attending listed on AMION To discuss care
    i. Progressive dysphagia
    ii. Anemia
    iii. Weight loss
c. Routine referral
    i. Uncomplicated GERD and Hiatal Hernia if the condition is refractory to medical and lifestyle therapy and therefore the patient is being considered for gastric fundoplication.

4. Please include the following with your referral

a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
    i. Medical history
        1. Timeline and previous GERD, previous fundoplication, dysphagia, severity of symptoms
        2. Reports and pathology from any GI visits if not on HL
    ii. Management to date, medications and lifestyle
    iii. Medications that the patient has failed
    iv. Other medical conditions that may affect the perioperative management (ie COPD, aspiration pneumonia etc)
    v. Investigations
        1. CBC, P7, iron studies, *H. pylori* (along with previous treatment for *H. pylori*)
b. ADDITIONAL INFORMATION THAT MAY BE HELPFUL
    i. EGD findings
    ii. Histology particularly if EGD mentions Barrett’s
    iii. Barium swallow studies
    iv. CT thorax (for patients with paraesophageal hernia)

GI STROMAL TUMOR

1. **Background**
2. **Pre-referral evaluation and treatment**
3. **Indications for referral**
4. **Please include the following with your referral**

PARAESOPHAGEAL HERNIA, after GI

1. **Background**
2. **Pre-referral evaluation and treatment**
3. **Indications for referral**
4. **Please include the following with your referral**

PEPTIC ULCER DISEASE

1. **Background**
    a. Peptic Ulcer will usually have an EGD with biopsy to ensure that the ulcer is benign. Treatment for gastric ulcers is medical unless refractory to treatment.

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. EGD
        ii. Biopsy if indicated
    b. Management
        i. Lifestyle Changes
            1. Optimize diet and nutrition
            2. Encourage smoking cessation
            3. Assist to cease alcohol if necessary
        ii. Medical Treatment
            1. Correct iron and vitamin deficiencies if needed
            2. Advise patient to go to ED if any RED FLAG symptoms occur
            3. Start PPI
            4. Investigate and treat associated *H. pylori* infection
            5. Refer to Gastroenterology for EGD, biopsy if indicated

3. **Indications for referral**

a. Consider immediate referral to Emergency-RED FLAGS
    i. Severe dysphagia with inability to swallow liquids
    ii. Signs of dehydration
    iii. Hematemesis/Melena
b. Referral to General Surgery would be for consideration for distal gastrectomy and /or vagotomy and drainage and would come through GI rather than primary care in the outpatient setting.

4. **Please include the following with your referral**
    a. Results of EGD
    b. Results of biopsy, if indicated

MISCELLANEOUS GENERAL SURGICAL CONDITIONS

LYMPHADENOPATHY REQUIRING BIOPSY

1. **Background**
2. **Pre-referral evaluation and treatment**
3. **Indications for referral**
4. **Please include the following with your referral**

SKIN CANCERS AND SUSPICIOUS SUBCUTANEOUS TUMORS

1. **Background**
    a. Skin cancer initial management may be Dermatology.

2. **Pre-referral evaluation and treatment**
    a. Testing
        i. CBC, LFT's
        ii. Biopsy for pathology
    b. Management
        i. Lifestyle Changes
            1. Advise patient regarding sun avoidance and use of sunscreens
            2. Educate patient on skin cancer surveillance
            3. Advise patients with retroperitoneal masses or masses close to the axial spine with RED FLAG conditions to go to the Emergency Room for evaluation.
        ii. Medical Management

1. Some small lesions that are suspicious for skin cancer can be initially biopsied within primary care
2. Refer all sessions that are unable to be excised completely with confidence
3. Refer all pathologically proven skin cancers for re-excision promptly
4. Arrange annual skin checks with Dermatology.

3. Indications for referral

a. Consider immediate referral to Emergency-RED FLAGS
    i. Neurologic changes associated with any soft tissue mass of the retroperitoneum especially those close to the spinal column
b. Please call the "Urgent Outpatient Referral" Attending listed on AMION to discuss care and arrange approval/scheduling of the urgent referral.
    i. All confirmed malignant soft tissue tumors
    ii. Confirmed cancers that are not metastatic
    iii. Large fixed masses with rapid growth rate
c. Referral to General Surgery
    i. Large lesions or large retroperitoneal or subcutaneous masses that have worrisome characteristics for malignancy
        1. Retroperitoneal or truncal sarcomas
        2. Desmoid tumors
        3. Neurofibroma
        4. Angiolipoma
        5. Fibroma
        6. Hemangioma
        7. Survivors of childhood cancer who were treated with Radiation Therapy are at risk for soft tissue sarcomas in the radiation bed. Refer all patients with this history and any suspicious lesion for evaluation.
d. Do not refer
    i. Extremity sarcomas
        1. Refer to Orthopedic Oncology
    ii. Small skin lesions
        1. Refer to Dermatology
            a. Suspected melanoma/melanoma-in-situ
            b. Squamous cell carcinoma
            c. Basal cell carcinoma
            d. Merkel Cell Tumors
        2. Dermatology can refer to General Surgery if assistance is required.

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history of condition.
            1. Duration, speed of growth, ulceration, history of radiation exposure etc
        ii. Management to date
        iii. Medications particularly blood thinners
        iv. Other medical conditions
        v. Examination findings
            1. Evidence of spread if malignant
        vi. Investigations
            1. CBC, LFT's
            2. All available pathology reports

SUBCUTANEOUS MASSES THAT ARE NOT ON THE FACE

1. **Background**
    a. Conditions in this category include:
        i. Lipomas
        ii. Pilar cysts of the scalp
        iii. Sebaceous or epidermal cysts
        iv. Skin tags (note that many may not be covered by insurance)

2. **Pre-referral evaluation and treatment**
    a. Management
        i. Many small skin lesions can be excised within primary care. Please call and ask if there you are not sure if the lesion should be referred for excision.

3. **Indications for referral**
    a. Consider immediate referral to Emergency-RED FLAGS
        i. Ulceration or skin changes overlying the mass
        ii. Active infection
        iii. Extremely rapid growth
    b. Urgent referral
        i. Lesions with size greater than 20 cm
        ii. Rapid growth
        iii. See "Skin Cancer and Subcutaneous Tumors" section
    c. Routine referral
        i. Benign masses of the skin or subcutaneous tissues that are not listed on do not refer list will be accepted by General Surgery
    d. Do not refer

        i. Benign masses that occur on the face or other cosmetically sensitive areas
            1. Refer to Plastic Surgery
        ii. Benign masses that occur on the wrist or hand should
            1. Refer to Plastic Surgery/Hand
        iii. Benign masses that occur on the genitalia
            1. Refer to Urology (males) or Gynecology (females)
        iv. Benign masses associated with a joint
            1. Refer to Orthopedic Surgery

4. **Please include the following with your referral**
    a. ESSENTIAL INFORMATION REQUIRED IN THE REFERRAL
        i. Medical history
            1. History of duration and speed of growth etc.
            2. Symptoms associated with the mass such as pain
        ii. Management to date, medications and lifestyle
        iii. Associated predisposing conditions such as Neurofibromatosis
    b. ADDITIONAL INFORMATION THAT MAY BE HELPFUL
        i. Any available imaging
        ii. Pathology from any previous biopsy (FNA, Core)
        iii. Previous excision

VASCULAR ACCESS FOR DIALYSIS (in conjunction with Vascular Surgery)

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1. **Background**
2. **Pre-referral evaluation and treatment**
3. **Indications for referral**
4. **Please include the following with your referral**

Revisions:
- May 2017, formatting
- Oct 2017, formatting