TARANAKI ADULT SURGICAL PRIMARY CARE MANAGEMENT/REFERRAL GUIDELINES

NB: These are summary guidelines for **adults** only. Variation from these guidelines may be indicated for specific patients. The actual threshold for hospital first specialist appointment (FSA) may not always correspond with the general referral recommendations given. Private referral is an option for appropriate patients. JUNE 2008

CONDITION/ SYMPTOM	**PRIMARY MANAGEMENT**	**INDICATIONS TO CONSIDER SPECIALIST REFERRAL**	**PRIOR TO REFERRAL (Required / *Optional*)**
ANAL CONDITIONS	Increase fluid/fibre; avoid constipation Local hygiene measures CONSIDER MALIGNANCY	Failed conservative management Suspicion of malignancy	Examine; PR Full clinical details
Haemorrhoids/ tags	Local cream/suppository Manual reduction	Irreducible prolapse; Severe pain Regular bleeding/ anaemia Multiple large tags	Rule out Anal Fissure CBC/ *iron studies* *Proctoscopy/sigmoidoscopy*
Anal fissure	Glyceryl trinitrate 0.2% ointment (Rectogesic): tds for 4-6wks (NS)	Recurrent attacks	
Anal fistula		Persisting fistula discharge/infections	
Rectal prolapse	Reduction if possible	Persistent, irreducible or disabling	
PILONIDAL SINUS	Incision/drainage & antibiotics	Abscess, recurrent infections Chronic discharge	
CHOLELITHIASIS	Controlled weight reduction Avoid aggravating foods	Biliary colic (one or more attacks) Cholecystitis/pancreatitis Abnormal LFT/ jaundice	Positive ultrasound result Full history & clinical details (eg number of attacks, pain severity) LFT/amylase, CBC, *Hepatitis serology*
HERNIA	Education re obstruction/incarceration Consider trial of truss if surgery contra-indicated or declined ? injury related – refer ACC	Irreducible or history of temporary incarceration/obstruction Significant symptoms, interfering with work/daily living activities Femoral, large, or stomal hernia Incisional hernia	History of attacks of obstruction/ incarceration (if any). Details of work/life impairment

CONDITION/ SYMPTOM	PRIMARY MANAGEMENT	INDICATIONS FOR HOSPITAL REFERRAL	PRIOR TO REFERRAL (Required / *Optional*)
BREAST CONDTNS Benign	**Appropriate patient education**	***See also local Breast Imaging flowcharts and national guidelines***	
Solitary breast cyst	Regular surveillance. Consider mammogram (age >30) / ultrasound	Suspicious features or abnormal mammogram/US or FNA	Mammogram (>30) and/or ultrasound *(FNA best left to specialist)*
Multiple lumps/pain	Mammography /US if risk features (US if age <30) Consider FNA; s.prolactin	Suspicious features on exam, FNA, imaging. High risk features, concern.	Ultrasound (US) / mammogram & other relevant investigations
Suspicious			
eg. solid lump, nipple discharge, dimpling,	Consider referral surgeon Consider cytology. R/U Galactorrhea	Any suspicious features, eg. blood in discharge, single duct involvement,	Mammogram AND US
Asymptomatic			
Very high risk breast CA *(See GL for categories)*	Regular surveillance/recall. Refer breast specialist/ (?geneticist) *See full Guideline (GL)/ flowchart*	Strong FH breast/ovarian cancer, previous CA/ cancer-in-situ, etc *See full Guideline/ flowchart*	Detail of family/past history etc
High/ moderate risk CA *(see GL)*	Annual breast exam, refer public/private for mammogram	Moderate FH breast/ovarian cancer, etc *See Guideline/ flowchart*	Detail of family/past history
Lower risk CA *(see GL)*	Annual breast exam, routine mammography screening	Patient/doctor concern (not normally seen in public OPD)	Detail of family/past history
Abscess	I & D if appropriate for GP. A'biotics	Recurrent abscess	Details of history & lactation
Cosmetic	(Consider private/plastic referral)	Severe physical or psych impairment	Psychiatric report if relevant
VARICOSE VEINS	Compression stockings Sclerotherapy; treat thrombophlebitis Unilateral painful oedema ? Duplex US	Complications – ulcers, bleeding, severe recurrent thrombophlebitis, eczema or oedema, unable to work or function	Exclude arterial disease Previous and current management Presence of serious comorbidity
LOWER GI/ Bowel	Review risk factors FBC B12/folate, iron studies, CRP, FOB etc. DRE, ?proctoscopy; barium enema (*see full national/local Guidelines*)	High risk features: age, iron deficiency, GI bleeding, loose/change in bowels, etc Abnormal investigations (*see full Guidelines*)	Results of investigations *Barium enema (in most cases)*

ABDOMINAL PAIN	Review risk factors FBC, ESR FOB etc. Consider IBS. 'Watchful waiting'. Consider barium enema (*see full GL*) Consider coeliac screen	Risk factors, abnormal investigations. Persistent pain, abnormal physical findings/mass. Failed treatment.	Full history and investigation results
ABDOMINAL MASS	Pregnancy test; ?plain abdomen for faecal loading. FBC, CRP, LFT	Non-faecal sinister mass	History, mass location/size, etc. Bloods *(Surgeon will order CT if indicated)*
CONDITION/ SYMPTOM	**PRIMARY MANAGEMENT**	**INDICATIONS FOR HOSPITAL REFERRAL**	**PRIOR TO REFERRAL (Required / *Optional*)**
THYROID Goitre, nodule, mass	Asymptomatic mild diffuse static goitre – TFS, CBC, autoantibodies; review at intervals. USS. **Hyperthyroidism** or diffuse thyroid enlargement – refer endocrinology	Cancer: proven (FNA) or suspected; Solitary nodule; retrosternal goitre Goitre enlarging or with significant. obstructive symptoms, dysphagia, stridor	CBC, TFS, autoimmune studies Ultrasound (any suspicious focal palpable mass/nodule)
SKIN / LUMPS	***Consider ORL (ENT) referral if lesion/lump in relevant territory***		*Consider clinical photograph*
Suspected cancer	Consider punch biopsy if appropriate for GP procedure (Not if suspicion of melanoma).	Melanoma Enlarging non-lipomatous painless mass Size/situation contraindicate GP excision	*Biopsy result* (NB. Weigh the result against patient general co-morbidities)
Lumps /lipoma	GP excision, ?FNA	Suspicion of malignancy Disabling, severe pain, etc	*FNA/biopsy result*
Sebaceous cysts	Excision, ?FNA, I & D if infected		
Lymph nodes Neck lumps	Full exam espec. node drainage area. Regular surveillance. ?FNA if safe Relevant investing. eg chest Xray, FBC, ESR, toxo titre, EBvirus	Rapid growth, hard, craggy, tethered, abnormal FNA, systemic illness suspicion of ca/sarcoma/lymphoma Previous malignancy	Chest xray Results of investigations *FNA result*
UPPER GI OESOPHAGEAL	Medical management of reflux, dyspepsia, etc. FBC, B12, ?faecal helicobacter, ?autoantibodies. barium swallow (dysphagia). *See GL*	Failed medical management, recurrent/ persistent symptoms, Risk features – wt loss, anaemia, dysphagia *(see GL)*	Investigation results and treatment history

INGROWING TOENAIL	Wedge resection, nail avulsion or longtitudinal nail filing, ?podiatry	Severe disability or failed conservative measures. Diabetic. PVD.	Relevant history and previous management. Relevant medical history
TESTICULAR/ SCROTAL DISEASE	*NB: These conditions should usually be referred to the urological service*		
Scrotal lump/mass	Cystic -aspirate if large. Ultrasound	Solid testicular or scrotal mass Recurrent/disabling varicocele	Ultrasound result *Aspirate cytology*
Undescended testis	Ultrasound if non palpable	Refer at diagnosis	*Ultrasound result*
Phimosis/Balanitis	Conservative management Consider circumcision	Urinary obstruction; suspicion malignant Circumcision required	
Hydrocele (adult)		Large/disabling, or significant	
CONDITION/ SYMPTOM	**PRIMARY MANAGEMENT**	**INDICATIONS FOR HOSPITAL REFERRAL**	**PRIOR TO REFERRAL (Required / *Optional*)**
OBESITY SURGERY	Medical/diet management	Not currently available in public	

NB: When referring, in all cases include the following:

- details of current pathology and clinical status (eg stable, deteriorating)
- degree of pain (including analgesia needed)
- functional and social impairment
- other medical conditions/medication
- details of previous referrals & name of surgeon(s)
- current medications

These Guidelines have been prepared by the Taranaki DBH Guidelines Development Group (GDOG) in collaboration with the Department of Surgery. June 2008