Guidance to Pre-hospital Investigations and likely patient journey if referred to gastroenterology (Available via Anglia ICE)

Presenting Symptoms/ abnormal tests	**Key investigations to include in referral**	**Guide to Patient Journey** (straight to test or OPD)
Bloody diarrhoea	Stool M&C (needs to be fresh sample) (stool CDT if appropriate), FBC, U&E, LFT+ALB, CRP	**Flex. sigmoidoscopy/ colonoscopy**
Diarrhoea (>4weeks)	Stool M&C (stool CDT if appropriate), FBC, U&E, LFT+ALB, CRP, TFT, coeliac serology *(Note: if age>60y and symptoms for ≥ 6weeks, see 2WW colorectal cancer referral guidelines and follow if apply)*	**Flex. sigmoidoscopy/ colonoscopy** + biopsy *or* colon radiology (dependent on patient fitness and mobility) **OPD** if age<45y, normal bloods and mainly functional symptoms *(abnormal pathology unlikely)*
Rectal bleeding	*Follow rectal bleeding guidelines*	
Constipation	FBC, U&E, TFT, Bone profile	**OPD** *(ps. long standing symptoms + normal bloods,should normally be managed in1 ^{o} care*
Positive coeliac serolgy	FBC, LFT, Bone profile, B12, Folate, Ferritin	**OGD+ D2 Biopsy** → OPD/ Dietitian
Iron Deficiency Anaemia **(IDA)** *(Anaemia unresponsive to Fe. or Post-menopausal or men)*	FBC, U&E, Bone profile, B12, Folate, Ferritin, coeliac serology, urine dip. * see comment (1) and (2) *(Note:FOB and serum Iron are of no real benefit)* *PS: see 2WW colorectal cancer referral guidelines and follow if apply*	**OGD+/- D2 Biopsy** **Colonoscopy /** colon radiology (dependent on patient fitness and mobility) * see comment (2)
Asymptomatic Fe def. without anaemia	*As for IDA*	*As IDA* **if post-menopausal or Men>50y**
B12 Deficiency	FBC, B12, Folate, Ferritin, CRP,Parietal cell and Intrinsic factor antibody and coeliac serology. * see comment (1) and (3)	**OPD** *(may not need referral if adequate reticulocyte response in 1 week to B12 replacement)*
Malabsorption	FBC, U&E, LFT+ALB, Bone profile, B12, Folate, Ferritin, CRP and coeliac serology.	**OPD**
Weight Loss	FBC, U&E, LFT, CRP, PSA, Glucose, TFT, Bone ,B12, Folate, Ferritin, Coeliac serology (Consider CXR)	**OPD**
Persistent Abnormal LFTs * see reverse	FBC, INR, LFT, TFT, Glucose, Lipids,Ferritin, Caeruloplasmin (age<40y), Immunoglobulins, Autoantibodies, coeliac serology, Hep B&C *(PS: enclose drug hx. and request USS abdomen)*	**OPD**
Jaundice	FBC, INR, LFT *(PS: request USS abdomen)*	**USS** → OPD review whilst USS awaited (USS+/- liver screen → OPD)

See comments overleaf

Abnormal LFT's

Isolated rise in Bilirubin (unconjugated)

Likely Gilberts disease (perform split bilirubin, if mainly unconjugated should be re-assured and no further tests) but consider haemolysis determined by Hx, raised reticulocyte count, +ve coomb's test (refer to haematology)

Isolated rise in gamma GT

Consider Alcohol, Non-alcoholic fatty liver disease / NASH (non-alcoholic steatohepatitis) or enzyme inducing drugs (eg anticonvulsants and oral contraceptives)

Isolated rise in ALP

Check gamma GT. Also consider non-hepatic cuases ie bony. Check bone profile

Mild elevation in ALT (<x2 ULN)

NASH most likely if BMI> 25 or features of metabolic syndrome. Encourage weight loss and check for DM. If persitently Abnormal or have known risk factors or cutaneous stigmata of chronic liver disease follow guidance overleaf.

Comments

Please state: if patient unlikely / unable to tolerate oral bowel preparation and if weight >135kg
Mobility status: specify if patient fully mobile/ limited mobility but able to lie prone/ immobile
Medication: Please list including antiplatelet agents (*eg aspirin, clopidogrel*) or anticoagulants

Please provide adequate information including relevant past history and current drug therapy.
We will not be able to send patient straight to test unless above information provided and may need to contact you again before proceeding which will inevitably lead to delay.

* (1) Suggest check dietary history (Leicestershire nutrition and dietetic service "Eating for Health" resource. http://www.lnds.nhs.uk/)
* (2) Female patients- rule out menorrhagia. Pre-menopausal >50y consider referral
* (3) If consistent with pernicious anaemia replace B12. Consider referral to haematology if felt more appropriate

References

1. Guidelines for investigation of chronic diarrhoea. *Gut* 2003;**52** (suppl V): v1-v15
2. BSG guidelines for management of Iron deficiency anaemia. 2005