Creating a healthy future for Buckinghamshire NHS

Buckinghamshire NHS Primary Care Trust

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Referral Threshold for Gastroenterology

1) DYSPEPSIA IN YOUNG PEOPLE

Patients < 55 years old with simple dyspepsia (and without associated 'red flag' symptoms) can be managed in primary care using a test-and-treat strategy. This involves testing for helicobacter using urea breath testing and then eradicating helicobacter if test positive or treating symptoms if negative. The strategy was introduced locally some years ago, and has been subsequently endorsed by NICE.
NICE 2004: 'Managing dyspepsia in adults in primary care'

2) IRRITABLE BOWEL SYNDROME / BLOATING.

IBS accounts for many consultations in both primary and secondary care. GPs are very experienced in managing IBS yet still there are numerous referrals to GI clinics which simply confirm the diagnosis. While confirming the diagnosis can be reassuring to patients who are very anxious, most of this work should stay in primary care.
NICE 2008: 'Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care'

3) FAECAL OCCULT BLOOD TESTING.

GPs should never request FOB tests in patients with GI symptoms or with iron deficiency anaemia. The tests are too unreliable to help decide whether an individual patient should or should not undergo further investigation or hospital referral. There are too many false positives and false negatives. Furthermore patients are often tested without being advised about dietary restriction or stopping antiplatelet/ NSAID treatment - this leads to many false positive results with subsequent hospital referral for colonoscopy. FOB testing should only be done in the setting of screening asymptomatic populations for colon cancer.

4) REFERRAL OF PATIENTS WITH ANAEMIA.

Although patients with iron deficiency anaemia may warrant GI referral/ investigation, patients are often referred with anaemia which is not due to iron deficiency. Iron deficiency should be confirmed before considering GI referral. Anaemic patients without

iron deficiency should be investigated either in primary care or via the haematology clinic.

5) REFERRAL OF ASYMPTOMATIC PATIENTS WITH A FAMILY HISTORY OF COLON CANCER

Only those individuals with a strong family history of colon cancer should be referred. In general this means the individual either has two first degree relatives who have had colon cancer, or one first degree relative that developed colon cancer below 45 years old.
BSG 2002: Guidelines for colorectal cancer screening

6) LFT ABNORMALITIES – SOLITARY RAISED GAMMA GT.

A solitary raised GGT is rarely important and does not require hospital referral.

7) LFT ABNORMALITIES – SOLITARY RAISED BILIRUBIN.

A solitary raised bilirubin is due to Gilbert's or haemolysis, and does not require hospital referral.

8) CEA TESTING

CEA testing should not be done when investigating patients with abdominal symptoms. It is unhelpful in the diagnosis of colonic adenocarcinoma and associated with too many false positives and false negatives.

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