Confluence Health Gastroenterology and Hepatology Referral Guidelines

If patient has a GI provider, and you have a question or need to get them in, please contact them directly by phone or Epic or call the clinic and leave a message. There is no need to place a new consult if they have been seen in the last 3 years (even if just for a scope). For providers outside of CH, please send your clinic note and relevant labs/xrays with all new referrals.

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Anemia

- Check iron panel, ferritin, B12, folate, retic
- If anemia is microcytic and iron studies are low or if there is concern for GI blood loss, refer for EGD/colonoscopy
- If anemia is not obviously iron deficiency, refer for a clinic visit (heme/onc is currently very short staffed so we can see them first and refer to hematology when appropriate).
- For B12 deficiency – consider ordering methylmalonic acid (MMA), homocysteine, and autoantibodies to intrinsic factor (IF) and gastric parietal cell antigens. For patients with pernicious anemia, EGD is recommended to rule out gastric cancer and intestinal metaplasia.

Bloating, Abdominal Distention or Excessive Gas

- Trial of FODMAP diet. This can be done several ways: The patient can eliminate all FODMAP foods at once for at least 2 weeks, of they can pick a category and remove all foods within that category for 2 weeks. If they feel better, they can continue avoiding those foods. If they do not feel better, they can choose a different category to eliminate for 2 weeks. The latter approach takes longer but is easier to follow.
- Other things to try include: FD-Gard which is encapsulated peppermint and carraway seed oil that has been shown to decrease pain and bloating. Some patients also find Simethicone helpful.
- If the patient is also having diarrhea, consider testing for Celiac.
- If the above is not successful, consider empiric treatment for small intestinal bacterial overgrowth with Rifaxamin 550 mg tid x 10 days
- Referral to GI is rarely needed unless they have alarm symptoms (severe or nocturnal abdominal pain, weight loss, bleeding, anemia, fever, vomiting, new onset diarrhea or steatorrhea)

Chronic Diarrhea (> 3 week)

- Check stool for cdiff and giardia
- Consider hyperthyroidism if they have tremors, anxiety, weight loss and check TSH
- Review medications
- If the above is unrevealing, refer for colonoscopy to look for microscopic colitis or IBD
- While waiting, trial of soluble fiber (Metamucil) – start low dose: 1 teaspoon twice daily and increase weekly to 3 teaspoon (one tablespoon) twice daily to avoid bloating
- You can also try Imodium 2 tablets in the morning and one with each additional BM

Constipation

- Check calcium and TSH
- Review meds and diet
- Trial Miralax titrated up as needed (max 8 doses per day) to allow one BM daily
- Trial Senna up to 2 tabs bid
- If red flags (weight loss, bleeding anemia) refer for colonoscopy if not done in last 3 years
- If above does not solve the problem or if you have additional concerns that would warrant a colonoscopy, refer to GI

Dyspepsia

- If alarm symptoms (weight loss, dysphagia, odynophagia, anorexia, anemia, vomiting, GI bleeding, family history of upper GI cancer or patients high risk for gastric cancer) → refer for EGD
- If patient is > 60 years old with new onset symptoms → refer for EGD
- For patients < 60 and no alarm features – test and treat for Helicobacter pylori. We believe our resistance to Clarithrymycin exceeds 15% so the best regiment is Bismuth Quadruple therapy for 14 days
    - Bismuth 300 mg qid
    - Flagyl 250 mg qid
    - Tetracycline 500 mg qid or doxycycline 100 mg bid
    - Any standard dose PPI bid (omeprazole 20 mg bid)
- Confirm eradication of Hp with stool antigen or urea breath test at least 2 weeks after holding PPI
- If patient did not have Hp, trial of daily PPI for 4-8 weeks. If symptoms persist, stop PPI and try a low dose TCA such as nortriptyline 10-25 mg QHS for 8-12 weeks (advise patient to take it 3 hours prior to bedtime and ensure ECG does not have QTc prolongation)
- UpToDate has a nice flow sheet for dyspepsia
- If the above does not work, refer to GI

Dysphagia

- For recurrent/persistent dysphagia on previously established patients who have had an EGD or clinic visit within the last 3 years à ask GI provider if they prefer EGD or office visit
- For new dysphagia patients
    - refer directly to EGD if patient also has evidence of:
        - Iron deficiency anemia (add colon if appropriate and patient agreeable)
        - Weight loss
        - UGI symptoms and gastrointestinal cancer in a first-degree relative
    - Otherwise, arrange for clinic consult to discuss symptoms further and determine appropriate evaluation and management
- For urgent, direct referral for EGD, please contact GI on call.

Globus

- Usually a benign condition.
- Red flags include: pain, lateralization of symptoms, dysphagia, odynophagia, weight loss, a change in voice, presence of a neck or tonsillar mass, and unexplained cervical adenopathy – if any of these exist, patient should be seen by GI or ENT as appropriate.
- An EGD can be helpful to rule out an inlet patch (gastric mucosa in the proximal esophagus) and esophagitis. It is also okay to try a PPI and see if things improve.
- If symptoms persist, we also recommend an esophageal motility study – this requires a consult with GI.
- If the evaluation is normal, PPI's and TCAs are also sometimes helpful for this benign but irritating condition.

GERD and/or Heartburn

- If alarm symptoms (weight loss, dysphagia, odynophagia, anorexia, anemia, vomiting, GI bleeding, family history of upper GI cancer) → refer for EGD
- For patients with > 5 years of GERD/heartburn and any of the following -> EGD to screen for Barrett's
    - Age > 50
    - Male
    - White
    - Known hiatal hernia
    - Obesity
    - Nocturnal reflux
    - Prior or current tobacco use
    - FDR with Barrett's or esophageal cancer
- If no alarm features -> trial of daily PPI for 4-8 weeks plus life style measures
    - ensure they are taking their PPI appropriately – 30 minutes prior to their first meal on an empty stomach to ensure adequate absorption
    - avoidance of identified dietary triggers – common ones are alcohol, peppermint, caffeine, carbonated beverages
    - weight loss for patients who are overweight or have had recent weight gain – please discuss a plan for modest weight loss of about 5% of their body weight.
    - elevation of the head of the bed in individuals with nocturnal symptoms – this means raising the head of the bed at least 4 inches with blocks. Pillows do not work.
    - refraining from assuming a supine position after meals and avoidance of meals three hours before bedtime
- If symptoms do not improve or partially improve -> trial of twice daily PPI for 4-8 weeks. PPI should be taken 30 minutes prior to breakfast and dinner on an empty stomach.
- If symptoms do not improve with BID dosing can change to another brand of PPI
- If you are still having problems, please refer to GI.

Feeding Tube Issues

- If patient needs a PEG or is having PEG issues call GI on call.
- We will want to know reason PEG is needed, prior abdominal surgeries, any concern for active infection, blood thinners, presence of ascites. Esophageal and Laryngeal cancers may benefit from IR placement to avoid seeing of the track that can occur with our method of placement.

Hematochezia

- Check hemodynamic status and CBC, INR, comprehensive panel
- Low volume – referral to GI – we will get them in within a few weeks
- Large volume – consider ED evaluation
- GI on-call available for questions and concerns

Hemorrhoids

- In general, internal hemorrhoids bleed and external hemorrhoids are painful and/or pruritic
- If patient presents with bleeding regardless of age, rectal cancer and referral for colonoscopy should be considered
- 20-30 grams of insoluble fiber per day (psyllium or methylcellulose) + 2 liters of water per day has been shown to decrease bleeding and flares by 50%
- Do not linger on toilet and do not strain
- Regular exercise
- Avoid medications and food that cause constipation or diarrhea, both can worsen hemorrhoids
- Limit fatty food and alcohol
- OTC topicals may help temporarily reduce symptoms (witch hazel, tucks pads, prep H)
- Hydrocortisone cream or suppositories may be used for up to 7 days
- Sitz baths help reduce pruritis and inflammation associated with acute flare ups
- If the above do not help, internal bleeding hemorrhoids may be banded. Refer to GI for office-based banding.
- Acutely thrombosed (1-3 days) external hemorrhoids are very painful and can be treated with office-based excision

Melena

- Check hemodynamic status and CBC, INR, comprehensive panel
- If concern for UGIB consider referral to ED
- If low volume, chronic and patient is hemodynamically stable without significant anemia or known cirrhosis, can consider urgent outpatient EGD – call GI on call

Unintentional Weight loss

- For all patients – verify true weight loss is >5% over 12 months or less.
- There are many things that can cause weight loss, so a good history and physical exam will help direct your evaluation. UpToDate has a nice algorithm.
- Check routine labs to include CBC, comprehensive panel, ESR, CRP, TSH, HIV, HCV, hemoccult (to screen for upper and lower GI causes of weight loss to include PUD, IBD upper and lower GI cancers) and CXR
- If the patient has GI symptoms, such as nausea, anorexia, dysphagia, odynophagia, diarrhea, bleeding, constipation consider GI referral for upper or lower endoscopy as indicated.

There are essentially 3 things that cause weight loss.

- Inadequate caloric intake. Is the patient nauseous? Having abdominal pain? Depressed? Are any new medications contributing to this? Do they have end stage liver, lung or heart disease – all of these can cause anorexia.
- Malabsorption which is usually associated with diarrhea. If the patient is having diarrhea check:
    - Fecal fat – spot or 72 hour
    - Fecal elastase – to look for pancreatic insufficiency
    - Celiac panel
- Hypermetabolic state which makes us worry about cancer although hyperthyroidism can also cause this. Check
    - TSH

- Ensure patient is up to date on cancer screenings. Routine colonoscopy is low yield unless they are more than 5 years from last colonoscopy or have a positive hemoccult.
- Consider CT chest, abdomen and pelvis if nothing found on the above

COLON CANCER SCREENING AND POLYPS

Screening for Average Risk Patients

- We begin screening all average risk patients at 45 years old. Average risk means no
  - personal history of polyps or colon cancer
  - inflammatory bowel disease
  - history of pelvic radiation
  - family history of colon cancer, high risk polyps or a genetic syndrome
- Screening for average risk patients can be done via
  - Colonoscopy every 10 years
  - FIT (Fecal immunochemical testing) annually
  - Stool DNA testing (Cologuard) every 3 years
- We stop screening as follows
  - When a patient's life expectancy is < 10 years
  - 75 years old if they have had at least one normal colonoscopy and no history of polyps.
  - For patients who have never had a colonoscopy offering one up to the age of 80 if otherwise healthy is beneficial.

Surveillance Colonoscopy for patients with a history of colon polyps or cancer

- Patients with prior pre-cancerous polyps (adenomas or sessile serrated lesions/polyps) enter a surveillance program.
- Only colonoscopy is recommended and the interval is dictated by the number, size and type of polyp.
- For patients scoped at CH, GI keeps track of when patients are due and sends patients reminders to schedule follow up colonoscopies. If you are unsure, or believe your patient is past due, send a staff note to the endoscopist who did their last scope or the GI doc on call if the provider is no longer working at CH
- We stop surveillance colonoscopies
  - When a patient's life expectancy is < 10 years
  - Otherwise it is individualized based on how many and the size of their polyps in the past. The GI department takes care of these recommendations and will discuss with the patient's primary care provider when it isn't clear. If you have questions, send the GI doc who last scoped them a MyChart message.

Interval Positive FIT

- Patients who are UTD on colonoscopy should not have a FIT. That being said, if they get a positive FIT we recommend the following:
  - For patients with positive FIT and colonoscopy > 2 years ago → directly to colonoscopy
  - For patients with positive FIT and colonoscopy < 2 years ago → review colonoscopy to determine prep quality, which endoscopist did it, other s/sxs that may be concerning

and determine on a case by case basis if they need repeat colonoscopy. Please send a referral for a clinic visit.

Family history of colon polyps or colon cancer

- Request family member's colonoscopy and path report if possible
- If first degree relative (FDR) or multiple second degree relatives have a history of colon cancer, large polyp (> one centimeter) or aggressive histology (villous, tubulovillous or high grade dysplasia), refer patient for screening colonoscopy 10 years younger than onset of cancer or polyps or 45 years (whichever is earlier).

Family history of FAP (familial adenoma polyposis) Syndrome (AKA Gardner's Syndrome)

- FDR with classic FAP: Screening flex sig or colonoscopy every 1-2 years beginning at age 10-12
- FDR with attenuated FAP: Screening flex sig or colonoscopy every 1-2 years beginning at age 25

Patients with known FAP (familial adenoma polyposis) Syndrome (AKA Gardner's Syndrome)

- Colonoscopy yearly
- EGD with forward and side viewing scope at time of onset of colonic adenomas or 25 years (whichever is first), interval determined by presence and number of adenomas
- Annual thyroid US
- CT to look for desmoid tumors if they have abdominal pain, weight loss, or family history of desmoid tumors

Patients with Hereditary Non-Polyposis Colon Cancer (HNPCC) syndrome (AKA Lynch Syndrome)

- colon cancer: colonoscopy every year with TI intubation to look for small bowel cancer
- gastric cancer: EGD every 3 years with stomach biopsies to r/o H.p and careful evaluation of duodenum
- ovarian: consider annual transvaginal ultrasound + Ca-125
- endometrial: consider annual endometrial sampling
- GU: annual UA
- Kidney: annual renal US if MSH2 pos
- skin: annual skin exam

LIVER

High Risk MASLD Screening:

1. See PDF flowchart at the bottom of this document for full screening protocol.
2. Refer to GI if:
    --Fib-4 score is >2.67
    --Fibroscan kPa score is >8

Abnormal AST/ALT:

- Prior to referral:
    - Review medications to include herbals and OTCs. Consider a trial of holding possible offending agents (especially nonessential herbal supplements) x 1 month and rechecking labs.
    - Quantify alcohol intake. If concerning, and patient is willing/able, repeat LFTs after 4-6 weeks of abstinence.
    - US Liver, spleen and 4 quadrants (IMG1077A)
    - viral hepatitis panel (hep C Ab, Hep B SAg, SAb)
    - ANA, Anti-smooth muscle Ab, IgG
    - Ferritin and iron panel
    - recent CBC, INR, hepatic panel (last 6 months)

Abnormal Alk Phos:

- Prior to referral obtain:
    - US Liver, spleen and 4 quadrants (IMG1077A)
    - AMA (anti-mitochondrial antibody)
    - GGT or ALP isoenzymes (if AST/ALT normal)

Positive HCV Antibody:

- Check HCV PCR/RNA
    - If negative, then the Ab was a false negative OR patient has cleared a prior infection. The patient should be counseled that this does NOT mean they are immune to HCV
    - If positive, the check the following:
        - HCV genotype, HIV, hepatitis B surface antigen, hepatitis B core antibody (total), CBC, CMP, INR
        - Order a Fibroscan for HCV (FIB33). If unable to get a fibroscan, order a fibrotest (LABR933)
        - Referral to gastroenterology if patient has fibrosis or cirrhosis
        - Referral to infectious diseases if co-existing HIV
        - Referral to GI or ID if no HIV and no fibrosis/cirrhosis

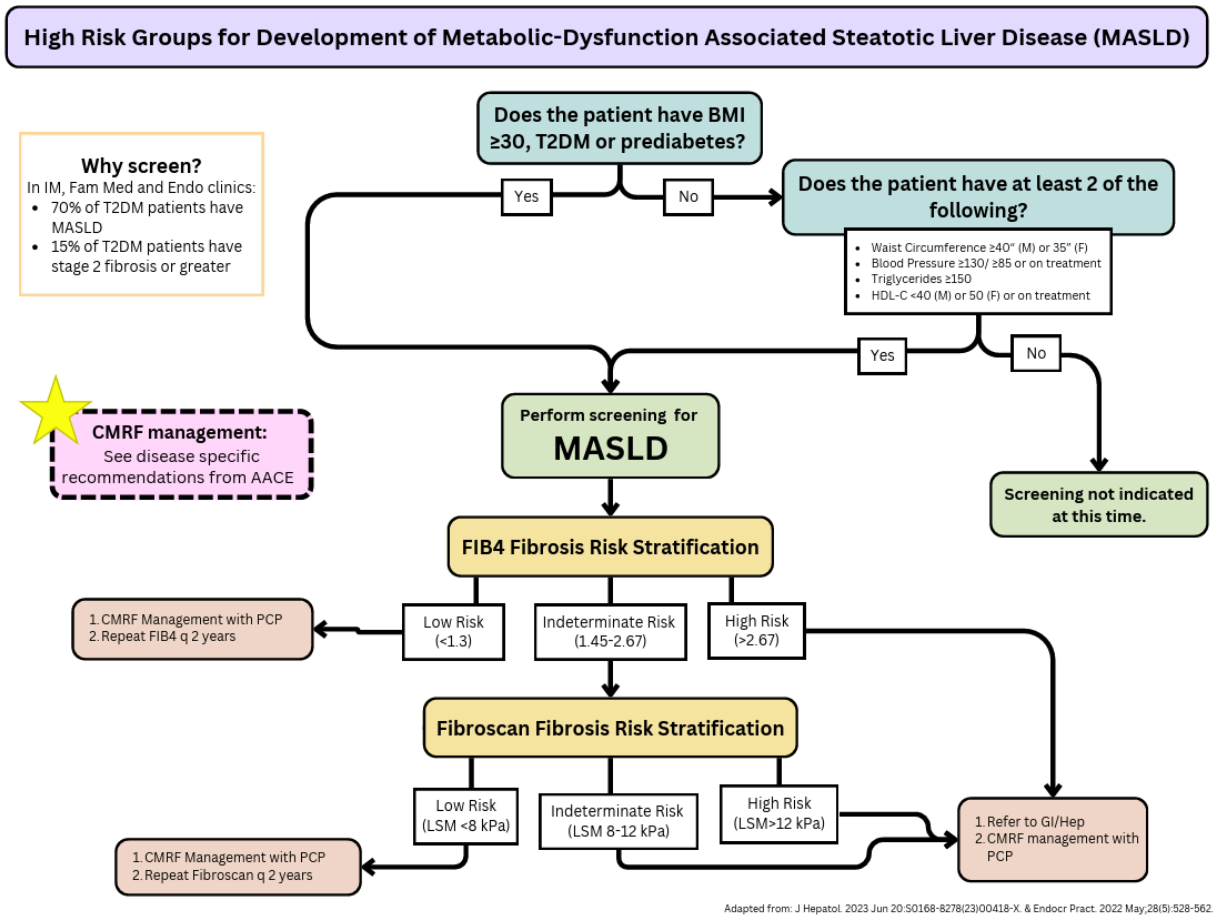
Liver mass:

- If known cirrhosis → AFP and Liver MRI IMG4051 (if unable to get MRI, then CT Liver IMG1429). Single phase CT scan (standard CT A/P is **not** adequate)
- If NO known cirrhosis → hepatitis B surface Ag, AFP, and multiphasic imaging IMG4051 (in women <50 – FNH protocol IMG4059 instead)
- Referral to gastroenterology (Newton)

Steatoic Liver Disease (formerly known as Fatty Liver)

- Please obtain
    - Recent LFTs - if elevated please see the above recommendations to ensure no co-existing liver disease present
    - US Liver, spleen and 4 quadrants (IMG1077A)

- Mainstay of treatment is weight loss, diet and exercise with a goal of losing 5-7 % of their body weight
- Optimize glucose control – start with metformin, but consider Pioglitizone as second line agent if appropriate
- Avoid all alcohol
- Optimize lipid control
- Ensure routine vaccines are up to date
- Vaccinate for Hepatitis A and B if not immune (neg HAV IgG or neg HBV SAb)
- Okay to refer to GI if further assistance is needed or Risk Stratification shows the patient is indeterminate or high risk (see below)



Provider Decision Support
Updated 10/2023 by Cassandra Slemmer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