ED to Subspecialty Referrals (RSCH & PRH)

This is a brief guide for UHSussex RSCH and PRH sites only; it is not exhaustive.

Different hospitals have different ways of managing some conditions. We may do things differently here, please understand that there is reasoning behind this and we do expect the local agreements to be followed.

This guide also assumes that the patient's condition has reached physiological and social criteria for referral, it does not imply that all patients with these conditions need referral.

This guidance is designed to make sure that the patient receives the care that they need on the best ward under the right team.

The Referral Process

Patients are referred to specialties by ED, based on the clinical assessment of the patient's differential diagnoses and physiological parameters.

When a patient has reached the threshold for ongoing care (>4hrs) or admission they will be referred to the specialty holding the most likely differential, or the most serious condition requiring exclusion. Please be aware that referrals are not dependent CT/US imaging as neither can be expected to be performed with 4 hrs of patient arrival.

1) ED will refer to a specialty. The specialty will accept the referral based on the defined criteria for that specialty (including guidance in this document). If the specialty declines referral ED will escalate to their senior for review of the patient and resolution. **Referrals cannot be declined on the basis of outstanding CT/US imaging.**

2) A formal assessment of this patient is made by the accepting specialty team at ST3 level or above.

3) The patient is managed until discharge by the specialty team.

4) Should the initial specialty believe, after ST3+ assessment or above, that the patient requires another specialty input/admission then:

    a. They must actively contact the new team by requesting an opinion. This should be an ST3 or above discussing directly with the most senior duty doctor for the new specialty.
    b. The initial team remains responsible for all care until the new specialty has formally accepted the referral by documenting in the clinical record that they will take over care.
    c. If the new specialty does not take over care, then the patient remains under the first team until appropriate escalation and outcomes have been resolved after discussion with the initial specialty consultant.

5) Until it is clear which team the patient would be best managed by the patient MUST remain on Level 5.

Guidance related to specific conditions

Cellulitis-

Lower limb- medical (unless recent prosthesis/ortho operation/abscess)

Upper limb- orthopaedics

Trunk- general surgery

Perineum/Genitalia- seek senior ED Guidance- if significant genital involvement urology/gynaecology.

Head and neck- maxfax/ophthalmology

Breast-

1. all local infections and small abscesses are referred via The Breast Service. If the presentation occurs OOH aim to send patient home with appropriate antibiotics and contact the breast service the next day.

2. If the patient is systemically unwell, or has an abscess that will clearly require surgery, they may require admission. In hours contact the breast team urgently. OOH refer to the general surgery team.

Jaundice

All significant jaundice is medical- including cholangitis.
Obstructive jaundice should be referred to gastroenterology as soon as possible, usually via the admitting medical team.

Gilberts Syndrome is relatively common. Consider this diagnosis in mild bilirubin rises in starved or generally unwell patients. Look for the primary pathology and refer appropriately.

Acute cholecystitis is a surgical diagnosis- mild bilirubin rises are possible, but overt clinical jaundice is not and would favour a diagnosis of cholangitis. An ultrasound can rule out cholecystitis. Such patients should remain under the care of the surgical team until imaging has excluded cholecystitis. An onward referral should then be made as described above.

GI Bleeding

Upper GI bleeding- Coffee ground vomiting is non-diagnostic, consider MI/sepsis and rule out GI obstruction prior to medical referral

Fresh blood vomit- Medical referral

Melaena- this is only confirmed on direct visulaisation, a patient account of melaena is not sufficient evidence and ongoing melaena must be confirmed- Medical referral

PR Bleeding- Surgical referral

Bloody diarrhoea- Medical referral

Undiagnosed Pain as the major presenting complaint.

(Many patients have minor degrees of pain at presentation but unless this is their major complaint do not follow this guideline)

Above the diaphragm- Medical referral

Below the diaphragm- See text.

All abdominal pain requires surgical/gynae causes to be excluded.

Epigastric pain requires amylase prior to consideration of medical causes.
Lower abdominal pain in females requires a B-HCG prior to considering a general surgical or medical cause.
Referral to another specialty requires convincing evidence of an alternative diagnosis.
Examples would include flank pain & leucocyte on urine dip or a positive pregnancy test.

Surgical causes of abdominal pain are not ruled out by the absence of peritonism. These patients can be diagnostically difficult and should all be reviewed in person by ST3 in surgery or above and should not be discharged or referred to other specialties before this review.
These patients often require specialist imaging which should be arranged, after review, by the surgical team.

If imaging confirms a medical cause an onward referral should be made as described above.
If imaging fails to identify a cause for the patient's symptoms the patient should remain under the care of the surgical team at least until the first surgical consultant review.

Chronic pancreatitis

These patients present with recurrent upper GI pain, often with a normal amylase. They are best managed by the team who has seen them before so check Panda for previous admissions.
If usually admitted under the gastroenterology team- refer to the medics, otherwise refer to surgery as above for 'undiagnosed pain'.

Genito-Urinary Tract.

UTI or sepsis with recent urological instrumentation or procedure, frank haematuria - Urology

All else- medical

Intracranial bleeds

Traumatic-discuss with neurosurgery if no surgery required admit general surgery

Non-traumatic- discuss with neurosurgery if no surgery required admit medical.

Back pain (updated 2023)

Fragility fractures – frailty

Spinal fractures – discuss with neurosurgery if no surgery required admit medicine/frailty.

C-spine fractures – if Rockwood >5 and not for surgery admit frailty. If Rockwood <5 admit spinal team.

MSK back pain – See cauda equina pathway. If requires admission for discussion at senior level.

Should disagreement occur then please escalate via your team.