Referral of Patients Presenting with Abdominal Pain

Patient's should be referred to the most appropriate specialty given the presumed diagnosis.

Referral should not be refused by a specialty without being reviewed.
(Unless they are the incorrect specialty for the working diagnosis.)

RIE - General Surgery ET	RIE - Gynaecology	WGH - Colorectal
Bleep 2254	Bleep 1625	Bleep 8272

Triage in ED

If Patient has a GP Letter with a Surgical or Gynaecological diagnosis or a post-operative complication the patient should be referred directly to the appropriate specialty for assessment.

All Patient must have a NEWS Score & should be offered analgesia if in pain.

Patients should be accepted by specialty without further investigation in ED unless unwell or NEWS > 5.

Surgical Patients should be seen in SOU
Gynaecology Patients should be seen in Gynae Triage

If the patient appears unwell or NEWS > 5, ED team will escalate to General Surgery Team and should start initial assessment & management of patient while awaiting Specialty review. (IV Access, Bloods, Fluids)

RIE General Surgery ET - Referral pathway

1) Patients who have been assessed and investigated in ED and have a provisional diagnosis of a General Surgery condition.
2) Patients who have an unclear diagnosis & require admission for investigation & analgesia.

Well Enough for Discharge	Requires Admission (Documented Review by ED ST4+)	Requires Emergency Surgery or NEWS2 Score > 5 / Clinical Concern
No evidence of Fever, Tachycardia, Localised Tenderness or Raised WCC / CRP / Lactate.	Refer to Surgery - Bleep 2254	Initial Assessment, Resuscitation, Investigation & Treatment in Resus. Involvement of ED ST4+
Do NOT refer to Surgery without clinical need.	Admit to SOU or Ward 106	Refer to Surgery - Bleep 2254
Advise patient to contact GP if they would benefit from non-emergency outpatient follow-up or investigation. (Abdominal USS, Outpatient Specialty Referral etc.)	**Surgical Review in ED should not routinely occur.** If review in ED is requested, it must occur within 60 minutes & a plan communicated within 90 minutes or patient will be admitted to SOU. If not felt to be surgical this should be directly communicated to ED team & documented on TRAK.	Surgical Review in ED
Discharge Home with Worsening Statement.		Transfer to Theatre Admit to Surgery / Critical Care
For Colorectal patients, discuss with on-call Colorectal Team if required and discharge.	For Colorectal patients, discussion between on-call Colorectal Team & ED to transfer to WGH. Should not be admitted under General Surgery at RIE or transferred to SOU. Responsibility for patient care lies with the ED team until patient transferred out of ED. Patient should undergo re-review by ED prior to transfer if delay >3hrs (from decision to transfer) or change to clinical change is noted If NEWS>5 then they should convert to right-hand pathway Provision for transfer to SAU at WGH should be made in the event of a bed being unavailable for colorectal accepted patients.	For Colorectal patients, patient should be reviewed by ED ST4+ Refer to Surgery Bleep 2254 RIE based General Surgery team to review in ED & discuss as required with Colorectal Team (ST3+/ Consultant Colorectal Surgeon) & Critical care

Abdominal Pain Pathway Notes:

1. Surgical review should occur within 1 hour, unless there is clinical exception, as per Internal Professional Standards. There should be early senior involvement to reduce crowding in the emergency department.

2. Patients who do NOT require admission and have no clear surgical problem should NOT be referred to General Surgery. If patients require non-emergency outpatient investigation, they should be advised to attend their GP for onward referral.

3. Patients thought to have a Gynaecology problem should be referred to Gynaecology. They should NOT refuse to see a patient prior to a surgical review if ED do not feel there is a General Surgery issue.

4. The ongoing care for analgesia, antibiotics, fluids and care remain the responsibility of the Emergency Department Team whilst the patient is within the Emergency Department

5. Guidelines for the assessment of surgical patients' suitability for transfer between RIE and WGH
    - Assessment of suitability for transfer between sites should be made by an ST3+/Consultant
    - The criteria below are a guideline and suitability should be determined on a case-by-case basis
    - The Critical Care team will also frequently contribute to decision making for unwell patients.
    - The receiving team should be notified regarding the transfer.
    - If there is clinical concern the patient should not be transferred and escalated to the appropriate Consultant
    - If transfer is delayed more than 3 hours, or there is clinical concern, re-review prior to transfer is required.

6. Guideline criteria for transfer (post resuscitation, this is not exhaustive)
    - RR >8 and <25/min
    - Pulse < 120/min
    - BP >110 mm Hg systolic
    - SpO2 >96% (on <60% oxygen)
    - K+ 3 to 5 mmol/L
    - Lactate <4 (or not rising following resuscitation)
    - Pain adequately controlled
    - Good IV access
    - No evidence of active bleeding
    - Other clinical concern

7. Minimum treatment and monitoring
    - Oxygen to achieve says > 96%
    - IV access and fluids (if required)
    - X-match and transfusion (if required)
    - Adequate analgesia and anti-emetics
    - Correction of potassium
    - ECG monitor, pulse oximeter, NIBP, urinary catheter (if required)

This has been agreed at Clinical Director level with relevant specialities;
Dr Dave McKean & Dr Dave Caesar - Emergency Medicine
Mr Chris Deans & MS Sarah Thomasset - General Surgery
Mr Jim Powell
Prof Michael Gillies