University Hospital Monklands Acute Adult Referral Guidelines

NHS Lanarkshire

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Guidance only. Interspeciailty debate or discussion can be resolved by consultant to consultant discussion

Medicine

- Chest pain and suspected acute coronary syndromes, heart failure, arrhythmias, endocarditis
- Pleural effusion, respiratory failure, pneumonia, asthma, primary lung tumours, DVT and /or PE, pneumothorax (non traumatic)
- Inflammatory bowel disease (unless suspected perforation/ obstruction/ perianal abscess- discuss), hepatitis, decompensated cirrhosis, infective gastroenteritis
- Exacerbation of *chronic* gastritis- NB patients with severe abdominal pain should be discussed with surgery
- Haematemesis & melaena
- Confusion, dizziness, blackouts, seizures, headache, stroke
- Acute non-traumatic arthropathy (NOT septic arthritis), gout/pseudo gout, AND unable to mobilise independently
- Renal failure, diabetic metabolic decompensation, hypoglycaemia, hypercalcaemia & other metabolic emergencies
- PUO
- Uncomplicated LOWER LIMB Cellulitis;
- *If concern re Nec. fasc. discuss immediately with senior decision maker & ortho*
- Self-poisoning, alcohol withdrawal
- Uncomplicated pyelonephritis
- Suspected DVT/ PE in pregnancy- admit medicine but inform obs & gynae if diagnosis confirmed/ alternative significant cardiorespiratory illness discovered
- Dislodged PEG (where parent team is medical)

Urology

- Urinary retention not suitable for out-patient pathway – females, males >1.2L, obstructive AKI etc
- Complex catheter issues e.g. known urethral stricture
- Acute loin pain with proven stone and not suitable for out-patient pathway
- Acute testicular pain/ swelling
- Visible haematuria requiring urgent assessment i.e. high risk of clot retention (passing clots, abnormal coagulation, low Hb)
- Priapism
- Fournier's gangrene (i.e. scrotal involvement)
- Penile fracture
- Complex pyelonephritis – emphysematous pyelonephritis, peri-nephric abscess, associated stone disease
- Blocked nephrostomies refractory to flushing

Frailty

Patients >65, CFS ≥ 5 (*scored on performance 2 weeks prior to admission*), who do not present with a single clinical syndrome best managed under another specialty.
E.g. Reduced mobility, falls , functional decline, delirium; in association with an acute or chronic illness.

All care home patients – use discretion if <65

- Non 'orthopaedic admission pathway' fractures in over 65s who require inpatient assessment and rehab
- Stroke pathway patients should be admitted to ward 21 through medical pathway.
- H@H admissions should not be admitted to frailty by default unless above criteria are met

ENT

- Airway Obstruction
- Pharyngitis/ tonsillitis if unable to eat + drink
- Quinsy/ epiglottitis/ deep neck space abscess
- Post-tonsillectomy bleed
- Acute neck mass/ abscess
- Soft food bolus if **supraclavicular**
- Non-organic foreign bodies (e.g. dentures)
- Acute head and neck cancer patients (e.g. uncontrolled pain/dysphagia)
- Neck/ skull base trauma
- Septal haematoma
- Epistaxis if not manageable in ED/ if packed
- Sinusitis complications- peri-orbital cellulitis, neurological/ orbital complications, Pott's puffy tumour
- Otitis media complications – mastoiditis/ neurological complications
- *ENT emergency clinic:*
  - *Otitis externa*
  - *External ear trauma/ pinna haematoma*
  - *Sudden (<72hrs) sensorineural hearing loss*
  - *Nasal trauma (within 14 days)*

-Dizziness due to suspected vestibular disorder without signs of acute ear infection – routine referral

Surgery

- Acute Abdominal pain- women should have negative pregnancy test
- Cholecystitis, obstructive jaundice, acute/chronic pancreatitis
- Rectal bleeding other than melaena, constipation (discuss prior to admission), perforation of bowel, ischaemic bowel
- Penetrating injury to chest / abdomen / perineum
- Abdominal/Chest trauma (inc. rib/sternal #)
- Dysphagia and oesophageal obstruction
- Stoma complaints
- Groin, perineal, natal cleft, breast abscesses
- ?Nec. fasc. of the abdomen, groin or torso (NOT Fournier's)
- Complications of surgical procedures (not medical complications)
- Intra-abdominal sepsis
- Complications of disseminated surgical cancers (unless chemotherapy related)
- Dislodged PEG (where parent team is surgery)

ED

- Head Injuries

Criteria led discharge:

- Alcohol Intoxication
- Low-risk toxicology

Others

- **Dermatology- no OOH on call service**, referrals by letter or cons-cons phone call/ email. No inpatient beds- if admission required admit under medicine.
- **ID/ Haematology/ Renal-** d/w on call reg/ cons
- **Max- Fax**- on call, no inpt beds UHM
- **Neurosurgery**- On call QEUH switch

Vascular (@UHH)

- Acute limb ischaemia - sudden onset ischaemia with loss of power and/or sensation (lower /upper limb).
- Critical limb ischaemia; severe rest pain or sepsis +/- tissue loss (ulceration / gangrene)
- Penetrating groin trauma
- Diabetic foot that requires urgent drainage or debridement (systemic symptoms / high WCC / fever / gas in tissues) - simple diabetic infections should be admitted to medicine
- Trauma with active bleeding (arterial or venous) - general surgical teams to provide immediate assessment if required
- Infrarenal AAA with symptoms (i.e. rupture or pain).
- Asymptomatic AAA can be referred to vascular clinic - mark as urgent if diameter >5.5 cm
- Pseudoaneurysm with rupture risk (usually IVDA).
- Aortic dissection - see NHSL aortic dissection protocol and refer to medical /cardiology usually for aggressive BP management. (If any end organ compromise (visceral/limb ischaemia) or rupture, refer vascular.)"
see: https://www.nhslcg.scot.nhs.uk/wp-content/uploads/2019/09/Vascular_Surgery_Referral_Guideline.pdf

- Bleeding or dysfunctional dialysis AV fistula, including cases where bleeding has now stopped (*also discuss with renal on call*)

Orthopaedics (@UHW/UHH)

- Fractures/injuries – Follow consensus document
- Limb wounds needing admission – Acute trauma only (not ulcers)
- Cervical spine trauma- Follow C-spine Protocol
- Hip pain with suspected fracture following fall but negative X-ray, and no contributing/acute medical issues
- Pelvic fractures with no significant contributing/acute medical issues
- Musculoskeletal back pain/suspected vertebral fractures for investigation or treatment, – IF disseminated metastatic Ca and atraumatic back pain –refer to team treating malignancy (not ortho, note malignant cord compression guidelines)
- Limb abscesses (excluding groin)
- Bone malignancy (without clear primary)
- Septic arthritis (no Hx of gout/pseudo gout)
- UPPER LIMB cellulitis
- Complications of orthopaedic procedures / operations (not medical complications – DVT/PE etc
- Suspected cauda equina syndrome
    - in hours- urgent MRI and refer QEUH neurosurgery if abnormal
    - out of hours- discuss with QEUH neurosurgery, if not for transfer admit under ortho for urgent MRI

Gynaecology (@UHW)

- Pelvic pain, without trauma (female)
- Patients with disseminated gynaecological cancers such as cervix, uterus or ovary
- Complications of Gynaecological procedures / operations (not medical complications – DVT/PE etc)
- Significant vaginal bleeding outwith pregnancy
- Collapsed suspected ectopic pregnancy
- Procidentia

EPAS

(Mon- Fri 0900-1700 and Sat 0900-1200- at all other times refer to maternity triage)

Bleeding +/- pain < 12 weeks gestation (if > 12 weeks refer to maternity triage)

- Discuss confirmed DVT/ PE in pregnancy with on call reg (managed locally)
- Hyperemesis (via maternity triage)