General Endocrinology Referral Guideline

Austin Health General Endocrinology Unit holds weekly clinics to manage general endocrine problems.

Department of Health clinical urgency categories for specialist clinics	
For all emergency cases that require immediate review, or pose an immediate risk to life or limb, please dial 000 or send the patient to the Emergency Department.	
Emergency	**Please Direct the patient to the Emergency Department for the following reasons:** • Patients with severe hyperthyroidism with haemodynamic compromise, • neutropaenic sepsis in patients taking carbimazole or propylthiouracil, • severe electrolyte disturbances and untreated cortisol deficiency.
Urgent	Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt.
Routine	Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.
Referral Process	
GP Referral Guide	• Please see below conditions accepted into this clinic. • Please provide the relevant investigations as requested below to aid in the appropriate triaging of your patient.
Patient Instructions	Please instruct your patient to bring **ALL** their diagnostic results to their Specialist Clinic appointment.
Exclusions	**The General Endocrinology Clinic does <u>not</u> provide the following services:** • Diabetes, Lipids, Osteoporosis, Obesity, Women's Health, Men's Health and Transgender Health (unless concurrent with another general endocrine problem.) • These conditions are managed in other specialist Endocrine clinics. • Austin Health does not manage any endocrine disorders in pregnancy.

Condition / Symptom	**GP Management**	**Investigations Required Prior to Referral**	**Expected Triage Outcome**	**Expected Specialist Intervention Outcome**	**Expected number of Specialist Appointments**
Hyperthyroidism	**When to Refer:** All patients with new diagnoses **Previous treatment already tried:** Carbimazole or propylthiouracil if appropriate	**To be included in referral** • Thyroid function tests • TSH receptor antibodies • anti thyroid peroxidase antibodies • anti thyroglobulin antibodies • +/- thyroid uptake	**Urgent:** if severe and untreated i.e. T4 >40 **Routine:** If patient treated and stable	• Assessment and investigation of cause. • Initiation of treatment. • Monitoring of treatment until stabilisation achieved with view to discharge back to primary care provider for ongoing monitoring	10 +

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Department of Health clinical urgency categories for specialist clinics					
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Hypothyroidism	**When to Refer:** Difficult to control with thyroxine **Previous treatment already tried:** Thyroxine	**To be included in Referral** • Thyroid function tests, • anti thyroid peroxidase antibodies, • anti thyroglobulin antibodies	**Urgent:** If untreated and T4 <8 **Routine:** This will be the majority	• Assessment and identification of complicating factors to treatment. • Adjustment of treatment. • Monitoring of treatment until stabilisation achieved with view to discharge back to primary care provider for ongoing monitoring	3
Thyroid nodules	**When to Refer:** Suspicious thyroid nodules with any of the following features; • single nodule, • nodule >1cm in size, • nodule increasing size on serial imaging, • microcalcifications, • increased vascularity • cervical lymphadenopathy, • thyroid function abnormality • cold nodule on uptake scan	**To be included in referral** • Serial thyroid ultrasound results • Thyroid function tests • +/- fine needle aspirate • +/- thyroid uptake scan	**Urgent:** N/A unless malignancy confirmed on FNA **Routine:** This will be the majority	• Assessment for malignant potential include fine needle aspirate and ultrasound. • Monitoring of size and for development of malignant features. • To make decisions regarding surgical intervention.	5
Pituitary adenoma	**When to Refer:** • Any pituitary hormone	**To be included in referral** • UEC, Prolactin, FSH, LH,	**Urgent:** If any obvious hormonal excess or deficiency.	• To be seen in multidisciplinary pituitary clinic.	5+

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	abnormality • pituitary adenoma >10mm in size **Previous treatment already tried:** N/A	• early morning cortisol level, ACTH • IGF-1, GH, • TSH, fT4, fT3 • Male: testosterone • Female: oestradiol. • Visual field tests if available. • MRI scans of pituitary if performed previously.	Any visual impairment. **Routine:** All others	• Assessment of pituitary hormones and size of adenoma. • Development of management plan in conjunction with neurosurgical unit.	
Hypercalcaemia	**When to Refer:** Repeated biochemistry shows elevated calcium levels with normal or high parathyroid hormone levels **Previous treatment already tried:** N/A	**To be included in referral** • Detailed history and medication list. • Serum calcium levels, • parathyroid hormone levels • Renal function, albumin • Vitamin D levels. • 24-hour urine calcium excretion.	**Urgent:** If patient is symptomatic from hypercalcaemia or if corrected calcium >3.0 mmol/L **Routine:** All others	• Assessment of cause of hypercalcaemia and management plan. • Monitoring of treatment until stabilisation achieved with view to discharge back to primary care provider for ongoing monitoring	5
Sodium abnormalities – Hyponatraemia or Hypernatraemia	**When to Refer:** Persistent sodium abnormality on repeat testing or if cause unclear. **Previous treatment already tried:** treatment of underlying cause i.e. cessation of offending medication	**To be included in referral** • Detailed history and medication list. • Serum sodium, • Serum electrolytes, • Serum osmolality. • Urine sodium • Urine osmolality. • Thyroid function • cortisol • Glucose levels.	**Urgent:** Sodium <130 mmol/L or >150 mmol/L, particularly if acute change. **Routine:** All others	• Investigate cause and develop appropriate management plan depending on cause • Monitoring of treatment until stabilisation achieved with view to discharge back to primary care provider for ongoing monitoring	5

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Addison's disease	**When to Refer:** All patients with suspected Addison's disease **Previous treatment already tried:** N/A	**To be included in referral** History and investigations including cortisol, UEC.	**Urgent:** untreated patients not on cortisol replacement **Routine:** treated patients on appropriate cortisol replacement	• Confirmation of diagnosis • Treatment with cortisol +/- mineralocorticoid replacement. • Patient education.	Indefinite
Adrenal adenoma	**When to Refer:** All newly diagnosed adrenal adenomas if GP is not able to monitor size or assess functional status. **Previous treatment already tried:** N/A	**To be included in referral** • Blood pressure readings, • medication list. • Imaging studies i.e. serial CT scans. • Biochemistry: as below • 24 hour urinary free cortisol excretion, • 24 hour urinary catecholamines, • plasma metanephrines, • aldosterone to renin ratio • 1mg dexamethasone suppression test	**Urgent:** Suspicion of malignancy i.e. metastases, any obvious hormonal excess or deficiency **Routine:** All others	• Assessment of adenoma size and hormonal functional status. • Monitoring of size (usually 6 monthly for at least 2 years).	5