Pediatric Gastroenterology
Consult and referral guidelines

Introduction

We care for children and teens from birth to 21 years. The most common reasons patients are referred include:

- Abdominal pain
- Constipation/encopresis
- Diarrhea
- Vomiting
- Gastroesophagael reflux
- Suspected inflammatory bowel disease
- Elevated liver enzymes or cholestasis

We want to make referrals easy, fast and efficient for primary care providers. This tool was developed to help create productive visits for you and your patient.

Each guideline includes three sections: suggested workup and initial management, when to refer,and information needed. Suggested workups may not apply to all patients, but these are studies we generally consider during office visits.

Feedback regarding these guidelines is encouraged. Please contact HDVCH Direct to share feedback.

For access to all pediatric guidelines, visit **helendevoschildrens.org/guidelines**

Appointment priority guide

Immediate	Call HDVCH Direct and/or send to the closest emergency department. Contact HDVCH Direct at 616.391.2345 and ask to speak to the on-call endocrinologist.
Urgent	Likely to receive an appointment within 2 days. Call HDVCH Direct and ask to speak to the on-call gastroenterologist regarding an urgent referral.
Routine	Likely to receive an appointment within 10 days. Send referral via Epic Care Link, fax completed referral form to 616.267.2401 or send referral through Great Lakes Health Connect.

Diagnosis/symptoms	Suggested workup/initial management	When to refer	Information needed
Abdominal Pain	Diet modification: Eliminate carbonated beverages, caffeine and gum chewing. Decrease intake of greasy or gas-producing foods, consider trial of dairy-free diet Consider counseling to address potential stress/anxiety issues and to learn relaxation techniques Probiotics Antispasmodic (Hyoscyamine or Dicyclomine) If not improving with the above recommendations: • Condsider CBC/diff, CRP or ESR, CMP, lipase, GGT, IgA, transglutaminase antibody (TTG), urinalysis, fecal hemoccult x 3, fecal leukocytes or calprotectin • Would not recommend imaging unless lab abnormalities suggest a more specific diagnosis	For patients age 0 to 4 years: If persistent for more than one week or if accompanied by persistent fever, diarrhea, vomiting, weight loss/growth failure or GI bleeding For patients age 5 years and up: If pain is persistent for more than 6 weeks and no improvement with conservative IBS management techniques or if accompanied by persistent fever, diarrhea, vomiting, weight loss/growth failure or GI bleeding	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.

Diagnosis/symptoms	Suggested workup/initial management	When to refer	Information needed
Constipation/Encopresis	Diet modification: decrease intake of dairy and increase intake of water and high-fiber foods Stool softener (polyethylene glycol 3350 suggested) Behavioral techniques (See handout) If not improving with the above recommendations: • Consider KUB if you suspect obstruction or if needed to assess fecal load. Consider barium enema if Hirschsprung's disease or neurogenic bowel suspected • Consider CBC/diff, CMP, TSH, IgA, transglutaminase antibody (TTG) • Consider sweat chloride	If not responding to standard bowel regimen or accompanied by obstructive symptoms or urinary incontinence.	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.
Diarrhea	Trial of dairy-free diet and/or decrease clear liquids, caffeinated beverages and simple sugars in diet If blood in stool or if patient fails to respond to dietary management, then: • Fecal hemoccult x 3, fecal leukocytes or calprotectin, bacterial culture, O&P (complete if patient immunocompromised or has history of recent foreign travel), C. diff screen, CBC/diff, CMP, CRP or ESR, IgA, transglutaminase antibody (TTG)	After infectious etiologies have been ruled out and appropriate dietary management has been initiated and if persistent for more than 2 weeks or accompanied by blood in stool or associated weight loss/growth failure	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.

Diagnosis/symptoms	Suggested workup/initial management	When to refer	Information needed
Vomiting	Consider trial H2 antagonist or proton pump inhibitor CBC/diff, CRP or ESR, CMP, lipase Consider fecal Helicobacter pylori antigen (for patients age 1 year and above) Consider KUB or UGI if anatomic etiology suspected	If persistent for more than 2 weeks or If experiencing recurrent episodes more than twice per year or **If accompanied by bilious emesis or hematemesis, may need immediate referral to emergency department.**	Please send growth chart, all lab and radiology reports, and list of treatments tried with referral information.
Gastroesophageal Reflux	Conservative GERD measures (See NASPGHAN handout) Consider trial H2 antagonist or proton pump inhibitor Consider Helicobacter pylori fecal antigen (for patients age 1 year and above) UGI if dysphagia present or anatomic etiology suspected	If accompanied by weight loss or failure to thrive, hematemesis or bilious emesis, respiratory symptoms, severe irritability (infants or nonverbal patients), dysphagia or pain despite observing conservative anti-reflux measures and using appropriate acid suppressive therapy. or If dependent on acid suppression for control of symptoms (has failed 2 or more attempts to wean acid suppression).	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.
Suspected Inflammatory Bowel Disease	Fecal hemoccult x 3, fecal leukocytes or calprotectin, bacterial culture, O&P (complete if patient immunocompromised or has history of recent foreign travel), C. diff screen, CBC/diff, CMP, CRP or ESR, IgA, transglutaminase antibody (TTG), PPD or t-spot	Can be referred directly.	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.

Diagnosis/symptoms	Suggested workup/initial management	When to refer	Information needed
Elevated Liver Enzymes or Cholestasis	Provided on a case-by-case basis Patients with BMI ≥ 95% with mild elevation of LFTs (less than twice the upper limit of normal): initiate weight management strategies and re-check in 6 months.	Elevated liver enzymes (greater than twice the upper limit of normal for over 2 weeks) or cholestasis (elevated direct bilirubin) can be referred directly	Please send growth chart, all lab and radiology reports and list of treatments tried with referral information.

HDVCH Direct phone: 616.391.2345

Helen DeVos Children's Hospital developed these referral guidelines as a general reference to assist referring providers. Pediatric medical needs are complex, and these guidelines may not apply in every case. Helen DeVos Children's Hospital relies on its referring providers to exercise their own professional judgment with regard to the appropriate treatment and management of their patients. Referring providers are solely responsible for confirming accuracy, timeliness, completeness, appropriateness and helpfulness of this material and making all medical, diagnostic and prescription decisions.