UROLOGY:

1. Apology Template

Although we are currently very overbooked it is important that we see this patient. We haven't forgot about them, and I have requested that they be scheduled at our next available appointment. Our scheduler should be contacting them soon. Sorry for the delay.

2. BPH - 5 alpha reductase inhibitor

Thank you for the consult. I recommend adding a 5 alpha reductase inhibitor (Dutasteride 0.5 mg or Finasteride 5mg daily). The combination of a 5 alpha reductase inhibitor and an alpha blocker has been shown to be very effective in men with BPH but can take 6 months to reach full effect.

If this therapy does not improve his symptoms in 6 months or if he wishes to discuss surgical treatment of his BPH, please resubmit an e-referral and we will schedule him for evaluation in clinic.

If there are other symptoms or issues such as hematuria (microscopic or gross), recent UTI, incontinence, or elevated PSA, please let me know and we may schedule an appointment to see him while you start the additional medication.

3. Bring Imaging to Clinic

Please provide the patient with a CD of their CT scan to bring with them to their Urology clinic visit. We need to review these images directly in clinic and cannot make any intervention decisions without imaging. Thank you.

4. Distal Stone

Thank you for the consult. Please make sure patient is staying well hydrated by drinking at least 2 liters of water/fluids per day, pain is controlled with ibuprofen or narcotic pain medication, and they are taking an alpha blocker (terazosin 4 mg daily at bedtime or tamsulosin 0.4 mg daily at bedtime) to help with stone passage. Many ureteral stones will pass on their own with these interventions.

The patient needs to be instructed to present to the emergency department immediately for any fevers or chills prior to stone passage since this may be caused by obstructive pyelonephritis and requires emergent treatment.

We will schedule a clinic appointment for evaluation in case the stone hasn't passed. Thank you.

5. Dysuria/Frequency

Thank you for the consult. For patients with chronic dysuria and urinary frequency, we recommend treating for a UTI even if the colony count is low. The urinary frequency may not allow bacterial colony counts to rise to levels that are normally considered positive for infection.

We recommend a trial of treatment with pyridium for dysuria and ensuring that they are emptying their bladder fully for their frequency. Please check a post-void residual urine volume with a bladder scan or straight catheterization. Normal post-void residual volume should be less than 100 mL.

If you have any questions regarding this, or if symptoms persist after these measures, please let us know. Thank you.

6. ED Clinic

Thank you for this consult. We will schedule a Urology Erectile Dysfunction clinic appointment for this patient at our earliest available time.

7. ED PDE5i

Thank you for this consult. You may trial a phosphodiesterase 5 inhibitor like sildenafil/viagra for this patient. We typically prescribe 50 mg tablets and instruct the patient to break them in half for a starting 25 mg dose. This should be taken 30 minutes to 4 hours prior to intercourse on an empty stomach. The patient also needs to be in the mood for intercourse and have some stimulation for erection to occur. If a partial erection occurs with sildenafil at a lower dose, the dose may be increased to a maximum of 100 mg po daily.

If a trial of a phosphodiesterase 5 inhibitor fails, please let us know and we can schedule the patient to be seen in our erectile dysfunction clinic to discuss additional treatment options like intercavernosal injection therapy and the vacuum erection device. Thanks.

8. Fax Results

Please fax results to 415-206-5153 attention: Urology Fellow. Thank you.

9. General BPH medical recs

Thank you for the consult. For patients with sypmtomatic BPH we recommend starting them on terazosin 2mg po daily at bedtime and titrating up the dose by 2mg per week to 10mg po daily at bedtime. Terazosin 10mg daily at bedtime is the effective dose, and titration helps to avoid orthostatic hypotension. If he is able to get tamslosin (flomax) 0.4 mg, this can be given daily at bedtime without the need for titration. Patients who have had dizziness or orthostatic hypotension with terazosin are eligible to receive tamsulosin if you fill out a TAR. These alpha blocker medications are beneficial in that they relax the muscle in the prostatic stroma allowing patients to void more effectively.

If he has an enlarged prostate on digital rectal exam, he may benefit from the addition of a 5 alpha reductase inhibitor (finasteride 5mg or dutasteride 0.5mg)as well. 5 alpha reductase inhibitors help by decreasing the overall size of the prostate, and usually take 3 months to become effective and 6 months before peak effect is noted.

If he still complains of significant voiding symptoms, wishes to discuss surgical treatment for BPH, or has an elevated post void residual of >150 mL (which can be checked with an ultrasound or by straight

catheterization) while on the appropriate medications, please re-refer him to us for evaluation for surgical treatment of BPH. Please don't hesitate to contact us with any questions.

10. General stone recs

Thank you for the consult. In all patients with nephrolithiasis we recommend primary preventative measures to help reduce the risk of future stone formation. These include drinking 2 to 3 liters of fluid daily, eating a low salt diet, and eating smaller portions of meat.

We will schedule a clinic appointment to review stone risk reduction strategies and assess for recurrent stone formation.

Please provide the patient with a radiology form to get a KUB plain film on the day of the scheduled clinic visit prior to coming to clinic. Thank you.

11. GID patients

Referrals for sex reassignment surgery for transgender patients with gender dysphoria should be redirected to the Transgender Health Services eReferral program, located in the "Other Programs" section.

12. Hematospermia

Thank you for this consult. Hematospermia is typically benign and self limited. It may be caused by inflammation or infection, so we recommend evaluation for urinary tract and sexually transmitted infections. We also recommend a blood pressure check as uncontrolled hypertension may result in hematospermia.

Trauma to or pressure on the perineum including constipation and bicycle riding have also been known to cause hematospermia.

Our typical evaluation of hematospermia includes history and physical examination including blood pressure, genital examination, and digital rectal examination. Laboratory testing includes a urinalysis +/- urine culture, testing for sexually transmitted diseases as indicated, and tuberculosis urine culture only as indicated.

In almost all cases hematospermia resolves spontaneously and no treatment is required. Please let us know if you have further questions. Thank you.

13. Hematuria Recs

Thank you for the consult. Microscopic hematuria is 3 or more RBC per high powered field on urinalysis with microscopy and cannot be diagnosed on urine dip. If the patient has microscopic hematuria confirmed on urinalysis with microscopy, please order a CT urogram (an abdominal/pelvic CT with and without contrast and with delayed imaging with contrast) for hematuria work up evaluation and let me know when it is scheduled. Then I will schedule a clinic visit to go over the results as well as discuss performing a cystocopy for lower tract evaluation. Thanks.

14. Infertility Work Up

Thank you for this consult. For infertility work up, please order two separate semen analyses to be performed with 7 to 21 days between specimens. These should be performed after abstaining from masturbation or sexual intercourse for > 48 hours and should be delivered to the laboratory within one hour of collection. Please also order a testosterone, follicle stimulating hormone, luteinizing hormone, and prolactin level. These tests should be completed in the morning before 10 am. Once these tests have been completed, please let us know so we can schedule him for urology clinic. Thanks.

15. Medical Stone Therapy

Patients that have kidney stones within the ureter of this size have a chance of passing the stone with hydration and medical therapy.

Randomized control studies show that administration of an alpha blocker with or without the addition of a short term steroid will speed stone passage, increase the rate of spontaneous passage, and decrease the patient's pain.

The alpha blockers we typically give are terazosin 4 mg po daily at bedtime or tamsulosin 0.4 mg po daily at bedtime. These should be given until the stone passes.

If the patient is healthy and there are no contraindications to taking a short course of steroids, we recommend prescribing a single medrol dose pack.

Additionally, NSAIDs are very effective in the treatment of stone pain along with narcotic medicines if needed.

Patients with ureteral stones need a CT scan (stone protocol) as well as a plain film of the abdomen (KUB). This allows us to track most stones with repeat KUB films rather than repeat CT scans.

16. Nocturia

Isolated nocturia as the primary complaint may also be due to lower extremity edema, fluid intake at night, or taking a large volume of pills with fluid or diuretics at night. We recommend lower extremity elevation in the afternoon if he has lower extremity edema, decreased fluid intake prior to bed, and diuretic administration in the morning.

17. OAB Initial Recs

Thank you for the consult. For patients with urinary frequency/overactive bladder in the setting of no infection, no urinary retention, and no hematuria, we recommend a trial of anticholinergic medication. We typically recommend oxybutynin 5 mg po daily, which should be titrated up to 5 mg po TID. Expected side effects include dry mouth and constipation. It is expected that patients will experience these side effects when they are on an effective dose of anticholinergic medication to help their bladder symptoms. Please let us know if you have questions or if symptoms are not well controlled on an appropriate dose of anticholinergic medication. Thanks.

18. Painful Ejaculation

Thank you for this consult. Painful ejaculation may occur due to infection/inflammation or during closure of the bladder neck during ejaculation.

We recommend physical examination of the external genitals and prostate. Laboratory testing includes urinalysis +/- urine culture and sexually transmitted infection testing as indicated.

NSAIDs may help reduce the pain. In the setting of negative infectious work up, we typically recommend a trial of terazosin 2 mg daily at bedtime to help relax the bladder neck during ejaculation. Men may note retrograde ejaculation with this medication. If you have additional questions, please let us know. Thank you.

19. Pediatric Urology Clinic Standard

Thank you for this consult. We will schedule a Pediatric Urology 6M clinic appointment for this patient at our earliest available time.

20. Peyronie's Disease

Thank you for this consult. It sounds like he likely has Peyronies disease with penile curvature caused by plaque calcification within the penis. Please start him on Pentoxifylline 400mg po BID x 1 week, then titrate up to 400mg po TID dosing if he has no GI upset. This medication has been shown to decrease calcified penile plaques in Peyronies disease and is the only treatment needed for some men.

If he has had unchanged penile curvature for several months that is interfering with sexual intercourse and he wishes to discuss risks and benefits of surgical intervention for Peyronies disease, please let us know so we can schedule him for a clinic visit. Please also ask him to bring a photograph of his erect penis to clinic. This is required prior to any surgical planning and will save him a return clinic visit. Thank you.

21. Phimosis

Thank you for the consult. Phimosis is a condition that usually can be treated medically, especially in a younger patient population. Please have the patient/parents apply 0.1% triamcinolone cream liberally to his foreskin (apply with a q-tip) BID for 3 mo and gently retract the foreskin after application of the cream. This usually loosens the skin enabling skin retraction without pain. If this treatment regimen is ineffective after 3 months, or if the patient/parents would like to proceed with a circumcision, please re-refer him and we can see him in clinic to discuss risks and benefits of circumcision.

Phimosis is physiologic in children under two years of age, and we typically do not treat until after this age.

22. Post Negative Microscopic hematuria w/u

Thank you for your referral. American Urological Association Guidelines recommend that persistent or recurrent microscopic hematuria should be followed with annual urinalysis with microscopy after initial negative workup. The guidelines also recommend re-evaluation with imaging and cystoscopy after 3-5 years.

23. Prostate Biopsy

Thank you for the consult. In men with over ten years life expectancy we recommend annual PSA checks and digital rectal examinations. Given his elevated PSA, we will schedule him in clinic to discuss the risks and benefits of prostate biopsy.

24. PVR/ Overflow Incontinence

Thank you for this referral. We want to make sure the patient is not retaining urine and having overflow incontinence. Prior to our evaluation in clinic, please check a post-void residual urine volume with a bladder scanner/ultrasound or with straight catheterization. If the post-void residual is higher than 150 mL, the patient likely needs a foley catheter placed to empty the bladder. If this cannot be assessed prior to our scheduled clinic visit, we will perform a flow rate/post void residual measurement in clinic during our evaluation. Thank you.

25. Recurrent UTI

Thank you for the consult. For patients with recurrent UTIs, we want to ensure they are emptying their bladder fully and are appropriately treated for their urinary tract infection with a test of cure urine culture. Please check a post-void residual urine volume with a bladder scan or straight catheterization. Normal post-void residual volume should be less than 100 mL.

In sexually active women with recurrent UTIs, use of a spermacidal agent on condoms or as a form of birth control frequently contributes to UTIs. We recommend eliminating spermacide from birth control, if possible, to help reduce UTIs. In women who only have UTIs after sexual intercourse, we sometimes prescribe prophylactic antibiotics with one tablet of ciprofloxacin or septra to be taken after intercourse.

For post-menopausal women with recurrent UTIs, we recommend vaginal estrogen cream to help alter vaginal pH to pre-menopausal states. This can significantly limit recurrent UTIs in this patient population.

Please order a CT Urogram if the patient's renal function is sufficient to tolerate IV contrast (preferable) or a non contrast CT abd/pelvis if not. This will allow us to evaluate for any abnormalities or foreign bodies in the urinary tract that may be a nidus for bacteria. Let me know when the study gets scheduled or completed and we can schedule her for a clinic visit to discuss the imaging, do a physical exam, and discuss cystoscopy for further evaluation. Thank you.

26. Spermatocele - non-op

Thank you for this consult. Based on the ultrasound findings and physical examination, the patient likely has a spermatocele. Spermatoceles are benign.

We typically do not operate on them unless they become large, painful, or very bothersome to the patient as there is a risk of recurrence and a small risk of chronic scrotal pain after operation. If the spermatocele becomes larger or very bothersome to the patient, please let us know so we can evaluate him in clinic and discuss risks and benefits of surgical intervention.

27. Spermatocele - Op

Thank you for this consult. Based on the ultrasound findings and physical examination, the patient likely has a spermatocele. We will schedule him in clnic so we can evaluate him and discuss risks and benefits of possible surgical intervention.

28. Standard

Thank you for this consult. We will schedule a Urology clinic appointment for this patient at our earliest available time.

29. Sterile Pyuria

Sterile pyuria is defined as 2-5 leukocytes per high powered field on urinalysis with microscopy. This must be diagnosed on UA with microscopy and not on urine dip stick.

Sterile pyuria may be associated with vaginal leukocyte contamination of the urine specimen, infection with non-commonly tested organisms for UTI, interstitial nephritis, nephrolithiasis, and transitional cell carcinoma.

As initial work up in the setting of no renal colic or history of nephrolithiasis, we recommend urine culture for the organisms listed below: tuberculosis, Haemophilus, Ureaplasma, Trichomonas, N. gonorrhea, and Chlamydia.

If these tests are negative, please contact us regarding recommendations for imaging to rule out other causes.

If the patient has HIV, HIV associated nephropathy may demonstrate sterile pyruia, is also typically associated with proteinuria, and may be associated with nephrotic syndrome and renal insufficiency. A nephrology consult is recommended if this diagnosis seems likely based on evaluation of proteinuria and renal function.

30. Testicular/Perineal Pain Recs

Our chronic testicular/perineal pain treatment algorithm recommendation for men with a negative infectious work up and negative imaging begins with empiric treatment with 4 weeks of ciprofloxacin 500mg po BID and scheduled NSAIDs (typically ibuprofen) for 1 month while using an athletic supporter/jock strap for continuous scrotal support. If this doesn't work we sometimes trial 3 months of neurontin 300mg po TID. After failure of these treatments, we recommend referral to chronic pain clinic. Please let us know if we can answer further questions or be of additional assistance. Thank you.

31. Urethritis/Urethral Discharge

Causes of urethritis and urethral discharge in males include chlamydia, N. gonorrhea, herpes, trichomoniasis, and ureaplasma. After testing and/or empiric treatment for GC/Chlamydia, we recommend testing and empiric treatment for these other organisms that may also cause urethritis. If he still has urethral discharge after appropriate treatment for these organisms or if you have questions about treatment, please let us know.

ENDOCINROLOGY:

1. 24 hour urine collection instructions

Patient instructions for 24 hour urine collection:
1. keep urine collection container in the refridgerator or on ice. It must be kept cold.
2. Flush the first urine of the morning down the toilet
3. Write down what time that was
4. Every urine after that for the next 24 hours must go into the bucket.
5. The next morning urinate one more time into the container.
6. Bring container to the lab.

2. agranulocytosis

As a reminder to review with a patient when prescribing methimazole or PTU, both drugs have a very rare but real SE of agranulocytosis. Patients should be instructed to come in immediately for any sore throat, fever, or other sign of infection to have a WBC with diff checked.

3. Andrenal Nodule

Every patient with an incidental adrenal nodule should have plasma or urine metanepharines. They should also all have a dexamethasone suppression test. If the patient has hypertension they should have an am aldo and renin done However, many BP meds can interfere with those results leading to false negatives or positives. Often we have to adjust meds and retest and the aldo/renin is not diagnostic of hyperaldo but rather the initial screening test. So if you have done a renin/aldo, please let us knwo what meds the patient was on at the time.

4. Dex Suppression

Dexamethasone Suppression Test: Patient is given one tab, 1 mg of dexamethasone to take at home sometime between 11 pm to MN. Patient comes into the lab first thing the next morning (8 am) and gets a cortisol level drawn. If cortisol suppresses normally, likelihood of Cushings is minimal.

5. Fax

As the test results and/or records mentioned are not available on our system, please fax them with any other relevant labs/radiology reports to 476-4918 Attn: Dr. Murphy and notify us via e-referral reply when they have been sent. If the fax does not work, please call 206-3828 (note this is not the clinic number and only can assist re fax problems).

6. hypogonadism - contraindications to rx

Conditions where testosterone is not recommended include prostate cancer, breast cancer, unevaluated prostate nodule or induration, PSA > 4 (>3 for high risk person), nct > 50%, severe BPH symptoms, poorly controlled CHF.

7. Fax-Park-Sigal

As the test results and/or records mentioned are not available on our system, please fax them with any other relevant labs/radiology reports to 206-8851 Attn: Dr. Park-Sigal and notify us via e-referral when you have faxed them. Thank you.

8. FRAX

The frax caclulator is often very helpful in determing 10 year probability of fracture in most patients. www.sef.ac.uk/FRAX/index.jsp then select for US and the appropriate race. FDA approval of osteoporosis drugs recommends treatment for osteoporosis (T score <-2.5) after excluding secondary causes. And for osteopenia (Tscore -1.0 to -2.5) at the femoral neck or spine with a 10 yr probability of hip fracture of >= 3% or major osteoposis related fracture >= 20% (both of those numbers are given with the FRAX calculator).

9. Lipid Clinic

This patient sounds like they need to be seen however would be more appropriately followed in Lipid Clinic which is not covered by this e-referral process as noted on the front. Please fax an old fashioned consult request to 355-0919. If there is no response to the fax, can call 734-2600 and leave a message.

10. No show

Regrettably, the patient did not show for his/her appointment in Endocrine Clinic. In an effort to reduce no-show rates and appointment wait times, we generally do not automatically reschedule no-shows. Please assess any barriers to attending clinic and reply via e-referral if you would like to reschedule the patient for another initial visit. Thank you.

11. reclast

IV bisphosphonates can be given in the infusion center on 4C. You will need to 1) get approval/prior auth for the medication 2) Call 4C at 206-3181 to schedule and 3) fax the referal form with an order for the medication to 4C. Typically for osteoporosis the dosing is zolendronic acid as Reclast 5 mg once a year (as opposed to Zometa which is used for cancer). Patient should have a recent normal Ca and normal CrCl > 35 mg/ml on file. There is renal dosing for reduced CrCl.

12. subclinical hyothyroidism

Labs are consistent with subclinical hypothyroidism. We don't typically see hypothyroidism (subclinical or otherwise) in endo clinic but are happy to help via e-referral. Consensus is to treat if TSH > 10. For others, first question is what is the risk of developing frank hypothyroidism. We generally check an antimicrosomal antibody and if that is positive (results appear in serology section) then there is a

significantly increased risk of developing overt hypothyroidism in the future and are more inclined to treat. Also consider treating if there are conditions possibly aggrevated by hypothyroidism such as high LDL, depression. Or if patient feels very strongly they want rx/attribute symtpoms to it. If treatment is initiated for possible symptoms alone, and if there is no improvement in 3 motnhs, therapy should be stopped. And as an additional note, no matter the circumstances, one would not want to treat someone with sublcinical hypothyroidism who has known active CAD, arrhythmias or is at signficant risk for same. If treatment is not instituted, TSH and FT4 can be rechecked in 6-12 months. Often a single abnormal TSH will resolve itself on repeat testing.

13. testosterone monitoring

Patients started on testosterone should have a baseline hct, PSA and if over 40 and PSA > 0.6, should have a DRE. PSA and hct shold be rechecked 3-6 months after starting testesterone. If there is an increase > 1.4 ng/ml or if the patient is having symptoms of urinary obstruction, they should be referred to urology. After the initial check after starting testosterone, PSA check is as you would for anyone and hct chould be yearly.

14. Thyroid cancer risk

Please note, if the patient has a family history of thyroid cancer or personal history of radiation exposure, these recommendations would change.

15. Transgender services

Please direct requests for advice about hormonal therapy for transgender patients with gender dysphoria to the Transgender Health Services eReferral program, located in the "Other Programs" section of eReferral.

Geriatrics:

1. Cognitive complaint

Thank you for referring your patient to Geriatrics.

{We will schedule your patient in the next available clinic.}

{We will not be able to schedule your patient at this time. However, we have several recommendations with regard to your primary question about his/her cognitive complaints.}

With regard to {his/her} cognitive complaint:

-Please make sure {his/her} labs are up to date: RPR/HIV/TSH/B12

-In this case, imaging may be helpful because: _____, please order a _____ to evaluate _____

-There are many community and on-line resources. Some that we find helpful are from Family Caregiver Alliance at www.caregiver.org and Alzheimer's Association: www.alznorcal.org

-Please refer {him/her} to your BHT team now to help connect to community resources and day program.

-Please refer to home health for: PT/OT/SW for home safety and connection to resources.

-Before we see your patient in clinic, can you elaborate on social environment and social supports? What is the caregiving situation?

With regard to our brief chart review of medications, we would currently recommend the following changes:

-

-

-

Again, please contact us with any questions or further information that may help our evaluation by resubmitting through eReferral or emailing directly at anna.chodos@ucsf.edu.

2. Geriatrics Neurology Clinic referral

Thank you for referring Mr/Ms. ____ to our service.

We would be happy to see him/her. Given the question around cognitive status, we will see her in our Geriatrics Neurology Cognitive Clinic. Please note, this is scheduled through a different mechanism, so it will say "Not Scheduled" here.

Before we see her, could you comment further on:

any cognitive testing you have done, current functional status and function trajectory, eg. has needed more help over time or has it been stable?

Thank you and we look forward to providing further recommendations when we see her/him.

3. We will schedule your patient.

Thank you for this interesting consult. We will schedule your patient in the next available clinic.

Before the appointment, please help us provide the best consultation possible by providing the following information and resubmitting the referral:

[]

[]

[]

If you have any further questions or concerns that you would like us to address, please also include that and resubmit. Also feel free to contact our service via anna.chodos@ucsf.edu.

GASTROENTEROLOGY:

1. Abdominal pain details

In order to help determine what workup might be appropriate and whether your patient with abdominal pain needs to be seen in the GI clinic, please provide the following information:

1) Where is the pain located?
2) Is the pain constant or intermittent?
3) Are there any exacerbating or alleviating factors?
4) Are there any associated symptoms?
5) Does the patient have any alarm symptoms such as GI bleeding, unexplained weight loss, dysphagia, early satiety?
6) Does the patient have any bowel habit abnormalities (i.e., constipation, diarrhea)?

2. Alarm symptoms?
Does the patient have any alarm symptoms, such as unexplained weight loss, GI bleeding, dysphagia or early satiety?

3. Alternate specialty
It seems that this patient's indication for referral would be more appropriate for a specialty other than gastroenterology. Please consider referring the patient to:

If you feel that a GI appointment is indeed indicated, please reply to this eReferral.

Thank you,
Justin Sewell

4. appending new information for visit
In the future, please open the original eReferral form and add comments to it, rather than initiating a new eReferral. This is the best way to ensure that all information is present at the time of the patient visit.

Thanks,
Justin Sewell

5. Appointment not needed
Based on the information you have provided in this eReferral, it does not seem that the patient needs an in-person evaluation in the GI clinic at this time. Please consider the suggestions I have provided. If you feel a GI clinic appointment is indicated (now or in the future), or if you have concerns or questions, please reply to this eReferral.

Thank you,
Justin Sewell

6. BRBPR
In order to judge the acuity and appropriately schedule your patient with apparent lower GI bleeding, please provide the following information:

1. Nature, severity, frequency, and duration of bleeding. Is the blood only on the toilet tissue or is it mized with stool and/or in the toilet water? How frequent is the bleeding?
2. Current and previous hemoglobin levels.
3. Clinical status at onset and subsequent course. Are there any associated symptoms such as pain, fever, lightheadedness?
4. Does the patient have any history of GI bleed in the past? Have they ever had a colonoscopy or upper endoscopy?

Thank you,
Justin Sewell

7. can't schedule procedures with eReferral
We cannot schedule or reschedule patients for procedures via eReferral (except using the Direct Access portal for appropriate patients). If the procedure was previously scheduled and the patient missed the appointment, or if the patient wishes to reschedule a future endoscopic apppointment, the patient (or their representative) can call the GI office at 206-8823 to reschedule.

Thanks,
Justin Sewell

8. Chronic Diarrhea
It sounds like you are referring this patient for chronic diarrhea. Please make sure the following studies have been performed to further evaluate this complaint:

1) Stool studies: fecal fat, fecal WBC, ova & parasites (3 specimens), stool culture, stool Giardia antigen
2) Serum studies: CBC, albumin, tissue transglutaminase antibody, IgA, TSH

If your labs are not reported in the LCR, please fax the results to 206-5199 to my attention.

Also, please review the patient's medication list to consider whether any medications may be causing diarrhea and try a trial off potential offending medications if possible.

Once the above workup has been completed, please reply to this eReferral so that I can make further recommendations, or have your patient scheduled for an appointment in the GI clinic, as appropriate.

If your patient has any concerning or alarm symptoms (i.e., weight loss, GI bleeding), please advise and we will see them whether or not the above workup is complete.

Thank you,
Justin Sewell

9. Constipation
For constipation without alarm symptoms (such as weight loss or rectal bleeding), the following regimen can be helpful. These should generally be tried in order, adding the next step to the regimen if the prior step does not produce satisfactory bowel habits.

1) Increased water and fiber intake. Decrease or discontinue medications that can cause constipation as possible (i.e., opiates, anticholinergics, calcium channel blockers).
2) Miralax 17g po daily to TID.
3) Stimulant laxative (such as senna or bisacodyl) taken once or twice daily.

Please try the above regimen. If it is ineffective or if the patient has alarm symptoms (i.e., weight loss, rectal bleeding) please advise and we will see her in GI clinic.

Thank you,
Justin Sewell

10. Direct Access through GI portal
Might your patient be a good candidate for Direct Access? If so, I can have your patient scheduled for Direct Access through this portal, but first I need you to provide answers to the following questions.

1) Does the patient have significant cardiopulmonary comorbidities, psychiatric disease, or other conditions that would make sedation difficult?
2) Does the patient drink alcohol heavily or use recreational drugs?
3) Does the patient take antiplatelet or anticoagulant agents? If yes, can these be safely held 7 days before the procedure?
4) What is the patient's primary language?

Once I receive your response to the above questions, I will have your patient scheduled either for clinic or Direct Access, as appropriate.

Thank you,
Justin Sewell

11. DIRECT COLONOSCOPY - query to PCP
The Gastroenterology Clinic is piloting a program in which appropriate patients can be directly scheduled for endoscopic procedures without the need to attend a class or clinic appointment. The GI clinic will call these patients to schedule their endoscopic procedure and provide pre-procedure instructions and prescription for appropriate bowel preparation.

Based on the referral information you have provided, it seems that your patient may be appropriate to directly schedule for colonoscopy. Please reply to the following queries to indicate whether you agree with having them directly scheduled and to provide other necessary information.

First, do you agree with directly scheduling this patient for colonoscopy? If the answer is “yes” please provide the following information. If the answer is “no” please advise and we will have the patient scheduled for GI Clinic or Direct Access Class as appropriate.

1) Does your patient routinely take aspirin, other NSAIDs, or any anticoagulants? If yes, would it be safe for the patient to hold these medications for 7 days prior to the planned procedure (please note that for most endoscopic procedures, these agents may be continued).
2) Does your patient regularly use narcotic pain medications? If yes, what agents and at what dose?
3) Does your patient have active substance or alcohol abuse?
4) Does your patient have any medical comorbidities that might be a contraindication to moderate sedation (such as active angina, congestive heart failure, myocardial infarction or stroke within the last 6 months, severe pulmonary disease)? If so, please specify.
5) Does your patient have diabetes mellitus requiring medications?
6) Does your patient have a history of constipation?
7) What is your patient's preferred language?

Once I receive your response, we can proceed with scheduling your patient accordingly.

Thank you,
Justin Sewell

12. Gallbladder polyps
Usually gallbladder polyps 1 cm in size or greater should be considered for surgical resection due to increased risk of malignancy. There are no uniform guidelines for surveillance of subcentimeter GB polyps. You should consider repeat US in 6-12 months. If stable in size you could consider annual surveillance with US, and if stable in size for years you could consider lengthening the interval. If the polyp is found to increase in size, then would refer for consideration of cholecystectomy.

13. Gastric cancer family history
There are no screening guidelines for patients with a family history of gastric cancer. This is in part because gastric cancer does not reliably arise from a detectable premalignant lesion (such as polyps in the colon). Patients with family history of gastric cancer should undergo EGD for any upper GI symptoms (including dyspepsia, abdominal pain, nausea, vomiting, early satiety, bloating, dysphagia, GI bleeding, or unexplained weight loss). Additionally, since H pylori increases gastric cancer risk, it is important to test for H pylori (using a serum antibody), treat if positive, and confirm eradication with an H pylori stool antigen (which tests for active infection).

If your patient meets any of the above criteria, or if there are other concerning or extenuating circumstances, let me know so that we can see them in clinic to discuss EGD.

Thank you,
Justin Sewell

14. Dysphagia
For your patient with dysphagia, please provide the following information to help me triage how soon the patient should be seen:

1) Is dysphagia for solids, liquids or both?
2) Is the dysphagia worsening in severity or frequency?
3) Does the patient ever have to regurgitate or does the food always pass?
4) Does the patient have a history of reflux symptoms?
5) Does the patient have any weight loss or GI bleeding?

15. Gastroparesis
Unfortunately, gastroparesis can be very difficult to manage clinically. The following are interventions that can be tried to improve symptoms:

1) Medications that can delay gastric emptying should be stopped or reduced in dose as much as possible. Common examples include: opioid pain medications, calcium channel blockers, medications with anticholinergic activity.
2) Patients should eat smaller, more frequent meals. Lower fat meals may be better tolerated as fat takes longer to empty from the stomach. Supplemental nutritional drinks (i.e., Ensure, Boost), may be helpful if caloric intake is inadequate.
3) Optimize glycemic control in diabetic patients.
4) Reglan should only be continued if patients experience substantial benefit, and at the lowest effective dose, as long-term use has risks of permanent neurologic side effects.

5) Antiemetic agents can be used prn or around the clock if helpful.
6) Acupuncture has shown some promise for reducing symptoms of gastroparesis.
7) In patients with severe, refractory gastroparesis, gastric pacemaker or surgical therapy can be considered.

16. H. pylori stool antigen test

H pylori stool antigen testing is useful in diagnosing the presence or absence of active H pylori infection in patients who have been previously treated for the infection. Testing should occur at least 8 weeks after completion of prior treatment and the patient should be off PPI's for 14 days before collecting the specimen. I will notify the lab and give my permission for the testing to be performed in your patient.

If stool antigen is positive, then would re-treat with a different regimen for H pylori. If stool antigen negative, or if dyspepsia does not resolve with re-treatment, or if patient has alarm symptoms (i.e., GI bleeding, weight loss, early satiety), then please advise and we will see the patient in GI clinic to consider endoscopy.

Thanks,
Justin Sewell

17. H pylroi does not cause reflux

H pyori does not cause reflux symptoms (i.e., epigastric burning, regurgitation of sour fluid into the back of the mouth) - these symptoms are usually caused by GERD. H pylori typically causes dyspeptic symptoms (i.e., epigastric pain, fullness, bloating, discomfort). Which type of symptom does your patient have - reflux or dyspepsia?

Once I receive your response to the above questions, I will make further recommendations or have your patient scheduled, as appropriate.

Thank you,
Justin Sewell

18.Lifestyle for GERD

Lifestyle modifications for GERD include:

1) Weight loss in patients who are overweight or obese. Losing even a small proportion of excess body weight can reduce GERD symptoms.
2) Avoid eating meals close to bedtime.
3) Elevated the head of the bed, or use a commercially available “acid wedge pillow,” which elevates the patient’s torso. Using more pillows elevates only the head/neck and is therefore not effective.
4) Minimize ingestions that can worsen GERD such as alcohol, caffeine, chocolate, and mint.
5) Eat smaller, more frequent meals.
6) Avoid foods that the patient can identify as potential GERD triggers.
7) Eat and drink slowly, and chew thoroughly, to minimize aerophagia, as stomach distension increases gastric acid output.

19. Non-PCP referrral

Referrals for appointments in GI Clinic are for specialty consultation. This requires appropriate primary care evaluation prior to the GI Clinic appointment, as well as a primary care provider to follow any

recommendations that we make. Therefore, our policy is that we generally only accept new patient referrals from primary care providers. I suggest that you discuss with the patient's PCP, and they can submit a referral if desired.

Thank you,
Justin Sewell

20. PPI risks
Long term PPI use is associated with slight increase in risk for osteoporosis, community acquired pneumonia, and infectious colitis. However, these risks are often outweighed by benefits of PPI if they are effective in controlling troublesome GERD symptoms.

21. SFGH guidelines for CRC screening and surveillance
Please see our screening and surveillance guidelines below.

Recommendations for Screening People at Average Risk:
Patients at average risk should be offered screening at age 50 years using annual FIT (single specimen) or FOBT (two samples from each of 3 consecutive stools without rehydration). Patients with a positive test should be followed up with colonoscopy.

Recommendations for Screening People at Increased Risk:
People With a Family History of Colorectal Cancer or Adenomatous Polyps
People with a first-degree relative (parent, sibling, or child) with colon cancer or adenomatous polyps diagnosed at age <60 years or 2 first-degree relatives diagnosed with colorectal cancer at any age should be advised to have screening colonoscopy starting at age 40 years or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeated every 5 years at minimum. People with a first-degree relative with colon cancer or adenomatous polyp diagnosed at age >60 years or 2 second-degree relatives with colorectal cancer should be advised to have first colonoscopy at age 40, and repeated at a minimum of every 10 years. People with 1 second-degree relative (grandparent, aunt, or uncle) or third-degree relative (great-grandparent or cousin) with colorectal cancer should be advised to be screened as average risk persons.

Familial Adenomatous Polyposis:
People who have a genetic diagnosis of familial adenomatous polyposis (FAP), or are at risk of having FAP but genetic testing has not been performed or is not feasible, should have annual sigmoidoscopy, beginning at age 10-12 years, to determine if they are expressing the genetic abnormality. Genetic testing should be considered in patients with FAP who have relatives at risk. Genetic counseling should guide genetic testing and considerations of colectomy.

Hereditary Nonpolyposis Colorectal Cancer:
People with a genetic or clinical diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC, also known as Lynch Syndrome) or who are at increased risk for HNPCC should have colonoscopy every 1-2 years beginning at age 20-25 years, or 10 years earlier than the youngest age of colon cancer diagnosis in the family, whichever comes first. Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited mismatch repair (MMR) gene mutation. It should also be offered when the family mutation is not already known, but 1 of the first 3 of the modified Bethesda Criteria is met (see Table 5 in the original guideline document).

Surveillance of People at Increased Risk

People with a History of Adenomatous Polyps:
Patients who have had 1 or more adenomatous polyps removed at colonoscopy should be managed according to the findings on that colonoscopy. Patients who have had numerous adenomas, a malignant adenoma (with invasive cancer), a large sessile adenoma, or an incomplete colonoscopy should have a short interval follow-up colonoscopy based on clinical judgment. Patients who have advanced or multiple adenomas (>3) should have their first follow-up colonoscopy in 3 years. Patients who have 1 or 2 small (<1 cm) tubular adenomas should have their first follow-up colonoscopy at 5 years.

People With a History of Colorectal Cancer:
Patients with a colon cancer that has been resected with curative intent should have a colonoscopy around the time of initial diagnosis to rule out synchronous neoplasms. If the colon is obstructed preoperatively, colonoscopy can be performed approximately 6 months after surgery. If this or a complete preoperative examination is normal, subsequent colonoscopy should be offered after 1 years, then after 3 years, and then, if normal, every 5 years.

People With Inflammatory Bowel Disease:
In patients with either ulcerative colitis or Crohn's disease involving a significant portion of the colon should embark on a program of surveillance colonoscopy after 8-10 years of disease. These patients should have a colonoscopy every 1-2 years, with systematic biopsies taken throughout the colon to evaluate for hidden dysplasia.

22. surveillance after adenomatous polyp
Patients who have multiple adenomas (>3) or an adenoma >1 cm should have their first follow-up colonoscopy in 3 years. Patients who have 1 or 2 small (<1 cm) tubular adenomas should have their first follow-up colonoscopy at 5 years. Patients who have tubulovillous adenomas, advanced dysplasia on pathologic exam, significant family history, incomplete removal of the lesion, or incomplete exam are treated on an individualized basis

Thank you,
Justin Sewell