PAEDIATRIC SURGERY

National Referral Guidelines

SPECIFIC PAEDIATRIC SURGERY REFERRAL LETTER GUIDELINES
• Referrals can only be accepted from registered Medical Practitioners; and Lead Maternity Care (LMC) providers in respect to perinatal (up to six weeks of age) paediatric surgical care. • The referral should also include Antenatal ultrasound reports in cases of post natal follow-up.

NATIONAL REFERRAL GUIDELINES : PAEDIATRIC SURGERY		
Diagnosis	**Comments**	**Referral Guidelines**
Signs and symptoms by anatomical site: • head and neck • chest • abdomen • anal • inguinal and scrotal • genitalia • urinary tract • skin and subcutaneous • limbs	Thorough history and physical examination is required to determine the specific diagnosis (see below). Child Development or Health Development Record needs to be considered. Specific treatment depends on the specific diagnosis identified, as noted below.	Circumstances for referral are indicated below with reference to the appropriate specialty / specialties and degree of urgency (category). “Category A” requires immediate telephone consultation with the nearest paediatric surgeon. Local access to specialist Paediatric Surgical Services is variable and should be taken into account when the referral is made, particularly in acute situations. Cross reference to both treatment and first assessment clinical priority access criteria should be made. In situations of acute referral, note Category 1 treatment clinical priority access criteria (CPAC). In Category A situations, telephone contact to the appropriate service is essential.

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Diagnosis	**Comments**	**Referral Guidelines**
HEAD & NECK		
Enlarged lymph node/s	• ? history of recent infection • ? infective focus, e.g. family history of TB or overseas exposure • consider Cat Scratch disease *Note: FNA is not indicated particularly in infection*	Observation for a month is appropriate for most enlarged lymph nodes of uncertain aetiology. If unresolved or diagnosis remains uncertain, refer to Paediatric Surgical Service depending on local situation. If nodes rapidly increasing in size, overlying skin erythema or very tender, refer urgently.
Abscesses	Look for tenderness & fluctuance. Drainage is needed, usually under a general anaesthetic.	Immediate referral - Category A
Other Lumps / Sinuses / Skin Tags	Examples: external angular dermoid, pre-auricular sinuses, branchial remnants, midline dermoid cysts, sialectasis.	Routine referral - Category 3
Tongue Tie	Key feature - inability to protrude tip of tongue beyond inferior gingival margin. If severe, may have difficulty saying "L", "T", "Th" and "N"	Routine referral optional - Category 3 *Note: ENT / Oral Maxillofacial referral recommendations*
Intraoral conditions not related to teeth, eg. ranula, lingual thyroid, haemangioma, mucus retention cyst.	Is this cystic or solid ? Cysts are usually removed. If solid, consider lingual thyroid. Thyroid function tests may be helpful. All require consultation.	Routine referral - Category 3 unless there is respiratory obstruction (in which case Category A)
Sternomastoid Tumour (congenital muscular torticollis)	Presents at 3 weeks of age. Look for tight and shortened sternomastoid muscle. Head rotation restricted to side of STM tumour limited. Usually resolves by 9-12 months without treatment. Plagiocephaly best demonstrated by looking down at the child's head from above.	Refer for confirmation of the diagnosis and to rule out other causes of torticollis. Routine assessment Category 3 (c.f. Orthopaedic referral recommendations). In most situations referral should be to Paediatric Surgical Service.
CHEST		
Chest Wall Deformities		Major chest wall deformities should be referred to paediatric surgery. A few cases of pectus excavatum and carinatum improve with time. Surgery is not undertaken until puberty and is for cosmetic reasons. Early referral is not required unless for reassurance and information.
Inhaled Foreign Body		Immediate referral to paediatric facility - Category A

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ABDOMEN		
Umbilical Hernia	Defect in linea alba often relatively small, even with large sac. Reassurance of parents because 90% resolve in first 2 years of life. Strapping not advised. Virtually never cause pain or strangulate. Surgical repair if persists at 3 years of age.	Persistent defects should be referred at 3 years - Category 3
Epigastric Hernia	Standard history and examination. Tend to persist. Repair if symptomatic eg: cause abdominal pain or for aesthetic reasons.	Refer - Category 3
Abdominal Pain - Acute	Standard history and examination. Consider appendicitis. Under 3 years of age, consider intussusception. If localised peritoneal irritation (guarding), needs surgical assessment.	Refer immediately if serious pathology suspected - Category A.
Abdominal Pain - Chronic	Standard history and examination. Differential diagnoses will include: • Constipation, faecal accumulation. Constipation - dietary advice, laxatives, bowel retraining, encourage fluids. • Non-specific abdominal pain of childhood. • Urinary tract infections UTI's - antibiotics as appropriate according to sensitivities. Further investigations according to age (See recommendations for UTI's in Paediatric Guidelines both for diagnosis and management). NB: Localised or lateral pain, pain at night or pain associated with bilious vomiting needs urgent referral. Investigations: consider abdominal x-ray, MSU, stool examinations. Blood tests seldom helpful. Consider ultrasound if abdominal mass suspected, or to exclude renal / ovarian pathology.	Option to refer those children with persistent symptoms - Category 3. Refer if serious pathology is suspected. Refer this group urgently - Category 2 (Note: Depending on local circumstances, Paediatric Medical referral may be appropriate in first instance.)
Suspected Gastro-Oesophageal Reflux	See Paediatric Medical referral recommendations	

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ABDOMEN		
Swallowed Foreign Bodies	Button batteries potentially hazardous. Note: Foreign bodies that reach the stomach will almost always pass uneventfully through the GI tract, - even sharp objects such as needles, pins and ends of thermometers. In these circumstances, reassurance is appropriate. Oesophageal foreign bodies require removal by oesophagoscopy. Note excessive salivation or difficulty swallowing.	Refer immediately those with ingested button batteries or signs of obstruction, e.g. excessive salivation - Category A. Option to refer those who require more reassurance - Category 1.
Ingested Caustic and Acid Substances	Peri-oral or intra-oral burns, excessive drooling, or a definite history of ingestion. Do not induce vomiting. Make nil by mouth. Oesophagoscopy performed if oesophageal injury suspected.	Immediate referral to Paediatric Surgical Service - Category A.
Abdominal Mass	Exclude faecal loading clinically. Refer all other masses. Other investigations prior to referral seldom required, and may result in repeated investigation if they are not adequate.	Urgent referral - Category 1.
Delayed passage of meconium	Timing of meconium passage > 24 hours suggestive of Hirschsprung's disease: needs to be excluded.	If no passage of meconium within first 24 hours in a term baby, immediate referral to Paediatric Surgical Service Category A.
Constipation < 2 months of age	Abdominal distension ? Vomiting ? If either present - refer.	Refer urgently if there is abdominal distension and / or vomiting - Category A. Immediate referral to Paediatric Surgical Service.
Constipation > 2 months of age	Check for acute anal fissure and faecal accumulation. History of blood or pain on defecation. If constipated, dietary advice, laxatives, bowel retraining.	Refer those children with persistent symptoms longer than 3 months. If serious pathology is suspected, refer urgently - Category 2 - to Paediatric Surgical Service, or if rural, via Paediatric Medical Service.

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ANAL		
Bleeding	Minor bleeding ? bright red. Associated symptoms, e.g. diarrhoea, mucus, abdominal pain, pain on defecation, abdominal distension. Age of patient. Note: Rectal bleeding in children is not usually associated with malignancy. Fissure-in-ano standard conservative management. Rectal polyps are not pre-malignant and usually auto-amputate. Major bleeding with or without altered blood (brick -red or maroon) consider Meckel's Diverticulum. If associated with pain and / or vomiting, consider intussusception.	Bleeding with diarrhoea which persists - seek Paediatric advice. Refer anal fissure cases after 4 weeks of conservative management as semi-urgent - Category 2. Chronic bleeding pre rectum greater than 3 months - refer routinely to Paediatric Surgical Service - Category 3. Bleeding with abdominal symptoms, especially infants, or major bleeding, refer urgently - Category A.
Perianal Abscess		Immediate referral to Paediatric Surgical Service or local Paediatric Medical Service - Category A.
Fistula-in-ano		Routine - Category 2
Rectal Prolapse	Internal haemorrhoids are extremely rare in children stool softness or Laxatives if associated with constipation.	Routine referral - Category 3.
INGUINAL AND SCROTAL		
Inguinal and / or Scrotal Swellings (undescended testes see below)	Sometimes herniae and hydroceles may be difficult to differentiate in children. It is important to recognise a hernia in a child under the age of 3 months. NB: herniae in children < 3 months may transilluminate. "Irreducible" (strangulated) herniae should be reduced promptly by manual taxis and referred. No narcotics or gallows traction. If unable to be reduced consider as strangulated. Hernias need herniotomy, hydroceles need herniotomy only if persistent beyond 2 years. If a hydrocele causes symptoms, consider an urgent referral - Category 2.	*Child under 3 months with hernia or uncertain diagnosis:* Refer urgently to Paediatric Surgical Service - Category 1. *Herniae over the age of 3 months:* Refer semi-urgently to Paediatric Surgical Service (or local General Surgical Service in some circumstances) - Category 2. *Difficult Hernia:* Any hernia that can be reduced only with difficulty is at significant risk of strangulation and should be referred urgently - Category A - irrespective of age, to Paediatric Surgical Service. *Hydrocele:* If a hydrocele is confidently diagnosed it can be treated expectantly. If it persists past the age of 2 or there is diagnostic doubt it should be referred routinely - Category 3.

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INGUINAL AND SCROTAL		
Acute Scrotal Pathology	The following conditions are included: • torsion of testis • torsion of appendix of testis Epididymo-orchitis is very rare in children and should not be diagnosed clinically. Mumps orchitis does not occur in prepubertal child. Ultrasound is not required. Urgent exploration of scrotum is required.	*Scrotal pain with or without swelling:* Refer immediately - Category A - to local surgical services.
Undescended Testis	An undescended testis is one that cannot be manipulated into the bottom of the scrotum, or will not stay there spontaneously. All testes should be situated within the scrotum by the age of 3 months post-term. Risk of infertility if orchidopexy is delayed, increases with age. Orchidopexy should be performed by the age of 1 year, or as soon as possible after diagnosis if the diagnosis is not made until after 1 year of age.	Refer from the age of 3 months to Paediatric Surgical Service. Routine referral - Category 2. If there is a clinically obvious associated inguinal hernia they should be managed as hernia referral recommendation, preferably by Paediatric Surgical Service.
Retractile Testis	Retractile testes are normal and can be manipulated into the scrotum and will stay there spontaneously (albeit often briefly). If markedly retractile, will require annual review.	Refer routinely to the Paediatric Surgical Service, if in doubt or retractility marked - Category 3.
GENITALIA		
Phimosis	No problem if good urinary stream. Normal in infant. A large percentage of foreskins are in young children fused to the glans and will separate spontaneously over the years. It is not necessary to forcibly retract the foreskin. Ballooning with micturition frequently occurs and is acceptable providing there is a good urinary stream. Phimosis can be treated by applying Betnovate ointment to tight part of the foreskin qid for 1 month.	Indications for referral: • Recurrent balanitis • Pinhole or narrowed preputial orifice with poor urinary stream • Scarring of foreskin • Failure of Betnovate treatment after 1 month Refer routinely - Category 3
Paraphimosis	Oedematous swollen foreskin behind coronal groove. Requires urgent reduction (often under a GA).	Refer immediately - Category A
Social / Religious Circumcision		Not currently provided in public health system.
Hypospadias	Do not circumcise. Evaluate adequacy of urinary stream. Aim for surgical repair at 9-12 months of age.	Refer at diagnosis routinely - Category 3 - to Paediatric Surgery / Paediatric Urology.

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GENITALIA		
Urethral Meatal Stenosis	Usually after circumcision. Evaluate urinary stream. Meatotomy may be required.	Refer routinely - Category 3.
Balanitis	Accumulation of smegma under the foreskin is common and normal but can be mistaken for pus. Referral and / or intervention is not required. It will continue to extrude spontaneously until all the preputial adhesions have disappeared. Forcible foreskin retraction and cleaning is not necessary. Frank infection requires treatment with oral antibiotics (e.g. Cotrimoxazole) and surgery if it is recurrent. If phimosis is present treat the acute episode as above and when settled, treat with local steroid cream - see "Phimosis"	Recurrent balanitis - refer routinely as above - Category 3.
Fused Labia	Benign, self-limited condition. No recognised association with other anomalies.	Refer routinely - Category 3.
Vaginal Discharge	If purulent or bleeding ? Consider the possibility of sexual abuse or foreign body.	Refer urgently - Category 2 - to either Paediatric Surgical Service, Paediatric Medical Service, or Paediatric Sexual Abuse team.
Ambiguous Genitalia	If it doesn't look right, refer. May be associated with significant (possibly fatal) endocrine anomalies.	Refer **urgently** - Category A - to Paediatric Surgical Service or appropriate local Paediatric Medical Service or Paediatric Endocrinologist.
URINARY TRACT		
Antenatally Diagnosed Hydronephrosis	Applies to hydronephrosis at any gestation. Post-natal examination for abdominal mass. Ultrasound after 5 days of age. LMC has responsibility to ensure GP is informed.	Referral to Paediatric Medical or Paediatric Surgical Service if dilatation is present - Category 1. Note: Majority of urinary abnormalities present as either UTI or as hydronephrosis following antenatal ultrasound. Most require referral to a Paediatric Centre for evaluation.
Urinary Tract Infection Many urological abnormalities will present as a urinary tract infection. These include: • vesicoureteric reflux • pelvi-ureteric junction obstruction • vesicoureteric junction obstruction	Evaluation of urinary tract infections: The diagnosis of UTI requires great care and skill. SPA in infant. Clear evidence of UTI is essential. (Note: Guidelines: Diagnosis of UTI in Children). Urine tests must be provided with the referral. Investigation: See Paediatric Medical Service Guidelines (check with local Paediatric Medical Service).	Refer for assessment patients with abnormal imaging results or if requiring investigations noting local recommendations. Routine - Category 3. Refer recurrent urinary tract infections. Routine - Category 3.

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URINARY TRACT		
Urinary Tract Infection (continued) • primary mega-ureter • neuropathic bladder • duplex system +/- ureterocele • posterior urethral valves	Treat constipation, toileting hygiene. Commence antibiotics if UTI confirmed or suspected strongly after MSU obtained	
Neuropathic Bladder	Check for spinal abnormality, i.e. mass or spina bifida occulta. Exclude and treat constipation. Management includes: • Regular urine check-ups. • Long-term antibiotics • Clean intermittent catheterisation	Refer to Paediatric Service if diagnosis suspected. Category 3
SKIN AND SUBCUTANEOUS		
Skin lesions / Cysts / Sinuses	Diagnosis according to site and appearance, e.g. midline neck: thyroglossal cyst.	Refer to Paediatric Surgical Service - Category 3.
Subcutaneous mass	Consider MAIS (atypical Tb) infection in pre-schooler, usually in neck. Overlying skin discoloration suggests impending ulceration.	Refer to Paediatric Surgical Service - Category 1 if MAIS suspected. Refer as Category A if skin discoloration.
Molluscum Contagiosum		No referral needed.
Perianal warts	Consider sexual abuse. (Not all cases are due to sexual abuse). Podophyllin application.	Refer if unresolved or extensive - Category 3. Consider referral to Child Sexual Abuse Team if sexual abuse suspected.
Lymphadenitis	Acutely tender, non-fluctuant mass. (Distinguish from the non-tender lymphadenopathy) Treat with short course of Flucloxacillin. (Most of these are due to staph aureus, and broad-spectrum antibiotics are not indicated.)	If not significantly better by 5 days, refer to Paediatric Surgery or Paediatric Medical Service - Category 1
Abscess	[c.f . Head and Neck] Drain abscess	Refer to Paediatric Surgical Services - Category A
Pigmented Skin Lesions This will include: • strawberry naevus • venous malformation • cafe-au-lait spots • giant hairy naevus	Usually observation, depending on site and complications.	Refer to Paediatric Surgical Service - Category 3
Male Gynaecomastia	Common in pre-pubertal boys. Reassurance. Analgesics if painful.	Refer if not resolving or causing symptoms, i.e. pain, tenderness, itchiness or becoming progressively larger - Category 3 - to Paediatric Surgical Service for consideration for surgery.

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SKIN AND SUBCUTANEOUS		
Sacral Sinus	Do not instrument in case there is a connection to the spinal canal. Antibiotics if infected. Needs surgical treatment if recurrent infection occurs.	Refer if doubtful about diagnosis or if infected, to Paediatric Surgical Service - Category 3.
Spina Bifida Occulta This may include: • Hairy patch in sacral area • Cystic or firm mass	X-ray of sacral spine.	Refer for investigation and treatment - Category 3 - to Paediatric Medical Service.
Cellulitis	NB: Peri-orbital cellulitis may result in cavernous sinus thrombosis. Blood culture and full blood count. Culture and antibiotic sensitivity test if pus available. Treat with intravenous antibiotics. Minor peripheral cellulitis may be treated with oral antibiotics.	Refer to Paediatric Surgical Service or Paediatric Medical Service - Category A
LIMBS		
Polydactyly / Syndactyly	X-ray of foot or feet or hand or hands as appropriate.	Contact Paediatric Surgical Service for referral to local area of expertise - Category 3
Ingrown Toenail	Treat with antibiotics when infected. Surgical treatment is rarely required in infants. Older children may require surgery.	Refer to Paediatric Surgical Service if severe or causing problems - Category 3