Inside Out: Gastroenterology & Hepatology Workshop

Saturday 25 October 2025
Clinical Skills Development Service | RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Dysphagia/ Eosinophilic Oesophagitis

Dr Richard Kai Yuan Cheng
Director of Gastroenterology
Redcliffe Hospital

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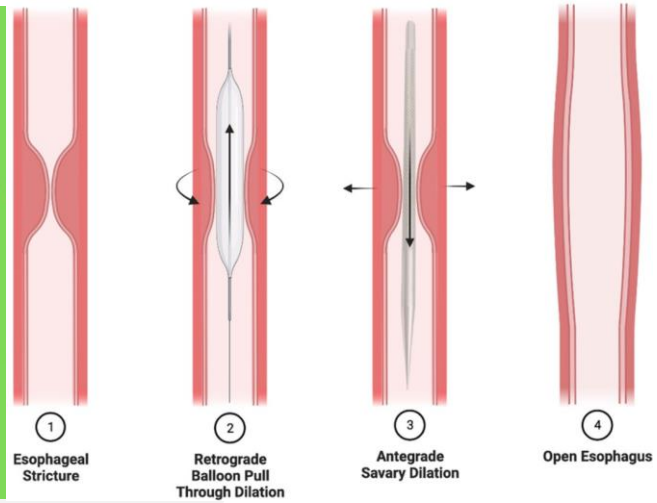
NORTH STAR GASTROENTEROLOGY



Eosinophilic Oesophagitis and Dysphagia

Dr Richard Kai Yuan Cheng

Director of Gastroenterology, Redcliffe Hospital

Agenda

01	Introduction to Mr JR: Case Study
02	Pathophysiology and Natural History
03	Diagnosis
04	Treatment
05	Questions

Mr JR: 54M

Thank you for seeing [redacted] for an opinion
These notes are from my patient records:

iron deficiency anaemia
Possible altered stools with dark motions
History eosinophilic oesophagitis
Last scopes years ago

- Dec 2024: GP Referral: Hb 134 Ferritin 12 MCV 84
- Clinic Review:
  - Reflux: breakthrough 1/26 despite Somac 40mg, typically nocturnal aluminum/magnesium carbonate liquid; diclofenac once per month – no other RFx
  - Dysphagic Epispodes to meat; ?Schatzki Ring, Dx 2010 RBWH; No elimination diet, swallowed fluticasone/budesonide slurry, onset in 20s
  - IDA: no overt bleeding, eats red meat, No FHx CRC
- Plan for Gastroscopy and Colonoscopy

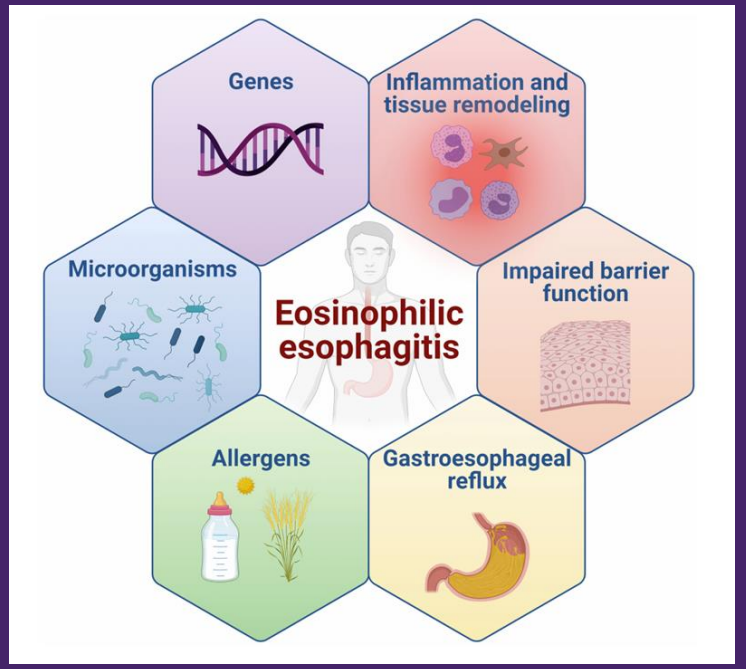
9/2010: Gastroscopy RBWH

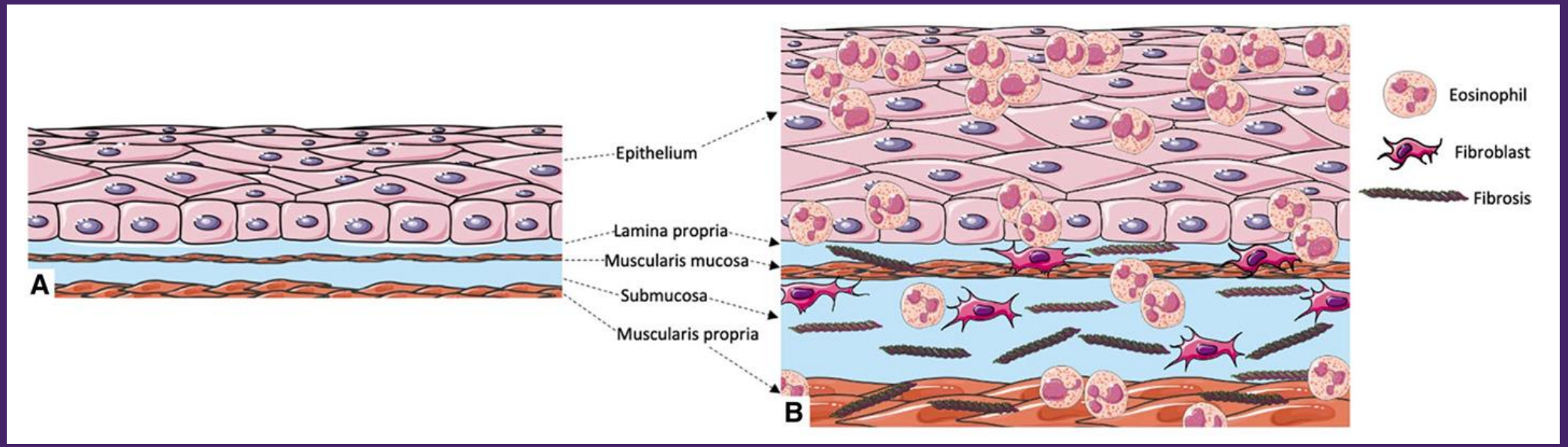
- Moderate Schatski Ring at GOJ; Bx
- Mucosal changes including **ringed oesophagus** and **longitudinal furrows** were found in the entire oesophagus; Bx

Pathophysiology

Increasing incidence (beyond increased recognition bias)
Male Sex
Adults: 20s-30s
Factors:

Risk: Antibiotic exposure, acid suppression, paed ICU admission
Protective: H pylori, breast milk exposure





Racca: Frontiers in Physiology (2022):https://doi.org/10.3389/fphys.2021.815842
Young: Digestive Diseases and Sciences (2022) 67:1101–1115

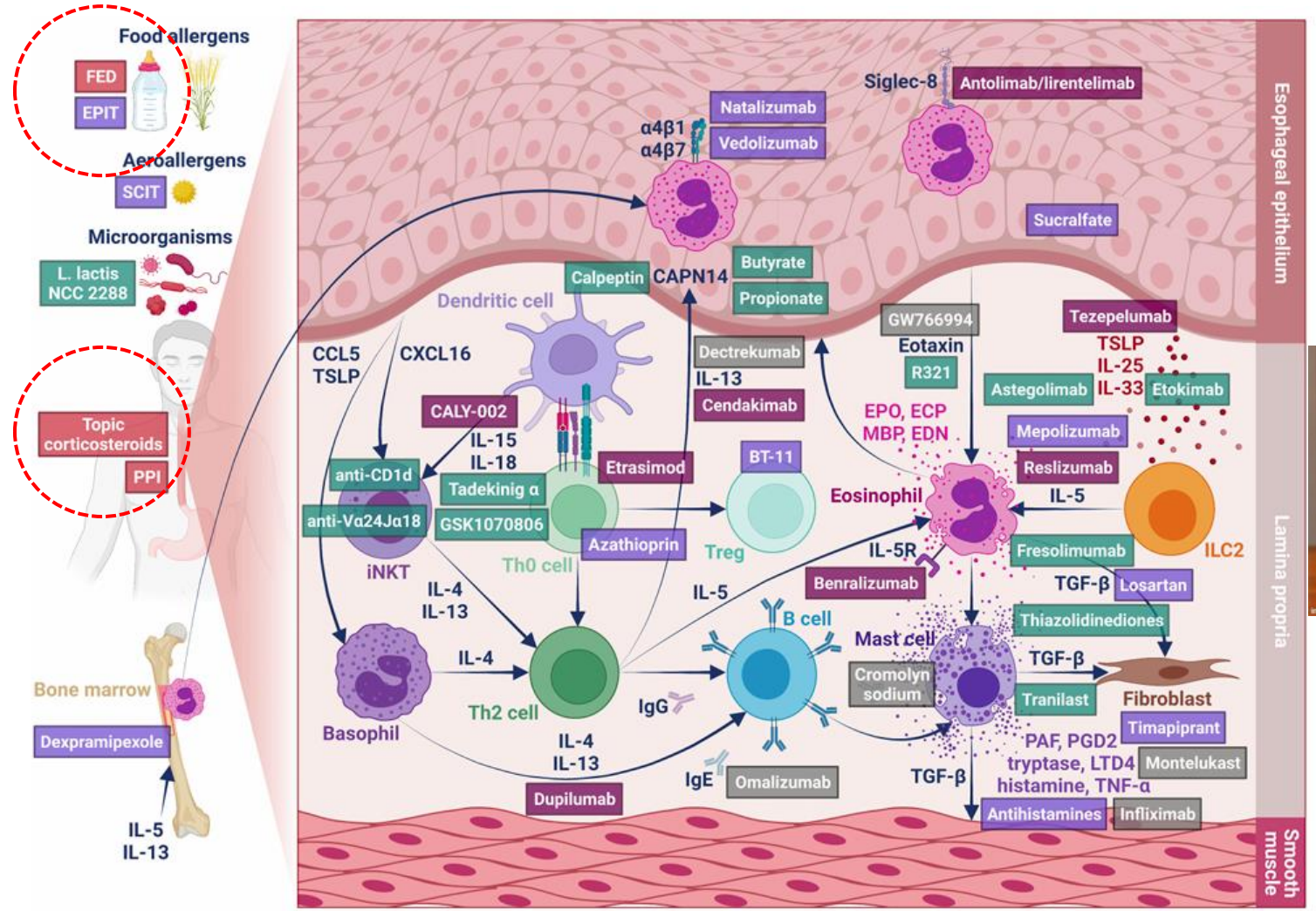
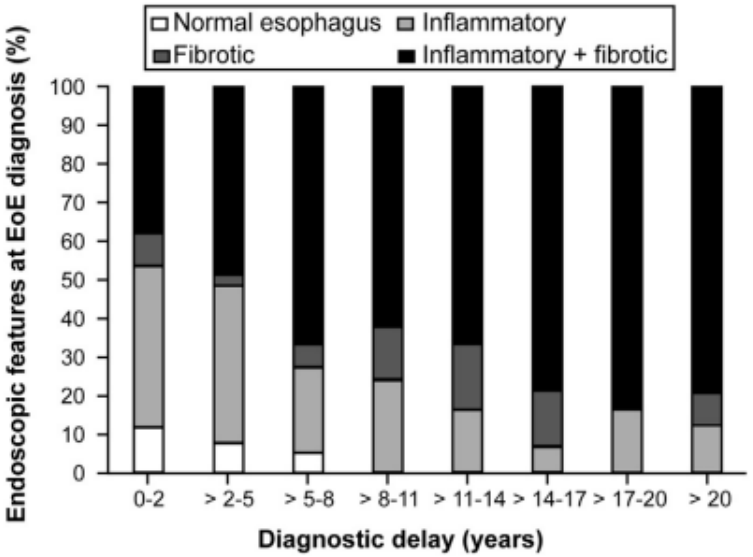
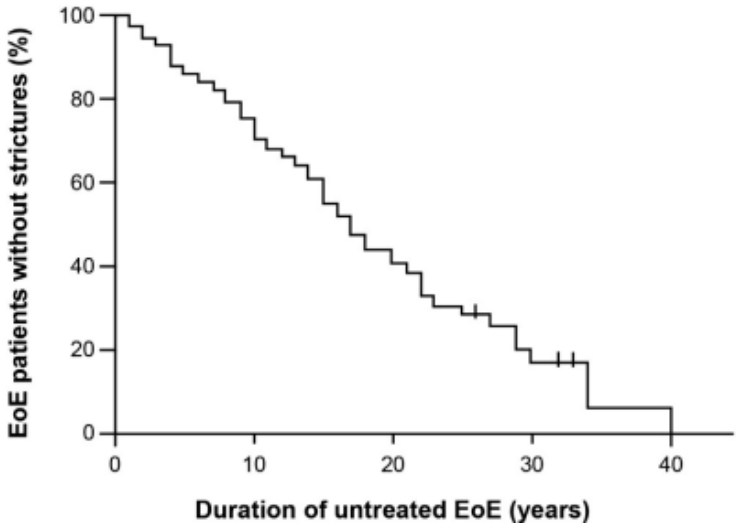


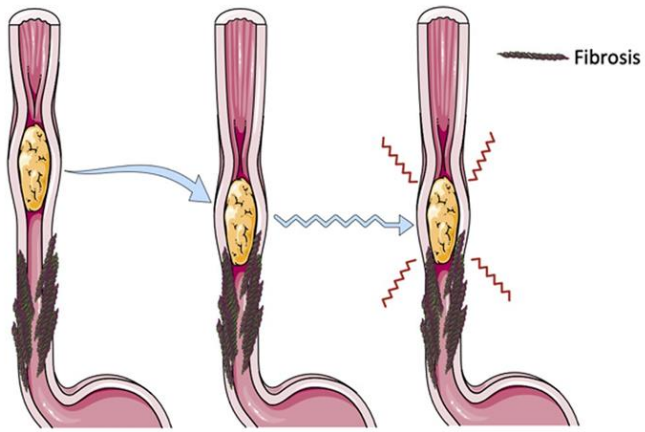
FIGURE 4 | Type 2 inflammation in EoE. The figure represents the involved cells and mediators and the therapeutic approaches described in the review. The drugs are colored as follows: Red tag: first-line therapy, Plum tag: orphan drugs, Lilac tag: drugs with reported results on human patients, Green tag: drugs without reported results on human patients, Gray tag: drugs that failed to obtain significant results on human patients.

Racca: Frontiers in Physiology
(2022):https://doi.org/10.3389/fphys.2021.815842

Natural History







Presentation (n=325)

Dysphagia (93%)
Food impaction (62%)
Heart burn (23.6%)

Allergic history (51.6%)
Peripheral Eϕ (30.8%)

IMPACT

- Imbibing fluids with meals to lubricate foods
- Modifying food (cutting into small pieces)
- Prolonged meal times
- Avoidance of hard texted foods (eg bread, meats)
- Chewing excessively
- Turning away pills

1. Schoepfer: GASTROENTEROLOGY 2013;145:1230–1236 ; 2. Sgouros SN: Eur J Gastroenterol Hepatol. 2006;18(2):211.

Mr JR: Endoscopic Findings (Jan 25)

not actual patient

NORTH STAR GASTROENTEROLOGY

northstargastro.com.au

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SERVICES
Gastroenterology
Bowel Cancer Screening
Liver Disease
Inflammatory Bowel Disease
Hepatitis B & Hepatitis C
Colonoscopy
Endoscopy/Gastroscopy

PROCEDURE LOCATIONS
NORTH WEST PRIVATE HOSPITAL (Everton Park)
PENINSULA PRIVATE HOSPITAL (Kippa-Ring)
NORTH LAKES DAY HOSPITAL Monserrat (North Lakes)

GASTROSCOPY REPORT

Procedure Date: 16-Jan-25 ***Medicare Billing Code:*** *30473*

Patient Name: [redacted] **DOB:** [redacted]

Proceduralist: Dr Richard Kai Yuan Cheng
Location: North West Private Hospital
Referral Source: [redacted]
Indication: Eosinophilic Esophagitis (PPI and Gaviscon only); Iron deficiency Anemia (Ferritin 12 Hb 134)

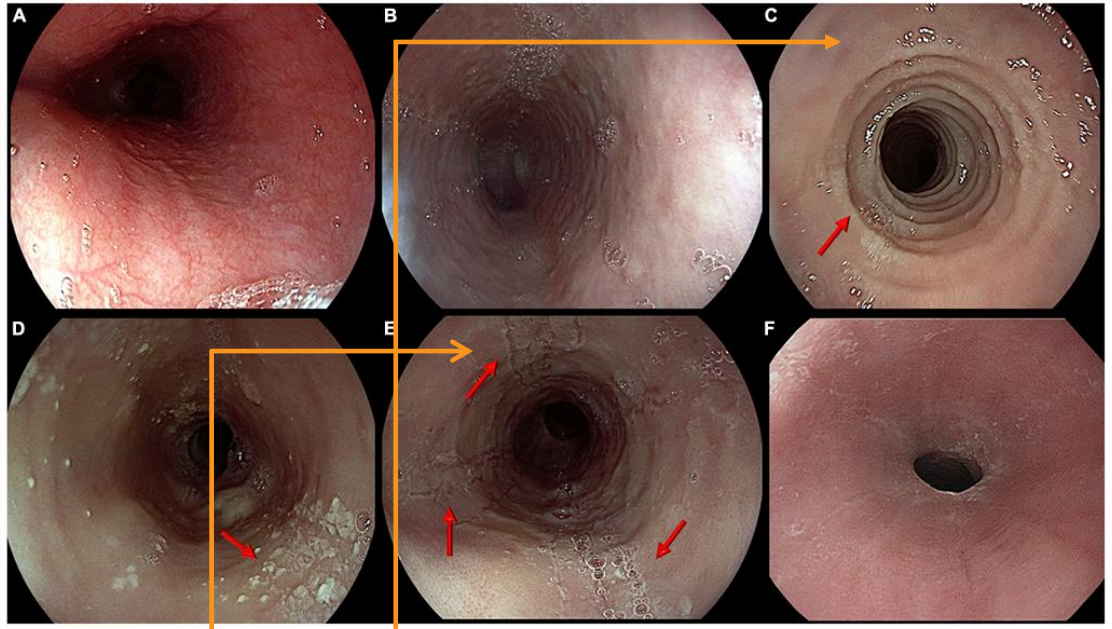
Medicine: Monitored anaesthesia care.
Procedure: After I obtained the patient's informed consent, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The gastroscope was introduced through the mouth and advanced to the second part of duodenum. The gastroscopy was performed without difficulty. The patient tolerated the procedure well.
Complications: No immediate complications.

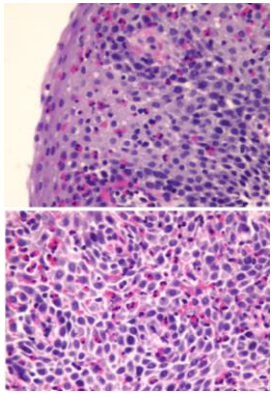
Findings:

- The Z line is measured at 40 cm
- The examination of the oesophagus was showed longitudinal furrows and circular rings in the low oesophagus. No evidence of stricture. Biopsies for purposes of histology was performed from mid, lower, and upper oesophagus to confirm active eosinophilic esophagitis.
- The examination of the stomach was normal. Biopsies (HUT/CLO test) for Helicobactor Pylori was performed in the stomach.
- The examined duodenum was normal. Biopsies was performed for assessment of coeliac disease from first and second parts of the duodenum

Impression:
Eosinophilic Esophagitis

Histology: ***(Envoi Pathology)***
1. Upper oesophagus: No specific abnormality
2. Mid oesophagus: No specific abnormality
3. Lower oesophagus: Oesophageal eosinophilia (16/HPF)
4. Duodenum D1: No specific abnormality
5. Duodenum D2: No specific abnormality
6. Urease: Negative





not actual patient

EoE Diagnositc Criteria

1. Symptoms related to esophageal dysfunction.

2. Eosinophil-predominant inflammation on esophageal biopsy, characteristically consisting of a peak value of ≥15 eosinophils per high power field (HPF) (or 60 eosinophils per mm2).

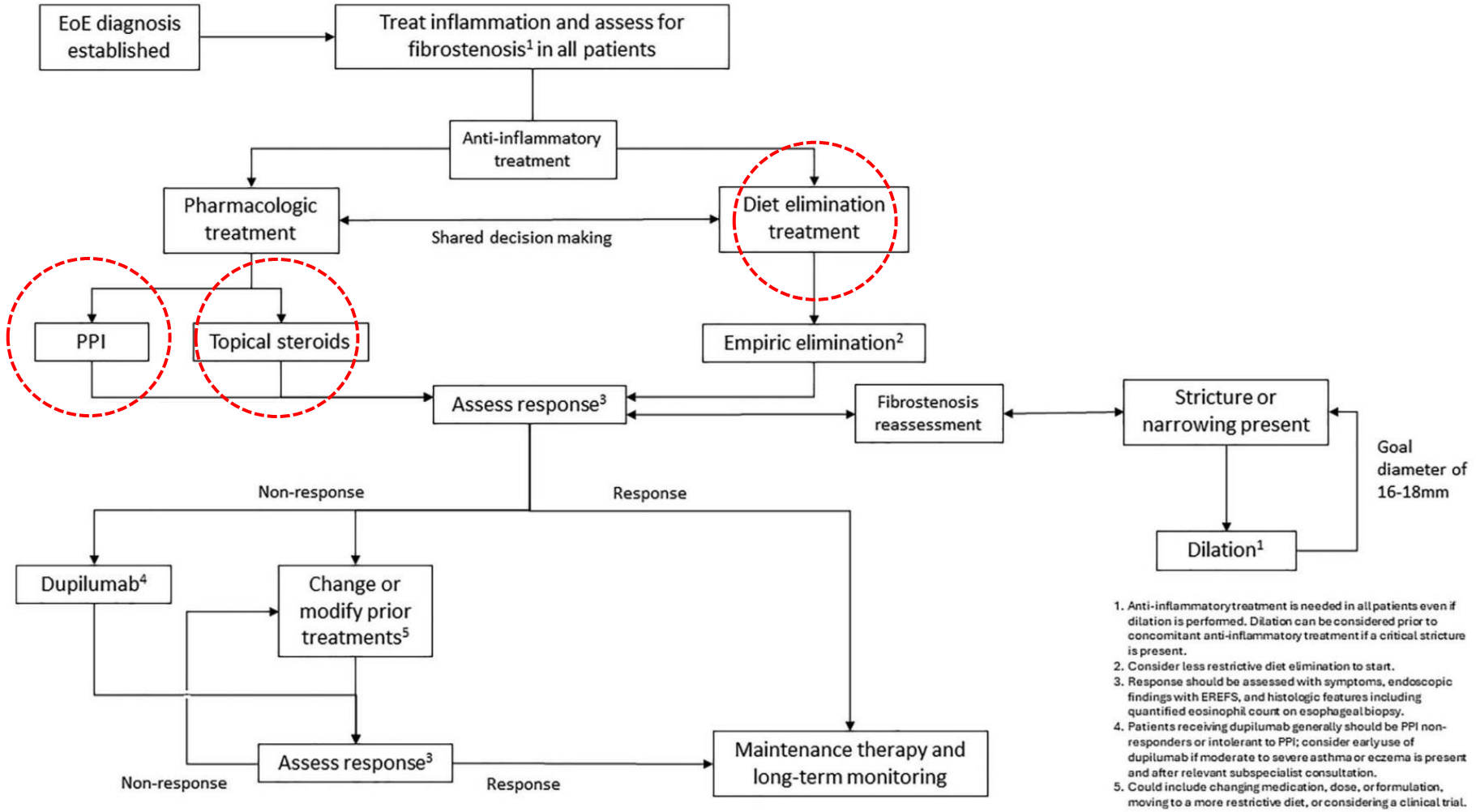
3. Exclusion of other causes that may be responsible for or contributing to symptoms and esophageal eosinophilia

Mr JR: Further Findings (Jan 25)

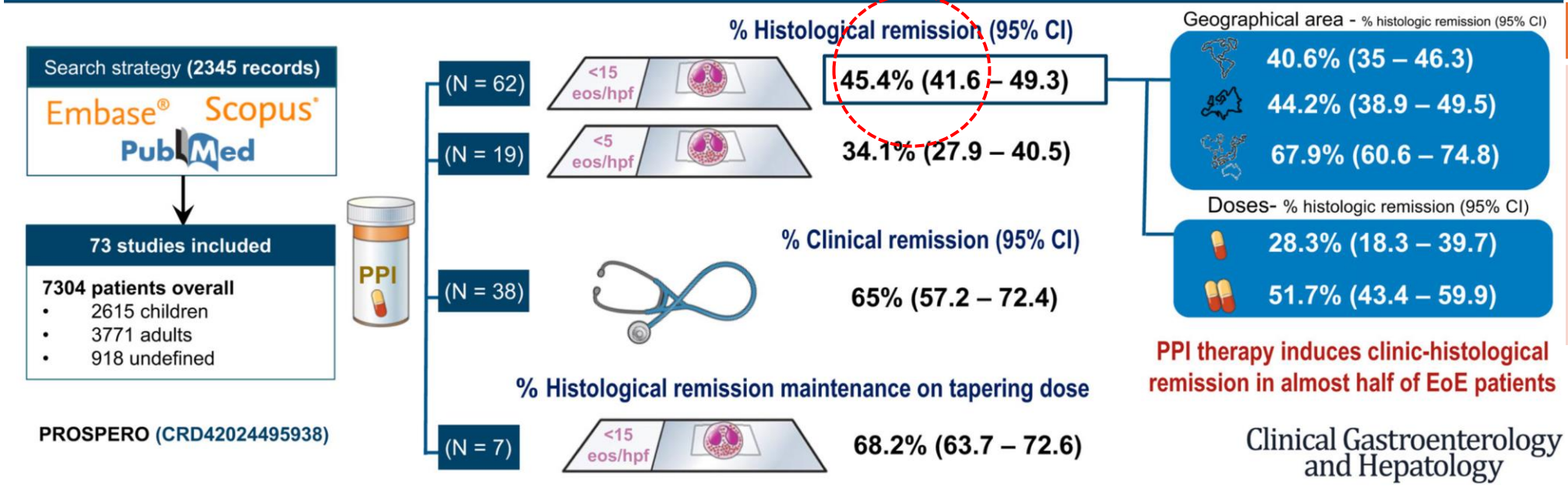
- Colonoscopy: Haemorrhoids otherwise normal
- Iron Infusion in theatre recovery same day

?Further management

Initial Treatment: Anti-inflammatory



Proton Pump Inhibitors for Inducing and Maintaining Remission in Eosinophilic Esophagitis: An Updated Systematic Review and Meta-Analysis



Induction:

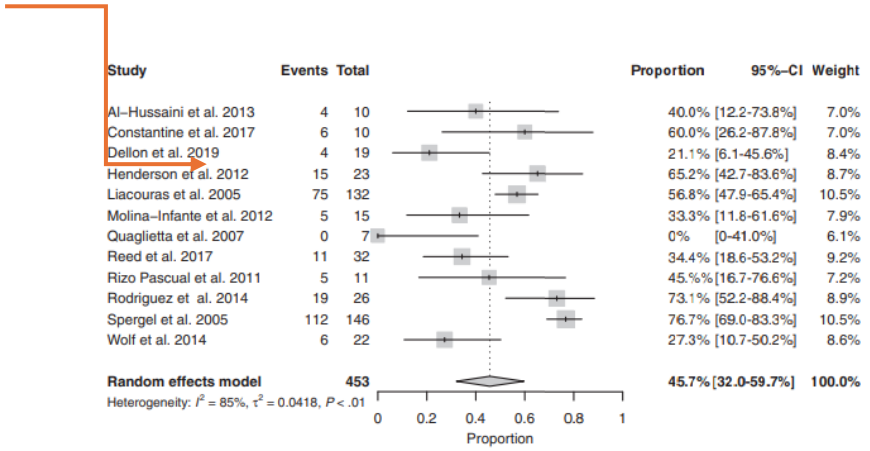
Double the approved reflux dose per day:

Omeprazole 20mg BD / 40mg daily

Lucendo: Clinical Gastroenterology and Hepatology https://doi.org/10.1016/j.cgh.2025.01.016

Food Elimination Diet (FED): Diminishing Returns?

Diet	Details	Efficacy
1FED	Dairy elimination alone; aka. Animal milk elimination	35-45%
2FED	Dairy and wheat	40-45%
4FED	Dairy, wheat, egg, and soy elimination	40-50%
6FED	Dairy, wheat, egg, soy, nuts, and seafood elimination	40-70%
Elemental Formula	Amino acid-based hypoallergenic formula	>90% (if adherent)
Allergy test-directed	Not recommended	----



Skin prick or patch testing in Meta-Analysis:

- 12 Studies: Remission 32.2%
- Lower than 1 FED response of 51.4%

Arias et al Nutrients 2024; Dellon et al Am J Gastroenterol 2025; Mayerhofer Clinical Gastroenterology and Hepatology 2023;21:2197–2210

FED considerations

- Adherence is poor: needs dietitian input/nutrition assessment
- Elemental Diet very effective for induction but unfeasible maintenance
- 1 FED (eg dairy) is as good as more restrictive & avoids gastroscopy
- Symptom control ≠ Treatment response

Google: Queensland Health 6 Food Elimination Diet

My Nutrition

Six food elimination diet for Eosinophilic Oesophagitis (EOE) in adults

This information is for people completing the six food elimination diet (6FED). It should be used with the resource Elimination diet for Eosinophilic Oesophagitis in adults which describes the disease process, diagnosis, elimination diet options and other treatments.

The Six Food Elimination Diet (6FED) involves strict removal of the following for 6-8 weeks:

- Animal Milk
- Egg
- Nuts
- Wheat
- Soy
- Fish and Shellfish

How do I remove milk from my diet?

- Avoid all animal milks (e.g., cow, goat, sheep) and foods made from milk, such as cheese, yoghurt, butter, or ghee.
- Read the labels on foods and drinks to check for milk or milk products.
- Look for hidden names: milk solids non-fat, milk solids, milk powder, whey protein, milk, casein, curd – these are added to some processed and ready-made foods.

What about calcium?

It can be hard to get enough calcium when avoiding milk. Calcium is important for bone health. Your bones can become weak if you are not eating enough calcium rich foods. You can do the following to make sure you get enough calcium:

- Include milk alternatives with added calcium (e.g., oat, rice, or coconut milks).
- Include sesame seeds, tahini, dried figs, green leafy vegetables (e.g., bok choy, broccoli, or spinach), baked beans and legumes (excluding soy beans).

How do I remove wheat from my diet?

- Avoid any food made from wheat and foods that have wheat in the ingredients list such as bread, pasta, biscuits, noodles, soy sauce, or Worcestershire sauce.
- Read the labels on foods and drinks to check for wheat.

This is a consensus document from Dietitian/ Nutritionists from the Nutrition Education Materials Online, "NEMO", team.
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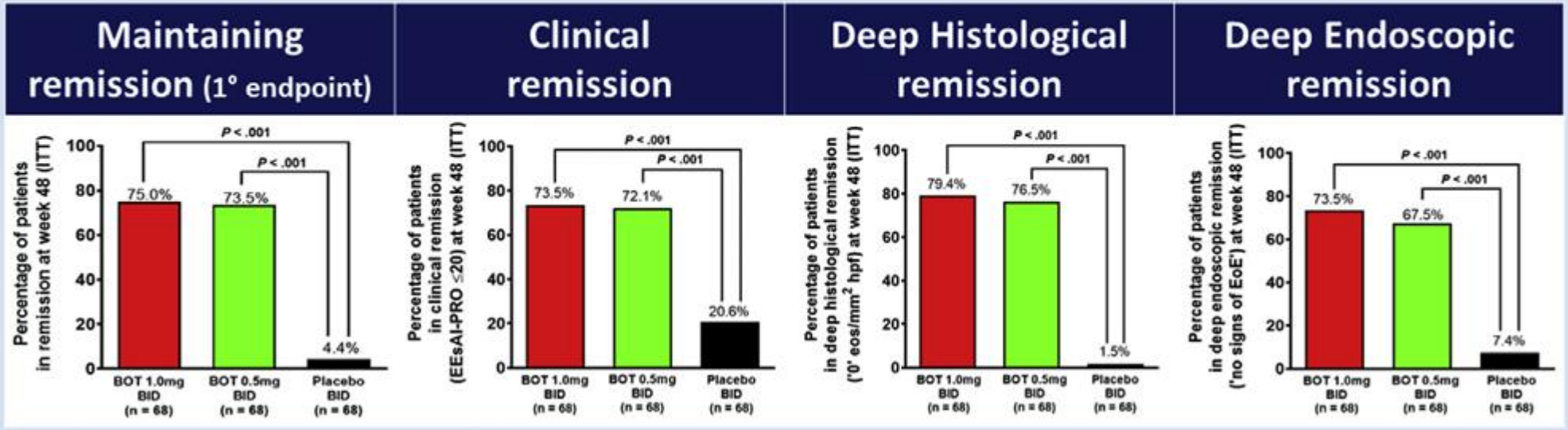
Queensland Government


Jorveza
Gastro Specialist
PPI
6 FED
Fluticasone
Budesonide
Slurry

Budesonide Orodispersible Tablets (BOTs) Maintain Remission in a Randomized, Placebo-Controlled Trial of Patients With Eosinophilic Esophagitis

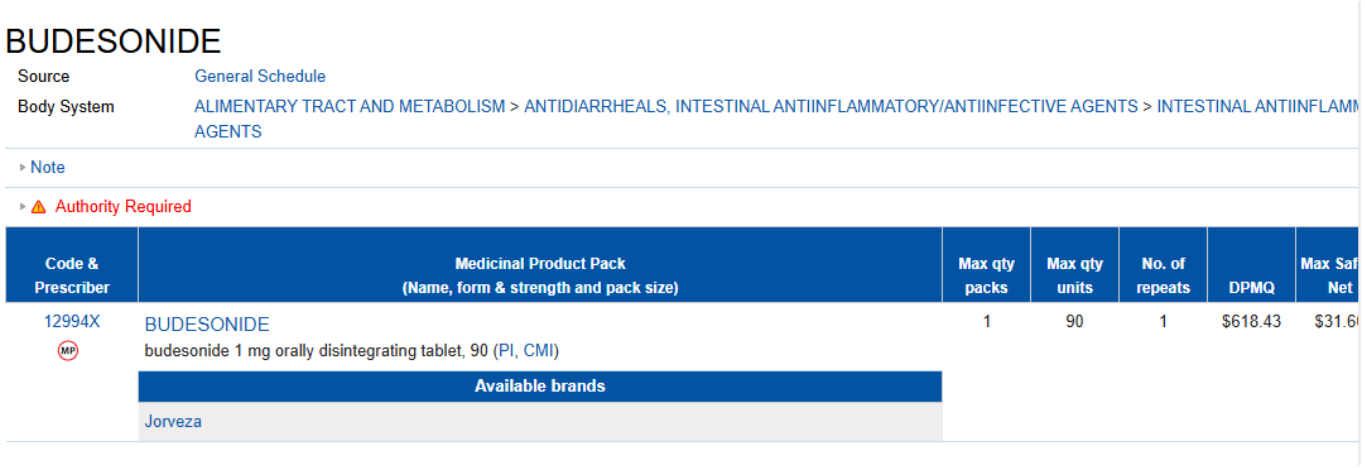
Quiescent eosinophilic esophagitis

A 48-weeks twice daily treatment with Budesonide 0.5mg or 1mg orodispersible tablets (BOT) was safe and highly effective for achieving:



Straumann, Lucendo: Gastroenterology 2020;159:1672–1685

BOT: PBS listed May 2022



BUDESONIDE

Source: General Schedule

Body System: ALIMENTARY TRACT AND METABOLISM > ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS > INTESTINAL ANTIINFLAMM AGENTS

▸ Note

▸ ⚠ Authority Required

Code & Prescriber	Medicinal Product Pack (Name, form & strength and pack size)	Max qty packs	Max qty units	No. of repeats	DPMQ	Max Saf Net
12994X (MP)	BUDESONIDE budesonide 1 mg orally disintegrating tablet, 90 (PI, CMI)	1	90	1	$618.43	$31.6

Available brands
Jorveza

PBS Authority Required

Induction Criteria

1. Eosophageal Dysfunction Sx
2. Eos Bx: >15Eϕ / hpf
3. No more than 90days Script Supply
4. Rx by Exp Gastro/Surgeon

Maintenance

1. 1st dose: Histological Ax (Gastroscopy Again!) within 48wks of initiating Rx
2. Advised apply no more than 2 weeks prior to cessation of induction script
3. 6 month maximum script
4. Clinical response for subsequent applications can substitute histology

Method of administration

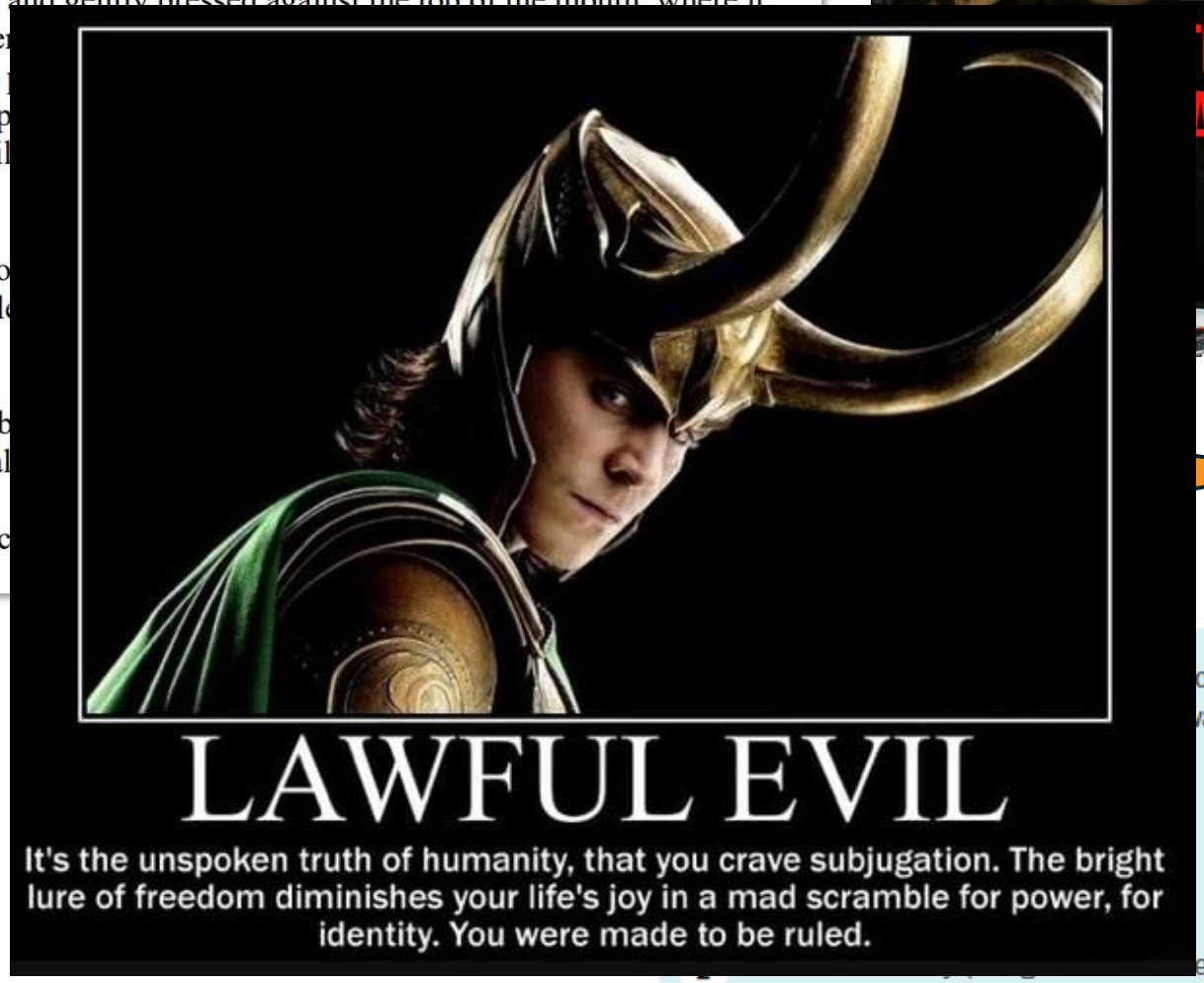
Jorveza®

The orally disintegrating tablet should be taken after a meal.
It should be placed on the tip of the tongue and gently pressed against the top of the mouth, where it will dissolve. This will usually take betwee
longer in some patients. The effervescence
into contact with saliva and stimulates the p
be swallowed with saliva little by little whil
should not be taken with liquid or food.

There should be at least 30 minutes after do
Any oral solutions, sprays or chewable tabl
after administration of Jorveza®.

The orally disintegrating tablet should not b
ensure optimal exposure of the oesophageal

The tablet should be taken immediately onc



crograms by metered dose inhaler, sprayed into
vallowed, once or twice daily depending on

er solution mixed with 3 to 5 g sucralose powder
[Splenda]) swallowed, twice daily [Note 3].

Source: Jorveza CMI, and eTG Gastroenterology

Mr JR: Decisions: FED vs BOT

Clinic Consultation: Feb 25

- Discussed histology and further management options
- Lived a “lifetime” of altered eating behaviour
- BOT 1mg BD induction for 3/12 + administration instructions
- Reassured to observe progress of IDA

Mr JR: “I still don’t feel 100%”

Thoughts? Where to Next?

Post Induction Re-Scope: Apr 25

NORTH STAR GASTROENTEROLOGY

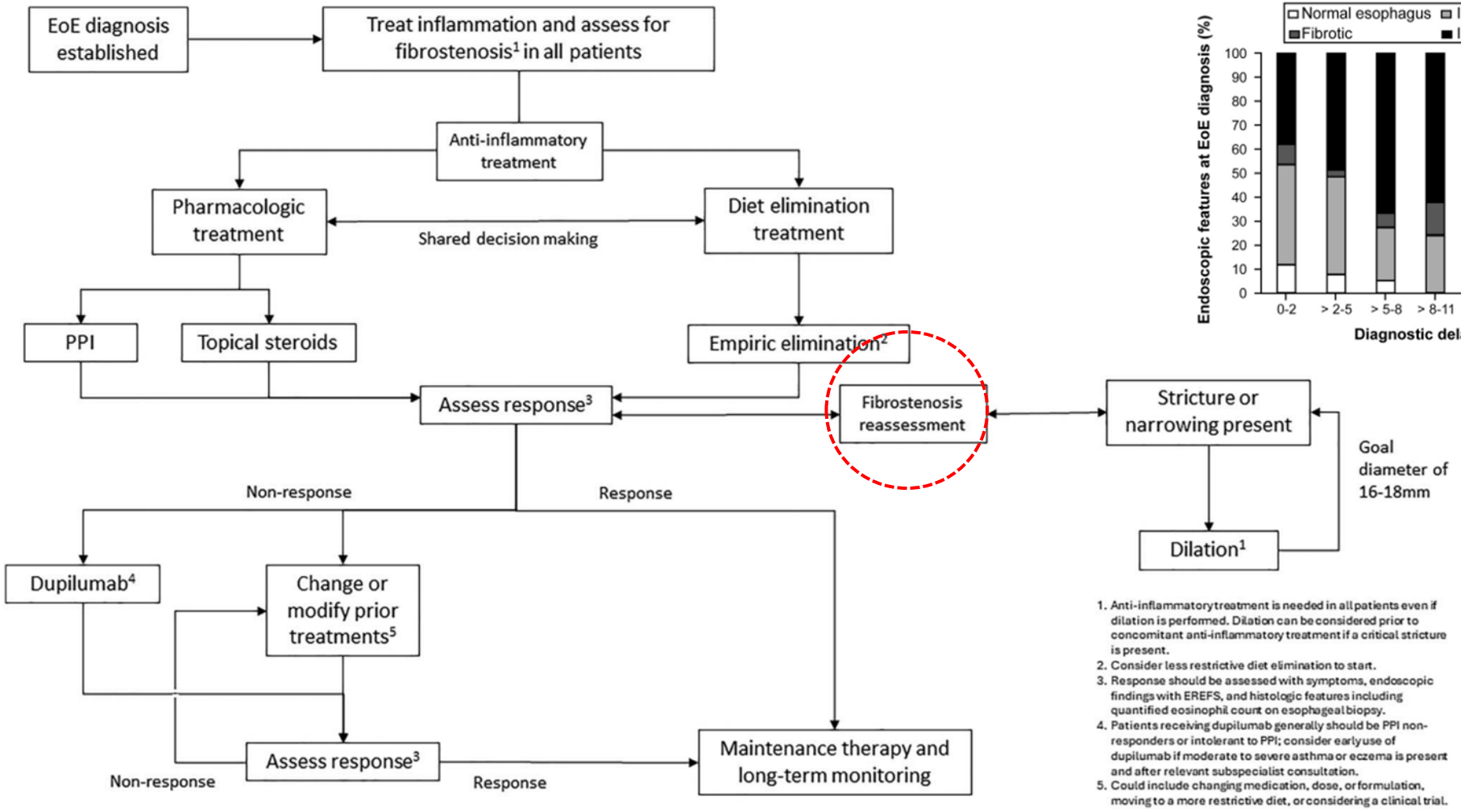
Findings:

- The Z line is measured at 39 cm
- A small hiatus hernia was noted in lower oesophagus, mild Schatzki ring at GOJ
- White plaques was found in the upper and mid eosophagus ? candidiasis – biopsies performed for histological examination.
- The rest of the oesophagus was otherwise normal – biopsies for mid and lower oesophagus (5cm above GOJ) was performed for evaluation of EoE
- The examination of the stomach was normal.
- The examined duodenum was normal.

Impression:	**Histology:** ***(Envoi Pathology)***
Small Hiatus Hernia with Mild Schatzki Ring	1. Mid oesophagus: No specific abnormality 2. Lower oesophagus: No specific abnormality 3. Lower oesophagus white plaque: Candidiasis
Oeosphageal Candidiasis	

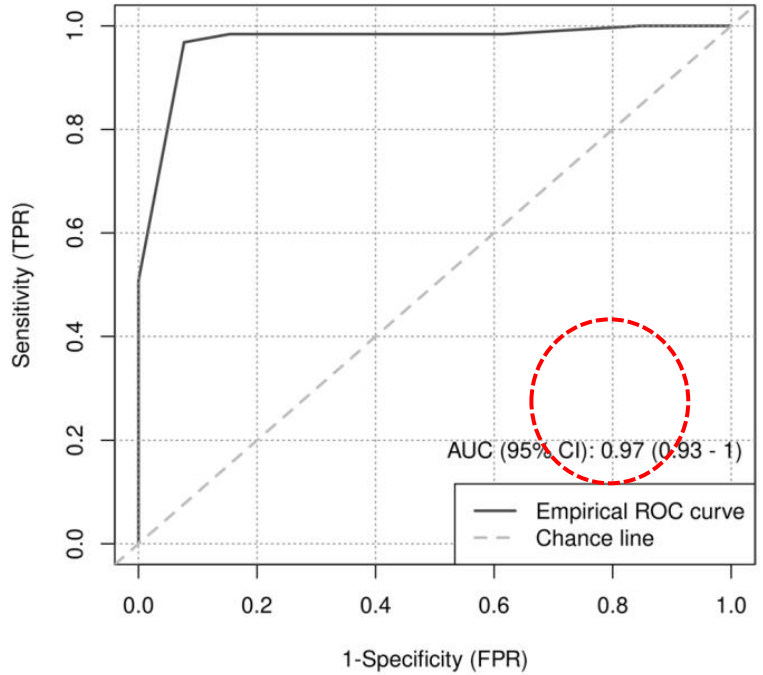
- Ascertained administration, PBS re-app, Amphotericin
- IDA resolved: Hb 151 Ferritin 259

Suboptimal response: Fibrostenosis excluded?



1. Anti-inflammatory treatment is needed in all patients even if dilation is performed. Dilation can be considered prior to concomitant anti-inflammatory treatment if a critical stricture is present.
2. Consider less restrictive diet elimination to start.
3. Response should be assessed with symptoms, endoscopic findings with EREFS, and histologic features including quantified eosinophil count on esophageal biopsy.
4. Patients receiving dupilumab generally should be PPI non-responders or intolerant to PPI; consider early use of dupilumab if moderate to severe asthma or eczema is present and after relevant subspecialist consultation.
5. Could include changing medication, dose, or formulation, moving to a more restrictive diet, or considering a clinical trial.

An Esophageal Luminal Diameter of 16mm Predicts Dysphagia Resolution in Eosinophilic Esophagitis



ROC analysis of esophageal lumen diameter size that predicts dysphagia in patients with eosinophilic esophagitis in histologic remission with a stricture.

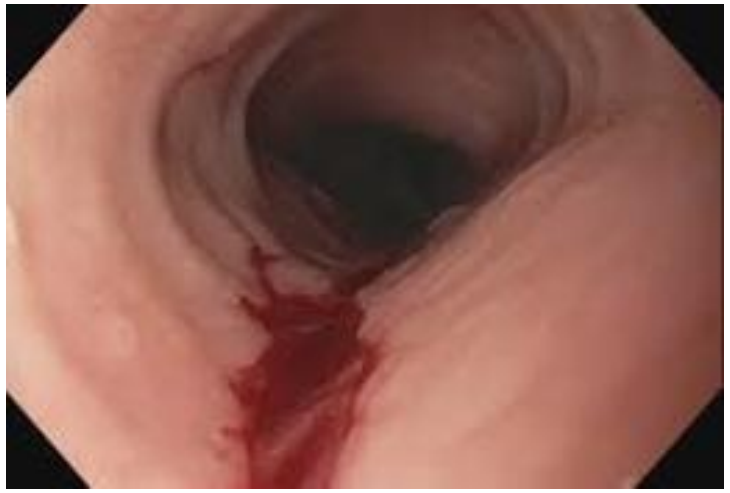
ELD of<16 mm was found to have a 96.8% sensitivity and 92.3% specificity with accuracy of 96.1% to predict dysphagia.

- N=289, single centre
- Majority of asymptomatic patients (92.3%) had an ELD≥16 mm.
- Of the 58 (76.3%) patients with stricture who underwent endoscopic dilation, luminal diameter prior to and post-dilation were **13.3±2.1 mm and 16.4±2.1 mm**, respectively.
- Dysphagia resolved in 84.5% of patients post dilation. All patients with resolution of dysphagia were dilated to a diameter of 15 mm or more

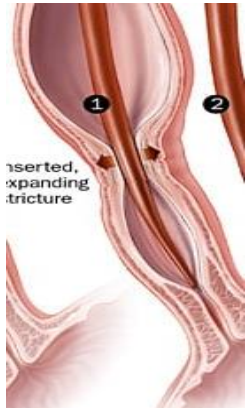
Beveridge: Digestive Diseases and Sciences (2025) 70:1824–1831

MR JR

- Relook Gastroscopy + Intent to Dilate: Sep 25



not actual patient



Findings:

- The Z line is measured at 40 cm
- The examination of the oesophagus was normal – no active endoscopic changes of eosinophilic oesophagitis
- Bougie Dilators with through the scope guidewire was introduced at 15, 16, and 18mm. Post dilation endoscopic examination showed no mucosal break at GOJ, but there was a superficial mucosal disruption at 15cm from the incisor in the upper oeosophagus.
- The examination of the stomach was normal.
- The examined duodenum was normal.

Impression:	**Histology:** *(Envoi Pathology)*
Dilation of Oesophagus 18mm – mucosal disruption at upper oeopshagus	No biopsy specimen taken
Known Esinophilic Oeosphagitis	

ACG Guidelines 2024 re: Dilation

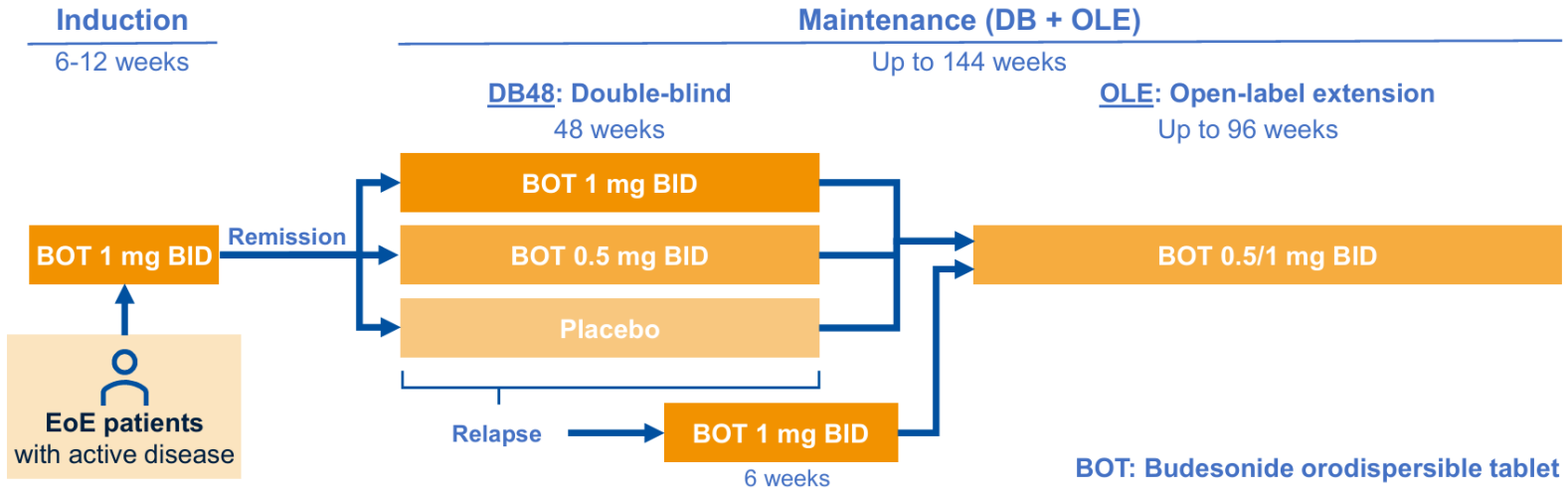
- High level suspicion for strictures/ narrowing in EoE, especially with dysphagia.
- Can be difficult to detect
- “Start low and go slow”
- Combine dilation with anti-inflammatory treatment

- Low Complication Rates :
- 2017 Meta-Analysis of 2034 dilations in 977 patients (37 studies):
- 0.033% perf per procedure (n=9)
- 0.689% admission
- No deaths

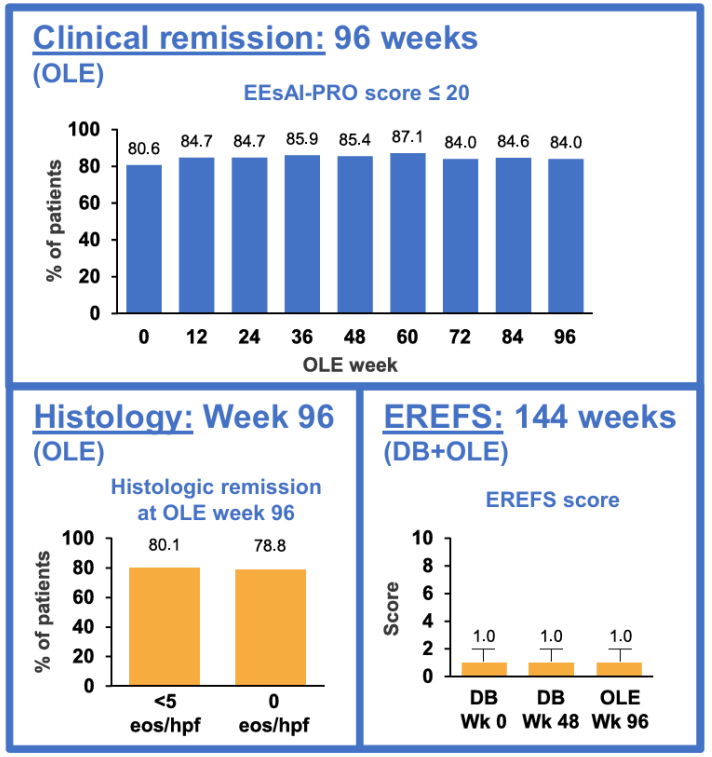
Dougherty: Gastrointest Endosc. 2017 October ; 86(4): 581–591

Long Term Efficacy (3y) of Budesonide Orodispersible tablets

Budesonide orodispersible tablets in eosinophilic esophagitis: open-label extension study up to 3 years



Budesonide orodispersible tablet therapy maintained clinical and histological remission of EoE in the great majority of patients for up to 96 weeks, and for up to 3 years in patients with uninterrupted BOT therapy



BID, twice daily; BOT, budesonide orodispersible tablet; DB, double-blind; EEsAI-PRO, EoE Symptom Activity Index Patient Reporte d Outcome; EoE, eosinophilic esophagitis; eos, eosinophils; EREFS, EoE endoscopic reference score; hpf, hi gh power field; OLE, open-label extension; Wk: week

Clinical Gastroenterology and Hepatology

Biedermann, Clinical Gastroenterology and Hepatology 2025

Long Term Safety (3y) of Budesonide Orodispersible tablets

Total (N=186; Total Person-years of exposure 320.9)

Localised Candidiasis (18.3%, n=34)

- Oesophageal (n=9), Oral (n=17); Oropharyngeal (n=17)
- None serious, majority mild intensity, all treated successfully

5 cases of Oesophageal Food impaction – 2 requiring endoscopy

Non-clinically relevant reduction in Cortisol (3.2%) – no signs of adrenal insufficiency

1 case of dysgeusia and depression; 2 cases of weight increase

Biedermann, Clinical Gastroenterology and Hepatology 2025

Non-response: What's on the horizon?

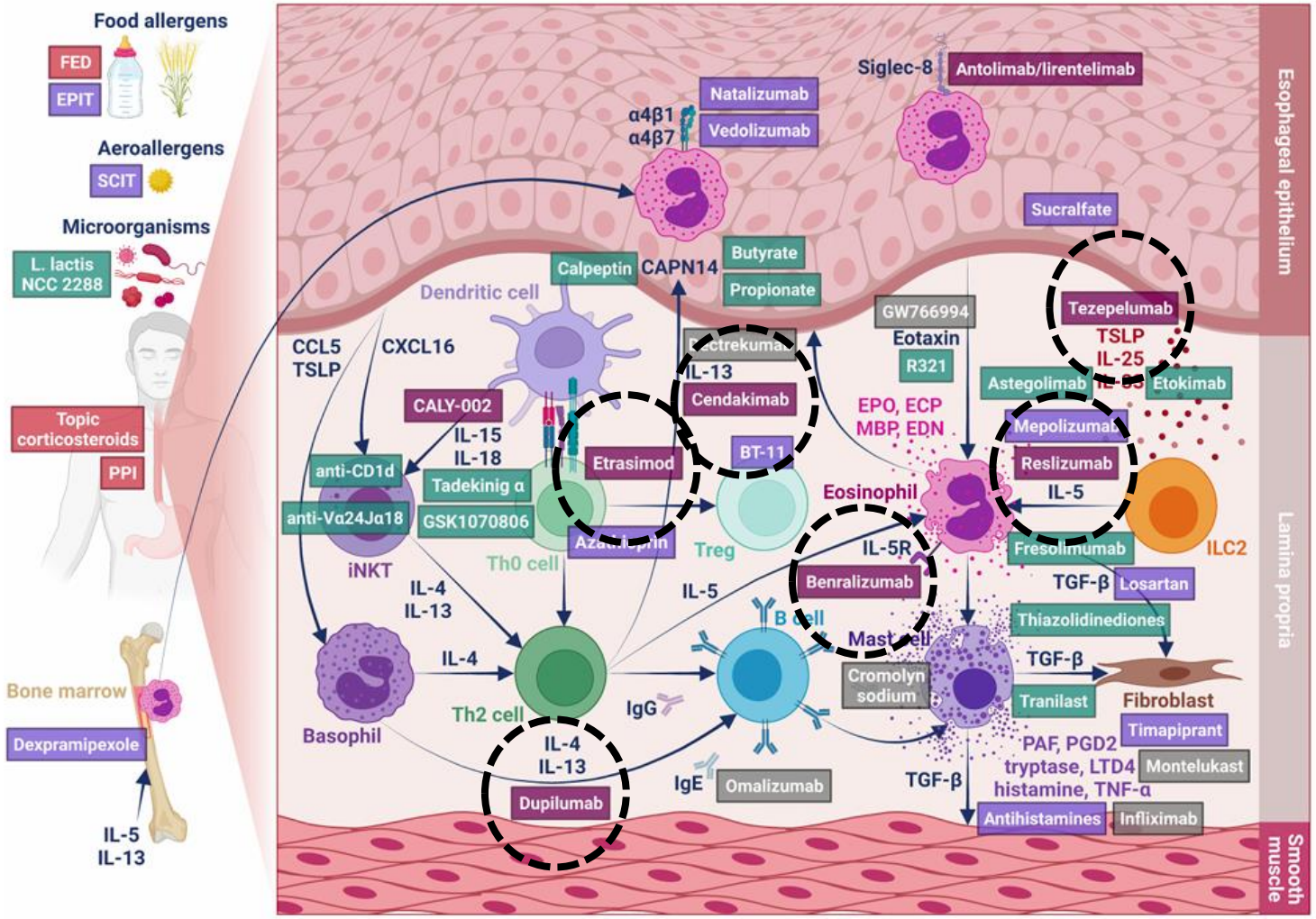
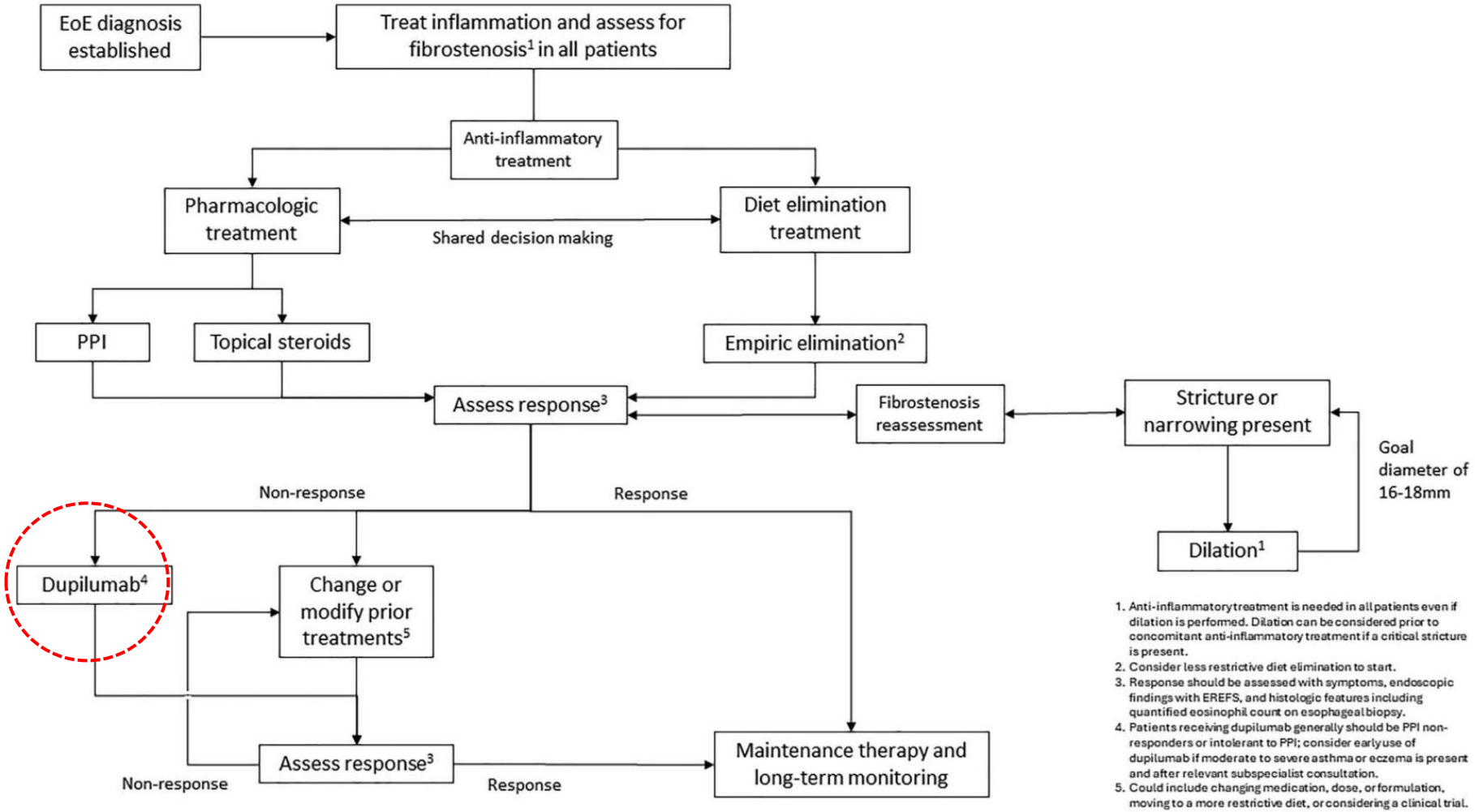


FIGURE 4 | Type 2 inflammation in EoE. The figure represents the involved cells and mediators and the therapeutic approaches described in the review. The drugs are colored as follows: Red tag: first-line therapy, Plum tag: orphan drugs, Lilac tag: drugs with reported results on human patients, Green tag: drugs without reported results on human patients, Gray tag: drugs that failed to obtain significant results on human patients.

Racca: Frontiers in Physiology
):https://doi.org/10.3389/fphys.2021.815842

Dellon: Am J Gastroenterol 2025;120:31–59

Non-response: USA



Non-response: Consider Dupilumab (Anti-IL4/IL13)

- PBS listed for: 1. Chronic Severe Atopic Dermatitis; 2. Uncontrolled severe asthma;
- **… NOT FOR EoE IN AUS**

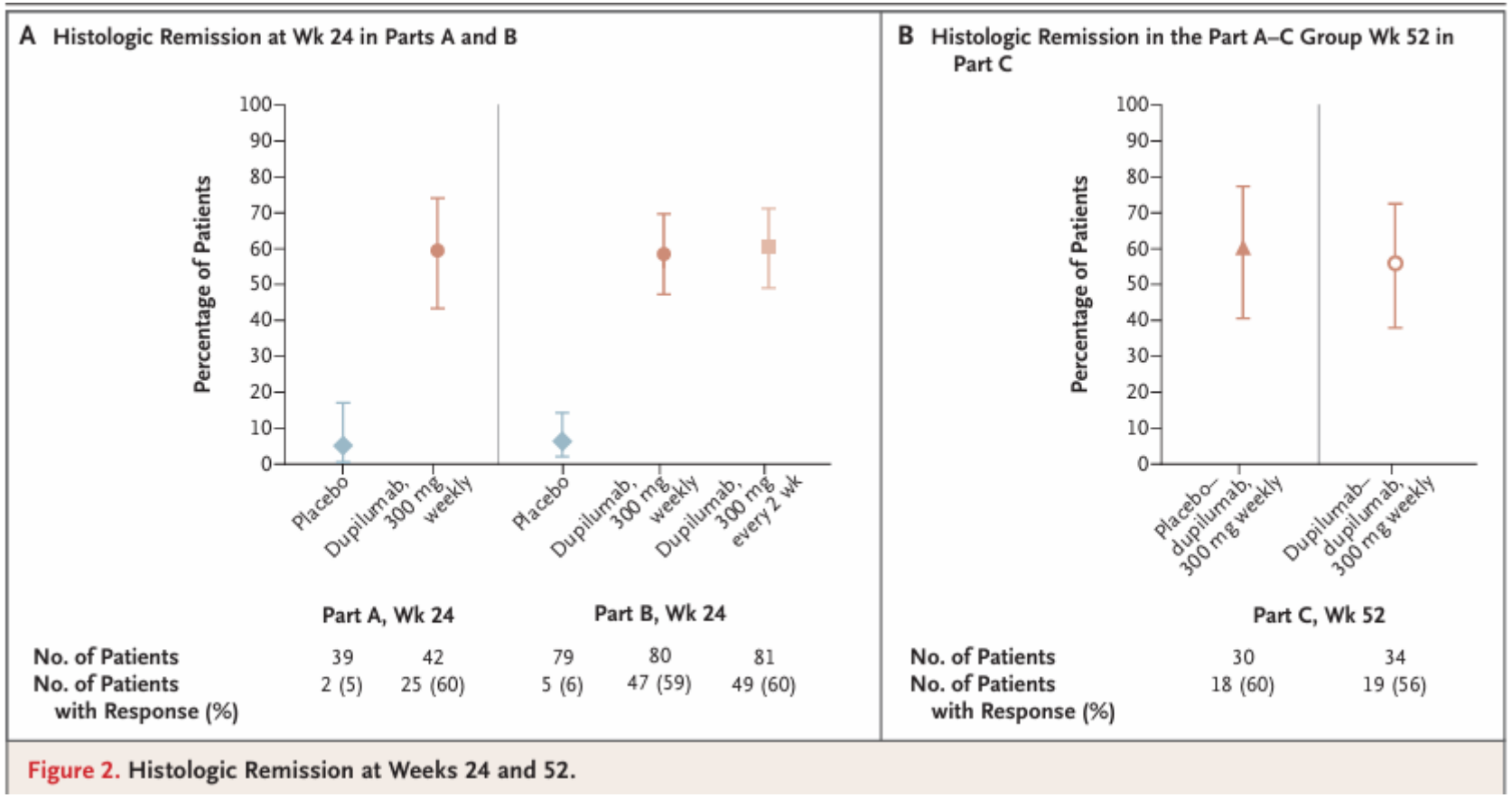


Figure 2. Histologic Remission at Weeks 24 and 52.

NEJM 2022: 3 Part, Phase 3 trial randomisation for Dupilumab vs Placebo

FDA: minimum 12yo +40kg weight

No risk for infection, No required screening for TB/HIV/Hepatitis

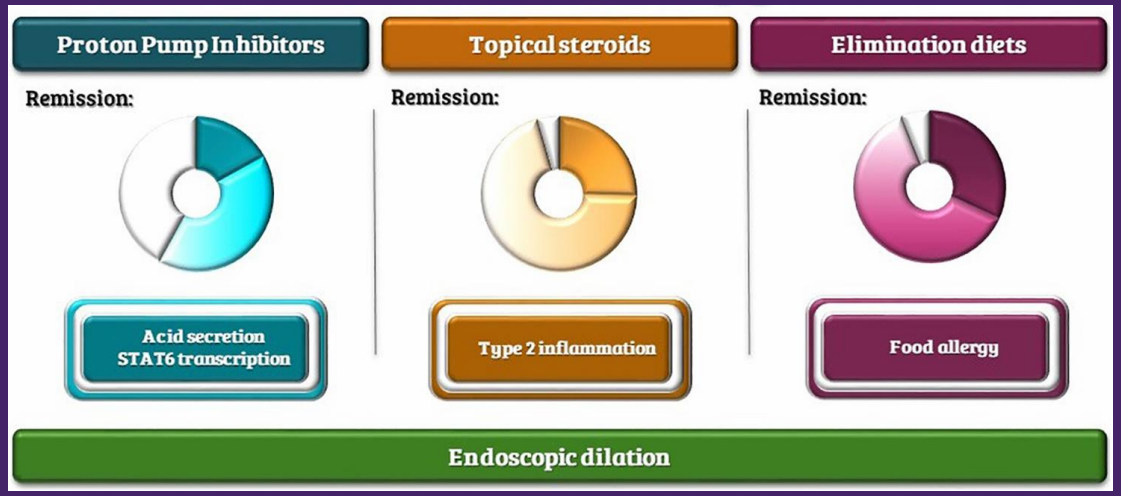
SE: injection site discomfort/erythema; arthralgias

60% histologic response rate despite refractory to all previous treatment and improvement in Esophageal diameter

Dellon: N Engl J Med 2022;387:2317-30.

Questions and Discussion

- Eosinophilic esophagitis (EoE) is a chronic allergen-induced, type 2 immune-mediated disease of the esophagus
- Treatment Logarithm as established currently:



Metro North Health | Queensland Government

NORTH STAR GASTROENTEROLOGY

.... And update on Mr JR

Community HealthPathways
Brisbane North
Lifestyle and Preventive Care
Medical
Assault or Abuse
Cardiology
Dermatology
Diabetes
Endocrinology
Gastroenterology
Acute Abdominal Pain in Adults
B12 Deficiency
Bowel Cancer Screening
Chronic Abdominal Pain in Adults
Bowel Polyp Surveillance
Coeliac Disease in Adults
Colorectal Symptoms
Constipation in Adults
Diarrhoea in Adults
Dysphagia
Managing Swallowing Difficulties
Dyspepsia and GORD
Enteral Feeding Tubes in Adults
Inflammatory Bowel Disease (IBD)
Medications - Inflammatory Bowel Disease
Irritable Bowel Syndrome (IBS)
Liver Conditions
Abnormal Liver Function Tests
Fatty Liver
Hepatitis B
Hepatitis C (HCV)
Hereditary Haemochromatosis and Raised Ferritin
Incidental Liver and Spleen Lesions
Gastroenterology Requests

Dysphagia

See also:

- Managing Swallowing Difficulties
- Foreign Bodies Ingested by Children
- Foreign Bodies Inhaled by Children

Red flags

- Total food obstruction with inability to swallow saliva
- Dysphagia increasing over a few weeks in an older person
- Associated weight loss

Background

About dysphagia

Assessment

Practice point

Prioritise referral of food obstructions

Do not delay specialist assessment of food obstructions by arranging investigations, as this increases the risk of aspiration and oesophageal perforation.

1. Exclude acute obstruction:
   - Determine the cause of the obstruction, e.g. food bolus, foreign body such as chicken or fish bone.
   - Determine whether the patient can swallow saliva. If not, this is a total obstruction which requires urgent transport to hospital for endoscopic removal of food bolus.
   - Do not arrange X-ray – it is not useful and may delay specialist assessment and treatment.
2. Take a history – Ask about:
   - symptoms.
   - smoking history, alcohol, gastro-oesophageal reflux (GORD).
   - medications, e.g. dopamine agonists, anticholinergics, bisphosphonates.
   - medical history.
3. Assess for risk factors and symptoms of head and neck cancers.

Queensland Government | Smart Referrals

Dr Fred Findacure

Patient name: Nicole METRONORTH DoB: 29 Sep 1977

Request information

Request date	21 Oct 2025
* Request type	New referral | Update | Continuation | Request for advice
* Reason for referral	(•) New condition requiring specialist consultation ( ) Deterioration in condition, recently discharged from outpatients < 12 months ( ) Other
* Priority	Urgent | Routine
* Provider	QHSR | Private

Consents

* Date patient consented to request	21 Oct 2025
* Patient is willing to have surgery if required?	Yes | No | Not applicable
* Condition and Specialty	Gastroenterology - Dysphagia (Gastroenterology) (Adult) — HealthPathways
Suitable for Telehealth?	Yes | No
* Are you the patient's usual GP?	Yes | No

Request recipient

* Service/Location	Please select
Specialist name	
Organisation details	

Gastroenterology	ROYAL BRISBANE & WOMEN'S HOSPITAL	6.4 km	
Gastroenterology	THE PRINCE CHARLES HOSPITAL	12.2 km	
Gastroenterology	REDCLIFFE HOSPITAL	31.5 km	
Gastroenterology	CABOOLTURE HOSPITAL	47.4 km	
Gastroenterology	PRINCESS	1.8 km	Out of catchment

Condition specific clinical information

Show emergency referral criteria

Minimum Referral Criteria

* Minimum referral criteria

[ ] Request clinical override of minimum referral criteria

Dysphagia/Odynophagia

Emergency department referrals

All urgent cases must be discussed with the on call Gastroenterology Registrar to obtain appropriate prioritisation and treatment. Contact through

- Royal Brisbane and Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Potentially life-threatening symptoms suggestive of:
  - acute upper GI tract bleeding
  - acute severe lower GI tract bleeding
  - oesophageal foreign bodies/food bolus
  - acute Severe Colitis*
  - bowel obstruction
  - abdominal sepsis
- Severe vomiting and/or diarrhoea with dehydration

*Acute severe colitis as defined by the Truelove and Witts criteria – all patients with ≥ 6 bloody bowel motions per 24 hours plus at least one of the following:

- temperature at presentation of > 37.8°C,
- pulse rate at presentation of > 90 bpm,
- haemoglobin at presentation of < 105 gm/l, CRP >30mg/dl at presentation (or ESR > 30 mm/hr)

Does your patient wish to be referred?

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1
Appointment within 30 days is desirable
	• For optimal care, patients should be seen within 1 week:
	  ◦ suspected GI cancer on clinical examination or abnormal imaging
	  ◦ dysphagia with poor oral intake
	• Significant dysphagia

Category 2 Appointment within 90 days is desirable	• No category 2 criteria
Category 3 Appointment within 365 days is desirable	• No category 3 criteria

+ Other Gastroenterology conditions

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
Medical Objects ID: MQ40290004P
HealthLink EDI: qldmnhhs

Mail:
Metro North Central Patient Intake
Aspley Community Centre
776 Zillmere Road
ASPLEY QLD 4034

Health pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:
healthpathways@brisbanenorthphn.org.au

Login to Brisbane North Health Pathways:
brisbanenorth.healthpathwayscommunity.org

Locations

Caboolture Hospital
Redcliffe Hospital
Royal Brisbane and Women's Hospital
The Prince Charles Hospital

Resources

Specialists list
General referral criteria