Inside Out: Gastroenterology & Hepatology Workshop

Saturday 25 October 2025
Clinical Skills Development Service | RBWH

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An Australian Government Initiative

Queensland Government
Metro North Health

Inflammatory Bowel Disease

Dr Anthony Croft
Staff Specialist & Clinical Lead for IBD Clinical Trials
Gastroenterology | RBWH

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Inflammatory Bowel Disease in Primary Care 2025

Tony Croft

BSc(Hons)(Otago) MBBS MPhil(Qld) FRACP

Staff Specialist and Clinical Lead for IBD Clinical Trials

Dept of Gastroenterology and Hepatology

Royal Brisbane and Women's Hospital

Senior Lecturer

Faculty of Medicine

University of Queensland

Disclosures

DR FALK PHARMA FOR EDUCATIONAL ASSISTANCE

ACKNOWLEDGE DR IAN ARNOTT FOR HIS SLIDES

Talk outline

- Approach to the patient with diarrhoea in primary care
- Illustrative case vignettes of IBD in primary care
- Public IBD Referrals: useful details to include

Infection screen

- Acute onset diarrhoea +/- vomiting
- History important: **duration**, frequency, bloody stools, immunocompromise, antibiotic usage
- Bacterial, parasite multiplex PCR + Clostridoides difficile toxin +/- viral multiplex PCR
- *Blastocystis, Aeromonas* and *Dientamoeba* species PCR positives are only treated if there are persistent, troubling symptoms
- Rarely stool microscopy if worried about helminths or treat empirically

Faecal calprotectin

Makes up ~60% of the soluble protein in the cytsol of neutrophils

Resistant to enzymatic degradation stable at room temperature for days

The strength of this test in primary and secondary care is the exclusion of an inflammatory (organic) cause of symptoms allowing for a positive diagnosis of a DGBI in the correct clinical context

Great for monitoring most types of IBD reducing the frequency of ileocolonoscopy and imaging

What are the changes?

From 1 November 2021 two new MBS items will be available to eligible patients, for the differential diagnosis of IBS and IBD. FC testing has shown improved diagnostic performance (sensitivity and specificity), while being safer and significantly cheaper than endoscopy/biopsy. The two new items include:

- A new MBS item 66522 for FC testing of patients with gastrointestinal symptoms suggestive of inflammatory or functional bowel disease presenting to a Medical Practitioner. These patients must:
    - have been experiencing symptoms suggestive of inflammatory or functional bowel disease for more than 6-weeks;
    - not be older than 50 years of age;
    - have had infectious causes excluded;
    - have a low likelihood of malignancy; and
    - must not be presenting with any clinical alarms (these include but are not limited to unexplained weight loss, anaemia, melaena, rectal bleeding, diarrhoea, family history of colon cancer or IBD or coeliac disease).
- A new MBS item 66523 for FC testing of patients presenting to a Specialist Gastroenterologist, where the initial FC test (66522) was inconclusive (50-100 ug/g) and the Specialist feels an endoscopic examination is not initially warranted.

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/15620E8DE95B7539CA2587830079604F/$File/Factsheet-Faecal-Calprotectin-IBD.04.11.21.pdf

New item descriptor (to take effect 1 November 2025)

Category 6 – Pathology Services

Group P2 - Chemical

66525

Faecal Calprotectin test for the management of a symptomatic patient with diagnosed inflammatory bowel disease, requested by, or on behalf of, a specialist or consultant physician.

Fee: $75.00 Benefit: 75% = $56.25 85% = $63.75

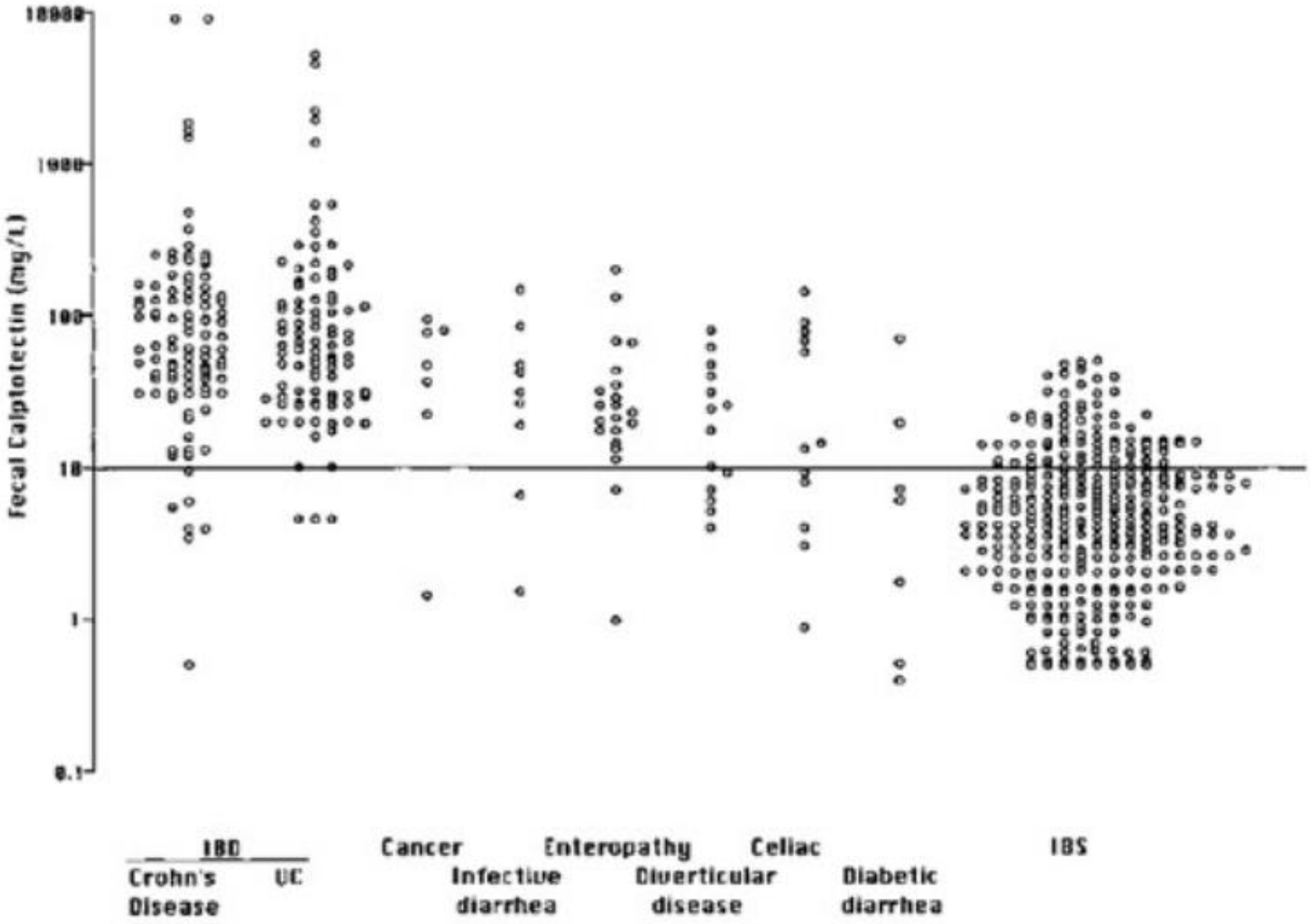
- Private Health Insurance Classification:
- Clinical category: Support list (pathology)
- Procedure type: Type C

https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/650f3eec0dfb990fca2569210006985 4/48c09ae96488a340ca258cba00162c2b/$FILE/Word%20Version%20-%20New%20Medicare%20Benefits%20Schedule%20item%20for%20faecal%20calprotectin%20testing.DOCX

Faecal calprotectin - Interpretation

- High values >1000ug/g: IBD flare, infectious gastroenteritis, pancreatitis, acute diverticulitis
- Moderate values 500-1000ug/g: IBD flare, COVID-19, influenza
- Low positive values 50-500ug/g: IBD flare, NSAID use, oesophagitis, gastritis, coeliac disease, colorectal cancer (only ~30% sensitive)
- Normal <50ug/g: Healthy gut, DGBI, IBD in deep remission

Organic v IBS



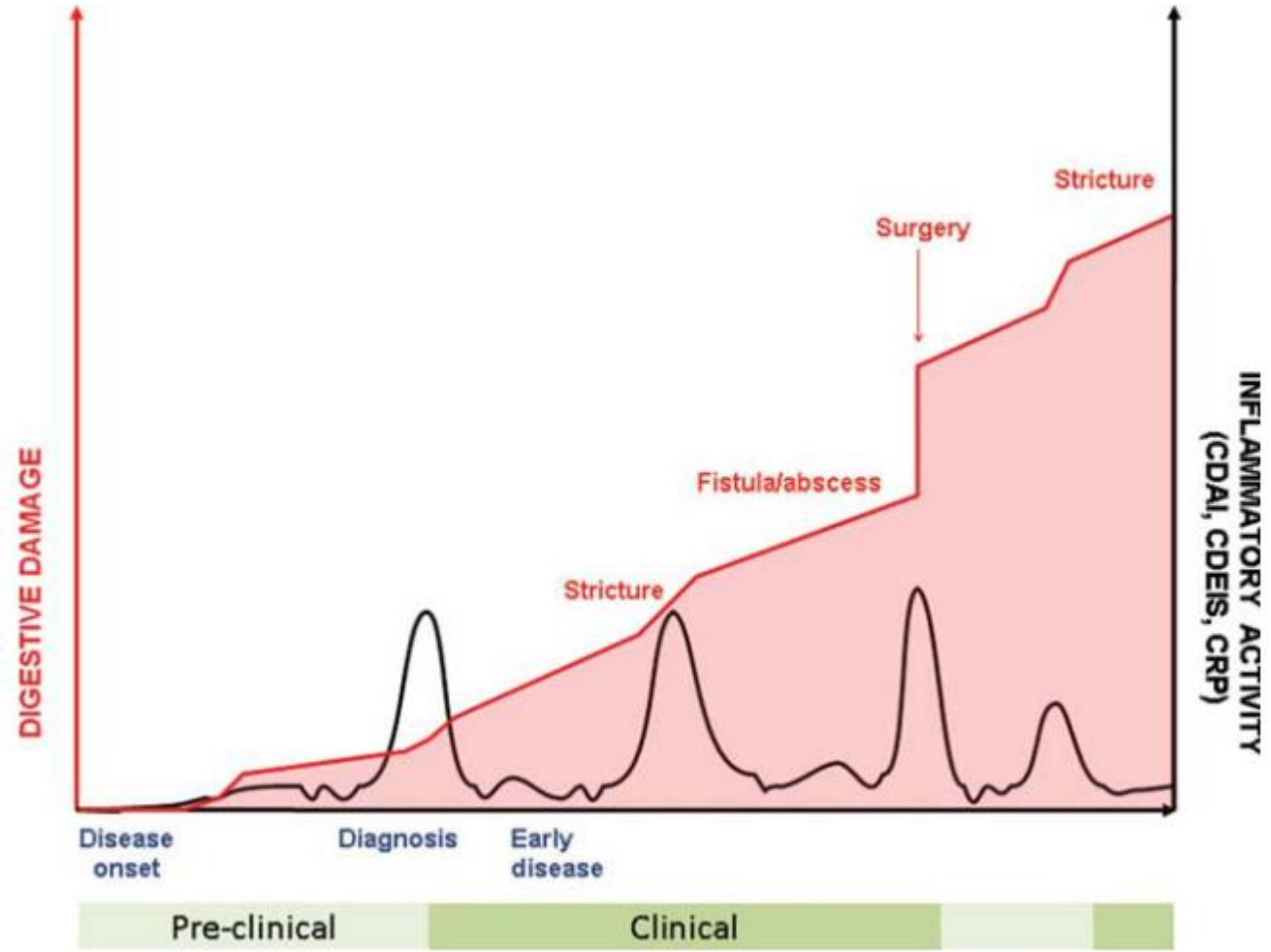
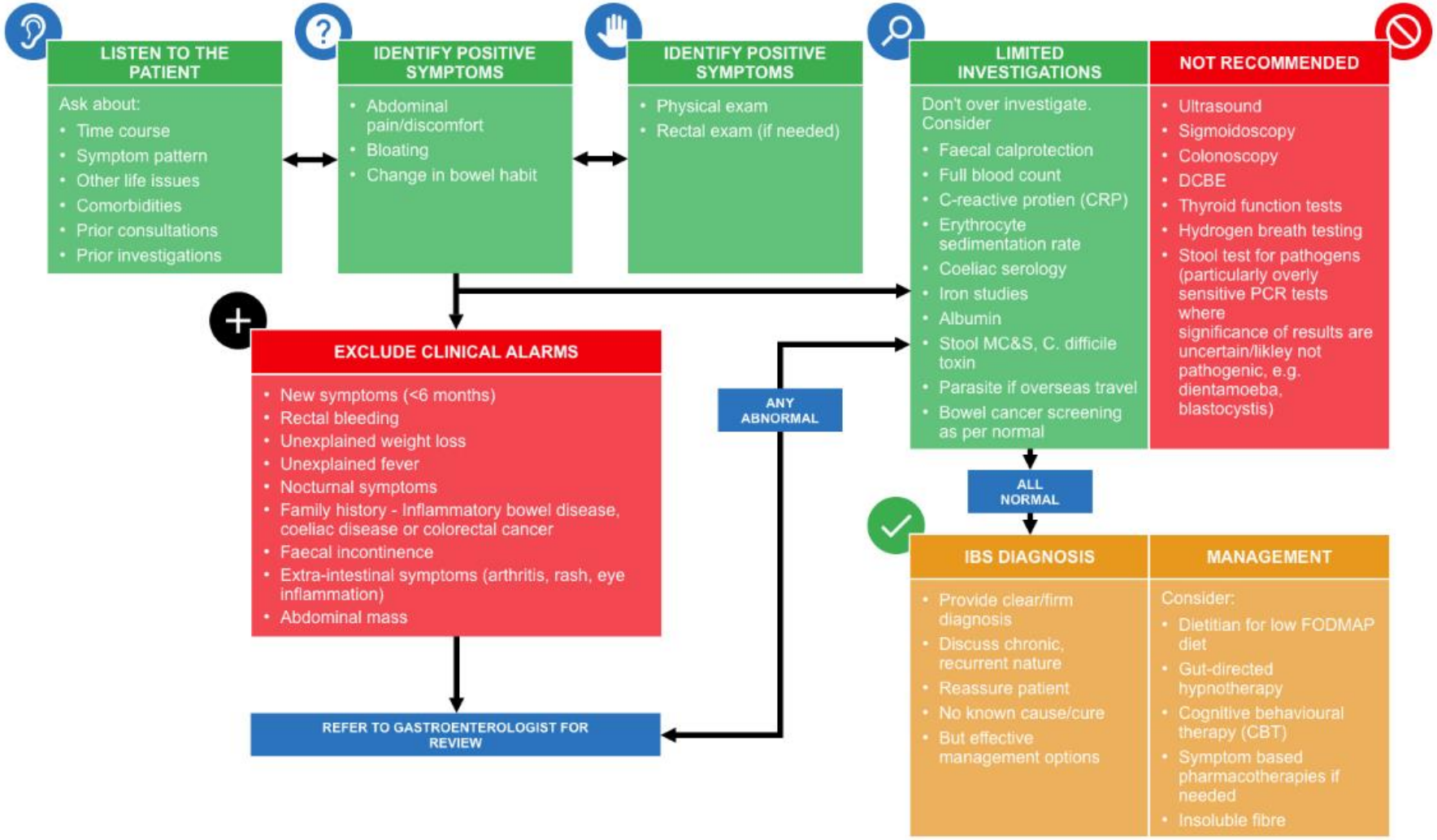


FIGURE 1. Progression of digestive damage and inflammatory activity in a theoretical patient with CD.

Pariente B, Cosnes J, Lémann M et al. Development of the Crohn's disease digestive damage score, the Lémann score. Inflamm Bowel Dis. 2011 Jun;17(6):1415-22. doi: 10.1002/ibd.21506. Epub 2010 Nov 28. PMID: 21560202; PMCID: PMC3116198.

GESA
Gastroenterological Society of Australia

IBS Diagnostic-Treatment Algorithm



ibs4gps.com

Back

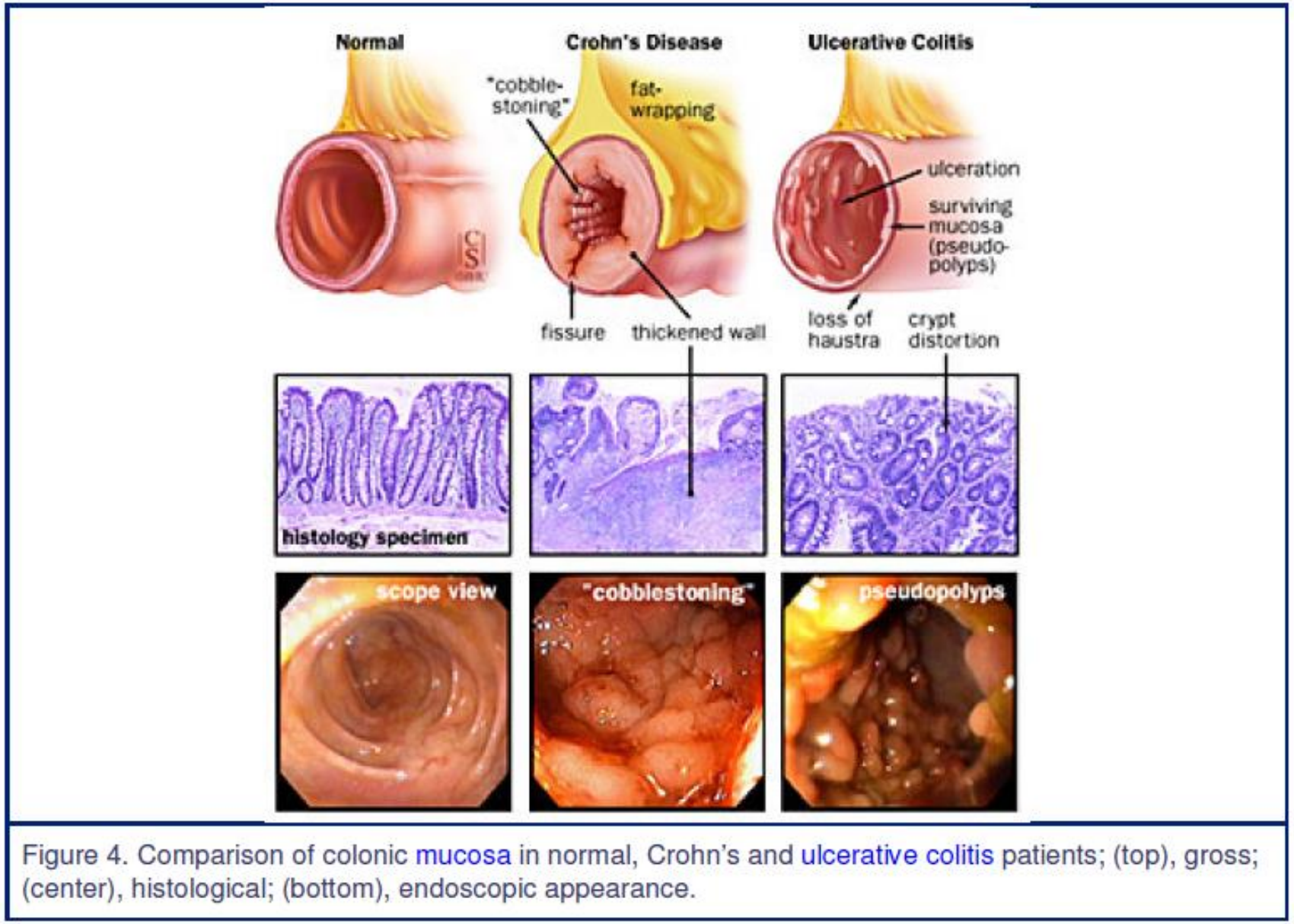


Figure 4. Comparison of colonic mucosa in normal, Crohn's and ulcerative colitis patients; (top), gross; (center), histological; (bottom), endoscopic appearance.

www.hopkinsmedicine.org/gastroenterology_hepatology/_docs/_pdfs/small_large_intestine/ulcerative_colitis.pdf

Case 1

- 31F south Asian presents to GP with one week of haematochezia
- 6-7 BM/24 hours
- Arranged blood and stool tests and abdominal US, for repeat appointment in 5 days

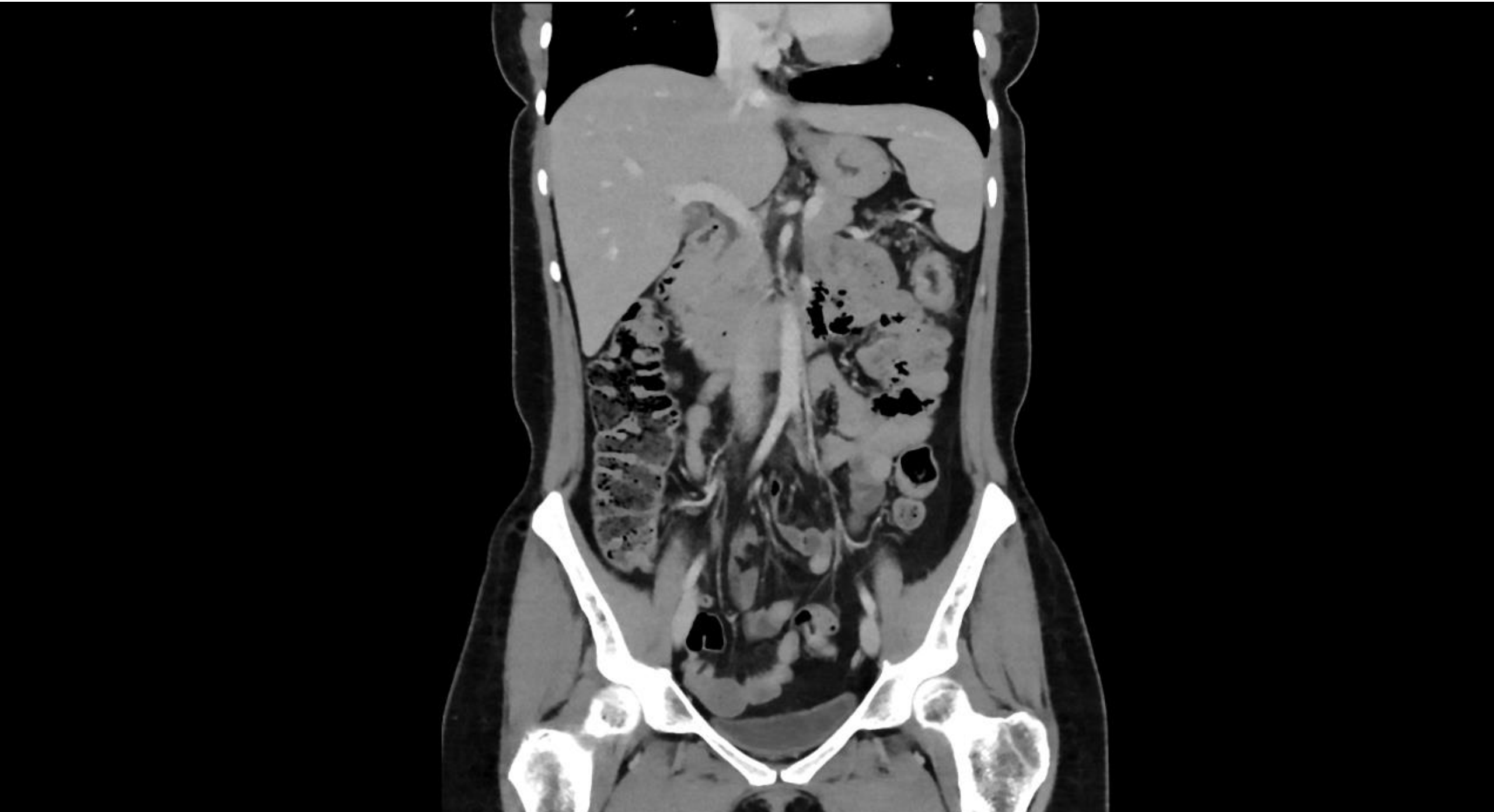
- Presented instead to ED after 5 days
- Tachycardic on arrival but now HR 80, afebrile
- FBC and CHEM20 normal, 70 leuks in urine

- Imp: infective gastroenteritis (gastrointestinal haemorrhage)
- Plan: follow up with GP to chase results, commence trimethoprim

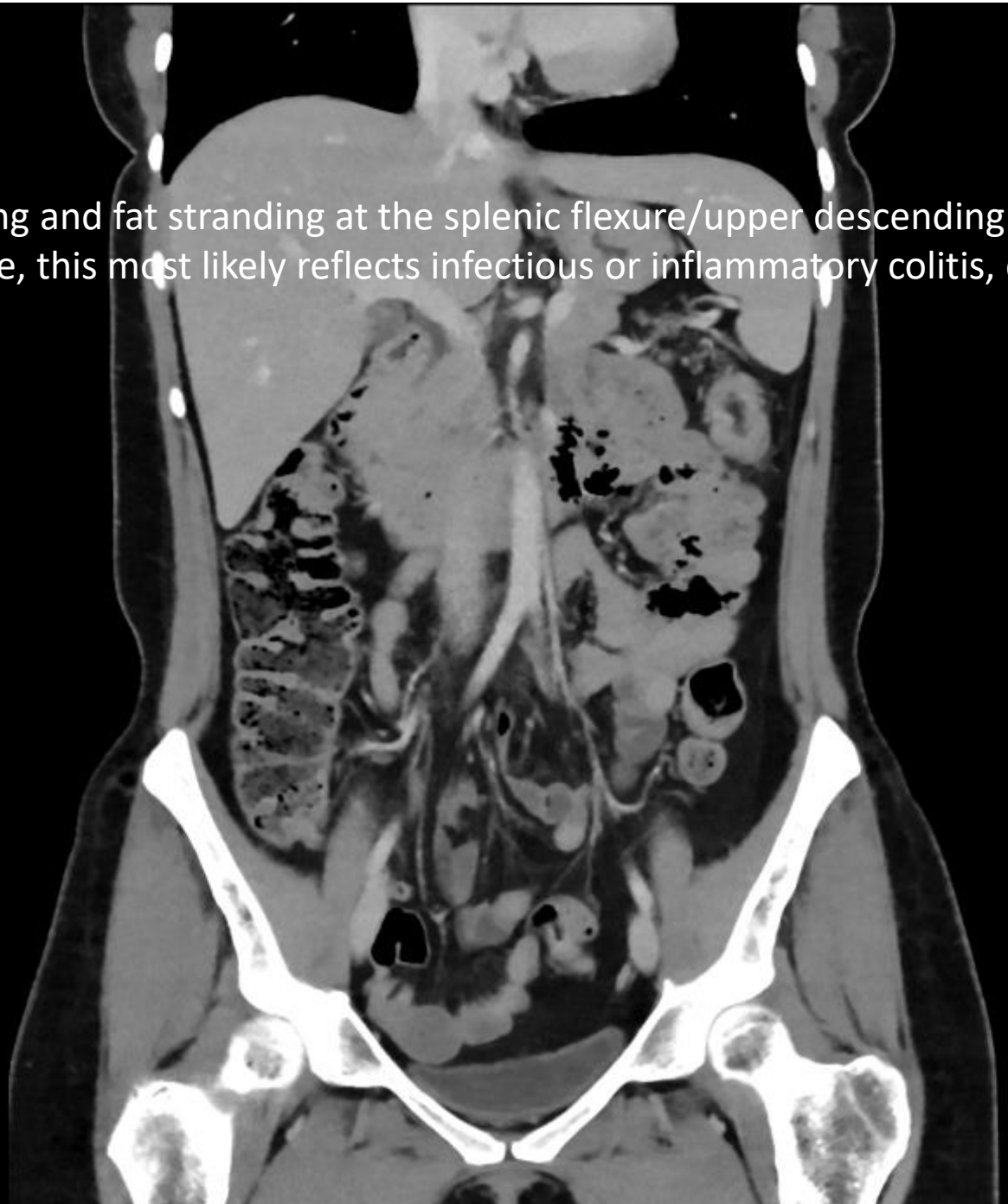
Case 1

- Next day: Represents to ED with letter from GP: “Please kindly review and assess for consideration of gastroenterology and surgical review with concern for ?de novo presentation for inflammatory bowel disease”,
- Seen by ED intern with senior input

- 2/52 of haematochezia
- 8-10 BM/24 hours
- Reperformed abdominal and PR exam
- Formal urine had returned with >500 leukocytes and *Candida* species
- D/W ED senior, GE fellow contacted: ?diverticulitis, for CT



Short segment of mural thickening and fat stranding at the splenic flexure/upper descending colon with prominent adjacent LNs. In a patient this age, this most likely reflects infectious or inflammatory colitis, colonoscopy advised



Case 1

- Haemoglobin 135
- Albumin 39
- CRP 12
- ESR 35
- Faecal calprotectin 1400

- Rediscussed with GE Fellow:
- For D/C home with augmentin DF, Cat 1 outpatient colonoscopy

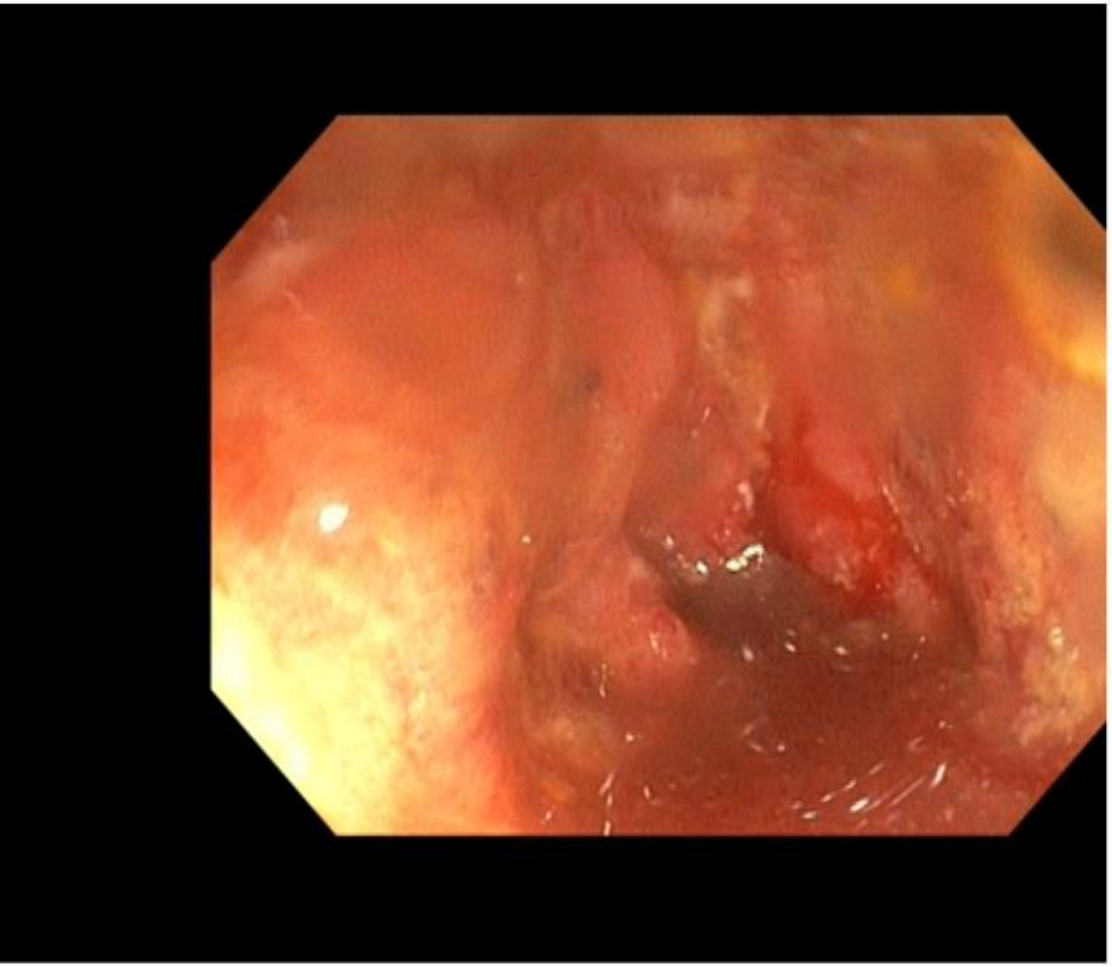
Case 1

- Four days later represented to ED
- Triaged as Cat 3
- Did not wait
- GP referral received by RBWH IBD service and actioned on the same day

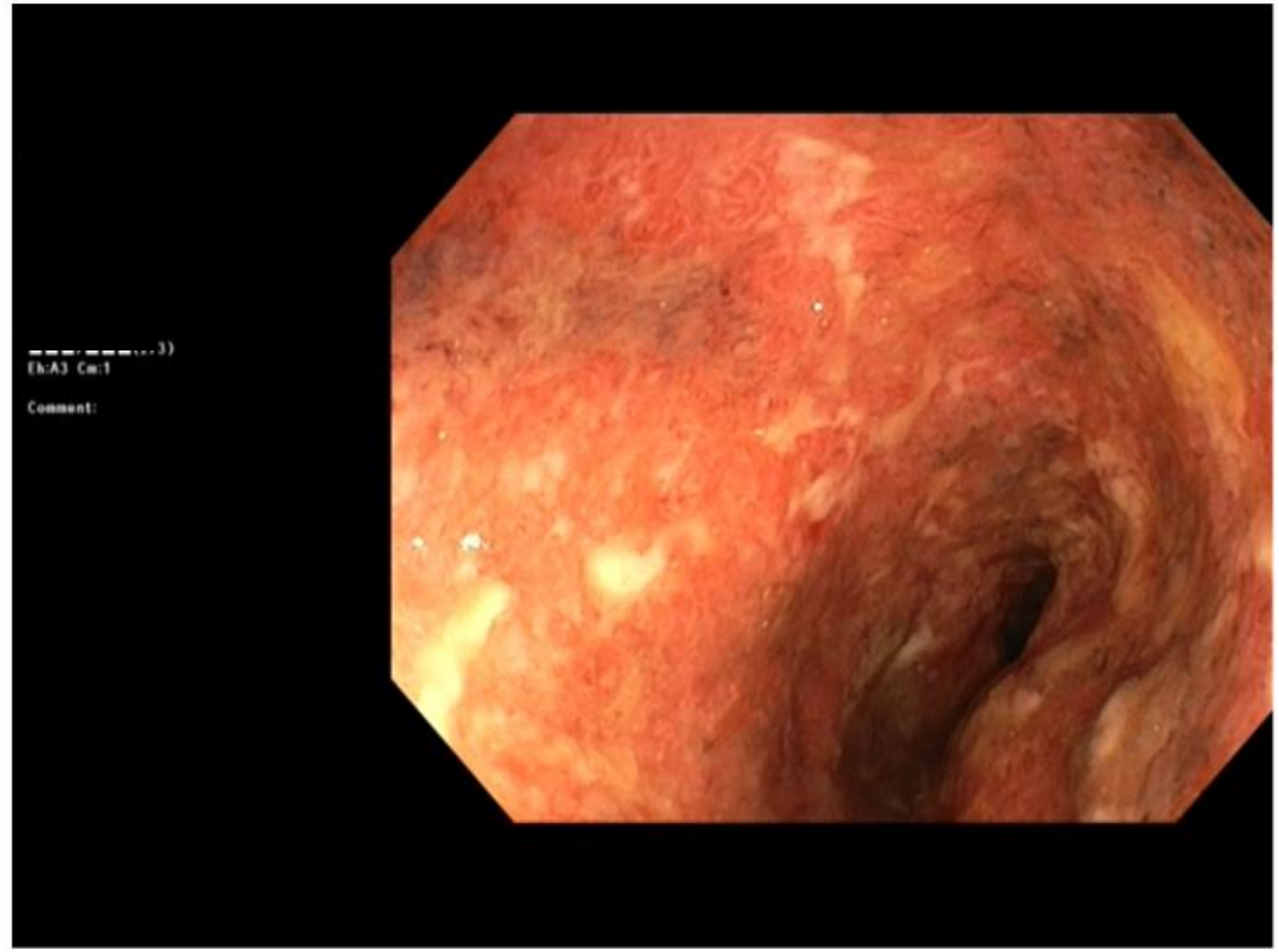
- Following day represented to ED
- Significant abdominal pain, chest pain and large PR blood loss, BM to 12 per 24 hours
- Triaged as a Cat 2
- IV hydrocortisone commenced

Case 1

- Haemoglobin 146
- Albumin 40
- CRP 75
- ESR 30



Sigmoid Colon



3 Sigmoid Colon

Case 1

- Histopathology report:

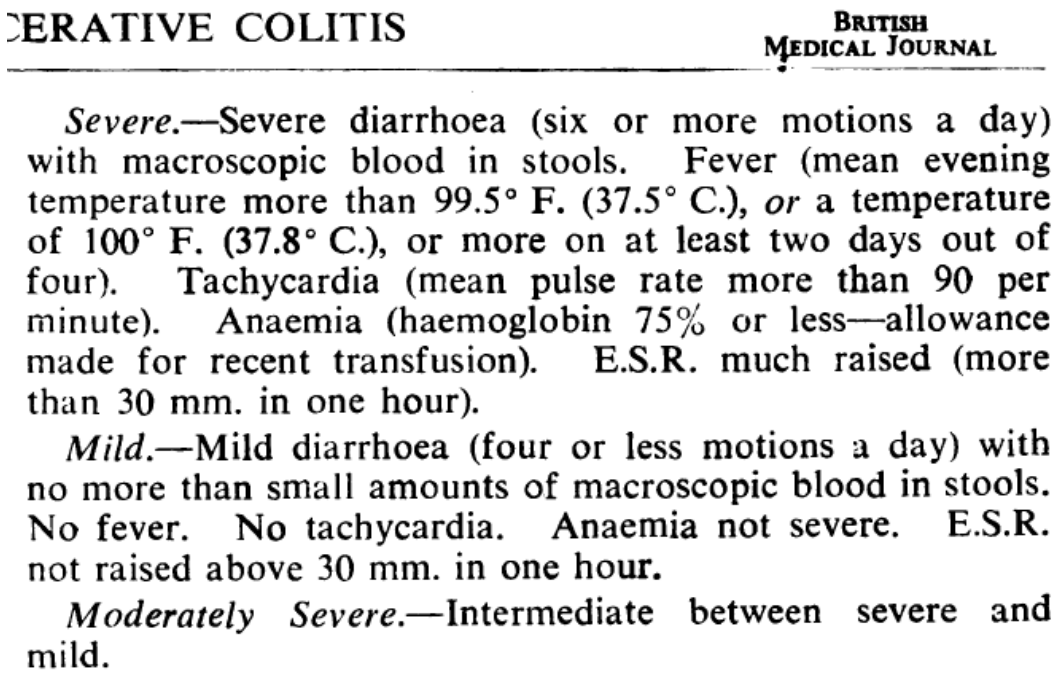
- *The tissue reaction of the colitis would support a clinical diagnosis of treated ulcerative colitis. The histologic differential diagnosis of features present would also include Crohn's colitis. There is no dysplasia.*

Case 1

- What is the diagnosis?

Case 1: What is the diagnosis?

- Truelove and Witts criteria for ASUC



CERATIVE COLITIS — BRITISH MEDICAL JOURNAL

Severe.—Severe diarrhoea (six or more motions a day) with macroscopic blood in stools. Fever (mean evening temperature more than 99.5° F. (37.5° C.), *or* a temperature of 100° F. (37.8° C.), or more on at least two days out of four). Tachycardia (mean pulse rate more than 90 per minute). Anaemia (haemoglobin 75% or less—allowance made for recent transfusion). E.S.R. much raised (more than 30 mm. in one hour).

Mild.—Mild diarrhoea (four or less motions a day) with no more than small amounts of macroscopic blood in stools. No fever. No tachycardia. Anaemia not severe. E.S.R. not raised above 30 mm. in one hour.

Moderately Severe.—Intermediate between severe and mild.

Br Med J 1955;2:1041

Journal of Crohn's and Colitis, 2022, **16**, 1089–1096
https://doi.org/10.1093/ecco-jcc/jjac014
Advance access publication 11 February 2022
Original Article

Markers of Systemic Inflammation in Acute Attacks of Ulcerative Colitis: What Level of C-reactive Protein Constitutes Severe Colitis?

Anthony Croft,[a,b,c,*] **Anton Lord,**[b,d] **Graham Radford-Smith**[a,b,c]

[a]Department of Gastroenterology & Hepatology, Royal Brisbane and Women's Hospital, Brisbane, Australia
[b]QIMR-Berghofer Medical Research Institute, Brisbane, Australia
[c]Faculty of Medicine, University of Queensland, Brisbane, Australia
[d]Centre for Health Services Research, University of Queensland, Brisbane, Australia

***Corresponding author**: Anthony Croft, Department of Gastroenterology & Hepatology, Royal Brisbane and Women's Hospital Butterfield Street, Herston, QLD 4029, Australia. Tel.: +61 7 3646 8111; email: Anthony.Croft2@health.qld.gov.au

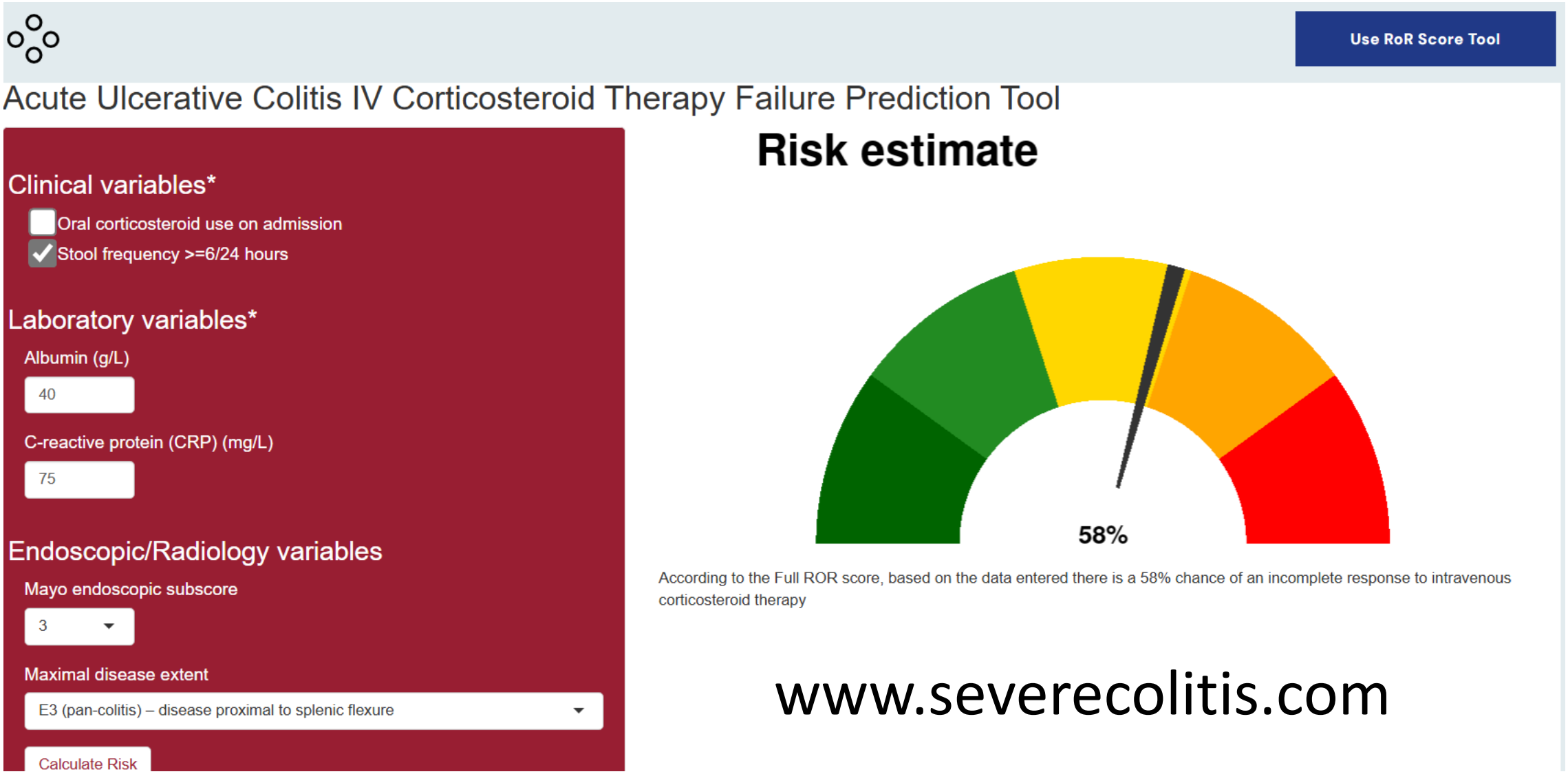
Abstract

Background and Aims: The erythrocyte sedimentation rate [ESR] as a component of the Truelove and Witts Criteria [TWC] is the traditional inflammatory marker used for the assessment of ulcerative colitis [UC] activity. However, the C-reactive protein [CRP] is preferentially used in contemporary clinical practice. We aimed to determine the equivalent CRP cut-off for an ESR of >30 mm/h in patients presenting with acute severe UC.

Methods: Clinical and pathological data were prospectively collected from 163 presentations of severe UC. A CRP cut-off corresponding to an ESR of >30 mm/h was determined using confusion matrices. A validation cohort of 128 presentations was prospectively collected and analysed.

Results: A CRP cut-off of ≥12 mg/L generated an 85% positive predictive value [PPV] with a sensitivity of 95% and an accuracy of 82% for having a paired ESR of >30 mm/h. There were no statistically significant differences between groups determined by the traditional ESR versus the new CRP-based criterion in the presenting faecal calprotectin, Mayo endoscopic subscore, or the rates of intravenous corticosteroid therapy failure and colectomy-by-discharge. Applying the CRP ≥12 mg/L criterion to a validation cohort of 128 presentations generated a PPV of 83% and a sensitivity of 94%.

Conclusions: The proposed CRP ≥12 mg/L cut-off is an inclusive, sensitive, and very practical alternative to ESR as part of the TWC for defining UC presentation severity. It demonstrated similar performance characteristics to the classical ESR criterion when used for the assessment of



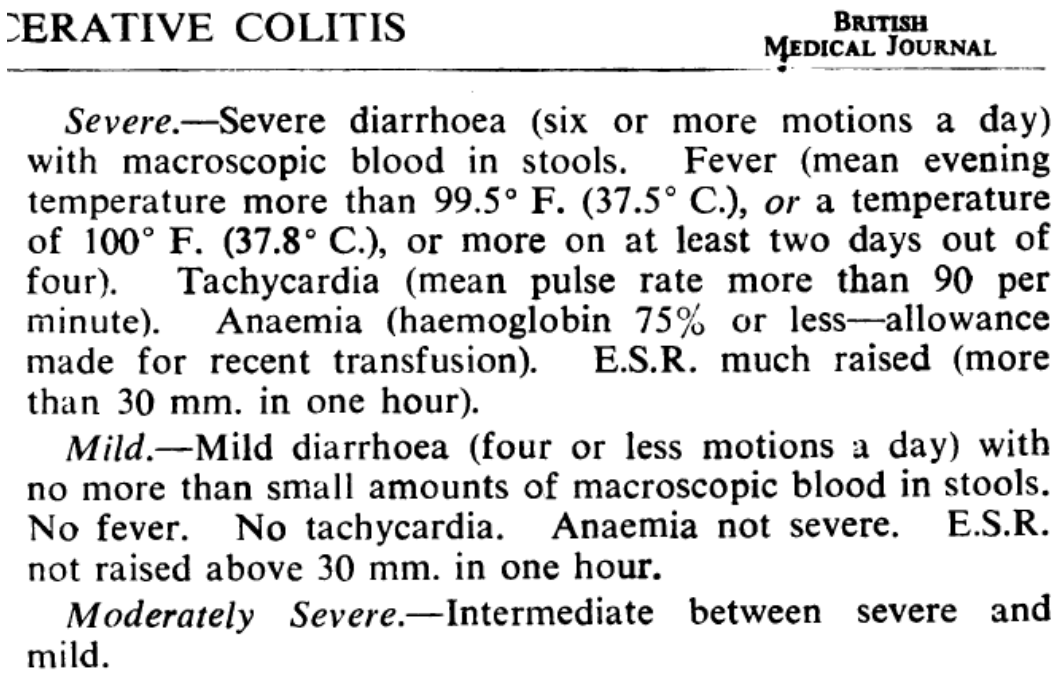
Croft A, Okano S, Hartel G, Lord A, Walker G, Tambakis G, et al. A personalised algorithm predicting the risk of intravenous corticosteroid failure in acute ulcerative colitis. *Aliment Pharmacol Ther*. 2024; 60: 921–933. **https://doi.org/10.1111/apt.18190**

Case 1: Practice points

- HISTORY: If the set up is right (>5 days diarrhoea in a younger person) think whether ASUC can be excluded on clinical grounds (examination).
- Do bloods (CRP and ESR!) a stool multiplex PCR for bacteria, parasites and C. difficile toxin
- Pick up the telephone and call the IBD/GE registrar (ideally during business hours)
- Send patient to ED with a letter of referral if you have a high suspicion of ASUC
- Beware the pregnant patient with persistent PR bleeding and faecal urgency
- ASUC is an emergency, delays to therapy are detrimental to clinical outcomes

Case 1: What is the diagnosis?

- Truelove and Witts criteria for ASUC



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Br Med J 1955;2:1041

Case 2

- A 28 year old female ileal Crohn's disease patient stable on 6-mercaptopurine 50mg/day for 3 years with therapeutic metabolites goes to fill her prescription
- She is asked by the pharmacist if she is pregnant and she relates that she is in the first trimester of her first pregnancy
- The community pharmacist refuses to fill the prescription and asks her to attend your practice to discuss next steps

Case 2: 6-mercaptopurine (Puri-Nethol)

Use in pregnancy.

(Category D)

Cytotoxic agents can produce spontaneous abortion, fetal loss and birth defects.

Substantial transplacental and transamniotic transmission of mercaptopurine monohydrate and its metabolites from the mother to the foetus have been shown to occur.

The use of mercaptopurine monohydrate should be avoided whenever possible during pregnancy, particularly during the first trimester. In any individual case the potential hazard to the foetus must be balanced against the expected benefit to the mother.

As with all cytotoxic chemotherapy, adequate contraceptive precautions should be advised if either partner is receiving Puri-Nethol tablets during treatment and for at least three months after receiving the last dose.

Puri-Nethol has been shown to be embryotoxic in rats at doses that are not toxic to the mother. It has also been proven to be embryolethal when administered at higher doses in the first half of the gestation period. The potential risk for humans is largely unknown.

Mercaptopurine monohydrate causes embryolethality and severe teratogenic effects in mice, rats, hamsters and rabbits at doses that are non-toxic to the mother. In all species, the degree of embryotoxicity and type of malformations is dependent on the dose and the stage of gestation at the time of administration.

Cholestasis of pregnancy has occasionally been reported in association with mercaptopurine therapy. Early diagnosis and discontinuation of mercaptopurine may minimise impact on the foetus. However, a careful assessment of benefit to the mother and impact on the foetus should be performed, if cholestasis of pregnancy is confirmed (see Section 4.4 Special Warnings and Precautions for Use).

Maternal exposure. Normal offspring have been born after mercaptopurine monohydrate therapy administered as a single chemotherapy agent during human pregnancy, particularly when given prior to conception or after the first trimester.

Abortions and prematurity have been reported after maternal exposure. Multiple congenital abnormalities have been reported following maternal mercaptopurine monohydrate treatment in combination with other chemotherapy agents.

eMIMSplus

Case 2

- Thoughts?

Case 2

- Thoughts?
- How do we know what to do?
  - PIANO registry
  - Australian guidelines

Laube R, Selinger CP, Seow CH, Christensen B, Flanagan E, Kennedy D, Mountifield R, Seeho S, Shand A, Williams AJ, Leong RW. Australian inflammatory bowel disease consensus statements for preconception, pregnancy and breast feeding. Gut. 2023 Jun;72(6):1040-1053. doi: 10.1136/gutjnl-2022-329304. Epub 2023 Mar 21. PMID: 36944479.

Case 2

- The clinical approach has changed because of increased experience and a recognition that unchecked inflammation also has teratogenic effects
- Women with active IBD during pregnancy have up to:
  - 3.6-fold risk of preterm birth (95%CI 1.14 to 11.36)
  - 2-fold risk of low birth weight (95%CI 0.37 to 11.35) compared with women with inactive IBD.
  - They have an increased risk of intrauterine growth restriction (3% vs 1%)
  - Increased rates of caesarean section (29–33% vs 16–22%)
  - Spontaneous miscarriage (13% vs 6.5%),44 and stillbirth compared with women without IBD.
- These risks appear proportional to the severity of disease activity during pregnancy. These effects highlight the importance of disease control before and during pregnancy.

Laube et al, *Gut* 2023 Jun;72(6):1040-1053

Case 2 Teaching points

So, potential risks posed by IBD medicines are thought to be less than the real risk posed to babies by unchecked inflammation

Notable exceptions include new small molecule drugs (JAK-I, S1P) and methotrexate, (allopurinol)

Ideally mucosal and histological healing is demonstrated prior to embarking on pregnancy

Case 3:

- 54M Recently diagnosed with extensive UC
- Commenced on mesalazine 4.8g daily orally
- Simple clinical colitis activity index = 0
- Letter from IBD clinic:
  - "Please arrange hepatitis B, varicella, pneumococcal and influenza vaccinations and a skin check."
- Is this otherwise well man immunosuppressed?

Symptom	Score
Bowel frequency (day)	
1-3	0
4-6	1
7-9	2
>9	3
Bowel frequency (night)	
1-3	1
4-6	2
Urgency of defecation	
Hurry	1
Immediately	2
Incontinence	3
Blood in stool	
Trace	1
Occasionally frank	2
Usually frank	3
General Well Being	
Very well	0
Slightly below par	1
Poor	2
Very poor	3
Terrible	4
Extracolonic features	1 point per manifestation

Walmsley RS, Ayres RCS, Pounder RE, Allan RN. A simple clinical colitis activity index. *Gut*. 1998; 43; 29-32

The current IBD advanced therapy PBS landscape October 2025

Crohn's disease adult - initial authority application form (PB087)

Use this form to apply for initial PBS-subsidised treatment with a biological medicine for adult patients with severe Crohn's disease.

How to use our forms

You must **download our forms and fill them in** so they are processed quickly. You can also electronically sign some of our forms. We have help available if you use assistive technology or need an interpreter.

You can **upload this form in HPOS**.

Biological medicine refers to:

- adalimumab
- infliximab
- upadacitinib
- ustekinumab
- vedolizumab.

Ulcerative colitis adult - initial authority application form (PB127)

Use this form to apply for initial PBS-subsidised treatment with a biological medicine for adult patients with moderate to severe ulcerative colitis or etrasimod for patients with moderate to severe ulcerative colitis.

How to use our forms

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- adalimumab
- etrasimod
- golimumab
- infliximab
- ozanimod
- tofacitinib
- upadacitinib
- ustekinumab
- vedolizumab.

The current IBD advanced therapy PBS landscape October 2025

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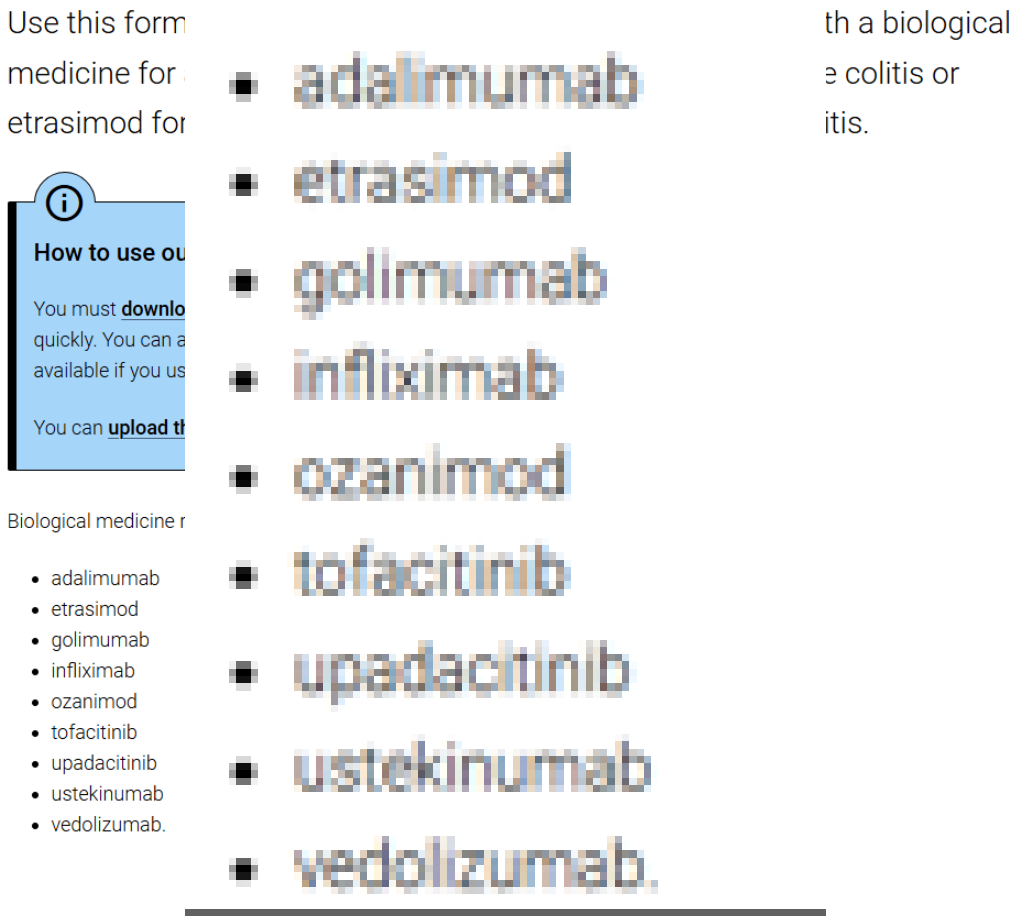

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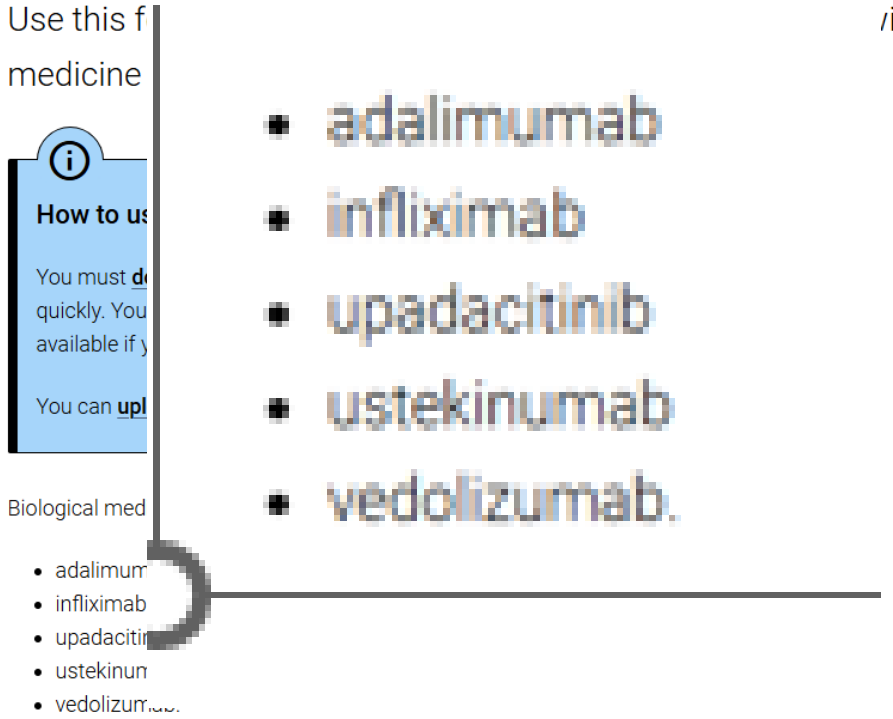

Table 1. IBD therapeutic agents and different degrees of immunosuppression.

Drugs	Degree of immunosuppression	Comment
Aminosalicylates		No systemic effects
Topical steroids		Systemic immunosuppression with oral topical steroids [oral budesonide] at doses >6 mg/day
Systemic steroids		Moderate-severe immunosuppression with doses of ≥20 mg for >2 weeks
Vedolizumab		Gut-selective treatment. No systemic effects, but increased risk for intestinal infections
Methotrexate		Moderate-severe immunosuppression with >20 mg per week [>0.4 mg/kg/week]. Lower doses can be considered as low immunosuppression
Azathioprine/6-MP		Moderate-severe immunosuppression with >3 mg/kg/day [AZA] or >1.5 mg/kg/day [6-MP]. Lower doses can be considered as low immunosuppression
Ciclosporin Tacrolimus Anti-TNF Tofacitinib Ustekinumab		There are different nuances within the group of moderate-severe immunosuppression that cannot be reflected by this simplified category. For instance, combination therapy [combination of any of these or combination with other immunosuppressive drugs such as AZA, methotrexate, or steroids] results in an increased risk for opportunistic infections. Immunosuppression of anti-TNF is probably higher compared with ustekinumab and tofacitinib

IBD, inflammatory bowel disease; 6-MP, 6-mercaptopurine; TNF,tumour necrosis factor; AZA, azathioprine.
Simplified degree of immunosuppression [the table helps to decide if live vaccines can be administered safely]:
No:

Selective:

Low:

Moderate-severe:

T Kucharzik, P Ellul, T Greuter, et al, on behalf of the European Crohn's and Colitis Organisation [ECCO], ECCO Guidelines on the Prevention, Diagnosis, and Management of Infections in Inflammatory Bowel Disease, *Journal of Crohn's and Colitis*, Volume 15, Issue 6, June 2021, Pages 879–913

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Occasionally frank	2
Usually frank	3
General Well Being	
Very well	0
Slightly below par	1
Poor	2
Very poor	3
Terrible	4
Extracolonic features	1 point per manifestation

- Is this otherwise well man immunosuppressed? No.
- What vaccinations can we offer him?

Walmsley RS, Ayres RCS, Pounder RE, Allan RN. A simple clinical colitis activity index. Gut. 1998; 43; 29-32

Table 5. Adult immunisation schedule for patients with IBD.

	Dosing, schedule, and remarks	Type of vaccine[a]	At diagnosis	At diagnosis and during follow-up	Strongly recommended before immunosuppressive treatment
IBD-specific vaccination programme					
Inactivated influenza [trivalent/quadrivalent or high dose]	Annual vaccination recommended for all patients on immunosuppressive therapy, according to national guidelines	Non-live		Yes	Yes
Zoster recombinant [RZV] [preferred]	For all patients ≥50 years. Consider in patients <50 years at increased risk of herpes zoster infection	Non-live			Yes
Zoster live [ZVL]	Use only if RZV is unavailable and patient is immunocompetent	Live-attenuated vaccine			Yes
Pneumococcal conjugate 13-valent [PCV13] and polysaccharide 23-valent [PPSV23]	Single dose of PCV13 followed by PPSV23 after 8 weeks, and a PPSV23 booster after 5 years. Additional PPSV23 booster according to national guidelines. If PPSV23 provided first, then administer a single dose of PCV13 after 1 year and a PPSV23 booster after 5 years. Additional PPSV23 booster according to national guidelines	Non-live	Yes	Yes	Yes
Hepatitis A [Hep A][b]	Consider hepatitis A vaccination. Schedule and dosage according to national guidelines	Non-live		Yes	
Human papillomavirus [HPV]	Two or three doses depending on age, for unvaccinated patients, both sexes	Non-live	Yes	Yes	
Hepatitis B [Hep B][c]	Three-dose series. Additional booster might be necessary according to level of seroprotection. Titres should be regularly checked	Non-live	Yes	Yes	Yes

Journal of Crohn's and Colitis, Volume 15, Issue 6, June 2021, Pages 879–913

Routine vaccination programme					
Tetanus, diphtheria, pertussis [Tdap or Td]	If previously immunised, single dose of Tdap, then Td or Tdap every 10 years according to national guidelines	Non-live	Yes	Yes	
Meningococcal vaccines[d]	For patients at high risk of invasive meningococcal disease. Schedule and dosage according to national guidelines	Non-live	Yes	Yes	
Measles, mumps, rubella [MMR]	Adults without evidence of immunity should receive 2 doses separated by at least 28 days	Live-attenuated vaccine	Yes		Yes
Varicella	Two doses 4–8 weeks apart only in patients with no history of chickenpox or shingles, no previous immunisation, and negative serology for varicella zoster	Live-attenuated vaccine	Yes		Yes
Poliomyelitis [inactivated parenteral poliovirus]	Schedule and dosage according to national guidelines	Non-live	Yes	Yes	
SARS-CoV-2	Schedule and dosage according to national guidelines	Non-live	Yes		Yes

Journal of Crohn's and Colitis, Volume 15, Issue 6, June 2021, Pages 879–913

Shared care of IBD patients

Vaccinations https://immunisationhandbook.health.gov.au/ SHINGRIX is on the NIP for immunosuppressed IBD patients

Blood tests FBC, ELFTs, CRP + 6 monthly micronutrients: B12, D, folate, Fe studies

- 5-ASA twice per year, Immunomodulator or advanced therapies 3-4 times per year

Iron infusions, B12 injections, vitamin D supplementation

Skin check annual or more frequently if indicated

Pap smear as per guidelines

DEXA as per guidelines

Smoking cessation

Mental health care plan

Contact in the event of flare for consideration of earlier IBD clinic visit +/- colonoscopy or flexible sigmoidoscopy for documentation of flare

Public IBD Referrals

- Please send to the MN catchment hospital for the patient's current home address (QAS postcode table)

- Please attach:
  - FBC, CHEM20 (ELFTs), CRP, [Fe studies, B12, coeliac serology]
  - Faecal calprotectin
  - (negative) stool infection screen
  - CT abdomen with contrast or other relevant imaging
  - Endoscopy and histology reports from St Elsewhere

Public IBD Referrals

- For more urgent matters call the relevant IBD/GE registrar during office hours or send the patient to the treating hospital ED with a letter of referral

Questions please

Inflammatory Bowel Disease (IBD)

Red flags

- Abscess
- Bowel perforation
- Bowel obstruction
- Systemic toxicity (e.g., toxic megacolon)

Background

About inflammatory bowel disease (IBD)

Practice point

Always consider IBD

Always consider IBD in the differential diagnosis of patients with persistent, unexplained abdominal pain or diarrhoea.

Assessment

1. Check for features of inflammatory bowel disease.
2. Check relevant history.
3. Consider differential diagnosis.
4. Perform a targeted examination – follow recommended protocol and consider a chaperone.
5. Consider and arrange investigations, and schedule follow-up appointment to review results:
   - Pathology
   - Imaging
6. Consider patients at increased risk of poor outcomes requiring early specialist management.

Management

1. If patient acutely unwell, or any red flags suspected, arrange emergency assessment.
2. If patient clinically stable and IBD suspected:
   - request non-acute gastroenterology assessment (mark as urgent if the patient is at increased risk of poor outcomes).
   - advise patient to seek medical attention if condition worsens while awaiting specialist assessment.
   - if patient moderately symptomatic, consider seeking gastroenterology advice regarding starting medications in primary care.
3. Once diagnosis is confirmed:

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 - Inflammatory bowel disease (Gastroenterolo 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
Inflammatory Bowel Disease	REDCLIFFE HOSPITAL	31.5 km
Gastroenterology	CABOOLTURE	47.4 km

Condition specific clinical information

Show emergency referral criteria

Minimum Referral Criteria

Show concerning features

* Minimum referral criteria

[ ] Suspected / un-diagnosed IBD without concerning features (see above)

[ ] Request clinical override of minimum referral criteria

Inflammatory bowel disease

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

- Previously diagnosed or suspected inflammatory bowel disease with any of the following **concerning features**
  - rectal bleeding
  - symptoms of bowel obstruction
  - fever and/or abdominal / perineal mass
  - significant bloody diarrhoea ≥6x/day
  - weight loss ≥5% of body weight in previous 6 months
  - significant abnormalities in investigations i.eHb <100 g/l, significant elevation of CRP or faecal calprotectin >200 mcg/g

Category 2
Appointment within 90 days is

- Stable previously diagnosed inflammatory bowel disease without **concerning features**

+ 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