TNW GP DIRECT ACCESS GUIDANCE FOR ULTRASOUND REFERRAL

Dear Colleagues,

Ultrasound can be very useful as a first line investigation; it is typically non-invasive and does not involve ionising radiation.

However, a significant number of requests are received where ultrasound is very unlikely to be helpful; this prolongs waiting times for all and can even delay some patients from being referred for a more appropriate test, thereby actually delaying their diagnosis.

If you aren't sure if ultrasound will change your patient's management please seek a second opinion from GP colleagues or our radiologists. Radiology advice and guidance is available at these addresses:

Newham: Radiology.gpsupport@nhs.net

Tower Hamlets: BartsHealth.imagingadviceandsupportrlh@nhs.net

Waltham Forest: bhnt.wxh.imagingctandmri@nhs.net

To support the radiologist/sonographer perform an optimal examination, it would be helpful to include the following details when appropriate.

- Presenting symptoms
- Requests should include a specific clinical question(s) to answer
- Findings on clinical examination
- Results of any other relevant investigations
- Relevant past history
- Differential diagnosis

Suspected diagnosis must be clearly stated, not implied by vague, non-specific terms such as 'pain query cause' or '? Pathology' etc

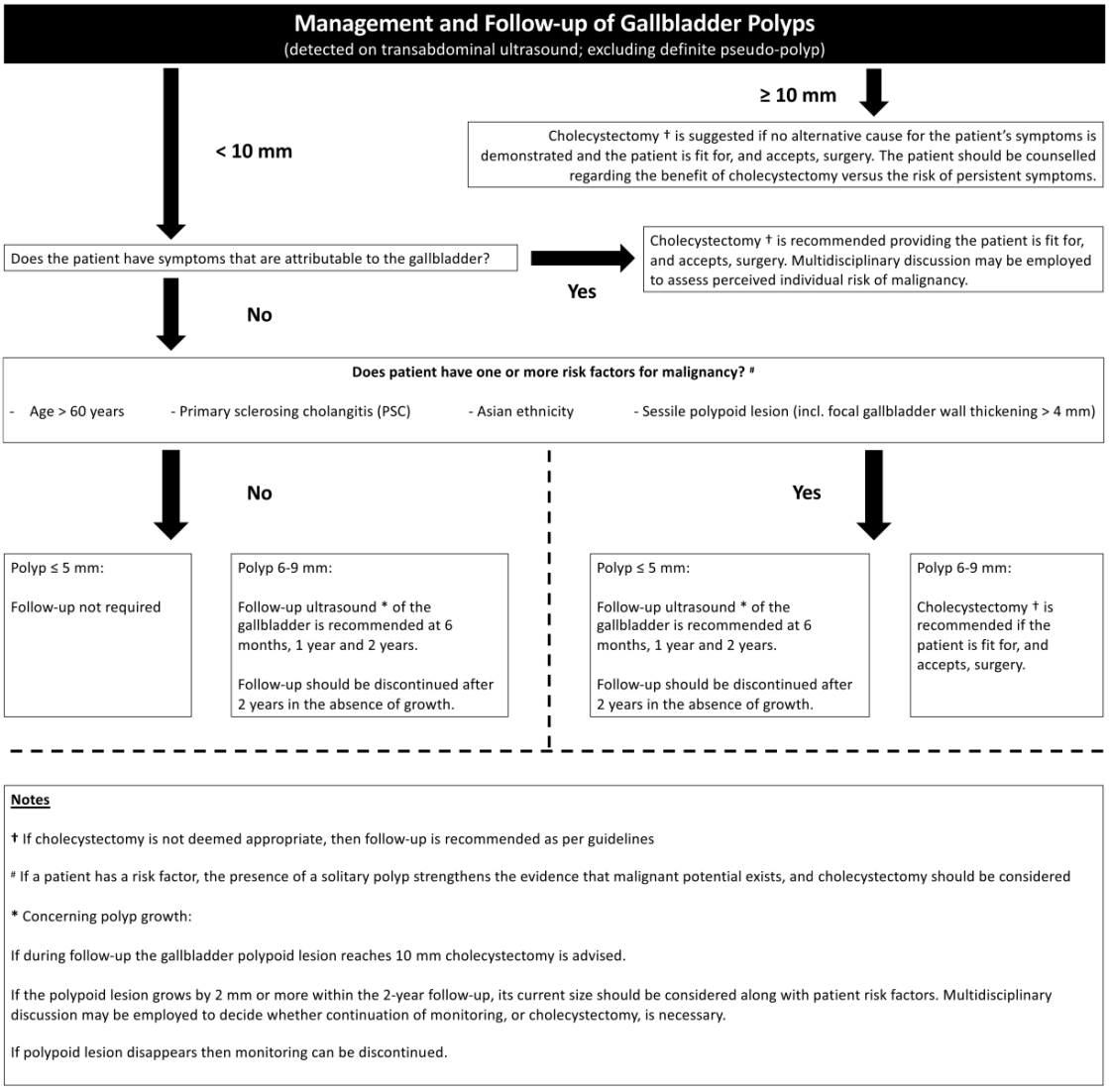
The aim is to make the best use of the resource available to us to provide the best outcome for your patient and not hinder good quality care for others - we appreciate your help.

This document has been compiled by Consultant Radiologists within Bart's Health Trust (in collaboration with consultant specialists in hepatology, urology, gynaecology and gastroenterology and primary care) to support good practice in vetting and justifying referrals for ultrasound examinations.

Please note if an US is not justified based on the following guidance then the request will be cancelled with the full reason and the name and email address of the consultant who vetted the request. This will enable a two way conversation to further discuss the scan request if necessary.

This document is current guidance and is subject to change. It will be regularly updated and redistributed as required and we welcome feedback from primary care colleagues.

Category	Can Request	Avoid request	Additional information/Advice
US Abdomen, US Liver			
Acute abdominal symptoms	Jaundice or raised bilirubin RUQ pain/ symptoms RUQ mass Suspected GB pathology -Bloating	-Chronic abdominal pain -Suspected occult malignancy / unexplained weight loss	Referral by 2 week wait pathway to upper GI or colorectal team Consider TVUS in female patients, to exclude ovarian cancer, if clinically appropriate or suspicious on TA Scan.
Abnromal LFTs	Persistently elevated LFTs for 3 to 6 months despite management of risk factors, request scan OR refer to hepatology		Specfic LFTs and risk factors should be included
? Pancreatic Pathology		? pancreatic lesion ? pancreatitis	**Requires speciality referral to upper GI 2 week pathway**
Spleen	? Splenomegaly		
Colonic symptoms	Irritable bowel syndrome Inflammatory bowel disease	Gastric/ colonic malignancy PR bleeding Diverticular disease	Suspected malignancy required referral by 2 week wait pathway to upper GI or colorectal teams
Hernia	If clinical doubt of hernia	Irreducible/ tender lumps/ if typical features if hernia	Surgical referral



Lumps and bumps			
Category	**Can Request**	**Avoid Request**	**Additional Information/Advice**
All superficial lumps	If features suggesting sarcoma ; >5cm, pain, rapid growth, overlying skin changes, fixed	Classical clinical benign lumps with no features of concern	
		Stable, soft, mobile, non-tender, <5cm do not routinely warrant imaging (iRefer/BMUS guidelines)	
		Uncomplicated ganglia	
		Small lipomata/ sebaceous cysts	
		Axillary lymphadenopathy	Refer to breast clinic

Vascular			
Category	**Can Request**	**Avoid Request**	**Additional Information/Advice**
Vascular ultrasound for lower limb venous mapping or venous insufficiency. We do not scan these in the main ultrasound department and the vascular lab does not have GP direct access. Please refer to vascular surgery on eRS.			

MSK			
Category	**Can Request**	**Avoid Request**	**Additional Information/Advice**
US Guided Injection		All US Guided injection requests- these are not currently commissioned as a direct access request	Refer via community MSK pathways for assessment +/- US guided injection

Genitourinary-US KUB, US Bladder, US Prostate, US Testes			
Category	**Can Request**	**Avoid Request**	**Additional Instructions/Advice**
Renal Calculi	US KUB only when: -Pregnancy -To exclude complications of known stones	-Acute setting + no contraindications for CT KUB -First line? renal calculi in non - pregnant patients -Follow up for renal calculi that are managed conservatively (unless new symptoms)	CT KUB advised. **Please note that until CT KUB pathways has been devised for GP direct access this section of guidance will not be implemented**
Macroscopic haematuria	>45 and - unexplained macroscopic haematuria without UTI or persistent macroscopic haematuria or recurs after successful Rx of UTI	Those who do not meet diagnostic criteria described	Urgent ultrasound and 2 week wait urology referral
Microscopic Haematuria		Low-risk microscopic haematuria (2 positive dipstix within 3 weeks) High risk microscopic haematuria (2 pstive dipstic within 3 weeks and age>60, smiking history, previous TCC, associated bladder plan, refractory to antibiotics, risk factors for TCC, previous visible haematuria	Refer to haematuria clinic (please note this is general urology currently on eRS) 2 WW referral to haematuria clinic
Microscopic haematuria and significant proteinuria		Microscopic haematuria and significant proteinuria (BAUS)	Refer to renal team/vCKD
Urinary tract infection	-Refractory to antibiotics -Frequent re-infections (> 3/ 12m), especially if >60 -History of stone/ obstruction -Male -Suspicion of pyonephrosis/ abscess	-1st episode (unless male) -Associated with uncomplicated UTI	
Chronic kidney disease (CKD)	-Rapid progression of CKD -Symptoms of obstruction -Visible or invisible haematuria -Family history of CKD and age > 20 eGFR < 30 Pre-biopsy		vCKD service may be most appropriate port of call for advice on appropriate imaging regarding CKD progression
LUTS in Men		Do not routinely offer imaging of the upper urinary tract to men with uncomplicated LUTS at initial assessment. Do not routinely offer flow-rate measurement to men with LUTS at initial assessment. Do not routinely offer a post void residual volume measurement to men with LUTS at initial assessment.	https://www.nice.org.uk/guidance/cg97/chapter/1-Recommendations
Scrotum/ Testes	-Mass or swelling -Acute pain + not suspecting torsion -Persistent symptoms of epididymitis despite treatment -Suspected complications of infection -Hydroceles (Chronic pain > 3months and no mass (low priority scan))	-Suspected torsion -Chronic varicocele, epididymal cysts (unless there is clinical doubt)	Refer acutely
Prostate	Specialist urology referral only	Specialist urology referral only	Currently only accepting specialist urology referral for prostate US

Gynaecology-Transvaginal US (All should be requested for TVUS unless VI or contraindication)			
Category	**Can Request**	**Avoid Request**	**Additional information/Advice**
IUD bleeding	Any intermenstrual bleed		
IUS (hormonal coil) bleeding	If still experiencing bleeding 6 months after insertion -Pain with no other symptoms	Irregular bleeding within first 6 months following insertion and no other symptoms	
IUD/IUS lost strings at/ immediately post fitting	If can't feel strings since fitting-order urgent scan to exclude perforation		
IUD/IUS? lost strings after fitting	If lost strings previously felt-routine sacn		
Post IUD/IUS fitting		No routine scan required	No routine scan required
Pain	Pelvic pain		
New Onset Sx of Irritable Bowel Symptoms	TVUS		This is to consider the possibility of ovarian pathology presenting as symptoms of IBS
Post-menopausal bleeding		Post-menopausal bleeding	2 week gynaecology referral
Intermenstrual bleeding	Any of the following high risk categories: High BMI or >45 or persistent bleeding > 3 months	Pre-menopausal bleeding with < 3 months history and normal BMI	Consider Urgent 2WW referral to gynaecology and ultrasound
Pre- menopausal menorrhagia	If abnormal examination/mass/ >45 years with new menorrhagia	If regular bleeding and normal examination or < 45 years	To exclude fibroids or endometrial hyperplasia/polyp
Post-coital bleeding		Do not refer	Clinical examination and management/smear test
? Pelvic mass	Scan all-please order urgent 2ww ultrasound		Refer also to 2 week gynaecology pathway
? Ovarian torsion		Do not refer	Refer acutely to gyanecology on call (will be scanned in hospital)
Polycystic ovarian syndrome	Hx of PCOS and atypical or change in nature of pain	Don't scan for typical pain or if the diagnosis has been made on clinical and biochemical parameters	Additional information needs to be provided regarding change/pain
Vaginal discharge	Only If unexplained or >45		
Vulval lesions		Do not scan for vulval lesions-clinical management/referral	
Ovarian cysts in pre-menopausal patients	Refer to table below		
Ovarian cysts in post-menopausal patients	Refer to table below		

Advice for follow up after finding of Ovarian Cysts

Cyst	Findings	Recommendation
Simple cysts (Pre-menopausal)	• < 30 mm.	No need to rescan.
	• 30 – 49 mm.	Almost certainly benign. No follow-up required.
	• > 50 mm < 70 mm.	Almost certainly benign. Rescan in 1 year (RCOG GG62). If the cyst has reduced in size at the next scan, no further follow up. If unchanged or larger, routine gynaecological re
	• > 70mm	Routine gynaecology referral is suggested

Simple cysts (Post-menopausal)	• ≤ 10 mm, with simple appearances. • 11-49mm, asymptomatic, unilateral, unilocular cysts with no solid component, with no free fluid • ≥ 50mm	No follow up. Rescan 4/12 RCOG GG34. If persistent then routine referral to general gynaecology. Urgent gynaecology referral and Ca125
Haemorrhagic cysts	• ≤ 49 mm. • ≥ 50 mm.	Consider stage of menstrual cycle. Likely to be physiological. No follow-up required. Rescan in 2 -3 months (RCOG GG62 / BSGE). If unchanged or larger consider alternative diagnosis and a routine referral to general gynaecology.
Endometrioma	Routine gynaecology referral, unless the endometrioma is small and the patient is asymptomatic in which case just report the finding back to the referring clinician.	Routine gynaecology referral, unless the endometrioma is small and the patient is asymptomatic in which case just report the finding back to the referring clinician.
Complex ovarian / adnexal cysts with malignant features.		Urgent gynae referral. Significant protocol pathway to be followed.
Dermoid		Routine Gynaecology Referral

Category	Can Request	Avoid Request	Additional Information/Advice
Neck			
Thyroid: Abnormal TFTs		Hypothyroidism	Treat in primary care
		Hyperthyroidism	Refer to Endocrinology
Thyroid: Swelling	Slowly growing thyroid mass over months to years with dysphagia or sensation of constriction-check TFTs and thyroid autoantibodies	*Rapidly expanding over week - months or fixed or hard / firm anterior neck mass*	*Direct ENT Ca2WW referral*
		Slowly growing thyroid mass over months – years with SOB or dysphonia	*Direct ENT Ca2WW referral*
		Thyroid masses with lymphadenopathy	*Direct ENT Ca2WW referral*
		Slowly growing thyroid mass over months to years with no compressive symptoms	Refer to Endocrinology if cosmetic disturbance or abnormal TFTs
		Routine FU of benign nodules is not recommended	
Thyroid: Painful	Acute onset and severe symptoms (haemorrhagic cyst needing drainage or de Quervain's thyroiditis)		Check TFTs, thyroid autoantibodies and ESR
		Mild to moderate, slow onset discomfort	Refer to Endocrinology
Cervical Lymphadenopathy (Adults-see pop up for advice on children)	Clinically reactive but unresolving after 6/52	*Rapidly or progressively enlarging and / or B symptoms and / or clinical concerns of cancer*	*Direct Head and Neck Ca2WW referral*
Superficial lumps	See lumps and bumps section	*> 5cm or fixed / tender / enlarging / overlying skin changes*	*Direct Head and Neck Ca2WW referral*
		Long standing epidermal cysts	
		Simple lipoma < 5 cm	
Focal / unilateral parotid or submandibular gland mass		>1 cm	*Direct Head and Neck Ca2WW referral*
Acute or intermittent salivary gland swelling	Obstructive sialectasis, presumed calculus		
		Severe viral parotitis or ? abscess	*Refer to A+E*
Diffuse chronic parotid swelling		Sialosis	
		Sjogren's / Sarcoidosis	Refer to Rheumatology
Globus / Foreign Body Sensation		Consider and treat for GORD if symptoms mild	*Direct ENT Ca2WW referral* if moderate - severe
Stridor / Dysphagia			*Direct ENT/Gastro Ca2WW referral or A+E*

For further information please contact gurinder.nandra@nhs.net

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Dr Emma Friedman, RLH Imaging Clinical Director

Dr Matthew Matson, Imaging Group Divisional Director

References

GI

https://www.bsg.org.uk/clinical-articles-list/nafld-diagnosis-assessment-and-management/
BMUS: Guidelines For Professional Ultrasound Practice, Revision 4: Dec 2019
BMUS Recommended Good Practice Guidelines. Justification of Ultrasound Requests. Revision 4: Dec 2017
(https://www.bmus.org/static/uploads/resources/Justification_of_Ultrasound_Requests_v4_Dec_2017.pdf)
https://www.nice.org.uk/guidance/ng49
UpToDate (https://www.uptodate.com/contents/gallbladder-polyps-and-cholesterolosis)
Management and follow-up of gallbladder polyps: updated joint guidelines between the ESGAR, EAES, EFISDS and ESGE: Dec 2021

GU

NICE Guidelines (https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!scenario)
BAUS guidelines
https://www.baus.org.uk/_userfiles/pages/files/professionals/sections/oncology/COVID-19%20BAUS%20Oncology%20Bladder%20final.pdf
https://www.baus.org.uk/_userfiles/pages/files/professionals/sections/oncology/COVID-19%20BAUS%20Oncology%20Kidney%20final.pdf
https://www.baus.org.uk/_userfiles/pages/files/professionals/sections/oncology/COVID-19%20BAUS%20Oncology%20Prostate%20final.pdf
https:/www.nice.org.uk/guidance/ng112/chapter/Recommendations
https://www.sor.org/sites/default/files/document-versions/ultrasound_guidance.pdf
https://www.nice.org.uk/guidance/ng148/chapter/Recommendations#identifying-the-causes-of-acute-kidney-injury
https://www.nice.org.uk/guidance/cg182/chapter/1-Recommendations#investigations-for-chronic-kidney-disease-2
https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517
Urological cancers: (https://cks.nice.org.uk/urological-cancers-recognition-and-referral#!scenario)

Gynaecology

BMUS Recommended Good Practice Guidelines. Justification of Ultrasound Requests. Revision 4: Dec 2017
Barts Health Gynaecology Guidelines 2019. Miss Sara Copsey
Barts Health COVID-19 Protocols for Imaging Urological Cancers (modified from BAUS Guidelines)
GYANE IMAGING DURING COVID 19 PANDEMIC, Modified from Joint RCOG and BSGE and BGCS Guidelines and local policies (AS/AH)

Vascular

UK abdominal aortic aneurysm screening: https://digital.nhs.uk/services/screening-services/abdominal-aortic-aneurysm-screening

MSK

iRefer RCR referral guidelines
Sconfienza, L.M., Albano, D., Allen, G. et al. Clinical indications for musculoskeletal ultrasound updated in 2017 by European Society of Musculoskeletal Radiology (ESSR) consensus. Eur Radiol 28, 5338–5351 (2018). https://doi.org/10.1007/s00330-018-5474-3
Ultrasound screening of masses in the trunk and extremity: a British Sarcoma group guide for ultrasonographers and primary care
Management of patients with musculoskeletal and rheumatic conditions who: are on corticosteroids; require initiation of oral/IV corticosteroids; require a corticosteroid injection. 16 June 2020. © BSR BOA BASS RCGP BSIR FPM BPS CSP

Lumps and Bumps

BMUS Recommended Good Practice Guidelines. Justification of Ultrasound Requests. Revision 4: Dec 2017

Neck / Thyroid

iRefer RCR referral guidelines
Ultrasound screening of masses in the trunk and extremity: a British Sarcoma group guide for ultrasonographers and primary care
https://www.baets.org.uk/wp-content/uploads/2020/05/BAETS-Statement-Thyroid-Cancer-Covid-0520.pdf
https://www.baets.org.uk/wp-content/uploads/2020/05/Benign-Thyroid-Covid-Final-05-2020.pdf
https://www.baets.org.uk/wp-content/uploads/2020/05/Parathyroid-Covid-Final-05-2020.pdf