South East London Acute Provider Collaborative

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS Lewisham and Greenwich NHS Trust

SE London Primary & Secondary care General Surgery Guidelines

May 2025

Due for review 2027

South East London Integrated Care System

South East London Acute Provider Collaborative

Introduction

Primary care guidelines to support the diagnosis and management of General Surgery conditions.

This guide has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across the South East London (SEL) General Surgery Network, South East London Integrated Care Board, South East London Primary Care representatives, South East London Cancer Alliance, South East London Integrated Medicines Optimisation Committee (IMOC), and with input from other speciality colleagues where relevant.

All prescribing should be in line with the SEL Joint Medicines Formulary.

It is intended to be a guide to assist Primary care colleagues in decision making and does not replace clinical judgement.

We encourage users of this document to seek advice from primary or secondary care colleagues when they are unsure, the later using established communication channels (e.g. Consultant Connect, e-RS Advice and Guidance).

Shortages of medicines are becoming a frequent issue that hinders patients getting access to their medicines in a timely manner. Please see the medicines supply tool, which can be accessed from the SPS website (linked here). The tool provides up to date information on medication shortages, and also includes advice on the prescribing of alternative products. Once supply resolves, patients should be transferred back to their original formulary option, following discussion with patients that original formulary option is appropriate

Authors and Governance

Version	Date signed off	Date of next review
V1.0	20th May 2025	May 2027

These guidelines have been drawn up with input from a number of clinicians across South East London (SEL). Key authors include Alexis Schizas (Consultant Colorectal Surgeon at Guys Hospital & Clinical Lead for the SEL General Surgery Network), Katie Adams (Consultant Colorectal Surgeon at Guys Hospital), Husam Ebeid (Consultant Upper Gastro-Intestinal, General and Abdominal Wall Surgeon) and Will Knight (Consultant Upper GI and General Surgeon), a number of other clinical specialists across SEL and Rebecca Holmes (GP & SEL Primary Care Lead for General Surgery).

The guidelines were reviewed and signed off in SEL General Surgery workstream meetings and by the SEL Network Board.

Medicines and prescribing recommendations made within these guidelines have been reviewed and approved by the SEL Integrated Medicines Optimisation Committee (IMOC).

Guidelines have also been circulated to LMC representatives, Planned Care Leads in each borough, SEL Cancer Alliance, SEL GP Cancer Leads, SEL APC Ultrasound Modality Group and all SELGP's via the bulletin for review and comment.The guidelines have also been reviewed by the Divisional Governance Committee in each trust as required.

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Surgical Same Day Emergency Care

Surgical Same Day Emergency Care (SDEC).
Also known as Surgical Acute Care Unit (SACU) /SAAU (Surgical Acute Assessment Unit)

- These units are led by specialist acute medicine and acute surgical consultants & registrars and provide rapid assessment, diagnostics and treatment for acute conditions.
- SDEC units are open to **referrals only**

Patient needs Same Day Emergency Care

Are Surgical Exclusion criteria (overleaf) present?

Yes → **EMERGENCY DEPARTMENT: Assessment by Surgeons or Emergency Medicine doctor as appropriate**

No

Contact Surgical SDEC / SACU / SAAU

Guys & St Thomas Hospital (8:30am-8pm, Mon-Fri, last referral 6pm)

Consultant Connect line: Mon – Fri – 8am – 6pm
If unable to access via Consultant connect:

Contact Emergency General Surgery Nurse Practitioner 0207 188 1203
Or via switchboard 020 7188 7188 Ext 81203

Kings College Hospital SACU (8am-8pm 7 days a week, last referral 6pm)

Consultant connect line: Mon – Fri – 8am – 4pm

If unable to access via Consultant Connect:
Surgical Registrar on-call via Switchboard: 020 3299 9000 – Ext 38154, Bleep 969

Lewisham Hospital (8am-8pm Mon-Fri, 8am-6pm Sat-Sun)

Surgical Registrar on-call via Switchboard: 02083333000 Bleep 2000

Princess Royal University Hospital SSAU (24 hours 7 days a week)

Consultant connect line: Mon – Fri – 8am – 4pm
Senior clinical fellow/ surgical registrar in the SAU: 63737 - Bleep 545

If unable to access via Consultant Connect:
Surgical Registrar on-call via Switchboard: 01689 863000 –Bleep 410

Queen Elizabeth Hospital (7:30am-7pm 7 days a week)

Surgical Registrar on-call via Switchboard: 020 8836 6000 Bleep 202

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Surgical Same Day Emergency Care

SDEC / SACU / SAAU Exclusion criteria:

- Age <16 years
- Not mobile
- Unstable patient / NEWS ≥4
- Sepsis
- Perianal sepsis
- Fournier's gangrene
- Abscess with extensive cellulitis
- Immunocompromised
- Unstable diabetes e.g. HbA1c >60
- New confusion
- Peritonitis
- Uncontrolled pain
- Vomiting
- Dehydration
- Severe perianal haematoma
- BMI>40

Common conditions seen in SDEC / SACU / SAAU:

- Patients between 16-50years presenting with isolated right iliac fossa pain with negative betaHCG/ no PV bleeding (if female)
- Known gallstones presenting with upper abdominal pain
- Post-op complications or wound issues within 30 days of surgery (not cardio-respiratory)
- Recurrent presentation within 30 days of previous admission/referral to surgery/SDEC
- Peri-anal or pilonidal Abscess
- Known abdominal wall or groin hernia presenting with irreducibility, worsening symptoms,
- irreducibility

Anorectal abscess and fistula

Suspected anorectal abscess

Is there Sepsis or Immunosuppression?
Is Perianal sepsis or Fournier's gangrene suspected?
Symptoms include: fever, severe pain (out of proportion), swelling, redness, skin discolouration, pus, crepitus.

Yes → **EMERGENCY DEPARTMENT ASSESSMENT**

No

Background:
- 30-70% of Anorectal abscesses have an associated fistula (recurrent abscesses are common)
- Consider: Fistula, Crohn's disease, STI

History:
- Abscess: Perianal pain and swelling, ± Fever / chills, ± Urinary retention
- Fistula: Chronic or recurrent perianal lump / pain / discharge

Examination:
- Low grade fever, Pulse (tachycardia common), RR, BP
- **Abscess:** Tender induration adjacent to the anus, within anal canal, or above the anorectal canal. **± Cellulitis**
  - Inter-sphincteric abscess (difficult to diagnose): little swelling, few perianal signs but severe anal pain precluding DRE
  - Supra-levator abscess: may mimic an intra-abdominal condition. DRE: tender, indurated area above the anorectal canal
- **Fistula:** hard, cord-like structure palpable in the soft tissues, leading toward the anus, often with external opening & longer term discharge.

Differentials:
- Infected epidermal inclusion cyst: usually >3cm from the anal verge
- Pilonidal disease: intergluteal
- Hidradenitis suppurativa
- Sexually transmitted infection e.g. syphilis

ABSCESS

REFER FOR AN ACUTE SURGICAL ASSESSMENT
E.g. via Consultant connect
Patient is likely to need Incision & Drainage

SDEC exclusion criteria: E.g.
- Unstable patient / NEWS ≥4
- Immunocompromise
- Extensive cellulitis
- Unstable diabetes
- Age <16 years
- Not mobile
- New confusion

No → **Consider Same Day Emergency Care (SDEC) assessment**

Yes → **EMERGENCY DEPARTMENT: Assessment by Surgeons or Emergency Medicine doctor as appropriate**

FISTULA (No abscess)

Referral to colorectal outpatients
- Advise on simple analgesia over the counter if needed
- Provide safety netting advice e.g. on acute symptoms

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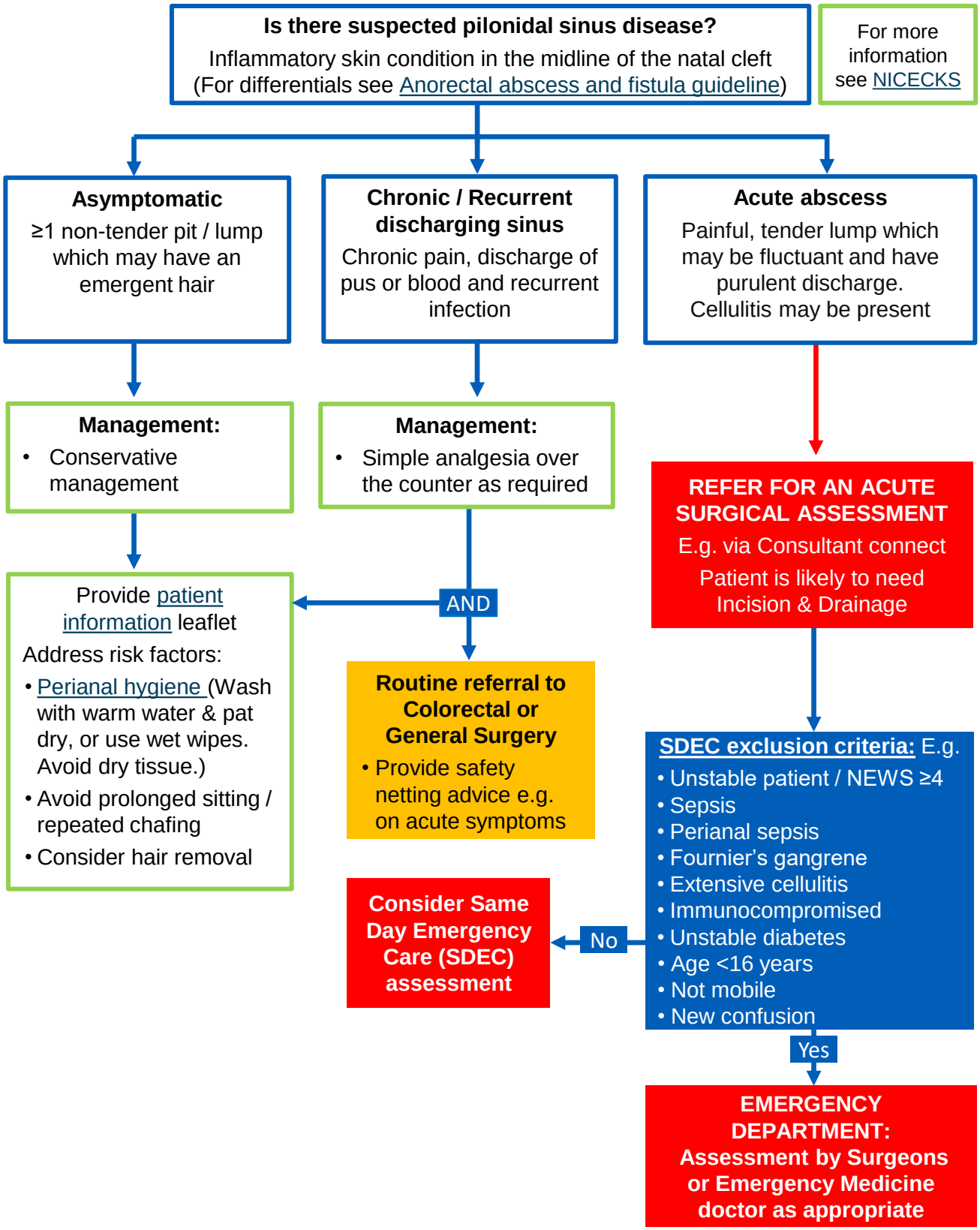
Pilonidal abscess and sinus



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Rectal Bleeding

Is there an acute abdomen, perianal sepsis or high risk rectal bleeding? E.g. Haemodynamic instability, Persistent bleeding

YES → **EMERGENCY DEPARTMENT ASSESSMENT**

NO

History:
- Perianal / Anal symptoms (see right)
- Constipation, impaction, straining
- Anticoagulants
- Consider: Infection, IBD, Colorectal Cancer / polyp, Diverticular disease, Angiodysplasia (often painless), Ischaemic colitis (especially if AF), Radiation proctitis and UGI causes.
- Uncommon: Solitary rectal ulcer, Anal cancer, Vasculitis, Varices & Endometriosis

Red flag symptoms:
- Altered bowel habit
- Anaemia
- Weight loss
- Personal or Family history of bowel cancer

Anal fissures (see overleaf):
- Less common in older adults
- Anal pain and bleeding (bright red, small amount, on tissue) on passing stool,
- ± Tearing sensation

Haemorrhoids (see overleaf):
- Bright red painless bleeding
- Anal itching/irritation. Soiling
- Pain if thrombosed / strangulated

Rectal prolapse: symptoms e.g. rectal fullness, discomfort or incomplete evacuation

Examination:
- BP, pulse if appropriate
- Perianal examination and DRE (Internal haemorrhoids are not palpable.) Check for fistula, fissure, prolapse and mass/ulcer *

Acute surgical cause requiring hospital assessment

Yes → **REFER FOR ACUTE SURGICAL ASSESSMENT** See SDEC Exclusion Criteria

No

FIT testing as per NICE DG56 / NG12 (Positive: ≥10 mcg Hb/g faeces))
- Abdominal mass
- Change in bowel habit
- Iron-deficiency anaemia
- <50 years, rectal bleeding and either unexplained: Abdominal pain or Weight loss
- ≥40 years with unexplained weight loss and abdominal pain
- ≥ 50 years and any of these unexplained symptoms: Rectal bleeding / Abdominal pain / Weight loss
- ≥60 years with anaemia even in the absence of iron deficiency

Additional Pan-London criteria (Any age):
- Abdominal pain, or Weight loss, or Rectal bleeding, or Non iron-deficiency anaemia

Offer even if previous negative screening FIT

Investigations:
- Bloods: FBC ferritin • FIT
- Consider: Calprotectin (if suspected IBD) Stool MC&S (if suspected infection)

FIT >10 → **Suspected LGI Cancer referral:**
- Positive FIT
- Rectal mass *
- Unexplained anal mass or ulcer *
- Suspected cancer

FIT <10 → High suspicion of Cancer e.g. due to other symptoms

Yes → Colo-rectal

Other → Consider other Cancer pathway or Rapid Access Diagnostic pathways

No → **Primary Care:**
- Management if appropriate (see p11).
- Safety net: Review persistent symptoms at 6 weeks and repeat FIT & FBC
- See SELCA FIT<10 pathway
- Consider Advice & Guidance

Urgent Colorectal Referral:
- Previous pelvic radiotherapy
- Concern re unexplained / persistent symptoms

Routine Referral:
- Rectal prolapse
- Persistent symptoms

Urgent Gastro Referral:
- Positive calprotectin

Required for referral: Examination • FIT (* not required if referring for unexplained mass / ulcer)

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Anal Fissure and Haemorrhoids

See NICE CKS Anal Fissure & Haemorrhoids

Anal fissure: (Chronic if >6 weeks)

Examination

- Primary fissure: Singular, usually posterior midline (can be anterior midline in women)
- Secondary/atypical (Requires Referral): May have an irregular outline, be multiple, or occur laterally

Risk factors for secondary anal fissures:

- Anal trauma,
- Skin conditions (Psoriasis, Pruritis Ani)
- IBD (perianal Crohn's)
- Sexual history (receptive anal)
- Drugs: Opioids, Nicorandil, Chemotherapy

Haemorrhoids:

Examination

- May be normal (non prolapsed internal)
- Bulging vessel covered by mucosa
- Acutely thrombosed external haemorrhoid: purplish, oedematous, tense and tender

Haemorrhoid risk factors:

- Constipation and straining
- Raised intra-abdominal pressure (pregnancy , childbirth, ascites, abdominal mass)
- Chronic cough
- Heavy lifting / exercising
- Age & Hereditary factors
- Low fiber diet

Primary Care Management for both:

- Advise on dietary fibre, fluid & perianal hygiene. (Keep clean and dry. Wash or use non irritant wipes. Pat dry and avoid rough wiping with dry tissue.) Consider Sitz baths.
- Ensure stools are soft and easy to pass. Avoid straining. Prescribe laxatives if required [BNF]
- Simple analgesia over the counter (avoid opioids)

Anal fissure specific:

- Provide patient information
- **GTN if no better after 1 week and no contra-indications:** Rectal 0.4% GTN ointment 2.5cm BD for 6-8 weeks Counsel on side effects [BNF]. Compliance low if not warned about headaches.

If some improvement at 6-8 weeks: Consider a second course of rectal GTN and review after a further 6-8 weeks

If no improvement at 6-8 weeks or unable to tolerate side effects before then: Seek specialist advice on alternatives via 'Advice and Guidance' or refer. E.g. Diltiazem 2% cream BD one tube (unlicensed special £13.49/tube (Drug tariff 2024), sufficient for 6 weeks. Amber 1), maximum use 8 weeks.

- **If severe pain on defecation:** Lidocaine 5% ointment 1-2ml PRN before passing stool [BNF]. Buy over the counter.

Routine Referral

- Fissure persists/recurs despite treatment
- Atypical fissure, new scarring

Haemorrhoid specific:

- Provide patient information
- Use over the counter topical haemorrhoid treatments [BNF]

If considering referral, counsel on Secondary Care Management:

- See SEL Treatment access policy (2024)
- 10% will require surgery
- Recurrence rate after surgery is 13%

Routine Referral

- No response to conservative management
- Large fourth degree (protrude outside anal canal & don't reduce) or third degree (protrude outside anal canal but reduce) haemorrhoids (may need surgery)
- Recurrent third or fourth degree haemorrhoids with persistent pain or bleeding
- Significant rectal bleeding (needs specialist examination)

± Refer to an appropriate specialist (urgency dependent on clinical judgement) if a serious underlying cause, e.g. IBD or STI (HIV), is suspected

Required for referral: ▪ Examination ▪ FIT ▪ Trial of conservative management

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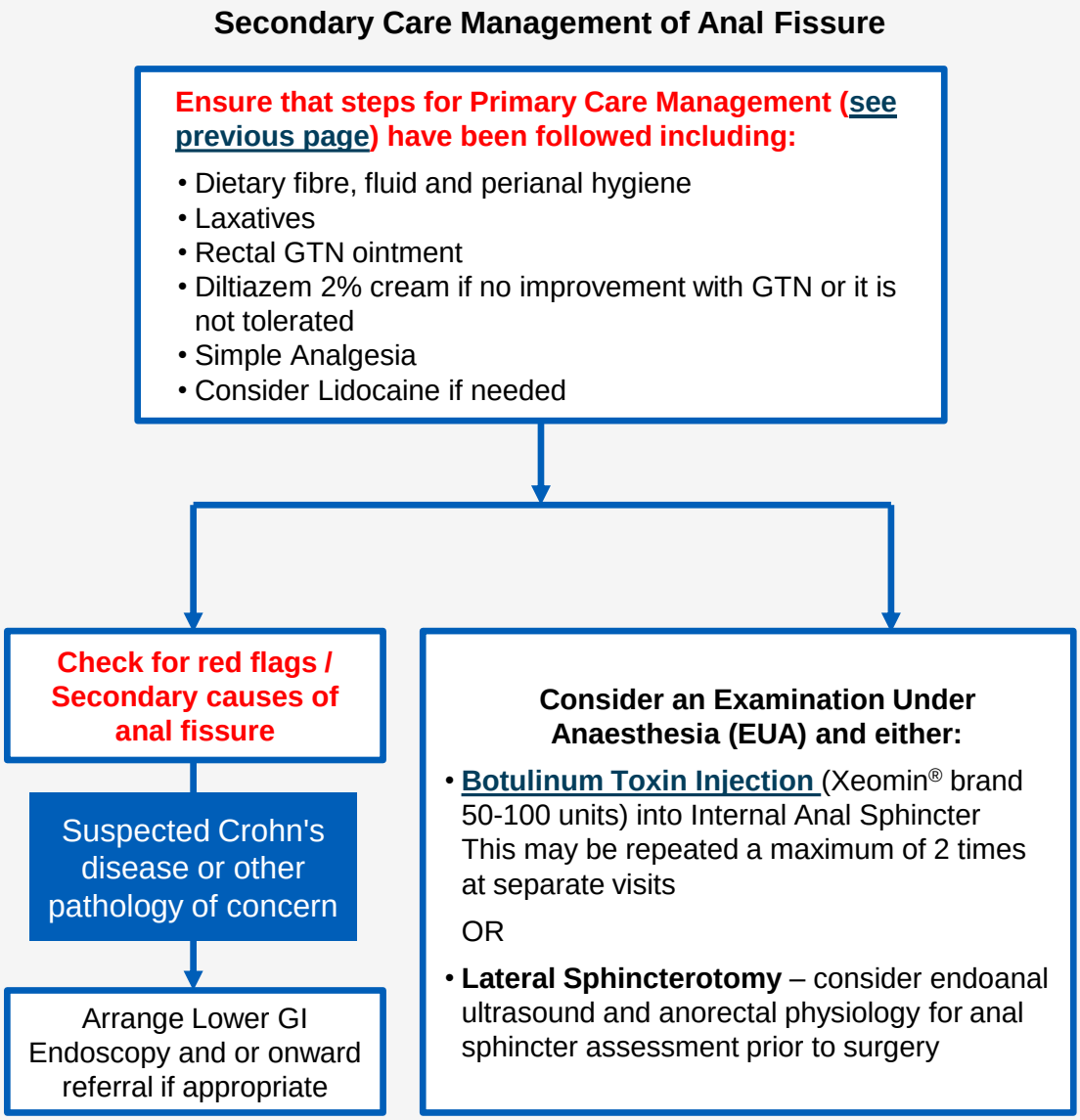
Anal Fissure Management in Secondary Care



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Right Upper Quadrant pain / Gallstones pathway

NICE CKS Gallstones

Abdominal pain (Right Upper Quadrant / Epigastric) due to suspected gallstones

History:
- Fever ± Rigors, Nausea / Vomiting, Anorexia
- Dyspepsia, Weight loss,
- Haematemesis or Melaena **(Emergency medical assessment required)**

Examination:
- Temperature, Pulse, BP RR, Jaundice (10%),
- RUQ tenderness ±mass,
- Murphy's sign (unreliable in older adults)

Consider differentials:
- Biliary colic (<24h pain, systemically well)
- Cholecystitis (90-95% gallstone related), Pancreatitis,
- Cholangitis (pain, fever & jaundice),
- Dyspepsia / Peptic ulceration, Hepatitis, Renal colic, Appendicitis,
- Pneumonia,
- Cardiac causes.

Are any of the following present?:
- Acute abdomen
- Low grade pyrexia or pain >24 hours
- Systemically unwell with complications of gallbladder disease: Acute Cholecystitis, Pancreatitis, Cholangitis
- Jaundice
- Clinical suspicion of biliary obstruction (e.g. painful jaundice, deranged LFT)
- USS showing stones in the CBD or a dilated duct

Yes

REFER FOR ACUTE SURGICAL ASSESSMENT
E.g. via Consultant connect

SDEC Exclusion criteria: E.g.
- Unstable patient / NEWS ≥4
- Sepsis
- Peritonitis
- Uncontrolled pain
- Vomiting
- Dehydration
- Non-ambulatory patient
- New confusion

Yes

EMERGENCY DEPARTMENT: Assessment by Surgeons or Emergency Medicine doctor as appropriate

No

Consider SDEC

No

Refer Urgently for Suspected Cancer (2ww):
See Pan London UGI Suspected Cancer Guidelines 2024
- Abdominal mass / Dysphagia / ≥40yrs and jaundice
- Age ≥50* and Weight loss with either: Upper abdominal pain / Dyspepsia / Reflux

Refer Urgently for Suspected Pancreatic Cancer or for Direct access CT if age ≥60 & available locally:
- Age ≥50** and Weight loss with either: Abdominal /Back pain / Diarrhoea / Constipation / Nausea / Vomiting / New diabetes

No

Are Urgent investigations needed? (NICE NG12):
- **FIT** (full list in SEL Rectal bleeding guideline):
  - Abdominal mass
  - Age ≥ 50 and Abdominal pain (un-explained)
  - Age ≥ 40, Weight loss and abdominal pain
- **CA125** (see NICE NG12) if: Abdominal pain / Bloating / Distension / Appetite loss or Early satiety

Is Non-urgent referral indicated?
Full list at Pan London 2024 / NICE NG12 Suspected Cancer guidelines E.g. Treatment resistant dyspepsia, Upper abdominal pain with Nausea or Vomiting

Primary care:
Further Investigation and Management over leaf

* NICE NG12 guideline uses Age ≥55
** NICE NG12 guideline uses Age ≥60

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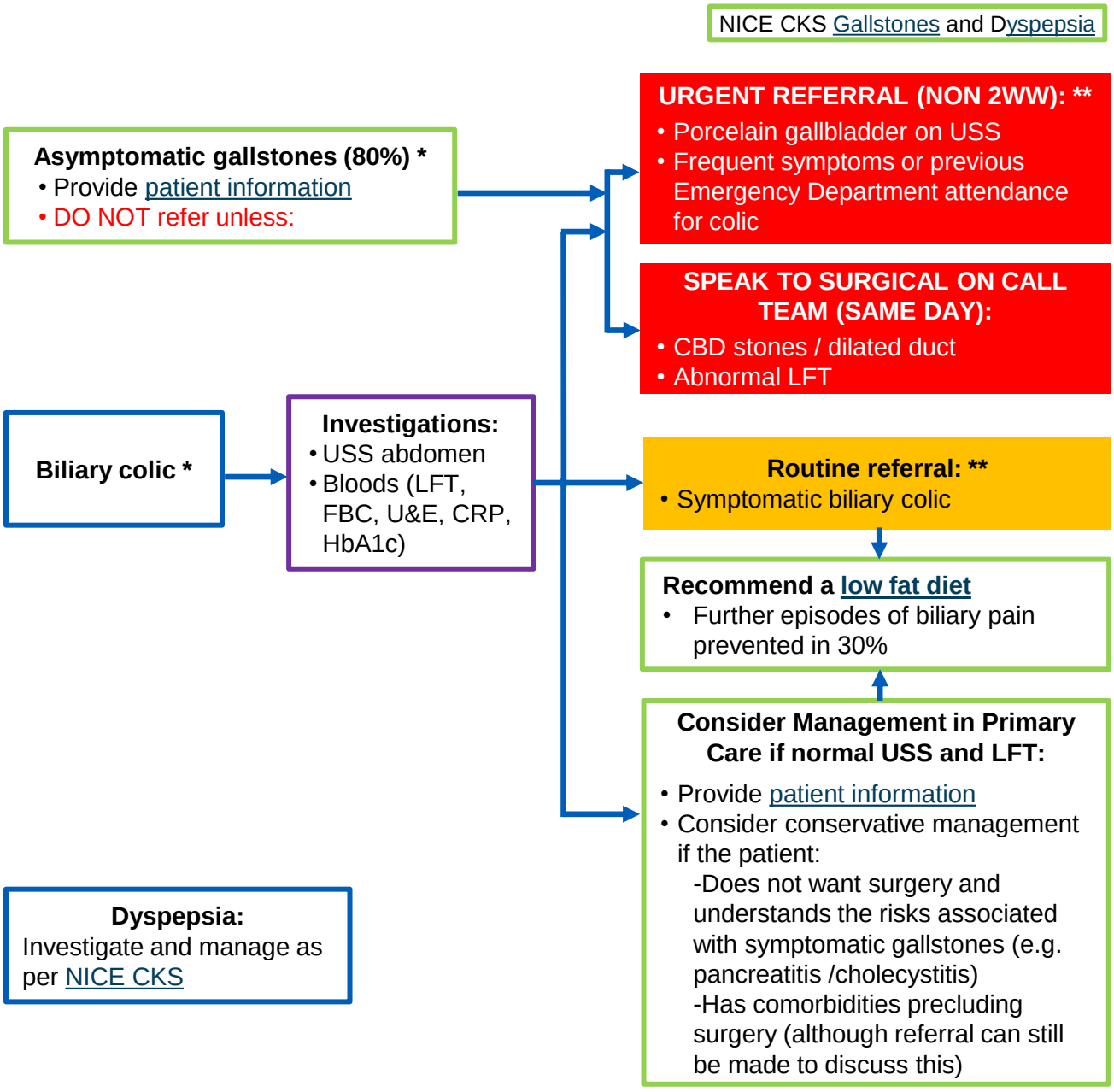
Right Upper Quadrant pain / Gallstones pathway



* Contact the patient's usual haematologist if the patient has Chronic Haemolytic disease / Sickle Cell Anaemia

** Refer to a center with a liver unit if the patient has:
- Alcoholic Liver Disease
- Ascites / Varices / Portal hypertension

Required for routine referral:
- **USS**
- **Bloods**

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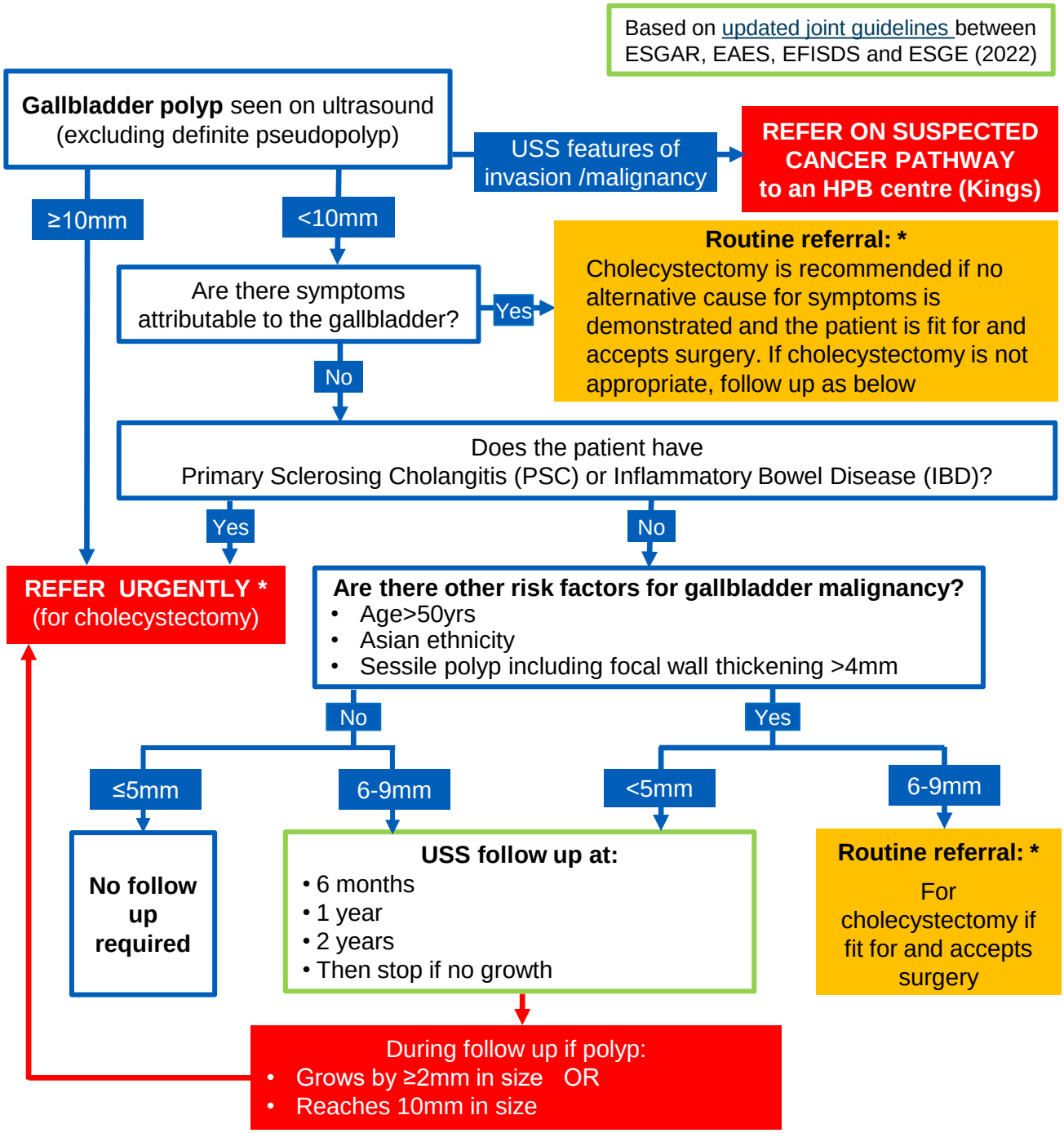
Gallbladder polyps



* Refer to a centre with a liver unit if the patient has :
- Alcoholic Liver Disease
- Ascites / Varicies / Portal hypertension

Required for referral:
- **USS (last 3 reports)**

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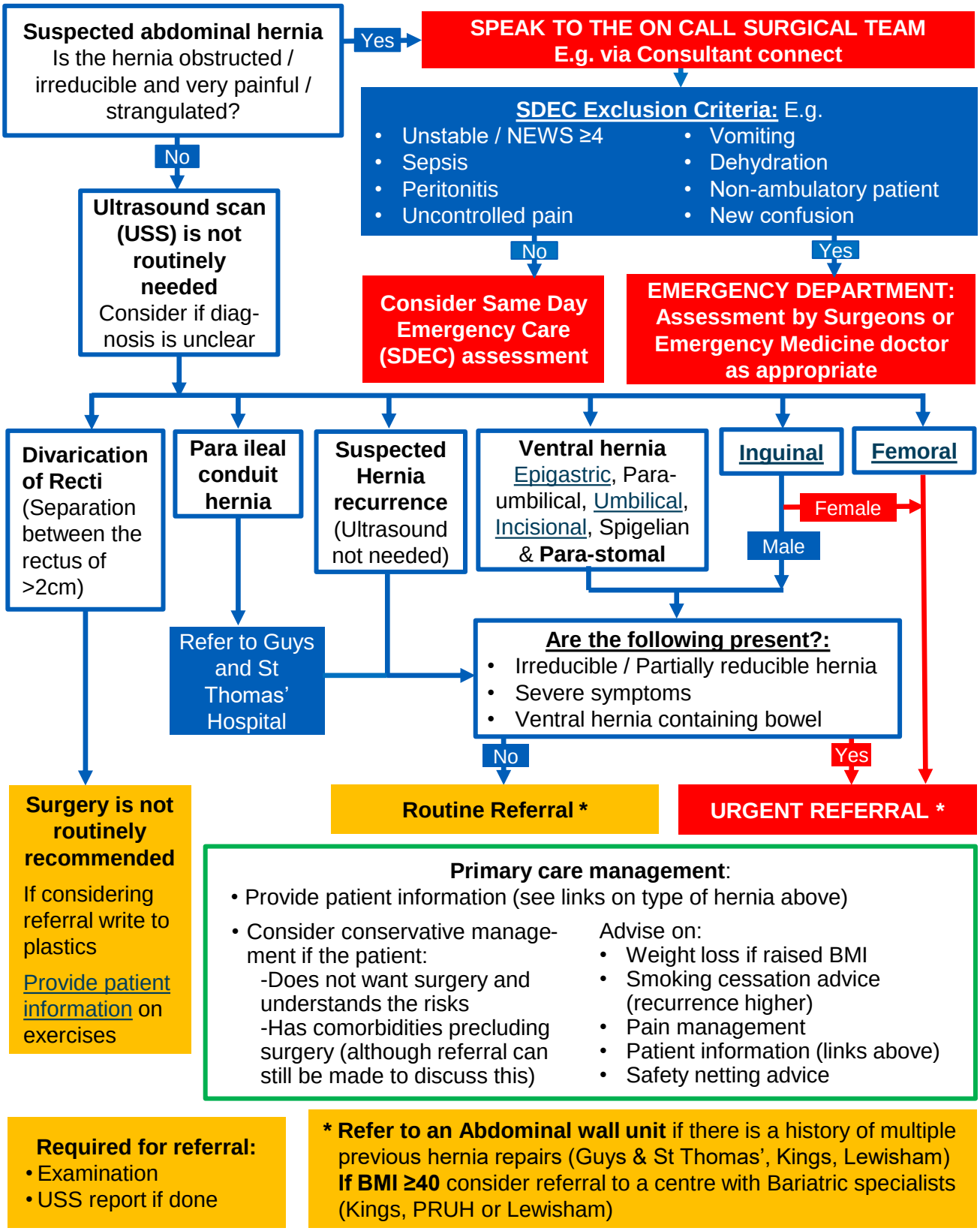
Hernia pathway



Hernia

Hernia Strangulation risk

Some information about strangulation rates by type of hernia is given below, however a number of factors affect this including age, obesity and size of the neck of the hernia.

Type of Hernia	Strangulation risk	Reference
Inguinal hernia	2 – 3 in every 100 in the first year strangulate. This risk becomes less after 1 year	NHS England Patient Decision Making Aid - Inguinal Hernia
Femoral hernia	The cumulative probability of strangulation for femoral hernias is 22% three months after diagnosis, rising to 45% 21 months after diagnosis.	Gallegos et al 1991
Ventral hernia	Probability of requiring emergency surgery is 4% after 5 years	Kokotovic et al 2016
Incisional hernia	Probability of requiring emergency surgery is 4% after 5 years	Kokotovic et al 2016

Abbreviations

2WW	Urgent Suspected Cancer ‘2 week wait’ referral
BMI	Body Mass Index
BP	Blood Pressure
CBD	Case Based Discussion
CRP	C-reactive Protein
DRE	Digital Rectal Examination
EFISDS	International Society of Digestive Surgery -European Federation
ESGAR	European Society of Gastrointestinal and Abdominal Radiology
ESGE	European Society of Gastrointestinal Endoscopy
EUA	Examination Under Anaesthetic
FBC	Full Blood Count
FIT	Faecal Immunochemical Test
GI	Gastro Intestinal
Hb	Haemoglobin
HbA1c	Glycosylated Haemoglobin
IBD	Irritable Bowel Disorder
INR	International Normalised Ratio
LFT	Liver Function Tests
LGI	Lower Gastro-Intestinal
Max	Maximum
MC&S	Microscopy Culture & Sensitivity
NEWS	National Early Warning Score
RR	Respiratory Rate
RUQ	Right Upper Quadrant
SAAU	Surgical Acute Assessment Unit
SACU	Surgical Acute Care Unit

Abbreviations

SDEC	Same Day Emergency Care
SEL	South East London
STI	Sexually Transmitted Infection
UTI	Urinary Tract Infection
U&E	Urea & Electrolytes
UGI	Upper gastrointestinal (GI) Surgery
USS	Ultrasound Scan