

# SE London Primary & Secondary care General Surgery Guidelines

December 2025

Due for review 2027





### 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 specialty colleagues where relevant.

All prescribing should be in line with the <u>SEL Joint Medicines Formulary</u>.

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 <u>SPS website</u> (registration required for access). 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	15 May 25	May 2027
V1.1	N/A – minor amendments	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

# Are Surgical Exclusion criteria (overleaf) present? Yes EMERGENCY DEPARTMENT: Assessment by Surgeons or Emergency Medicine doctor as appropriate

#### 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



# **Surgical Same Day Emergency Care**

#### SDEC / SACU / SAAU Exclusion criteria:

- Age <16 years</li>
- 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

# 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

#### 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:**

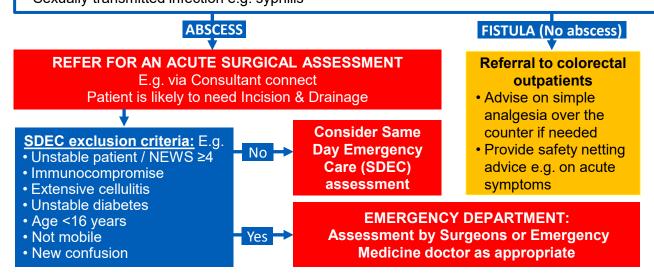
- Low grade fever, Pulse (tachycardia common), RR, BP
- **Abscess:** Tender induration adjacent to the anus, within anal canal, or above the anorectal canal, **± Cellulitis**

<u>Inter-sphincteric abscess</u> (difficult to diagnose): little swelling, few perianal signs but severe anal pain precluding DRE

- <u>Supra-levator abscess</u>: 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.

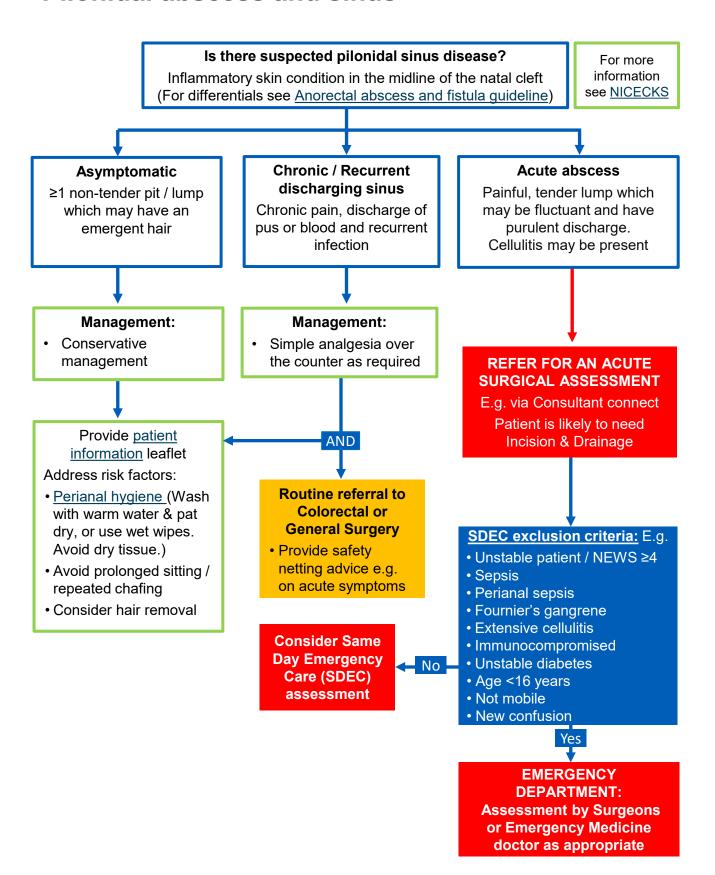
#### Differentials:

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





## Pilonidal abscess and sinus



# **Rectal Bleeding**

NO

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



EMERGENCY DEPARTMENT ASSESSMENT

#### 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

#### **Examination:**

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

REFER FOR ACUTE SURGICAL ASSESSMENT See SDEC Exclusion Criteria Acute surgical cause requiring hospital assessment

essm No

#### 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

# FIT testing as per NICE <u>DG56</u> / <u>NG12</u> (Positive: ≥10 mcg Hb/g faeces))

Abdominal mass

FIT >10

High sus-

picion of

Cancer e.g.

due to other

symptoms

- 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

Colo-

rectal

<u></u>

Yes

Other

#### **Investigations:**

- Bloods: FBC ferritinFIT
- Consider: Calprotectin (if suspected IBD)
   Stool MC&S (if suspected infection)

#### **Urgent Colorectal Referral:**

- Previous pelvic radiotherapy
- Concern re unexplained / persistent symptoms

#### **Routine Referral:**

- Rectal prolapse
- Persistent symptoms

#### **Urgent Gastro Referral:**

Positive calprotectin

#### **Primary Care:**

Management if appropriate (see p11).

 <u>Safety net</u>: Review persistent symptoms at 6 weeks and repeat FIT & FBC

FIT <10

- See SELCA FIT<10 pathway
- Consider Advice & Guidance

# Suspected LGI Cancer referral:

- Positive FIT
- Rectal mass \*
- Unexplained anal mass or ulcer \*
- Suspected cancer

Consider other Cancer pathway or Rapid Access Diagnostic pathways

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

# **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 fibre 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.

#### 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)

#### **Routine Referral**

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

 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

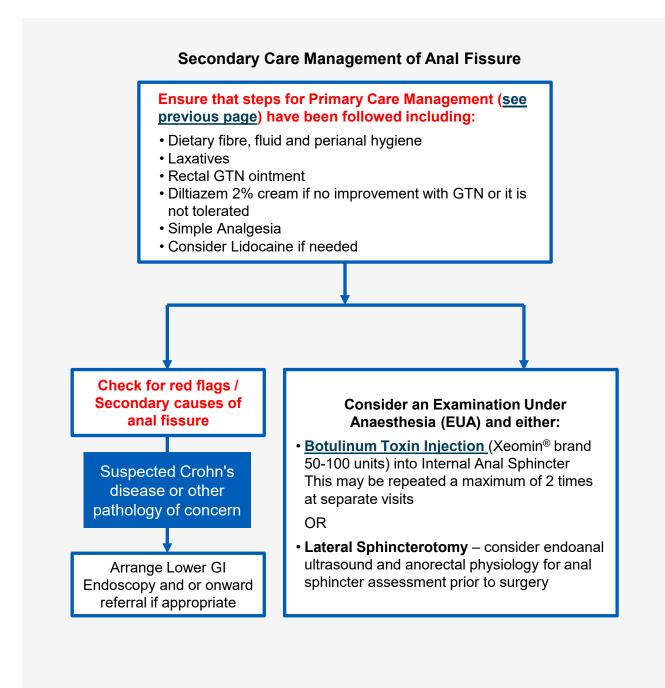
• FIT

±>

Trial of conservative management



# **Anal Fissure Management in Secondary Care**



# 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

#### 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

# • FIT (full list in SEL Rectal bleeding guideline): Abdominal mass

pain / Dyspepsia / Reflux

New diabetes

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

Refer Urgently for Suspected Cancer (2ww):

See Pan London UGI Suspected Cancer Guidelines 2024

Age ≥50\* and Weight loss with either: Upper abdominal

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

**Are Urgent investigations needed?** (NICE NG12):

pain / Diarrhoea / Constipation / Nausea / Vomiting /

Abdominal mass / Dysphagia / ≥40yrs and jaundice

# **EMERGENCY** DEPARTMENT:

Assessment by Surgeons or **Emergency Medicine doctor** as appropriate

#### Consider **SDEC**

#### Primary care:

Further Investigation and Management over leaf

#### \* NICE NG12 guideline uses Age ≥55

\*\* NICE NG12 guideline uses Age ≥60

#### 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

# Right Upper Quadrant pain / Gallstones pathway

NICE CKS Gallstones and Dyspepsia **URGENT REFERRAL (NON 2WW): \*\***  Porcelain gallbladder on USS Asymptomatic gallstones (80%) \* Frequent symptoms or previous Provide patient information **Emergency Department attendance**  DO NOT refer unless: for colic SPEAK TO SURGICAL ON CALL **TEAM (SAME DAY):**  CBD stones / dilated duct Abnormal LFT Investigations: USS abdomen Routine referral: \*\* Biliary colic \* Bloods (LFT, Symptomatic biliary colic FBC, U&E, CRP, HbA1c) Recommend a low fat diet Further episodes of biliary pain prevented in 30% **Consider Management in Primary** Care if normal USS and LFT: Provide patient information Consider conservative management if the patient: -Does not want surgery and understands the risks associated Dyspepsia: with symptomatic gallstones (e.g. Investigate and manage as per NICE CKS pancreatitis /cholecystitis) -Has comorbidities precluding surgery (although referral can still

- \* Contact the patient's usual haematologist if the patient has Chronic Haemolytic disease / Sickle Cell Anaemia
- \*\* Refer to a centre with a liver unit if the patient has:
  - Alcoholic Liver Disease
  - Ascites / Varices / Portal hypertension

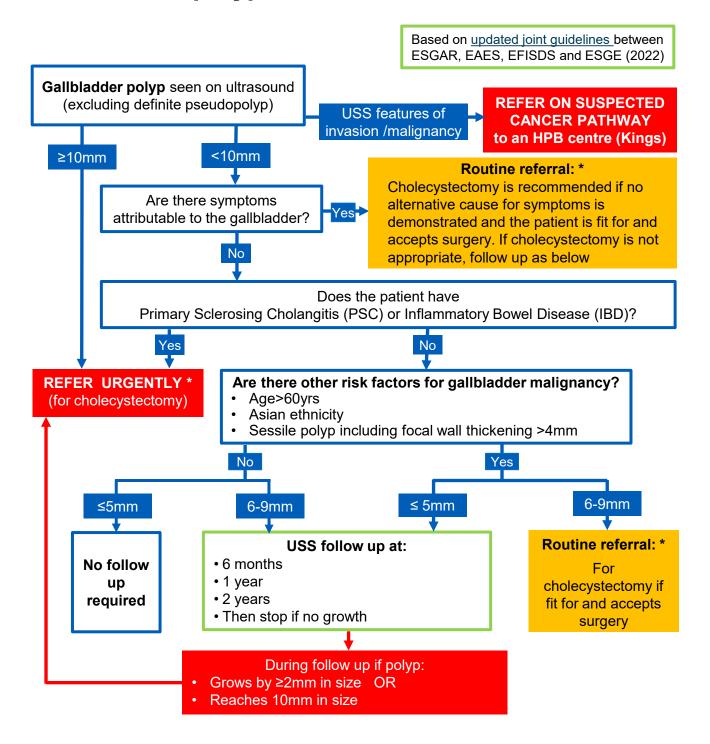
#### Required for routine referral:

- USS
- Bloods

be made to discuss this)



# Gallbladder polyps

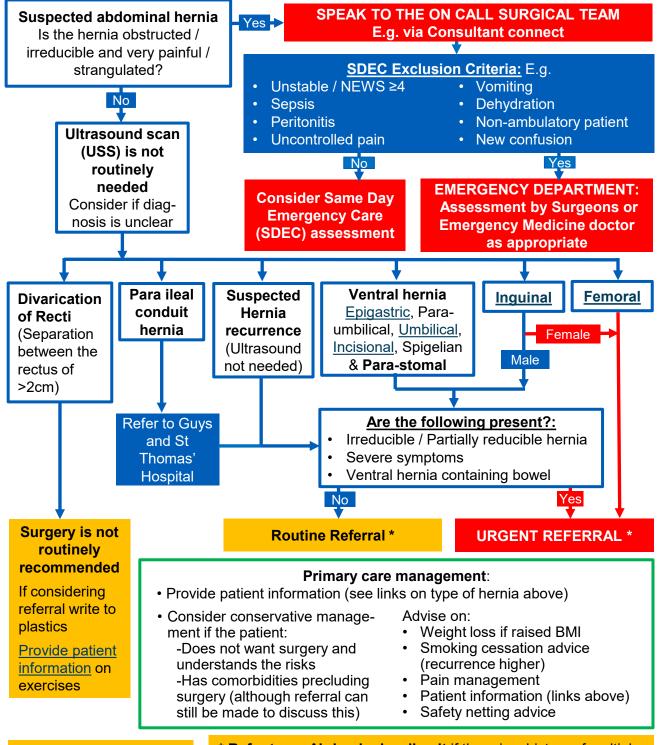


- \* Refer to a centre with a liver unit if the patient has
  - Alcoholic Liver Disease
  - Ascites / Varicies / Portal hypertension

Required for referral:
• USS (last 3 reports)



# Hernia pathway



## Required for referral:

- Examination
- USS report if done
- Refer to an Abdominal wall unit if there is a history of multiple previous hernia repairs (Guys & St Thomas', Kings, Lewisham)

  If BMI ≥40 consider referral to a centre with Bariatric specialists (Kings, PRUH or Lewisham)



# 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
ВМІ	Body Mass Index
ВР	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