

General Surgery Consult Guidelines

1. HERNIA

- **Inguinal Hernia:** Refer for outpatient clinic visit if hernia is reducible (even if the patient complains of severe pain) or has a chronic incarceration and no acute changes.
- **Acutely incarcerated IH or strangulated Inguinal Hernia:** (bowel obstruction or bowel compromise). ED physician must attempt reduction as long as there is no concern for bowel compromise. If successful refer to outpatient clinic, if not successful please call surgery consult. CT scan is not necessary.
- **Incisional/Ventral/Umbilical:** Call surgery consult only for signs for acute incarceration, bowel obstruction, signs of bowel compromise, elevated WBC >12. Discuss with surgery before ordering a CT scan.

2. **SKIN ABSCESS:** ED should drain if fluctuant area < 5cm (do not count area of cellulitis/erythema in this measurement). I & D should be adequate no small cruciate incisions for abscess > 2 cm since this is inadequate drainage. Referral to nursing wound care clinic for dressing changes.

3. R/O NECROTIZING SOFT TISSUE INFECTION CONSULTS:

LRINEC score must be >6 to merit a consult (Na and WBC very predictive). Consults should be directed to the correct service by location on body. Any upper extremity consult goes to upper extremity on call, foot/ankle consult podiatry, Scrotum consult GU, trunk consult general surgery, leg consult ortho or general surgery.

4. **APPENDICITIS:** Workup must include CBC w diff, U/A, pregnancy test female <55 y/o. ED physician must do an ALVARADO score prior to consultation or ordering of any imaging.
- **Alvarado score ≤4** – d/c to home, no CT or surgery consult
 - **Alvarado score 5-8** – CT scan with IV contrast (if renal function OK) and call surgery consult if CT findings suggestive of appendicitis.
 - **Alvarado score >8** – Surgery consult, surgery will decide if they want to get a CT

5. BOWEL OBSTRUCTION:

- Must r/o incarcerated IH hernia first by PE.
- If no hernia, start with 3 view abdominal x-ray to r/o ileus. If ileus then no surgery consult necessary.
- Obtain CBC w/ diff, chem 7, U/A, start IVF and begin resuscitation.
- Place NGT if severe nausea/vomiting or distention.
- CT scan with IV contrast if possible and PO contrast if patient is not extremely distended or has severe nausea/vomiting.
- Call surgery after CT is done.

6. **DIVERTICULITIS:** Obtain WBC with diff, U/A, and CT scan w/ IV contrast.
- Uncomplicated diverticulitis: Stranding wall thickening, or inflamed sigmoid without perforation/abscess consult medicine (no surg. consult)
 - Complicated diverticulitis: Abscess, fistula, large inflammatory mass, free air-surg consult.
7. **GALLBLADDER DISEASE:** Obtain CBC with diff, LFTs, amylase, lipase. Imaging as convenient RUQ US or Ct w/ IV contrast. If bilirubin elevation must image CBD to r/o possible cholangitis, if CBD > 1cm please call GI for ERCP, start antibiotics, admit to medicine.

Tokyo Criteria for Diagnosis of Acute Cholecystitis

- a. PE signs of inflammation
 - (1) Murphy's sign, (2) RUQ mass/pain/tenderness
- b. Systemic signs of inflammation:
 - (1) Fever (2) elevated WBC count
- c. Imaging findings: characteristic of acute cholecystitis
 - US:**
 - Positive Sonographic Murphy sign
 - Thickened gallbladder wall (>4 mm; if the patient does not have chronic liver disease and/or ascites or right heart failure)
 - Pericholecystic fluid collection
 - CT:**
 - Thickened gallbladder wall
 - Pericholecystic fluid collection
 - Linear high-density areas in the pericholecystic fat tissue

ACUTE CHOLECYSTITIS MUST HAVE:

- One item from (a) and one item from (b)
- Imaging findings confirm the diagnosis

8. **ACUTE ABDOMEN**

If hemodynamically stable do appropriate ED workup (CBC, diff, INR, Chem 7, LFT, CT) and then call surgical consult.

If hemodynamically unstable, start resuscitation, call ICU service and surgery consult. Get portable upright CXR.

9. HEMORRHOIDS:

1. External thrombosed hemorrhoids

>48 hours history, sitz bath, pain meds, Metamucil, colace no need for clinic f/u. Long term fiber is treatment (must get a script Metamucil x 6 weeks)) not “dietary fiber”.

2. Bleeding internal hemorrhoids

- Hemodynamically stable and **not actively** bleeding: if Hct > 30, colace, referral for colonoscopy if not done in last 2 years. 6 month fiber script. No acute surgery consult needed. GMC can do if no relief after 6 weeks of Metamucil treatment.
- If actively bleeding in ER call surgery after CBC, INR completed and a DRE has been performed. Start IVF resuscitation ASAP.

2. Perirectal/ Perianal Pain/Abscess

- Perianal pain

Most likely 1 of 3 diagnoses

1. Fissure (sitz bath, fiber X 6 weeks, colace, no need for consult from ER)
2. External thrombosed hemorrhoid (see above)
3. Perianal abscess (see below)

Abscess must be with 4 cm of the anus otherwise these are buttock abscess and the ER should do the I/D. If within 4 cm of the anus obtain CBC, INR, Chem 7 and call a surgery consult.