Clinical prioritisation criteria

Vascular surgery CPC V1.03

Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for Vascular. It is a consultation document only. This is a drafting document and should be read in conjunction with the consultation overview.

The final format will be as indicated on the CPC website https://cpc.health.qld.gov.au/ and embedded into your local HealthPathways site or HHS site i.e. 'Refer your patient' website https://metrosouth.health.qld.gov.au/referrals or www.health.qld.gov.au/metronorth/refer.

For more information about the CPC development process and purpose, please see the accompanying CPC Consultation Overview.

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Vascular inclusion for outpatient services

The following conditions are proposed to be considered under the Vascular CPC.

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the CPC exclusions section.

- Carotid artery disease
- Aortic aneurysm
- Dialysis access procedure
- Peripheral arterial disease
- High risk foot
- Venous disease

Vascular exclusions for outpatient services

Not all services are appropriate to be seen in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Vascular service

The following are not routinely provided in a public Vascular service.

- Asymptomatic / cosmetic varicose veins (unless within scope of your local health service)

Referral and outpatient criteria

Carotid artery disease

Referral to emergency

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.

- Crescendo or multiple recent TIA (Transient Ischemic Attack) / amaurosis fugax
- Acute stroke

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Isolated Transient Ischemic Attack (TIA)/stroke, amaurosis fugax • Symptomatic internal carotid stenosis of >50% on imaging • Symptomatic occluded internal carotid
Category 2 (appointment within 90 calendar days)	• Asymptomatic internal carotid stenosis of >80% on imaging • Symptomatic <50% internal carotid stenosis • Symptomatic subclavian steal syndrome • Asymptomatic occluded internal carotid • Carotid body tumour
Category 3 (appointment within 365 calendar days)	• Asymptomatic carotid stenosis of between 50-79% on imaging

1. **Reason for request,** indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. **Essential referral information,** Referral will be returned without this

- Clinical history
- History of TIA/stroke (Motor changes, dysarthria, ocular visual changes)
- History of risk factors and management
- Type/location/timing of symptoms (contralateral sensory/motor, monocular visual change)
- Cardiovascular assessment
- USS, duplex scan (carotid artery) results
- BSL Lipid profile U&E FBC & coags Homocysteine level (HbA_{1C} if diabetic)

3. **Additional referral information,** Useful for processing the referral

- No additional information

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.

- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Advance health directive (where available)
- Atherosclerosis risk factor management (antihypertensive; diabetes, dyslipidaemia)
- Lifestyle modification (Increased activity, dietary, weight, smoking, alcohol)
- It is strongly recommended that people who smoke stop before surgery as it is associated with delayed skin healing. Please consider directing your patient to a smoking cessation program.
- Commence anti-platelet agent aspirin (clopidogrel if there is allergy or other contraindication to aspirin)
- Active cholesterol and blood pressure lowering (if appropriate)

Clinical resources (links)	Patient resources (links)
• Advance health directive (where available) • Transient Ischemic Attack definition https://strokefoundation.org.au/About-Stroke/Types-of-stroke/Transient-Ischaemic-Attack-TIA	

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Aortic aneurysm

Referral to emergency

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.

- Acute aortic dissection
- Ruptured AAA
- Symptomatic AAA (abdominal/back pain/tenderness, compressive symptoms, distal embolisation)

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Abdominal aortic aneurysm >5.0cm AP or transverse diameter measure (increasing size, tenderness) • Thoracic aneurysm >5.0cm transverse diameter measure (increasing size, tenderness) • Rapid AAA expansion (>1.0cm / year)
Category 2 (appointment within 90 calendar days)	• Abdominal aortic aneurysm 4.0-5.0 cm - transverse diameter measure • Thoracic aneurysm 4.0-5.0cm - transverse diameter measure
Category 3 (appointment within 365 calendar days)	• Abdominal aortic aneurysm <4.0cm - transverse diameter measure • Thoracic aneurysm <4.0cm - transverse diameter measure

1. Reason for request, indicate on the referral

- To establish a diagnosis

- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. Essential referral information, Referral will be returned without this

- Genetic factors and collagen disorder
- Significant co-morbidities
- Cardiovascular assessment
- Current aneurysm size, AP or transverse diameter measurement last 6 months (if known)
- Vascular risk factors
- U&E FBC & coags results, BSL Lipid profile
- CXR report
- Abdominal USS

3. Additional referral information, Useful for processing the referral

- Fine slice CT (if available) patient to bring CD

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Advance health directive (where available)
- AP and Transverse dimensions - Please note length of aneurysm is irrelevant
- Atherosclerosis risk factor management (antihypertensive; diabetes, dyslipidaemia)
- It is strongly recommended that people who smoke stop before surgery as it is associated with delayed skin healing.
- It is strongly recommended that people who smoke stop before surgery as it is associated with delayed skin healing. Please consider directing your patient to a smoking cessation program.
- Where serial/follow-up >3.5cm-5cm, 6-monthly surveillance USS is performed.
- Where serial/follow-up <3.5cm, 12-monthly surveillance USS is performed.
- Any increase of 1cm or more within a 12-month period is an indicator for early referral.
- Driving should cease if AAA is >5.0cm or the patient is considered at risk of dissection or rupture (Austroads 2013).

Clinical resources (links)	Patient resources (links)
	• Advance health directive (where available) • Ausroads Assessing fitness to drive

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Dialysis access procedure (specialist-to-specialist referral)

Referral to emergency

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.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• A patient with a catheter insitu for dialysis who is awaiting an AVF formation • A patient currently on haemodialysis who has a failing AVF • Renal access referral prioritisation score >8 (statewide renal access surgery: dialysis access referral form)
Category 2 (appointment within 90 calendar days)	• Renal access referral prioritisation score 5–8 (statewide renal access surgery: dialysis access referral form)
Category 3 (appointment within 365 calendar days)	• Renal access referral prioritisation score <5 (statewide renal access surgery: dialysis access referral form)

1. Essential referral information, Referral will be returned without this

- General referral information

2. Additional referral information, Useful for processing the referral

- USS (optional)

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Advance health directive (where available)
- Statewide renal access surgery
- Refer as per local access guidelines

Clinical resources (links)	Patient resources (links)
• Dialysis access referral form http://qheps.health.qld.gov.au/cairns/docs/sw268.pdf	• Advance health directive

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Peripheral arterial disease

Referral to emergency

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.

- Active infection in leg with peripheral arterial disease
- Diabetic foot infection (refer to high-risk foot CPC or HealthPathways)
- Acute arterial ischemia/threatened limb

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Refer directly to emergency if clinically indicated: – ischaemic changes and/or threatened limb (ulcer, gangrene, rest pain) – diabetic foot with ulcer or infection (refer to HealthPathways) • Claudication <50m • Significant impact on quality of life • Peripheral aneurysm above the treatment threshold
Category 2 (appointment within 90 calendar days)	• Intermittent claudication with no signs of limb-threatening ischaemia >50m • Arm ischaemia with non-critical limb • Asymptomatic peripheral aneurysms below the treatment threshold
Category 3 (appointment within 365 calendar days)	• Claudication with no impact on quality of life

1. Essential referral information, Referral will be returned without this

- History including:
  - incapacitating claudication distance
  - rest pain
  - ischaemic changes
- Peripheral pulses: femoral/popliteal/foot
- Risk factors particularly smoking and diabetes
- Recent cardiac tests, including stress test results
- Duplex USS scan results (Cat 1 case only)
- U&E FBC & coags, BSL Lipid profile

2. Additional referral information, Useful for processing the referral

- Homocysteine level (HbA1C if diabetic),

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Advance health directive (where available)
- Asymptomatic tibial disease should follow risk modification pathway and exercise therapy as first option.
- Atherosclerosis risk factor management (antihypertensive; diabetes, dyslipidaemia)
- Lifestyle modification (Increased activity, dietary, weight, smoking, alcohol)
- Graduate exercise therapy (as appropriate)
- Commence anti-platelet agent (aspirin)

Clinical resources (links)	Patient resources (links)
	• Advance health directive

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

High-risk foot

Referral to emergency

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.

- Active infection in leg with peripheral arterial disease
- Diabetic foot infection (refer to high-risk foot Healthpathway)
- Acute arterial ischemia/threatened limb

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Refer directly to emergency - Foot ulcer with infection and systemically unwell or febrile, invasive infection or rapidly spreading cellulitis (defined by peripheral redness around the wound >2cm), acute ischaemia, wet gangrene, acute or suspected Charcot - **A** • Foot ulcer or pressure injury with mild to moderate infection <2cm around wound. - **B** • Necrosis/dry gangrene (with or without ulceration) - **B** • Non-infected foot ulcer - **B** **Urgent cases – (refer to key below)** • **A** – client to present to emergency department immediately • **B** – client to present to diabetes specialist service within 24 hours. If no specialist service is available, present to an emergency department.
Category 2 (appointment within 90 calendar days)	• Diabetic with high-risk foot* *High-risk foot has 2 or more of the following: • peripheral neuropathy (PN), • peripheral arterial disease (PAD), • foot deformity • or a history of: – previous amputation or – previous foot ulceration
Category 3 (appointment within 365 calendar days)	• Peripheral arterial disease, peripheral neuropathy or foot deformity in the absence of adequate community resources

4. Essential referral information, Referral will be returned without this

- Details of all treatments offered and efficacy
- Peripheral pulses, femoral/popliteal/foot

5. Additional referral information, Useful for processing the referral

- Is the ulcer neuropathic or ischaemic (or both) in origin?
- Is there active infection? Consider deep wound swab/pathology for culture, ESR CRP FBC
- Is there invasive infection with spreading cellulitis around the wound?

- Is there bony infection? XR if required.
- If suspected arterial disease –Doppler Ankle Brachial Pressure Index (ABPI), toe pressures, duplex scan etc
- Appropriate medical history including claudication distance, rest pain, ischaemic changes and risk factors
- Results of depression screening (PHQ-2)
  - over the last 2 weeks, how often have you been bothered by any of the following problems?
    - little interest or pleasure in doing things?
    - feeling down, depressed, or hopeless?

6. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Diabetic foot ulcer: High-risk foot clinic (referral via podiatry and access via telehealth available –- Statewide Diabetes Clinical Network will provide details)
- For adults with diabetes, assess their risk of developing a diabetic foot problem at the following times:
  - when diabetes is diagnosed, and at least annually thereafter
  - if any foot problems arise
  - on any admission to hospital, and if there is any change in their status while they are in hospital.
- For low risk of developing a diabetic foot problem, continue to carry out annual foot assessments, emphasise the importance of foot care, and advise they could progress to moderate or high risk
- Basic foot care advice and the importance of foot care
- ATSI people with diabetes are considered to be at high risk of developing foot complications until adequately assessed otherwise
- Commence antibiotics as per therapeutic guidelines https://tgldcdp.tg.org.au/etgAccess
  Off-loading https://www.sdc.qld.edu.au/courses/176
- Renal impairment increases the risk of amputation for people with diabetes who experience amputation rates 11 times that of the general diabetic population, which in turn is 15 times the rate in people without diabetes

Examine both feet for evidence of the following risk factors:

- Neuropathy (use a 10 g monofilament as part of a foot sensory examination)
- Limb ischaemia (see CPC on peripheral arterial disease)
- Ulceration
- Callus
- Infection and/or inflammation
- Deformity
- Gangrene
- Charcot arthropathy

Clinical resources (links)	Patient resources (links)
	• Advance health directive

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Venous disease

Referral to emergency

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.

- Axillary vein thrombosis, iliofemoral DVT

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Refer directly to emergency if clinically indicated – acute DVT • Haemorrhage from varicose veins • Venous ulcer
Category 2 (appointment within 90 calendar days)	• Acute thrombophlebitis (clexane for 6 weeks) • Lipodermatosclerosis
Category 3 (appointment within 365 calendar days)	• Symptomatic varicose veins (excluding cosmesis (Spider/cosmetic vein)) • Chronic DVT

1. Essential referral information, Referral will be returned without this

- History and examination findings in particular commenting on:
  - bleeding venous ulcer
  - venous ulcer
  - thrombophlebitis
  - DVT
  - lipodermatosclerosis
  - varicose eczema
  - previous surgery
  - details how varicose veins limit activity (executing activities) and participation restrictions (involvement in life situations) e.g. standing long periods at work.
- Conservative measures trialled
- If peripheral arterial disease, please indicate if ulcers or ischaemic rest pain.
- U&E FBC results
- If history of DVT: ensure hypercoagulable screen and coag results

2. Additional referral information, Useful for processing the referral

- USS mapping of varicose veins

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways or local guidelines
- Consider referral to occupational therapy outpatients for compression garments

Clinical resources (links)	Patient resources (links)
• Deep vein thrombosis and air travel http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-communic-factsheets-thrombosis.htm	• Patient information http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Varicose_veins_and_spider_veins • Patient information from NIH

• DVT prophylaxis http://www.surgeons.org/media/19372/VTE_Guidelines.pdf	http://www.nlm.nih.gov/medlineplus/ency/article/001109.htm

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Other referrals to emergency not covered within these conditions

Referral to emergency

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.

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Intervention criteria

Out-of-scope for Vascular interventions

Not all services are funded in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Vascular service:

- asymptomatic / cosmetic varicose veins (unless within scope of your local health service)

Urgency category for intervention

Intervention	Minimum Criteria	Urgency
Abdominal or thoracic aortic aneurysm by any means – (AAA TEVAR/EVAR/OPEN)		Cat 1
Amputation of digit (toe/finger)	Category 1: Gangrene /osteomyelitis	Cat 1
Amputation of limb		Cat 1
Bifurcated aortic graft	Category 1: Critical limb ischaemia Category 2: Claudication	Cat 1
Carotid endarterectomy	Category 1: Symptomatic >50% Category 2: Asymptomatic >80%	Cat 1 or 2 *(Cat 1 – National Elective Surgery Categorisation)*
Dialysis access procedure	Category 1: On dialysis with permacath Category 2: Pre-dialysis	Cat 1 or 2 *(Cat 2 - National Elective Surgery Categorisation)*
Peripheral angioplasty =/- stent	Category 1: Pain at rest with critical ischaemia Category 2: Peripheral angioplasty with significant lifestyle symptoms Category 3: Claudication	Cat 1 or 2
Femoro-popliteal bypass graft	Category 1: Pain at rest with critical ischemia Category 2: Claudication distance <50m, or for claudication that prevents employment	Cat 1 or 2 *(Cat 2 – National Elective Surgery Categorisation)*
Varicose veins treatment by any means (for reasons other than cosmetic)	Category 2: Venous ulcer/ lipodermatosclerosis Category 3: Recurrent phlebitis Category 3: Symptomatic veins	Cat 1-3 *(Cat 3 – National Elective Surgery Categorisation)*

Version control

Version	Date	Author	Nature of amendment
v0.01		Dr Jason Jenkins, CPC Team (Liz Travers, Lana Conde)	Initial version
v0.02 – v0.11		Dr Jason Jenkins, CAG, CPC Team (Liz Travers, Lana Conde)	CAG consultation
v0.12	1/02/2016	CPC Team (Liz Travers, Lana Conde)	Amendments following stage 1 consultation and desktop audit
v0.13	11/04/2016	CPC Team (Liz Travers, Lana Conde)	Transfer into 'phase 2' consultation template and editorial review
v0.14	28/04/2016	CPC Team (Liz Travers, Lana Conde)	Minor amendments
v0.15	19/05/2016	Dr Jason Jenkins, CPC Team (Liz Travers, Lana Conde)	Minor amendments following final endorsement with CAG
v1.0	24/05/2016	CPC Team (Liz Travers, Lana Conde)	Final endorsed CPC
V1.01	1/8/2017	CPC Team (Liz Travers)	Rebranding and incorporating amendments from feedback received 1/7/2016-30/6/2017
V1.02	26/6/2018	CPC Team (Liz Travers)	Preparing for CPC review and incorporating amendments from feedback todate
V1.03	27/8/2018	Vascular CAG and CPC Team (Liz Travers)	Amendments from Vascular CAG review