

Endocrinology Specialist Clinics at Western Health:

Western Health provides the following Specialist Clinics for patients who require assessment and management of Endocrine conditions. Patients will be triaged by health professionals into management pathways according to specific clinical requirements.

In particular, Endocrinology Specialist Clinics at Western Health manage:

- Endocrine adrenal disorders including adrenal insufficiency, primary aldosteronism, and adrenal mass
- Endocrine thyroid disorders including hyperthyroidism, persistent hypothyroidism, and thyroiditis
- Endocrine pituitary disorders including prolactinoma, Cushing's disease, and acromegaly
- Primary and secondary hypogonadal disorders
- Familial or severe dyslipidaemia
- Amenorrhoea
- Suspected insulinoma and other disorders of endogenous hyperinsulinaemic hypoglycaemia

Conditions not seen by Endocrinology Specialists at Western Health:

- Clinically stable hypothyroidism
- Primary hypothyroidism (except in patients with cardiac disease, pregnancy or if thyroxine treatment is contraindicated) that has not been treated with replacement therapy
- Adrenal mass >3cm in size or confirmed malignancy – refer to **General Endocrine Surgery**
- Obesity (without diabetes): Consider referral to **Obesity Clinics** at RMH, Alfred Health or Monash Health
- Transgender care: Consider referral to **Monash Health or Austin Health**
- Polycystic Ovarian Syndrome: Consider referral to **Gynaecology Service**
- Patients with diabetes to **Diabetes Specialist Clinic**
- Patients with osteoporosis or hypercalcaemia to **Metabolic Bone Disorder Specialist Clinics**
- Patients with thyroid mass or nodules with normal thyroid function to **General Endocrine Surgery Specialist Clinic**
- Pregnant patients with endocrine conditions to **Antenatal Clinic** (*ensure endocrine issues stated on referral to assist with triage/urgency)
- Patients with menopause and perimenopause to the **Women's Health Clinic**

Endocrinology Alarm Symptoms:

Direct to emergency department:

- Vomiting or persistent diarrhoea in patient with adrenal insufficiency
- Malignant hypertension
- Hyperthyroidism complicated by cardiac, respiratory compromise or other indications of severe illness (fever, vomiting, labile blood pressure, altered mental state)
- Neutropenic sepsis in patient taking carbimazole or propylthiouracil
- Hyperthyroidism with hypokalaemia or paralysis
- Suspected myxoedema coma (impaired conscious state, hypothermia, bradycardia) with high thyroid stimulating hormone level
- Severe headache or visual impairment in patient with pituitary mass
- Suspected new onset arginine vasopressin (AVP) deficiency (formerly diabetes insipidus)

Call Endocrinology Registrar to discuss (03 8345 6666 and page):

- Newly diagnosed or suspected adrenal insufficiency

Access & Referral Priority Endocrinology:

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

<p style="text-align: center;">URGENT</p> <p style="text-align: center;">Appointment timeframe 30 days.</p>	<p style="text-align: center;">ROUTINE</p> <p style="text-align: center;">Appointment timeframe greater than 30 days, depending on clinical need.</p>
<p>Adrenal</p> <ul style="list-style-type: none"> • Acute adrenal insufficiency (suspected or confirmed) • Severe untreated chronic adrenal insufficiency • Severe hypertension in primary aldosteronism • Adrenal mass less than 3cm with hypersecretion <p>Thyroid</p> <ul style="list-style-type: none"> • Hyperthyroidism in pregnancy (please refer to Obstetric Endocrinology) • Hypothyroidism with mild symptoms or TSH >20 <p>Pituitary</p> <ul style="list-style-type: none"> • Pituitary disorder with headache or features of hormone excess or deficiency <p>Male hypogonadism</p> <ul style="list-style-type: none"> • Acute onset male hypogonadism <p>Amenorrhoea</p> <ul style="list-style-type: none"> • Amenorrhoea with galactorrhoea, acute virilisation, or features of hypopituitarism <p>Hirsutism</p> <ul style="list-style-type: none"> • Hirsutism with virilisation, Cushingoid features, or rapid progression <p>Hypoglycaemia</p> <ul style="list-style-type: none"> • Hypoglycaemic disorder worsening in severity or frequency 	<p>Adrenal</p> <ul style="list-style-type: none"> • Established adrenal insufficiency on treatment • Steroid-induced insufficiency on glucocorticoids • Primary aldosteronism without severe hypertension • Adrenal mass less than 3cm without features of malignancy or hypersecretion (>3cm refer to General Endocrine Surgery) <p>Thyroid</p> <ul style="list-style-type: none"> • Newly identified or recurring hyperthyroidism (including Graves' disease) • Persistent inadequately controlled hypothyroidism <p>Pituitary</p> <ul style="list-style-type: none"> • Pituitary disorder without headache or features of hormone excess or deficiency <p>Male hypogonadism</p> <ul style="list-style-type: none"> • Subacute or chronic male hypogonadism <p>Amenorrhoea</p> <ul style="list-style-type: none"> • Isolated amenorrhoea for investigation and management <p>Hirsutism</p> <ul style="list-style-type: none"> • Hirsutism without features of severe androgen excess <p>Hypoglycaemia</p> <ul style="list-style-type: none"> • Non-severe fasting or postprandial hypoglycaemic disorder

Condition Specific Referral Guidelines:

Key information enables Western Health to triage patients to the correct category and provide treatment with fewer visits to specialist clinics, creating more capacity for care. If key information is missing, you may be asked to return the referral with the required information.

Condition:	Key Information Points:	Clinical Investigations:
Adrenal insufficiency	Essential: <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history • Current medication list • Previous management details • Relevant family history • Any history of hyperpigmentation 	Essential: <ul style="list-style-type: none"> • Electrolytes and creatinine • Fasting glucose • Early morning cortisol Provide if available: <ul style="list-style-type: none"> • ACTH • Renin and aldosterone • Pituitary hormonal panel
Primary aldosteronism	Essential: <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history • Current medication list • Previous management details • Relevant family history • Any history of hypokalaemia 	Essential: <ul style="list-style-type: none"> • Electrolytes and creatinine • Renin and aldosterone • Aldosterone to renin ratio (ARR) Provide if available: <ul style="list-style-type: none"> • 1mg dexamethasone suppression test • Plasma metanephrines
Adrenal mass* - *Less than 3cm without features of malignancy (>3cm or features of malignancy refer to General Endocrine Surgery)	Essential: <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history • Current medication list • Previous management details • Relevant family history • Any history of change over time 	Essential: <ul style="list-style-type: none"> • Dedicated adrenal CT • Plasma metanephrines • 1mg dexamethasone suppression test • Renin and aldosterone Provide if available: <ul style="list-style-type: none"> • 24-hour urinary catecholamines • Testosterone and DHEAS
Hyperthyroidism	Essential: <ul style="list-style-type: none"> • Details of clinical presentation including thyroid tenderness or features of ophthalmopathy. • Past medical history • Current medication list • Pregnancy status • Previous management details • Relevant family history 	Essential: <ul style="list-style-type: none"> • Full blood examination (FBE) • Thyroid stimulating hormone (TSH) • Free thyroxine (T4) • Free triiodothyronine (T3) Provide if available: <ul style="list-style-type: none"> • TSH-R Antibody (TRAb) or TSI results • Anti-TPO Antibody results • Liver function tests • Current and previous scan results (e.g. nuclear thyroid scan) • Thyroid ultrasound is not useful in assessing hyperthyroidism

Western Health Specialist Clinics Access & Referral Guidelines

<p>Hypothyroidism</p> <p><i>Refer if:</i></p> <ul style="list-style-type: none"> - Persistent hypothyroidism despite adequate replacement treatment - Suspected or confirmed secondary hypothyroidism (i.e. low TSH and low T4) - Persistent thyroiditis that has lasted for more than 6 months 	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history • Current medication list • Previous management details including radioactive iodine • Relevant family history • Any history of thyroid surgery 	<p>Essential:</p> <ul style="list-style-type: none"> • Thyroid stimulating hormone (TSH) • Free thyroxine (T4) • Historic results (if persistent thyroiditis) <p>Provide if available:</p> <ul style="list-style-type: none"> • Anti-TPO Antibody results • Thyroid ultrasound is not useful in assessing hyperthyroidism
<p>Pituitary disorders</p>	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation and assessment of visual fields • Past medical history • Current medication list • Details of any radiotherapy or pituitary surgery • Previous management details • Relevant family history • 	<p>Essential:</p> <ul style="list-style-type: none"> • Electrolytes and creatinine • Prolactin • Cortisol ± Adrenocorticotrophic hormone (ACTH) • 24-hour urine free cortisol (UFC) in suspected Cushing's • IGF-1 level (in suspected acromegaly) <p>Provide if available:</p> <ul style="list-style-type: none"> • TSH and free thyroxine (T4) • FSH, LH and oestradiol or testosterone • MRI pituitary • Visual fields report (optometrist)
<p>Male hypogonadism</p>	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation • Past medical and pubertal history including any testicular trauma • Current medication list and past anabolic steroid use 	<p>Essential:</p> <ul style="list-style-type: none"> • Full blood examination (FBE) • Total and free testosterone • SHBG • FSH and LH <p>Provide if available:</p> <ul style="list-style-type: none"> • Prolactin • Bone densitometry
<p>Amenorrhoea</p>	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history incl menstrual and pubertal history, any history of eating disorders or cancer treatment. • Current medication list • Relevant family history 	<p>Essential:</p> <ul style="list-style-type: none"> • BHCG • Prolactin • FSH, LH and oestradiol • Testosterone • TSH <p>Provide if available:</p> <ul style="list-style-type: none"> • SHBG • DHEAS • Pelvic ultrasound

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<p>Hirsutism</p>	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation • Past medical history including pubertal and menstrual history • Current medication list • Relevant family history 	<p>Essential:</p> <ul style="list-style-type: none"> • Electrolytes and creatinine • Testosterone • FSH and LH • SHBG • Free androgen index <p>Provide if available:</p> <ul style="list-style-type: none"> • Fasting glucose and lipids • DHEAS
<p>Hypoglycaemia</p>	<p>Essential:</p> <ul style="list-style-type: none"> • Details of clinical presentation including Fasting or postprandial pattern. • Details of possible access to hypoglycaemic agents and inappropriate use • Past medical history incl abdominal surgery and past management • Current medication list • Relevant family history 	<p>Essential:</p> <ul style="list-style-type: none"> • Electrolytes and creatinine • Fasting glucose, insulin and c-peptide • Early morning cortisol • Thyroid stimulating hormone (TSH) • Sulfonylurea screen <p>Provide if available:</p> <ul style="list-style-type: none"> • IGF-1 level • Proinsulin • Beta-hydroxybutyrate / Ketones