



Urology Clinic

Contents

- 1 Haematuria
- 1 Lower Urinary Tract Symptoms in Men
- 1 Recurrent Urinary Tract Infection
- 2 Renal Colic
- 2 Abnormal P.S.A Test
- 3 Female Incontinence
- 3 Male Genitalia

Definitions

- EMERGENCY** Proceed to Emergency Department
Please contact the senior clinician for medical advice
24hrs Direct Line 9288 4356 Fax 9288 4368
- URGENT** Appointment within **2 weeks** of receipt of the referral
- SEMI URGENT** Appointment within **8 weeks** of receipt of the referral
- ROUTINE** Next available appointment

Unless otherwise stated on individual referral guidelines



Mandatory Referral Content

Demographic:

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements

Clinical:

- Reason for referral
- Duration of symptoms
- Management to date and response to treatment
- Relevant pathology and imaging reports (please refer to specific guidelines)
- Past medical history
- Current medications (and medication history if relevant)

Preferred Referral Content

- Functional status
- Psychosocial history
- Dietary status
- Family history
- Usual GP



St Vincent's

Continuing the Mission of the Sisters of Charity

Haematuria

Patient Presentation

- Painful or painless
- Initial, terminal or total
- Associated features:
 - Lower urinary tract symptoms
 - Fever or rash
 - Trauma
 - Flank pain
 - Irritative voiding symptoms
- Examination:
 - Blood pressure
 - Abdominal or loin mass
 - Prostate

Initial Work Up

- Confirm +ve dipstix with formal MSU
- MSU including RBC morphology
- U & E's/ Cr/ eGFR
- Urine cytology (if smoker or >50 years)
- Coags (if on anticoagulant treatment)

Micro Haematuria

- US urinary tract, KUB

Macro Haematuria

- Renal CT/Intravenous pyelogram (urogram)

When to Refer

Urology Referral

- If haematuria (macro or micro) confirmed
- For cystoscopy

Nephrology Referral if:

- Hypertensive
 - Nephrotic
 - Increasing Cr
 - Proteinuria with painless haematuria
- Organise random urine protein/ Cr ratio*

Lower Urinary Tract Symptoms in Men

Patient Presentation

- Assess severity of symptoms:
 - Nocturia
 - Weak stream
 - Urgency
 - Straining
 - Terminal dribbling
 - Hesitancy
 - Intermittency
 - Bladder emptying
- Past history of retention or stricture
- Examination
 - Palpable bladder?
 - Phimosis
 - Direct rectal examination – size, consistency, features of cancer (hard/ nodular)

Initial Work Up

- Urinalysis
- U & E's
- Creatinine
- PSA
- Renal bladder U/S including post void residual

GP Management

Mild / moderate symptoms

Medical therapy options:

1. Prazosin (Pressin) – Initially 0.5 mg bd increasing (if required) to 2.0mg bd over 3–4 weeks
2. Tamsulosin (Flomaxtra) 400 mcg/d
No dose titration – Less side effects but cost ~ \$60 per month (not on PBS but is DVA)
3. Proscar 5 mg/d – Especially for larger prostates and if prazosin fails. 6/12 for maximal effect but cost ~ \$100 per month (not on PBS but is DVA)

When to Refer

- If severe symptoms
- If failed medical therapy
- Haematuria
- Bladder stones
- If abnormal:
 - Direct rectal examination
 - PSA
 - Renal U/S
 - MSU
 - Increasing creatinine

Recurrent Urinary Tract Infection

Patient Presentation

- Single episode male or recurrent in female

Initial Work Up

- Previous abnormal MSU x 1 in males; MSU x 3 in females
- Renal/bladder U/S
- Fasting blood glucose

When to Refer

- Refer for specialist assessment

Renal Colic

Patient Presentation

- Consider differential diagnosis:
 - AAA
 - Testicular pathology
 - Pyelonephritis
 - Appendicitis
 - Renal infarct
- Past history of stones

Initial work up

- FBE
- U&Es/ Cr
- Ca++
- Urate
- MSU
- KUB
- CT (non-contrast) will confirm stone size and position and likelihood of passing:
 - <4mm – 90% pass
 - 4–6 mm – 50% pass
 - >6mm – 10% pass

In order to diagnose and treat both KUB and CT are required

GP Management

- Analgesia
 - Morphine initially
 - Indomethacin 100 mg bd pr or 25 mg tds orally
 - Panadeine forte/ tramadol breakthrough
- Advise patient – strain urine (send stone for analysis) and moderate fluid intake
- Consider need for urgent referral to the emergency department or urology clinic

When to Refer

URGENT

Emergency Department or urgent referral to Urology Clinic

- For possible removal, stenting or drainage if:
 - Infection
 - Unrelieved pain or recurrent pain
 - Persisting nausea and vomiting
 - Increasing creatinine
 - Single kidney
 - Stone unlikely to pass on basis of size

SEMI URGENT

- Within 2–4 weeks of initial diagnosis if no indication for early review (very unlikely that renal damage will occur in this time)
- Patient must have had redo imaging within 24hrs of outpatient appointment and bring films
- KUB (only) – If stone easily seen on original KUB
- CT – If stone not seen on original KUB but was seen on CT

Abnormal P.S.A Test

Patient Presentation

- Routine yearly PSA testing if 10 year life expectancy and
 - 50–70 years
 - 40–70 years and positive family history
- Consider/ exclude other causes of raised PSA:
 - UTI, prostatitis
 - BPH
 - Recent instrumentation
- Direct rectal examination – any nodule, hard, size
- 71–75 years – Do PSA test only if the patient is in excellent health for his age or if symptoms of LUTS or metastatic prostate cancer

Initial Work Up

- Repeat PSA test in 4–6 weeks
 - Instruct patient to avoid bike riding, intercourse and ejaculation for 48 hours before second test
- If the initial PSA 2-10 µg/L repeat PSA test including free total ratio

GP Management

- If second test in normal range and free total ratio is >25% – GP review for repeat test in 6 months
- Then continue yearly PSA screening for increase – refer later if abnormal PSA or if PSA velocity is >0.75 µg/L/yr

When to Refer

- All abnormal PSA tests (confirmed on second test) in a patient with a 10 year life expectancy need specialist review
 - For consideration of biopsy
- Abnormal direct rectal examination (hard, nodule) in a patient with a 10 year life expectancy need specialist review (regardless of PSA level)
 - For consideration of biopsy
- Increased PSA velocity (>0.75 µg/L/yr) in patient with at least x2 PSA's one year apart

Female Incontinence

Patient Presentation

- Predominantly stress incontinence
- Predominantly urge incontinence
- Urge/ stress incontinence
- Does the patient require pads, number per day?
- History of UTIs
- Duration of symptoms
- Obstetric history
- Previous gynaecological/ urological surgery
- PV findings

Initial Work Up

- MSU
- Renal/bladder U/S
- U&Es

When to Refer

- Refer for specialist assessment
- Conservative management by a trained physiotherapist or continence specialist

Male Genitalia

Patient Presentation

- Testicular, epididymal, scrotal abnormality key points:
 - Right, left, bilateral
 - Body of testis
 - Cord or vas including varicocele
 - Epididymal
 - Hydrocoele
 - Epididymal cyst
- Acutely painful testis ? Torsion

Initial Work Up

- Testicular/ scrotal U/S

When to Refer

EMERGENCY

- Severe pain
- Torsion

URGENT

- Intra-testicular mass, refer urgently