UROLOGY

UROLOGY REFERRAL RECOMMENDATIONS			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
These referral recommendations are provided for core Urology Services in the public health system. They exclude social or cultural circumcision, vasectomy and vasectomy reversal, and access to impotence treatment.			
In the context of these referral recommendations Urology Specialist services have been grouped under the following headings: • PSA screening • Haematuria • Female incontinence • Stones • Male infertility • Lower urinary tract symptoms (male) • Suspected cancer of the prostate • Male genitalia • Paediatrics - male genitalia • Paediatrics - congenital abnormality	Evaluation is indicated from a primary care perspective. Standard history and examination is required for all situations. Key points in relation to individual diagnoses are highlighted and investigations indicated.	Treatment options at a primary level may be minimal for surgical diagnoses. However, options are indicated where appropriate.	This explains the primary/secondary interface, when a patient should be referred and the category of urgency. See ACA. Telephone/fax/e-mail communication will enhance access to the service.
HAEMATURIA Macroscopic (gross)	**KEY POINTS:** • ?Complete (urine uniformly blood stained). • ?Initial stream, ?end stream, ?clots • ?Pain/dysuria • Onset, duration, episodes **Females:** • Other gynaecological symptoms • PV findings **Males:** • Other urological symptoms • DRE **INVESTIGATIONS:** • MSU (RBCs, WCCs, culture) • PSA Consider: KUB US, IVU] in consultation with specialist Urology service (See Imaging Referral Recommendations.)		Continuous gross haematuria refer as category 1, OPD assessment, otherwise – category 2.
Microscopic (defined as >25RBCs in 3 urine specimens)	**INVESTIGATIONS:** • MSU x 3		

UROLOGY REFERRAL RECOMMENDATIONS			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
FEMALE INCONTINENCE	**KEY POINTS:** • 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	Conservative management by a trained physiotherapist or continence specialist • pelvic floor exercises • bladder drills **See also Primary Case Management Guidelines for Incontinence** **www.nzgg-careplans.org.nz/esg-onepage/**	Refer for OPD assessment – category 2-3.
STONES	**KEY POINTS:** • Past history of stones & stone surgery • Pain score: - Severe, poorly controlled - Moderate controlled - Minimal well controlled - Asymptomatic • Analgesia requirement • Acute renal coli - right/left - duration of symptoms • Known urinary tract calculus - size of stone - location - how diagnosed **INVESTIGATIONS:** • MSU (microscopy) • Serum Ca++, K+, uric acid • 24 hour urine Ca++, K+, oxalate, uric acid for recurrent stone makers Consider: KUB, USS, IVU – in consultation with urology service (See Primary Referred Imaging Referral Recommendations).		Poorly controlled renal/ ureteric colic refer for OPD assessment – category 1. This is usually via an A&E department. Otherwise – category 2. Obstructed kidney refer category 1.

<table>
<tr><th colspan="4">UROLOGY REFERRAL RECOMMENDATIONS</th></tr>
<tr><th>Diagnosis</th><th>Evaluation</th><th>Management Options</th><th>Referral Guidelines</th></tr>
<tr><td>MALE INFERTILITY</td><td>KEY POINTS:
• Has the patient had unprotected intercourse for 12 months or more?
• Has the patient previously biologically fathered children?
• Has the current partner had previous pregnancies?
• Has his partner undergone any investigations?
• Does the patient have a past history of:
- Mumps orchitis
- Inguinal hernia repair
- Testicular torsion
- Orchidopexy
- Varicocoele repair
- Any significant illness in the last six months?
Physical examination with emphasis on genitalia - size, symmetry and presence of Varicocoele.
INVESTIGATIONS:
• Serum testosterone
• FSH + LH
• Prolactin
• Sperm counts x 3 (or more). (After 3 days sexual abstinence, examine within two hours of collection.)</td><td></td><td>Referral depends on local service provision</td></tr>
<tr><td>LOWER URINARY TRACT SYMPTOMS (MALE)</td><td>KEY POINTS:
• Completed symptom score (see NHC Urology CPAC) (Appendix 1)
• Completed quality of life score (see NHC Urology CPAC) (Appendix 1)
• Previous lower urinary tract surgery
• Has the patient required catheterisation?
• Is he catheterised?
• Haematuria?
• Documented previous UTI's
PHYSICAL EXAMINATION:
• Palpable/percussible bladder?
• DRE - asymmetry, hardness, nodules, induration
INVESTIGATIONS:
MSU - WCC, RBC culture</td><td>Trial of alpha adrenergic blockers.</td><td>Refer to OPD assessment – category 2 after trial of alpha adrenergic blockers.</td></tr>
</table>

UROLOGY REFERRAL RECOMMENDATIONS			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
SUSPECTED CANCER OF THE PROSTATE Including elevated PSA	**KEY POINTS:** • Family history of Ca prostate • Completed symptom score (see Urology CPAC) (Appendix 1) • Completed quality of life score (see Urology CPAC) (Appendix 1) • Weight loss • Bony pain • Haematuria • Previous bladder/prostate surgery **PHYSICAL EXAMINATION:** • Palpable/percussible bladder? • DRE - asymmetry, hardness, nodules, induration **INVESTIGATIONS:** • PSAs • FBC, + ESR • U+E • Creatinine • Alkaline Phosphatase		Refer for OPD assessment – category 2.
MALE GENITALIA Testicular Abnormality	**KEY POINTS:** • Right, left, bilateral • Body of testis		Intra-Testicular mass refer urgently – category 1
Epididymal Abnormality	• Right, left, bilateral • Cord or vas including varicocoele • Epididymal • Hydrocoele • Epididymal cyst		Refer for OPD assessment – category 2.
Scrotal Abnormality			Refer to OPD assessment – category 2-3.
Penis Deformity	• Foreskin • Glans • Shaft • Functional		Refer for OPD assessment – category 2-3.

PAEDIATRIC UROLOGY - (see also Paediatric Surgery Referral Recommendations)			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
INGUINAL & SCROTAL			
Inguinal and/or Scrotal Swellings	Non acute herniae and hydrocoeles can be difficult to differentiate in children. It is important to recognise a hernia in a child under the age of 3 months. Varicocoeles are difficult to differentiate. If suspected, refer as per hernia Recommendation.	See also paediatric surgery referral guidelines.	*Child under 3 months with Hernia or uncertain diagnosis:* Refer urgently – category 1 to Paediatric Surgery/Urology Service. *Herniae over the age of 3 months:* Refer semi-urgently to paediatric surgical service or local general surgical service – category 2. *Difficult Hernia:* Any hernia that is reduced with difficulty, is at significant risk of strangulation and should be referred urgently, category 1, irrespective of age. *Hydrocoele:* If a hydrocoele is confidently diagnosed it can be treated expectantly. If it persists past the age of 2 or causes symptoms or grows rapidly it should be referred routinely – category 3.
Acute Scrotal Pathology	Epidydimo-orchitis is very rare in children and should not be diagnosed clinically. The following conditions are included: - torsion of testis - torsion of appendix of testis - strangulated hernia - incarcerated hernia - idiopathic scrotal oedema - uncertain mumps orchitis.	See also paediatric surgery referral guidelines.	Scrotal Pain with or without swelling: Refer immediately – category 1.
Undescended testis	Risk of infertility if orchidopexy is delayed, increases with age. It is now recommended that orchidopexy should be performed by the age of 1 year. An undescended testis is one that cannot be manipulated into the bottom of the scrotum. All testes should be situated within the scrotum by the age of 3 months.	See also paediatric surgery referral guidelines.	Refer from the age of 6 months to paediatric surgery or Urology service. Routine referral – category 3. In a clinically obvious associated hernia they should be managed as hernia Referral Recommendation.

PAEDIATRIC UROLOGY - (see also Paediatric Surgery Referral Recommendations)			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Retractile testis	Retractile testes are not normally situated within the scrotum but can be manipulated into the scrotum. The current recommendation is that they be fixed in the scrotum surgically if they remain retractile after the age of 2.	See also paediatric surgery referral guidelines.	Refer routinely at the age of 2 to the paediatric surgery or Urology service – category 3.
Acute Scrotal Pathology	Epidydimo-orchitis is very rare in children and should not be diagnosed clinically. The following conditions are included: - torsion of testis - torsion of appendix of testis - strangulated hernia - incarcerated hernia - idiopathic scrotal oedema - uncertain mumps orchitis.		Scrotal Pain with or without swelling: Refer immediately – category 1.
GENITALIA			
Phimosis/Paraphimosis	No problem if good urinary stream. A large percentage of foreskins are fused to the glans and will separate spontaneously over a number of months or years. There is no necessity to retract or be able to retract the foreskin (at least before 5 years of age). Ballooning with micturition frequently occurs and is acceptable providing there is a good urinary stream.	See also paediatric surgery referral guidelines.	*Phimosis:* Indications for referral: • Inability to retract after the age of 5. • Recurrent balanitis • Pinhole prepucial orifice with very poor urinary stream. • Refer routinely – category 3. *Paraphimosis:* Refer immediately – category 1.
Social/Religious Circumcisions			Not provided in public health system.
Hypospadias	Do not circumcise. Evaluate adequacy of urinary stream.		Refer at diagnosis routinely – category 3, to paediatric surgery or Urology service Refer immediately if poor urinary stream – category 1.
Urethral Meatal Stenosis	Usually neonatally circumcised boys. Evaluate urinary stream.		Refer routinely – category 3.

PAEDIATRIC UROLOGY - (see also Paediatric Surgery Referral Recommendations)			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
Balanitis	Accumulation of smegma under the foreskin is common and normal but can be mistaken for pus. Referral and/or intervention is not required. It will continue to extrude spontaneously until all the prepucial adhesions have disappeared. Foreskin retraction and cleaning is not necessary.	Frank infection requires treatment with oral antibiotics (eg. cotrimoxazole) and surgery if it is recurrent.	Recurrent balanitis – refer routinely, as above – category 3.
Other Genital Anomalies			Refer routinely category 3 to paediatric surgical service or appropriate local Paediatric Medical service.
URINARY TRACT			
Antenatally Diagnosed Hydronephrosis	Applies to hydronephrosis at any gestation. Post natal examination for abdominal mass. Ultrasound after 5 days of age. LMC has responsibility to ensure GP is informed.		Referral to paediatric or Urology service if dilatation is present – category 1. *Note:* Majority of urinary abnormalities present as either UTI or as hydronephrosis following antenatal Ultrasound.
Urinary Tract Infection Many urological abnormalities will present as an urinary tract infection. These include: • Vesicoureteric reflex • Pelvi-ureteric junction obstruction • Vesicoureteric junction obstruction • Primary Mega-ureter • Neurogenic bladder • Duplex system +/- ureterocoele • Posterior urethral valves	Evaluation of urinary tract infections: The diagnosis of UTI requires great care and skill. Clear evidence of UTI is essential. Urine results must be provided with the referral. Investigation: With reference to local recommendation.	Start antibiotics pending culture report. Five day course. Consider long term surveillance and prophylactic antibiotics until investigations are completed. Treat constipation, toileting hygiene. **See paediatric medicine guidelines for management UTI in children.**	Refer for assessment patients with abnormal imaging results or if requiring investigations noting local Recommendations. Routine category 3. Refer recurrent urinary tract infections. Routine category 3.
Neuropathic Bladder	Check for spinal abnormality i.e. mass or spina bifida occulta. Exclude constipation. Regular urine check ups.	• Treat constipation. • Long term antibiotics	Refer to Paediatric or Urology service if diagnosis suspected.