Urology Guidelines

(Approved by APC from a medicines perspective)

Sept 2022 For review Sept 2025

INTRODUCTION

This document is an update of the NORTH OF TYNE AND GATESHEAD GUIDELINES FOR MANAGEMENT OF COMMON UROLOGICAL CONDITIONS IN ADULTS IN PRIMARY CARE.
Changes have been made to fit with current practice and align recommendations with NICE guidance and **North of Tyne/Gateshead guidelines for detection, management and referral of adults with kidney disease.**

The guidelines are intended to guide clinical management, but every patient should be assessed and managed individually.

How to Use Guidelines

The BNF and the NoTGNC formulary should be referred to as appropriate.

Referrals

When referral to secondary care urology clinic is recommended in the guideline, referral for patients to be seen at a local outreach clinic may be preferred

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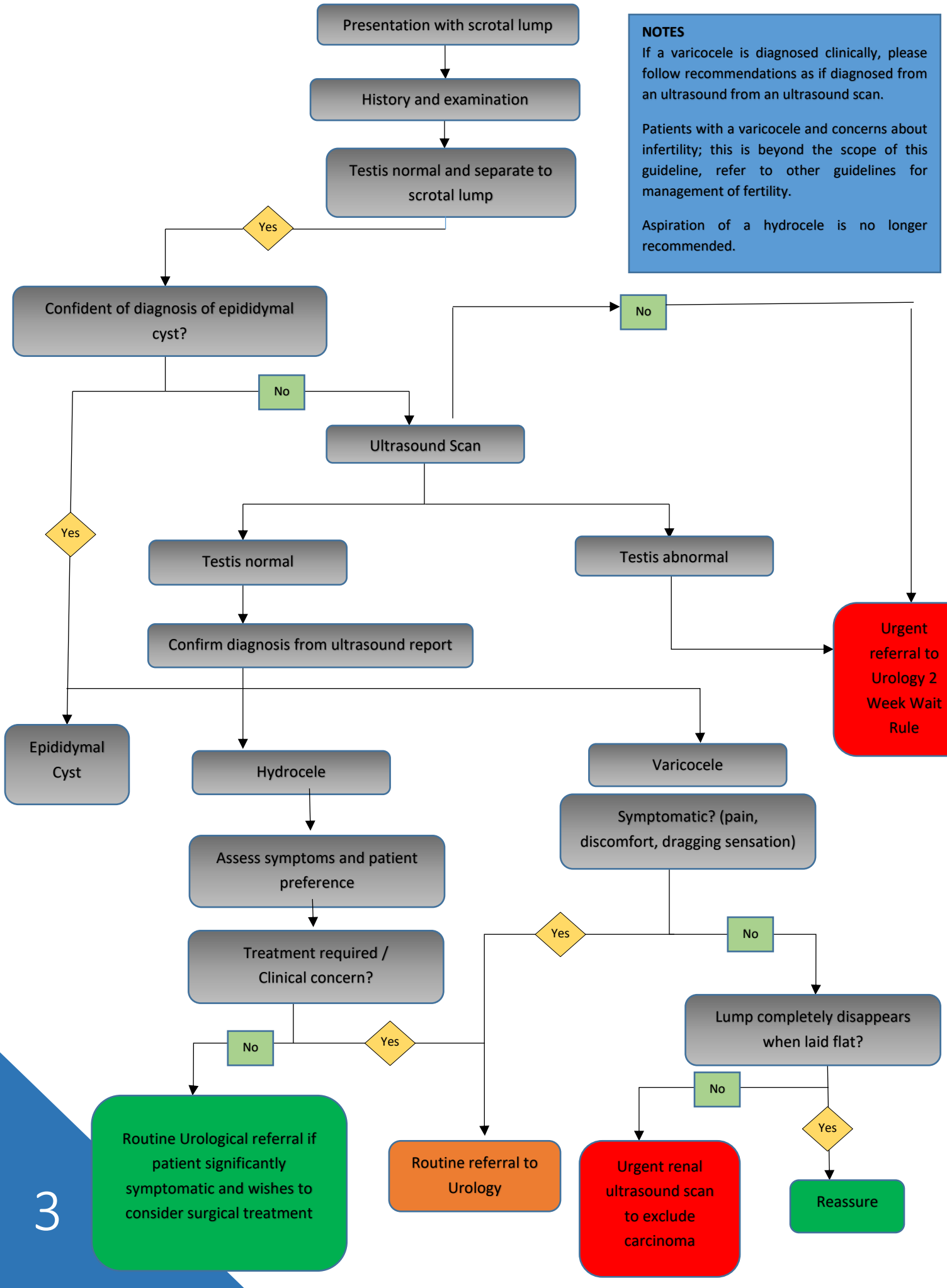
SCROTAL LUMPS



Testicular Microcalcification

If risk factors for testicular cancer i.e. history of undescended testis or Klinefelter's refer to Urology.
If no risk factors, there is no need for serial imaging and self-assessment as per standard advice is all that is required.

Idiopathic Chronic Testicular Pain

In the absence of abnormality on community ultrasound scan – for 3 months trial of NSAID and scrotal support.

In no improvement – for three months trial of low dose amitriptyline (10-25mg). If no improvement, consider referral to local specialist for consideration of surgical management.

RECURRENT URINARY TRACT INFECTIONS IN NON-PREGNANT FEMALES

Recurrent, microbiologically confirmed, symptomatic UTI
2 or more UTIs in 6/12, or 3 or more in 1 year.
Must obtain cultures where possible to guide further treatment

Exclude Persistent UTI – i.e. poor eradication after treatment

Consider extended course 7-14 days of antibiotics if
– persistent UTI
– Renal Tract
– Abnormality
Immunosuppressed

Examine sensitivities of previous MSUs

Undertake - Renal tract USS – including kidneys, full bladder and post void residual (PVR)

Abnormal USS or PVR>100mls **Refer to Urology**

Lifestyle/Self-care Advice

- Increase fluids : 24 hr urine output > 2 litres
- Ensure regular voiding (i.e. every 3 hours and undertaking doublemicturition)
- Address constipation
- If diabetic – ensure blood sugar controlled
- Post-coital voiding - NB diaphragm use can increase risk of UTI
- Avoid irritants e.g. bubble bath, spermicide
- Non-pregnant women may wish to try D-Mannose
- Limited evidence for use of probiotics and cranberry products

Age over 60 with new onset recurrent UTIs.

Refer to Urology

No Improvement

Postmenopausal Women	**Identifiable /trigger for UTI e.g. Intercourse**	**Trial of Daily Antibiotic Prophylaxis**	**Methanamine Hippurate**	**Self-Start Antibiotics**
Consider vaginal (not oral) oestrogen. Review at 6-12months Take account of severity and frequency of symptoms, risk of complications, benefits for other symptoms (vaginal dryness) possible adverse effects (breast tenderness and vaginal bleeding), unknown long-term endometrial safety and preferences for treatment.	Consider Single-dose antibiotic prophylaxis Advise how to use, possible adverse effects of antibiotics, particularly diarrhoea and nausea and need toseek medical help if symptoms of UTI develop. Review efficacy at 3-6months.	Advise about risk of resistance with long-term antibiotics, possible adverseeffects of long-term antibiotics and need to seekmedical help if symptoms ofan acute UTI develop. Review at 3 months and consider cessation of antibiotics. If decision made to continue antibiotics review every 6 months. There is no evidence to support rotation of different antibiotics.	Approved on formulary as second line agent for prophylaxis in patients with recurrent UTI's who have failed long-term antibiotic prophylaxis, have contraindication to antibiotics or breakthrough infection with resistant organisms.	Consider in exceptional cases e.g.recurrent admission with pyelonephritis/sepsis

Treatment Failure – **Refer to Urology**

[Recurrent UTI NICE guidance]

UTIs in Men

A proven UTI in a male should be investigated with an ultrasound scan of the urinary tract including ultrasound bladder and assessment of post micturition residual.

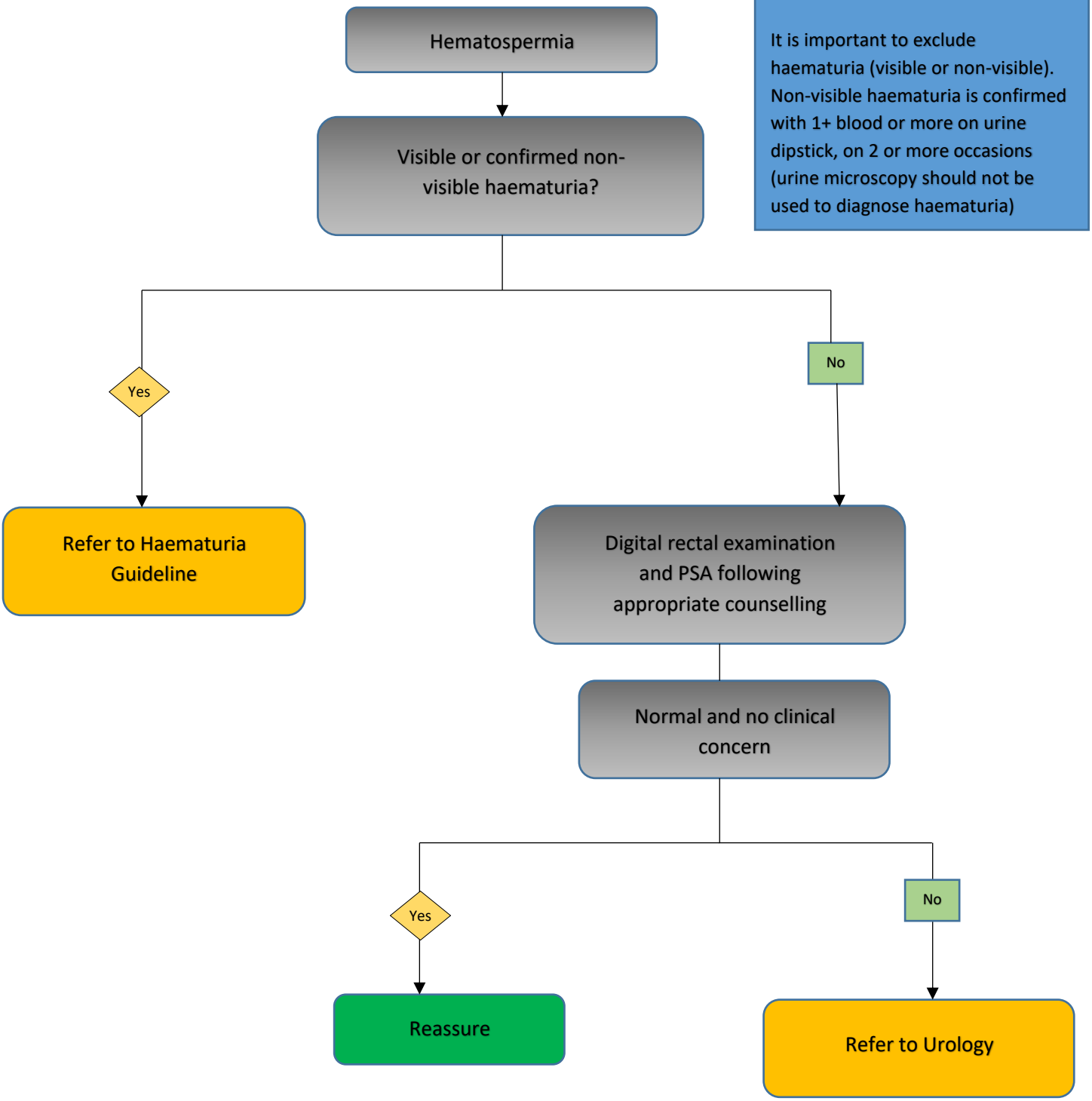
Urological referral is appropriate if there is an abnormality of the urinary tract if the post micturition residual is greater than 100mls. If ultrasound scan is normal then urology referral may be indicated based on haematuria or cancer guidelines or if there is a clinical concern.

Local expert opinion id that UTI's in men should not be treated with a 3-day course of nitrofurantoin due to this antibiotics poor tissues penetration. A 1-week course of an antibiotic with good tissue penetration such as trimethoprim (or alternatively cephalexin or ciprofloxacin) is appropriate.

Hematospermia

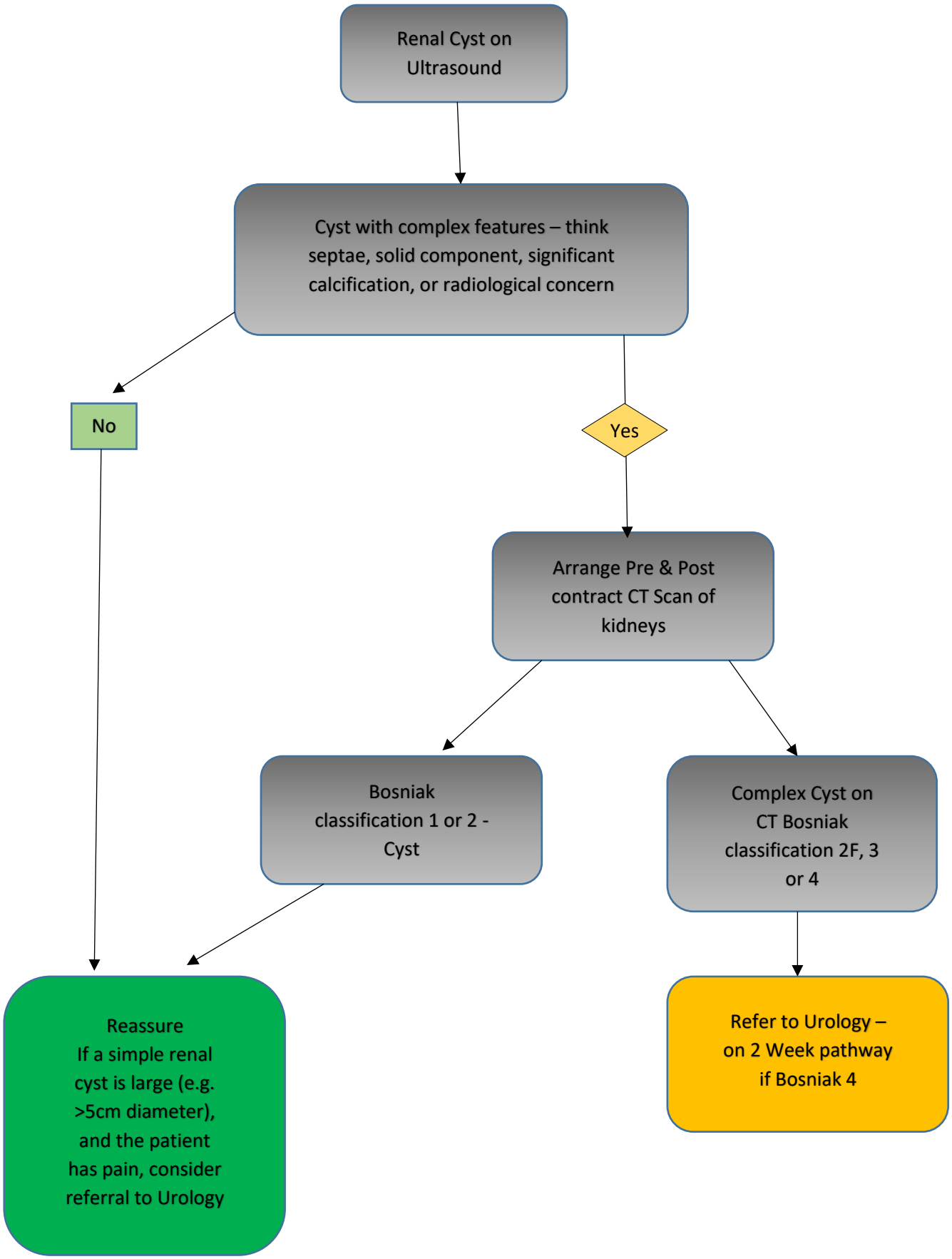
Notes
There is low correlation between Hematospermia and prostate cancer.

It is important to exclude haematuria (visible or non-visible). Non-visible haematuria is confirmed with 1+ blood or more on urine dipstick, on 2 or more occasions (urine microscopy should not be used to diagnose haematuria)

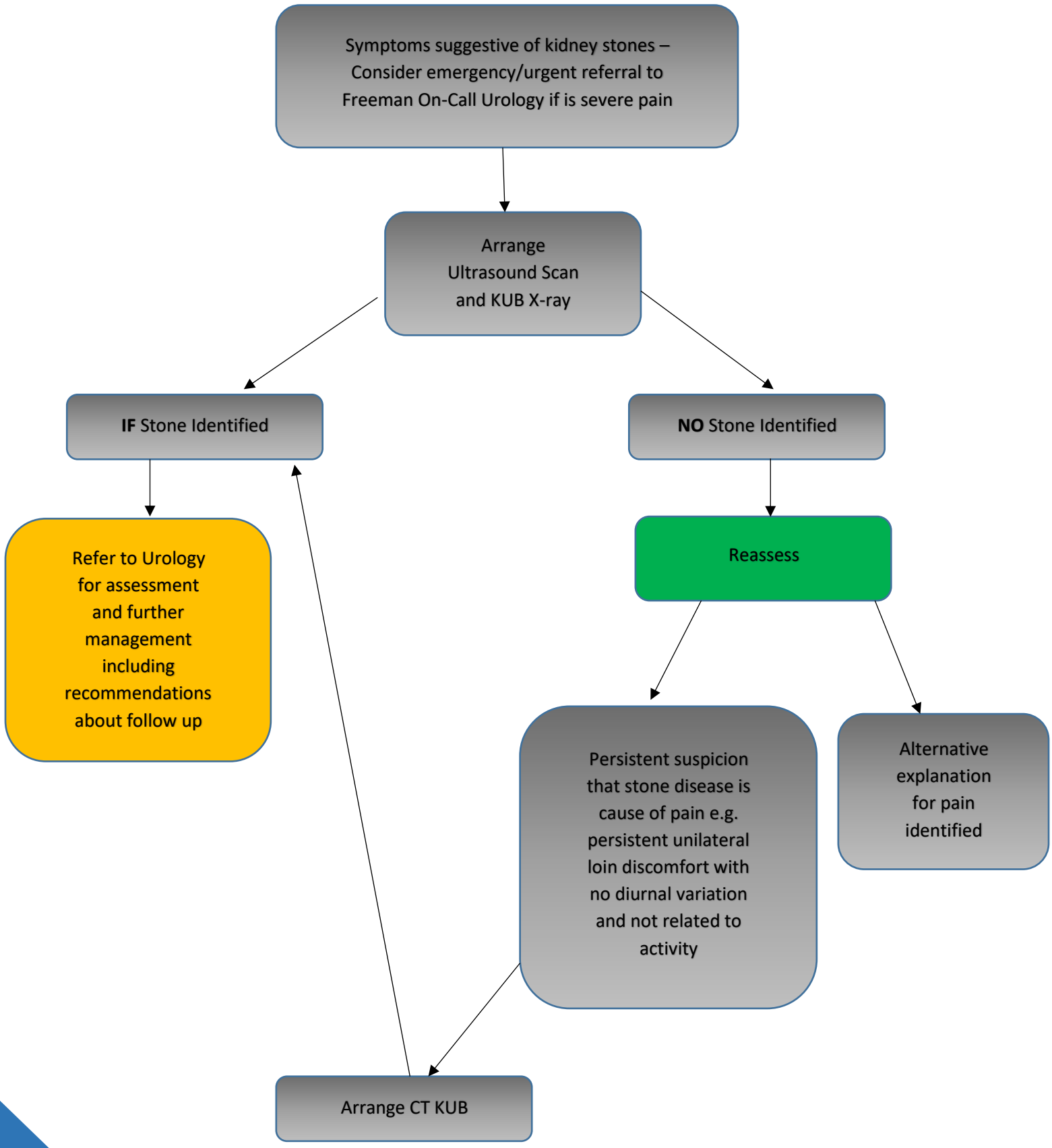


Please note we are aware that these guidelines do not align with a NICE guideline but there is clinical consensus with the above approach. If Hematospermia is recurrent or persistent (i.e. 6 months) consider referral to Urology.

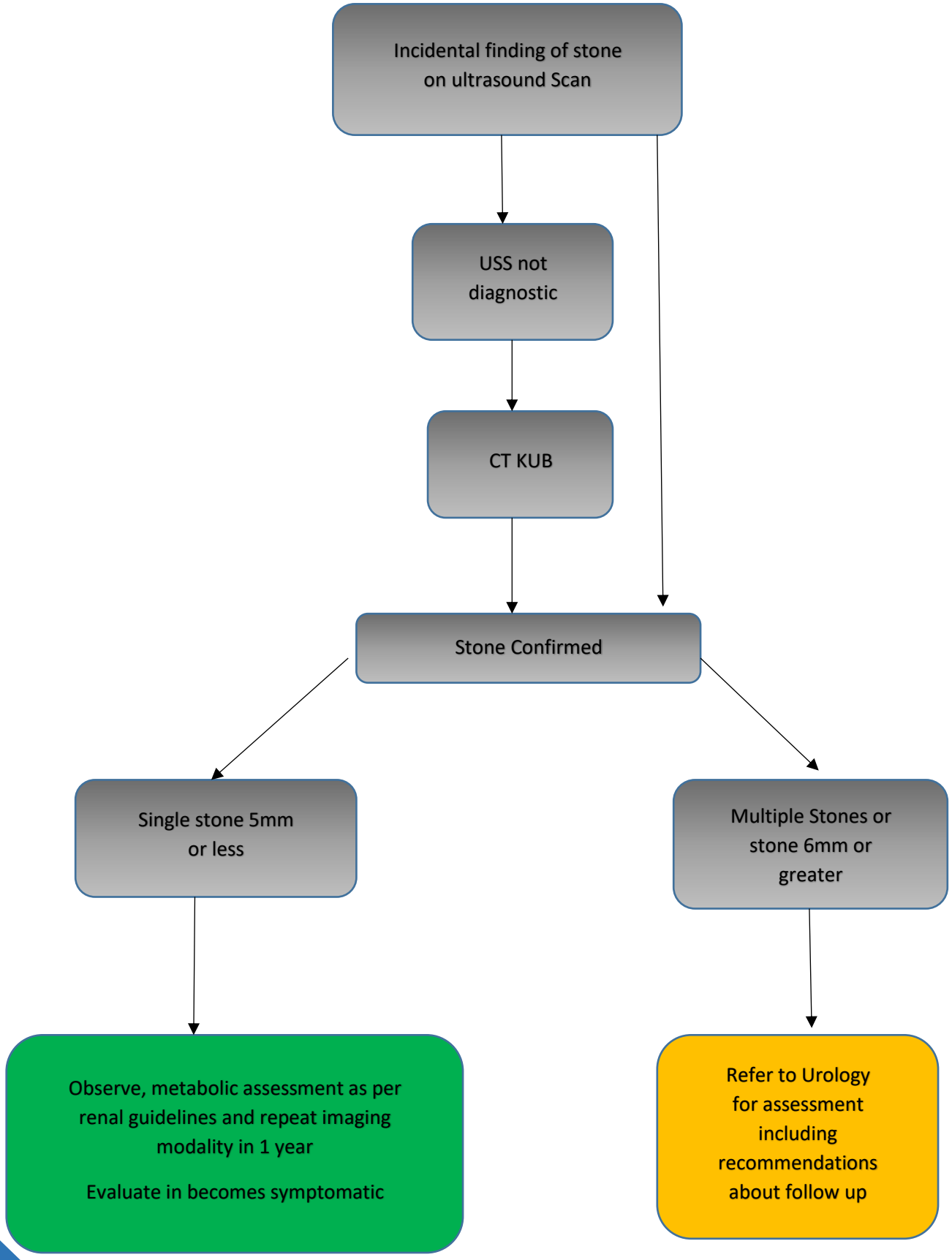
Renal Cysts


Renal Cyst on Ultrasound
Cyst with complex features – think septae, solid component, significant calcification, or radiological concern
No
Yes
Arrange Pre & Post contract CT Scan of kidneys
Bosniak classification 1 or 2 - Cyst
Complex Cyst on CT Bosniak classification 2F, 3 or 4
Reassure
If a simple renal cyst is large (e.g. >5cm diameter), and the patient has pain, consider referral to Urology
Refer to Urology – on 2 Week pathway if Bosniak 4

Symptoms of Urinary Tract Stones



Incidental Findings of Renal Stones



Lower Urinary Tract Symptoms (LUTS) in Men: Assessment and Management

Suspected LUTS in a man

Refer to Urology (2 Week Wait Rule) if urological cancer suspected:

- Haematuria (refer to haematuria guideline)
- Raised PSA (refer to PSA Guideline
- Abnormal prostate on DRE

Other Symptoms for urgent referral (use clinical judgement to determine urgency)

- Palpable bladder
- Neurological symptoms

Initial Assessment

- Access symptoms: voiding storage, nocturia, post micturition dribble
- Ask about lifestyle including caffeine, alcohol, prescribed and OTC drugs, fluid intake
- Assess how troublesome symptoms are and complete IPSS score (see next page)
- Examine abdomen and external genitalia
- Perform DRE
- Perform urine dipstick for blood, glucose, leucocytes and nitrites
- Check eGFR if renal impairment suspected
- Offer PSA testing after appropriate counselling if:
  - Suspected BPH or
  - Prostate abnormal or
  - Prostate cancer suspected

Consider if there is an underlying cause for obstructive symptoms (e.g. drugs, urethral stricture, urological cancer, neurological problems)

PSA raised
Refer to flow chart for raised PSA for further management

If troublesome LUTS symptoms assess severity with urinary frequency volume chart

Refer for further assessment in clinically indicated.

Use clinical judgement to determine urgency

Symptoms not very troublesome and low risk of progression

Lifestyle advice
Review after 3 months

If troublesome LUTS symptoms assess severity with urinary frequency volume chart

Lifestyle Advice

Consider drug treatment (see flow chart for drug treatment)

Consider conservative measure, which may include:

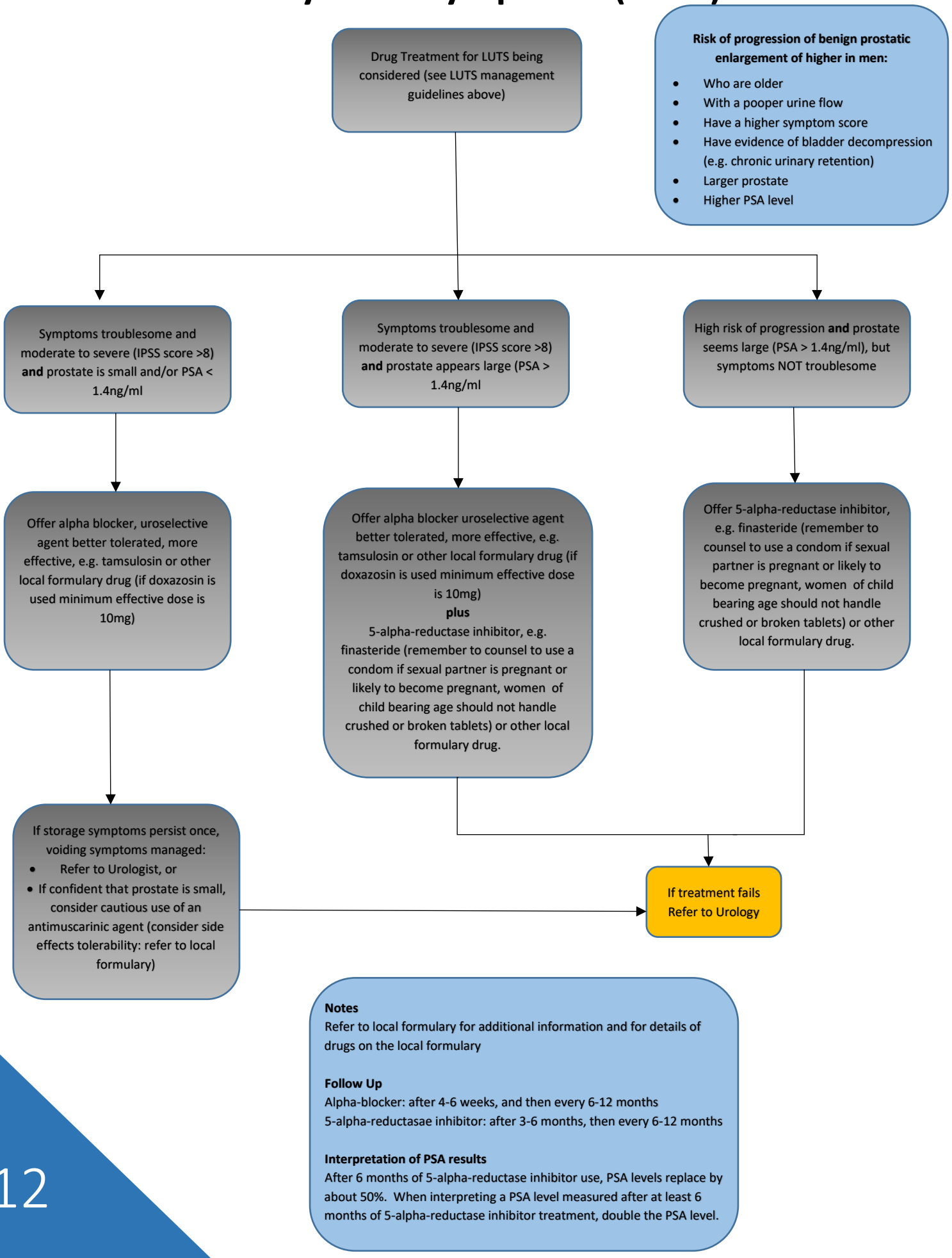
- Pelvic floor muscle training
- Bladder training
- Post void milking
- Prudent fluid intake
- Healthy lifestyle
- Containment products (pads, waterproof pants, external sheath)
- Catheter only if no other option

Regular review
if symptoms become more troublesome, consider drug treatment (see flow chart for drug treatment)

Risk of progression of benign prostatic enlargement is higher in men:

- Who are older
- With a poorer urine flow
- Have a higher symptoms score
- Have evidence of bladder decompression (e.g. chronic urinary retention)
- Larger prostate
- Higher PSA level

Drug Treatment in Male Patients with Lower Urinary Tract Symptoms (LUTS)



Female LUTS Guidelines

If suspected neurological cause refer to Urology or Neurology depending on circumstances

If significant pelvic mass/significant vaginal prolapse refer to Gynaecology

Female LUTS

Exclude UTI

If persistent NVH or VH refer to Haematuria Guidelines

Incontinence – see Community Incontinence Pathway

Lifestyle Modification

- Modify high/low fluid intake
- Reduce Caffeine
- Weight reduction
- Smoking cessation
- Bladder Training
- Pelvic floor exercises

Mainly Voiding
Lower urinary tract symptoms: poor flow, sensation of incomplete bladder emptying

Mainly Storage
Lower urinary tract symptoms: frequency, nocturia, urgency, urge incontinence

If introital atrophy consider oestrogen

No Improvement

Refer to Urology

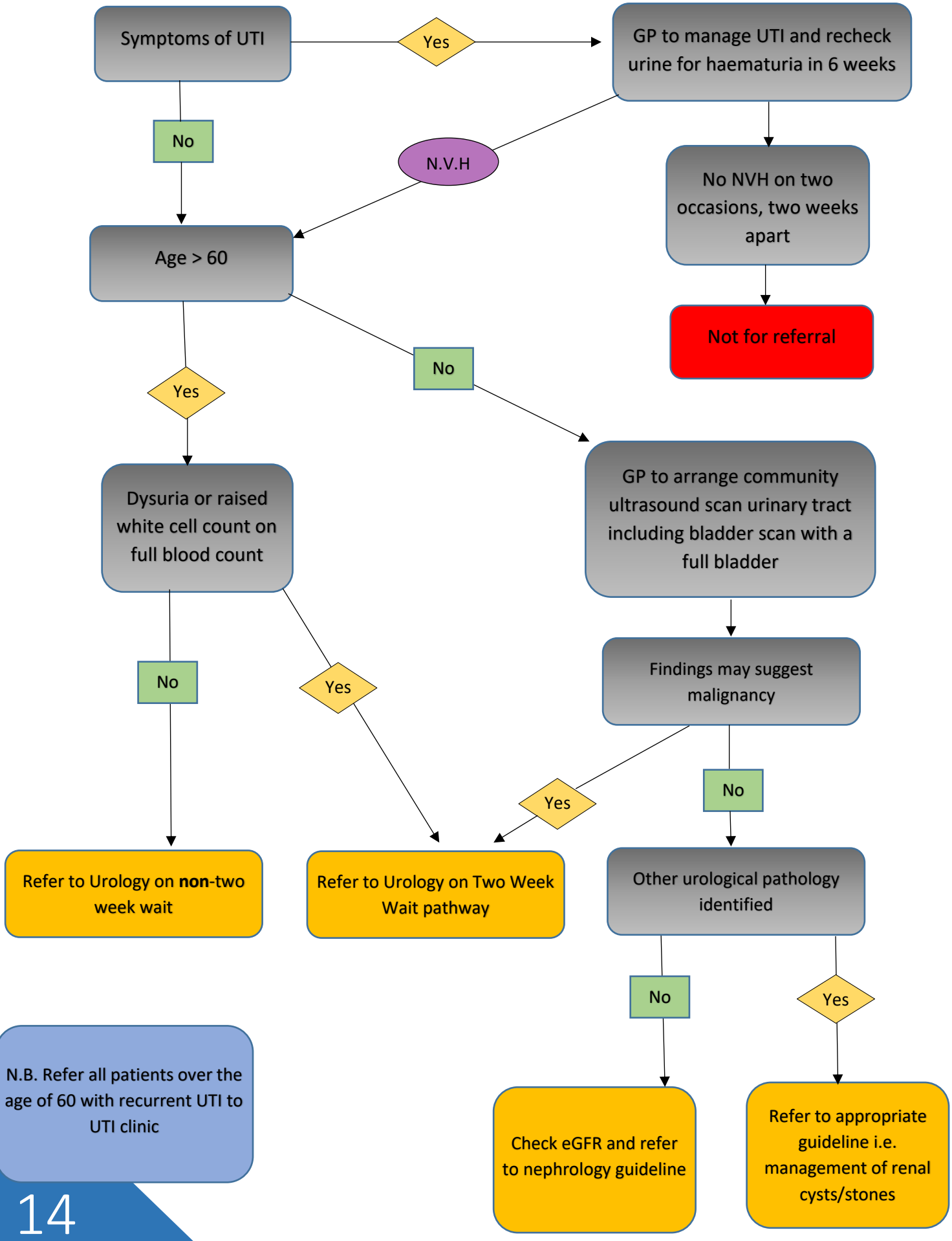
? Overactive bladder (OAB) as per North of Tyne OAB pathway.
Consider 6/52 trial of anticholinergic – Oxybutynin IR/Tolterodine IR/Solifenacin
(do not offer oxybutynin IR to frail elderly women)

Consider Mirabegron if anticholinergics contraindicated, clinically ineffective, or have unacceptable side effects.

If single agent ineffective consider trial of combination of anticholinergic and Mirabegron (It is acknowledged that this advice is not contained in current iteration of NoT OAB. However, it does reflect latest evidence and local expert opinion).

No Improvement

Non Visible Haematuria - NVH

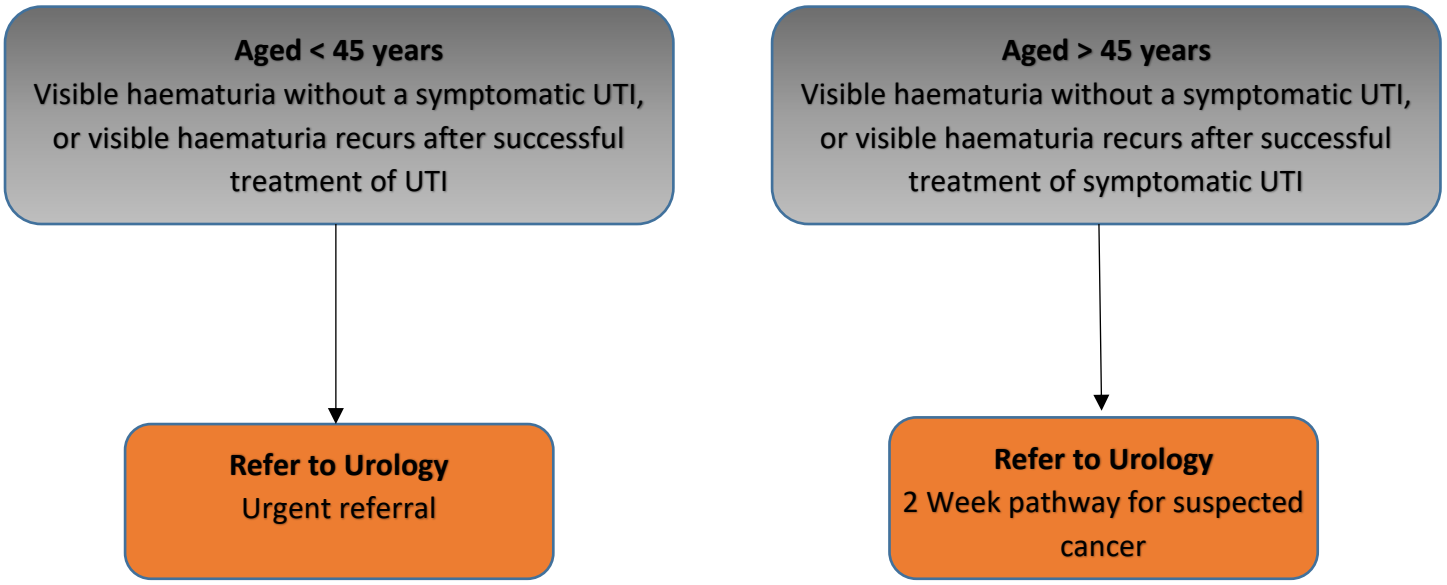


Non-visible haematuria does not need reinvestigation if investigated previously and no significant abnormality detected, unless accompanied by new bladder symptoms or if visible haematuria develops

Visible Haematuria

Taken from North Tyne/Gateshead guidelines for detection, management and referral of adults with kidney disease

Assessment and referral of patients with visible haematuria



Notes
Visible haematuria should not be attributed to oral anticoagulants in the therapeutic range and/or anti-platelet agents as a cause

Blockage of Indwelling Catheter

- Consider alternative diagnosis of bypassing secondary to bladder spasms and consider trial of anticholinergic agent to Mirabegron
- Consider inserting a tipless catheter
- Bladder washouts on a weekly basis – saline moving to Suby G if not effective
- Arrange community USSS to AXR to exclude bladder stone

Peyronie's Disease

Guidelines for Primary Care

1. GPs should assess the patient for possible Peyronie's disease. This involves a careful history (to assess penile deformity, interference with intercourse, penile pain, and/or distress) and a physical examination of the genitalia to assess for palpable abnormalities of the penis.

2. GP's may offer oral non-steroidal anti-inflammatory medications to the patient suffering from active Peyronie's disease who is in need of pain management.

3. There is no effective pharmacological treatment to reduce curvature and GP's should not offer oral therapy with tamoxifen etc.

4. Patients may enquire about intralesional collagenase injections. This is not available through the NHS and is not offered at Newcastle Urology.

5. Patients who develop erectile dysfunction in association with Peyronie's disease should be prescribed phosphodiesterase inhibitors (e.g. sildenafil) with appropriate advice.

6. The natural history of the condition should be discussed with the patient and reassurance provided this is a benign condition. The penile pain usually subsides with a few months and there may be spontaneous improvement in a minority (10%). Further patient information is available on the BAUS website:

   https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Peyronies.pdf

7. Surgical intervention is only indicated if the penis is too bent for penetration (penile straightening surgery – Nesbits (plication) or modified Lue (grafting) procedures) or if the disease prevents distal tumescence (when implantation of a penile prosthesis may be considered). No surgical intervention will be considered however, until the disease has been stable for at least 6 months.

8. Referral for Peyronie's disease **is unnecessary** unless the deformity prevents penetration, and/or the disease prevents erection (with no response to phosphodiesterase inhibitors) and the condition has been stable for at least 6 months.

9. If penetrate intercourse is not possible and patient wishes to be assessed for surgery please refer to Newcastle Urology, Male Reconstructive Surgery.