# Urology

## Referral Guidelines for Urology Outpatients

## University Hospital Geelong

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# Haematuria

| Evaluation | Investigations | Referral Guidelines |
|---|---|---|
| • Painful or painless<br>• Initial terminal or total<br>• Associated features<br>L.U.T.S.<br>▪ Fever or rash.<br>▪ Trauma<br>▪ Flank pain<br>▪ Irritative voiding symptoms<br>• Examination:<br>▪ BP<br>▪ Abdo/loin mass | Confirm +ve dipstix with formal MSU<br>**Minimum investigations prior to referral**<br>• MSU inc RBC morphology<br>• U+E's/Cr/eGFR<br>• Urine cytology (if smoker or >50yrs)<br>• Coags (if on anticoag. Rx.)<br>• US urinary tract, KUB | **Please ensure investigations completed**<br>**UROLOGY REFERRAL**<br>• If haematuria (macro or micro) confirmed<br>• For cystoscopy<br>• Possibly further imaging – IVU or CT<br>**NEPHROLOGY REFERRAL**<br>• If HT, nephrotic, increasing Cr, proteinuria<br>with painless haematuria<br>• organise – random urine protein/Cr ratio |

# LUTS in Men

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| • Assess severity of symptoms:<br>• Nocturia<br>• Weak steam<br>• Urgency<br>• Straining<br>• Terminal dribbling<br>• Hesitancy<br>• Intermittency<br>• Bladder emptying<br>How bothered is the patient?<br>Phx – retention, stricture.<br>• Examination<br>Bladder palpable?<br>▪ Phimosis<br>▪ DRE – size,<br>▪ consistency features of Ca (hard/nodule | **Minimum investigations prior to referral**<br>• MSU<br>• U+E's/Cr<br>• US urinary tract – Inc. post void<br>residual<br>• PSA | **GP MANAGEMENT**<br>• If mild/moderate symptoms – medical therapy<br>• Options:<br>1. Prazosin (Pressin) – initially 0.5mg bd inc. to 2.0mg bd over 3-4 weeks<br>2. Tamsulosin (Flomaxtra) 400mcg/d no dose titration, less s/e's but cost ~ $60 month (not on PBS but is DVA)<br>3. Proscar 5mg/d – esp. for larger prostates and if prazosin fails, 6/12 for maximal effect but cost ~ $100 month (not on PBS but is DVA)<br><br>**UROLOGY REFERRAL**<br>• If severe symptoms<br>• If failed medical therapy<br>• Abnormal – DRE, PSA, US, MSU. Inc Cr. Haematuria or bladder stones |

# Renal Colic

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| • Consider Ddx.<br>• AAA<br>• Testicular pathology<br>• Pyelonephritis<br>• appendicitis<br>• Renal infarct<br>• Phx. stones | **Minimum investigations**<br>• FBE<br>• U+E's/Cr<br>• Ca++<br>• Urate<br>• MSU<br>• KUB<br>• CT (non-Contrast) will confirm stone size and position (CT) and likelihood of passing:<br><4mm – 90% pass<br>4-6mm – 50% pass<br>>6mm - 10% pass<br>**** Imaging – in order to dx and treat both KUB & CT reqd. **** | **GP MANAGEMENT**<br>• Analgesia<br>- Morphine initially<br>- Indomethacin 100mg bd pr or 25mg tds orally<br>- panadeine forte / tramadol for breakthrough<br>• Advise pt - strain urine (send stone for analysis) and moderate fluid intake<br>• Consider need for early / emd / urgent review – see below<br>**URGENT / EMD / EARLY REVIEW**<br>For possible removal, stenting, or drainage if:<br>• Infection<br>• Unrelieved pain or recurrent pain<br>• Persisting n. and v.<br>• Increasing Cr.<br>• Single kidney<br>• Stone unlikely to pass on basis of size<br>**OUTPATIENT REVIEW**<br>• Within 2-4 weeks of initial dx. If no indication for early review (very unlikely that renal damage will occur in this time)<br>**Patient must have had redo imaging within 24hrs of outpatient review and bring films to Outpatient appointment.**<br>• KUB (only) - If stone easily seen on original KUB<br>• CT – if stone not seen on original KUB but was seen on CT |

# Abnormal PSA Test

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| Ensure patient understands the risks and benefits of screening<br>• Routine yearly (screening) PSA testing if 10yr life expectancy and:<br>▪ 50 – 70 yrs<br>▪ 40 – 70yrs and +ve family hx.<br>• Consider/Exclude other causes raised PSA<br>▪ UTI, prostatitis<br>▪ BPH<br>▪ Recent instrumentation<br>▪ DRE – any nodule/hard/size<br>**• >70yrs. – do PSA test only if in excellent health for his age. (up to 75yrs) or if symptoms of LUTS or metastatic Ca** | **Repeat PSA test in 4-6 weeks**<br>o Instruct patient to avoid bike riding, intercourse and ejaculation for 48hrs before second test<br>• If the initial PSA 2 -10ug/L repeat PSA test including free total ratio. | **GP MANAGEMENT**<br>• If second test in normal range and free total ratio is >25% - GP review for repeat test in 6 months<br>• Then continue yearly PSA screening for increase – refer later if abnormal. PSA or if PSA velocity is >.75ug/L/yr<br>**OUTPATIENT REVIEW**<br>• All abnormal PSA tests (confirmed on second test) in a patient with a 10yr life expectancy need specialist review<br><br>o For consideration of biopsy<br>• Abnormal DRE (hard, nodule) in a patient with a 10yr life expectancy need specialist review (regardless of PSA level)<br><br>o For consideration of biopsy<br>• Increased PSA velocity (>.75ug/L) in pt with at least x2 PSA's a year apart |