

Urologic Referral Guidelines

Urology Network of Colorado

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Urology Network of Colorado

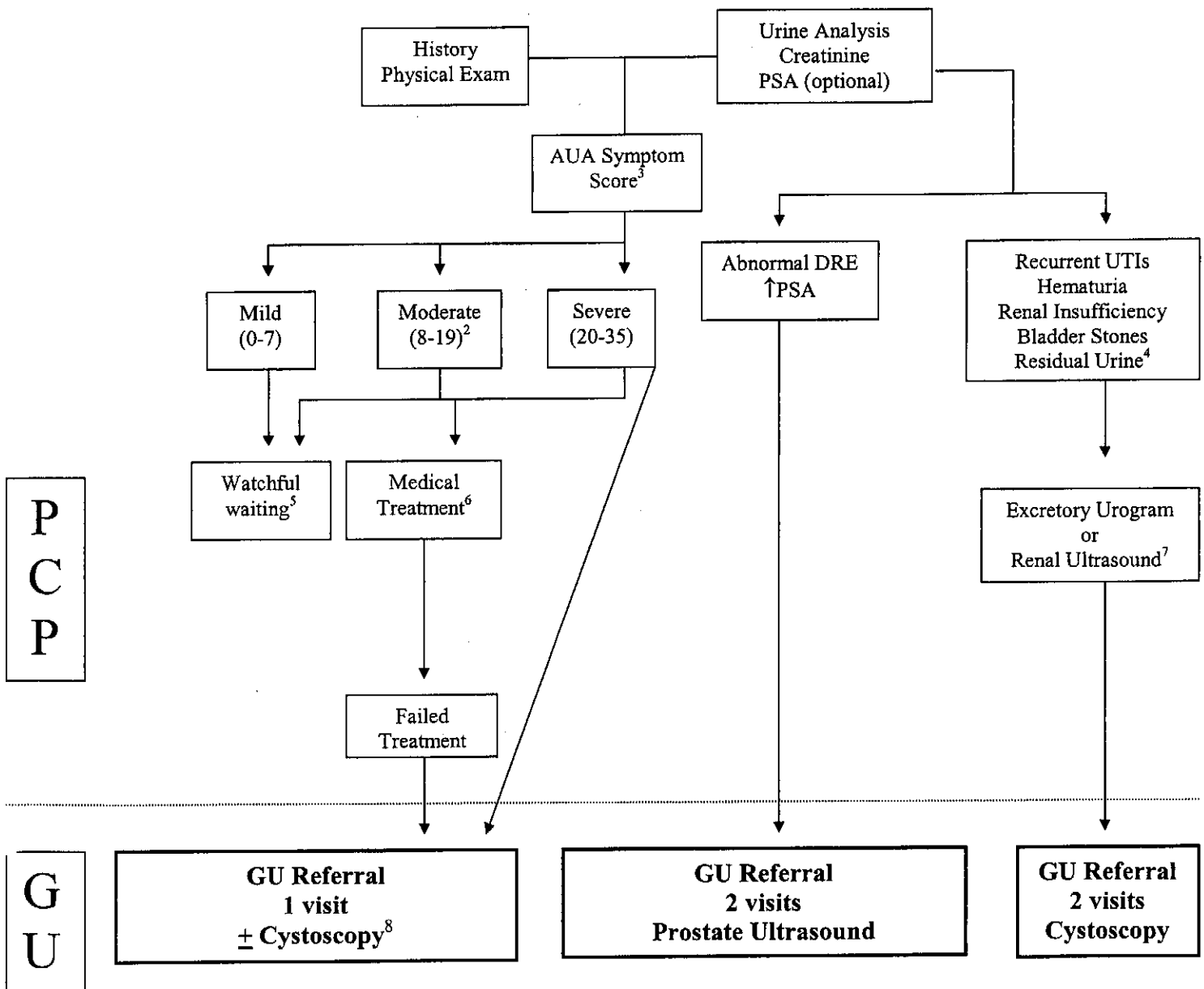
Urologic Referral Guidelines

The *Urologic Referral Guidelines* have been developed by the Urology Network of Colorado to help our primary care colleagues decide the appropriate time to seek urologic consultation. The *Guidelines* are designed to provide the highest quality of care in the most cost efficient manner. We are well aware that not all patients will fit a standard pattern of care. As such, the urologists of UNC are always available by phone or in the office to assist you in the care of your patients. Do not hesitate to call. In the guidelines there are a suggested minimum number of visits and procedures that may be required to adequately evaluate the condition. If the recommended visits and procedures are preapproved in the authorization process, efficient management of your patient can be accomplished with less disruption to your practice as well as ours.

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Referral Guideline Benign Prostatic Hypertrophy¹



¹ U.S. Department of Health and Human Service, Clinical Practice Guidelines: Benign Prostatic Hyperplasia: Diagnosis and Treatment, 2/94.

² The majority of patients with moderate symptoms can be initially managed with medical therapy.

³ Attached AUA Symptom Score Sheet is self administered by the patient.

⁴ Residual Urine greater than 20% of capacity (100cc) needs referral.

⁵ Periodic (probably annual) reassessment: review symptoms, AUA symptom score, PE, (uroflow, post void residual urine optional).

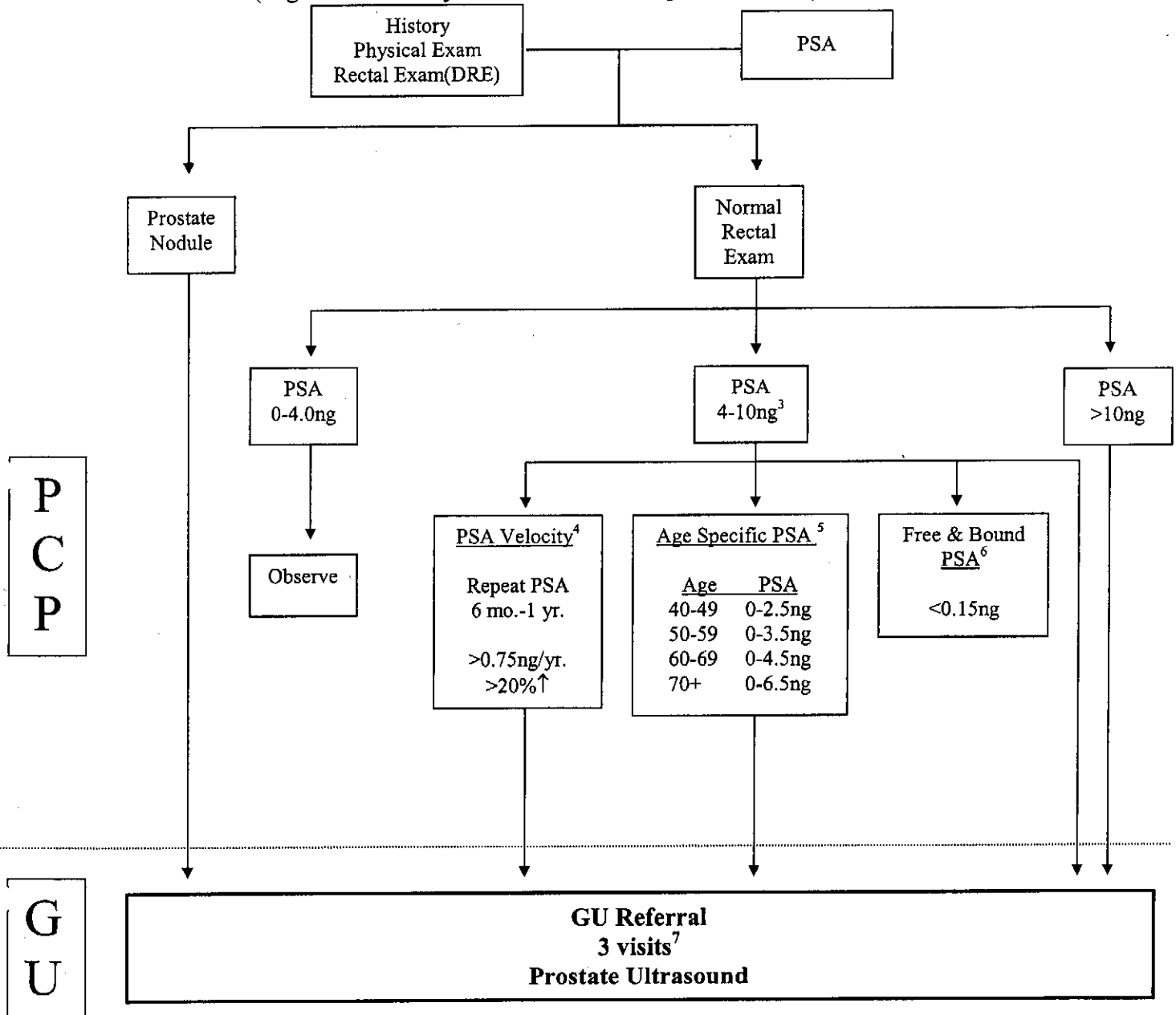
⁶ Current Medical Therapy --

α-Blockers	-Hytrin up to 10 mg/day
	-Cardura 4 mg/day
	-Flomax 0.4 Mg qd
5-α-reductase inhibitor	-Proscar 1 qd (minimum 6 mo./need pre-Rx PSA)
	(Proscar is no better than Placebo in controlled trials)

⁷ For evaluation of upper tract causes – obtain prior to referral.

Referral Guideline Prostate Cancer Screening (PSA)^{1,2}

(begin at 50 or 40 years old in blacks or positive family history)



¹ Recommendations of American Academy of Family Practice and American College of Physicians: between the age 50-70 a discussion of the pro/cons of screening with the patient is appropriate prior to deciding if the patient wants to be screened for prostate cancer.

² Recommendations of the American Urologic Society and the American Cancer Society: begin annual DRE and PSA at age 50, with a positive family history or in blacks begin at age 40, and stop PSA after age 75. If the initial PSA is ≤ 2 , once every 2 years is sufficient. **Both** a DRE and a PSA are needed since 20% of men with prostate cancer have a normal PSA.

³ This is a gray area where several management options are available. Repeat PSA may confirm increase.

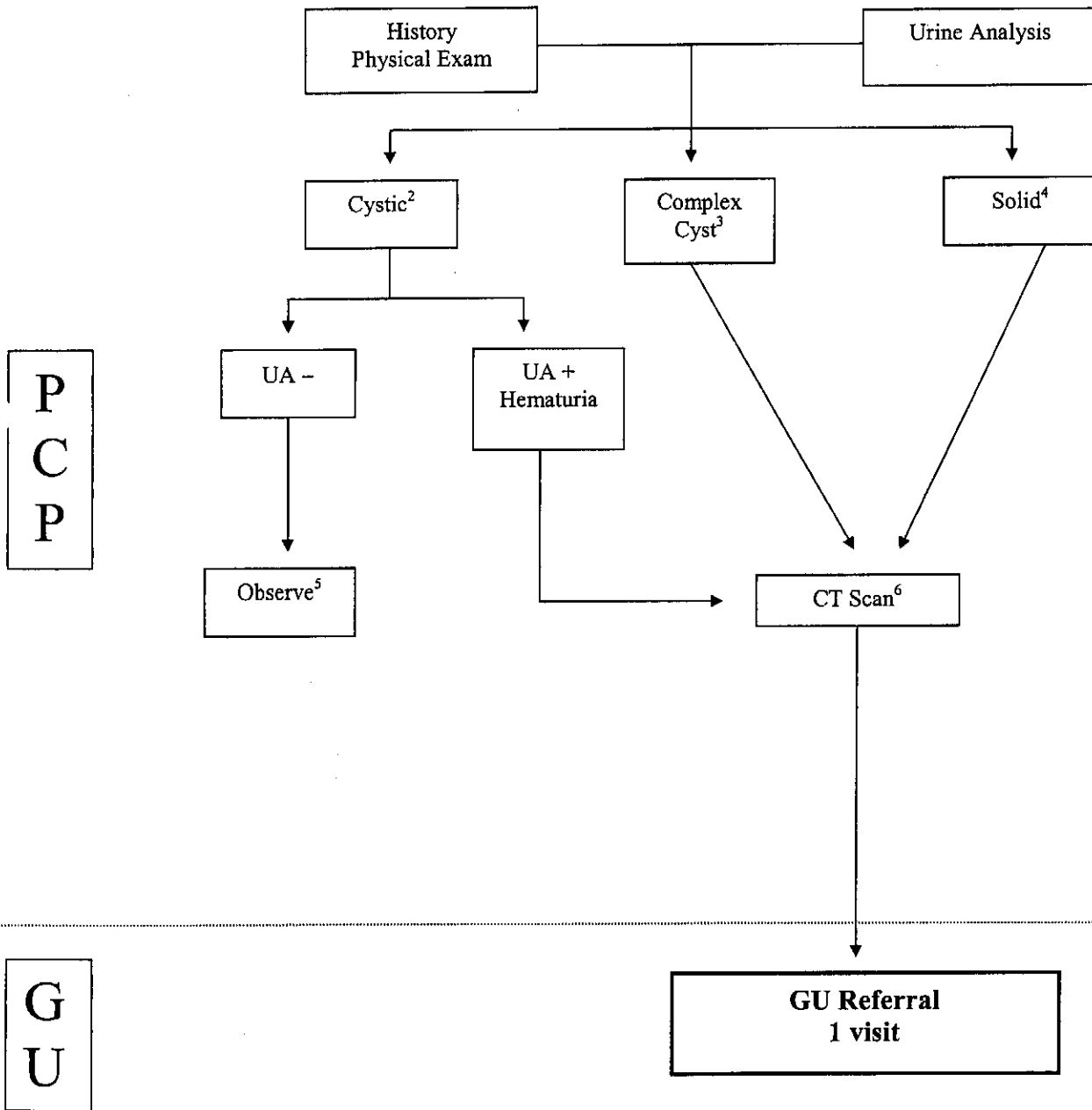
⁴ PSA velocity is the rate of rise of PSA over a 1 year period. Refer if the rate of rise is greater than the levels above.

⁵ Age specific PSA has value in decreasing the number of prostatic biopsies. It has a tendency to under diagnose prostate cancer in older men where treatment is less likely to influence outcomes. Refer if the PSA is greater than the values above.

⁶ A new test (needs further clinical conformation) useful in discriminating between benign disease and prostate cancer in patients who have borderline elevation of their PSA. A ratio of Free to Bound PSA of <0.15 is suggestive of prostate cancer.

⁷ First visit – explain findings; Second visit – prostate ultrasound and Bx; Third visit – discuss Bx results.

Referral Guideline Renal Mass¹



¹ Incidental renal mass detected on renal ultrasound, excretory urogram or abdominal CT.

² True cystic masses are rarely malignant, however; if there are any internal echos it should be considered a complex cyst.

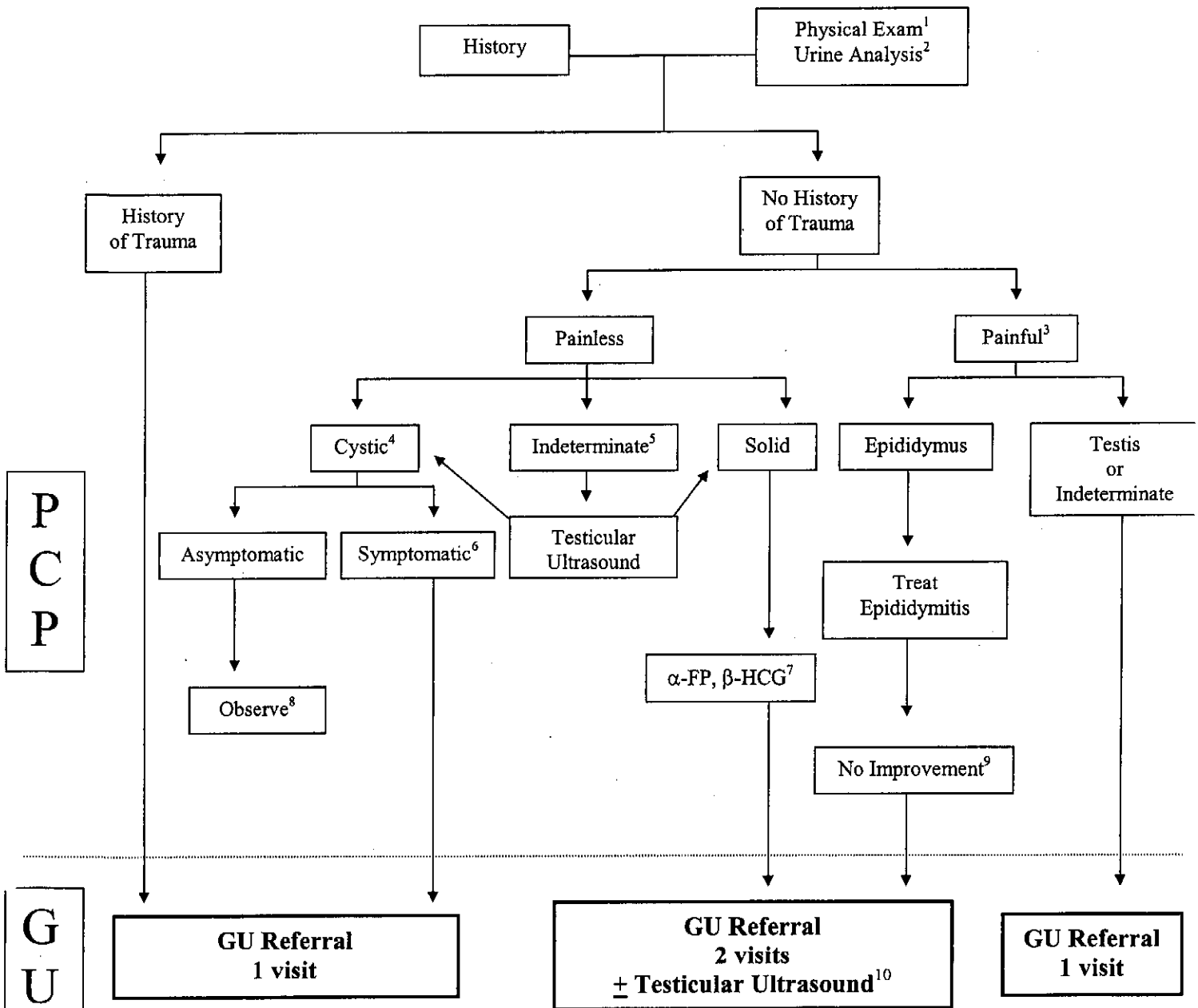
³ A mass that is a complex appearance on ultrasound or CT should be referred for further evaluation.

⁴ All solid masses should be considered malignant and do not require a needle biopsy to confirm.

⁵ Repeat Renal Ultrasound in 6 mo.- 1 yr.

⁶ If the mass has been detected by renal ultrasound or excretory urogram, obtain a renal CT scan prior to referral.

Referral Guideline Acute Scrotal Mass



¹ Transilluminate the mass to determine if it is solid or cystic.

² A Urine Analysis is useful in differentiating epididymitis from torsion of the testis if pyuria is present.

³ Any painful testicular swelling in **children** needs **immediate** referral. In adults determine if the pain and swelling is in the epididymus or the testis.

⁴ Most cystic masses are either a hydrocele or a spermatocele and do not require referral unless they are symptomatic.

⁵ If the physical exam can not determine whether the lesion is cystic or solid, a testicular ultrasound is indicated.

⁶ Symptoms associated with a hydrocele or spermatocele are pain, discomfort from size, or increasing size.

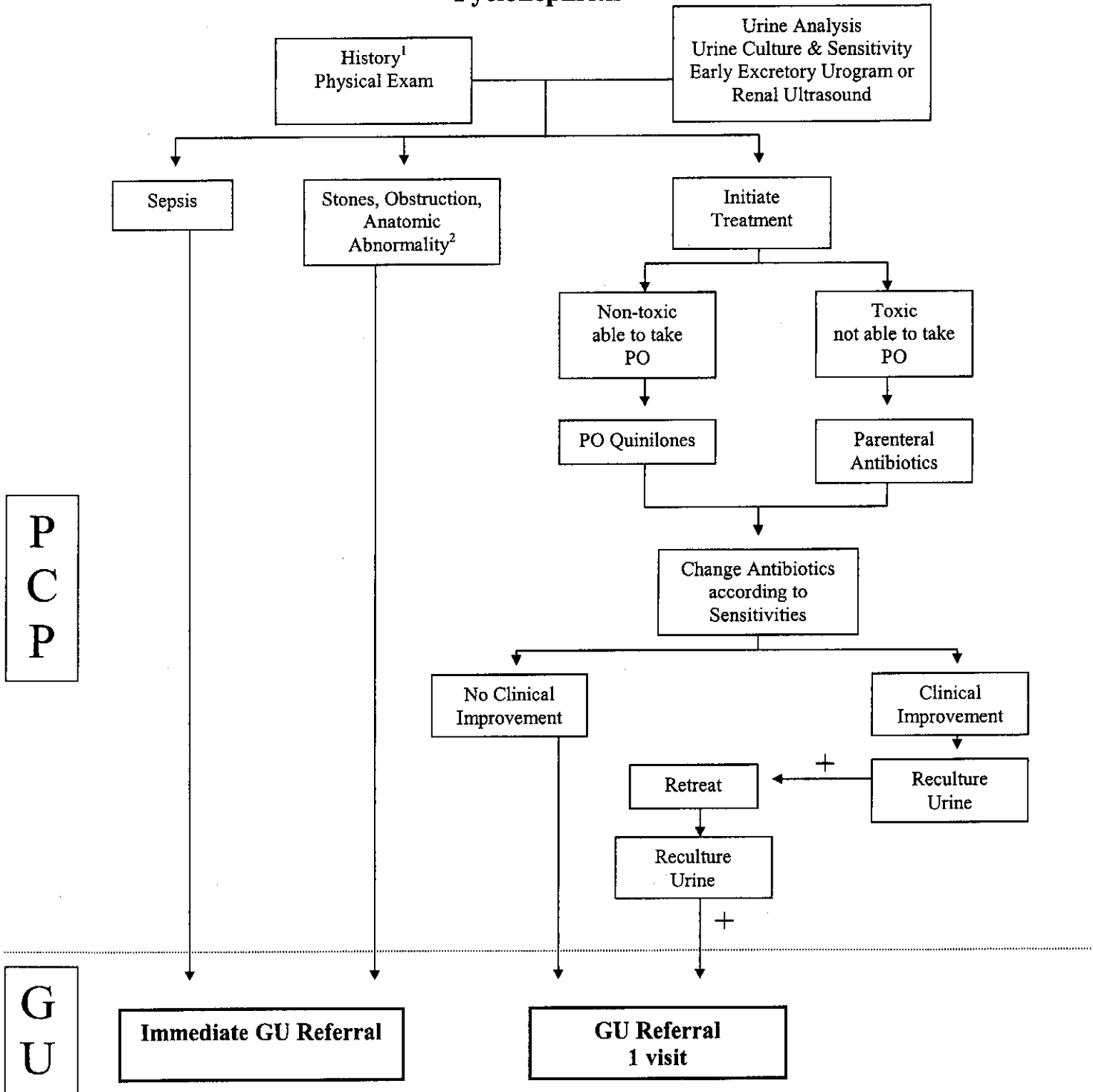
⁷ If the mass appears to be intratesticular, obtain an α -Fetoprotein and β -HCG prior to referral.

⁸ Follow-up exam in 3-6 mo. If enlarging, refer.

⁹ If mass persists beyond 2 months after adequate treatment or the pain does not improve in 4-5 days of treatment, GU referral is indicated.

¹⁰ A testicular ultrasound may be indicated if on physical exam the character of the lesion intratesticular or extratesticular can not be established.

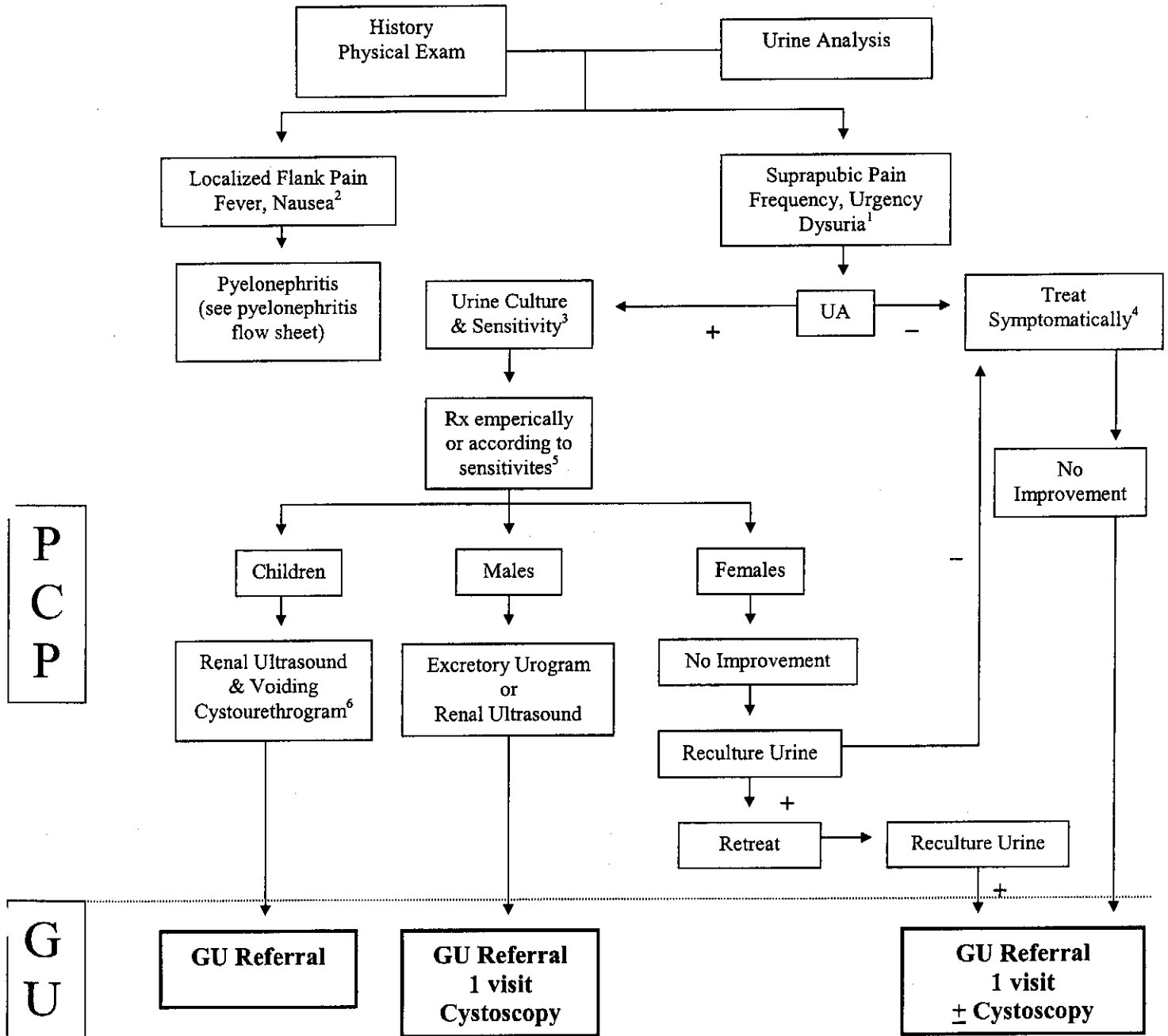
Referral Guideline Pyelonephritis



¹ Symptoms of fever, localized flank pain, and nausea are suggestive of upper tract urinary infections. An early excretory urogram or renal ultrasound is indicated to evaluate for stones, obstruction or anatomic abnormalities.

² Stones, obstruction or anatomic abnormalities need immediate GU referral as surgical or radiological intervention may be required.

Referral Guideline UTI -- Cystitis



¹These symptoms are commonly seen with lower urinary tract infections, cystitis. Treatment can be instituted without a urine culture being obtained if the UA is positive for pyuria or bacteruria.

²These symptoms are more typical of upper urinary tract infection, pyelonephritis. See pyelonephritis referral guideline for management recommendations.

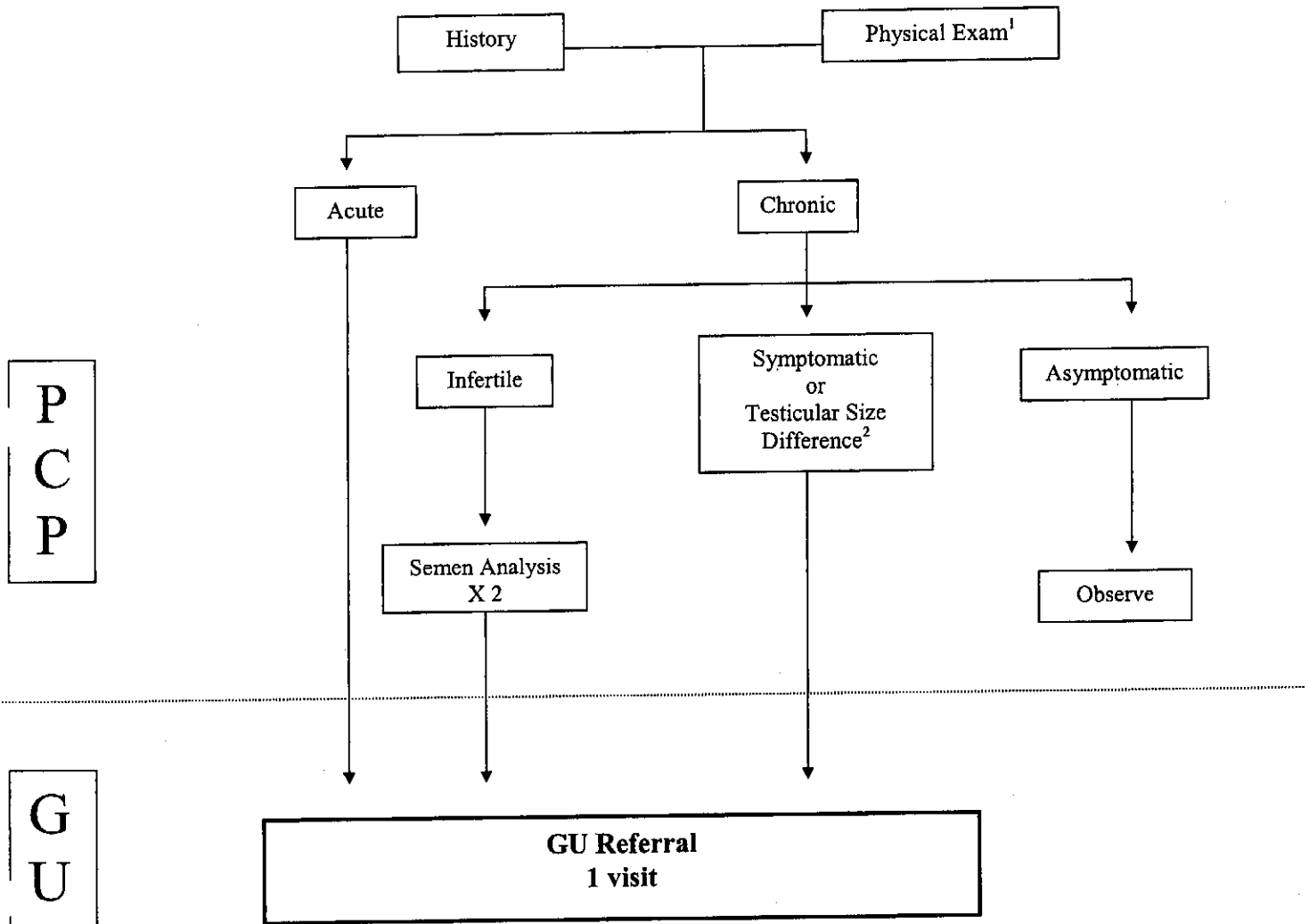
³A positive culture is considered when there are > 100,000 colonies from a clean catch midstream urine. A positive culture is not needed for empiric therapy.

⁴Symptomatic treatment may include a change in water intake and/or diet, pyridium, and antispasmodics.

⁵Short term therapy (3 or 5 days) is as effective as long term therapy (7-14 days).

⁶All children, both males and females, need a basic evaluation after their first urinary tract infection. An evaluation to rule out reflux with a voiding cystourethrogram (VCUG or Nuclear Medicine Cystogram) and an assessment of the upper tracts with a renal ultrasound (avoids excess radiation) or an excretory urogram.

Referral Guideline Varicocele



¹ The majority of varicoceles occur on the left. If present on the right, the patient needs referred.

² In children, if there is a significant difference in testicular size (>0.5 cm difference in length), a referral is appropriate.

AUA SYMPTOMS SCORE

Patient Name: _____

DOB: _____ ID#: _____ Date of assessment: _____

Initial assessment: () monitoring during _____ therapy (), after _____ therapy/surgery ()

	not at all	less than 1 time in 5	less than half the time	about half the time	more than half the time	almost always
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	none	1 time	2 times	3 times	4 times	5 or more times
7. Over the past month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

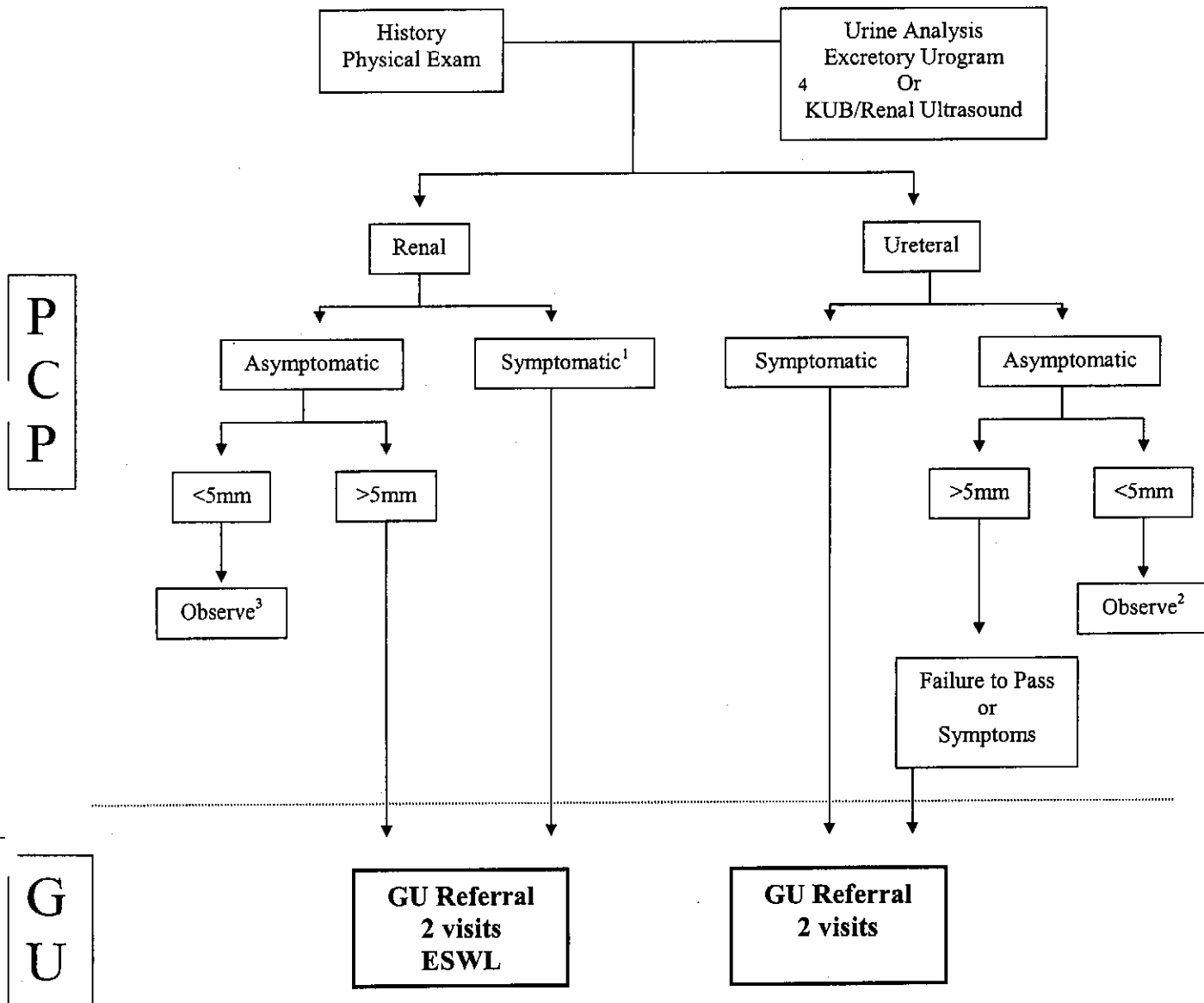
Total Score = _____

QUALITY OF LIFE DUE TO URINARY SYMPTOMS

	delighted	pleased	mostly satisfied	mixed about equally satisfied and dissatisfied	mostly dissatisfied	unhappy	terrible
1. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Quality of Life assessment index L = _____

Referral Guideline Calculi – Renal/Ureteral



¹ The symptoms of stone include pain, infection, high-grade obstruction and failure to pass the stone. If patient is septic, immediate referral is needed.

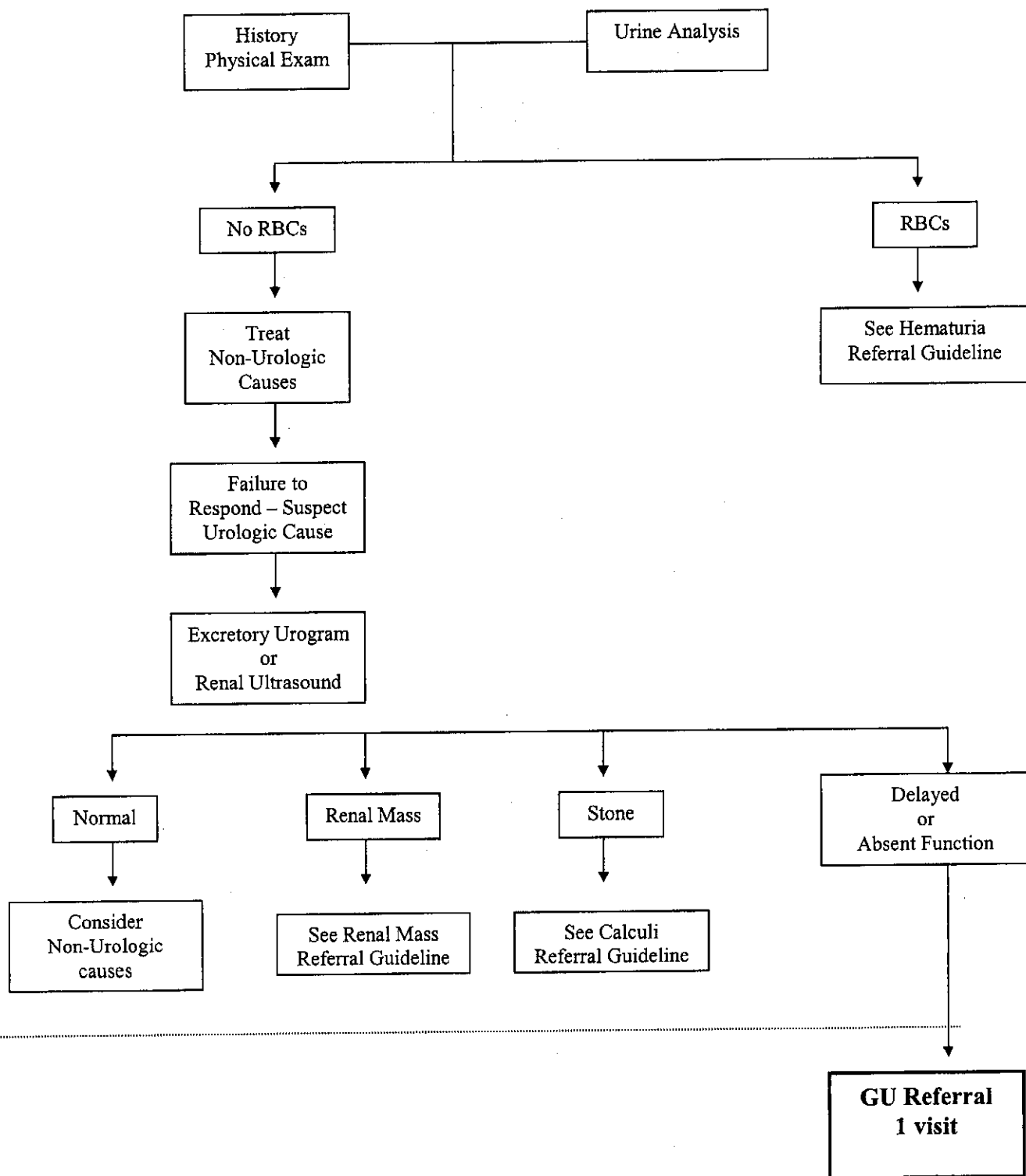
² If the stone fails to pass in a 4-6 week period, refer.

³ When observing a small renal calculus a repeat KUB at one and two years is important to determine if the stone is increasing in size. If the stone grows to a size > 5mm, then refer.

⁴ Helicol CT if allergic to contrast if CT positive add Kub.

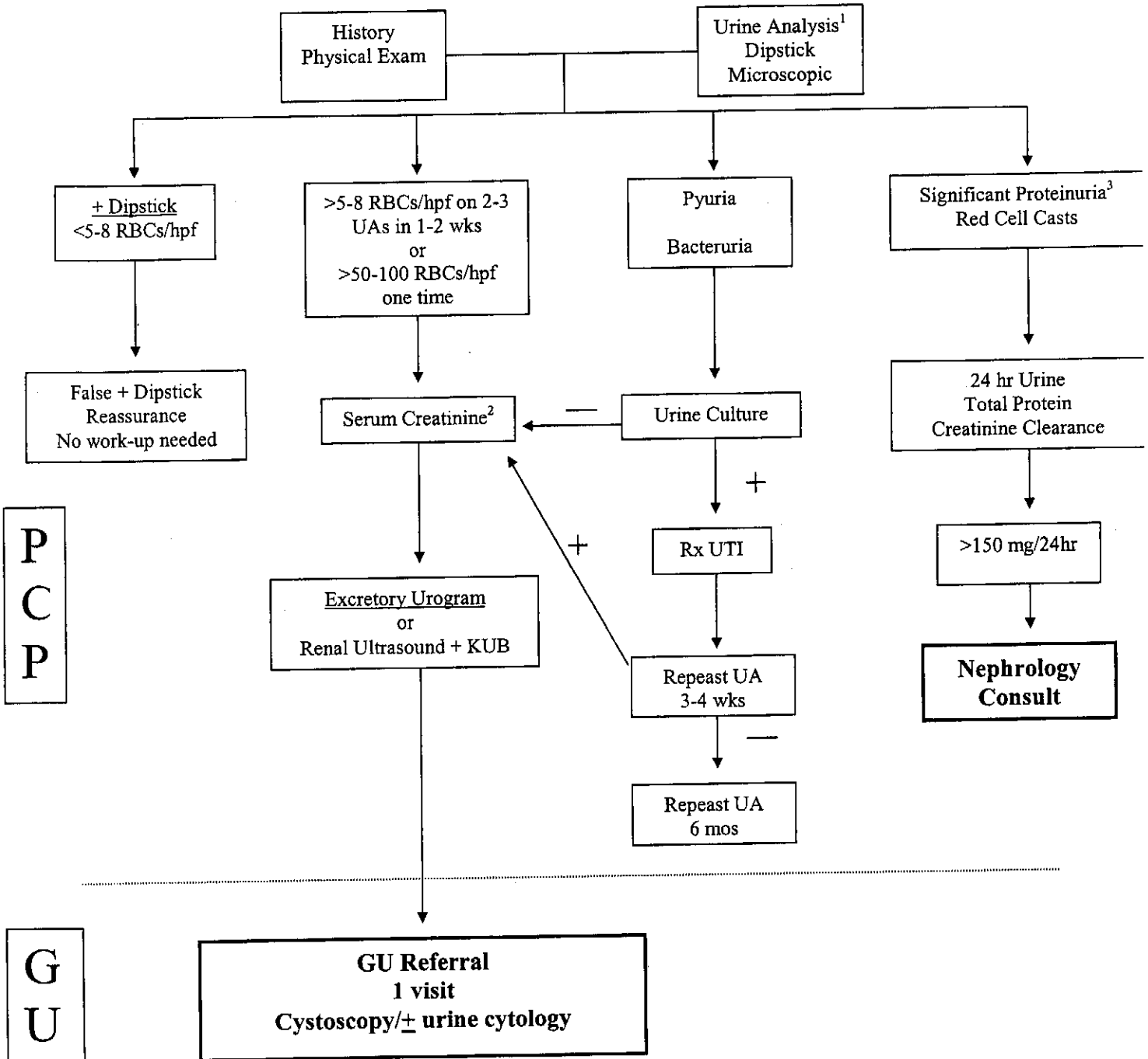
Referral Guideline Flank Pain

P
C
P



G
U

Referral Guideline Microscopic Hematuria

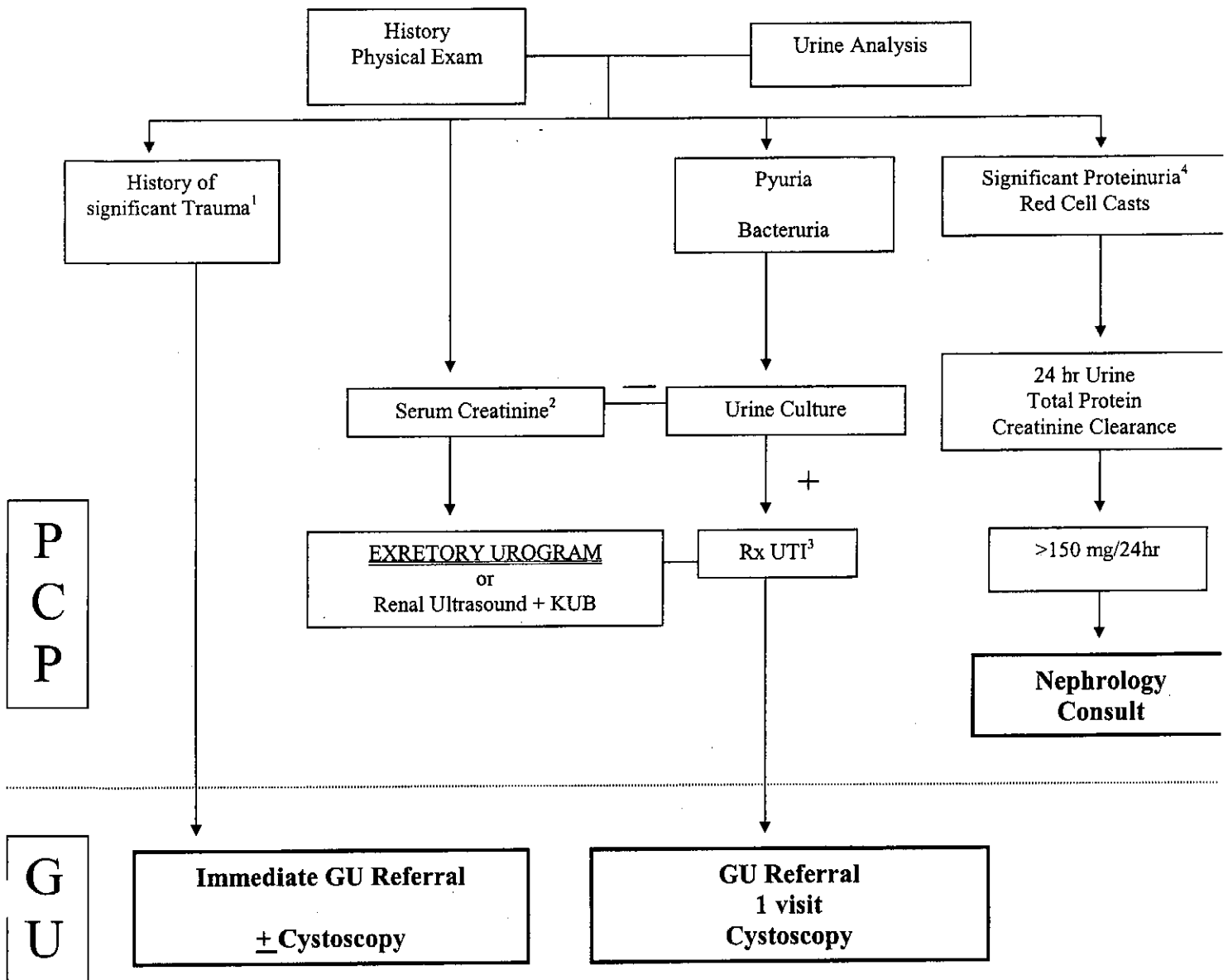


¹ Mid stream urine for analysis. If dipstick is positive, then microscopic analysis to evaluate presence of RBCs.

² If the serum creatinine is elevated (especially in the presence of diabetes mellitus) a renal ultrasound should be done instead of an excretory urogram. The x-ray studies are for evaluation of the upper tracts and should be obtained prior to referral. The excretory urogram is the preferred study. If an ultrasound is done, a KUB is needed to evaluate for stones.

³ With $\geq 2+$ proteinuria and red cell casts, a medical cause for hematuria should be pursued.

Referral Guideline Gross Hematuria



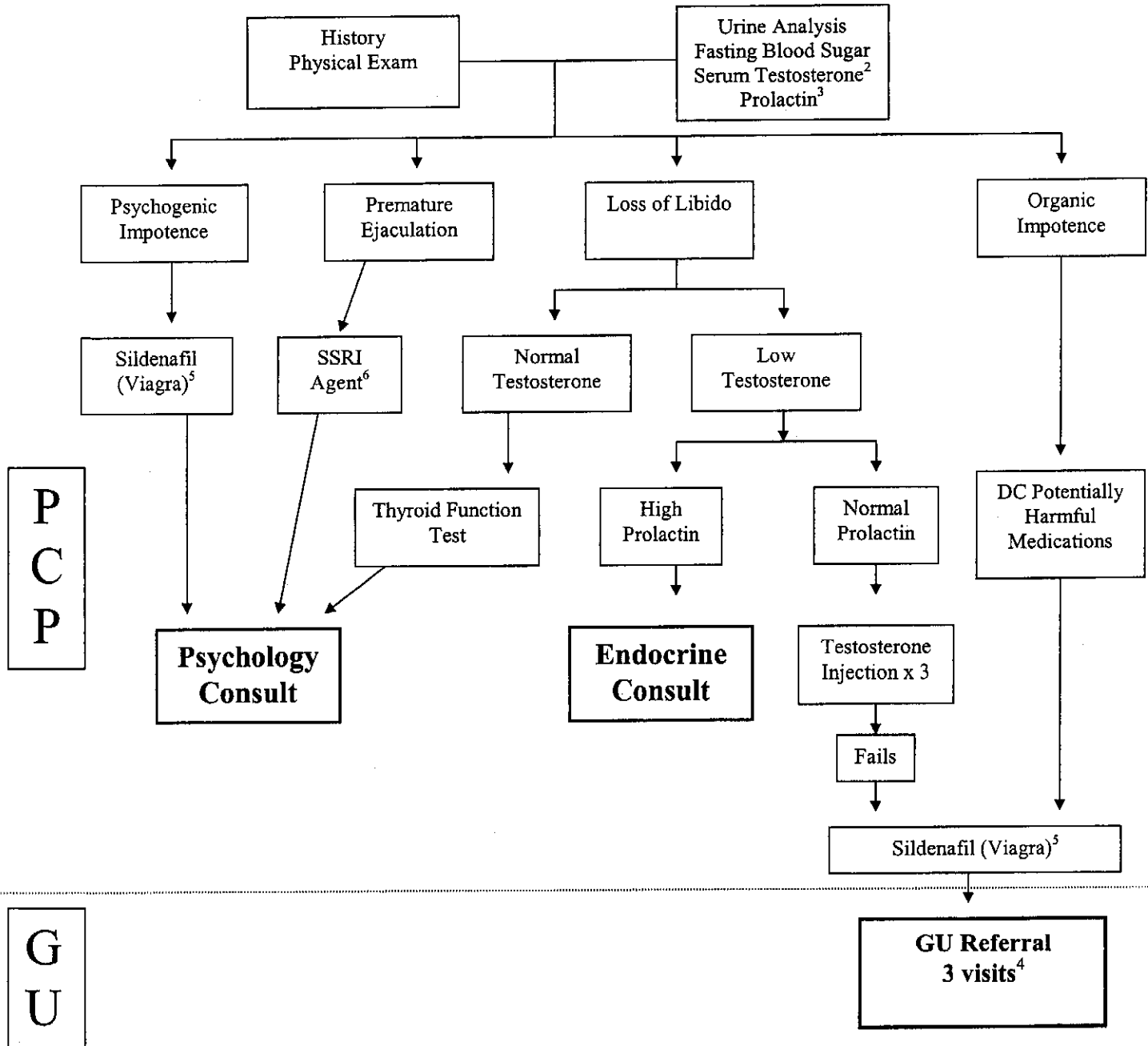
¹ If there is a history of significant abdominal, flank, pelvic, or perineal trauma that results in gross hematuria, immediate GU referral is indicated. The Urologist should determine what is the appropriate diagnostic studies to order i.e. CT scan, Excretory Urography etc.

² If the serum creatinine is elevated (especially in the presence of diabetes mellitus) a renal ultrasound should be done instead of an excretory urogram. The excretory urogram is the preferred study. If an ultrasound is done, a KUB is needed to evaluate for stones.

³ A positive culture does not rule out the presence of a tumor. After the UTI has been treated, a complete work-up with excretory urogram or renal ultrasound and cystoscopy should be considered.

⁴ With $\geq 2+$ proteinuria and red cell casts, a medical cause for hematuria should be pursued.

Referral Guideline Sexual Dysfunction – Impotence¹



¹ American Urological Association Erectile Dysfunction Clinical Guidelines Panel, The Treatment of Organic Erectile Dysfunction, 1996.

² Early morning level of testosterone is needed as this is the peak level of the diurnal variation.

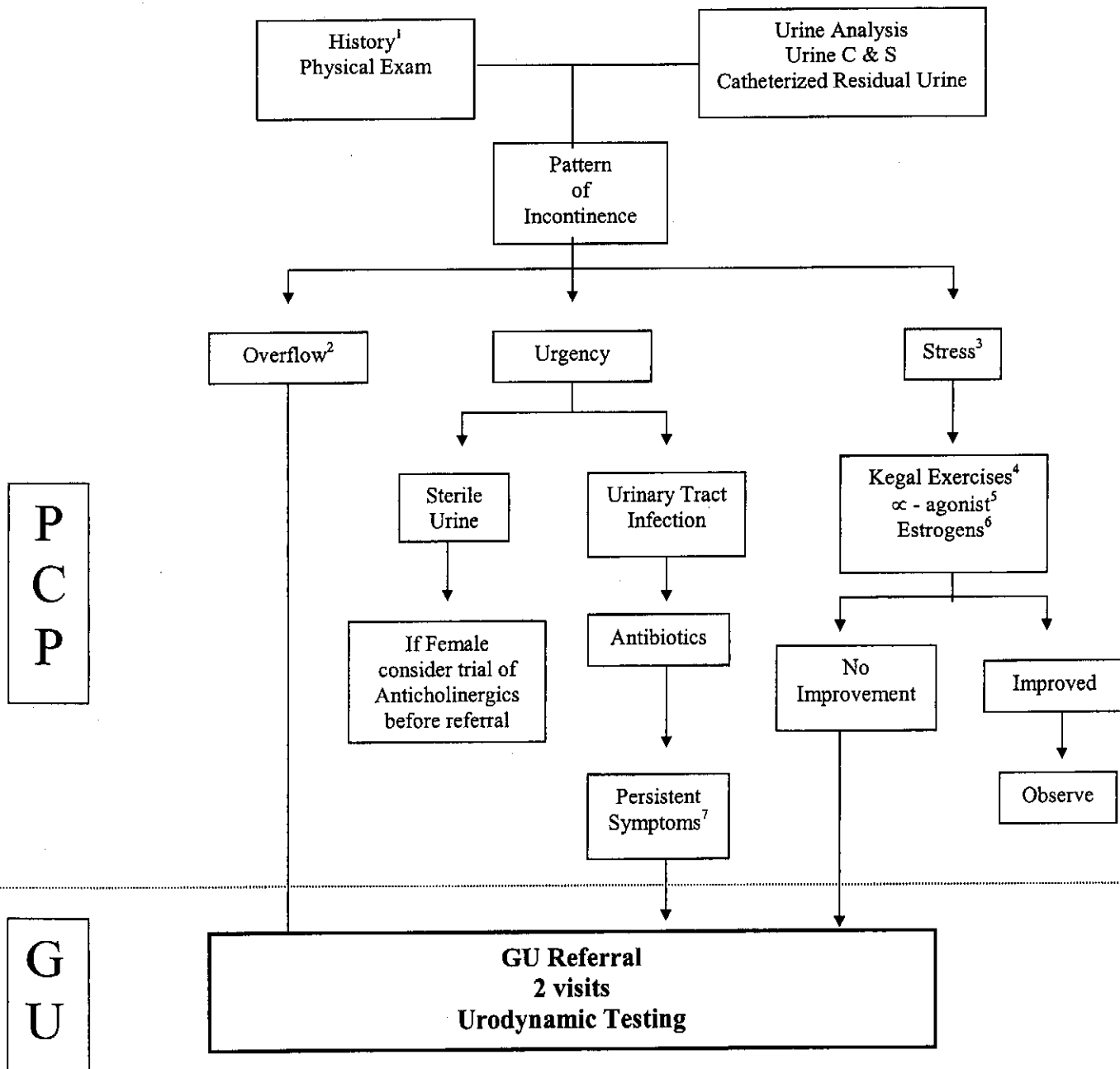
³ Serum Prolactin measured only if the serum testosterone is below low normal levels.

⁴ In highly selected cases a vascular evaluation to include corpora cavernosometry, corpora cavernosography and angiography.

⁵ Oral Sildenafil (Viagra) should be tried initially prior to referral. The usual dosage is 50 to 100 mg, 1-3 hours prior to intercourse. The patient can not be taking Nitroglycerine products.

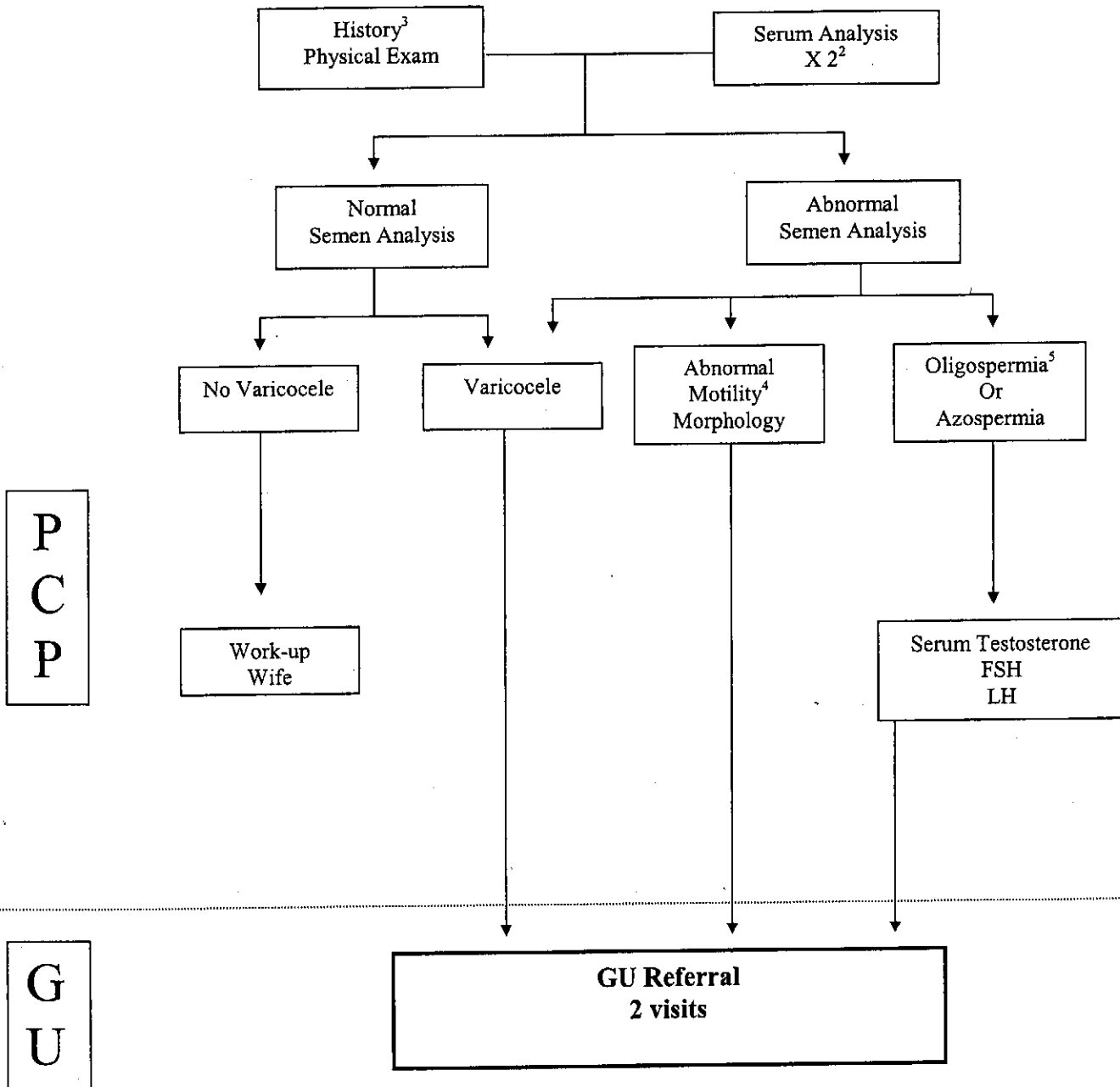
⁶ SSRI agents are effective in the management of premature ejaculation.

Referral Guideline Male/Female Urinary Incontinence



¹ With significant irritative symptoms (frequency, urgency) and hematuria we need to rule out carcinoma-in-situ. Do first morning urine cytology X 2.
² Overflow incontinence results when the patient is in urinary retention and therefore would have an elevated residual urine.
³ Leakage with increased intra-abdominal pressure, i.e. cough, lifting, etc.
⁴ Physiotherapy, kegal exercises and biofeedback teaching of kegal exercises, has a role in conservative treatment of stress incontinence.
⁵ α-agonists such as imipramine, ephedrine, phenalpropanolamine has a limited role in mild incontinence.
⁶ Topical or oral estrogen should be used in postmenopausal ladies with mild stress incontinence.
⁷ See footnote number four under cystitis.
⁸ For male consider referral if unknown prostate status.

Referral Guideline Male Infertility¹



¹ Infertility is defined as an inability to achieve a pregnancy after one year of unprotected intercourse.

² The semen analysis should be done at a good lab.

³ Since 40% of the causes of infertility are female factor, 40% are male factor and 20% are both; work-up both the partners at the same time.

⁴ Motility of less than 60% is abnormal.

⁵ Counts of less than 20 million are abnormal.