Newcastle upon Tyne, Gateshead and Northumbria Urology guidelines

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.

These guidelines are intended for all clinicians in primary care in the Newcastle, North Tyneside, Northumberland and Gateshead areas involved in managing patients with urological conditions. .

How to use the guidelines

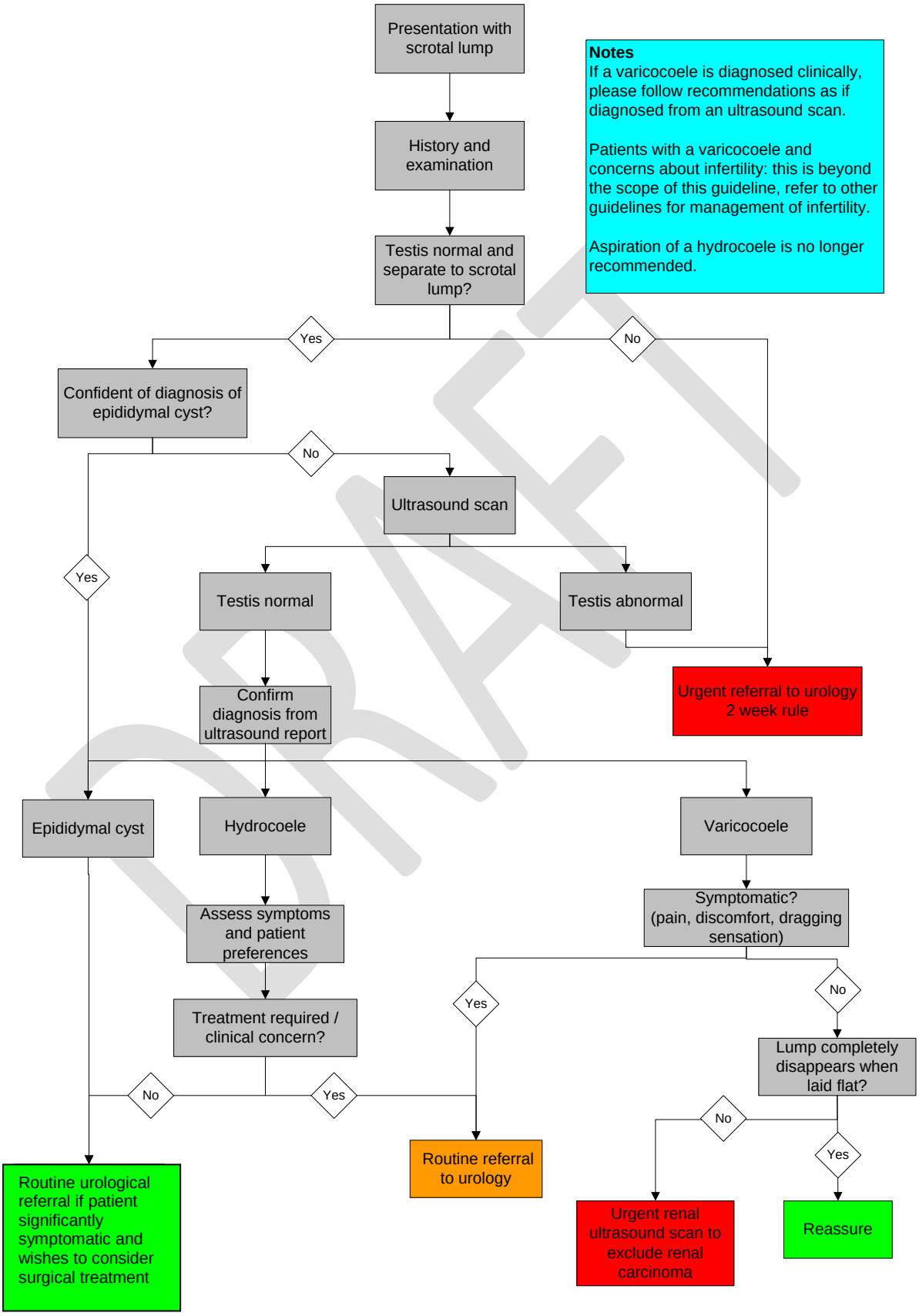
The BNF and the North of Tyne / Gateshead Formulary should be referred to as appropriate.

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

Contents

Scrotal lumps



Recurrent Urinary Tract Infections in Non-Pregnant Females

Exclude persistent UTI – i.e. poor eradication after initial treatment

Consider extended course 7-14 days of antibiotics if
-Persistent UTI
-Renal Tract Abnormality
Immunosuppressed
-
Examine sensitivities of Previous MSUs

Age over 60 with new onset recurrent UTIs. **Refer to Urology**

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

↓

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 double micturition)
- 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

↓

No improvement

↓

Postmenopausal Women	Identifiable /trigger for UTI e.g. Intercourse	Trail 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 to seek medical help if symptoms of UTI develop. Review efficacy at 3-6months.	Advise about risk of resistance with long-term antibiotics, possible adverse effects of long-term antibiotics and need to seek medical help if symptoms of an acute UTI develop. Review at 3 months and consider cessation of antibiotics. If decision made to continue antibiotics review every 6 month. There is no evidence to support rotation of different antibiotics. See '*North East and Cumbria Antimicrobial Prescribing Guideline for Primary Care'* for further antibiotic treatment/advice	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

↓

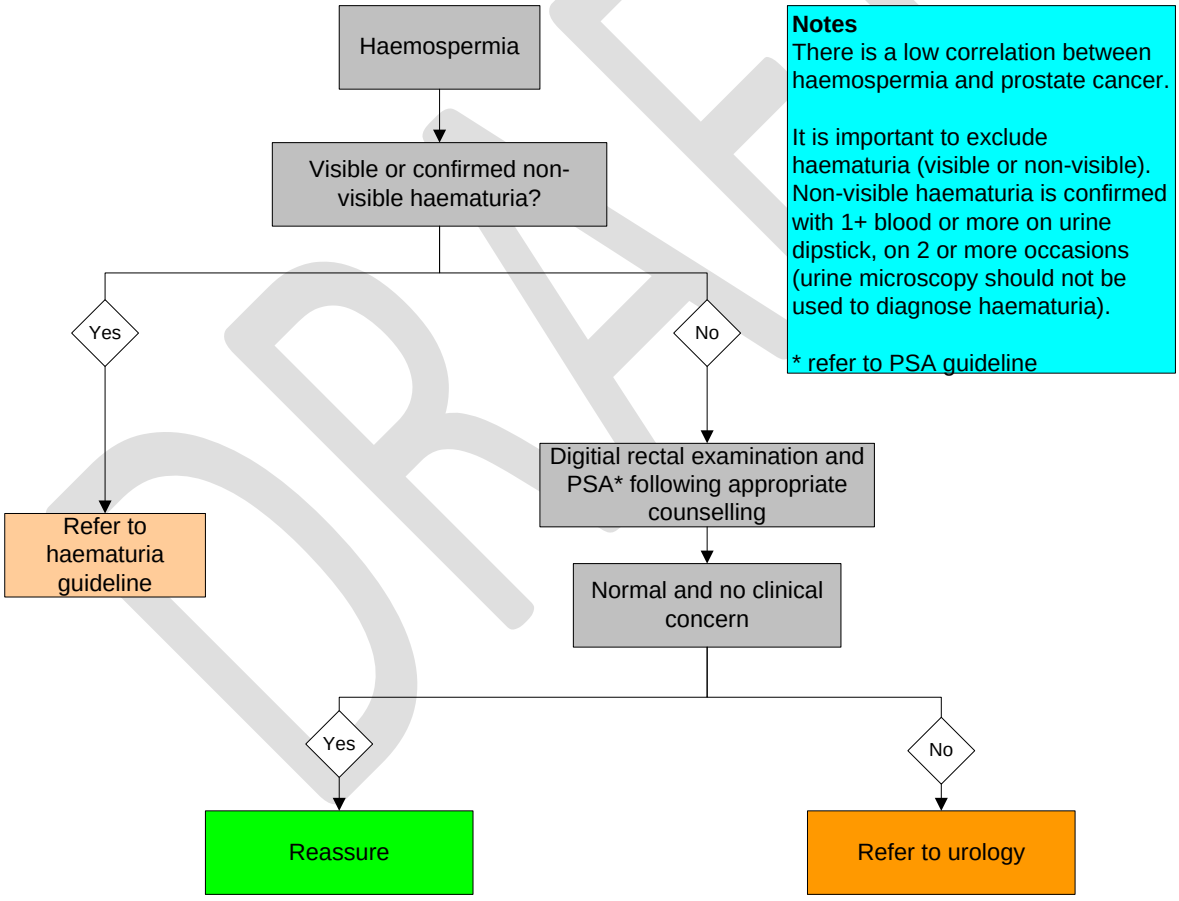
Treatment failure – **Refer to Urology**

Recurrent UTI NICE guidance

UTIs in men

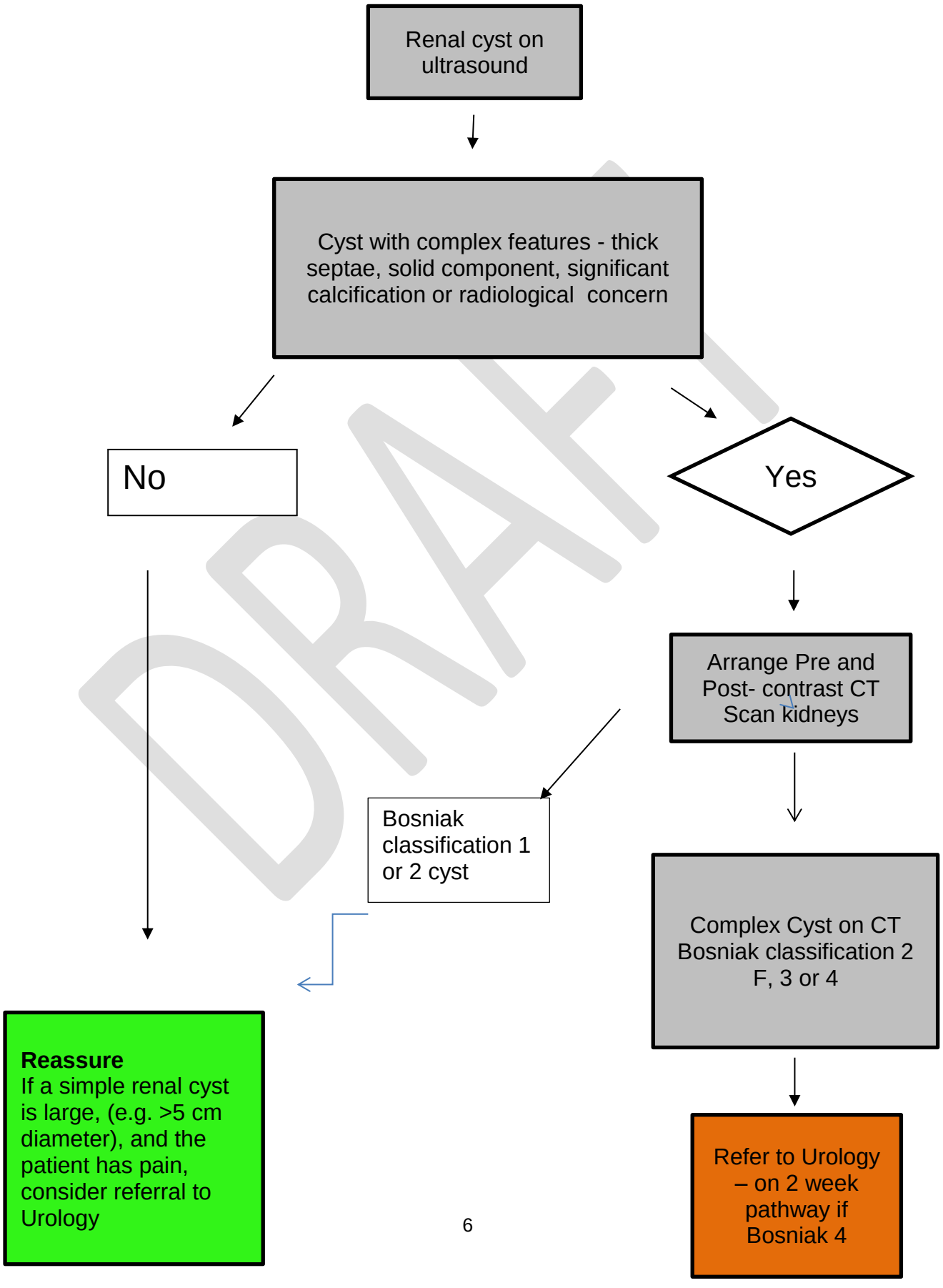
A proven UTI in a male should be investigated with an ultrasound of the urinary tract including ultrasound bladder and assessment of post micturition residual
Urological referral is appropriate if there is an abnormality of the urinary tract of if the post-micturition residual is greater than 100mls.
If ultrasound is normal then urology referral may be indicated based on haematuria or cancer guidelines or if there is clinical concern

Haematospermia

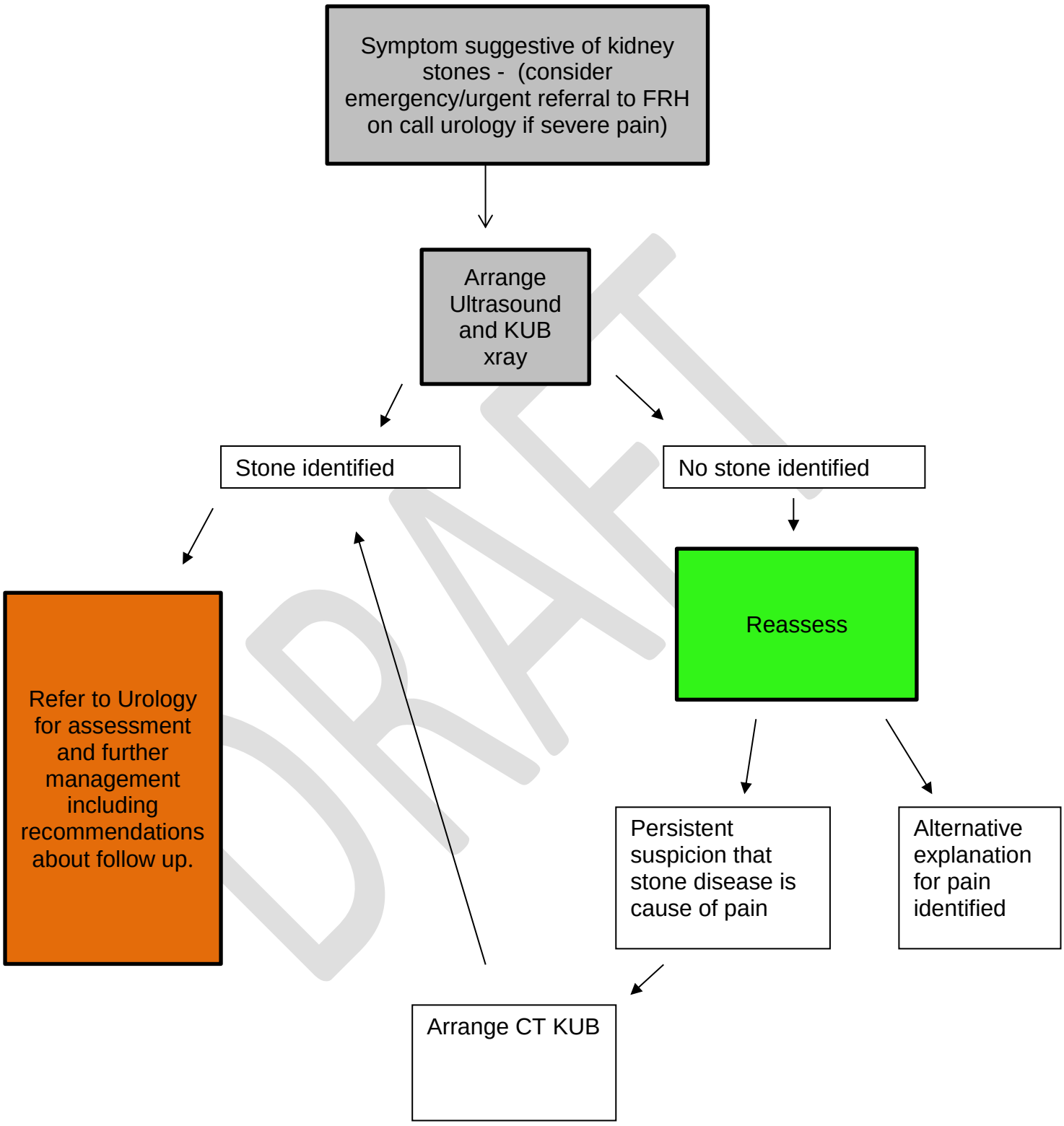


Please note we are aware that these guidelines do not align with NICE guideline but there is clinical consensus with above approach
If haematospermia is recurrent or persistent – consider referral to urology

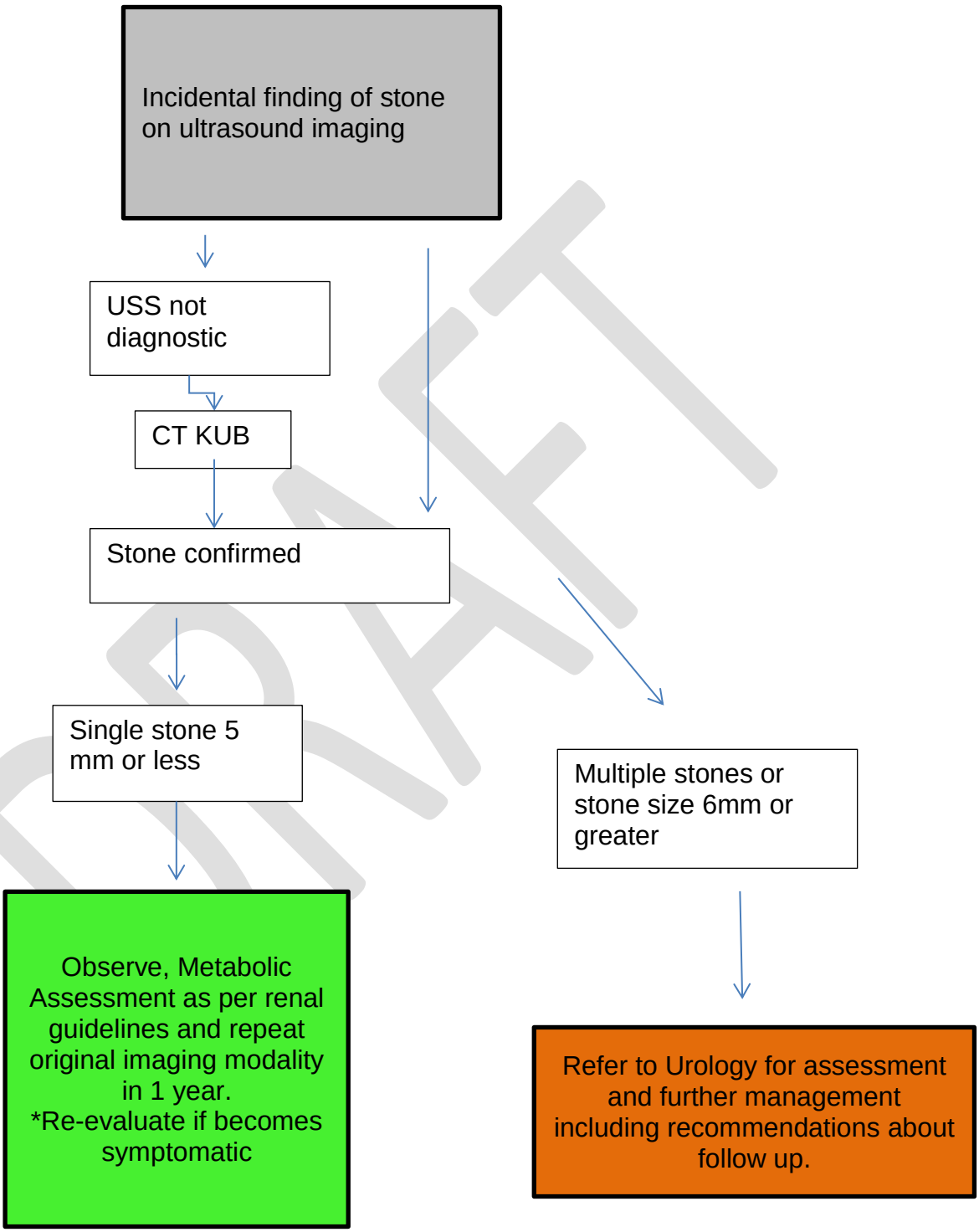
Renal cysts



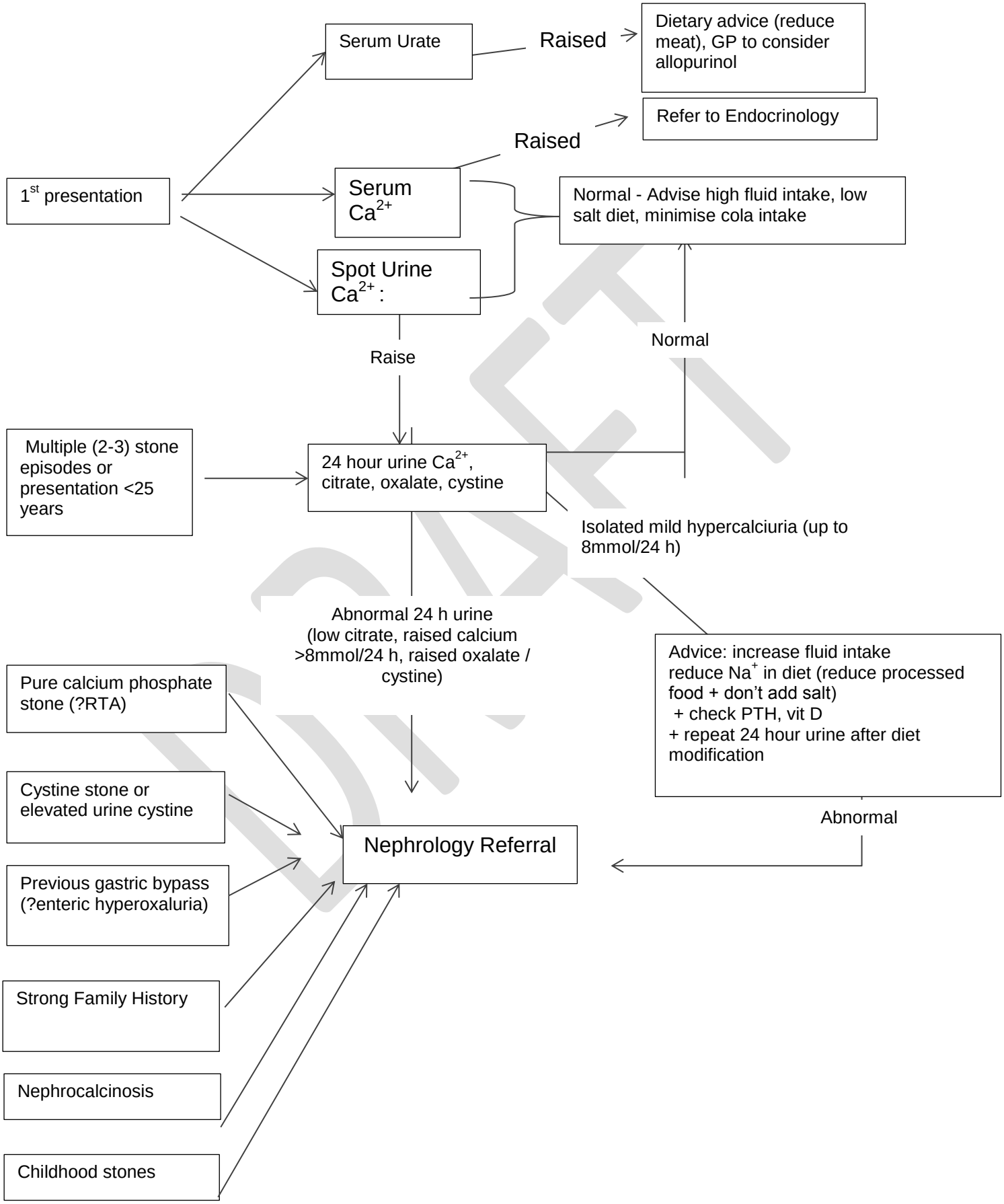
Symptoms suggesting urinary tract stones



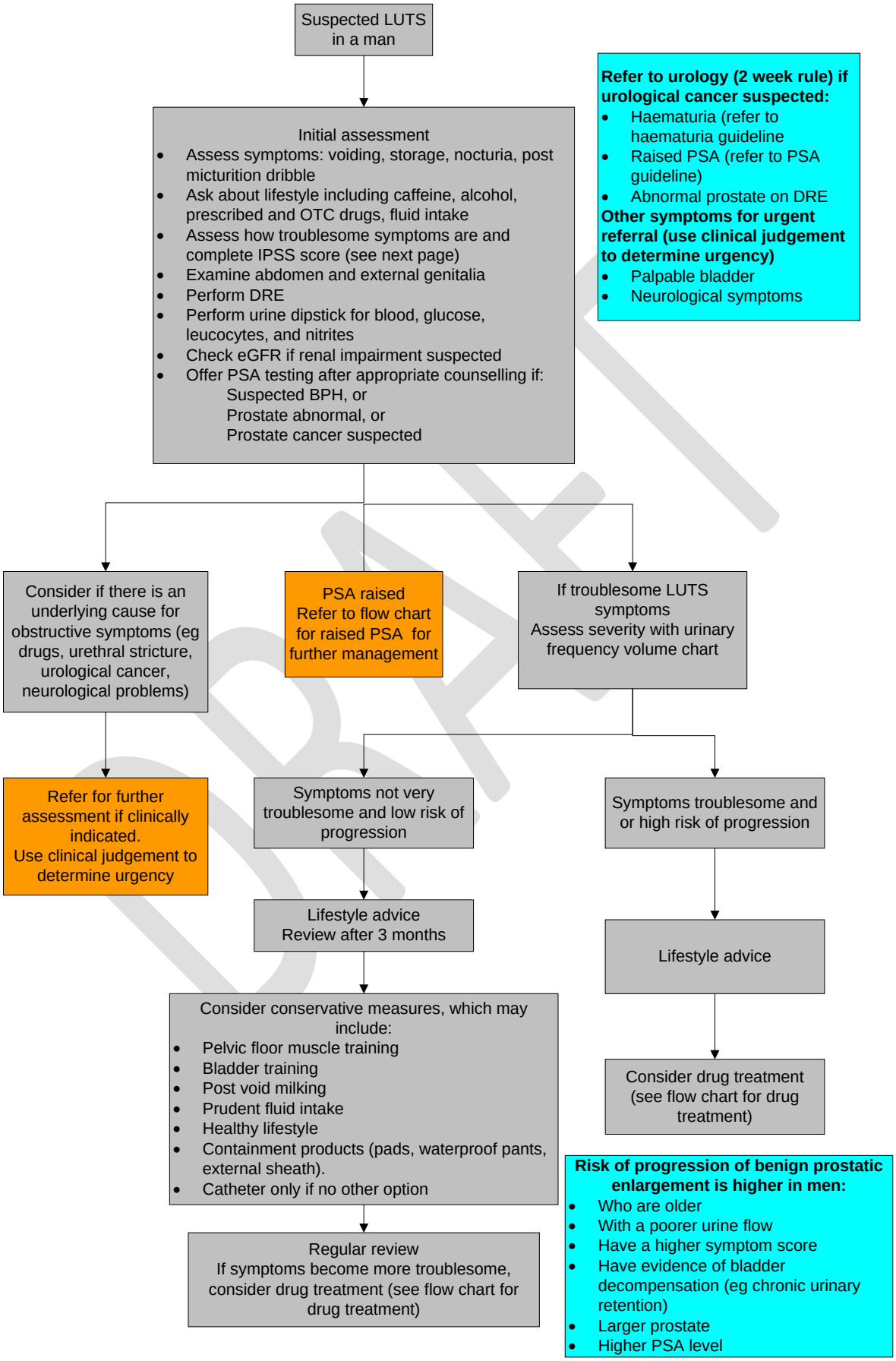
Incidental finding of renal stones



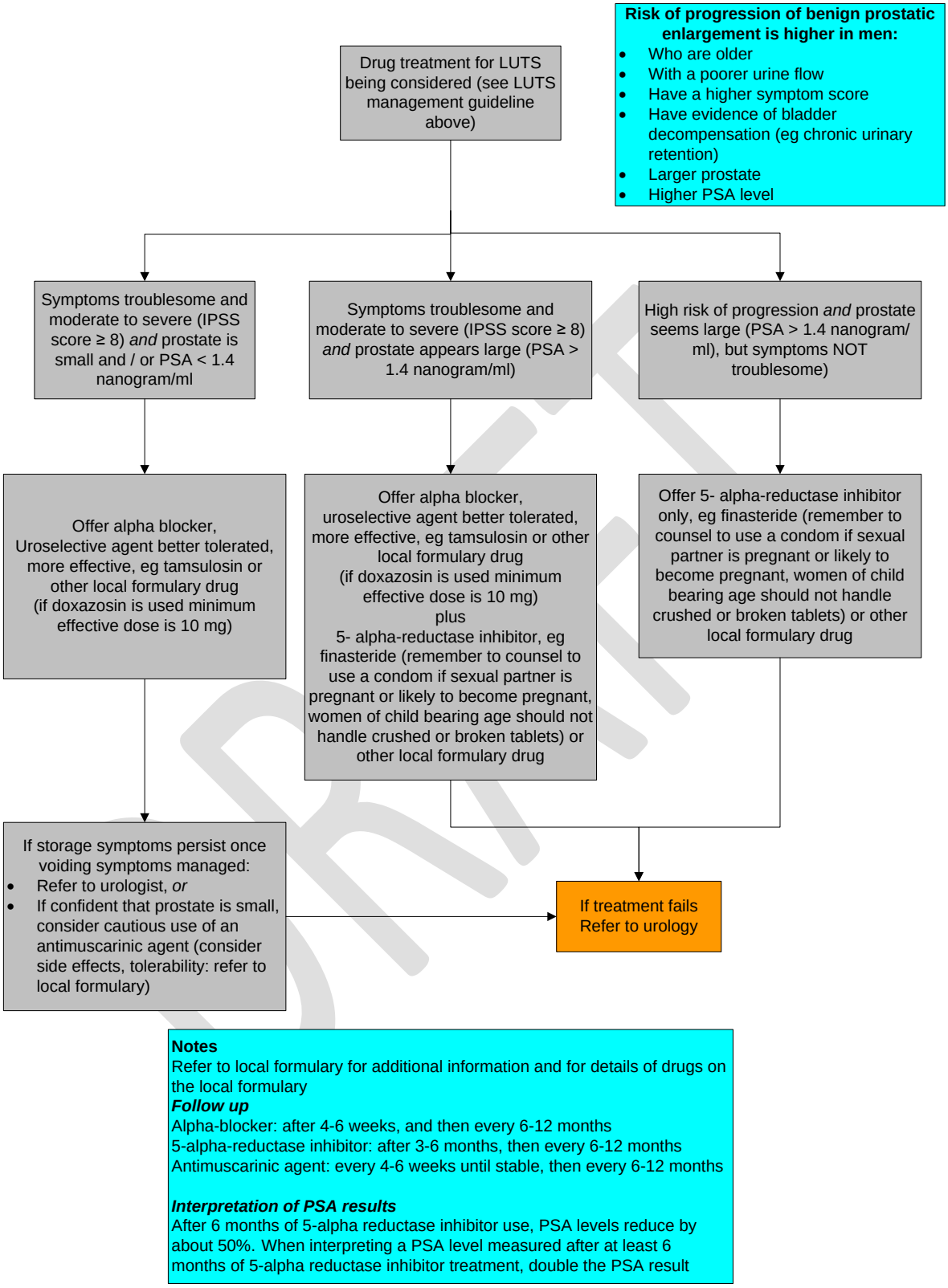
Kidney Stone Patient Metabolic Assessment



Lower urinary tract symptoms (LUTS) in men: assessment and management



Drug flow chart for drug treatment in male patients with Lower urinary tract symptoms

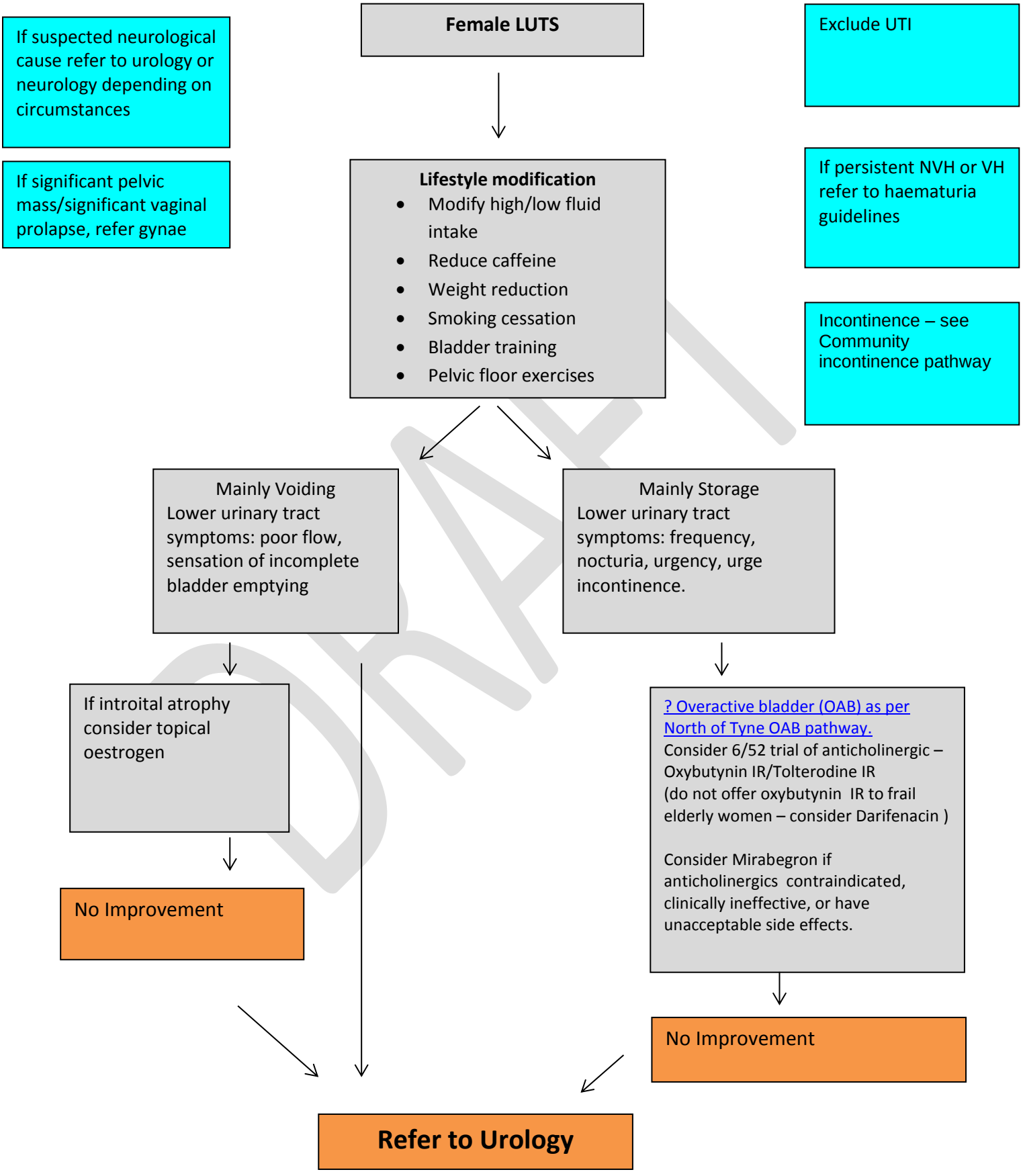


Notes
Refer to local formulary for additional information and for details of drugs on the local formulary

Follow up
Alpha-blocker: after 4-6 weeks, and then every 6-12 months
5-alpha-reductase inhibitor: after 3-6 months, then every 6-12 months
Antimuscarinic agent: every 4-6 weeks until stable, then every 6-12 months

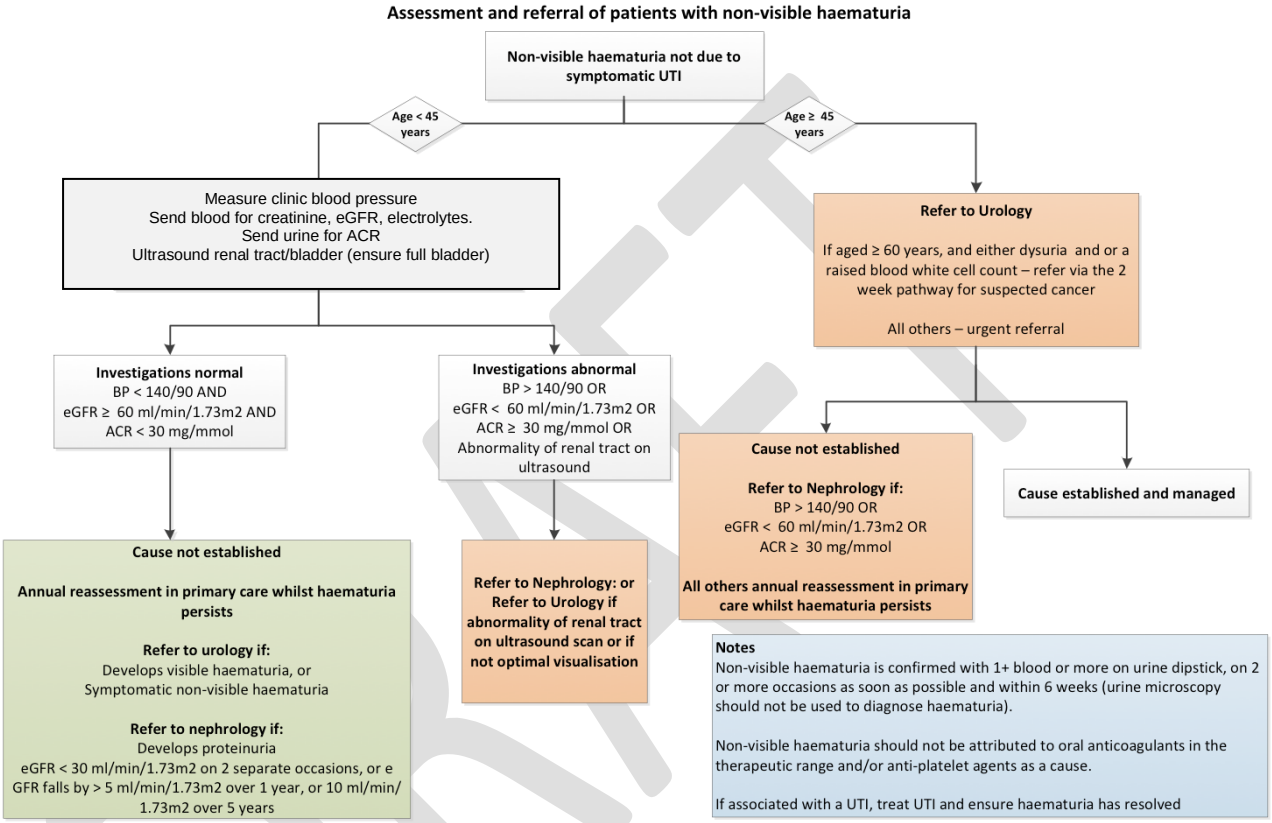
Interpretation of PSA results
After 6 months of 5-alpha reductase inhibitor use, PSA levels reduce by about 50%. When interpreting a PSA level measured after at least 6 months of 5-alpha reductase inhibitor treatment, double the PSA result

Female LUTS guidelines



Assessment and referral of non-visible haematuria

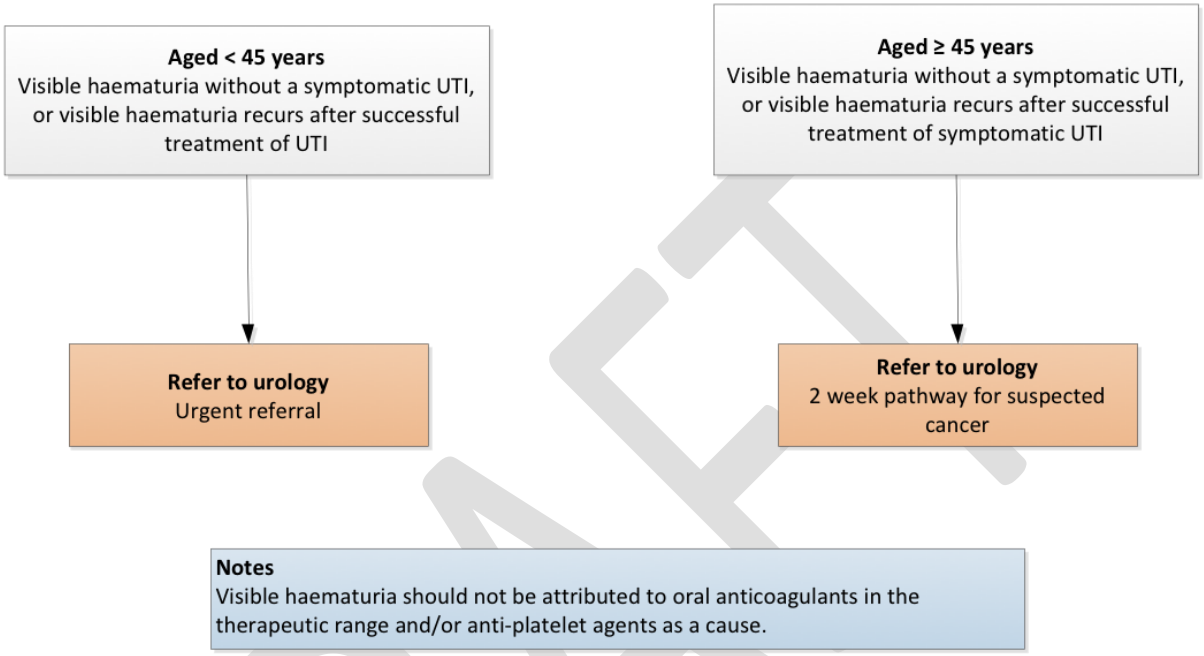
– taken from North of Tyne/Gateshead guidelines for detection, management and referral of adults with kidney disease



Visible haematuria

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

Assessment and referral of patients with visible haematuria



Summary of urology referral for cystoscopy

Visible haematuria (no UTI) > 45 years – 2 week cancer pathway
Visible haematuria (no UTI) < 45 years – urgent referral
Non- visible haematuria (no UTI) age > 60 with dysuria or raised wcc – 2 week cancer pathway
Non- visible haematuria (no UTI) age > 45 – urgent referral

Visible haematuria associated with UTI, persisting for > 2 weeks – urgent referral
Non visible haematuria associated with UTI, persisting for > 6 weeks, age > 45 – urgent referral
Recurrent UTIs (with or without haematuria) over the age of 60 – referral to urology

Membership of the guideline development group

Mr David Rix Consultant Urologist, The Newcastle upon Tyne Hospitals Trust
Dr Anna O'Riordan, Consultant Urologist, The Newcastle upon Tyne Hospitals NHS Foundation Trust
Dr Toby Page, Consultant Urologist, The Newcastle upon Tyne Hospitals NHS Foundation Trust
Dr Matthew Shaw, Consultant Urologist, The Newcastle upon Tyne Hospitals NHS Foundation Trust
Dr David Grainger, NHS Newcastle and Gateshead CCG
Dr Malcolm Orr, GP, Guidepost Surgery
Dr Chris Jewitt, NHS Newcastle and Gateshead CCG
Dr Katharine Greenough, NHS Newcastle and Gateshead CCG
Dr Steven Llewellyn , NHS Newcastle and Gateshead CCG
Mr Zachariah Kuruvilla, Associate Specialist in Urology, Northumbria
Dr Hassan Gali, GP Specialty Registrar HENE

Feb 2019