Newcastle upon Tyne, Gateshead and Northumbria Urology guidelines

(Minor revisions to assessment and referral of non-visible haematuria – May 2020, Peyronie's Disease guidelines added – October 2020)

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

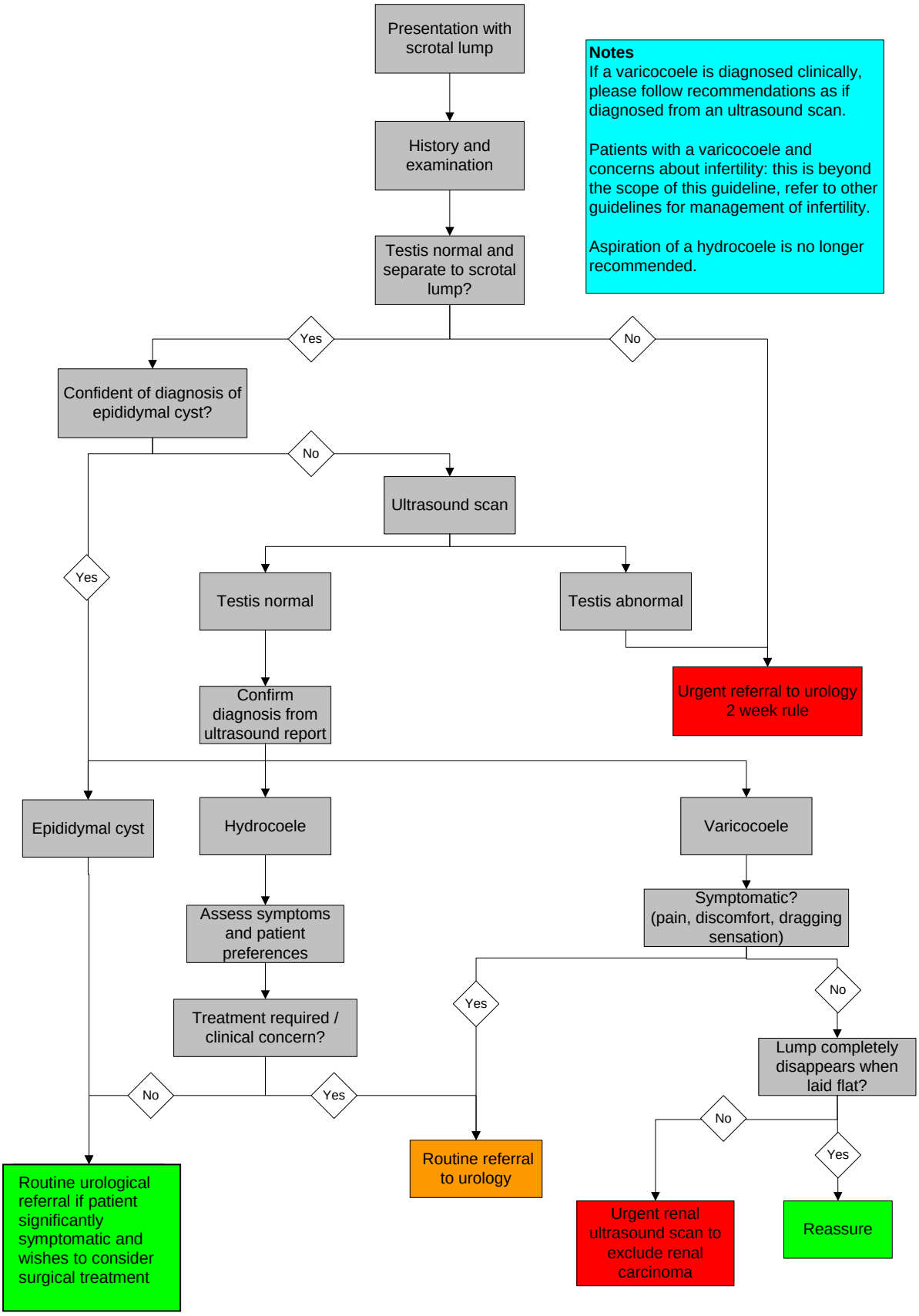
The BNF and the North of Tyne / Gateshead Formulary should be referred to as appropriate.

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

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Undertake - Renal tract USS – including kidneys, full bladder and post void residual (PVR) → Abnormal USS or PVR>100mls **Refer to Urology**

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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

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No improvement

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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

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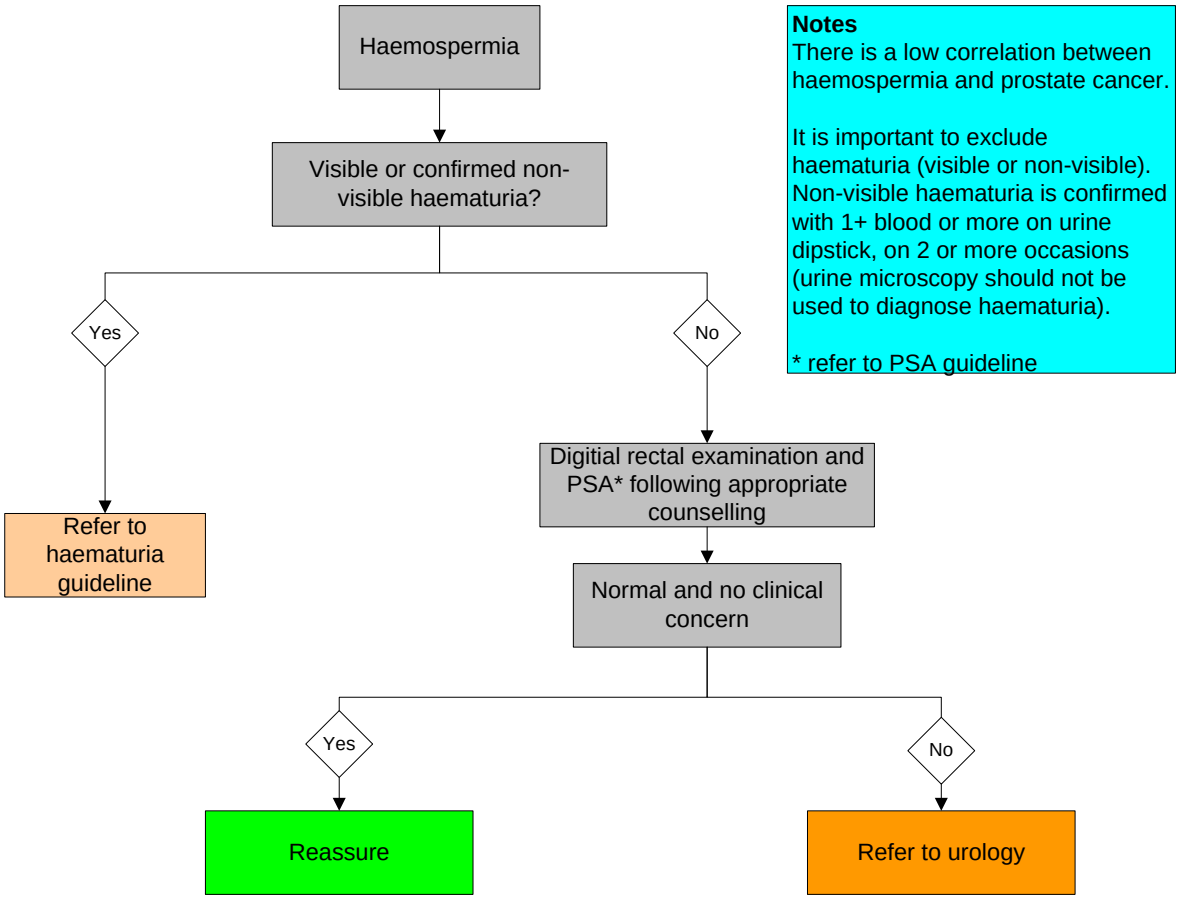
Treatment failure – **Refer to Urology**

Recurrent UTI NICE guidance

UTIs in men

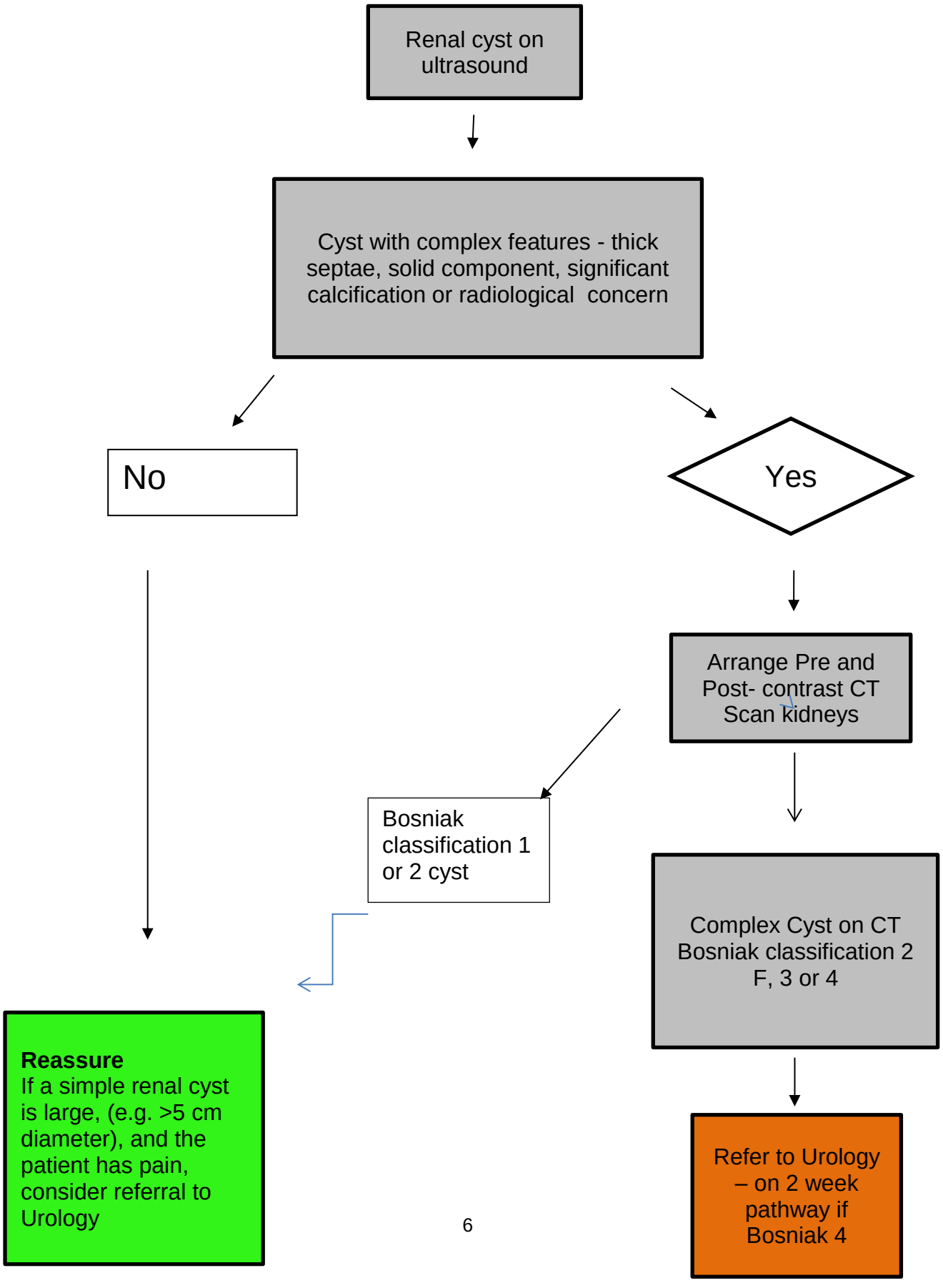
A proven UTI in a male should be investigated with an ultrasound of the urinary tract including ultrasound bladder and assessment of post micturition residual
Urological referral is appropriate if there is an abnormality of the urinary tract of if the post-micturition residual is greater than 100mls.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

Haematospermia

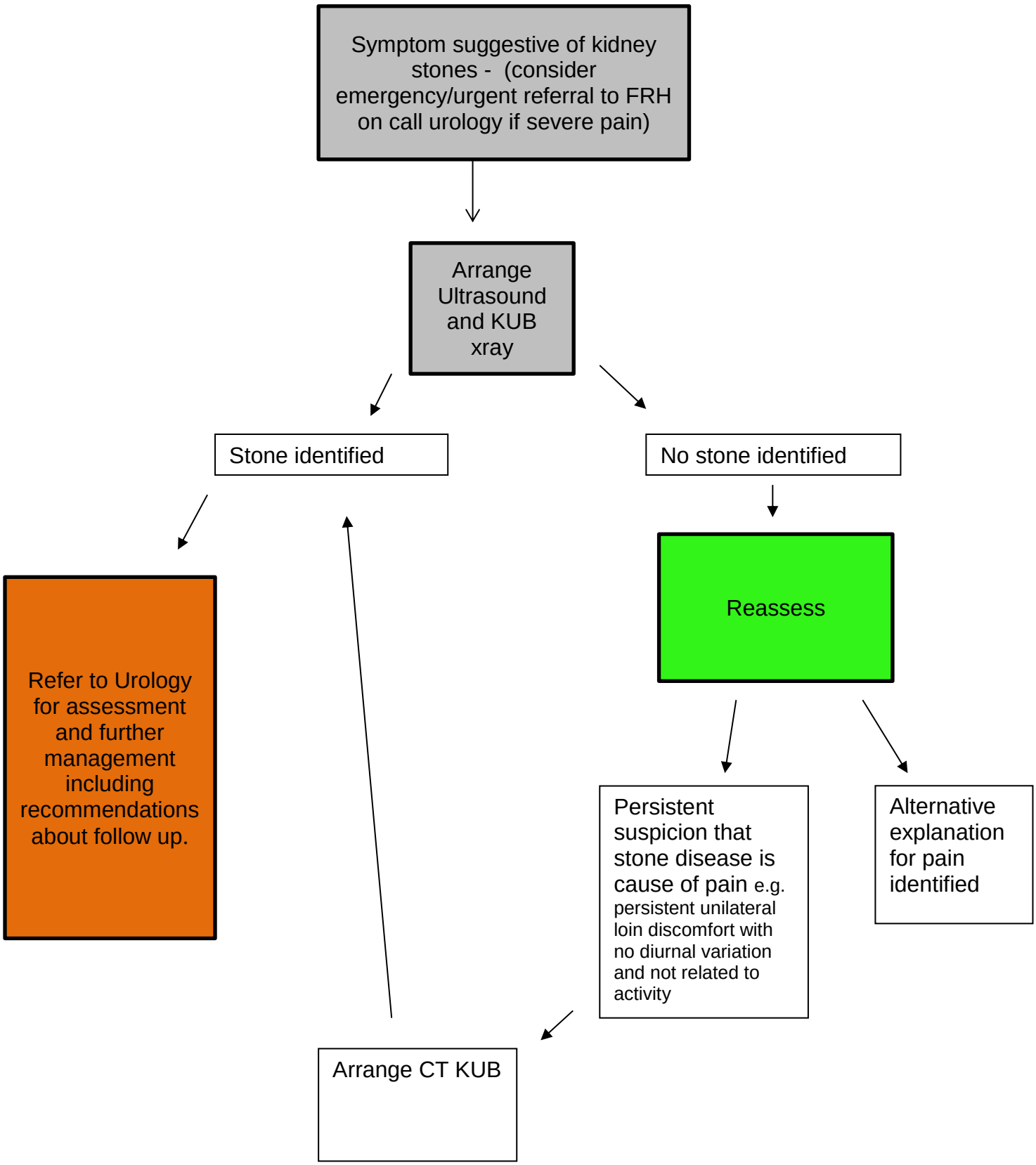


Please note we are aware that these guidelines do not align with NICE guideline but there is clinical consensus with above approach
If haematospermia is recurrent or persistent – consider referral to urology

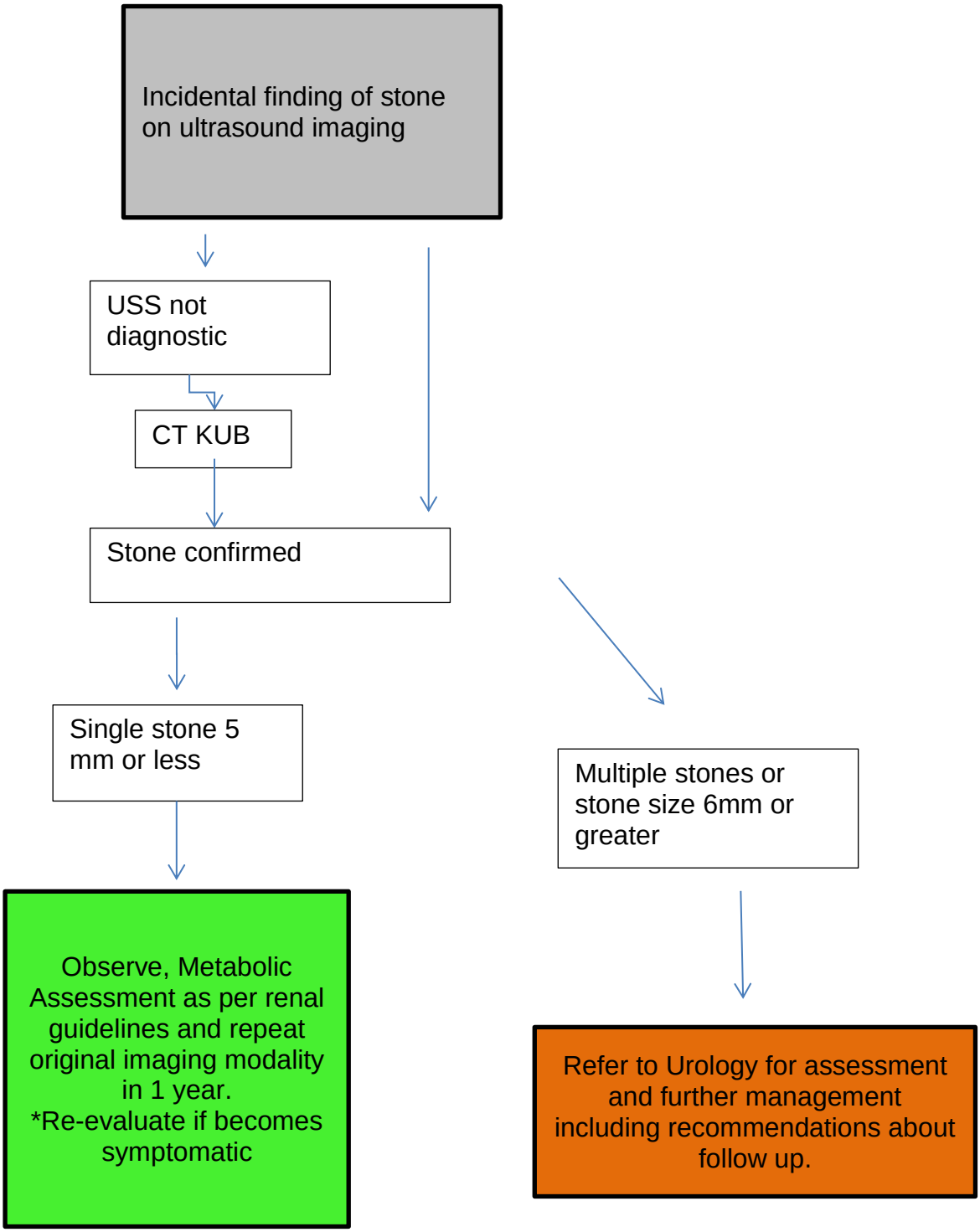
Renal cysts


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

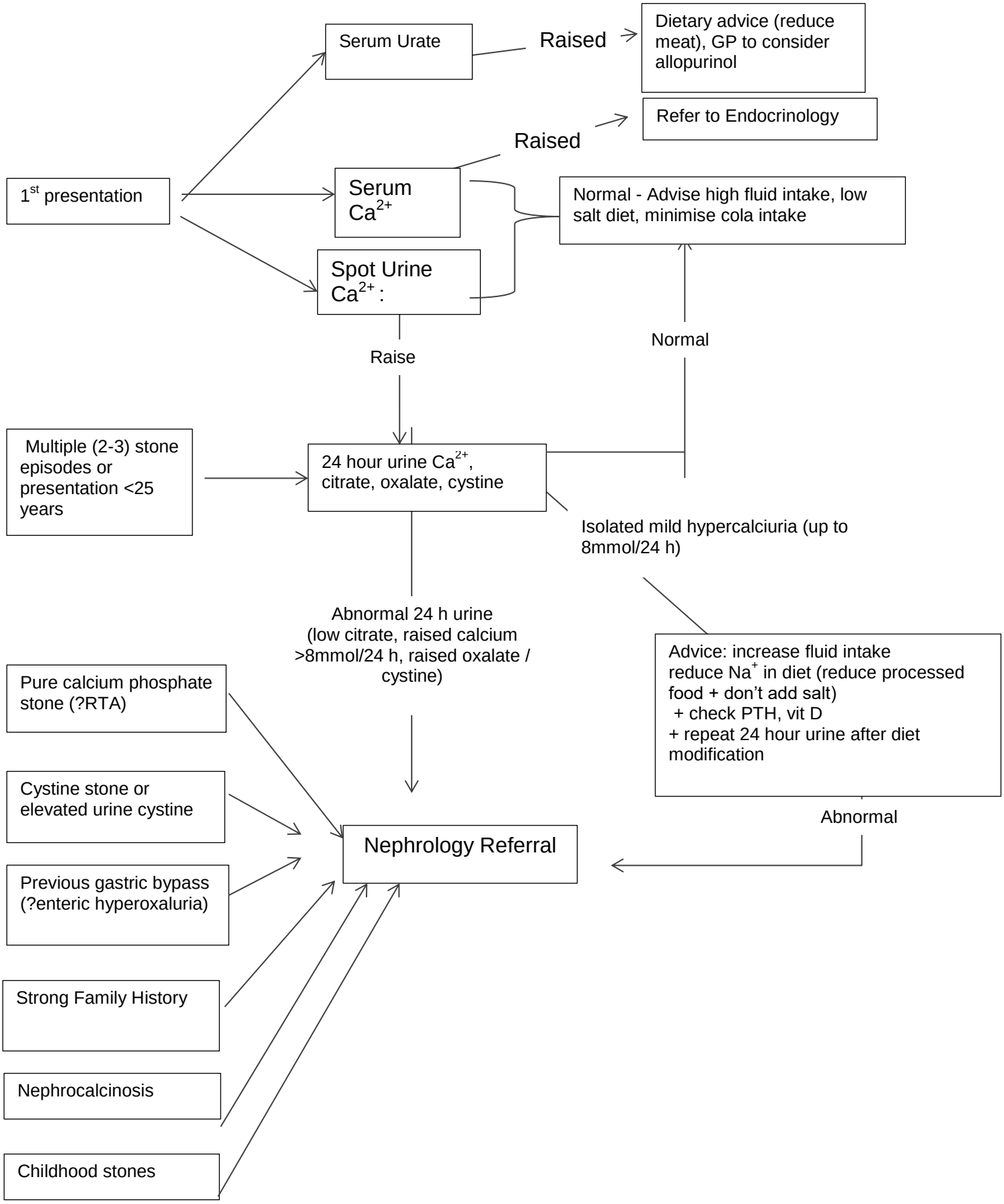
Symptoms suggesting urinary tract stones



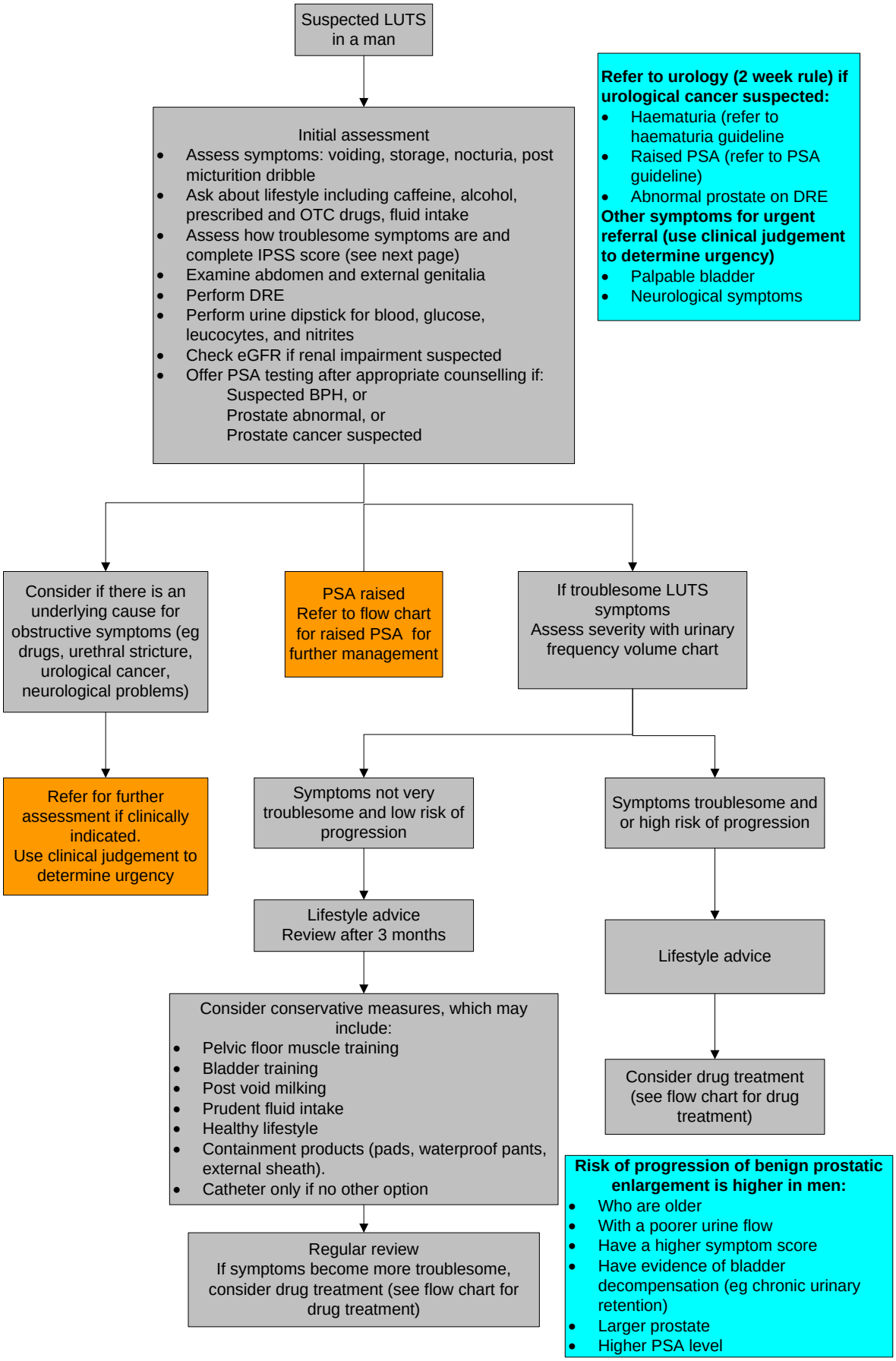
Incidental finding of renal stones



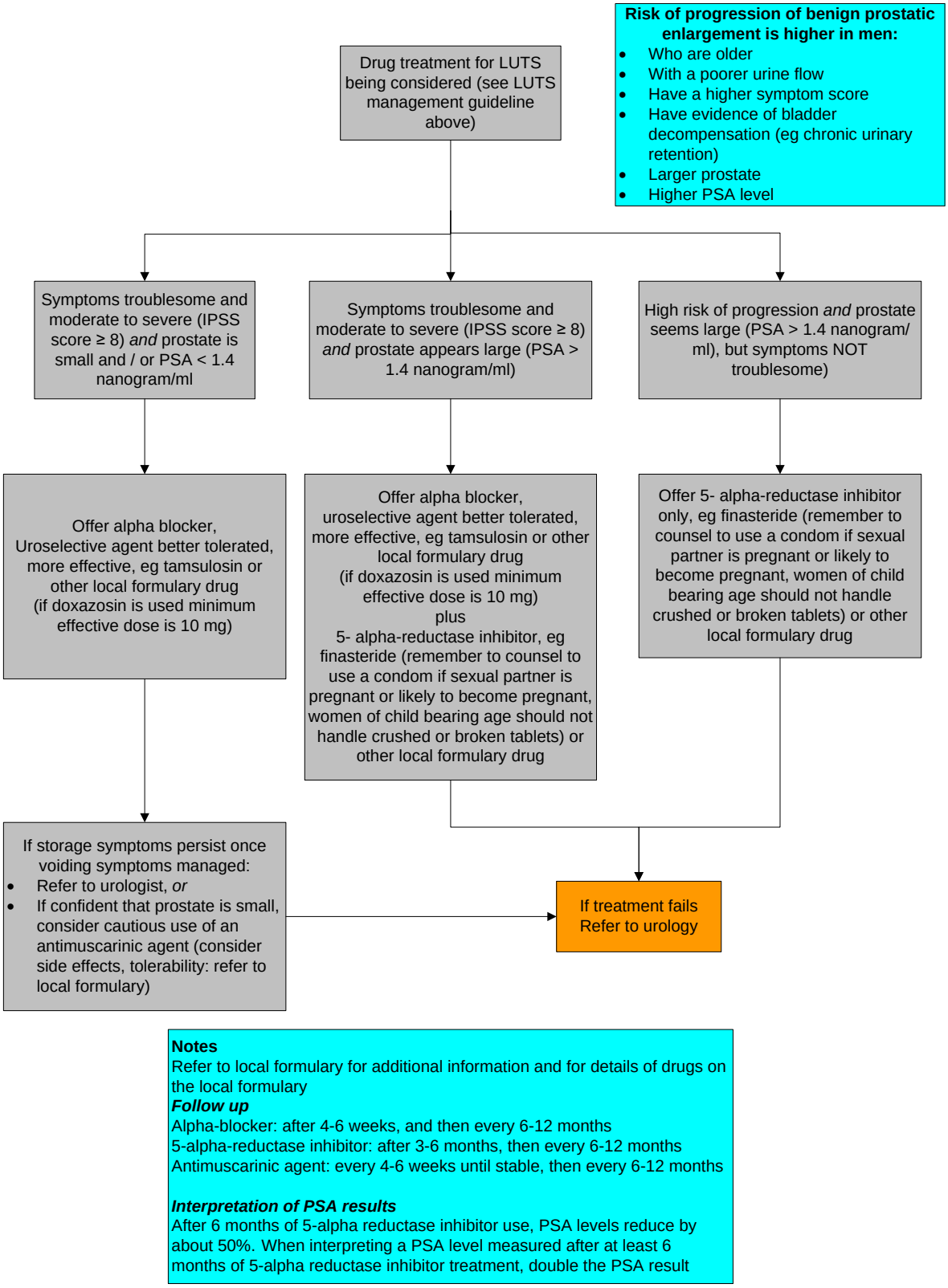
Kidney Stone Patient Metabolic Assessment



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



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

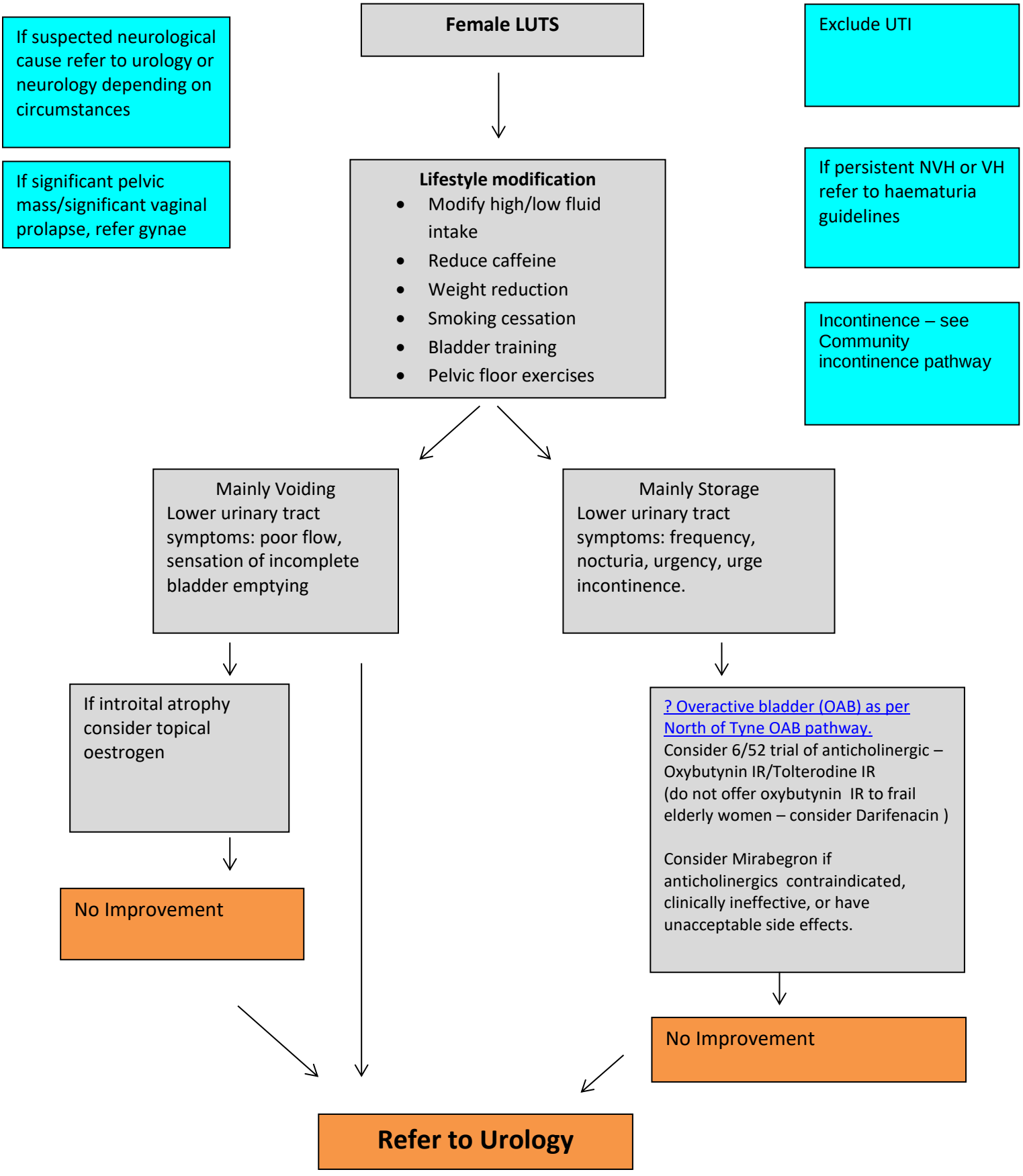


Notes
Refer to local formulary for additional information and for details of drugs on the local formulary

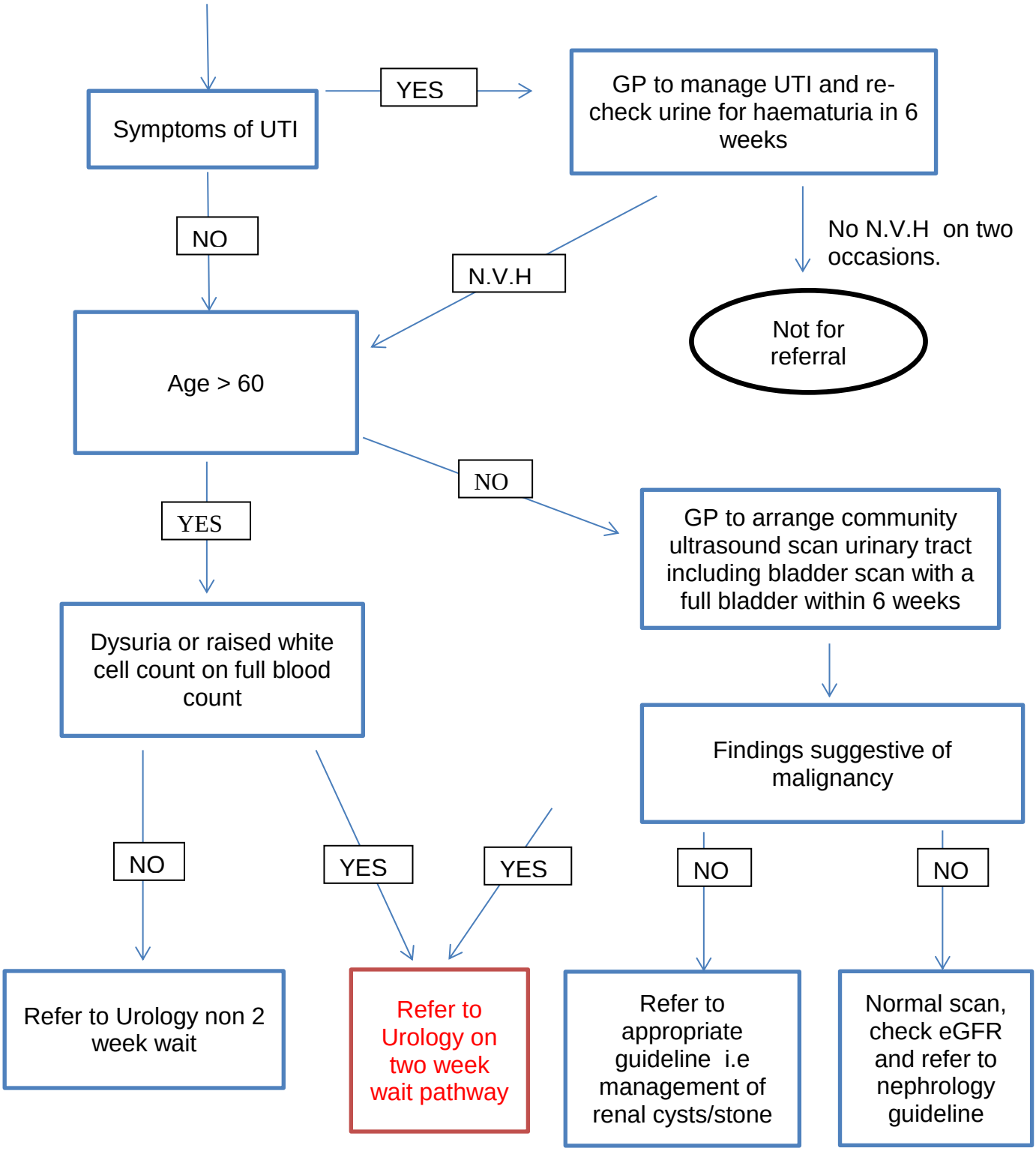
Follow up
Alpha-blocker: after 4-6 weeks, and then every 6-12 months
5-alpha-reductase inhibitor: after 3-6 months, then every 6-12 months
Antimuscarinic agent: every 4-6 weeks until stable, then every 6-12 months

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



Non Visible Haematuria – NVH

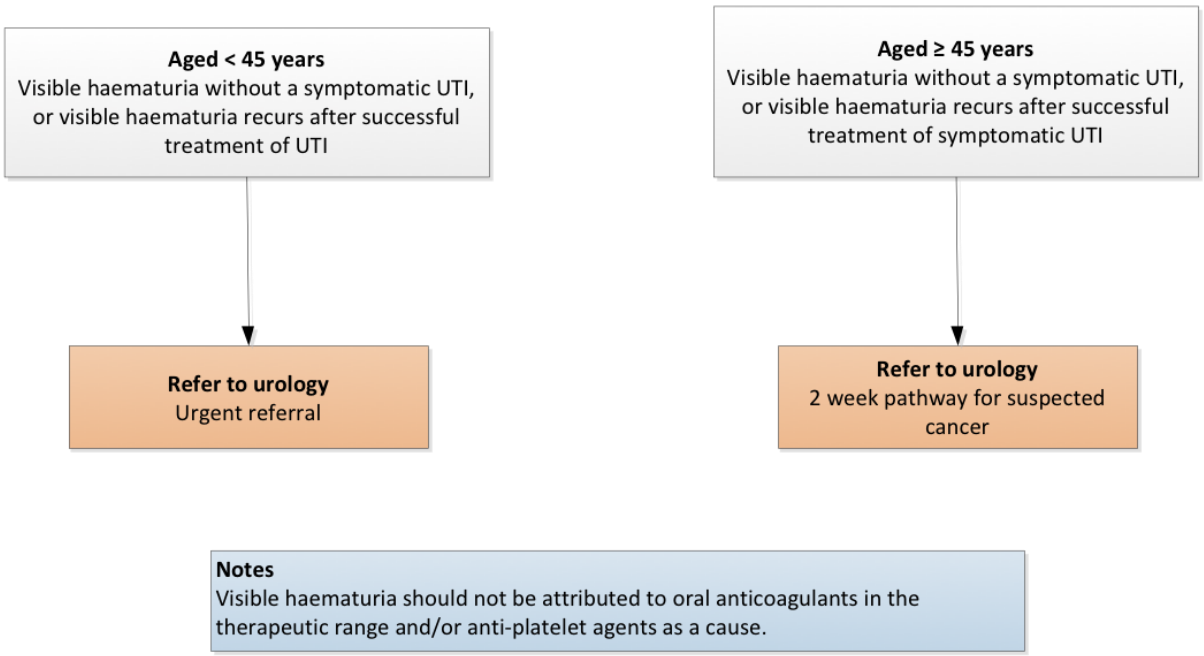


Recent or persistent UTI's over age of 60 -> refer to UTI clinic.

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



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

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 > 60 – urology 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

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. GPs 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 GPs 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 within 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 penetrative intercourse not possible and patient wishes to be assessed for surgery please refer to Newcastle Urology, Male Reconstructive Surgery

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Feb 2019