Urology Referral Guidelines

If your patient has been seen in Urology within the last 3 years, please have the patient call the Urology dept to schedule a follow up with their Urologist or with a Urology APP.

New consults – In order to expedite your patient's care with a specialist we need to have labs and imaging available for review at the time of their referral. Outside imaging needs to be pushed to our PACS system.

Outside imaging - please indicate in the referral where and when the imaging is scheduled.

CONTENTS

ACUTE EPIDIDYMITIS

- Microscopic UA / culture LAB348
- STI testing when STI suspected
- Initiate empiric antibiotics while awaiting culture results

Managed conservatively with antibiotics, NSAID/Acetaminophen, rest, and scrotal elevation

ADRENAL MASS

- MRI Adrenal protocol IMG319A
- BMP LAB15

BPH / DYSFUNCTIONAL VOIDING

- Microscopic UA/ culture LAB348
- PSA LAB166
- Bladder scan/PVR if available
- Trial of Alpha-blocker

Caffeine, EtOH and constipation will all contribute to complaints of urgency, frequency, and retention. Counsel patient on modification.

CYSTOCELE

- Will schedule with Dr Clark only if patient has hx of hysterectomy.
- Refer to OB/GYN if patient has NOT had a hysterectomy.

ELEVATED PSA

- Microscopic UA / culture LAB348
- Refer if
  - >2.5 (<50 years old)
  - >3.5 (50-60 years old)
  - >4.0 (> 60 years old)

UTI, obstruction and prostatitis can elevate PSA levels.

PSAV (PSA velocity) requires at least 3 PSA levels taken at least 6 months apart.

Finasteride causes a **decrease in serum PSA concentrations by approximately 50%** in patients with BPH, even in the presence of prostate cancer.

ERECTILE DYSFUNCTION

- All men with ED that want to resume sexual activity should be assessed for cardiovascular risk before ED therapy is administered. See the Princeton III consensus.
- Trial of oral agents (PDE5i)
- Discuss lifestyle modification including smoking cessation and weight loss.
- Successful use of oral ED medication requires sexual stimulation and avoid taking Sildenafil or Vardenafil with a high-fat meal.

- Cardiovascular Risk Assessment in Men Resuming Sexual Activity
- (Based on the Princeton II and III Consensus Recommendations)
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History (including exercise ability) & and Physical Exam (including BP, cardiac auscultation, peripheral pulses, carotid bruits)

- ** Sexual activity is equivalent to walking 1 mile on a flat course in 20 minutes or briskly climbing 2 flights of stairs in 10 seconds.

Low Risk	**Indeterminate or Intermediate Risk**	**High Risk**
-Asymptomatic CAD - < 3 CAD risk factors (excluding gender) - Asymptomatic controlled HTN - LVD/CHF NYHA class I or II with ischemia on recent exercise test. - Successful coronary revascularization - Mild valvular heart disease	- >3CAD risk factors (excluding gender) - Mild or Moderate stable angina - Recent MI 2-8 weeks ago - LVD/CHF NYHA class III - Non-cardiac sequela of atherosclerosis - Murmur of unknown significance - Uncertain Cardiac Condition	-Unstable or refractory angina -Uncontrolled hypertension -LVD/CHF NYHA class IV - Recent MI < 2 weeks ago - High risk arrythmia - Obstructive hypertrophic cardiomyopathy - Moderate to severe valvular disease

-- Treat ED -- The patient may engage in sexual activity	--Refer to internist or cardiologist --Defer sexual activity until cardiovascular testing is complete --Reclassify as low or high risk based on cardiovascular testing	--Refer to cardiologist --Defer sexual activity until the cardiac condition stabilizes and the patient is cleared by a cardiologist

** Note: The patient is assigned to the highest risk category in which he has one or more risk factors.

GROSS HEMATURIA

- Microscopic UA / culture LAB348
- Abdomen/Pelvis CT IVP IMG1038
    - Contrast identifies renal masses or filling defects of the collecting system that may be concerning for upper tract urothelial carcinoma.

HEMATOSPERMIA

- Microscopic UA LAB348
- PSA LAB166

Hematospermia is a very common condition and is almost always benign and self-limiting. Possible etiologies include inflammation (prostatitis), trauma, vascular abnormalities, or stones in the ejaculatory ducts. Rarely, it can be caused by a malignancy, such as prostate cancer. Evaluation includes a cystoscopy, and digital rectal exam/PSA. In most cases, hematospermia resolves spontaneously, and no intervention is required.

HERNIA / INGUINAL PAIN

- Refer to General Surgery

HYDRONEPHROSIS

- Microscopic UA / culture LAB348
- Serum Creatinine LAB66
- Abdomen/Pelvis CT IVP IMG794
    - Contrast identifies the level of obstruction causing hydronephrosis.

HYPOGONADISM

- Refer to Testosterone Replacement Therapy specialty clinic in the Seattle / Spokane area or an online TRT clinic

- A specialty clinic can offer a customized TRT plan with regular follow up.

INCONTINENCE

- Microscopic UA / culture LAB348
- Bladder scan/PVR if available

- ** **Incontinence with overactive bladder symptoms.**
- **First line treatment:** Behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, fluid management)
  - Referral to physical therapy – in the comment section add "pelvic floor therapy"

- **Second line treatment:** Trial of OAB medication – Anti-muscarinic agent or Mirabegron (ß3-adrenoceptor agonists)
  - Expect it will take 30 days to see the full therapeutic effect of a new medication – refer to Urology if patient fails initial medication trial.
  - Extended release (ER) formulations should preferentially be prescribed over immediate release (IR) formulations because of lower rates of dry mouth
  - Use caution in prescribing anti-muscarinics or ß3-adrenoceptor agonists in the frail OAB patient
  - Manage constipation and dry mouth before abandoning effective anti-muscarinic therapy. Management may include bowel management, fluid management, dose modification or alternative anti-muscarinics
  - Clinicians should not use anti-muscarinics in patients with narrow-angle glaucoma unless approved by the treating ophthalmologist and should use anti-muscarinics with extreme caution in patients with impaired gastric emptying or a history of urinary retention

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INFERTILITY

- Refer to infertility specialty clinic in Seattle area
  - A specialty clinic can offer a customized fertility plan.

INTERSTITIAL CYSTITIS

- Microscopic UA / culture LAB348

IC is a chronic disorder and symptoms should be present for at least six weeks with documented negative urine cultures for infection. The number of voids per day, sensation of constant urge to void, and the location, character and severity of pain, pressure or discomfort should be documented. Dyspareunia, dysuria, ejaculatory pain in men and the relationship of pain to menstruation in women should also be noted.

KIDNEY STONES / FLANK PAIN

- CT KUB (non-contrast) IMG3050
- Microscopic UA / culture LAB348

MICROSCOPIC HEMATURIA

- Microscopic UA / culture LAB348
- New AUA guidelines now recommend shared decision making and alternate imaging options based on risk stratification – Urology is not requiring imaging prior to referral.

Define microhematuria as >3 red blood cells per high-power field on microscopic evaluation of a single, properly collected urine specimen

Clinicians should not define microhematuria by positive dipstick testing alone. A positive urine dipstick test (trace blood or greater) should prompt formal microscopic evaluation of the urine

In patients diagnosed with gynecologic or non-malignant genitourinary sources of microhematuria, clinicians should repeat urinalysis following resolution of the gynecologic or non-malignant genitourinary cause. If microhematuria persists or the etiology cannot be identified, clinicians should refer to Urology

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NEUROGENIC BLADDER

- Microscopic UA / culture LAB348

Neurogenic bladder is when a patient lacks bladder control due to a brain, spinal cord or nerve problem. This includes patients with Multiple Sclerosis (MS), Parkinson's disease and spina bifida, and those who have had stroke or spinal cord injury. Major pelvic surgery, diabetes and other illnesses can also damage nerves that control the bladder.

NOCTURIA

- No studies needed.

- Nocturia is one of the most common and the most bothersome lower urinary tract symptom in adults. Incidence and prevalence rates of nocturia increase with advancing age and the condition frequently occurs in geriatric patients. The etiology is often multifactorial and may include nocturnal polyuria, increased evening fluid consumption, peripheral edema, congestive heart failure, electrolyte imbalances and sleep apnea or other sleep disturbances.

NOCTURNAL ENURESIS

- Microscopic UA / culture LAB348
- Renal/bladder US IMG1080
- Children – KUB X-ray to rule out constipation IMG154

OVERACTIVE BLADDER

- First line treatment: Behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, fluid management)
- Second line treatment: Trial of OAB medication – Anti-muscarinic agent or Mirabegron (ß3-adrenoceptor agonists)
    - Expect it will take 30 days to see the full therapeutic effect of a new medication – refer to Urology if patient fails initial medication trial.
    - ER formulations should preferentially be prescribed over IR formulations because of lower rates of dry mouth
    - Use caution in prescribing anti-muscarinics or ß3-adrenoceptor agonists in the frail OAB patient
    - Manage constipation and dry mouth before abandoning effective anti-muscarinic therapy. Management may include bowel management, fluid management, dose modification or alternative anti-muscarinics
    - Clinicians should not use anti-muscarinics in patients with narrow-angle glaucoma unless approved by the treating ophthalmologist and should use anti-muscarinics with extreme caution in patients with impaired gastric emptying or a history of urinary retention

PENILE LESION

- No studies needed

PEYRONIES'S

- No studies needed
- Visit will be an evaluation and either reassurance or referral to specialty clinics in Seattle or Spokane that offer treatment options.

PHIMOSIS

- Trial administration of topical corticosteroid applied twice a day, and stretching exercises, starting five days after the initial application.

PROSTATITIS

ACUTE PROSTATITIS

- Microscopic UA/culture LAB348
- STI testing
- Treat with antibiotics for up to four-six weeks to ensure eradication of the infection – shorter courses have been associated with increased likelihood of relapse.

Prostate exam with firm, boggy and exquisite tenderness. Inflammation of the prostate can increase PSA levels – avoid checking a PSA for at least 2 months.

CHRONIC PROSTATITIS

- Microscopic UA/culture LAB348
- STI testing
- Treat with antibiotics for longer than 6 weeks may be necessary for recurrent symptoms

Chronic bacterial prostatitis is often presumptively diagnosed and empirically treated with antimicrobials when men present with chronic (eg, longer than three months) or recurrent urogenital symptoms, particularly if bacteriuria is also present.

RECURRENT UTI

- Microscopic UA-culture LAB348
- Renal/Bladdder US IMG1080

To make a diagnosis of recurrent UTI, clinicians must document positive urine cultures associated with prior symptomatic episodes.

Clinicians should obtain urinalysis, urine culture and sensitivity with each symptomatic acute cystitis episode prior to initiating treatment in patients with recurrent UTIs.

In peri–and post–menopausal women with recurrent UTIs, clinicians should recommend vaginal estrogen therapy to reduce the risk of future UTIs if there is no contraindication to estrogen therapy.

ASYMPTOMATIC BACTERIURIA

- Clinicians should omit surveillance urine testing, including urine culture, in asymptomatic patients with recurrent UTIs.
- Clinicians should not treat asymptomatic bacteriuria in patients.

RENAL CYST

- Please order the requested image modality if recommended in the radiology impression of initial imaging. IE: Initial renal US impression may recommend repeat imaging with CT abd/pelvis renal mass protocol or MRI.

Imaging is a reliable means for differentiating benign from malignant cystic lesions.

CT renal mass protocol is the initial test of choice. IMG238

MRI indications: IMG321 (Comment: Renal cyst)

- Clinical indications – recommended by the Radiologist.
- Patient population:
  - Contrast allergy
  - Renal Insufficiency
  - Pregnancy
  - Serial follow up imaging
  - Young patients

RENAL MASS

- CT - **renal mass protocol** IMG238

RETENTION - ACUTE

- Foley catheter for 7-10 days for bladder rest prior to Urology apt.
- Trial of Flomax 0.4mg daily
- Treat constipation

SCROTAL PAIN

- Microscopic UA/culture LAB348
- Scrotal US IMG1220

Epididymal cyst, hydrocele and varicocele - Managed conservatively with antibiotics, NSAID/Acetaminophen, rest, and scrotal elevation. Educate patients it can take up to 6 months or longer for resolution of symptoms.

TESTICULAR MASS

- Scrotal US with doppler IMG1220

UNDESCENDED TESTES

- No studies needed

Updated 10/2023 Kerry Madland PA-C