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## Essential Referral Content

**Demographic**

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements
- Medicare number

**Clinical**

- Reason for referral
- Duration of symptoms
- Relevant pathology & imaging reports
- Past medical history
- Current medications



## Exclusion Criteria

**The following conditions are not routinely seen:**

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen
- Vasectomy reversal
- Erectile dysfunction unrelated to previous surgery or radiation therapy
- Cosmetic surgery including circumcision, penile enhancements & penile

# REFERRAL PROCESS: UROLOGY



**STEP 1**

You will be notified when your referral is received by outpatients.

Essential referral content will be checked and you may be contacted for further information if required.



**STEP 2**

The referral is triaged by the specialist unit according to clinical urgency.

This determines how long the patient will wait for an appointment.



**STEP 3**

Patients with **urgent** conditions are scheduled to be seen within 30 days. Patients with **routine** conditions are given the next available appointment according to clinical need.

Both the referrer and patient are notified.

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

| **IMMEDIATE**<br>**Direct to the Emergency & Trauma Centre** | **URGENT**<br>**Appointment timeframe within 30 days** | **ROUTINE**<br>**Appointment timeframe greater than 30 days depending on clinical need** |
|---|---|---|
| • Poorly controlled renal or ureteric colic<br>• Acute painful urinary retention<br>• Urinary tract trauma<br>• Urinary tract septicaemia | • Suspected testicular malignancy<br>• Obstructed kidney<br>• Continuous gross haematuria / Bladder malignancy<br>• Renal carcinoma +/- masses<br>• Rising PSA in male <72 years<br>• Incidentally diagnosed hydronephrosis<br>• New microscopic haematuria<br>• Single episode of resolved macroscopic haematuria<br>• Urinary retention with catheter in situ | • Lower urinary tract symptoms (LUTS)<br>• Female incontinence<br>• Epididymal cysts (diagnosis confirmed on testicular USS)<br>• Intrarenal calculus (pain-free with no alteration in renal function)<br>• Recurrent UTIs<br>• Post treatment reviews |
| Phone +27 (0)65 978 6966 | Urgent cases must be discussed with the Urologist Phone +27 (0)65 978 6966 | Phone +27 (0)65 978 6966 |

**If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Surgical Registrar on call on +27 (0)65 978 6966.**

# Haematuria:

# MACROSCOPIC (VISIBLE) HAEMATURIA

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Complete (urine uniformly blood-stained)<br>• Initial stream, end stream, clots<br>• Pain/dysuria<br>• Onset, duration, precipitating factors<br>• Smoker<br>• Previous treatment prostate/bladder cancer<br>**Females:**<br>• Other gynaecological symptoms<br>• PV findings<br>**Males:**<br>• Other urological symptoms<br>• Digital prostate exam<br>**Investigations:**<br>• MSU micro and culture<br>• Urine cytology x3<br>• Triphasic CT IVP scan with excretory urogram<br>• Electrolytes, Urea, Creatinine, GFR<br>• FBE, PSA | All patients with visible haematuria require a CT IVP scan and Cystoscopy to exclude malignancy urinary tract. | Refer - urgent |

# Haematuria:

## MICROSCOPIC HAEMATURIA

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| Defined as the presence of RBCs in at least two out of three episodes<br>Investigations:<br>• MSU x 3<br>• Urine cytology x3<br>• USS Urinary tract | • Lower risk for urinary tract malignancy than macroscopic haematuria<br>• Consider glomerulonephritis if isomorphic RBC/proteinuria/urinary casts on MSU present<br>• Flexible cystoscopy may be required<br>• Renal biopsy may be advised | Refer urgently if urine cytology is positive for malignancy or if USS suggestive of tumour.<br>Otherwise refer - routine |

## FEMALE INCONTINENCE

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Predominantly stress incontinence<br>• Predominantly urge incontinence<br>• Urge/stress incontinence<br>• Does the patient require pads, number per day?<br>• History of UTIs<br>• Duration of symptoms<br>• Obstetric history<br>• Previous gynaecological/ urological surgery<br>• PV findings<br>• Document episodes of incontinence – Bladder chart<br>• MSU<br>• USS Urinary tract<br>• U&Es | • Conservative management by a continence physiotherapist or continence nurse<br>• Pelvic floor (Kegel) exercises<br>• Bladder drills<br>• Videourodynamics testing may be required for more complex cases and those requiring surgery<br>Management options include:<br>• Medication/Botox injection for overactive detrusor function<br>• Colposuspension for vaginal prolapse<br>• Reconstruction or urethral sling | Refer - routine |

## URINARY TRACT INFECTIONS (Single episode in males or recurrent episodes in females)

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| • Previous abnormal MSU x 1 in males; MSU x 3 in females<br>• USS urinary tract | May require more detailed imaging and cystoscopy. | Refer - urgent |

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Past history of stones and stone surgery<br>• Pain score:<br>– Severe: poorly controlled<br>– Moderate: adequately controlled<br>– Minimal: well controlled<br>– Asymptomatic<br>• Analgesia required<br>• Acute renal colic – right/left<br>– duration of symptoms<br>• Known urinary tract calculus<br>– size of stone<br>– location<br>– how was it diagnosed?<br>**Investigations:**<br>• MSU (microscopy and culture)<br>• Serum $Ca^{++}$, uric acid and phosphate for recurrent stone makers<br>• CT KUB (kidneys/ureters/bladder) (non-contrast)<br>• U&Es, Creatinine, GFR | Ureteric stones:<br>• <5mm have 50% probability of passing without surgical intervention, facilitated by treatment with Tamsulosin and NSAIDs<br>• Larger stones/ureteric obstruction/ associated with infection - require surgical intervention. May require insertion of ureteric stent or percutaneous nephrostomy prior to definitive stone treatment.<br>• Definitive stone treatment options include video pyeloscopy/lastertripsy, ESWL, or PCNL | • Poorly controlled renal/ureteric colic/infection, refer urgently for Assessment.<br>• Obstructed kidney and others, refer - urgent |

# LOWER URINARY TRACT SYMPTOMS (MALE)

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Completed prostate symptom score and quality of life score<br>• Previous lower urinary tract medication/surgery<br>• Has the patient required catheterisation?<br>• Is the patient in retention?<br>• Haematuria/UTI<br>• Erectile dysfunction<br>**Physical Examination:**<br>• Palpable/percussible bladder<br>• DRE - smooth prostate/BPH or abnormal - possible prostate cancer?<br>**Investigations:**<br>• MSU (micro and culture)<br>• USS Urinary tract<br>• PSA<br>• U&Es<br>• Bladder chart and prostate symptom score and quality of life score | • Trial of alpha adrenergic blockers eg Tamsulosin or Prazosin for LUTS<br>• Trial of Duodart (Tamsulosin with Finasteride) for BPH<br>• Trial of Tadalafil for BPH with erectile dysfunction<br>Surgical options:<br>• TURP<br>• TUR bladder neck<br>• Open prostatectomy | Urgent referral for assessment after trial of alpha-adrenergic blockers.<br>If catheterised, refer urgently–need to know if suitable for surgery. |

# SUSPECTED CANCER OF THE PROSTATE (Including elevated PSA)

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Family history of Ca prostate<br>• Completed prostate symptom score and quality of life score<br>• Bone pain<br>• Haematuria<br>• Previous TURP/prostate biopsy<br>**Physical Examination:**<br>• DRE – asymmetry, hardness, nodules, induration<br>**Investigations:**<br>• PSA on 2 or more interval specimens<br>• PSA with free/total%<br>• FBE + CRP<br>• U& E's, creatinine and GFR<br>• MSU | • Patients over 75 years of age should not undergo routine PSA screening.<br>• Men at risk of prostate cancer require prostate biopsy<br>• Consider multiparametric MRI scan of prostate before biopsy<br>• Assess for suspicious prostate lesions<br>• Options of transrectal or transperineal prostate biopsy | Refer - urgent |

# Male Genitalia:

# TESTICULAR ABNORMALITY

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| **Key Points:**<br>• Acute, painful swollen tesis<br>• Palpable testicular mass<br>• Previous vasectomy/scrotal surgery<br>• Previous undescended testis (UDT)<br>• Small testes bilaterally—Klinefelter's syndrome<br>**Investigations:**<br>• Testicular/scrotal USS<br>• XY karyotype<br>• Testosterone level | • Testis tumour requires inguinal orchidectomy after pre-operative AFP, βHCG, LDH markers<br>• Androgen replacement for Klinefelter's syndrome<br>• Urgent orchidectopexy for torsion of testis | Acute painful swollen testis, refer IMMEDIATELY<br>Testis tumour and others, refer - urgent |

# EPIDIDYMAL ABNORMALITY

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| • Post vasectomy pain<br>• Varicocele<br>• Epididymal cyst<br>• Hydrocoele<br>• Epididymitis<br>**Investigations:**<br>• Testicular/scrotal USS<br>• Scrotal USS for post vasectomy pain, varicocele, epidiymal cyst and hydrocele<br>• MSU/urine PCR for epidymitis | | If severe pain, refer - urgent<br>Others refer - routine |

# SCROTAL ABNORMALITY

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| • Fournier's gangrene of the scrotum<br>• Others | Urgent debridement/antibiotics/ hyperbaric oxygen | Refer IMMEDIATELY<br>Other abnormalities, refer - routine |

# PENIS/FORESKIN ABNORMALITY

| Evaluation | Management | Referral Guidelines |
|---|---|---|
| • Foreskin—phimosis/paraphimosis<br>• Glans penis ulcer/balanitis<br>• Shaft ulcer/tumour<br>• Functional - Peyronie's curvature<br>• Priapism | • Penile biopsy<br>• Circumcision<br>• Penectomy<br>• Penis reconstruction for Peyronie's | • Priapism – refer immediately<br>• Penile ulcer or carcinoma refer - urgent<br>• Other conditions refer - routine |