NHS
Oxfordshire
Clinical Commissioning Group

REFERRAL GUIDELINES: UROLOGY

Document Purpose

- To ensure patients are more likely to benefit from a specialist opinion
- Revised to take account of national guidance from NICE and Oxfordshire Clinical Commissioning Group policies

Contents

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Oxford Radcliffe Hospital Urology Department

Registrar on call	01865 741841 (Switchboard)
Email advice link via	oxon.urologyadvice@nhs.net
Consultants contact details :Churchill	
Mr Simon Brewster/ Tina Robins	01865 225944
Mr Jeremy Crew/Tina Robins	01865 225944
Mr David Cranston/Rosie Llewellyn	01865 226145
Mr Mark Sullivan/Rosie Llewellyn	01865 226145
Mr Jeremy Noble/ Adi Bourke	01865 225942
Mr John Reynard/Adi Bourke	Any of the above or 01865 226083
Prof F Hamdy- Academic Team	
Consultants contact details :Horton	01295 229202
Mr Jeremy Crew	

Change Control

Contributors	Simon Brewster/Consultant Urologists at the Oxford Radcliffe Hospital, and Oxfordshire GPs Paul Roblin, KS Pandher and Andy Chivers, with comments from Stephen Smith and Phillip Ambler				
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1. Erectile Dysfunction

DIAGNOSIS

- ED may be presenting feature of depressive illness, anxiety states, psychosis, body dysmorphic disorders, gender dysphoria and alcoholism
- Clues to psychogenic origin
  - sudden onset, early collapse of erection, good quality self-stimulated or early morning erections, premature ejaculation, relationship problems/changes, major life events, psychological problems
- Clues to organic cause
  - gradual onset, lack of tumescence, normal ejaculation, normal libido, risk factors e.g., vascular, endocrine, neurological, pelvic operations, radiotherapy or trauma, medications, smoking, high alcohol, recreational or body-building drugs
- Drug causes
  - Antihypertensives: ß-blockers/Thiazides/Hydralazine; α-blockers/ACE inhibitors/Ca-channel blockers
  - Diuretics: Thiazides/K sparing/carbonic anhydrase inhibitors > Loop diuretics
  - Antidepressants e.g SSRI's, tricyclics, MAOI's
  - Antipsychotics e.g phenothiazines, carbamazapine, risperidone
  - Hormonal agents e.g CPA, LHRH analogues, oestrogens
  - Lipid regulators: Gemfibrozil/Clofibrate > statins
  - Anticonvulsants e.g phenytoin/carbamazapine
  - Antiparkinsonian e.g levodopa
  - Ulcer healing: H2 antagonists > Proton pump inhibitors
  - Miscellaneous: allopurinol, indomethacin, disulfiram
- **Examine**:
  - Blood pressure, peripheral pulses
  - Genitalia: testicular size, penile fibrosis, retractable foreskin.

MANAGEMENT/ INVESTIGATION

Clinical Suspicion	Investigation
Diabetes	Usual appropriate management
Heart disease	Usual appropriate management - Chol, BP
If history (decreased libido) or examination suggests hypogonadism	Testosterone (free and morning (7-11am))
If testosterone low	LH/prolactin
If suspected renal impairment	Usual appropriate management - C&E
If suspected liver impairment	Usual appropriate management - LFTs
Afro-Caribbean patients	Sickle cell screen

- If initial screenings tests indicate significant abnormality, manage as appropriate for underlying condition

REFER Email Advice

Cost £20

- Prior to referral, check whether consultant referral required using e-mail advice service
- oxon.urologyadvice@nhs.net

REFER ONLY *Cost £145*	▪ Under Consultant direction, following email advice ▪ Young patients who have always had difficulty ▪ Patients with history of pelvic trauma ▪ Abnormality of testes or penis ▪ Starting hormone replacement therapy (DRE and PSA measurement) **NB: All other, less complex, patients will not be seen by ORH consultants**
Other	The investigation and treatment of less complex cases of erectile dysfunction is usually managed in primary care. If specialist NHS services are considered necessary for a patient in this group, a request for prior approval of referral should be made through the PCT's **Individual Funding Request** process, and sent to: Healthcare Priorities Directorate of Public Health Oxfordshire Primary Care Trust Jubilee House 5510 John Smith Drive Oxford OX4 2LH
ADDITIONAL INFORMATION	Not applicable.

2. Curved Erection (Peyronie's Disease)

DIAGNOSIS

Patients may first notice a tender lump in the penis, and complain of painful curvature of the erect penis, usually making intercourse difficult or impossible. The symptoms are:

- **a plaque on the concave surface of the flaccid penis:** this can develop slowly, taking 12 -18 months to reach its full extent. Usually the plaque forms on the top of the shaft, making the penis bend upwards, but if the plaque is on the underside it will bend downward. In some cases, the plaque develops on both top and bottom, leading to indentation and shortening of the penis. In the worst cases, the hardened plaque reduces flexibility and causes pain, bending, and emotional distress such that sexual intercourse becomes impossible.
- **pain in the shaft of the penis:** two-thirds of men with Peyronie's disease will experience pain in the penis. In most cases, it will gradually settle down and disappear without treatment in a few months.
- **abnormal angulation of the erect penis:** during the 12-18 months that the plaque or lump is developing, the deformity of the erect penis can change. During that time 30-40% get worse; 10-20% get better; and 50% remain the same.

There is an association with Dupuytren's and heavy alcohol intake.

The degree of erectile dysfunction as a consequence of Peyronie's can vary from a complete inability to attain and/or maintain an erection adequate for satisfactory sexual experience, to a slight reduction in penile rigidity.

MANAGEMENT

The main aims of treatment of Peyronie's are to help the man stay sexually active, and reduce pain.

Mild cases

As the plaque of Peyronie's disease often shrinks or disappears without treatment, it may be appropriate to have a period of surveillance of 1-2 years, or longer. If the problem has been present for a long time, is not changing, and is not causing the patient much trouble, no treatment is needed. The patient should be reassured and asked to return if the condition worsens.

Moderate/severe cases

- **Surgery**

If the problem does not resolve with time, surgery to correct the deformity may be warranted. Indications for surgery are:
- unacceptable difficulty with penetration during sex
- pain during sex for either partner that is a consequence of the penile deformity

The 3 most common operations are:
- Removal/expansion of the plaque followed patching with skin/artificial material. [This can involve partial loss of erectile function, especially rigidity].
- Removal/pinching of tissue from the side of the penis opposite the plaque, which cancels out the bending effect. [This causes a shortening of the erect penis].
- Implantation of a device that increases rigidity of the penis. An implant alone may straighten the penis adequately, or sometimes implantation is combined with incisions/ grafting/plication

Surgery is usually combined with circumcision, and almost always results in 1cm or more of shortening.

NB Surgery is not warranted solely for cosmetic reasons. Surgery does not guarantee that the penis will be perfectly straight afterwards, and some men will develop erectile dysfunction or even numbness of the penis following surgery.

- **Drug and other therapies**

	A number of drug treatments and other therapies are sometimes used (eg, Vit E; para-aminobenzoate tablets; injections of collagenase, dimethyl sulfoxide, steroids and calcium channel blockers directly into the plaques) but currently these are of unproven benefit.
REFER Email Advice *Cost £20*	▪ Prior to referring, check whether consultant referral required using e-mail advice service. ▪ **oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	Patient unable to have intercourse, meet the criteria for surgery, and are aware of the likely outcome.

3. Haematospermia

DIAGNOSIS

Primary haematospermia
A benign self-limiting condition – common in the 30s-40s.

- Blood in the ejaculate is the only symptom.
- There is no blood in the urine, macro or microscopically.
- The patient has no evidence of any urinary irritation or infection and physical examination is completely unremarkable.
- The condition is self-limiting.

Primary haematospermia patients have been studied extensively in the past and most studies show no other associated problems. About 15% of patients will have one episode and never have another.

Secondary haematospermia
The cause of bleeding is known or suspected e.g. immediately after a prostate biopsy, or in the presence of a urinary or prostate infection or cancer.
Unusual causes or predisposing factors:

- Prostatitis
- Epididymitis
- Urinary calculi
- TB
- Cirrhosis of the liver
- Arterial hypertension
- Haematological disorders affecting clotting e.g. haemophilia
- Parasitic infections

MANAGEMENT

Consider DRE and PSA in patients with haematospermia if Ca prostate thought to be a risk.

Primary haematospermia usually resolves spontaneously, and reassurance is usually all that is required after full physical examination and investigations of any ancillary symptom or signs.

REFER Email Advice

Cost £20

- Check referral criteria – do not refer unless haematospermia is recurrent over 4-6 months
- **Oxon.urologyadvice@nhs.net**

REFER ONLY

Consultant
Cost £145

- If the problem is persistent, as above
- Abnormal external genitalia
- Abnormal prostate on digital rectal examination(in absence of symptoms)
- Abnormal PSA if age > 40 years
- Normal age-specific range for PSA used by the ORH is
  - age 40-50 <2.5
  - age 50-60 <3.5
  - age 60-70 <4.5
  - age >70 <6.5
  - age >80 < 10

NB

This does not imply routine screening with PSA is recommended. This range is ideal for fit men with at least 5 years' life-expectancy. If the patient is elderly, unfit or frail then clinical judgement should influence decision to refer

ADDITIONAL INFORMATION	▪ http://www.patient.co.uk/doctor/haematospermia

4. Hydrocele (fluctuant/transilluminable scrotal swelling)

DIAGNOSIS	▪ Clinical/ultrasound diagnosis.
MANAGEMENT	▪ Arrange ultrasound ▪ If ultrasound demonstrates a hydrocoele or epididymal cyst with normal testes, the patient should be managed conservatively. ▪ Needle aspiration is **not recommended** unless under sterile conditions, and may only provide temporary help.
REFER Email Advice *Cost £20*	▪ Check referral criteria – do not refer unless criteria met ▪ **Oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145* **NB**	▪ considerable discomfort, affecting normal activity e.g. off work because of it ▪ so large that directional voiding is becoming difficult ▪ so large that clothing no longer fits **Patients not meeting these referral criteria will not be treated by the ORH Urology Department**
ADDITIONAL INFORMATION	▪ Not applicable

5. Lower Urinary Tract Symptoms (male 40+ with mild/moderate LUTS/no haematuria)

DIAGNOSIS	▪ Clinical symptoms of bladder outflow obstruction
MANAGEMENT	▪ Dip urine to look for infection or blood. ▪ Do DRE, check renal function and PSA, and consider renal tract ultrasound. ▪ If referral criteria do not apply, offer trial of alpha-blocker NB continuous usage requires monitoring of renal function.
REFER Email Advice *Cost £20*	▪ Diagnostic difficulty - if the diagnosis is in doubt or for re-assurance - contact **Oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	▪ If symptoms persist and no response to 3 months' alpha blocker ▪ Palpable bladder ▪ Abnormal-feeling prostate ▪ HA creatinine or eGFR ▪ Postvoid residual on U/S >300mls ▪ Abnormal kidneys on ultrasound, ○ abnormal PSA for age age 40-50 <2.5 ○ age 50-60 <3.5 ○ age 60-70 <4.5 ○ age >70 <6.5 ○ age >80 < 10
ADDITIONAL INFORMATION	▪ Not applicable

6. Phimosis (presenting with tight foreskin)

DIAGNOSIS	▪ In children, usually presented by concerned parents, who need reassuring that foreskin doesn't need to fully retract until 5-6 yrs old. ▪ Wine bottle phimosis, with reports of ballooning during micturition, may result in recurrent balanitis. ▪ In adults, mild degrees of phimosis may be treated with steroid cream.
MANAGEMENT	▪ If the glans is visibly/palpably normal, the patient could be managed conservatively with topical steroids and hygiene advice
REFER Email Advice *Cost £20*	▪ Diagnostic difficulty- if the diagnosis is in doubt or for reassurance **oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	▪ Recurrent balanitis ▪ Difficulty voiding ▪ Recurrent pain, tearing/bleeding during sexual activity ▪ Suspicion of malignancy
ADDITIONAL INFORMATION	▪ Not applicable

7. Male circumcision – non therapeutic

MANAGEMENT	Circumcision may be offered for ▪ Pathological phimosis ▪ Recurrent UTI ▪ Balanoposthitis Recurrent pain, bleeding or splitting during intercourse after treatment for candidal or other balanitis ▪ Suspected cancer Circumcision for religious, cultural or lifestyle reasons is not commissioned.
DO NOT REFER	As above, non therapeutic circumcision is not commissioned.
ADDITIONAL INFORMATION	Treatment threshold statement: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/03/PS173-Male-Circumcision.pdf

8. Recurrent Female Urinary Tract Infection (adult female)

DIAGNOSIS	***Recurrent*** UTI is defined as 3+ laboratory confirmed UTIs in 12 months, with proven clearance of infection between them.
MANAGEMENT	▪ Patient could be managed conservatively with short courses of appropriate antibiotics for at least 3 months if ○ physical examination is unremarkable + ○ a normal ultrasound + ○ a post void residual is <100 mls ▪ Consider renal calculus which may only show on a KUB x-ray ▪ Recurrence may be avoided by high fluid intake, including cranberry juice; advice on perineal hygiene; postcoital voiding; treating constipation promptly.
REFER Email Advice *Cost £20*	▪ Diagnostic difficulty ▪ Check referral criteria **oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	▪ If UTI continue to recur despite treatment actions ▪ Post void residual volume >100ml ▪ Unusual patterns of disease
ADDITIONAL INFORMATION	▪ Not applicable

9. Urge incontinence of urine (female)

DIAGNOSIS

Urge incontinence (involuntary loss of urine, associated with urgency) and overactive bladder (urgency, without incontinence) are common in postmenopausal women; may be associated with neurological disorders. Symptoms include:

- Urgency
- Frequency
- Nocturia

Exclude UTI/haematuria with stick-test.
If no mass or significant prolapse on abdominal/PV examinations then manage as below.

MANAGEMENT

Lifestyle advice:

- Initial Advice and Conservative Management
- Limit intact of caffeine, spicy food, carbonated drinks
- Limit daily fluid intake to 1.5-2.5 litres
- Weight loss if BMI >30

Bladder training (at least 6 week trial) – prompted, scheduled voids may help reduce leaking episodes

- regular voiding (6-8 times during the day)
- increasing the time between voids to 3-4 hours during the day
- urge suppression between timed voids

Pharmacological therapies (combined with bladder training):

1st line option:
Tolterodine 2mg standard release bd
If not tolerated due to side effects e.g. dry mouth reduce dose to 1mg bd
(28 days treatment 2mg £2.88, 1mg £2.56)

2nd line options:
Fesoterodine 4mg od titrating to 8mg od if necessary.
(28 days treatment £25.78)

Patients with swallowing difficulties ONLY
Oxybutynin patches *3.9mg/24hrs*
8 patches (4 weeks supply) £27.20 (traffic lighted brown)

On specialist (including nurse specialist) recommendation only:
Mirabegron 25mg to 50mg od
(30 days treatment £29.00)
Following referral mirabegron may be recommended before considering other treatment options. Mirabegron should be used in accordance with the NICE Technology Appraisal Guidance 290 and should therefore be reserved for patients who have exhausted the other anticholinergics detailed above or in whom anticholinergics are contraindicated.

Plus
Topical vaginal oestrogens for postmenopausal women with vaginal atrophy

Prescribing tips:

- **Patient education:** inform patients that some adverse effects, such as dry mouth and constipation, may indicate treatment is working and that they are unlikely to see the full benefits until they have been taking the treatment for ***at least 4*** **weeks**. They should be encouraged to persevere with treatment. Access to advice should be available.
- There is an association between anticholinergic use and both dementia and mortality. Be aware of the anticholinergic burden of drugs, particularly in patients taking multiple medications. Ensure that all non-pharmacological options are fully explored and that medication is reviewed regularl

	• **Medication review:** Evidence suggests high levels of discontinuation with all antimuscarinics. NICE suggests that realistic expectations of treatment are likely to improve continuation with treatment. Review treatment at 4 weeks after initiation or changes to treatment. NICE opinion is that a further review should be offered at 12 weeks to assess on-going effectiveness after which treatment should continue for as long as outcomes remain satisfactory, with annual reviews (6 monthly if over 75 years). • At 6 month review consider stopping treatment for a short period to assess if there is any natural remission in the condition. A bladder diary could be used to assess symptoms both on and off of the drug. Bladder diaries are available; for example from Patient.co.uk http://www.patient.co.uk/health/Incontinence-/-Bladder-Chart.htm. • **Bladder training** and lifestyle modification should continue throughout treatment. • Where **side effects** are an issue taking the drug in the evening may improve tolerability. • Most treatments are licensed for men and women. NICE Clinical Guideline 171 Urinary Incontinence considers women only NICE Clinical guideline CG97 Lower Urinary Tract Symptoms considers symptoms in men. • Cochrane review on OAB drugs: http://www.ncbi.nlm.nih.gov/pubmed/22258963 **Other Drugs** • Patients currently taking **oxybutynin** or **trospium** should be allowed to continue with this treatment. • **Trospium** may be an appropriate choice for patients taking multiple concomitant therapies as it does not interact with drugs metabolised by CYP 450 liver enzymes. • Primary care prescribing expenditure on **solifenacin** in Oxfordshire was nearly £800,000 in 2014 this is more than the total spend on all the other antimuscarinics for OAB. It is the most expensive drug choice; it should not be initiated for new patients. After a break to review continued benefit of antimuscarinic therapy consider switch to tolterodine if this has not previously been tried. • There is no evidence to support the efficacy of **propantheline** and it should not be used. • **Duloxetine** is licensed for stress incontinence and should not be prescribed for OAB.
REFER **Email Advice** *Cost £20*	▪ Primary care management unsuccessful **oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	Refer non-responders after 6-12 weeks.
ADDITIONAL INFORMATION	NICE Clinical Guideline Female Urinary Incontinence http://pathways.nice.org.uk/pathways/urinary-incontinence-in-women Referral protocol for ORH urogynae services:

	http://tinyurl.com/lapf2lg

10. Scrotal pain	
DIAGNOSIS	▪ Common problem in 20-35 yr old men, usually self limiting over several months. ▪ Often no palpable pathology, nor any findings on USS.
MANAGEMENT	▪ Conduct examination (lying and standing) ▪ Investigate using scrotal and renal ultrasounds ▪ A trial of NSAIDs or antibiotics for epididymo-orchitis (ciprofloxacin and doxycycline) for 2 weeks or more may be worthwhile
DO NOT REFER	▪ Referral is not needed if: ○ scrotal examination lying and standing is unremarkable + ○ scrotal and renal ultrasounds unremarkable
REFER **Email Advice** *Cost £20*	▪ Diagnostic difficulty ▪ Check referral criteria **oxon.urologyadvice@nhs.net**
REFER ONLY **Consultant** *Cost £145*	▪ Only refer if indicated through email advice ▪ Treatment above fails
ADDITIONAL INFORMATION	▪ Not applicable

11. Cancer referral guidelines	
Information	▪ http://www.nice.org.uk/guidance/csguc

Note *Costs shown in this guideline are for consultant-led first outpatients appointments (2009-10 HRG). Email advice is charged at 25% of the cost of a consultant-led outpatients follow-up appointment (2009-10 HRG).*