Urology Clinic Worksheet

Distal Stone

Thank you for the consult. Please make sure patient is staying well hydrated by drinking at least 2 liters of water/fluids per day, pain is controlled with ibuprofen or narcotic pain medication, and they are taking an alpha blocker (terazosin 4 mg daily at bedtime or tamsulosin 0.4 mg daily at bedtime) to help with stone passage. Many ureteral stones will pass on their own with these interventions.

The patient needs to be instructed to present to the emergency department immediately for any fevers or chills prior to stone passage since this may be caused by obstructive pyelonephritis and requires emergent treatment.

We will schedule a clinic appointment for evaluation in case the stone hasn't passed. Thank you.

Dyuria/Frequency

Thank you for the consult. For patients with chronic dysuria and urinary frequency, we recommend treating for a UTI even if the colony count is low. The urinary frequency may not allow bacterial colony counts to rise to levels that are normally considered positive for infection.

We recommend a trial of treatment with pyridium for dysuria and ensuring that they are emptying their bladder fully for their frequency. Please check a post-void residual urine volume with a bladder scan or straight catheterization. Normal post-void residual volume should be less than 100 mL.

If you have any questions regarding this, or if symptoms persist after these measures, please let us know. Thank you.

Erectile dysfunction

Thank you for this consult. You may trial a phosphodiesterase 5 inhibitor like sildenafil/viagra for this patient. We typically prescribe 50 mg tablets and instruct the patient to break them in half for a starting 25 mg dose. This should be taken 30 minutes to 4 hours prior to intercourse on an empty stomach. The patient also needs to be in the mood for intercourse and have some stimulation for erection to occur. If a partial erection occurs with sildenafil at a lower dose, the dose may be increased to a maximum of 100 mg po daily.

If a trial of a phosphodiesterase 5 inhibitor fails, please let us know and we can schedule the patient to be seen in our erectile dysfunction clinic to discuss additional treatment options like intercavernosal injection therapy and the vacuum erection device. Thanks.

BPH Medical Recs

Thank you for the consult. For patients with sypmtomatic BPH we recommend starting them on terazosin 2mg po daily at bedtime and titrating up the dose by 2mg per week to 10mg po daily at bedtime. Terazosin 10mg daily at bedtime is the effective dose, and titration helps to avoid orthostatic hypotension. If he is able to get tamslosin (flomax) 0.4 mg, this can be given daily at bedtime without the need for titration. Patients who have had dizziness or orthostatic hypotension with terazosin are eligible to receive tamsulosin if you fill out a TAR. These alpha blocker medications are beneficial in that they relax the muscle in the prostatic stroma allowing patients to void more effectively.

If he still complains of significant voiding symptoms, wishes to discuss surgical treatment for BPH, or has an elevated post void residual of >150 mL (which can be checked with an ultrasound or by straight catheterization) while on the appropriate medications, please re-refer him to us for evaluation for surgical treatment of BPH. Please don't hesitate to contact us with any questions.

General Stone Recs

Thank you for the consult. In all patients with nephrolithiasis we recommend primary preventative measures to help reduce the risk of future stone formation. These include drinking 2 to 3 liters of fluid daily, eating a low salt diet, and eating smaller portions of meat.

We will schedule a clinic appointment to review stone risk reduction strategies and assess for recurrent stone formation.

Please provide the patient with a radiology form to get a KUB plain film on the day of the scheduled clinic visit prior to coming to clinic. Thank you.

Hematospermia

Thank you for this consult. Hematospermia is typically benign and self limited. It may be caused by inflammation or infection, so we recommend evaluation for urinary tract and sexually transmitted infections. We also recommend a blood pressure check as uncontrolled hypertension may result in hematospermia.

Trauma to or pressure on the perineum including constipation and bicycle riding have also been known to cause hematospermia.

Our typical evaluation of hematospermia includes history and physical examination including blood pressure, genital examination, and digital rectal examination. Laboratory testing includes a urinalysis +/- urine culture, testing for sexually transmitted diseases as indicated, and tuberculosis urine culture only as indicated.

In almost all cases hematospermia resolves spontaneously and no treatment is required. Please let us know if you have further questions. Thank you.

Hematuria Recs

Thank you for the consult. Microscopic hematuria is 3 or more RBC per high powered field on urinalysis with microscopy and cannot be diagnosed on urine dip. If the patient has microscopic hematuria confirmed on urinalysis with microscopy, please order a CT urogram (an abdominal/pelvic CT with and without contrast and with delayed imaging with contrast) for hematuria work up evaluation and let me know when it is scheduled. Then I will schedule a clinic visit to go over the results as well as discuss performing a cystocopy for lower tract evaluation. Thanks.

Infertility Workup

Thank you for this consult. For infertility work up, please order two separate semen analyses to be performed with 7 to 21 days between specimens. These should be performed after abstaining from masturbation or sexual intercourse for > 48 hours and should be delivered to the laboratory within one hour of collection. Please also order a testosterone, follicle stimulating hormone, luteinizing hormone, and prolactin level. These tests should be completed in the morning before 10 am. Once these tests have been completed, please let us know so we can schedule him for urology clinic. Thanks.

Medical Stone Therapy

Patients that have kidney stones within the ureter of size less than 1 cm have a chance of passing the stone with hydration and medical therapy.

Randomized control studies show that administration of an alpha blocker with or without the addition of a short term steroid will speed stone passage, increase the rate of spontaneous passage, and decrease the patient's pain.

The alpha blockers we typically give are terazosin 4 mg po daily at bedtime or tamsulosin 0.4 mg po daily at bedtime. These should be given until the stone passes.

If the patient is healthy and there are no contraindications to taking a short course of steroids, we recommend prescribing a single medrol dose pack.

Additionally, NSAIDs are very effective in the treatment of stone pain along with narcotic medicines if needed.

Patients with ureteral stones need a CT scan (stone protocol) as well as a plain film of the abdomen (KUB). This allows us to track most stones with repeat KUB films rather than repeat CT scans.

Nocturia

Isolated nocturia as the primary complaint may also be due to lower extremity edema, fluid intake at night, or taking a large volume of pills with fluid or diuretics at night. We recommend lower extremity elevation in the afternoon if he has lower extremity edema, decreased fluid intake prior to bed, and diuretic administration in the morning.

Overactive Bladder Initial Recs

Thank you for the consult. For patients with urinary frequency/overactive bladder in the setting of no infection, no urinary retention, and no hematuria, we recommend a trial of anticholinergic medication. We typically recommend oxybutynin 5 mg po daily, which should be titrated up to 5 mg po TID. Expected side effects include dry mouth and constipation. It is expected that patients will experience these side effects when they are on an effective dose of anticholinergic medication to help their bladder symptoms. Please let us know if you have questions or if symptoms are not well controlled on an appropriate dose of anticholinergic medication. Thanks.

Painful Ejaculation

Thank you for this consult. Painful ejaculation may occur due to infection/inflammation or during closure of the bladder neck during ejaculation.

We recommend physical examination of the external genitals and prostate. Laboratory testing includes urinalysis +/- urine culture and sexually transmitted infection testing as indicated.

NSAIDs may help reduce the pain. In the setting of negative infectious work up, we typically recommend a trial of terazosin 2 mg daily at bedtime to help relax the bladder neck during ejaculation. Men may note retrograde ejaculation with this medication. If you have additional questions, please let us know. Thank you.

Peyronie's Disease (curvature of the penis)

Thank you for this consult. It sounds like he likely has Peyronies disease with penile curvature caused by plaque calcification within the penis. Please start him on Pentoxifylline 400mg po BID x 1 week, then titrate up to 400mg po TID dosing if he has no GI upset. This medication has been shown to decrease calcified penile plaques in Peyronies disease and is the only treatment needed for some men.

If he has had unchanged penile curvature for several months that is interfering with sexual intercourse and he wishes to discuss risks and benefits of surgical intervention for Peyronies disease, please let us know so we can schedule him for a clinic visit. Please also ask him to bring a photograph of his erect penis to clinic. This is required prior to any surgical planning and will save him a return clinic visit. Thank you.

Phimosis

Thank you for the consult. Phimosis is a condition that usually can be treated medically, especially in a younger patient population. Please have the patient/parents apply 0.1% triamcinolone cream liberally to his foreskin (apply with a q-tip) BID for 3 mo and gently retract the foreskin after application of the cream. This usually loosens the skin enabling skin retraction without pain. If this treatment regimen is ineffective after 3 months, or if the patient/parents would like to proceed with a circumcision, please re-refer him and we can see him in clinic to discuss risks and benefits of circumcision.

Phimosis is physiologic in children under two years of age, and we typically do not treat until after this age.

Post Negative Microscopic hematuria w/u

Thank you for your referral. American Urological Association Guidelines recommend that persistent or recurrent microscopic hematuria should be followed with annual urinalysis with microscopy after initial negative workup. The guidelines also recommend re-evaluation with imaging and cystoscopy after 3-5 years.

Overflow Incontinence

Thank you for this referral. We want to make sure the patient is not retaining urine and having overflow incontinence. Prior to our evaluation in clinic, please check a post-void residual urine volume with a bladder scanner/ultrasound or with straight catheterization. If the post-void residual is higher than 150 mL, the patient likely needs a foley catheter placed to empty the bladder. If this cannot be assessed prior to our scheduled clinic visit, we will perform a flow rate/post void residual measurement in clinic during our evaluation. Thank you.

Recurrent UTI

Thank you for the consult. For patients with recurrent UTIs, we want to ensure they are emptying their bladder fully and are appropriately treated for their urinary tract infection with a test of cure urine culture. Please check a post-void residual urine volume with a bladder scan or straight catheterization. Normal post-void residual volume should be less than 100 mL.

In sexually active women with recurrent UTIs, use of a spermacidal agent on condoms or as a form of birth control frequently contributes to UTIs. We recommend eliminating spermacide from birth control, if possible, to help reduce UTIs. In women who only have UTIs after sexual intercourse, we sometimes prescribe prophylactic antibiotics with one tablet of ciprofloxacin or septra to be taken after intercourse.

For post-menopausal women with recurrent UTIs, we recommend vaginal estrogen cream to help alter vaginal pH to pre-menopausal states. This can significantly limit recurrent UTIs in this patient population.

Please order a CT Urogram if the patient's renal function is sufficient to tolerate IV contrast (preferable) or a non contrast CT abd/pelvis if not. This will alow us to evaluate for any abnormalities or foreign bodies in the urinary tract that may be a nidus for bacteria. Let me know when the study gets scheduled or completed and we can schedule her for a clinic visit to discuss the imaging, do a physical exam, and discuss cystoscopy for further evaluation. Thank you.

Spermatocele

Thank you for this consult. Spermatoceles are benign.

We typically do not operate on them unless they become large, painful, or very bothersome to the patient as there is a risk of recurrence and a small risk of chronic scrotal pain after operation. If the spermatocele becomes larger or very bothersome to the patient, please let us know so we can evaluate him in clinic and discuss risks and benefits of surgical intervention.

Sterile Pyuria

Sterile pyuria is defined as 2-5 leukocytes per high powered field on urinalysis with microscopy. This must be diagnosed on UA with microscopy and not on urine dip stick.

Sterile pyuria may be associated with vaginal leukocyte contamination of the urine specimen, infection with non-commonly tested organisms for UTI, interstitial nephritis, nephrolithiasis, and transitional cell carcinoma.

As initial work up in the setting of no renal colic or history of nephrolithiasis, we recommend urine culture for the organisms listed below: tuberculosis, Haemophilus, Ureaplasma, Trichomonas, N. gonorrhea, and Chlamydia.

If these tests are negative, please contact us regarding recommendations for imaging to rule out other causes.

If the patient has HIV, HIV associated nephropathy may demonstrate sterile pyruia, is also typically associated with proteinuria, and may be associated with nephrotic syndrome and renal insufficiency. A nephrology consult is recommended if this diagnosis seems likely based on evaluation of proteinuria and renal function.

Chronic Testicular/Perineal Pain Recs

Our chronic testicular/perineal pain treatment algorithm recommendation for men with a negative infectious work up and negative imaging begins with empiric treatment with 4 weeks of ciprofloxacin 500mg po BID and scheduled NSAIDs (typically ibuprofen) for 1 month while using an athletic supporter/jock strap for continuous scrotal support. If this doesn't work we sometimes trial 3 months of neurontin 300mg po TID. After failure of these treatments, we recommend referral to chronic pain clinic. Please let us know if we can answer further questions or be of additional assistance. Thank you.

Urethritis/Urethral Discharge

Causes of urethritis and urethral discharge in males include chlamydia, N. gonorrhea, herpes, trichomoniasis, and ureaplasma. After testing and/or empiric treatment for GC/Chlamydia, we recommend testing and empiric treatment for these other organisms that may also cause urethritis. If he still has urethral discharge after appropriate treatment for these organisms or if you have questions about treatment, please let us know.

Urethral Stricture

This is a narrowing of the uretra that is caused by scar tissue. It may be caused from trauma or infection. It can block the flow of urine and may need an operative intervention to fix this. Do NOT insert any catheter unless the patient is unable to void. Please obtain a retrograde urethrogram via radiology and refer to the Urology clinic ASAP for further evaluation.

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