ED GUIDELINES
UROLOGICAL EMERGENCIES

Reviewed June 2020 - Dr R Loffhagen / Ms. F McMeekin

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Referral Pathways for Advice or Admission

Urology Registrar

- Correct as at 15 June 2020 – subject to change, if in doubt contact Switchboard
- Registrar is on site at CGH 08:00 – 20:00, 7 days/week
- Urology Assessment Unit 0300 422 4358, open 0800-1800
- Urology Reg mobile 07812 489530
- Urology Reg bleep 1180

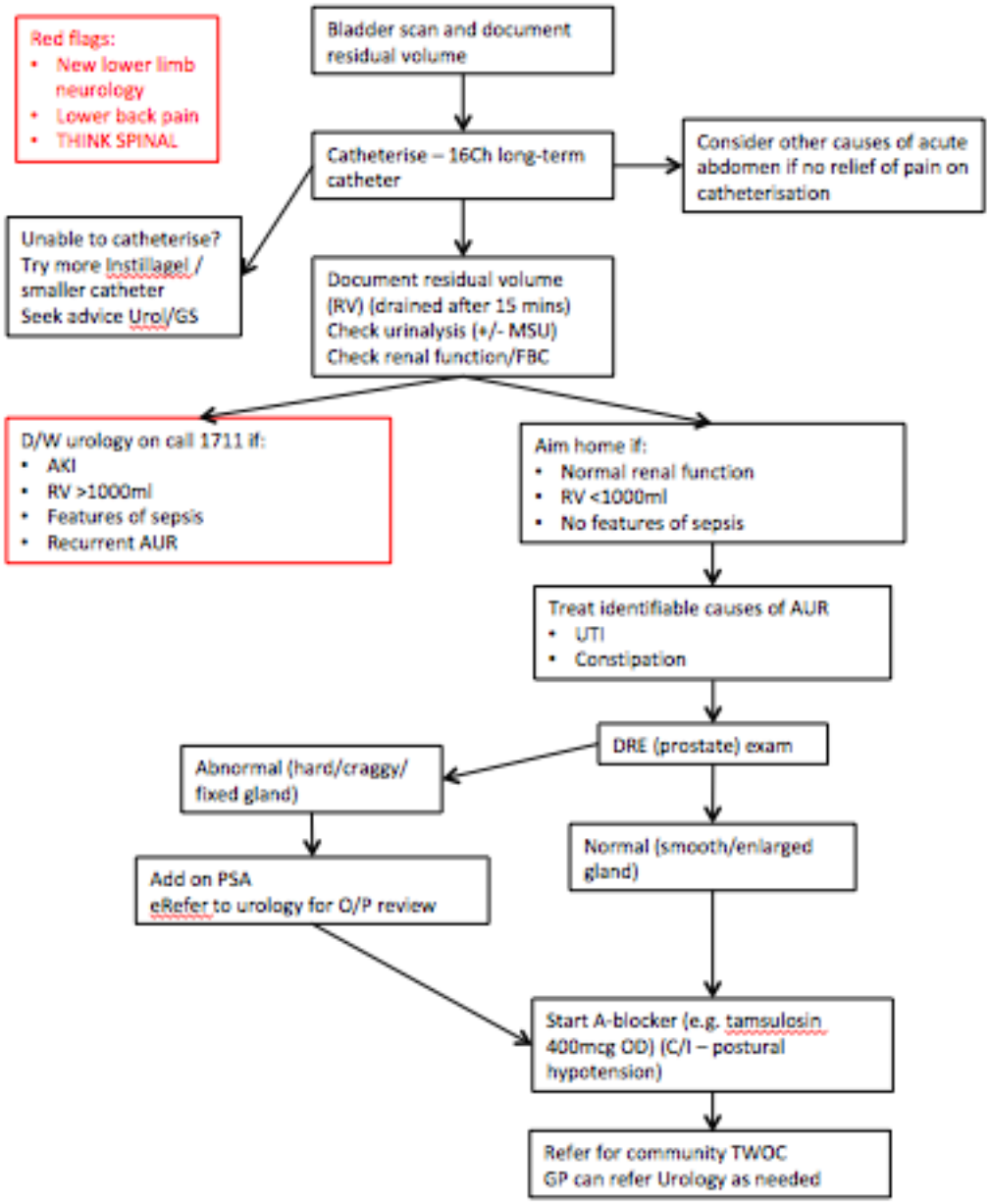
How to Refer

- 08:00-20:00 - Refer to Urology Registrar on call
- Out of Hours:
    - GRH - Refer to on-call Surgical Registrar for review
    - CGH - Currently under review – if in doubt contact Switchboard

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Urinary Retention (without Haematuria)



Note: For female patients ignore parts of chart relating to Prostate, and do not prescribe Tamsulosin.

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Acute Haematuria and Urinary Retention

General

- In Women consider Gynaecological cause – ensure not PV bleed
- Ensure Udip and Upreg if appropriate
- Check FBC U+E CRP, Coag if appropriate
- Consider admission if – clinically unstable, clot retention, significant AKI, other renal risk factors including single kidney, transplant patient

Non Visible Haematuria (NVH – previously 'microscopic')

- Very rarely an emergency
- Consider causes including – trauma, ureteric stone, infection, medications, bleeding disorders, malignancy
- If clinically stable, refer back to GP to arrange ongoing follow up as needed

Visible Haematuria +/- Retention (VH - previously 'macroscopic')

- Unless contraindicated, stop antiplatelets / anticoagulants
- Dark red urine +/- clots – pass 3 way catheter size 22Ch, start bladder washout/irrigation, admit Urology
- 'Pink / Rosé urine but not in retention – ereferral for assessment in Urology 2WeekWait clinic
- 'Pink / Rosé urine with retention – pass 16Ch catheter, ereferral for assessment in Urology 2WeekWait clinic

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Testicular Torsion & Other Testicular Problems

Key Messages

- Testicular Torsion can present in ANY male
- If you are unsure of the diagnosis of a painful testicle, ask for an urgent ED Senior or Urology opinion

Testicular Torsion

This is an **ABSOLUTE EMERGENCY** and should be referred to Urology without delay once suspected

- Most common age 10-25, but can present at any age
- Under 10 often a torted hydatid
- Triage nurse to immediately inform senior doctor of any acute painful testicle
- Ensure early analgesia
- ED doctor to assess immediately and prioritise early referral if Torsion suspected
- Cannula will be required if going to theatre, blood tests are not required in a previously well young male / child
- Children - inform Paediatric registrar as well as Urology on call

Other Testicular Problems

General Approach

- Check Urine Dip, FBC/U+E/CRP
- **Consider malignancy** in any man with a swollen or tender testicle, especially if urine does not show infection. Most common age is 25-40
- Discuss any suspected malignancy with Urology on call.

Epididymo–orchitis

- In men < 40:
    - Usually associated with GU infection (STD) – Chlamydia (most common) and gonococcal infection.
    - Send a urine specimen for MSU
    - Treat with oral Ciprofloxacin for 10/7. If Chlamydia suspected add Doxycycline 100mg o.d for 10/7. Partners also require screening and treatment if GU infection suspected (GP or GUM clinic) - advise patient accordingly.
- In men>40:
    - Usually associated with UTI. Treat with oral Ciprofloxacin for 10/7.
- In severe cases, admit and treat with IV Gentamicin.
- Follow up (any age) - If recurrent (>2 episodes in 6/12, or > 3 in a year) make ereferral to Urology. Otherwise GP follow up.

Varicocele / Hydrocele

- If stable, not septic, no other issues, give analgesia and discharge with GP to follow up

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Suspected Ureteric Colic - Severe Abdominal Pain

- **Always consider AAA in those > 50**
- **Ensure NOT referred pain from testicle**
- **Ensure NOT pregnant**
- **An infected & obstructed kidney needs Emergency Referral**
- **Ensure early analgesia**

- Give analgesia – First choice Diclofenac 100mg PR, IV opiates if needed
- Examine patient including AAA and testicles (if male) to exclude torsion
- Dip urine – 95% have +ve blood, Upreg if appropriate
- FBC CHAP, Blood Cultures and Clotting* if septic (*if may require urgent Nephrostomy)
- Consider Sepsis - treat if urine suggestive, AND fever or high inflammatory markers (note WCC may be mildly elevated in any Ureteric Colic)

There after, if renal colic considered to be the pertinent diagnosis see link to renal colic pathway here Acute renal colic management

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Urological Trauma, Priapism, Foreskin Problems

Trauma

- **Follow ED trauma guidelines**
- **Trauma related haematuria** will require urgent CT in adults and children
- **Renal/Bladder/Urethral Injury -** discuss urgently with the on-call Urologist
- **Penile Fracture** - History is one of trauma usually during sexual activity. Often the patient will hear a crack, the erection goes down immediately and the penis will swell immediately. The classical appearance is one of an “aubergine” penis. Admit, analgesia, ice packs and keep nil by mouth. Discuss urgently with the on-call Urologist.

Priapism

- Consider cause – spinal trauma, haematological disease, PDE5 inhibitors (Viagra, Cialis, Vardenafil)
- Refer urgently to Urology

Paraphimosis

- Analgesia
- Ice / Osmotic Solutions may be tried to reduce swelling prior to Manual Compression
- Manual Compression, increasing pressure gradually for a minimum of ten minutes to reduce swelling and replace foreskin
- Refer Urology if unable to reduce
- Early Urology referral for all Paediatric as may require GA /Penile block

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Catheters & Catheterisation

Failure to Re-insert Catheter

- May be due to false passage or resistance/obstruction at the prostatic or sphincter level
- Try again *(VERY GENTLY)* with a size 16 silastic catheter, these are slightly stiffer than the normal Foley catheter and may go in more easily. Use lignocaine gel and wait at least 5 minutes for it to work.
- Do not try with three way catheters as these will cause more damage
- Multiple attempts may cause false passages within the urethra.
- Refer to Urology if unable to pass catheter

Dislodged Suprapubic catheter

- Usually needs re-siting within a short time, otherwise the tract will close up.
- Try and reinsert through previous site directly into bladder using some instillagel. If unable to pass, discuss with Urology on-call.