

Urology guidelines

(Approved by APC from a medicines perspective)

March 2022

For review March 2025

INTRODUCTION

This document is an update of the NORTH OF TYNE AND GATESHEAD GUIDELINES FOR MANAGEMENT OF COMMON UROLOGICAL CONDITIONS IN ADULTS IN PRIMARY CARE.

Changes have been made to fit with current practice and align recommendations with NICE guidance and **North of Tyne/Gateshead guidelines for detection, management, and referral of adults with kidney disease**

The guidelines are intended to guide clinical management, but every patient should be assessed and managed individually.

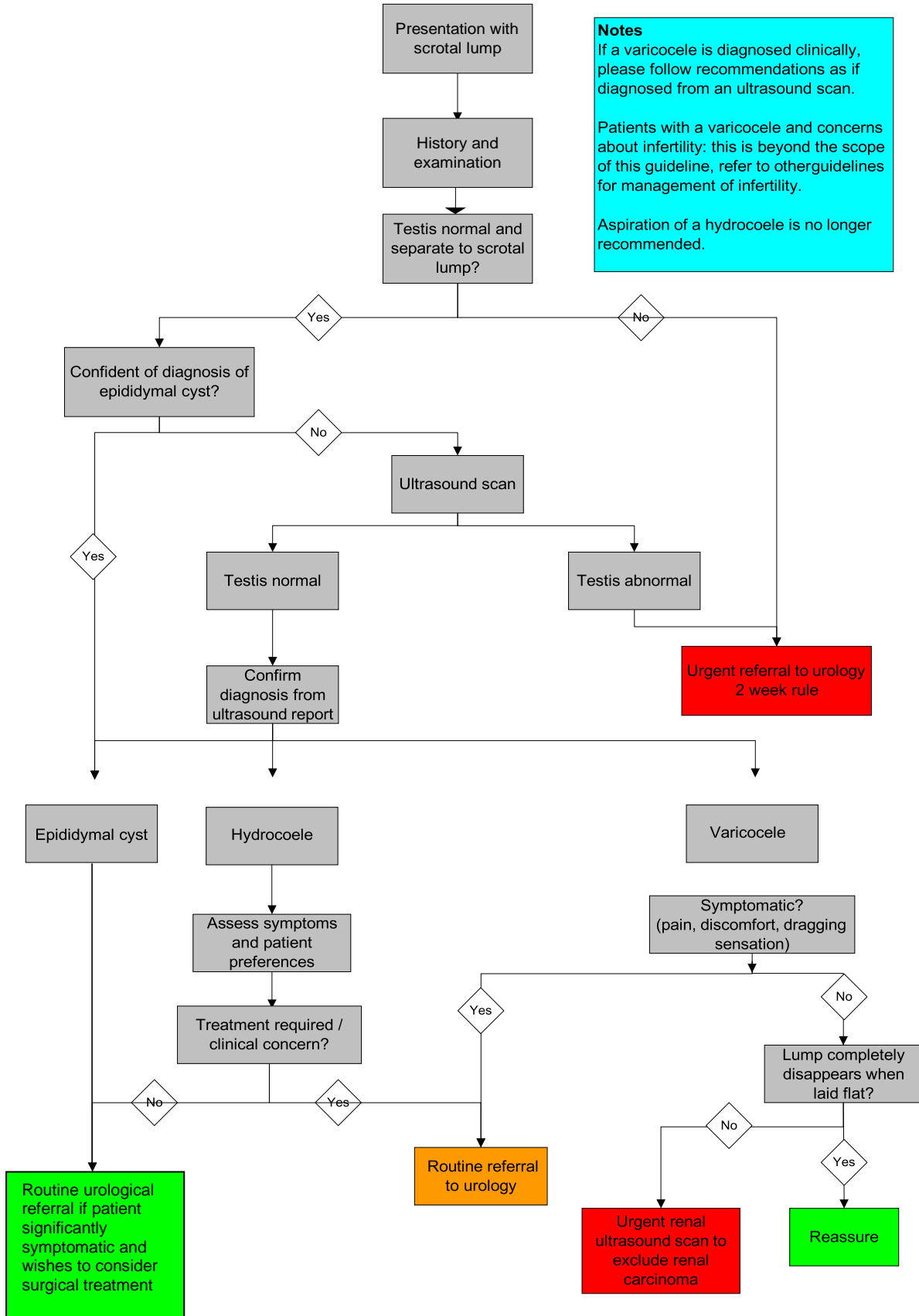
How to use the guidelines

The BNF and the North of Tyne / Gateshead Formulary should be referred to as appropriate.

Referrals

When referral to secondary care urology clinic is recommended in the guideline, referral for patients to be seen at a local outreach clinic may be preferred

Scrotal lumps



Testicular Microcalcification

If risk factors for testicular cancer i.e. history of undescended testis or Klinefelter's refer to Urology.

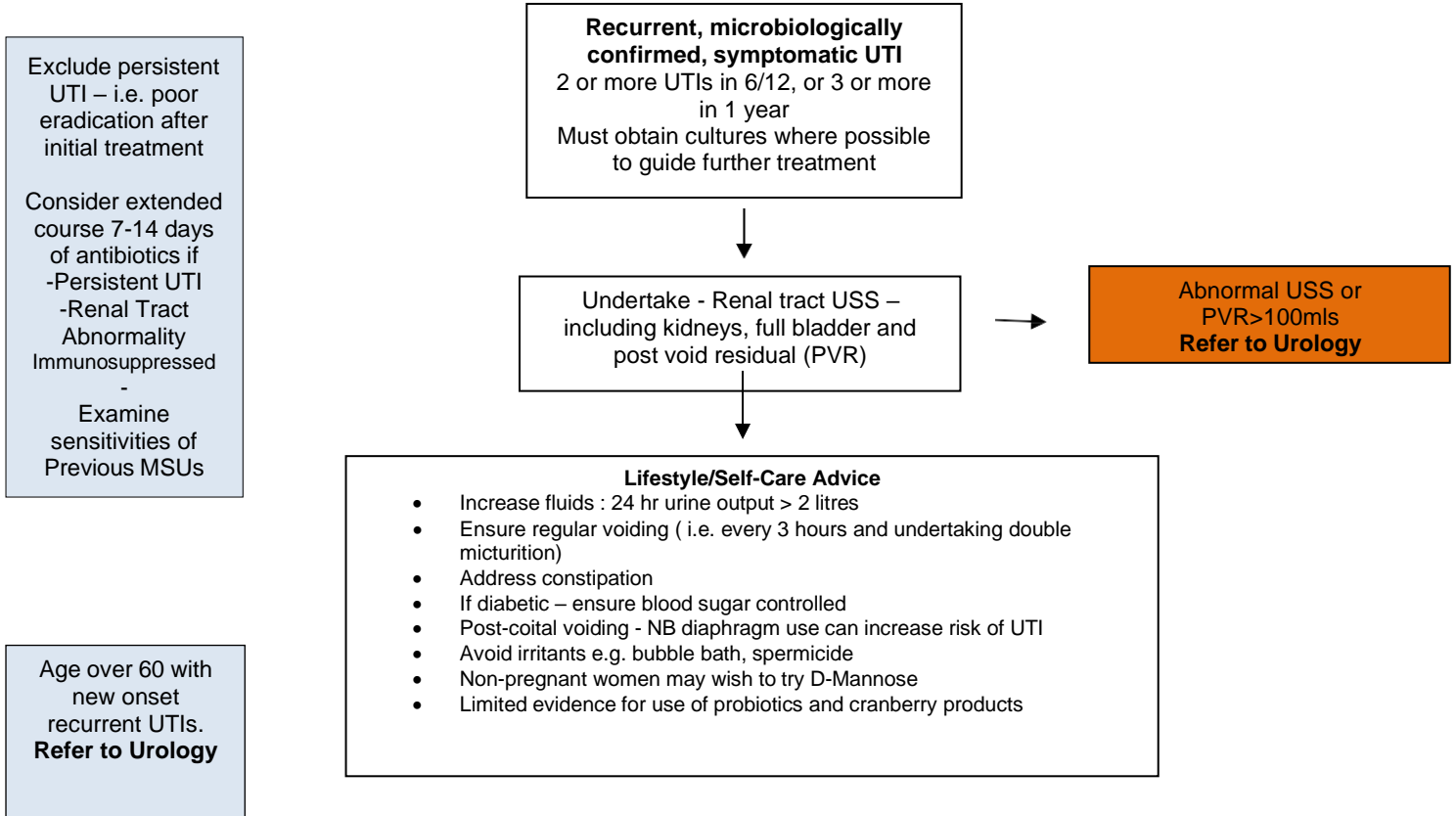
If no risk factors, there is no need for serial imaging. and self-assessment as per standard advice is all that is required.

Idiopathic Chronic Testicular Pain

In the absence of abnormality on community USS – for 3 months trial of NSAID and scrotal support.

If no improvement for 3 months trial of low dose amitriptyline. If no improvement, consider referral to local specialist for consideration of surgical management.

Recurrent Urinary Tract Infections in Non-Pregnant Females



↓
 No improvement
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Postmenopausal Women	Identifiable /trigger for UTI e.g. Intercourse	Trial of Daily Antibiotic Prophylaxis	Methenamine Hippurate	Self-Start Antibiotics
Consider vaginal (not oral) oestrogen. Review at 6-12months Take account of severity and frequency of symptoms, risk of complications, benefits for other symptoms (vaginal dryness) possible adverse effects (breast tenderness and vaginal bleeding), unknown long-term endometrial safety and preferences for treatment.	Consider Single-dose antibiotic prophylaxis Advise how to use, possible adverse effects of antibiotics, particularly diarrhoea and nausea and need to seek medical help if symptoms of UTI develop. Review efficacy at 3-6months.	Advise about risk of resistance with long-term antibiotics, possible adverse effects of long-term antibiotics and need to seek medical help if symptoms of an acute UTI develop. Review at 3 months and consider cessation of antibiotics. If decision made to continue antibiotics review every 6 months. There is no evidence to support rotation of different antibiotics.	Approved on formulary as second line agent for prophylaxis in patients with recurrent UTI's who have failed long-term antibiotic prophylaxis, have contraindication to antibiotics or breakthrough infection with resistant organisms.	Consider in exceptional cases e.g. recurrent admission with pyelonephritis/sepsis

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Treatment failure – Refer to Urology

[Recurrent UTI NICE guidance](#)

UTIs in men

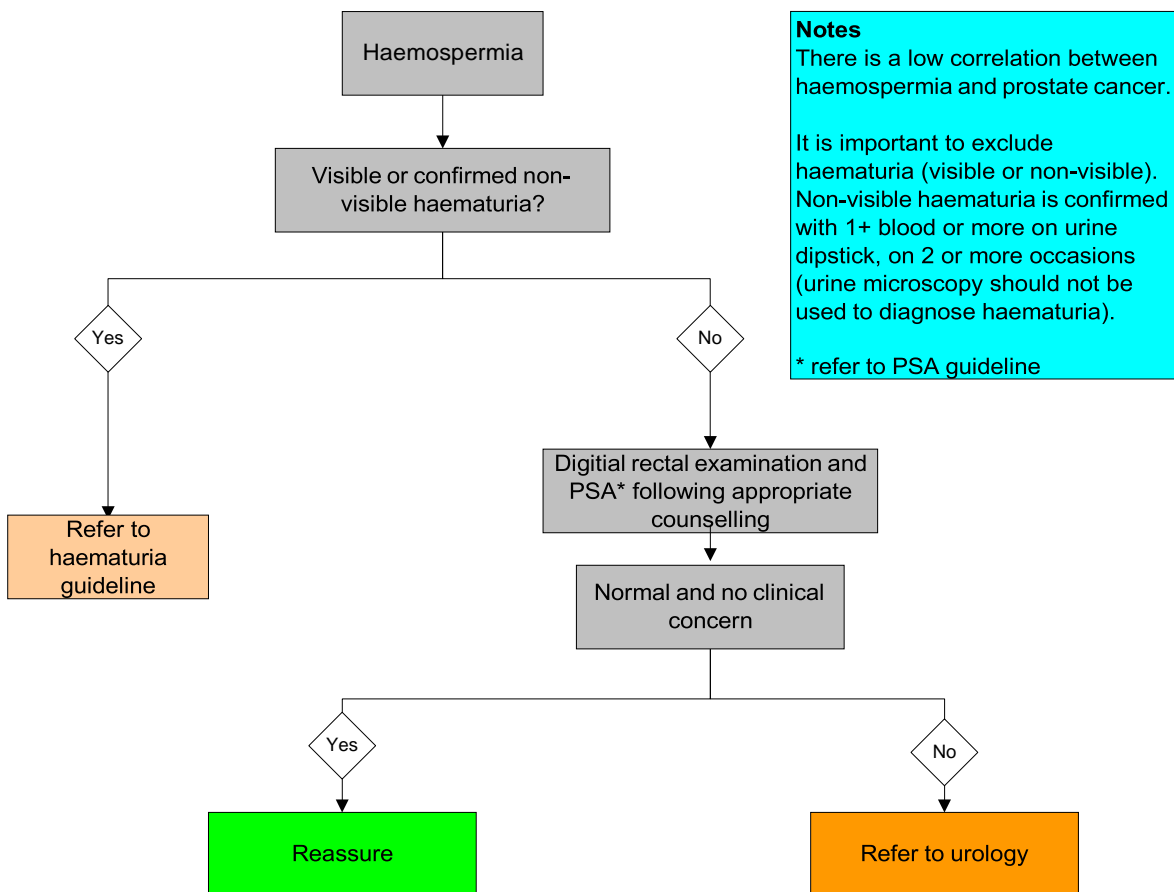
A proven UTI in a male should be investigated with an ultrasound of the urinary tract including ultrasound bladder and assessment of post micturition residual

Urological referral is appropriate if there is an abnormality of the urinary tract or if the post-micturition residual is greater than 100mls.

If ultrasound is normal, then urology referral may be indicated based on haematuria or cancer guidelines or if there is clinical concern

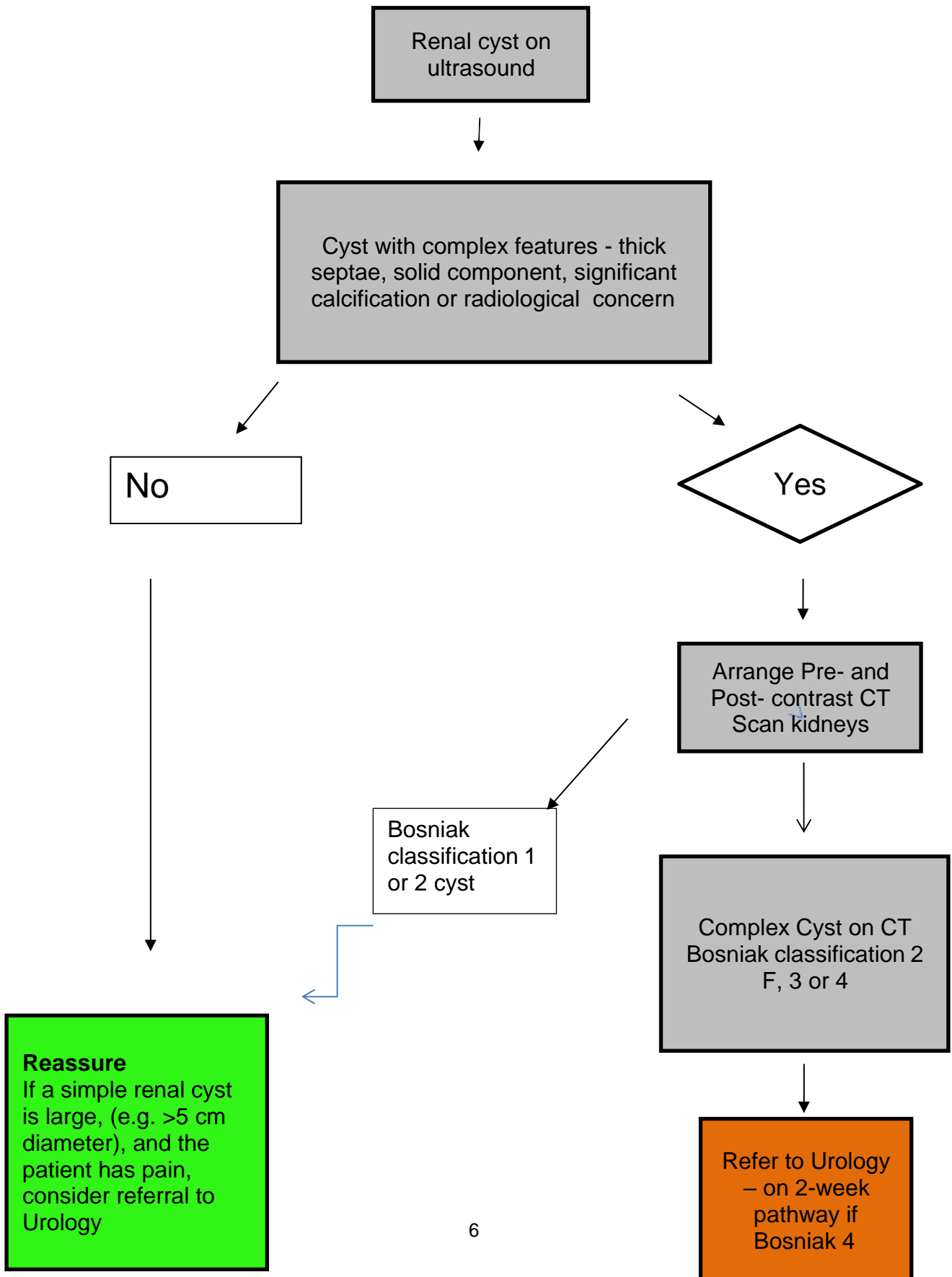
UTI's in men should not be treated with a 3-day course of antibiotics. Local expert opinion is that nitrofurantoin should not be used due to this antibiotic poor tissue penetration. A one-week course of an antibiotic with good tissue penetration such as trimethoprim, is appropriate.

Haematospermia

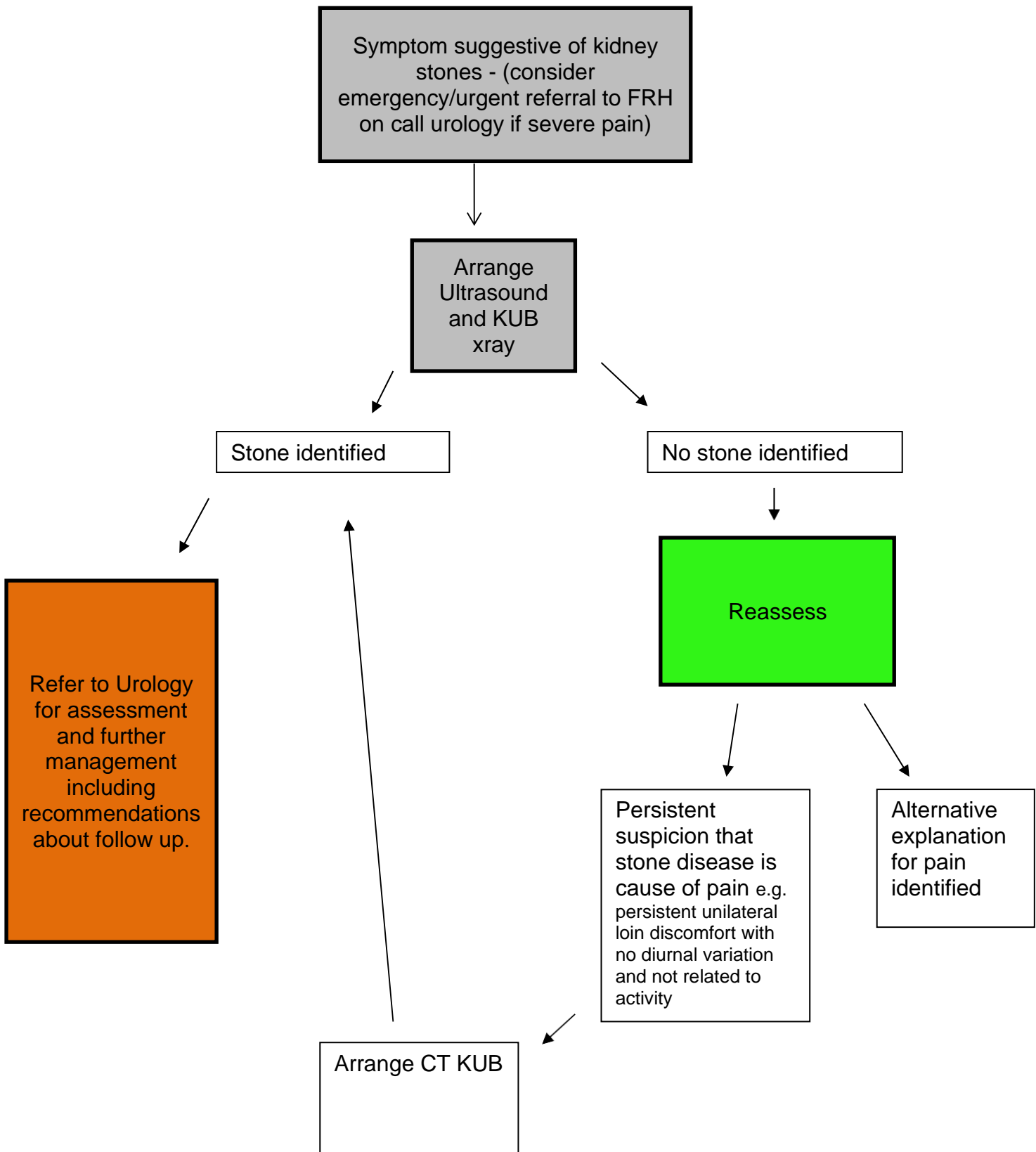


Please note we are aware that these guidelines do not align with a NICE guideline but there is clinical consensus with above approach
 If haematospermia is recurrent or persistent (i.e. 6 months)– consider referral to urology

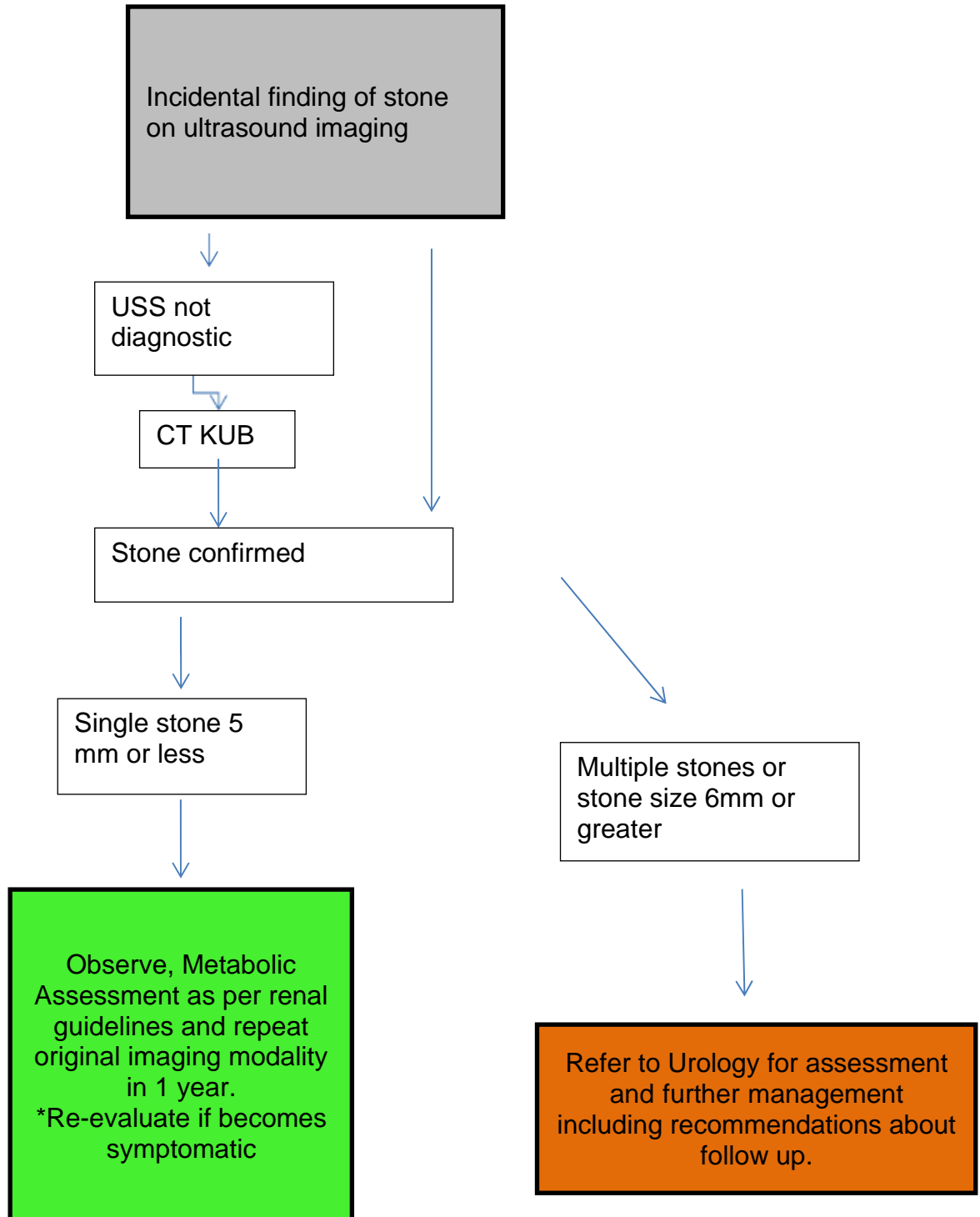
Renal cysts



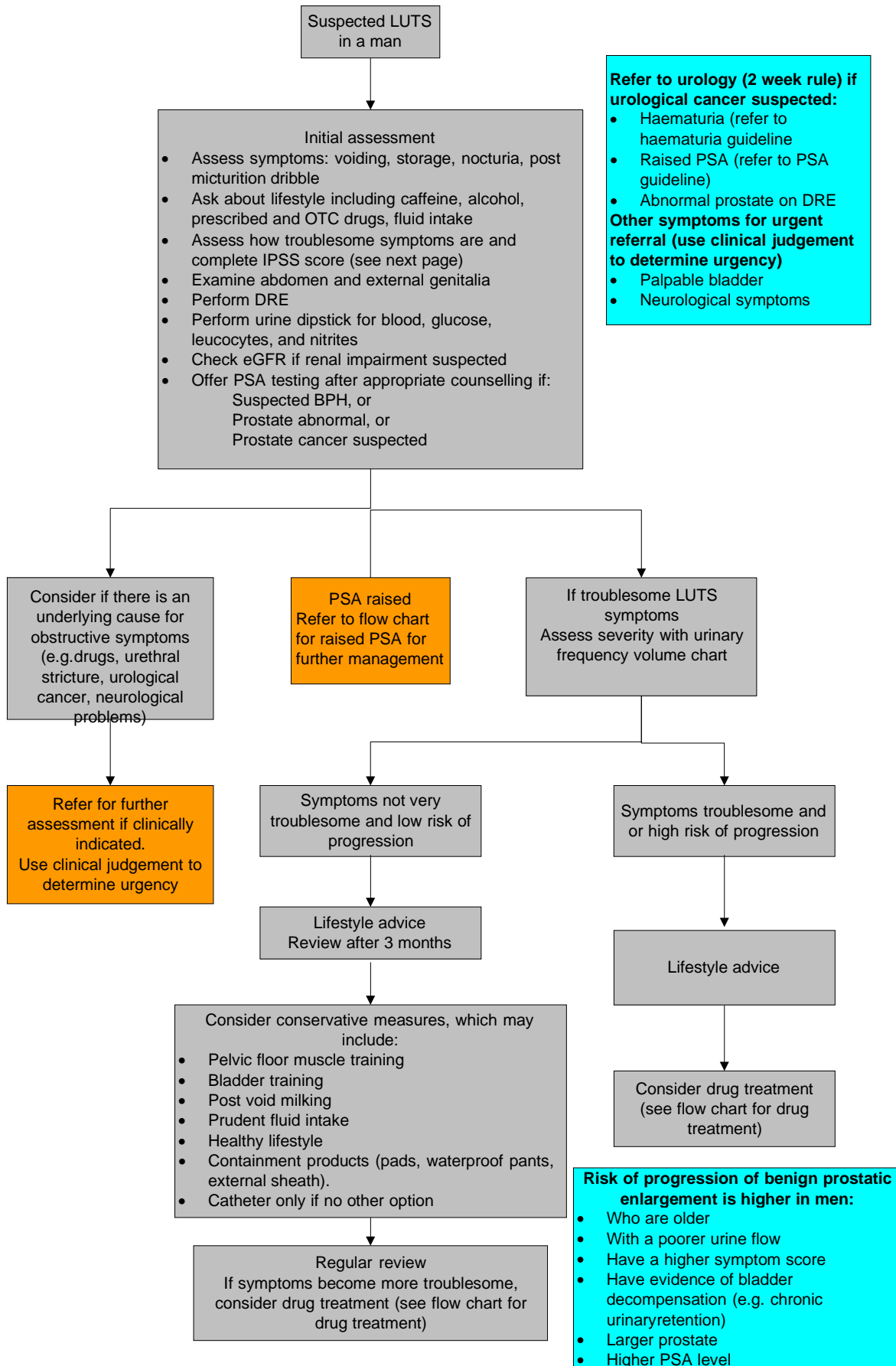
Symptoms suggesting urinary tract stones



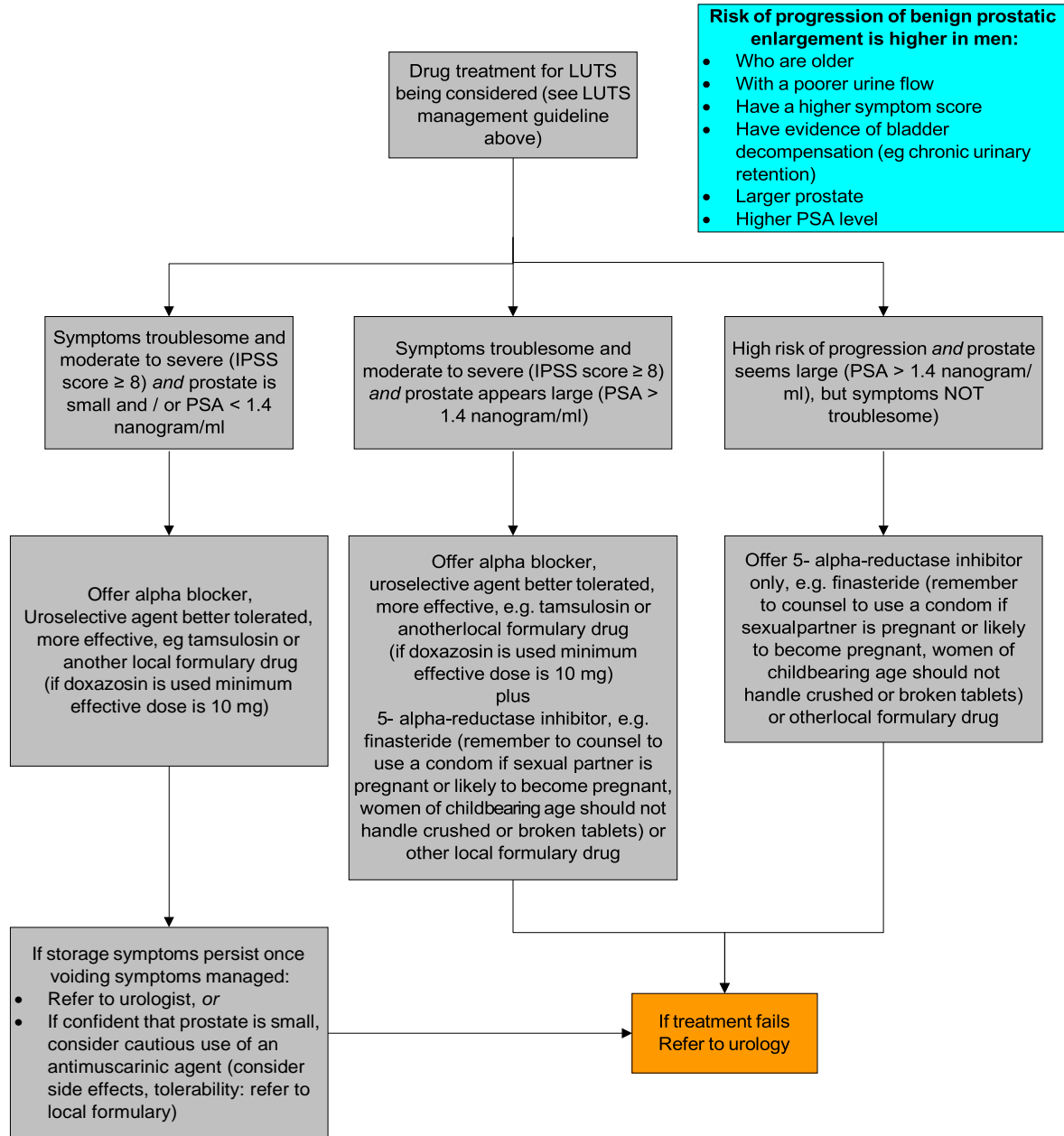
Incidental finding of renal stones



Lower urinary tract symptoms (LUTS) in men: assessment and management



Drug flow chart for drug treatment in male patients with Lower urinary tract symptoms

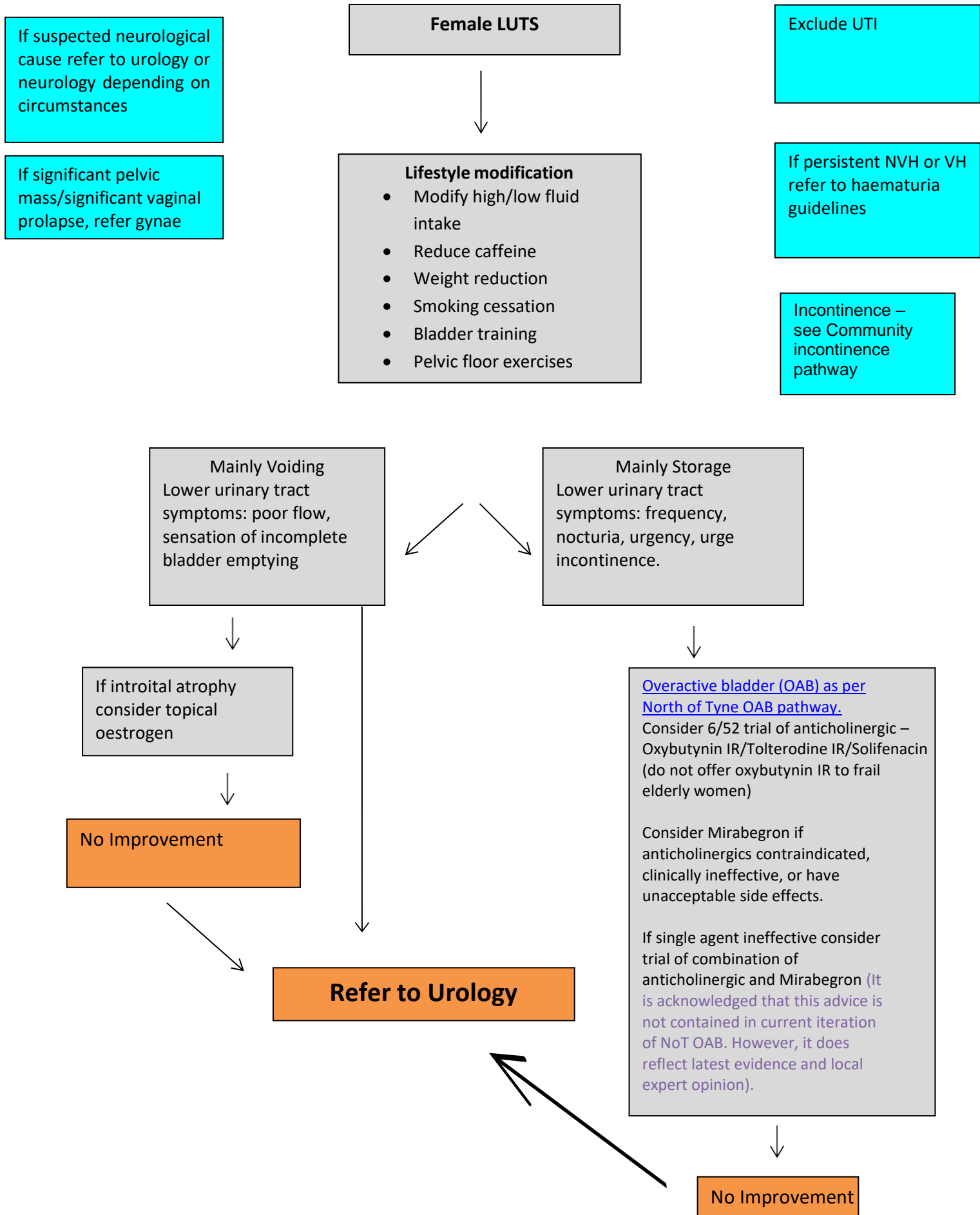


Notes
 Refer to local formulary for additional information and for details of drugs on the local formulary

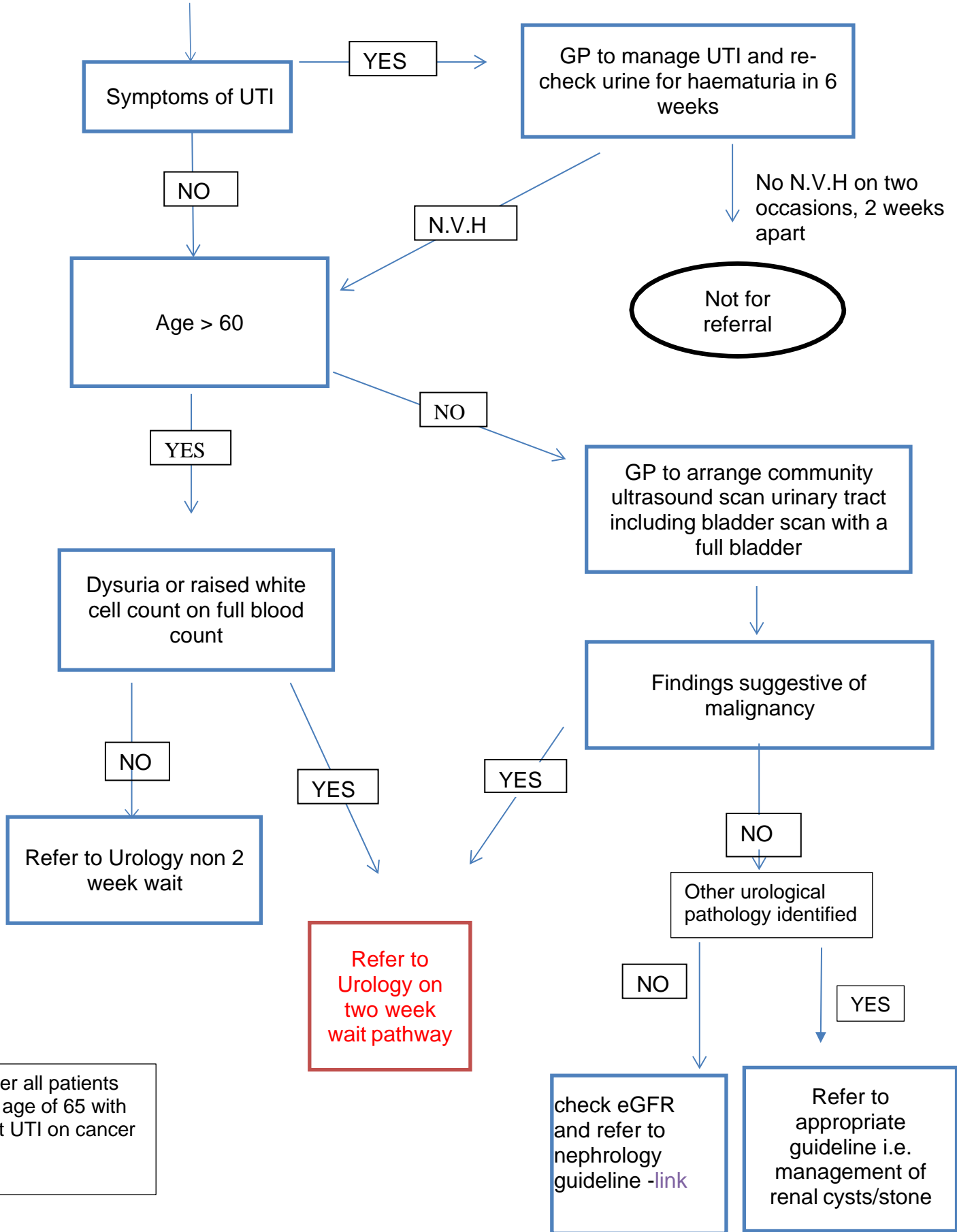
Follow up
 Alpha-blocker: after 4-6 weeks, and then every 6-12 months
 5-alpha-reductase inhibitor: after 3-6 months, then every 6-12 months
 Antimuscarinic agent: every 4-6 weeks until stable, then every 6-12 months

Interpretation of PSA results
 After 6 months of 5-alpha reductase inhibitor use, PSA levels reduce by about 50%. When interpreting a PSA level measured after at least 6 months of 5-alpha reductase inhibitor treatment, double the PSA result

Female LUTS guidelines



Non Visible Haematuria – NVH



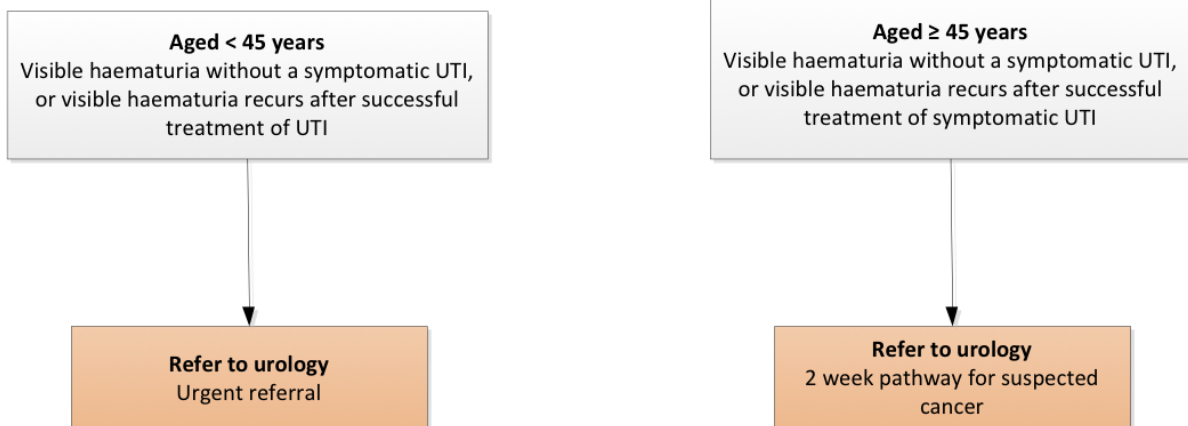
N.B. Refer all patients over the age of 65 with recurrent UTI on cancer pathway

Non-visible haematuria does not need reinvestigation if investigated previously and no significant abnormality detected, unless accompanied by new bladder symptoms or if visible haematuria develops.

Visible haematuria

taken from North of Tyne/Gateshead guidelines for detection, management, and referral of adults with kidney disease

Assessment and referral of patients with visible haematuria



Notes

Visible haematuria should not be attributed to oral anticoagulants in the therapeutic range and/or anti-platelet agents as a cause.

Blockage of Indwelling Catheter

- Consider alternative diagnosis of bypassing secondary to bladder spasms and consider trial of anticholinergic agent or mirabegron
- Consider inserting a tipless catheter
- Bladder washouts on a weekly basis – saline moving to Suby G if not effective
- Arrange community USS or AXR to exclude bladder stone.

Peyronie's Disease – Guidelines for Primary Care

1. GPs should assess the patient for possible Peyronie's disease. This involves a careful history (to assess penile deformity, interference with intercourse, penile pain, and/or distress) and a physical examination of the genitalia to assess for palpable abnormalities of the penis.
2. GPs may offer oral non-steroidal anti-inflammatory medications to the patient suffering from active Peyronie's disease who needs pain management.
3. There is no effective pharmacological treatment to reduce curvature and GPs should not offer oral therapy with tamoxifen etc.
4. Patients may enquire about intralesional collagenase injections. This is not available through the NHS and is not offered at Newcastle Urology.
5. Patients who develop erectile dysfunction in association with Peyronie's disease should be prescribed phosphodiesterase inhibitors (e.g. sildenafil) with appropriate advice.
6. The natural history of the condition should be discussed with the patient and reassurance provided this is a benign condition. The penile pain usually subsides within a few months and there may be spontaneous improvement in a minority (10%). Further patient information is available on the BAUS website:
<https://www.baus.org.uk/userfiles/pages/files/Patients/Leaflets/Peyronies.pdf>
7. **Surgical intervention** is only indicated if the penis is too bent for penetration (penile straightening surgery – Nesbitts (plication) or modified Lue (grafting) procedures) or if the disease prevents distal tumescence (when implantation of a penile prosthesis may be considered). No surgical intervention will be considered, however, until the disease has been stable for at least 6 months.
8. Referral for Peyronie's disease **is unnecessary** unless the deformity prevents penetration, and/or the disease prevents erection (with no response to phosphodiesterase inhibitors) and the condition has been stable for at least 6 months
9. If penetrative intercourse not possible and patient wishes to be assessed for surgery please refer to Newcastle Urology, Male Reconstructive Surgery