HPH Guidelines for Adult Urologic Clinical Referrals

Effective December 21, 2017

The following guidelines are designed to help the primary care physician determine the specific labs and/or imaging studies that should be done before a patient is seen by the specialist. These recommendations will help to expedite the care of your patients but all members of the urology service line are available through EPIC to assist with any specific questions.

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Department of Urology	Department of Urology	Department of Urology
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1. **Microhematuria or gross hematuria**: AUA guidelines 2012
   a. Needs urine microscopy (x2) to confirm >/=3 rbc/hpf, not based only on UA dipstick
   b. Upper tract imaging – CT IVP if no contraindication. A cystoscopy if over 35 years.
   c. MRI abdomen/pelvis with contrast or renal ultrasound as alternative
   d. Urine cytology and urine markers (NMP22, BTA-stat, and UroVysion FISH) is NOT recommended prior to urologic consultation

   Referral after the UA and imaging should be considered.

2. **Benign Prostate Hyperplasia (BPH):** AUA guidelines 2014
   a. PH with resulting lower urinary tract symptoms (LUTS) include storage and/or voiding disturbances in aging men – frequency, nocturia, urgency, sensation of incomplete emptying, intermittency, straining, weak stream.
   b. UA recommended
   c. Digital rectal exam (DRE) recommended
   d. Trial of medical management with alpha blockers (flomax, uroxatral, rapaflo, hytrin, cardura). If not imporved in 1 month referral can be considered.
   e. Use of proscar or avodart should be considered if the prostate gland is enlarged on DRE and PSA >1.5

3. **Detection of Prostate Cancer:** AUA guidelines 2013
   a. Men under 40 year of age should not have routine PSA screening
   b. Men 40-54 years of age should have PSA screening done on individual basis for those at higher risk (family history and / or African American race)
   c. Men 55-69 years of age recommend shared decision-making with the patient for PSA screening
   d. Men 70+ years of age or less than 10 years life expectancy do not recommend routine screening
   e. Men 70+ year of age in excellent health may benefit from routine PSA screening
   f. PSA testing should be done with instructions of no ejaculation for 3-5 days before the testing

   Digital rectal exam (DRE) recommended.
   Referral at any time can be considered.

4. **Erectile Dysfunction (ED):** AUA guidelines 2011
   a. Trial of medical management with PDE 5 inhibitors (levitra, Viagra, cialis) if not contraindicated.

   Referral at any time can be considered.

5. **Nephrolithiasis:** AUA guidelines 2014
   a. First time stone patient with passage of stone and no other stones on imaging study does not require routine referral
   b. UA should be obtained
   c. Straining of all urine should be done to obtain stone for analysis if stone in ureter
   d. CT KUB preferred for the initial diagnosis –routine follow-up with x-ray KUB or renal ultrasound in 1 year. If increase in size, consider referral
   e. Recurrent stone former should be followed by urology for metabolic work up. Refer if 6 weeks of less than 1cm stone in ureter.

   Referral at any time can be considered.

6. **Male Infertility:** AUA guidelines 2011
   a. At least one year of unprotected sexual intercourse without conception
   b. Semen analysis x 2 samples (abstain from ejaculation for at least 3-5 days before providing sample and needs to be at the lab within 30 minutes of collection)
   c. If semen analysis is abnormal order scrotal ultrasound and refer to urology

7. **Recurrent Urinary Tract Infections:** AUA update 2016
   a. Greater than 2 documented infections per year
   b. UA and Urine Culture should be obtained
   c. Should have culture proven urinary tract infection – may require lab comment when ordering urine culture ***"run to complete"***
   d. Renal ultrasound can be considered prior to referral

8. **Overactive Bladder (OAB):** AUA guidelines 2014
   a. Is a symptom complex – frequency, urgency, nocturia, that can be easily quantified by having the patient do a voiding diary marking every time they void in a 24 hour period greater than 8 is consistent with OAB
   b. UA and Urine Culture recommended
   c. Trial of medical management for 1 month with anti-muscarinics (detrol, ditropan, vesicare, sanctura – some available in immediate release and extended release) if not contraindicated