# Urological presentation 2015

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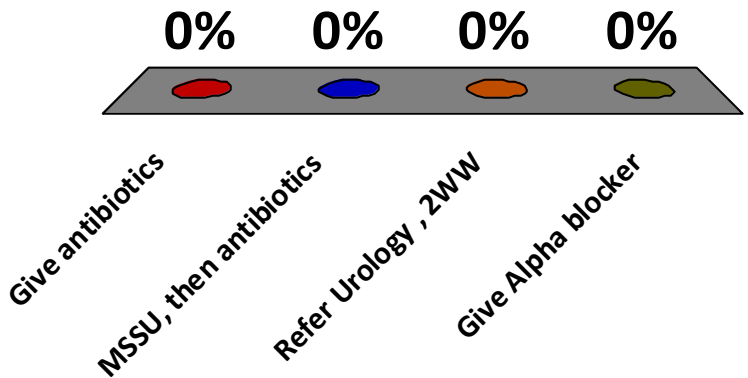
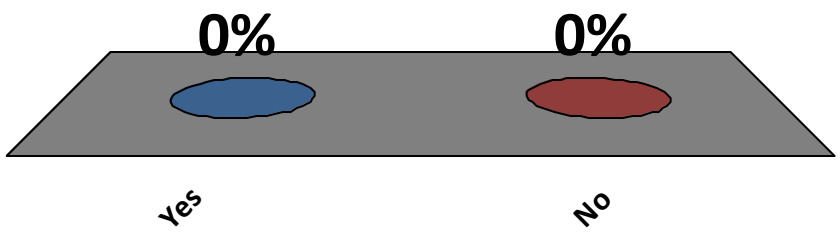
# Q1. 78yr old man, well. smoker >70 yrs. Haematuria and LUTS. What would you do?

A. Give antibiotics
B. MSSU, then antibiotics
C. Refer Urology , 2WW
D. Give Alpha blocker



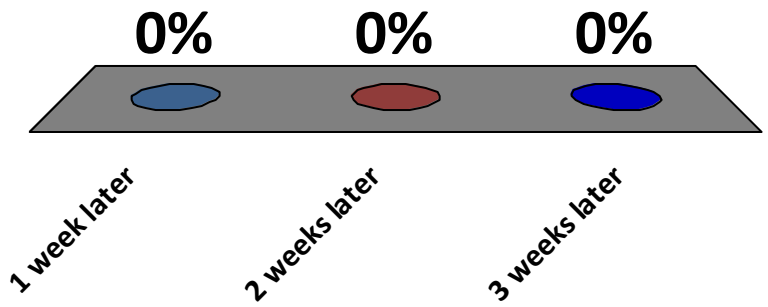
# would you refer someone who has a ***trace*** of blood in their urine dipstick ..twice…?

A. Yes
B. No



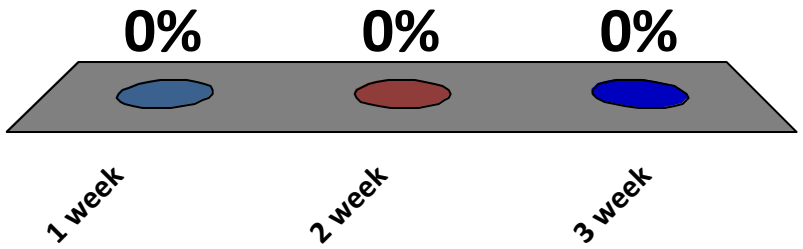
If case suspected UTI
dipstick blood +  /  MSU proves UTI
when should you repeat the urine dipstick after Abx treatment?

A. 1 week later
B. 2 weeks later
C. 3 weeks later



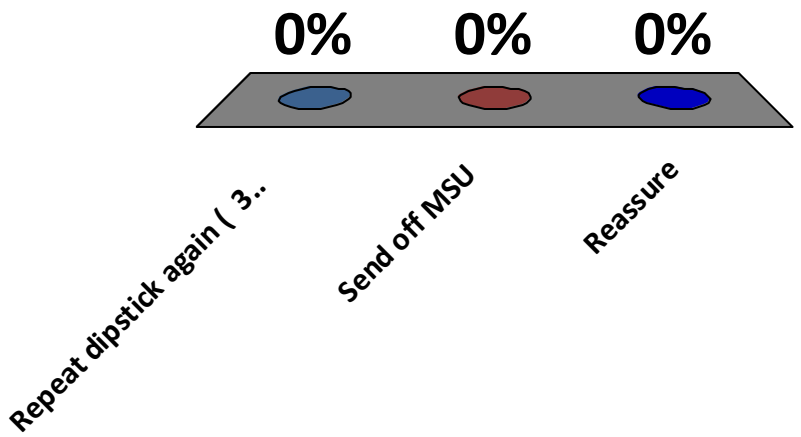
46 yr man, NO urinary symptoms,
dipstick blood + but MSU –ve
When should you repeat dipstick?

A. 1 week
B. 2 week
C. 3 week



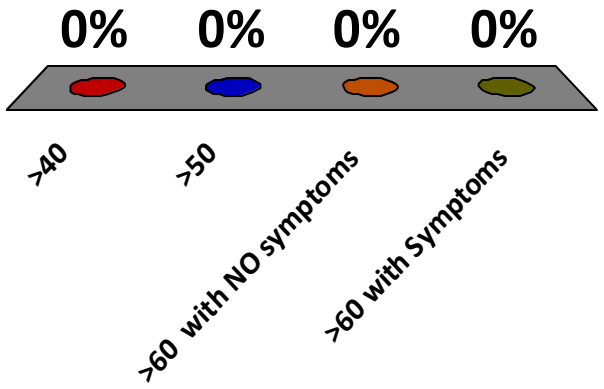
# Same man, second dipstick –ve
# What next?

A. Repeat dipstick again ( 3rd time)
B. Send off MSU
C. Reassure



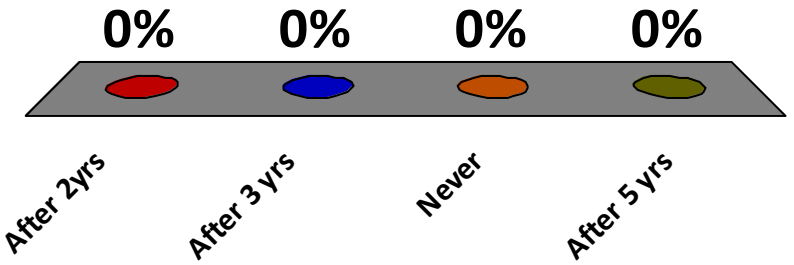
# New NICE Guidelines 2015
# What age should patients be referred with Unexplained non- visible Haematuria?

A. >40
B. >50
C. >60 with NO symptoms
D. >60 with Symptoms



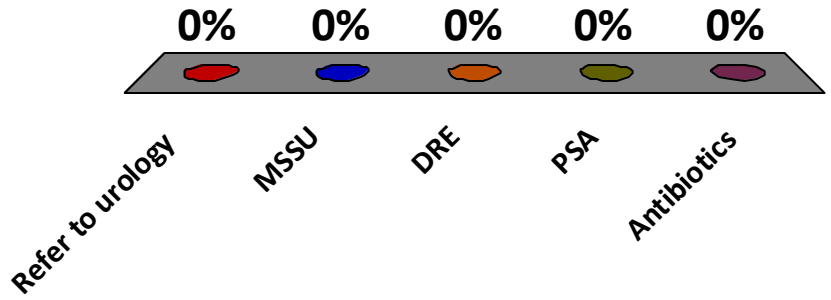
# When should patients be Re-referred to urology with recurrent NON- VISIBLE haematuria after previous negative investigations?

A. After 2yrs
B. After 3 yrs
C. Never
D. After 5 yrs



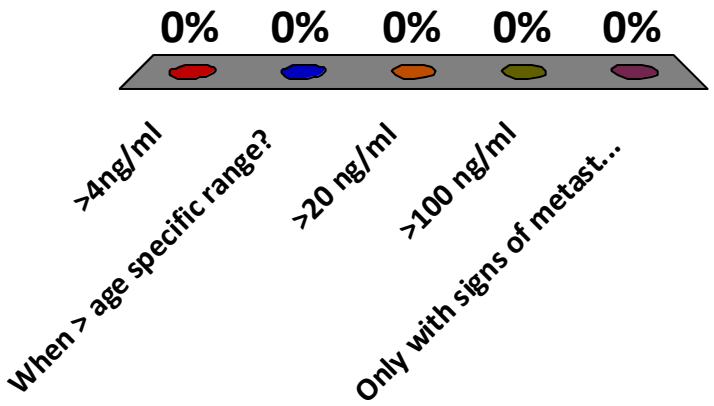
# Haematospermia.
# What should GPs do?

A. Refer to urology
B. MSSU
C. DRE
D. PSA
E. Antibiotics

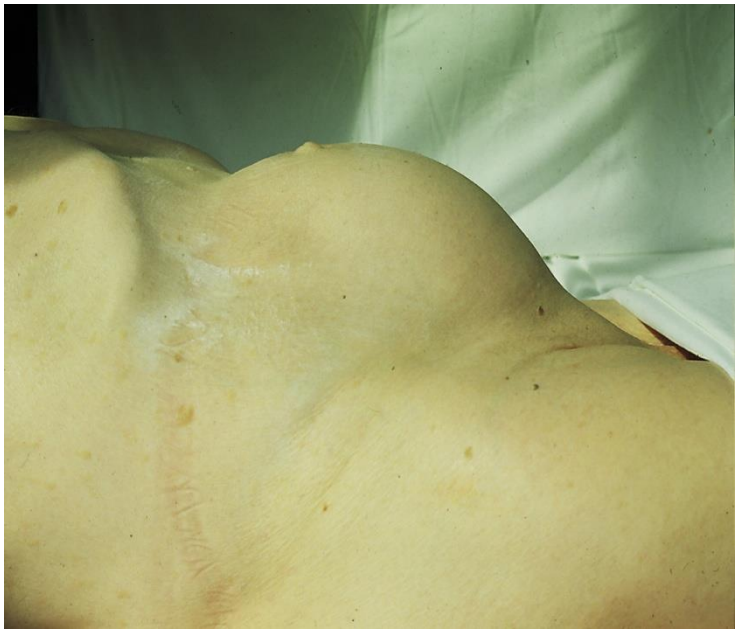


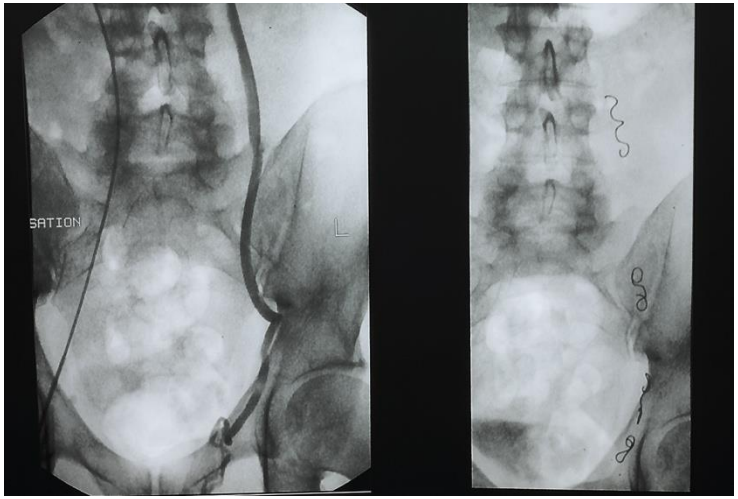
# At what PSA level should GPs refer to urology as a 2WW?

A. >4ng/ml
B. When > age specific range?
C. >20 ng/ml
D. >100 ng/ml
E. Only with signs of metastatic disease?



# Spot diagnosis ?





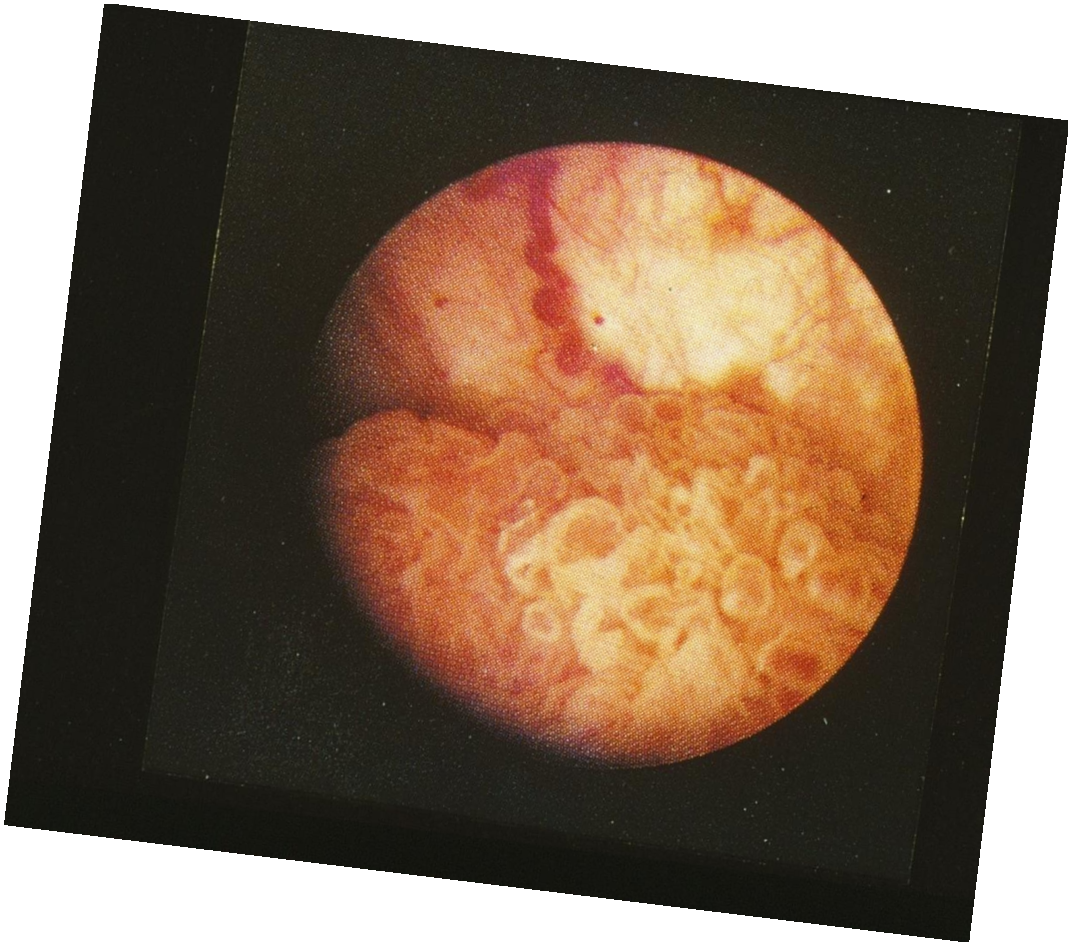
# What would you do ?

- 78 yr old fit and well man
- Smoker since age 15 yrs
- Haematuria, with some urge/frequency
- Lower urinary tract symptoms for years

**GP gave 5 days Ab and reassured him, with no follow up**

Cystoscopy, followed by biopsy confirmed leiomyosarcoma.

Had cysto-prostatectomy and ileal conduit on 4/9/15

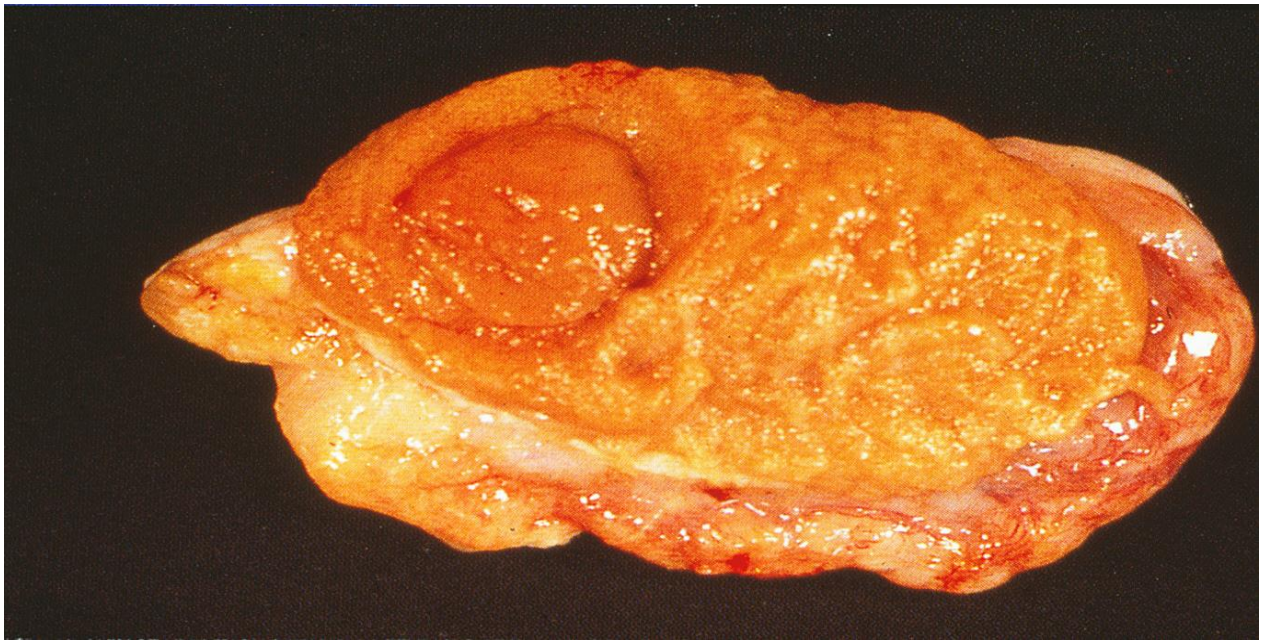


# Urothelial cancer : why ?

- UK overall survival from bladder cancer has not really altered for 30 – 40 yrs
- Within UK, South Yorkshire has very poor survival rates

- “Blood in pee”
- Increasing trend to radical ablative therapy
- Smokers and steel/heavy metal industry

# What are Haematuria referral guidelines ?



# Management of Haematuria

- GP referral guidelines.

- Any age with visible macroscopic haematuria
- >40 yr with recurrent UTI with haematuria
- >50 yr unexplained persistent non-visible haematuria
- Abnormal suspicious urological mass on imaging

# Joint statement on Haematuria

- Visible haematuria (VH)
- Symptomatic-non visible haematuria (s-NVH)
- Asymptomatic-non visible haematuria (a-NVH)
- Significant haematuria = VH,s-NVH, 2/3 a-NVH

When a-NVH investigations are normal then only re-refer if visible haematuria appears

# Practical tips

- Dipstick urinalysis is adequate, and reliable
- Unselected screening is not advised
- Single or 2/3 positive dip – pragmatic, risk factors
- Essential to exclude UTI; dip urine ? Adequate
- >50 yr then refer urology 2 week
- <50 yr – exclude nephrological causes (eGFR, protein)
- Recurrent UTI with persistent haematuria – refer
- Investigate patients on anti-coagulants
- Only 2-6% of dip positive haematuria have cancer

# New NICE guidelines: June 2015

- >45 yrs with unexplained visible Haematuria and no UTI
- Visible haematuria that persists/recurs after uti
- >60 yr with unexplained non-visible haematuria WITH  either dysuria or a raised WCC on bloods
- Consider non-urgent referral in people >60yrs with recurrent/persistent uti

# Haematuria clinic-referral

- Urologist expects –

- Haematuria confirmed
- UTI and proteinuria excluded
- FBC,U+E, performed (result from last 3/12)
- Relevant past medical history
- Brief explanation of what to expect to patient

- ? PSA

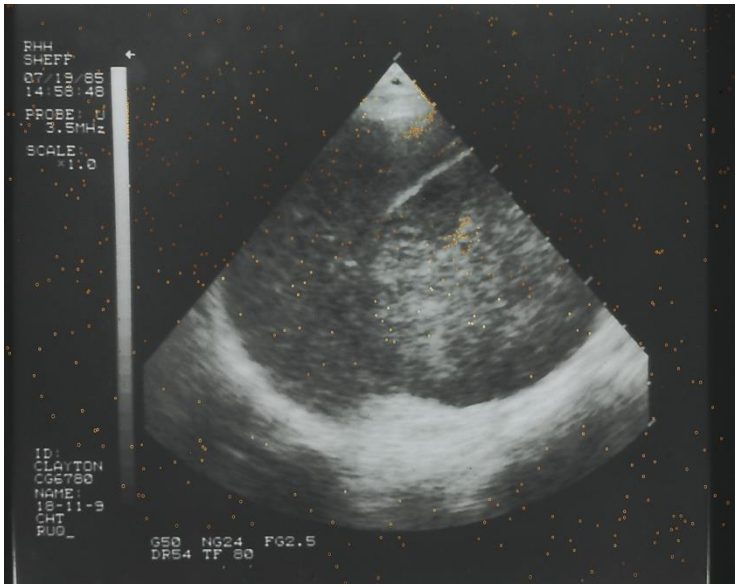
# Haematuria clinic

- History & examination
- Abdominal CT Urogram. (U/S scan and KUB – low risk)
- LA Flexible Cystoscopy
- Discussion of results
- If negative investigations then discharge to GP

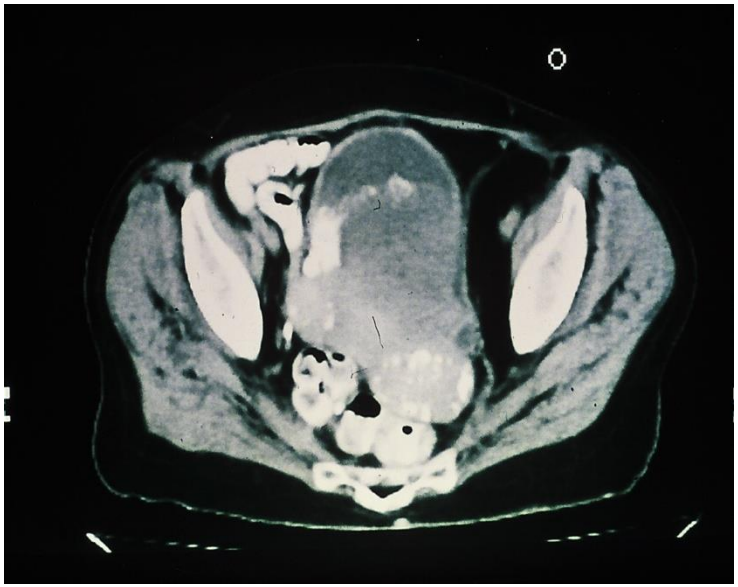
- Renal mass = Chest/Abdo CT and consider surgery
- Bladder tumour = GA Cystoscopy, advice to stop smoking. Cystoscopic surveillence.

# Urological treatments ?

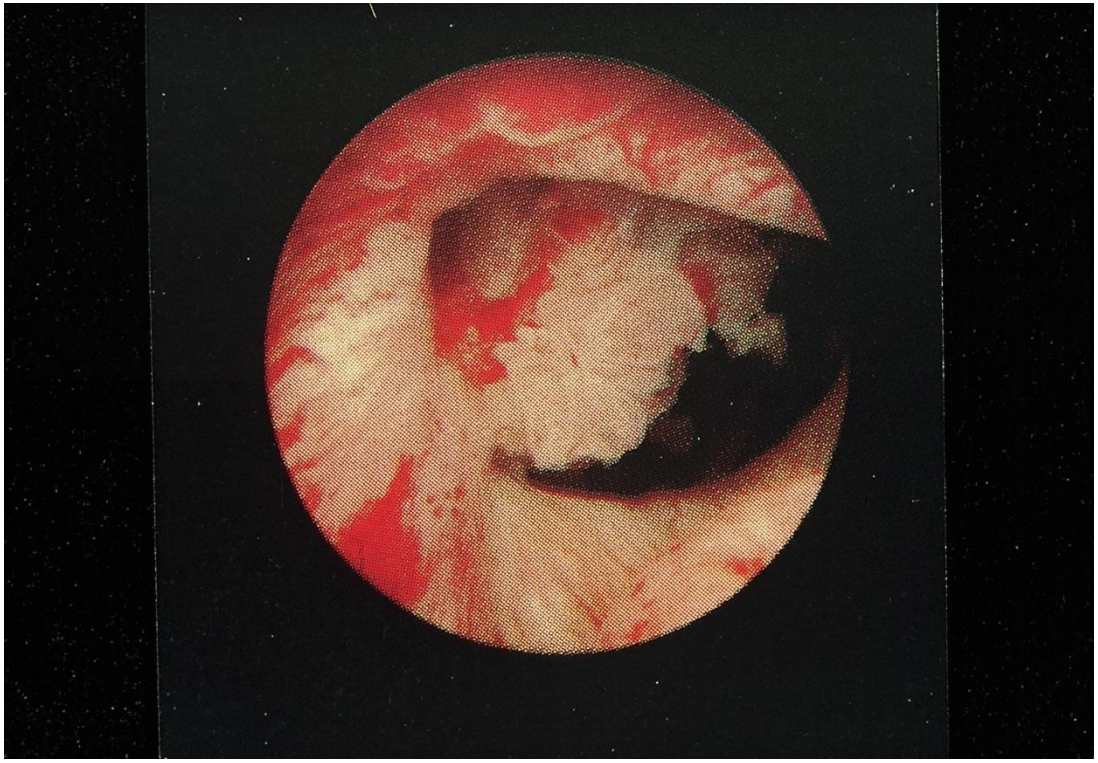
**Stage ?**




**Surgical options ?**



# Questions ?



# Prevalence of Haematuria

- Common
- 9 – 18 % in Normal individuals

- “strenuous exercise causes transient haematuria for 48 hours”
- “menstruation”
- Red Urine (MSSU –ve)
  - Porphyria, rifampicin, beetroot, veg dyes
- Dip +ve but MSSU –ve
  - Haemolysis, myoglobinuria, vit C excess

# Longer term monitoring

- Nephrological concerns:
- Deteriorating eGFR
- Proteinuria
- Development of hypertension

- Urological concerns:
- Development of visible haematuria
- Voiding lower urinary tract symptoms
- No further Urological review unless develops visible haematuria.

# NICE:Bladder cancer 2015

- Follow up of low grade superficial cancer
- 20% of all new cancers
- TURBT ; 3/12 cyst, 12/12 cyst – discharge to GP

- Intermediate group
- 60% of all new cancers
- TURBT ; 3/12,9/12,18/12 then annual cyst.
- Discharge to GP after 5 clear years

# NICE: Bladder cancer 2015

- High grade superficial & Muscle invasive bladder ca
- 20 % of all new diagnoses

- Neo-adjuvant chemo, then Radical cystectomy

- Longer term follow up of ileal conduit
- Community care of stomas, 6/12 review of U&E

- 30 % recurrence rate, and 50% 5 yr survival

# Recurrent UTI

- Bowel action
- Drinking Habits
- Menstrual history
- Intercourse history

- Only then Urological history
- Lower urinary tract symptoms ? obstructive

- MSSU, Abdo U/S, Residual volume.

# Need referral & cystoscopy ?

**NICE**

- 2015 guidelines
- > 60 yrs

- Smoking history
- New irritable symptoms

**Females**

- >60 yrs
- Recurrent uti
- Excessive persistent haematuria
- New irritable symptoms

# PSA : Prostate-related symptoms

- PSA
- PSA >6.5 with metastatic symptoms
- PSA > 20
- PSA – when serum level is above age specific range in absence of UTI
- 40-49, <2.5 : 50-59, <3.5, 60-69, <4.5 : 70-79, <6.5

- Lower urinary tract symptoms

# NICE June 2015 :

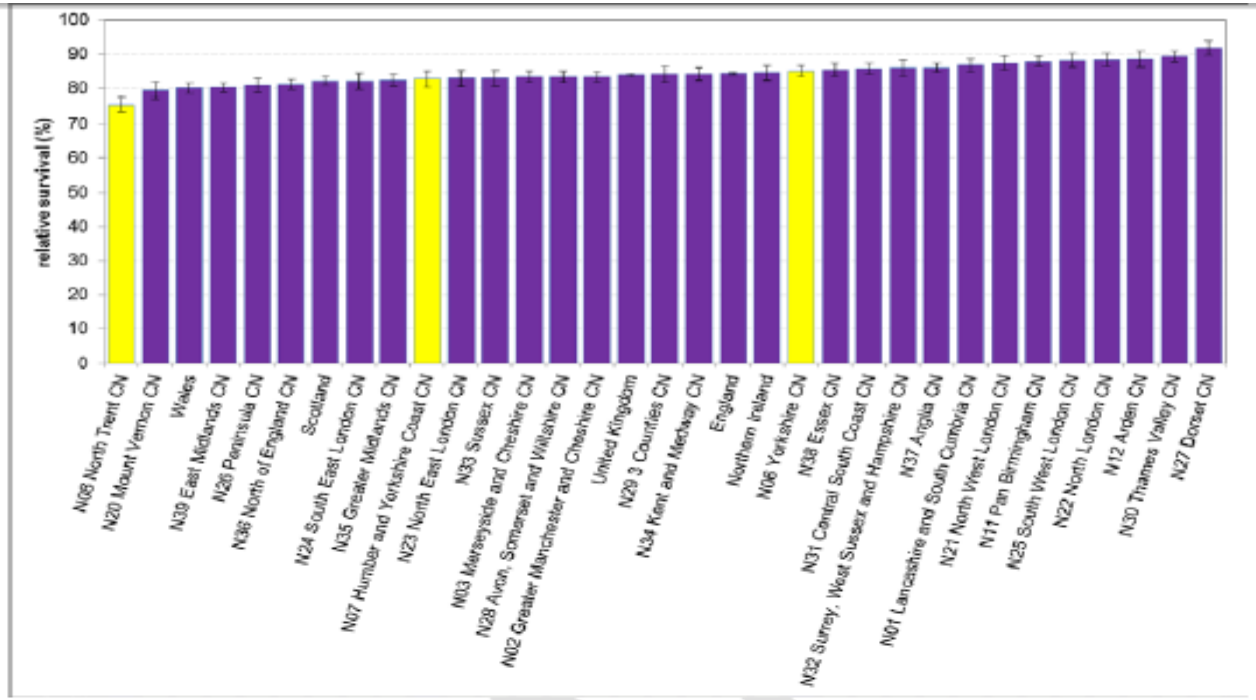
- On DRE if prostate feels malignant [new 2015]
- PSA levels are above age-specific reference age ranges

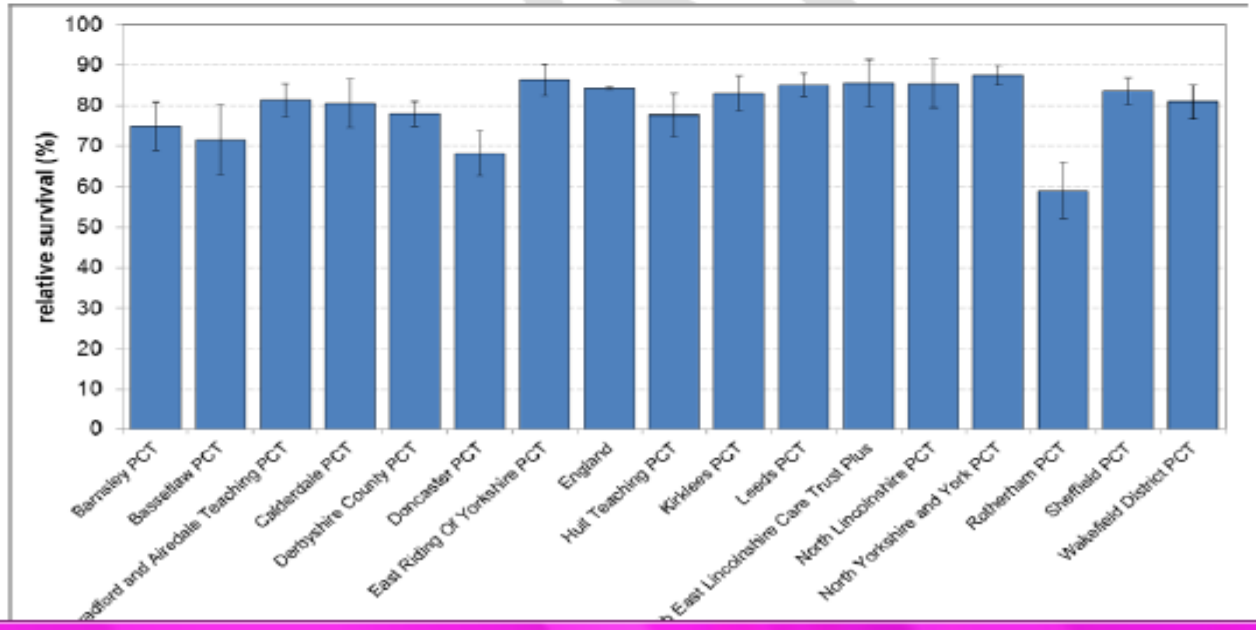
- Consider a PSA test and DRE in men with
- LUTS, nocturia, frequency, hesistancy, urgency, ROU
- Erectile dysfunction
- Visible haematuria [new 2015]

# Prostate cancer

- Common cancer, 35,000 new diagnoses per yr (UK)
- Very uncommon in <50 yr men (with no FH)
- Very common in men >80yr
- Increased risk with in Afro-Carribean men
- Increased risk with family history

- Comparable to local PCT's we have high mortality


relative survival (%)
100
90
80
70
60
50
40
30
20
10
0
N08 North Trent CN
N20 Mount Vernon CN
Wales
N39 East Midlands CN
N26 Peninsula CN
N36 North of England CN
Scotland
N24 South East London CN
N35 Greater Midlands CN
N07 Humber and Yorkshire Coast CN
N23 North East London CN
N33 Sussex CN
N03 Merseyside and Cheshire CN
N28 Avon, Somerset and Wiltshire CN
N02 Greater Manchester and Cheshire CN
United Kingdom
N29 3 Counties CN
N34 Kent and Medway CN
England
Northern Ireland
N06 Yorkshire CN
N38 Essex CN
N31 Central South Coast CN
N32 Surrey, West Sussex and Hampshire CN
N37 Anglia CN
N01 Lancashire and South Cumbria CN
N21 North West London CN
N11 Pan Birmingham CN
N25 South West London CN
N22 North London CN
N12 Arden CN
N30 Thames Valley CN
N27 Dorset CN


relative survival (%)
100
90
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60
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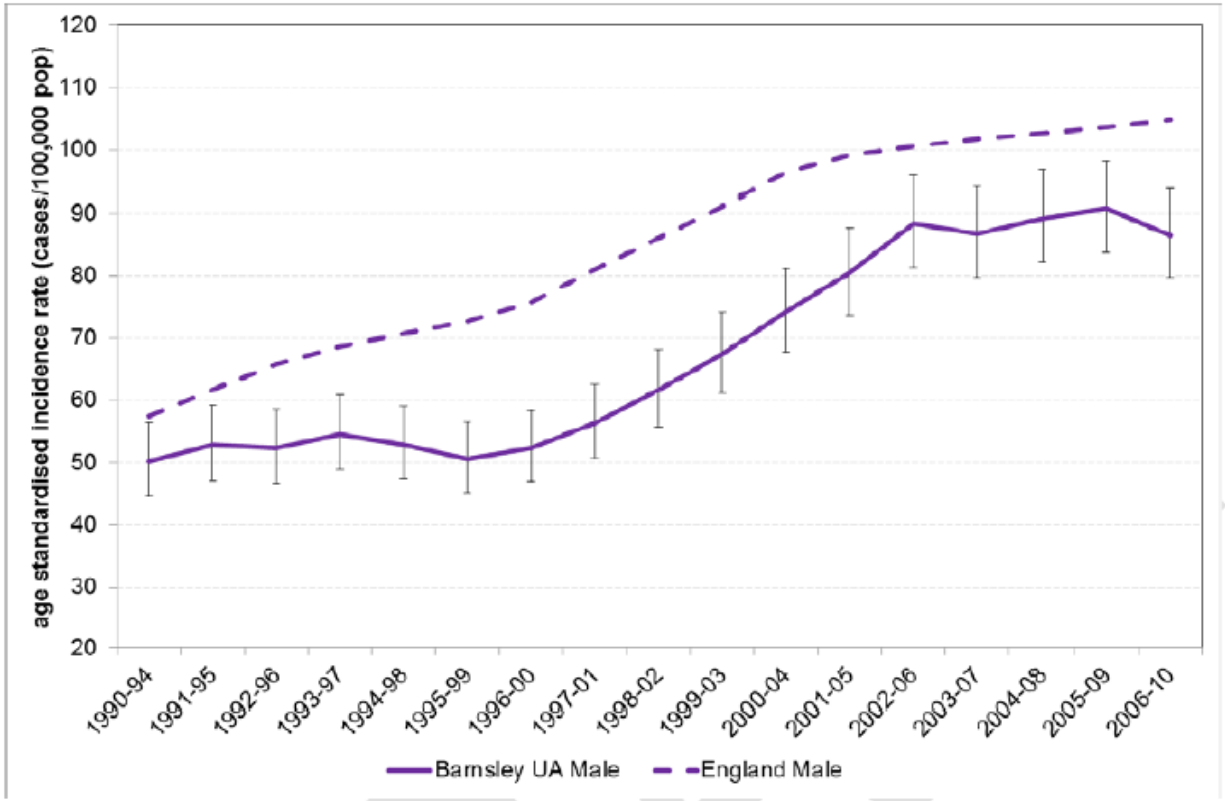
40
30
20
10
0
Barnsley PCT
Bassetlaw PCT
Bradford and Airedale Teaching PCT
Calderdale PCT
Derbyshire County PCT
Doncaster PCT
East Riding Of Yorkshire PCT
England
Hull Teaching PCT
Kirklees PCT
Leeds PCT
North Lincolnshire PCT
North Yorkshire and York PCT
Rotherham PCT
Sheffield PCT
Wakefield District PCT

# 1 Incidence

## 1.1 Barnsley Health & Wellbeing Board

### 1.1.1 Barnsley LA

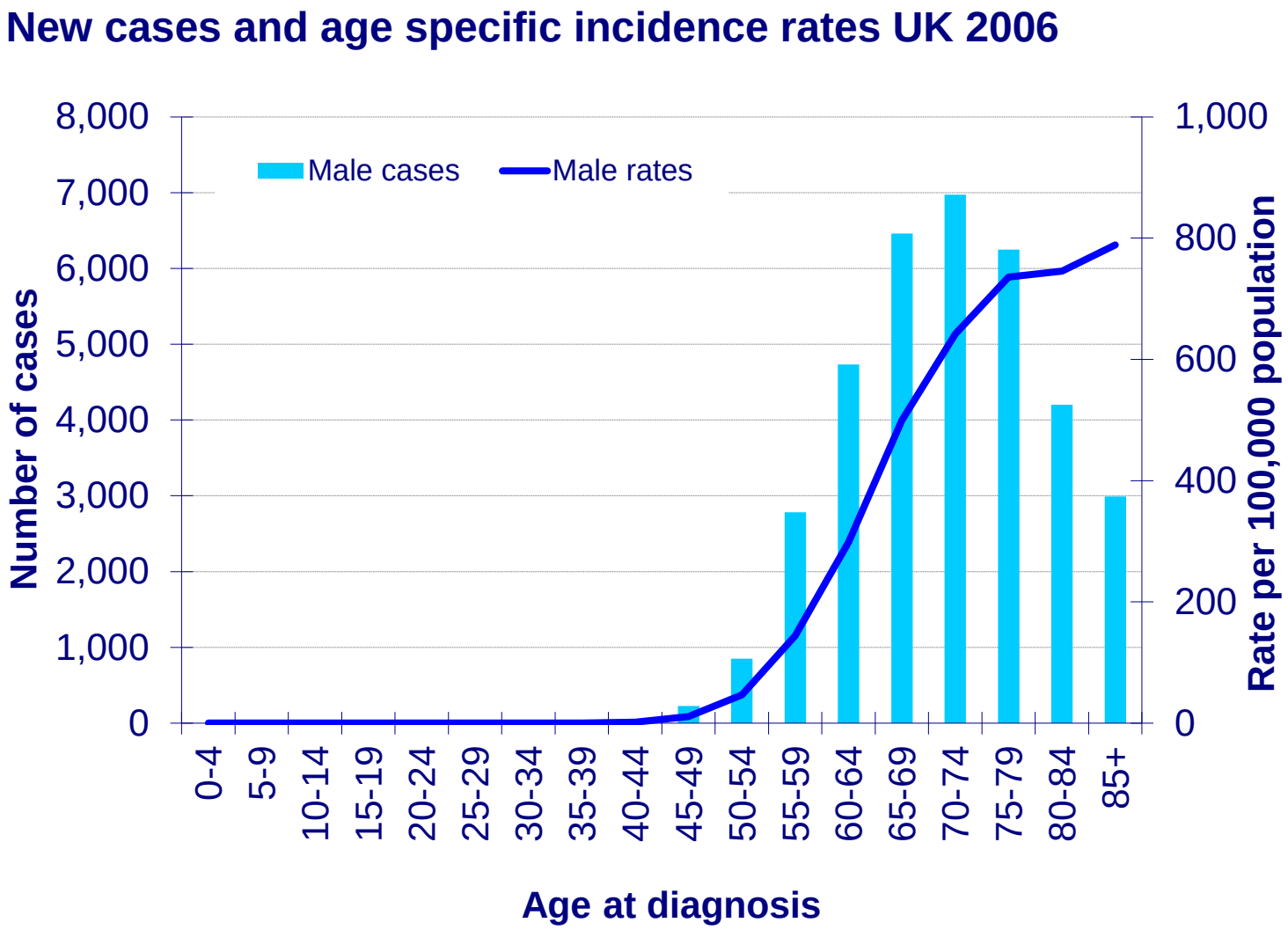


# Counselling. Decision to test.

- No evidence to screen general male population

- Screen those with Family history, Afro-Caribean men (50-70). What is family history ?
- BAUS/NICE advise consider PSA test in urologically symptomatic men
- Asymptomatic men offer counselling, but no general offer to test
- Vast difference in No's of PSA testing per GP

# The incidence of prostate cancer increases with age

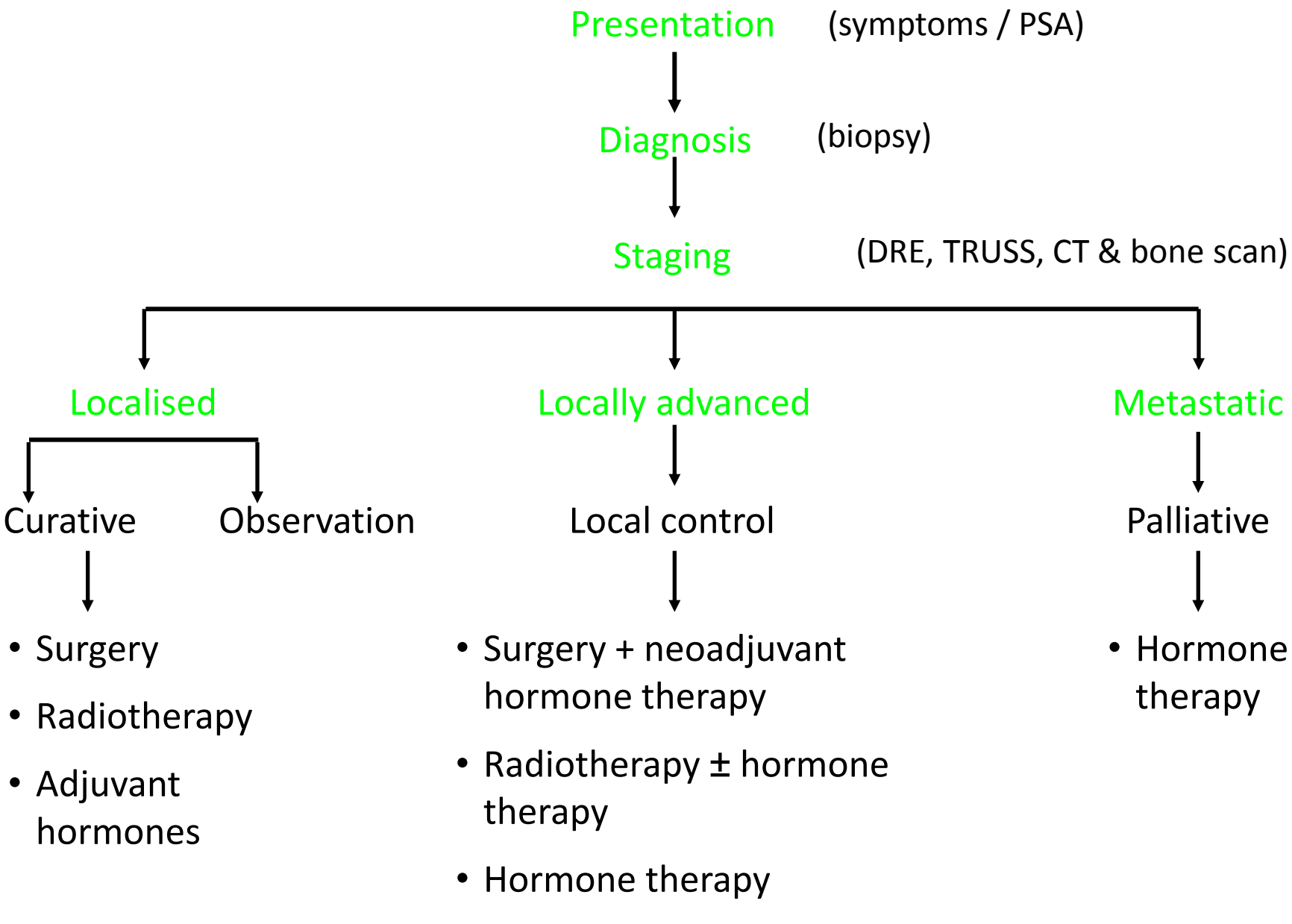


# Facts:

- 2/3 of men with raised PSA will not have cancer
- A normal PSA level does not exclude cancer
- If PSA persistently raised after first negative biopsy then advice will be a second biopsy
- True screening TRUS & biopsy/perineal biopsy
- Increasing evidence of diagnostic MRI scanning

- If localised prostate cancer found then treatment decisions include: active surveillance, surgery, DXT.

# Prostate Cancer



# Should I have a PSA test-benefits

- Reassurance if test is normal
- May find cancer before symptoms occur
- Earlier found cancer maybe low stage and allow curative treatments
- If treatments successful then may avoid symptoms and possibly death
- Even if cancer is advanced then treatment may extend life

# Limitations

- Can miss cancer and provide false reassurance
- May lead to unnecessary worry and further medical tests when no cancer present
- Will struggle to tell difference between slow-growing and aggressive cancers
- May make you worried about slow growing cancer that may never cause symptoms or shorten life
- 48 men will need to undergo treatment in order to save one life

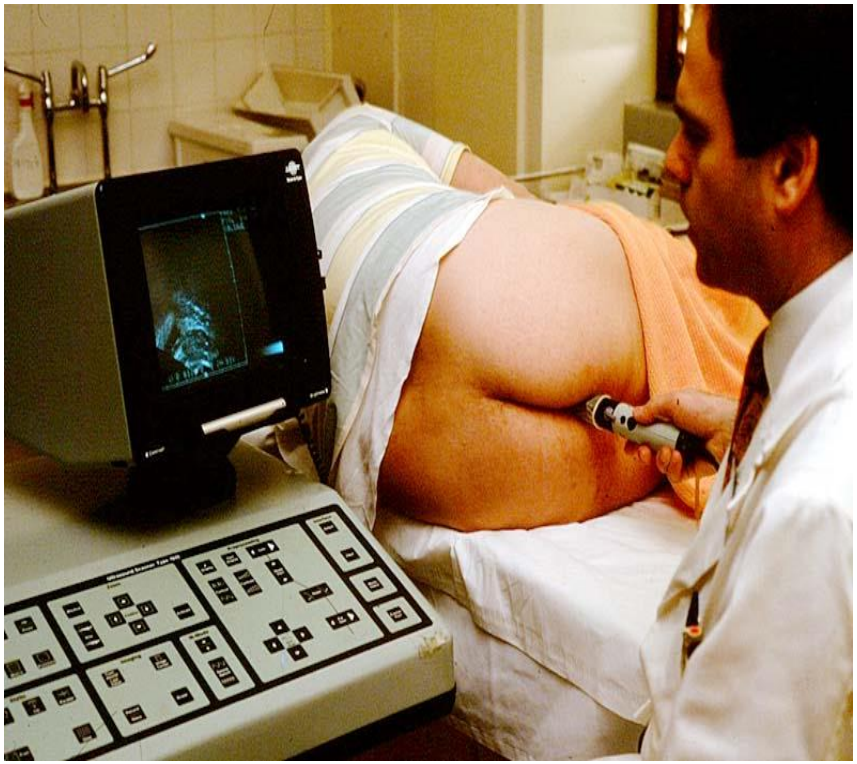
# PSA testing: avoid -

- Active UTI, postpone PSA for 1 month
- Ejaculation in previous 48 hours
- Heavy exercise in last 48 hours
- Lower GI endoscopy, previous prostate biopsy in last 6 weeks
- Vigorous DRE in last week

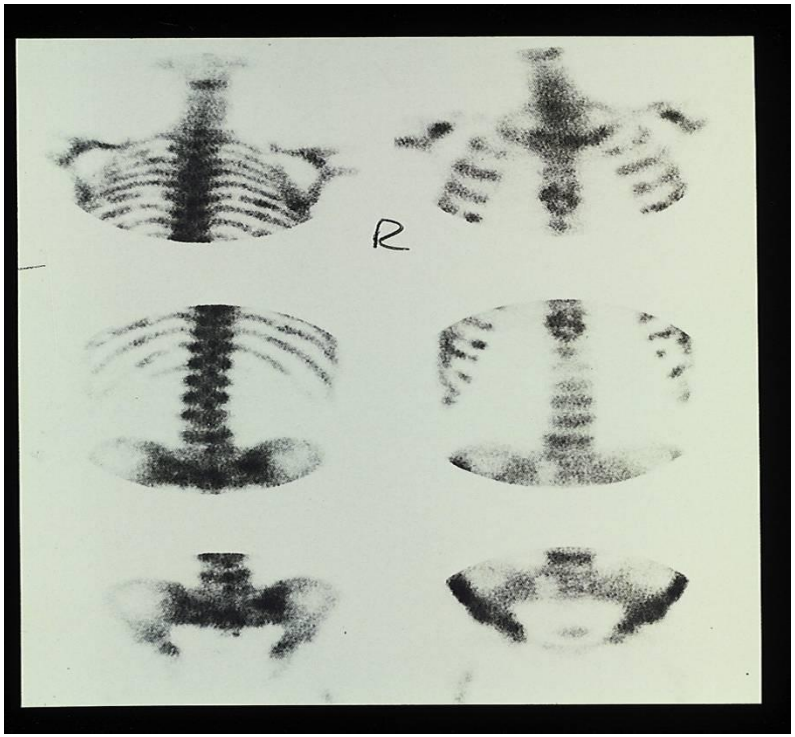
- Patient who is not aware that TRUS biopsy to follow and difficult treatment decisions if positive

# Questions ?

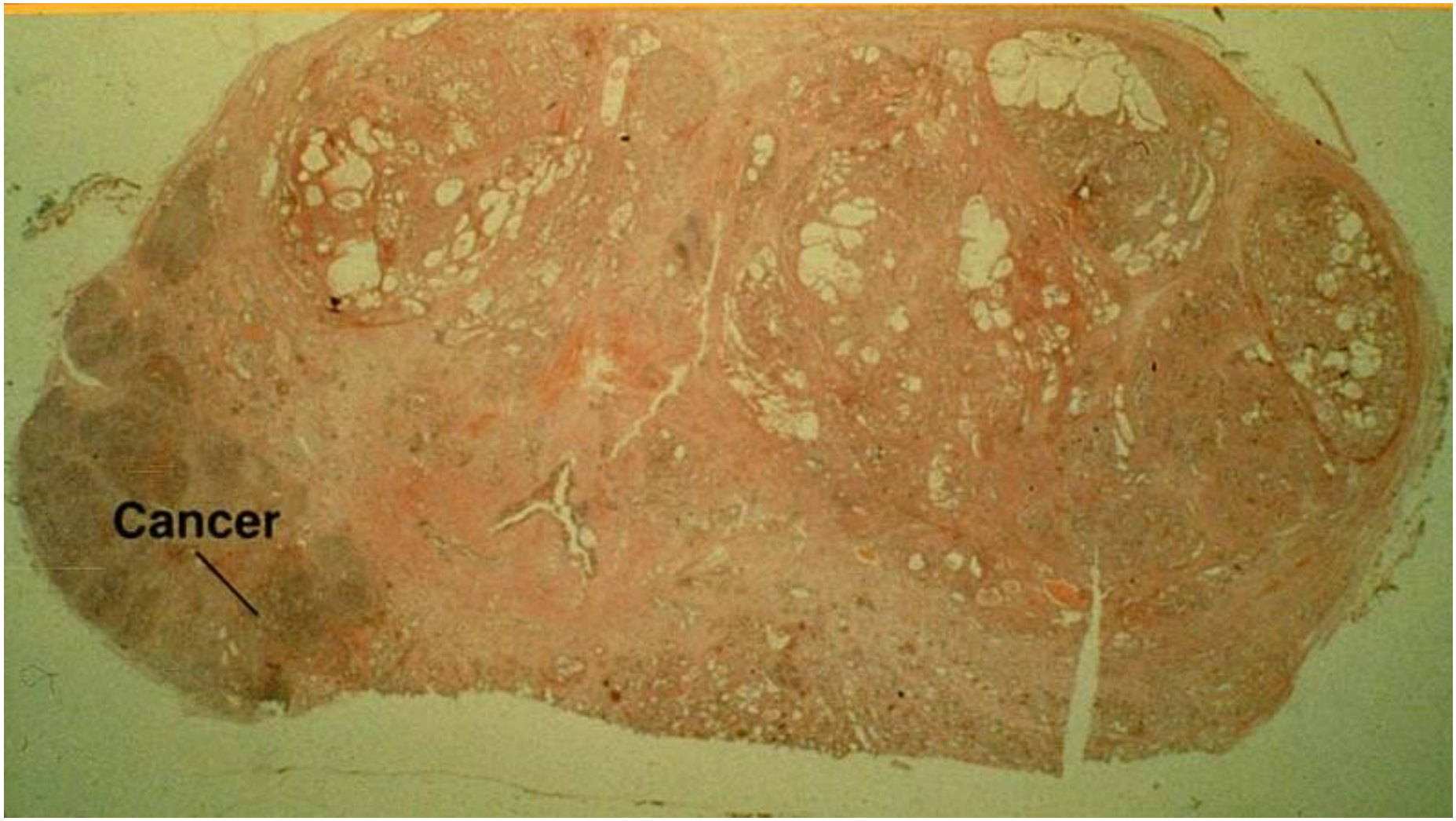
**TRUS bx or MRI ?**



**Avoid metastatic disease ?**

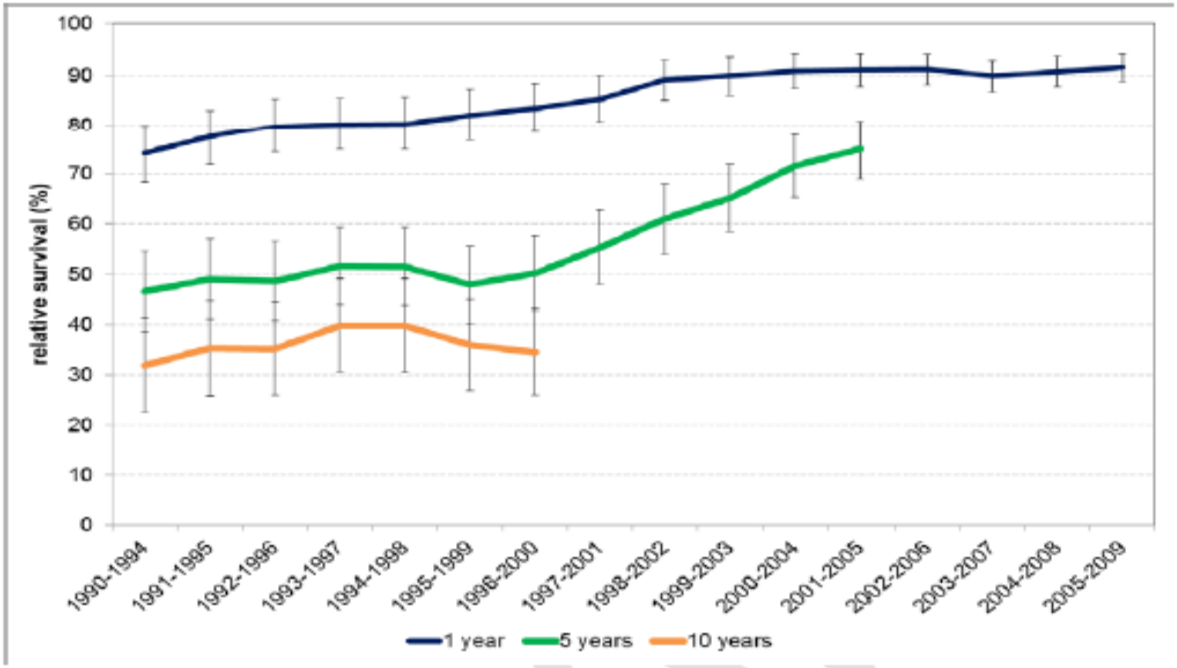


# Prostate Cancer - Diagnosis and Treatment

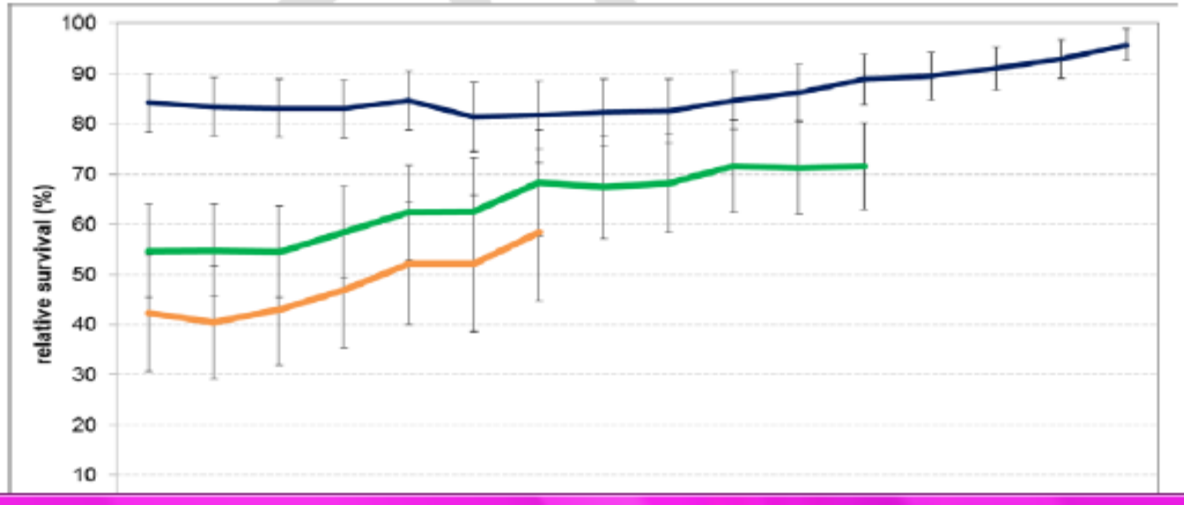


## 7.6 1, 5 and 10 year survival by PCT

### 7.6.1 Barnsley PCT



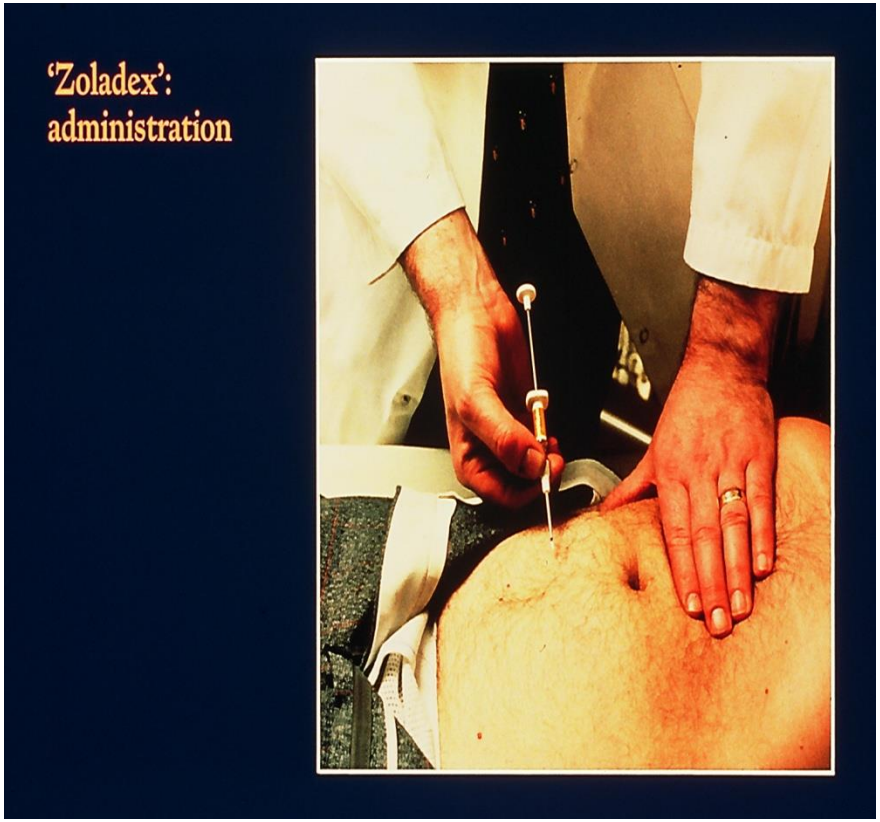

### 7.6.2 Bassetlaw PCT



# PSA – last word or plea

- Consider reason for test
- Counsel patient

# Zoladex




- Safe
- 3 monthly injection
- Community

- Expensive in long term

# Lower Urinary Tract Symptoms

- Obstructive-flow, hesitancy, poor emptying
- Irritative – urgency, frequency, nocturia, leaks

- Exclude UTI, pharmacy problems, diabetes, excess fluid intake,

- Are symptoms bothersome ? *****
- Counsel re-PSA testing

## Figure 1: Causes of male lower urinary tract symptoms (LUTS)

# Treatment advice

- Reassure over prostate cancer risk
- Simple advice over reduce caffeine, xs fluid intake
- Simple bladder re-training
- Pelvic floor exercise, (post mict dribble – urethral massage)
- Control diabetes
- Avoid poly-pharmacy and timings of drugs

- Will GP counselling be allowed ?

- At initial assessment, offer men with LUTS an assessment of their general medical history to identify possible causes of LUTS, and associated comorbidities. Review current medication, including herbal and over-the-counter medicines, to identify drugs that may be contributing to the problem.

(Selection criteria: A, B, C. Implementation support: W)

- At initial assessment, offer men with LUTS a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE).

(Selection criteria: A, B, C.)

- At initial assessment, ask men with bothersome LUTS to complete a urinary frequency volume chart.

(Selection criteria: B, C. Implementation support: X)

- Refer men for specialist assessment if they have LUTS complicated by recurrent or persistent urinary tract infection, retention, renal impairment that is suspected to be caused by lower urinary tract dysfunction, or suspected urological cancer.

(Selection criteria: A, B. Implementation support: Y)

- Offer men with storage LUTS (particularly urinary incontinence) temporary containment products (for example, pads or collecting devices) to achieve social continence until a diagnosis and management plan have been discussed.

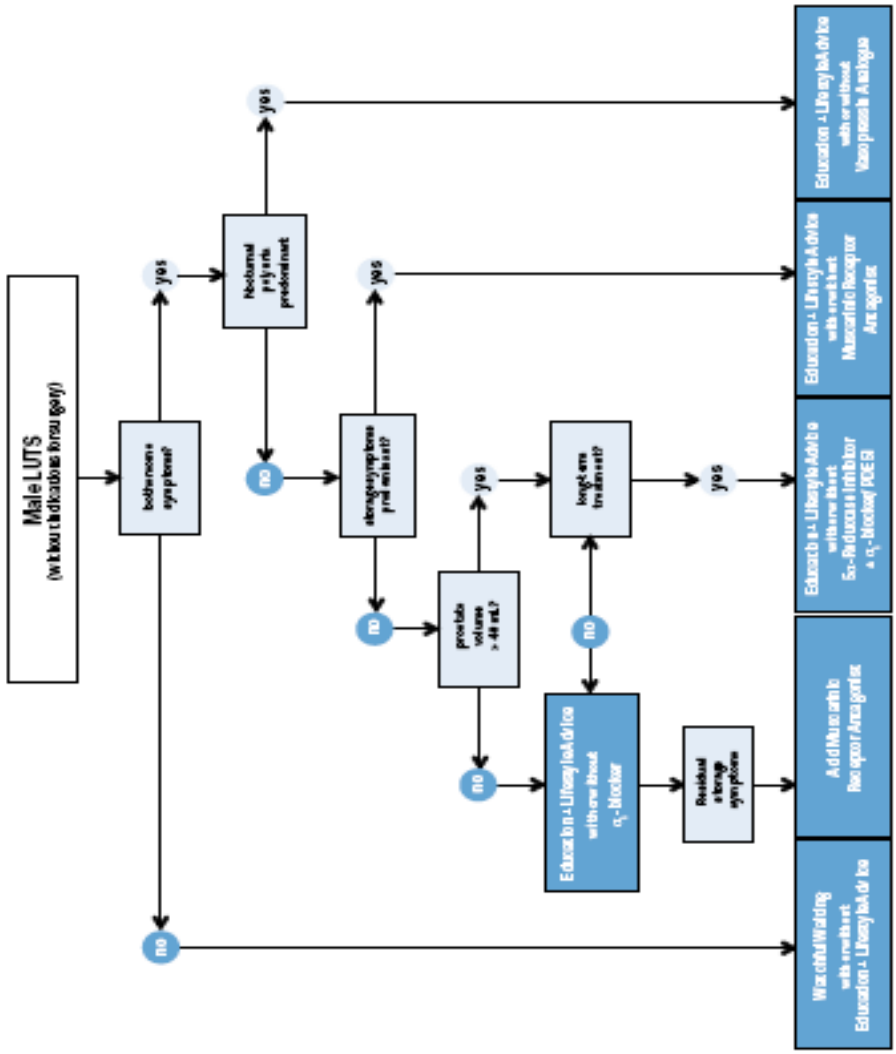
# Pharmaceutical treatment

- Alpha blocker – selective, (or doxasasin) [s/e]
- Anti-cholinergic agents [s/e]
- Combination treatments – Combidart/Vesonmi
- 5 alpha reductase inhibitors
- Combination of all treatments

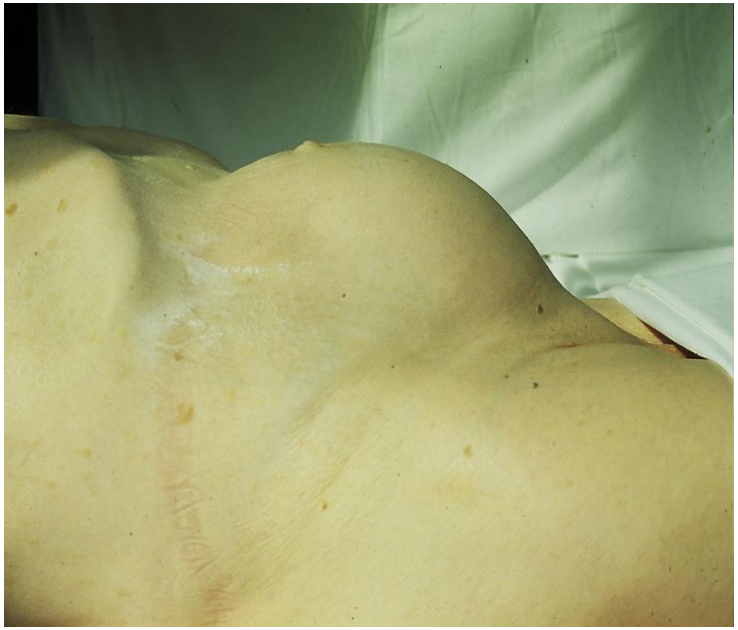
- Conveen, catheter

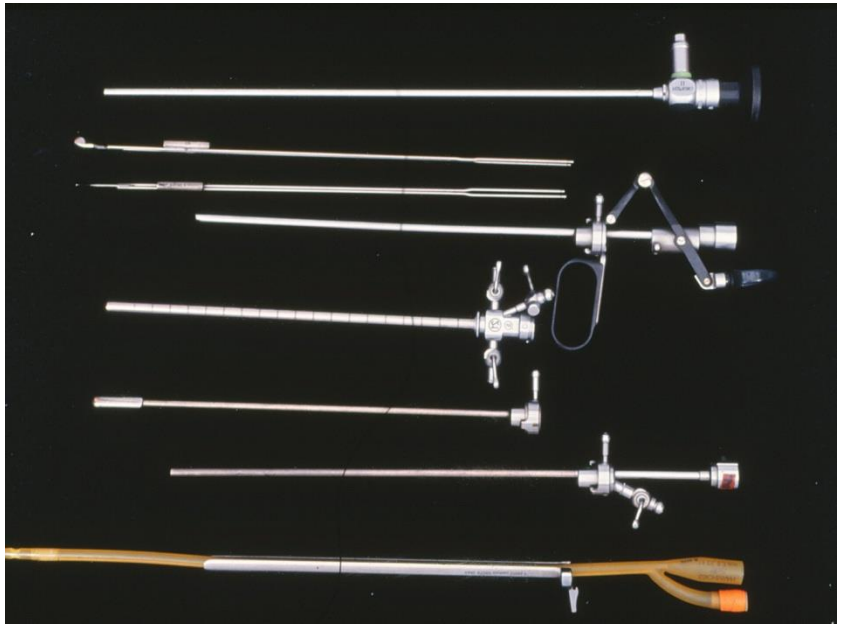
- Urological referral for retention, surgery

**Figure 3: Treatment algorithm of male LUTS using medical and/or conservative treatment options. Treatment decisions depend on results assessed during initial evaluation (◊).The absence ("-") or presence of the condition ("+") are indicated in circles (o).**



# Surgically treatment of BOO.





# Nocturia:

- Difficult
- Multifactorial – cardio-, noct polyuria, OAB, sleeplessness

- Discussion and assess bother ?

- Restrict pm fluid intake
- Warm, relaxed night-time
- Anti-cholinergic
- Diuretic in afternoon
- Desmopressin ???

# Detrusor Instability/Overactive Bladder

- Urgency
- Frequency, small volume voids
- Nocturia
- Urge incontinence

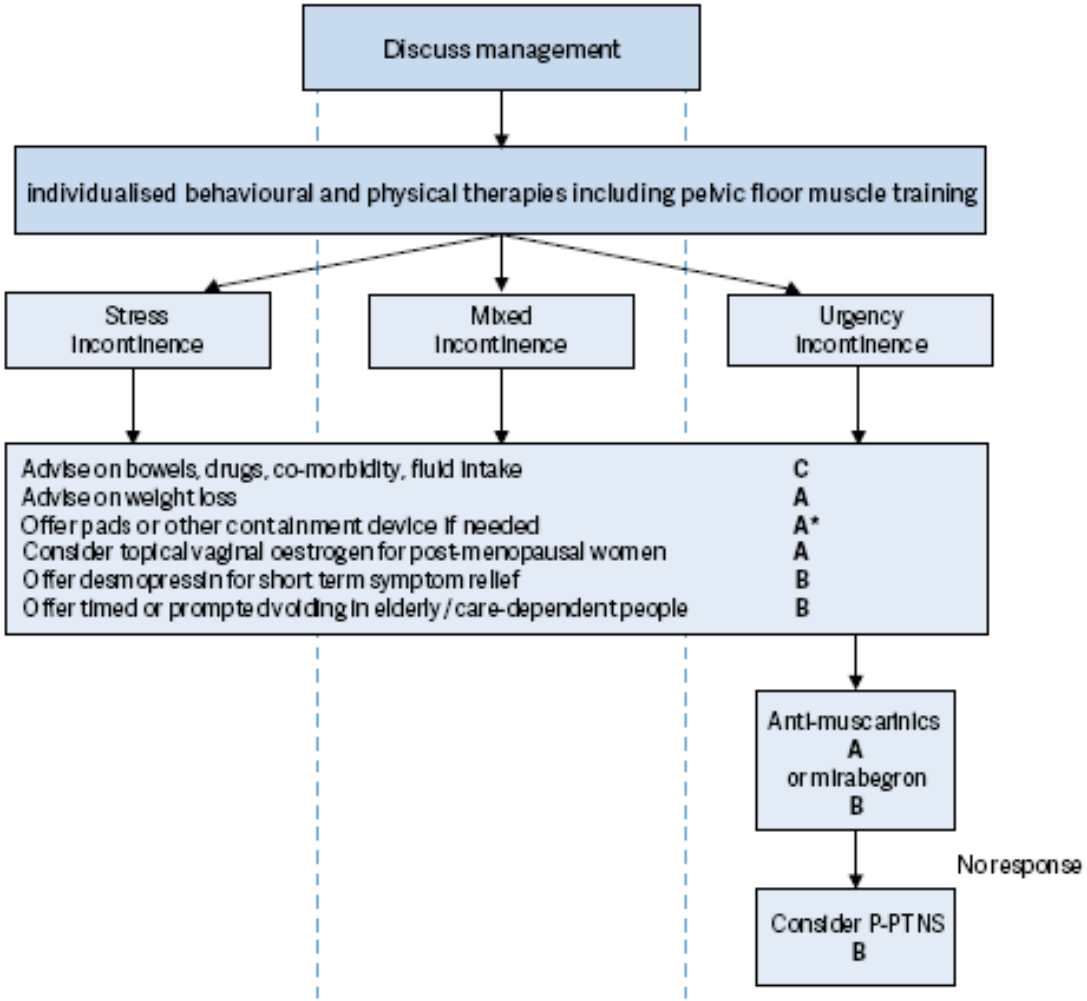
- Any age (increasing incidence in older pop.)
- Consider excess fluid intake, nocturnal polyuria)
- Ketamine !!

# Treatment:

- Thorough explanation of disease (no cure). Variable.

- Mild : fluid intake advice, bladder re-training
- Mod:  bladder re-training with offer of anti-cholinergic
- Severe: trial anti-cholinergic, flexible cystoscopy, and likely urodynamics to confirm

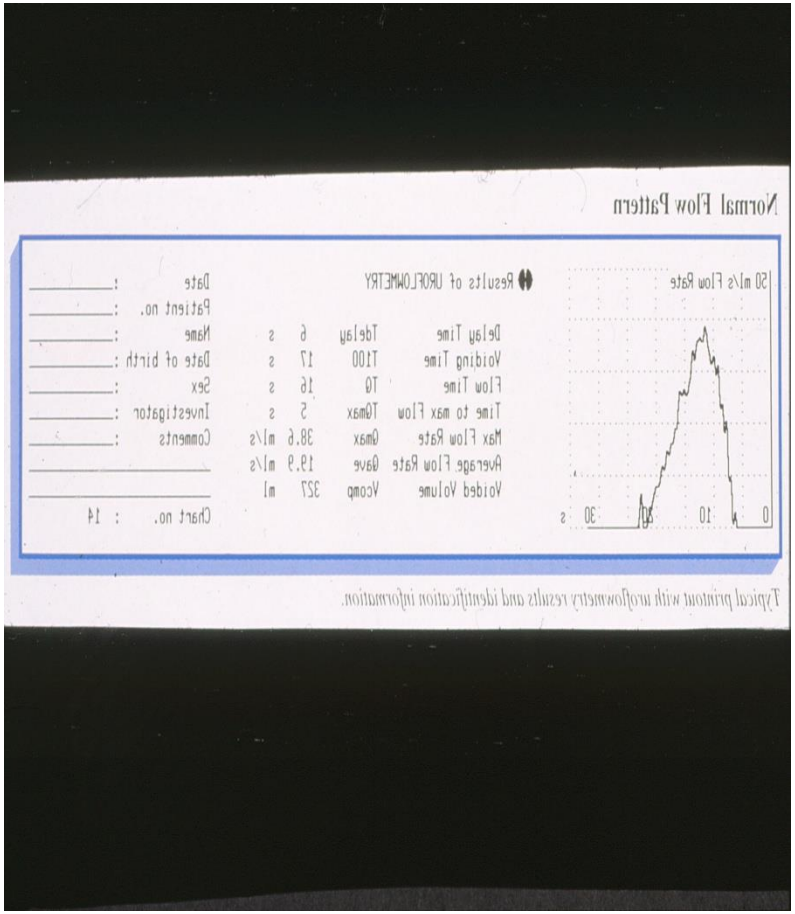
- Combination;  vesicare(solifenacin) and mirabegron
- Consider intra-vesical botulinum (10% retention, and 6-9 months repeat instillation)

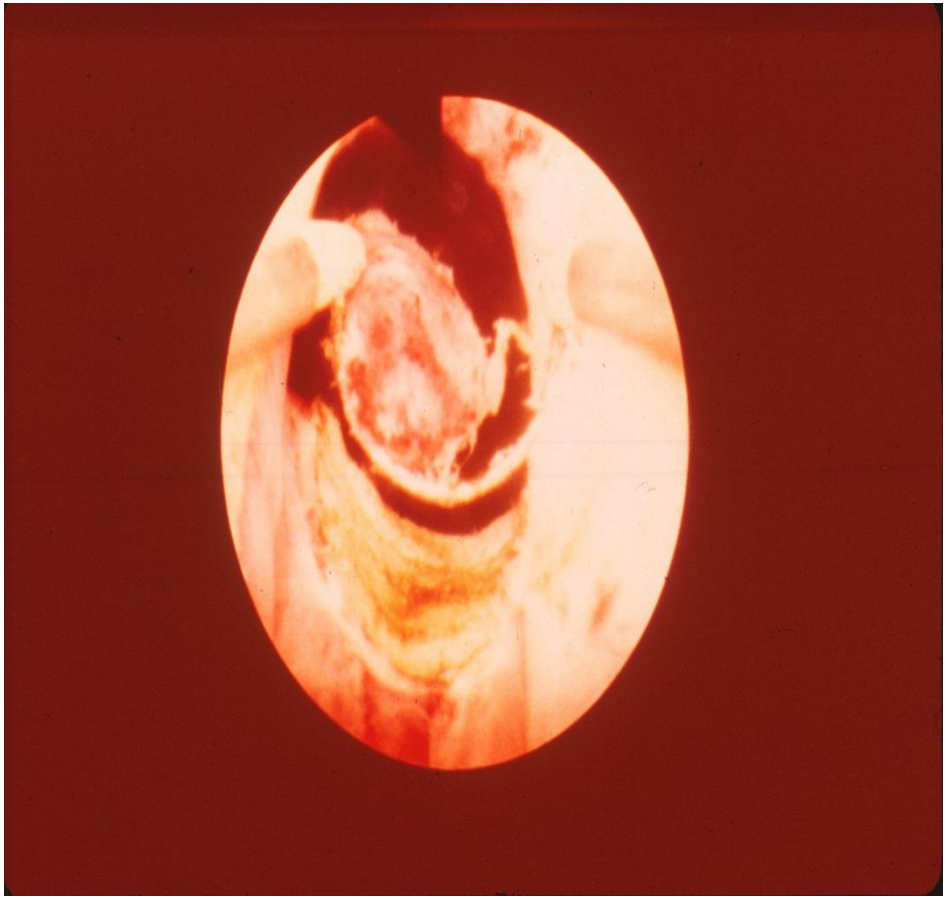



* *Based on expert op opinion.*

continued on page 211

# Any questions?



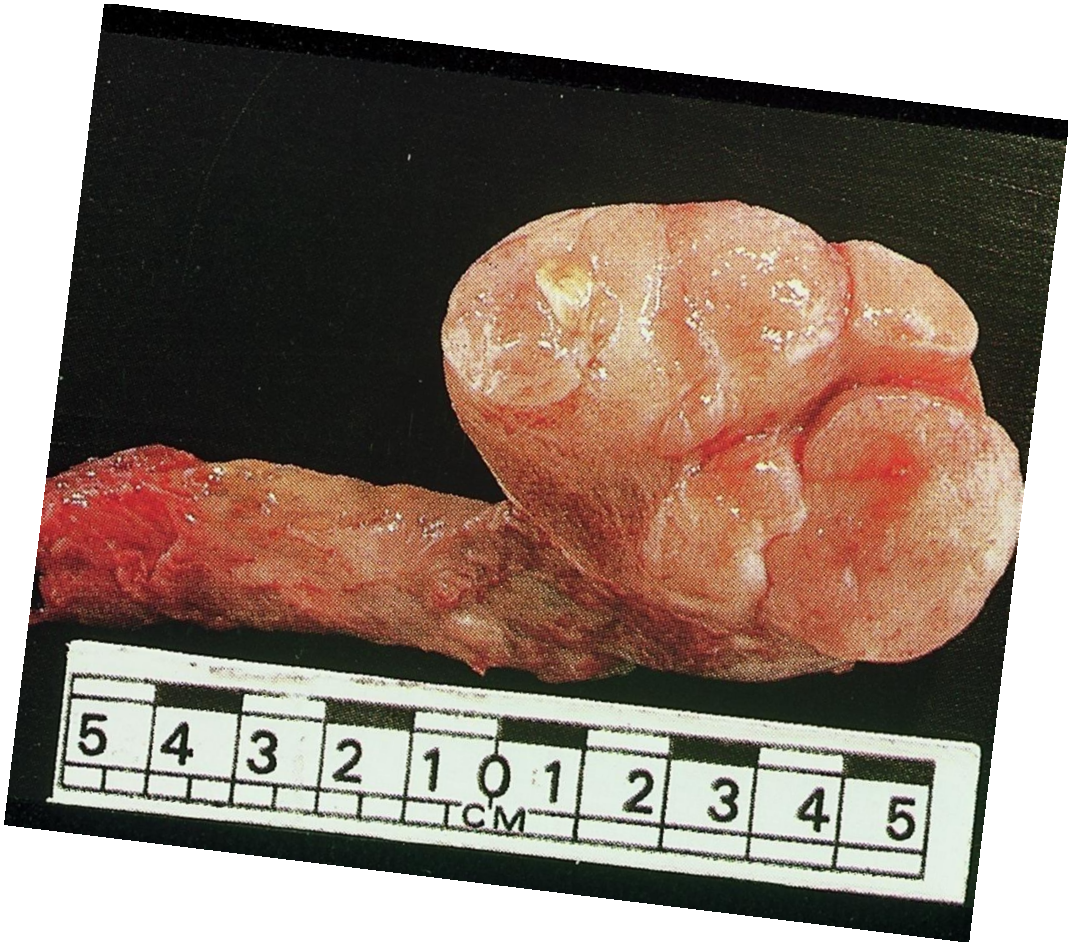



**What is important when examining the scrotum ??**

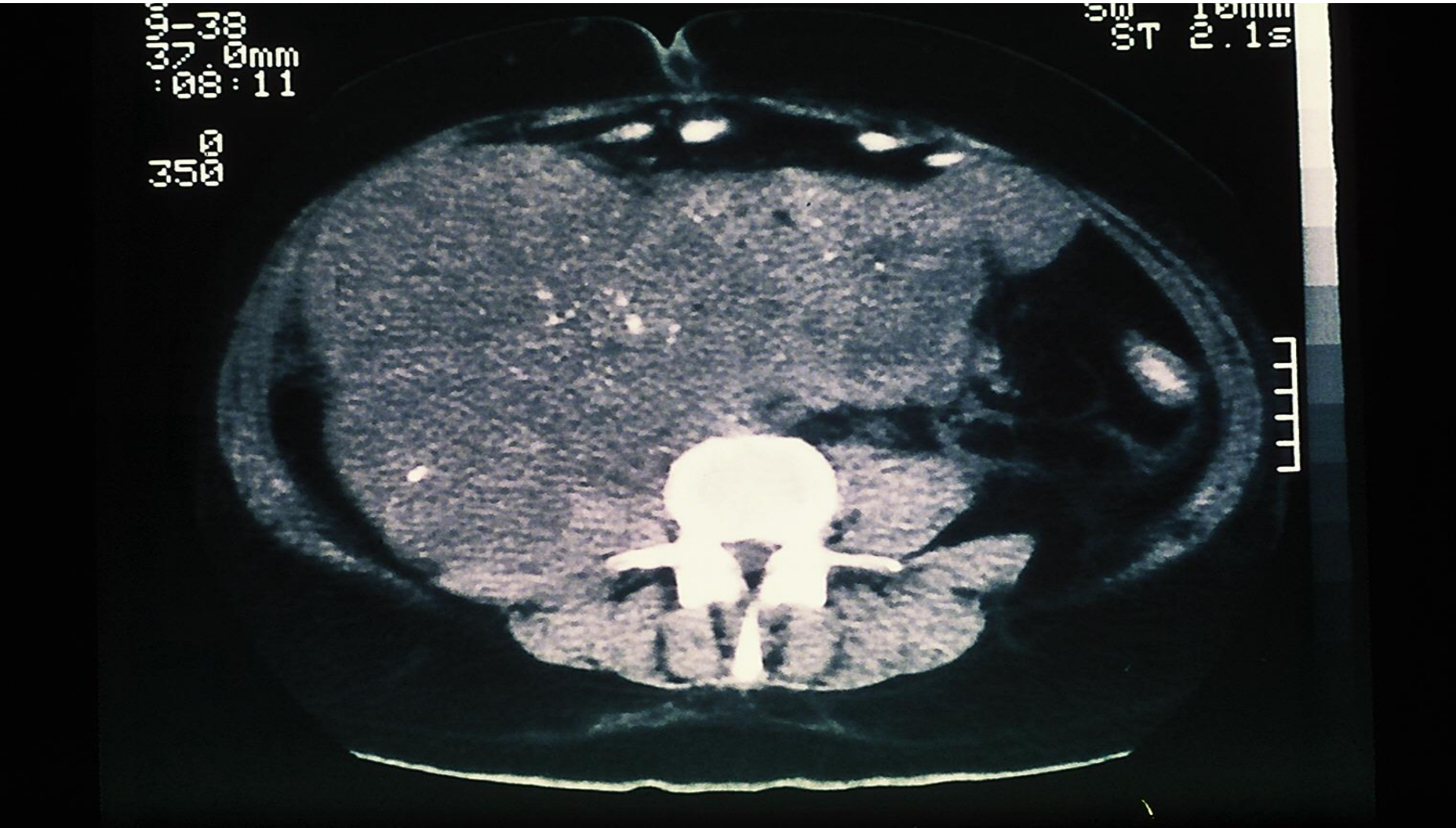
Is the mass in body of testis ?

Is it really in the “ball” ?

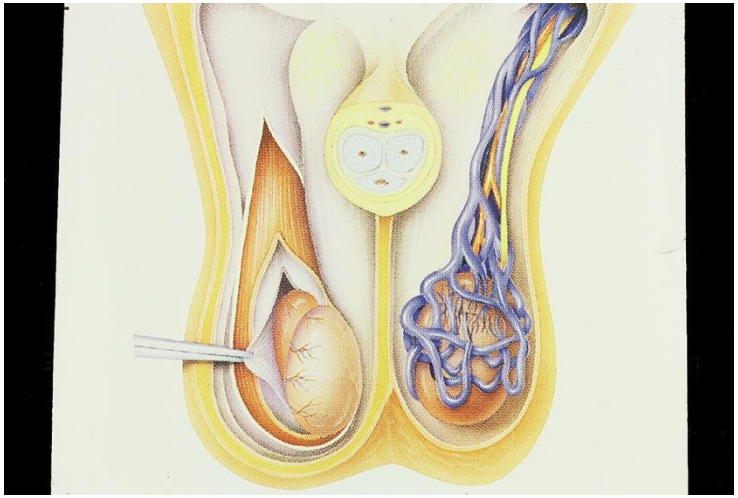
Or can you feel it on the outside ?

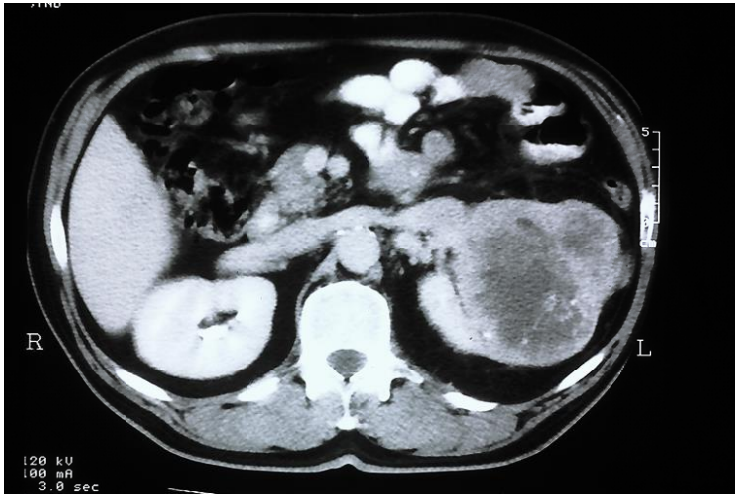


# Diagnosis ?



# Sudden onset varicocoele !





# Questions ?

# Peyronie's disease ?

- Penile ache with erection
- Palpable lump
- Developing penile bend on erection

- Reassure and explain
- Review in 3-6 months
- If penetrative intercourse impossible, consider surgery
- If co-existant ED, then likely penile prosthesis only option

# Haematospermia ?

- What we concerned about ?
- What tests ?
- Treatments ?

# Information

- Joint consensus statement on initial assessment of Haematuria
- NICE guidelines on Haematuria
- NICE guidance CG 175 Prostate cancer 2014
- NICE guideline June 2015 : suspected cancer recognition
- Pulse-Management of dipstick haematuria

- Information sheet – PSA testing for prostate cancer
- PSA testing in asymptomatic men – Prostate cancer risk management programme (information for primary care) www.orderline.dh.gov.uk
- www.BSSM.org.uk