Conditions including

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**Haematuria**

**Evaluation**

- History and clinical examination
- Painful or painless
- May be associated with urinary symptoms or UTI
- Smoking or occupational history - urological history eg. Previous TURP, etc
- Exclude menstrual contamination

**Indications for specialist referral**

- ED presentations
- Ongoing heavy haematuria
- Light, microscopic or heavy haematuria that has settled

**Referral information required**

- Please include all of the general referral criteria listed on page 1
- History and examination
- MSU, U+E, Urine cytology, FBC, U&Es
- Upper tract imaging
- CT urogram or ultrasound if renal dysfunction or other contra-indication to contrast, or under 40 years old
Lower urinary tract symptoms in men

Evaluation

- Voiding: poor flow, straining, sensation of incomplete emptying
- Storage - frequency, urgency, nocturia
- Previous urological intervention
- Fluid/caffeine intake

Indications for specialist referral

- Severe symptoms
- Failed medical therapy (documented)
- Evidence of retention (acute or chronic)
- Abnormalities detected of ultrasound or cytology such as calculi or bladder tumour

Referral information required

- Please include all of the general referral criteria listed on page 1
- History and examination
- Urine dipstick and formal MSU if abnormal
- U+E, FBE, PSA if age >40 (and no evidence of current UTI)
- Renal tract ultrasound including post void residue and prostate size estimation
- Examination - DRE and external genitalia. Exclude palpable bladder and severe phimosis
Recurrent urinary tract infection

Evaluation
- History and examination
- 24 hour bladder diary

Considerations for GP/Primary care management
- Treat current UTI
- If relapsing infection treat with appropriate antibiotic for 6 weeks

Indications for specialist referral
- 3 or more episodes in females
- Males should be offered investigation after a single episode

Referral information required
- Document any bacterial growth and sensitivities - in clean catch specimens (<10 epithelials per high powered field)
- Renal tract ultrasound with post void residue
- U+E, fasting blood glucose, urine MCS
- 24 hour bladder diary

Do not measure PSA during or until approx 4 weeks after a UTI as likely to give false elevation
Elevated PSA

Evaluation

- History and examination, including digital rectal exam
- Exclude UTI as cause of false positive
- Identify and treat UTI
- Repeat PSA minimum 4 weeks apart if elevated

Indications for specialist referral

- Refer any true elevation in PSA
- Refer if evidence of false elevation due to UTI

Referral information required

- Copy of PSA results - including all previous results
- U+E, urine MSU
- Ultrasound renal tract
- DRE for prostatic nodules
- Consider use of free/total ratios if between 4-10 mg/L
- Previous PSA history
- Family history
Renal Mass

Evaluation

- May range from benign cyst to complex cyst or solid mass

Indications for specialist referral

- Any lesions should be referred other than benign cysts

Referral information required

- Ultrasound kidney/bladder - benign cysts clearly reported as such need no further investigation
- If identified on u/s - triple phase CT kidneys should be requested ahead of the referral to accurately assess any lesion not clearly a simple cyst of ultrasound
- U+E, LFTs, FBC, urine MCS, urine cystology

If renal mass identified on ultrasound
- eLFTs, FBC, MSU for mcs, CXR PA, Ct abdomen and pelvis - with and without contrast
Ureteric colic/stones

Evaluation

- Stones may be present as ureteric colic with severe pain and haematuria
- Or as renal stones diagnosed on imaging after pain, UTI or as incidental finding

Considerations for GP/Primary care management

- Renal stones identified on imaging with mild or no symptoms
- Request urine collection urine MCS
- Colic that has settled and stone in distal ureter < 5mm on CT -> conservative management and consider medical therapy with alpha blocker eg. Flomaxtra or prazosin to aid expulsion - must demonstrate passage of stone with collection or lucent imaging even if asymptomatic
- High fluid intake is likely to increase pain and does not aid expulsion

Indications for specialist referral

- Pain or infection. Presence of either symptoms with obstructive stone on scan necessitates Emergency presentation

Referral information required

- U+E, FBE, MSU for m/c/s, CMP (calcium, magnesium, phosphorus)
- CT KUB and xray KUB, ultrasound and xray if female of child bearing age. CT only if associated hydronephrosis

‘Red flag’ items

- Refer to Emergency if severe pain due to ureteric colic
Male genitalia

Indications for specialist referral

- Acute scrotal pain
- Chronic scrotal pain
- Scrotal lump/swelling
- Phimosis
- Penile lesions
- Penile discharge

Referral information required

Scrotal pain/lump/swelling
- Scrotal ultrasound
- MSU for m/c/s
- If solid testicular mass HCG, aFP and ELFTs

Phimosis
- Be wary of underlying squamous cell carcinoma in older men with phimosis and the onset of symptoms
- Not considered urgent unless causing obstruction (demonstrated as ballooning with vomiting) or suspected underlying tumour

Lesions
- Swab, sexual health history

‘Red flag’ items

- If suspicion of tumour after ultrasound - urgent referral
- Acute pain - refer to Emergency Department
TCC Bladder

Evaluation

- Patient History
- Smoking
- Occupational exposure (hairdressing, textiles, heavy degreasing agents, coal or tar exposure)
- Age
- Sex

Indications for specialist referral

- Painless haematuria
- Loin pain

Referral information required

- eLFTs + FBC
- MSU for m/c/s
- CXR PA
- CT with contrast, CT urogram with delayed phase

‘Red flag’ items

- Bilateral uteric obstruction
Testicular Tumour

Considerations for GP/Primary care management

- Direct contact with Urology Registrar or call to ensure review within days of diagnosis

Indications for specialist referral

- Any suspicion of solid lesion in testis or retroperitoneal nodes consistent with diagnosis

Referral information required

- FBC, eLFTs, MSU for m/c/s
- Ultrasound testes
- Contrast CT
- Chest xray
- LDH, Afp (fetoprotein) beta HCG