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SPA PCP Treatment & Referral Guidelines

Urology

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I. Acute Scrotal Pain

- A) Diagnosis
 - a) epididymitis vs. testicular torsion
 - b) urinalysis
 - c) doppler ultrasound
- B) Indication for Referral
 - a) if torsion suspected

II. Benign Prostatic Hypertrophy

- A) Diagnosis
 - a) obstructive urinary symptoms
 - b) U/A, PSA, creatinine, AUA BPH score
 - c) no imaging needed
- B) Treatment
 - a) a blocker (check PSA first)
 - b) Proscar drops PSA 50%.
- C) Indications for Referral
 - a) obstructive symptoms not controlled with oral medicine
 - b) persistent hematuria
 - c) recurrent urinary tract infection
 - d) acute or chronic urinary retention
 - e) suspicious prostate nodule on DRE
 - f) elevated creatinine with hydronephrosis

III. Erectile Dysfunction

- A) Diagnosis
 - a) medications account for 25% of cases
 - b) organic causes
 - c) CBC, U/A, glucose, lipids, serum testosterone.
 - d) no imaging needed
- B) Treatment
 - a) change in medication
 - b) testosterone if hypogonadism
 - c) c) Viagra (only works if testosterone is normal)
- C) Indications for Referral
 - a) if no easily correctable cause found and Viagra was ineffective
 - b) counseling for psychological issues

IV. Prostate Cancer

A) Diagnosis

- a) asymptomatic
- b) DRE on annual basis for men over 40 who are at increased risk of CA prostate (family history and African-American males). All men to be examined yearly after 50.

B) Medicare pays for PSA screen now

- a) P.S.A. – free PSA (if PSA between 4.0 – 10.0)
 - 1) if > 25%: low likelihood of Prostate CA
 - 2) if < 10%: high likelihood of Prostate CA
- b) Recommendation of both American Urological Association (do PSA on all men over 50) & American College of Physicians (discuss with all men over 50, pros / cons of doing the test)
- c) If patient has prostate CA, DRE can increase PSA levels

C) Treatment

- a) if suspicion of CA Prostate, patient should be referred to urology

D) Indications for referral

- a) suspicious nodule on DRE
- b) elevated PSA (taking into account patient's age)

Age	PSA should be
40-50	2
50-60	3
60-70	4
	5

- c) 30% of patients with Prostate CA have normal PSA
- d) If patient >80, do only DRE;
 - 1) if normal DRE: no PSA
 - 2) if abnormal DRE: check PSA

V. Prostatitis

A) Diagnosis

- a) main causes: residual urine, urethral strictures
- b) systemic symptoms-- (if fever +, treat for 6 weeks)
- c) urinary symptoms
- d) U/A and C/S
- e) no imaging needed

B) Treatment

- a) antibiotic therapy

C) Referral

- a) recurrent episodes not controlled with oral medicine

- b) persistent hematuria
- c) suspicious prostate nodule

VI. Pyelonephritis

A) Diagnosis

- a) systemic symptoms
- b) urinary symptoms
- c) U/A and C/S
- d) if complicated, needs I.V.P.

B) Treatment

- a) antibiotics
- b) if systemic symptoms treat 10 days with regular high dose and 1 more month with Macrochantin in females and Bactrim in males.

C) Referral

- a) obstruction or vesico ureteral reflux

VII. Renal Colic

A) Diagnosis

- a) flank pain
- b) U/A and C/S
- c) BUN, creat all the time prior to I.V.P.
- d) non-contrast CT (NOT ultrasound) and KUB (to see the stone if radiopaque).

B) Treatment

- a) pain meds, fluids

C) Referral

- a) concomitant infection and obstruction is an absolute emergency
- b) persistent high-grade obstruction
- c) referral for non-obstructive stones >5 mm in kidney

VIII. Scrotal Mass

A) Diagnosis

- a) testicular mass vs. hydrocele vs. spermatocele vs. varicocele
- b) ultrasound needed if suspicious testicular mass

B) Treatment

- a) scrotal support

C) Referral

- a) if symptomatic, hydrocele, spermatocele, varicocele
- b) testicular mass

IX. Urinary Incontinence

- A) Diagnosis
 - a) stress vs. urgency vs. overflow incontinence
 - b) U/A and C/S ALWAYS check residual urine
- B) Treatment
 - a) anticholinergics in urge incontinence (avoid in men)
- C) Referral
 - a) to R/O neurogenic bladder
 - b) for surgical correction if anatomical cause is found

X. Urinary Tract Infection – Female/Male

- A) Diagnosis
 - a) urinary symptoms
 - b) U/A and C/S
 - c) imaging if complicated infections
- B) Treatment
 - a) antibiotics
- C) Referral
 - a) persistent hematuria
 - b) unsatisfactory response to treatment

XI. Hematuria

- A) Microhematuria
 - a) refer if persisting >3-4 RBC/HPF
 - b) IVP if persisting
 - c) Do not need to do cytology if urine is normal.
- B) Gross hematuria
 - a) refer
- C) Hematospermia
 - a) Treat with antibiotics for 10 days – if recurrence then refers.
(Proscar--prescribed by an urologist)

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Date

Date

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