Women's & Children's Hospital

Paediatric Urology referral guidelines

Contents

Mandatory referral content

Demographic

- child's name
- date of birth
- parent/guardian contact details
- referring GP details
- interpreter requirements

Please include clinical content as appropriate

May include:

- reason for referral
- clinical urgency
- duration of symptoms
- management to date and response to treatment
- relevant pathology and imaging reports
- past medical history
- current medications
- functional status
- family history

Priority

Priority will be based upon the information provided in this referral. They will be triaged by a Paediatric Urology Consultant according to the clinic process and booked accordingly:

Emergency: Proceed to the emergency department

Urgent: We aim to see these patients as soon as possible

Semi-urgent/ routine: Next available appointment. Please note many routine referrals may not be seen at present due to the increasing demand on the service

To help us best triage your referral it may be returned for further investigations if the following process has not been adhered to.

Please note this is a guideline for referral only. If concerned about a patient please contact the Urology Registrar during hours or the General Surgical Registrar out of hours via the Women's and Children's Hospital switchboard on 8161 7000.

Women's & Children's Hospital

Abdominal pain - acute – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history acute - link to general surgery referral guidelines acute abdominal pain chronic > abdominal pain long term > differential diagnosis • constipation • non-specific childhood abdominal pain • urinary tract infection **Investigations** > consider abdominal x-ray > mid-stream urine > stool examinations	Chronic constipation > dietary advice, laxatives, bowel retraining urinary tract infections > see guideline for urinary tract infection > stomach ache fact sheet > constipation fact sheet > constipation easy read fact sheet	**Routine** > refer children with persistent symptoms lasting more than 2 weeks > **If serious pathology is suspected contact on-call urology / general surgery registrar via switchboard 8161 7000**

Genitourinary tract haemorrhage or haematuria – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history Microscopic haematuria > greater than14 RBC/µl in urine microscopy Macroscopic haematuria > visible darkening of the urine > urinalysis positive for blood **Investigations** > check blood pressure and growth > urine tests: • urinalysis with micro • urine culture, protein, creatinine ratio, calcium to urine creatinine ratio > serum tests: • creatinine, U&Es • electrolytes, FBC • for macroscopic haematuria test for serum coags	> perform at least two consecutive urine dipsticks or urinalysis 1-2 days apart > consider renal ultrasound	**Urgent** > recurrent episodes > family history or renal failure > microscopic haematuria in multiple family members > associated symptoms • weight loss, fever, joint pain or rash • poor growth • pain • elevated blood pressure • oedema • elevated serum creatinine/ potassium • red blood cell casts • abnormal renal ultrasound • reduced urine output > **If concerned contact on-call urology / general surgery registrar via switchboard 8161 7000**

Hydronephrosis – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > commonly unilateral > not always caused by obstruction **Congenital** > usually discovered on prenatal ultrasounds **Acquired** > can develop due to urinary reflux or an obstruction > signs depend on the cause and may include: • abdominal, back or flank pain • nausea and vomiting • pain when urinating • frequency of urination • urgency of urination • recurrent UTI • fever • cloudy urine • painful urination • weak urine stream • pain	**Reassurance** > in many children diagnosed prenatally hydronephrosis disappears spontaneously by the time of birth or soon after however close monitoring is recommended **Investigations** > ultrasound	**Urgent** > close assessment and monitoring of enlarged kidneys is required by a paediatric urologist > treatment will depend on the cause

Hypospadias and chordee – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > **chordee** – significant downward curvature and angulation of the penis associated with erection > asymmetry of the foreskin with a normal urethral meatus • this may occur by itself or in-conjunction with a hypospadias > **hypospadias** – birth defect in boys where the urethral opening is not located in the normal position this can be anywhere on the under surface of the penis extending down behind the scrotal sac (see image) > incomplete foreskin forming a hood	> refer to urology department for surgical assessment	**Semi-urgent** > when surgical correction is considered to correct urination function

Penile conditions

Balanitis - pre referral

Please note: the Women's and Children's Hospital does not offer circumcision for social/religious reasons.

Referral for penile conditions when parents actually want elective circumcision will also result in unhappiness as they will wait for an appointment and be refused an operation.

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination > condition affects boys older than 3years of age > foreskin may have a white scarred appearance and or be swollen or oedematous	**Reassurance** > infection requires treatment with oral antibiotics and surgery if recurrent	**Routine** > recurrent infective balanitis > clinical indication for circumcision

Foreskin adhesions / smegma cysts - pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination > many foreskins are fused to the glans and separate by themselves over time. There is no need to retract or be able to retract the foreskin (at least before 7 years of age). > accumulation of smegma under the foreskin is common and normal	> hygiene advice for smegma build up > reassurance	> referral and surgical intervention is not usually required

Paraphimosis - pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination > commonly result from a previous normal foreskin that has been retracted and not been replaced > oedema makes foreskin stuck behind glans	> try to reduce > keep fasted as this is an urgent surgical condition	**Emergency** > if oedematous and unable to replace foreskin > **immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000**

Phimosis - pre referral

Please note: the Women's and Children's Hospital does not offer circumcision for social/religious reasons.

Referral for penile conditions when parents actually want elective circumcision will also result in unhappiness as they will wait for an appointment and be refused an operation.

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination Pathological phimosis > tight foreskin opening	**Reassurance** Pathological phimosis > consider topical creams e.g.1/2 strength betnovate for 2 weeks	**Emergency** > **urinary retention secondary to phimosis requires immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000** **Urgent** > pin hole prepucial orifice with poor urinary stream **Routine** > pathological phimosis • clinical indication for circumcision and failed conservative treatment of creams • inability to retract foreskin in boys older than 7 years of age

Renal and ureteric calculi – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > cramping, intermittent abdominal and flank pain. Often accompanied by haematuria, nausea or vomiting, and malaise; fever and chills may also be present. > stones in the renal pelvis may be asymptomatic. • risk factors for stones • past history of stones and stone surgery • not drinking enough • ketogenic diet • cystic fibrosis • urinary tract abnormalities • some medications • some inherited disorders **Investigations** > non-contrast CT is the only way to diagnose > consider FBC; ELFTs; MSU for MCS, Plain KUB as work up for urology review	> if the stone is small, pain is manageable, and the child is otherwise healthy, it is often possible to treat the stone at home. Stones smaller than 5mm often pass on their own without treatment. > simple non-steroidal analgesia for pain management > advise increase fluid intake > advise family to strain urine for a few days until stone passes and save it in a clean container to enable analysis to guide future treatment > after passing stone consider ultrasound to confirm stone is passed and none further present. **If further stones present contact on-call urology/general surgery registrar via switchboard 8161 7000**	**Emergency** > severe and uncontrolled pain > vomiting > blockage of the urinary tract > **immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000** **Urgent** > known presence of asymptomatic stones > poorly controlled renal or ureteric calculi

Scrotal pathology - acute - pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > age of the child > previous trauma > onset of pain > fever > consider sexual activity > prior genito-urinary surgeries/ known abnormalities **Physical examination** > presence or absence of cremasteric reflex (this is usually absent in torsion of the testes) > observation of gait and resting positioning > transillumination > reducible swelling > palpate and compare the lower abdomen and inguinal area > palpate and compare the scrotum and testes **Investigations** > urinalysis MSU and MCS > blood tests are not used in the acute setting > diagnostic imaging has no role in the management of these conditions	> acute scrotal pain requires an immediate surgical assessment due to the risk of torsion of the testes or strangulation inguinal hernia > infarction may occur within the first 4-12 hours of a torted testis > sometimes a surgical exploration may be the only way to diagnose the condition > keep the child fasted > hydrocele fact sheet	**Emergency** > **immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000** > for any of the following findings: • absence of cremasteric reflex • acute uncontrolled pain • swelling with pain • tender testis • significant trauma • systemically unwell infant or child with fever > these findings could indicate these conditions • testicular torsion • torsion of the appendix • incarcerated inguinal hernia • testicular trauma • epididymoorchitis **Urgent** > testicular mass > **contact on-call urology/general surgery registrar via switchboard 8161 7000** **Semi-urgent / routine** > irreducible swelling > soft, non-tender > transilluminable > normal testis > these findings could indicate these conditions • hydrocele • idiopathic oedema • hernia

Undescended/retractile testes - pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination > diagnostic imaging has no role in the management of undescended testes <u>Retractile testes</u> > testis normal in size that reach the bottom of the scrotum without tension <u>Undescended testes</u> > cannot be manipulated into the bottom of the scrotum by the age of 3 months	> risk of infertility if orchidopexy is delayed > undescended testes fact sheet	**Semi urgent** > refer at 6 months of age if the testes are not fully descended by 3 months – will most likely require surgery > orchidopexy is performed from 9 months of age > retractile testes require a routine referral as a small percentage may become truly undescended overtime

Urinary Incontinence – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > consider the following when performing a clinical history and examination: • daytime accidents • frequency • urgency • straining • pain on urination • if periods of dryness ask about physical, emotional and social triggers • previous treatments • history of constipation > consider medical problems that may contribute to bedwetting (diabetes, UTI, faecal soiling, pin worms, renal failure, seizures, sleep problems etc.)	**Investigations** > bladder diary (input and output frequency) > investigate daytime symptoms before addressing night time enuresis > urinalysis only if symptoms suggestive of diabetes, UTI or constipation **Nocturnal enuresis** > reassurance > manage constipation > education and reassurance consider the following options: • motivational therapy • enuresis alarms • self-awakening • medications - Desmopressin > bedwetting fact sheet > continence foundation website	**Routine** > daytime wetting and nocturnal enuresis • severe daytime symptoms • continual urinary dripping • recurrent UTIs • failed previous treatments • abnormal renal ultrasound (investigation not required for isolated nocturnal enuresis) • any child with a congenital anatomic genitourinary concern

	> parenting SA Bedwetting fact sheet	

Urinary tract infection - recurrent - pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history and physical examination > dysuria, frequency, haematuria, offensive urine > bed wetting > abdominal pain > fever > general malaise > failure to thrive **Investigations** > microscopy followed by culture, MSU for MCS > consider renal and bladder ultrasound to rule out kidney stones and anatomical defects	> prescribe preventative antibiotics for recurring UTIs > education around perineal hygiene, bladder emptying and hydration > UTI in young children fact sheet	**Emergency** > for infants and young children with a high grade fever and confirmed UTI > **immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000** **Urgent** > ultrasound shows anatomical defect such as hydronephrosis see link **Routine** > a child that has a confirmed UTI > three or more reoccurring UTIs > associated elevated blood pressure

Voiding dysfunction – pre referral

Initial pre-referral workup	GP management	Guidelines for specialist referral
Clinical history > may have a neurological condition or spinal injury > may have had recent surgery <u>Underactive bladder/ retention</u> > retention > painful urination > pain in the lower abdomen > bloated lower abdomen <u>Overactive bladder</u> > incontinence > bladder spasm > painful urination > frequent or urgent urination <u>Obstruction</u> > fever > nausea and vomiting > pain in midsection, back or flank > change in urinary habits: > difficulty passing urine > urinary hesitancy, dribbling, slow stream > frequency and urgency > incomplete emptying > intermittent or decreased urine flow > blood in the urine > constipation **Investigations** > exclude constipation > regular urinalysis > bladder diary > bladder scan if available pre and post urination > may consider CT scan to locate any blockages	<u>Obstruction</u> > **referral level dependant on symptoms contact on-call urology/general surgery registrar via switchboard 8161 7000** **Reassurance** > treat constipation > long term oral antibiotics may be considered <u>Underactive bladder</u> > toileting education > scheduled voiding > double voiding > medications may be considered to assist emptying the bladder > catheterisation may be required if patient in urinary retention. **See emergency referral** <u>Overactive bladder</u> > toileting education • delayed voiding • scheduled voiding • bladder exercises • medications may be considered to relax the bladder muscle > continence Foundation website	**Emergency** > if urinary retention present > **immediate referral to emergency department and contact on-call urology/general surgery registrar via switchboard 8161 7000** **Routine** > refer if to urology if neuropathic bladder suspected > surgical procedure is considered to help improve the condition > conditions include: • overactive bladder • incontinence • obstructive bladder

For more information

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