

South East London Urology Adult Primary Care Guidelines

November 2023

Reviewed 2026

Next review due 2028

Table of Contents

1	<u>Haematuria</u>
2	<u>Renal mass and cyst</u>
3	<u>PSA testing</u>
4	<u>Male Lower Urinary Tract Symptoms</u>
5	<u>Prostatitis</u>
6	<u>Erectile Dysfunction</u> (Replaces SEL IMOC guidance 2020-2022)
7	<u>Haematospermia</u>
8	<u>Male infertility</u>
9	<u>Penile deformity</u>
10	<u>Chronic Scrotal Pain</u>
11	<u>Scrotal Lumps and Acute Pain</u>
12	<u>Stones and Colic</u>
13	<u>Female Lower Urinary Tract Symptoms</u> (Replaces SEL IMOC guidance 'Over-active Bladder (OAB) Care Pathway for adults in Primary Care 2017- Feb 2022)
14	<u>Female Recurrent Urinary Tract Infection</u>
15	<u>Pelvic organ Prolapse</u>
16	<u>Catheter Pathway</u>
	<u>Abbreviations</u> and <u>Glossary</u>

Introduction

This guide has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across the South East London (SEL) Urology Network, South East London Integrated Care Board, South East London Primary Care representatives, South East London Integrated Medicines Optimisation Committee (IMOC), and with input from Gynaecology colleagues where relevant (eg for the Urogynaecology Pathways).

All prescribing should be in line with the [SEL Joint Medicines Formulary](#). The guidelines for Erectile dysfunction & Female Urinary Tract Symptoms were originally drawn up in 2023 in conjunction with IMOC and replace previous IMOC guidelines as above.

It is intended to be a guide to assist Primary care colleagues in decision making and does not replace clinical judgement.

We encourage users of this document to seek advice from primary or secondary care colleagues when they are unsure, then later using established communication channels (e.g. Consultant Connect and e-RS Advice SPoA/ A&R)

Authors and Governance

These guidelines have been drawn up with input from a number of clinicians across South East London. Key authors include Mr Rick Popert (Consultant Urologist Guys Hospital & Clinical Lead for the Urology Network), a number of clinical specialists across SEL, Dr Rebecca Holmes (GP & SEL Primary Care Lead for Urology) and Dr Pandu Bilaji (GP).

The guidelines were reviewed and signed off in subspeciality workstream meetings and by the subspeciality clinical lead.

Medicines and prescribing recommendations made within these guidelines have been reviewed and approved by the SEL Integrated Medicines Optimisation Committee (IMOC).

Guidelines have also been circulated to LMC representatives, Planned Care Leads in each borough and all SEL GP's via the bulletin for review and comment.

The guidelines have also been reviewed by the Divisional Governance Committee in each trust as required.

These guidelines have been reviewed 2026 through the APC Urology Network. Key authors for the reviewed guidelines are Dr Amanda Rea, Primary Care Clinical Lead for Urology Network and Mr Majed Shabbir, Secondary Care Clinical Lead for Urology Network

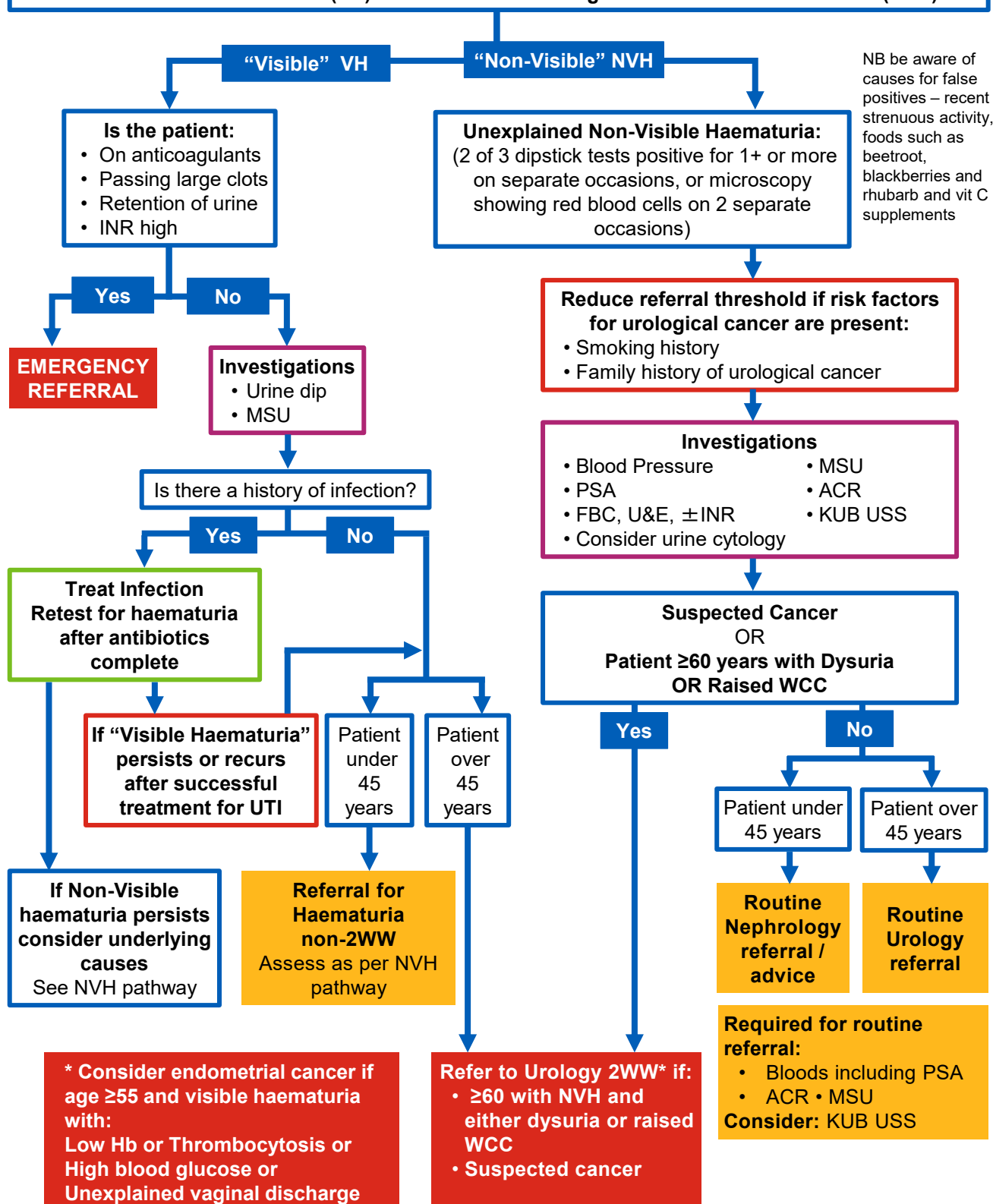
These Urology Guidelines are V3 have been circulated to primary and secondary care colleagues (April/ May 2026) and will be presented to the June IMOC Committee with sign off shortly afterwards. Review date will be 2 years later.

Version	Date signed off	Date of next review
2	November 2023	November 2025
2.1	May 2025	November 2025
3	?June 2026	?Summer 2028

1. Guidelines for Haematuria

For more information see NICE CKS [suspected cancer](#) and [UTI with non/ visible haematuria](#)

Is there “Visible Haematuria” (VH) or an incidental finding of “Non-Visible Haematuria” (NVH)?

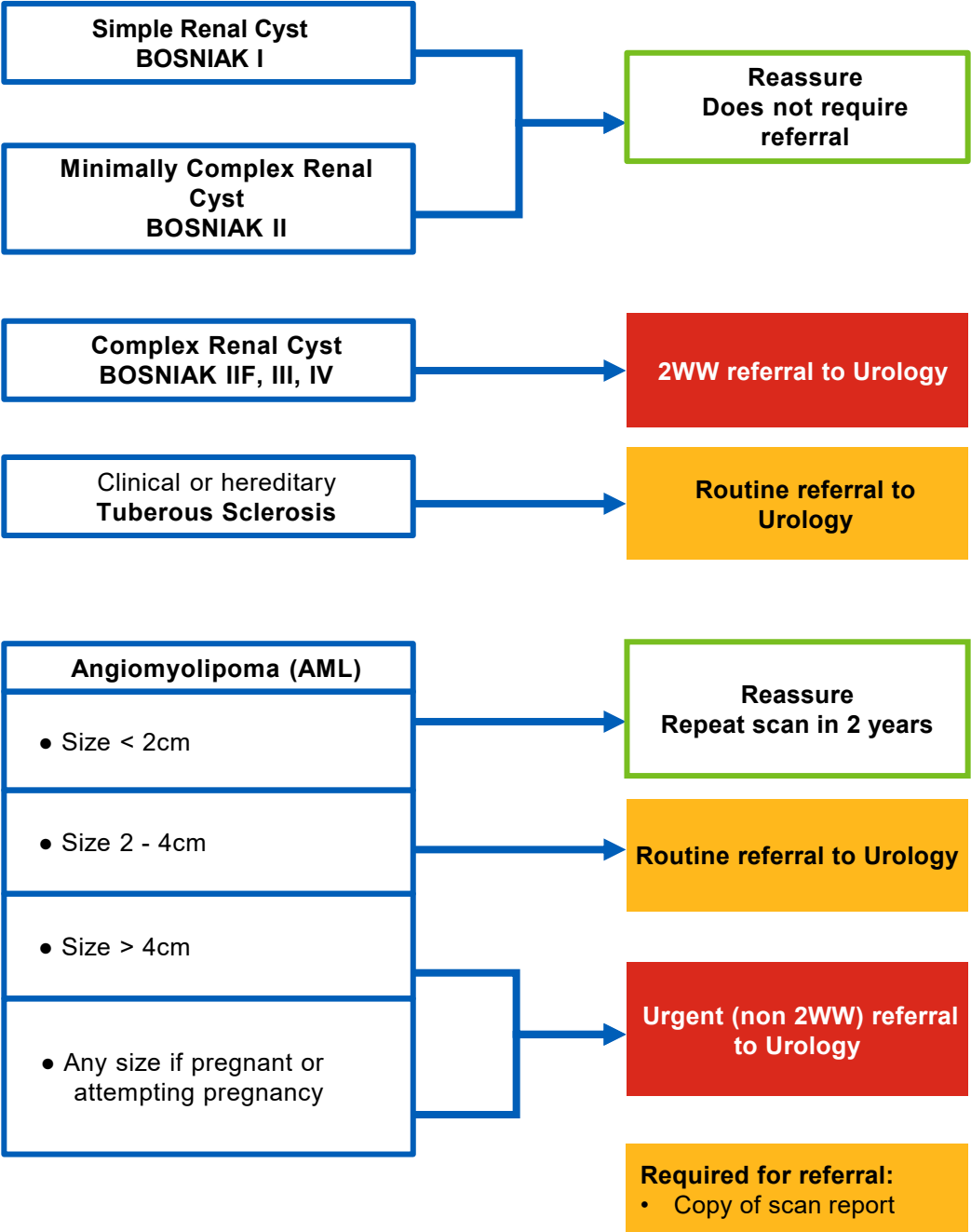


2. Guidelines for Incidental Renal Mass or Cyst

Note: Approximately 50% of the population over 50 years have renal cysts which do not normally cause pain.

Ultrasound: Renal cysts can be Simple (Uncomplicated) requiring no follow up, or Complex (Complicated) requiring referral for contrast enhanced CT.

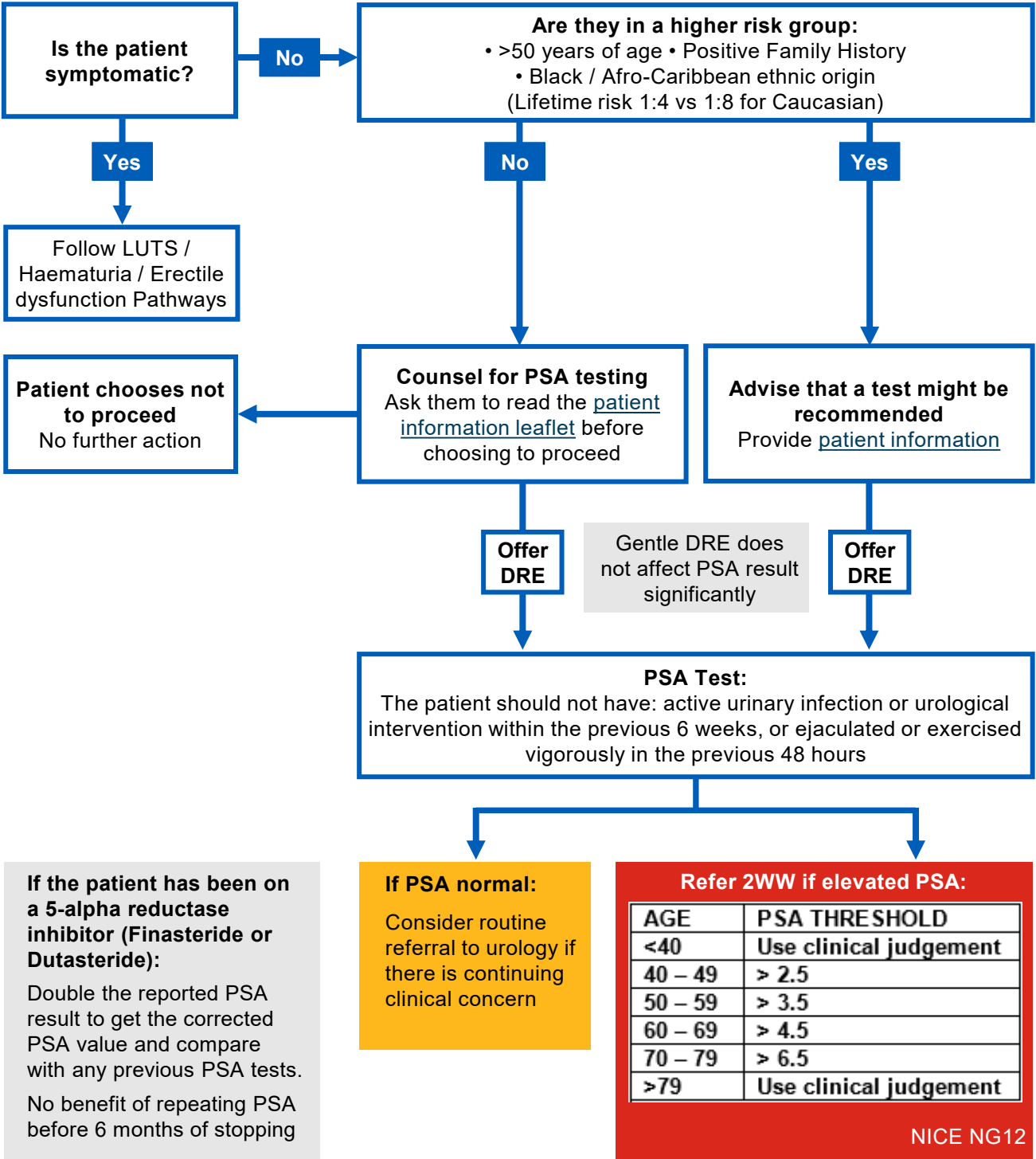
CT with contrast: Renal cysts are described as Simple or Complex, or the Bosniak Classification is used to characterise renal cystic masses.



3. Guidelines for patients requesting routine PSA testing

For more information see [NICECKS](#)

Check if patient has had previous PSA tests (as a base line) and repeat PSA
Reassure patients over 80 years with normal DRE (unless symptomatic)
If no previous PSA documented, discuss PSA testing as below



4. Guidelines for Male Lower Urinary Tract Symptoms (LUTS)

For more information see [NICECKS](#)

- Check for palpable bladder
- Complete [IPSS Questionnaire](#) and a frequency-volume [3-day bladder diary](#)

Investigations

- Urine dipstick and MC&S to exclude UTI
- Serum Creatinine, eGFR & HbA1C. PSA where indicated ([refer 2WW if PSA is raised](#))
- Consider DRE (**if abnormal – CHECK PSA & REFER 2WW**)
- Consider USS-KUB with pre and post micturition bladder volume

Predominantly Storage Symptoms

- Frequency
- Urgency
- Dysuria
- Nocturia

Provide Bladder training advice

Assess nature of predominant symptoms

[Male LUTS Information](#)

Predominantly Voiding Symptoms

- Poor stream
- Hesitancy
- Terminal dribbling
- Incomplete emptying
- Overflow incontinence

Provide Pelvic floor exercises

Offer an Anti-cholinergic [BNF]

e.g. [Solifenacin](#).
Avoid Oxybutynin IR in older men at risk of deterioration in physical or mental health. [See Female LUTS guideline](#).
If unsuitable (e.g. high anticholinergic burden or dementia risk) consider [Vibegron \[BNF\]](#) or [Mirabegron \[BNF\]](#)

Consider Urology Referral if no improvement after 6 months

IPSS ≤ 7 (Mild)

Manage in primary care until symptoms become bothersome

IPSS 8-19 (Moderate)

Assess Prostate Size* (if DRE done) & Progression risk factors

Prostate <30g PSA < 1.4ng/ml

Prostate >30g PSA > 1.4ng/ml

Alpha blocker
[Tamsulosin \[BNF\]](#)
OR Alfuzosin (less ejaculatory dysfunction)

Alpha blocker ± 5 Alpha Reductase Inhibitor [BNF]
([Finasteride](#) for 6 months)

Consider adding an anticholinergic if “mixed” symptoms present e.g. Solifenacin (or Vibegron, see left)

* **Approximate Prostate Size:**
<30g, small, walnut size.
>30g enlarged

Risk factors for progression:

- Older age
- Increased prostate size
- Symptom severity at presentation
- PSA > 1.4ng/ml

[NHSE information sheet](#)

[SEL Decision support tool on Prostate procedures](#)



Routine Referral to Urology if:

- No improvement after a 6 month trial of medication (consider stopping)
- Worsening urinary symptoms (IPSS)
- Patient is intolerant of medication

Urgent Referral to Urology (non 2WW) if:

- Recurrent UTI
- Chronic urinary retention +/- Overflow incontinence
- Abnormal eGFR

EMERGENCY REFERRAL

(same day / via on call)
In the event of acute kidney injury and / or urinary retention

Required for referral:
Recommended:

- Urine MC&S
- Bloods + PSA (if indicated)
- 3-day bladder diary
- Trial of medication
- DRE finding if done

5. Guidelines for Prostatitis

Suspect Chronic Prostatitis (CP) if:

Pain or discomfort (≥3 months) in the:

- Perineum (the most commonly reported location)
- Suprapubic or inguinal region
- Scrotum, testis, or penis (especially pain at the penile tip)

Other symptoms may include:

- Lower urinary tract (voiding or storage) symptoms and Dysuria
- Erectile dysfunction.
- Pain or discomfort during / after ejaculation.

Past history of:

- Acute bacterial prostatitis- Around 1 in 9 men develop chronic bacterial prostatitis or Chronic Pelvic Pain Syndrome (CPPS)
- Recurrent or relapsing urinary tract infections- may indicate Chronic Bacterial Prostatitis (CBP)
- Haemospermia- presents not only in CBP
- Sexually transmitted infections and sexual health history
- Prostate cancer radiation / focal therapy treatment

Chronic Prostatitis: 90% is CPPS, <10% is CBP

For more information see NICE CKS [acute](#) & [chronic](#) prostatitis

CONSIDER URGENT TREATMENT / ADVICE / ADMISSION:

Suspect acute bacterial prostatitis if pain & UTI with sudden onset fever +/- rigors, arthralgia or myalgia

Examination

- Abdomen to exclude distended bladder
- External genitalia
- Gentle DRE of the prostate (may be tender)
- Do not perform prostatic massage

Investigations

Urine dip & MC&S for urine infection

- **Semen culture** (if available) OR **Post Ejaculatory Urine Culture (first-catch not MSU)** - Positive urine culture may indicate CBP. Negative culture does not exclude it.
- **Sexually Transmitted Infection (STI)** screen, particularly if age <35 years or higher risk
- **PSA should be considered**, if normal reassure, [if elevated, repeat](#) & consider **2WW referral**

Primary Care Management of Chronic Prostatitis

Triple therapy: Anti-inflammatory + Alpha-blocker + Antibiotics if positive semen or post ejaculatory urine culture (see below)

Anti-inflammatory pain relief ([NSAID](#)) if no contraindication +/- paracetamol.

Alpha-blocker: [Tamsulosin](#) [BNF] or Alfuzosin (causes less ejaculatory dysfunction)

Antibiotics: (*consider MHRA warning on quinolones*) and *give patient information*:

- **If semen or post ejaculatory urine culture positive. Review at 14 days:** Treat as per culture result
- **If Acute on Chronic Prostatitis treat as per Acute Prostatitis. Review at 14 days:**
 - **1st line:** [Ciprofloxacin](#) 500mg BD or [Ofloxacin](#) 200 mg BD, or Trimethoprim 200mg BD if quinolones aren't appropriate (seek specialist advice). 2-4 weeks based on clinical response
 - **2nd line:** [Levofloxacin](#) 500mg OD or Co-trimoxazole 960mg BD after discussion with specialist. 2-4 weeks based on clinical response.
- **If Chronic pain for <6 months in the absence of positive cultures OR If suspected CBP (history of UTI or an episode of acute prostatitis in the last 12 months):**

Single course- Trimethoprim 200mg twice daily or Doxycycline 100mg twice daily (4-6 weeks)

If STI suspected refer to sexual health clinic

Add Laxative if defecation is painful (e.g. lactulose/docusate)

Required for referral: • Urine MC&S

• 6 weeks of alpha-blocker + analgesia +/- antibiotics

Recommended: • STI screen

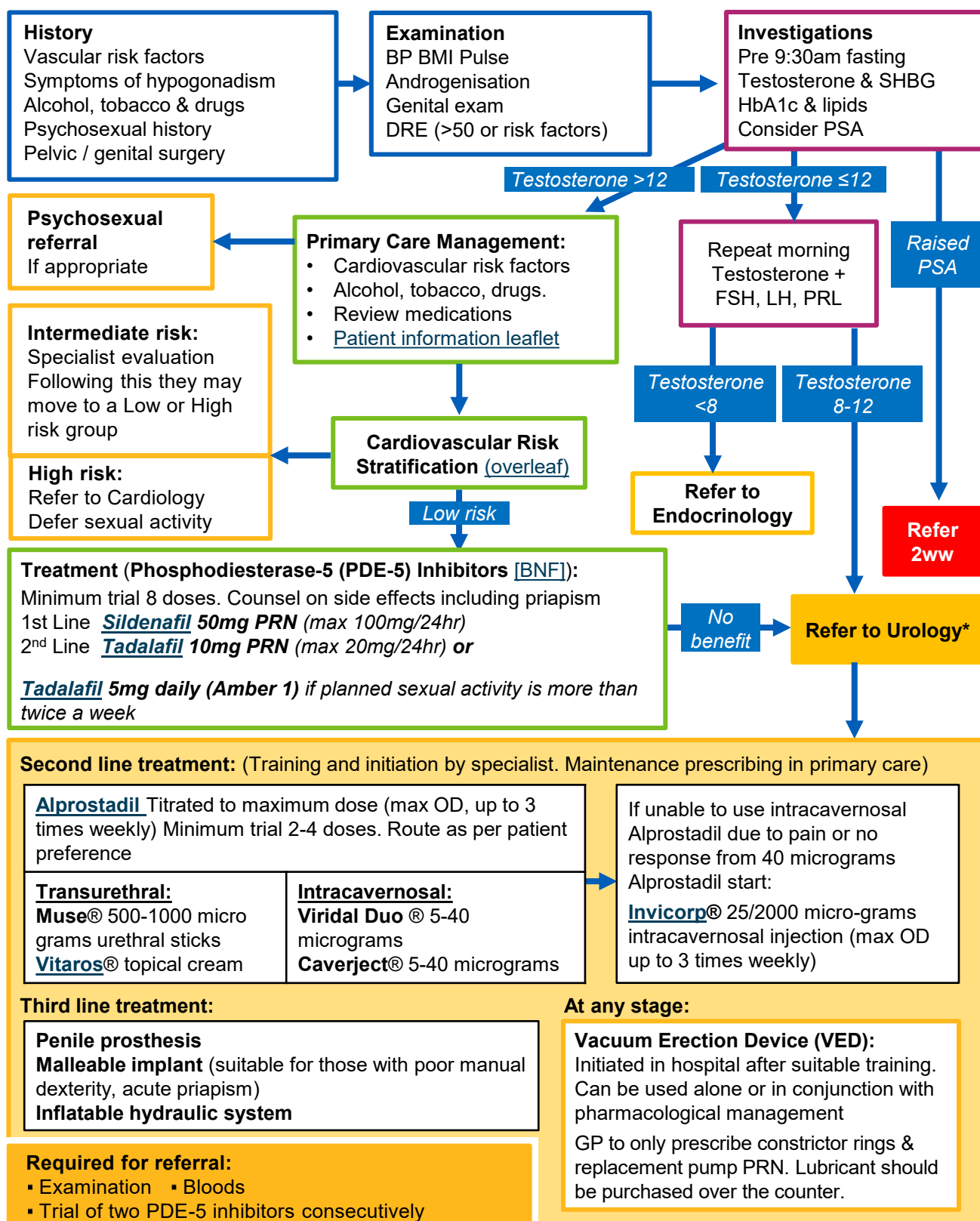
• Semen (or Post-ejaculatory urine) culture

Refer to Urology

- Suspected CBP
- No improvement after 3 months
- Diagnostic uncertainty

6. Guideline for Erectile Dysfunction (ED 1 of 3)

For more information see [NICECKS](#)



6. Guideline for Erectile Dysfunction (ED 2 of 3)

History

- True nature & severity of sexual function
- Previous treatments (success & failure)
- Medication for comorbidities**
- Alcohol, tobacco & illicit drug use**
- Vascular risk factors
- Past medical & surgical history
- Symptoms of hypogonadism & LUTS
- Psychosexual history
- Exercise tolerance

Examination

- Secondary sexual characteristics
- Check for gynaecomastia & reduced body hair to assess degree of androgenisation
- BMI
- Blood pressure (BP) & pulse
- Genital exam e.g. Peyronie's plaques, size of testes
- Digital rectal examination (>50 or risk factors)
- Neurological & vascular assessment

Investigations

- Testosterone & SHBG (pre 9:30am fasting sample) • HbA1c & lipids
- PSA if >50 years OR >40 years with family history of prostate cancer or black ethnicity

Interpretation of Blood results

↓ **Testosterone:** Repeat morning sample. Add in: FSH, LH, PRL

If testosterone <8: **Refer to Endocrinology.**

If testosterone 8-12: **Refer to Urology**

↑ **PSA: Refer on 2WW pathway if raised PSA (see PSA guideline) for any age group**

Primary Care Management

- Manage modifiable risk factors e.g. BP, raised BMI, smoking, inactivity, stress, alcohol & illicit drugs.
- Manage raised cholesterol & HbA1C
- Prescribe a PDE-5 inhibitor unless contra-indicated.
Minimum 6-8 doses before titrating.
Counsel on side effects please see BNF for list of side effects.

1st Line: Sildenafil 50mg/dose/day PRN
(increase to max 100mg/24hr if required)

Follow-Up in 6-8 weeks

Initial Treatment Ineffective

(Insufficient erection for penetrative intercourse)

- Confirm use of PDE-5 inhibitor to max. dose
- Reconsider comorbidities & risk factors
- Consider hypogonadism (makes PDE-5 inhibitors ineffective).
- Enquire about how medication was obtained, to ensure that a licensed product has been used.

2nd Line: Tadalafil 10mg PRN (max 20mg/24hr) or Tadalafil 5mg Daily (Amber 1) if planned sexual activity is more than twice a week.

Routine referral to:

- **Urology *** - complex medical issues e.g. sickle cell, history of trauma to the genital area / pelvis / spine, borderline hypogonadism, or no response to 2nd line PDE-5 inhibitor. For Peyronie's disease (see [SEL Penile deformity guideline](#)).
- **Endocrinology** - men with severe hypogonadism or hyperprolactinaemia
- **Cardiology** - see risk stratification below
- **Psychosexual services** - men with a psychogenic underlying cause or severe mental distress

If unsure, ask for Advice & Guidance

Bexley only: Community ED clinic

Mickey Adagra via DXS email to:

bex.erectiledysfunction@nhs.net

Endocrine:

GSTT – Paul Carroll

KCH – Dr Benjamin Whitelaw

Lewisham – John Miell, Aarthi Surendran

Greenwich – Jennifer Tremble

QM Sidcup – Serife Mehmet

Psychosexual services:

KCH – Leonor Herrera Vega

GSTT – Leila Frodsham

SLAM – psychosexualservice@slam.nhs.uk

6. Guideline for Erectile Dysfunction (ED 3 of 3)

****Drugs associated with ED**

- Antihypertensives- beta-blockers, verapamil, methyldopa, & clonidine.
- Diuretics- spironolactone & thiazides.
- Antidepressants & Antipsychotics- selective serotonin reuptake inhibitors, tricyclics, monoamine oxidase inhibitors, chlorpromazine, haloperidol
- Antiarrhythmic drugs- digoxin, amiodarone.
- Hormones & hormone-modifying drugs- antiandrogens (flutamide, cyproterone acetate), LHRH agonists (leuprorelin, goserelin), corticosteroids, 5-alpha reductase inhibitors (e.g. finasteride).
- Histamine (H2)-antagonists- cimetidine, ranitidine.
- Recreational drugs- alcohol, heroin, cocaine, marijuana, methadone, synthetic drugs, anabolic steroids.

Generic sildenafil and tadalafil do not require SLS.

SLS' Selected List Scheme Criteria

Viagra and Cialis are not prescribable on the NHS except for men who have:

- Diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single-gene neurological disease (e.g. Huntington's disease), spina bifida, or spinal cord injury.
- Renal dialysis
- Radical pelvic surgery, prostatectomy, or kidney transplant
- Were receiving treatment on the NHS before 14/09/98

Instructions for patients starting a PDE-5 inhibitor

Note: 30 - 35% of men fail to respond to initial treatment largely due to inadequate counselling & unrealistic expectations.

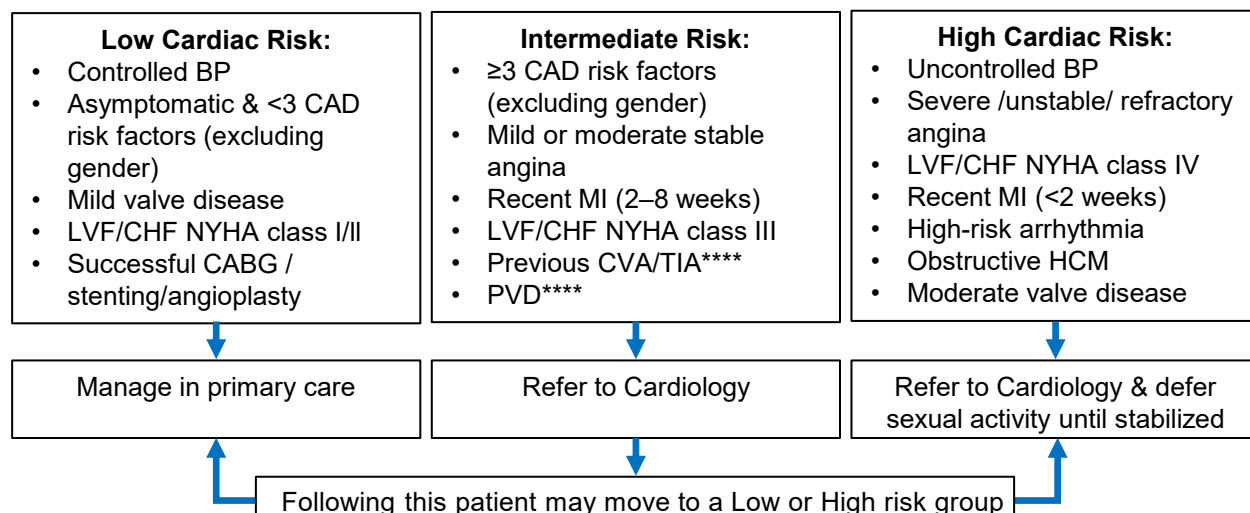
Therefore advise patients:

- normal desire & sexual stimulation needed
- adequate dosage needed
- avoid use with alcohol or illicit drugs
- avoid black-market products
- for sildenafil, take on an empty stomach
- wait adequate time:
Sildenafil & Tadalafil – 30-60 minutes

Contra-indications to PDE-5 inhibitors

- Patients taking nitrate medications
- Recent stroke
- Non-arteritic anterior ischaemic optic neuropathy
- BP<90/50

Assess cardiovascular risk before prescribing**

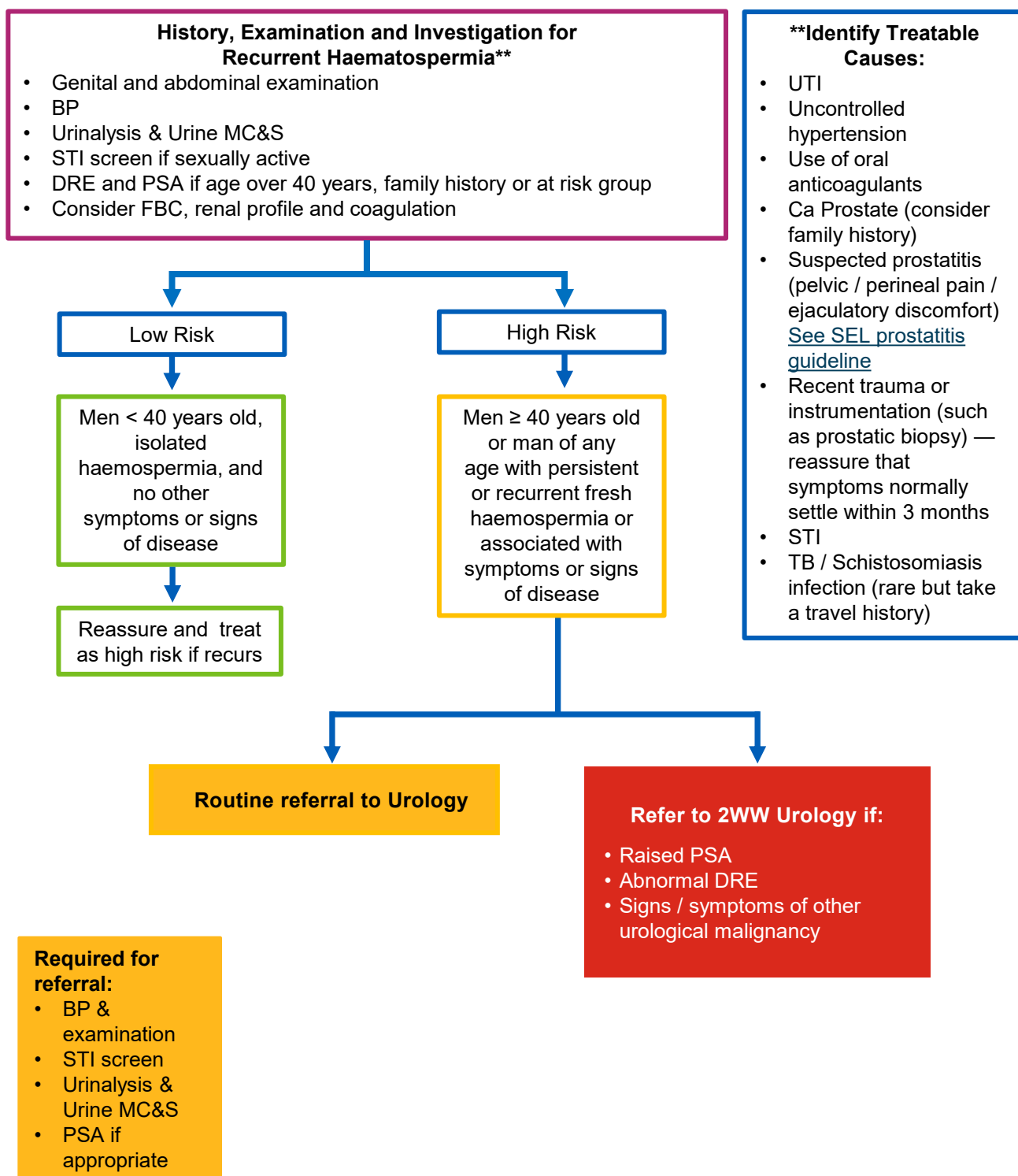


*** Risk stratification based on: [BSSM](#) & [EAU guidelines](#) & adapted from the [Fourth Princeton Consensus](#).

**** Additional tests may be required

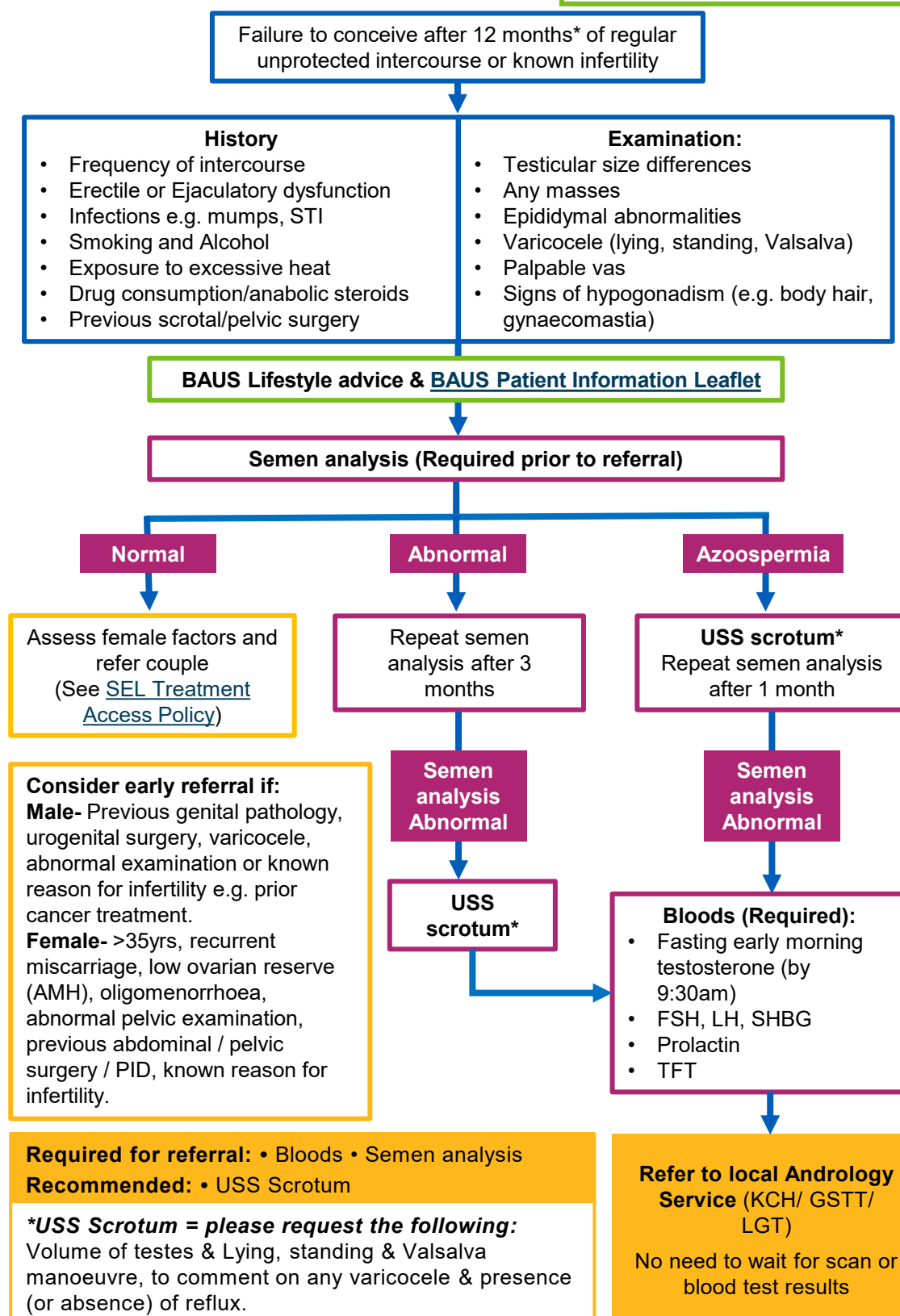
7. Guidelines for Haematospermia

For more information see [NICECKS](#)

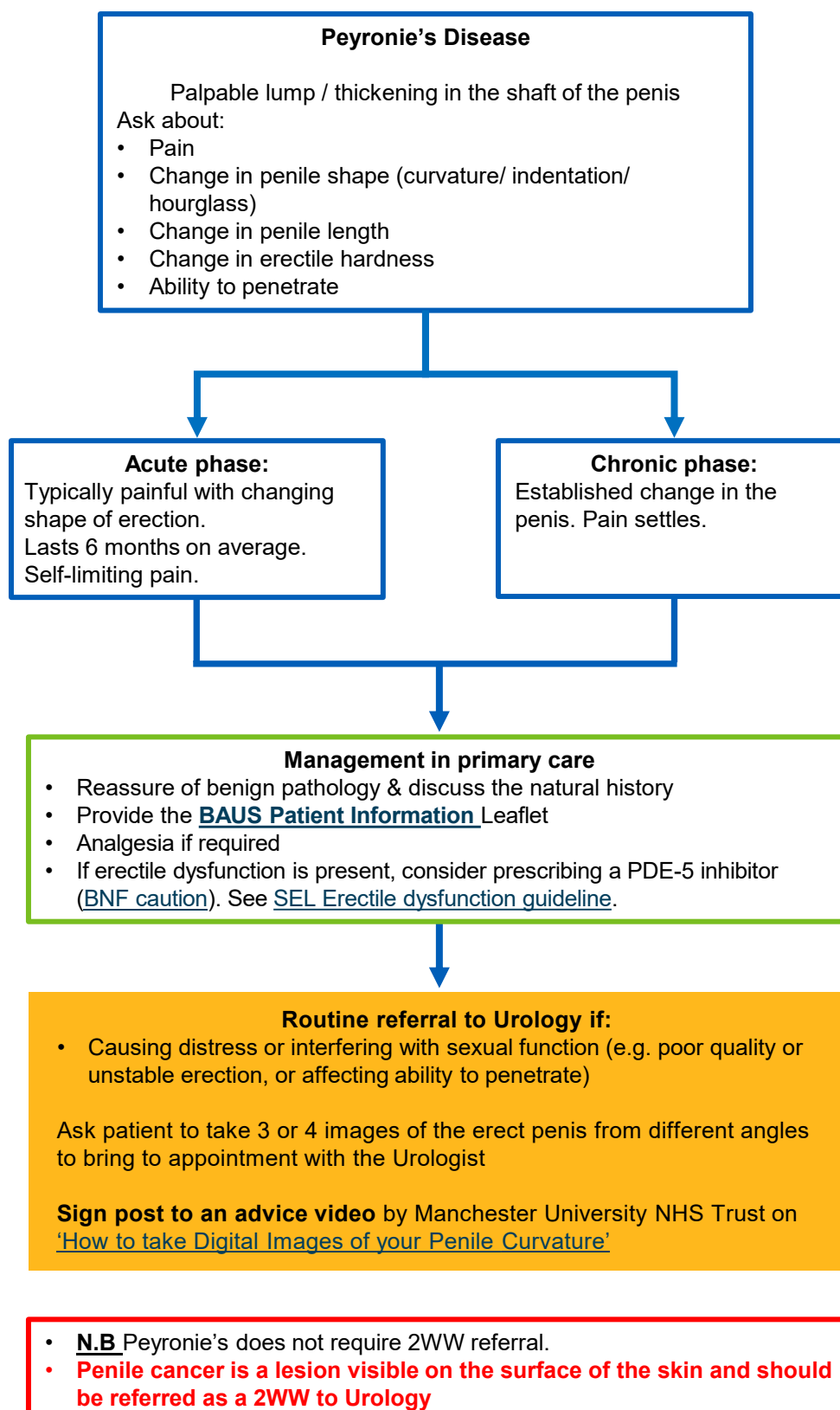


8. Guidelines for Male Infertility

For more information see [NICECKS](#)

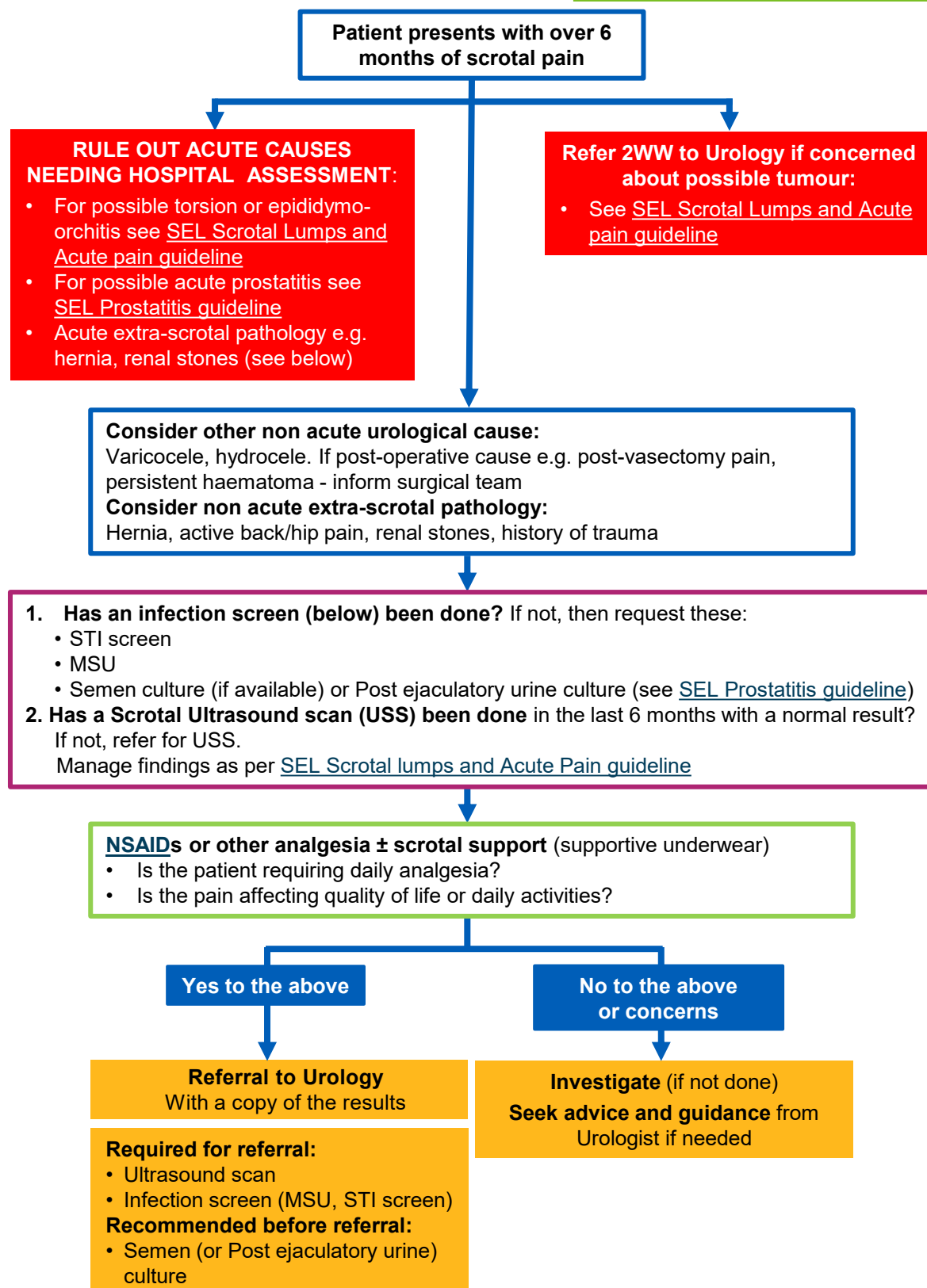


9. Guidelines for Penile Deformity



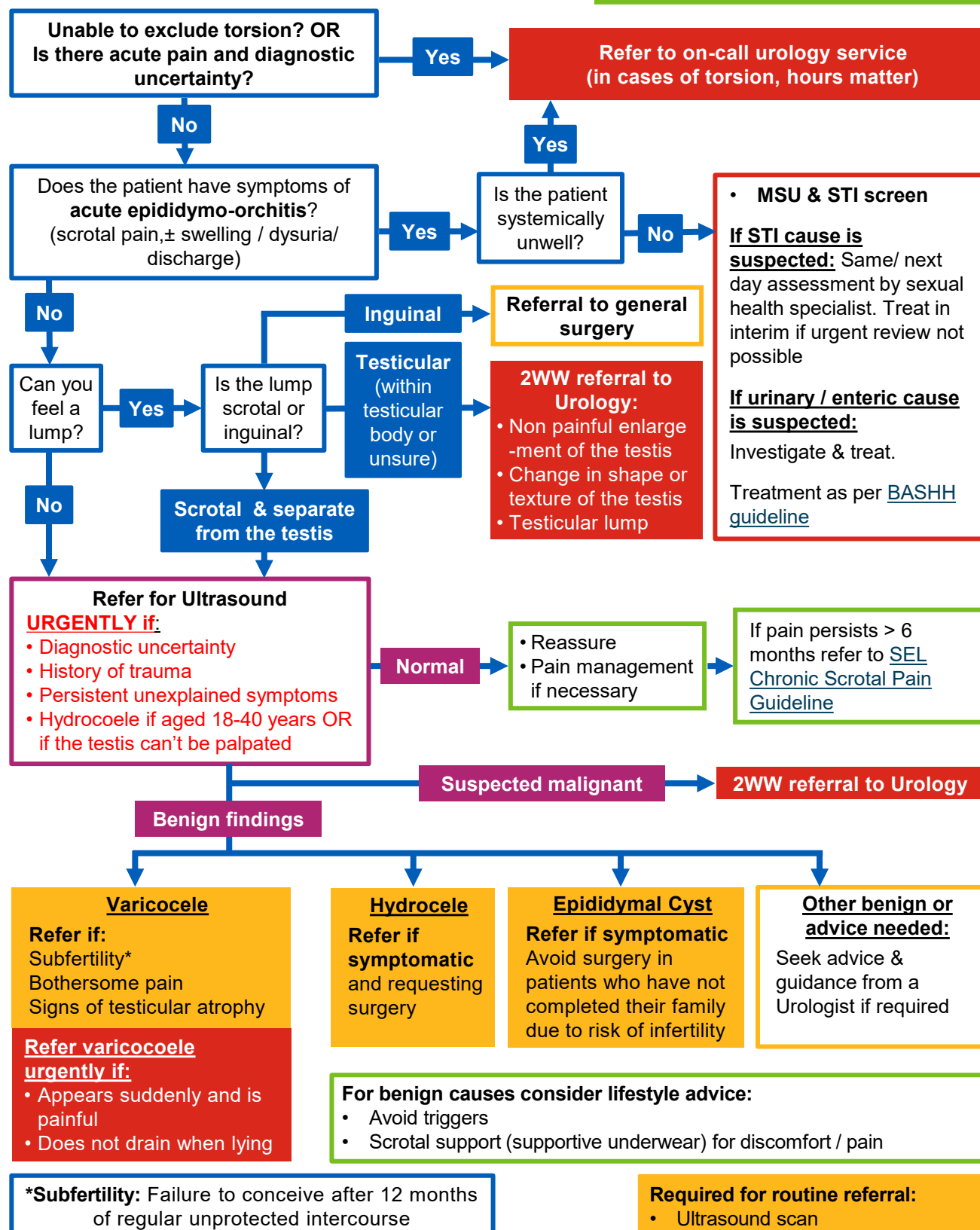
10. Guidelines for Chronic Scrotal Pain

For more information see [NICECKS](#)



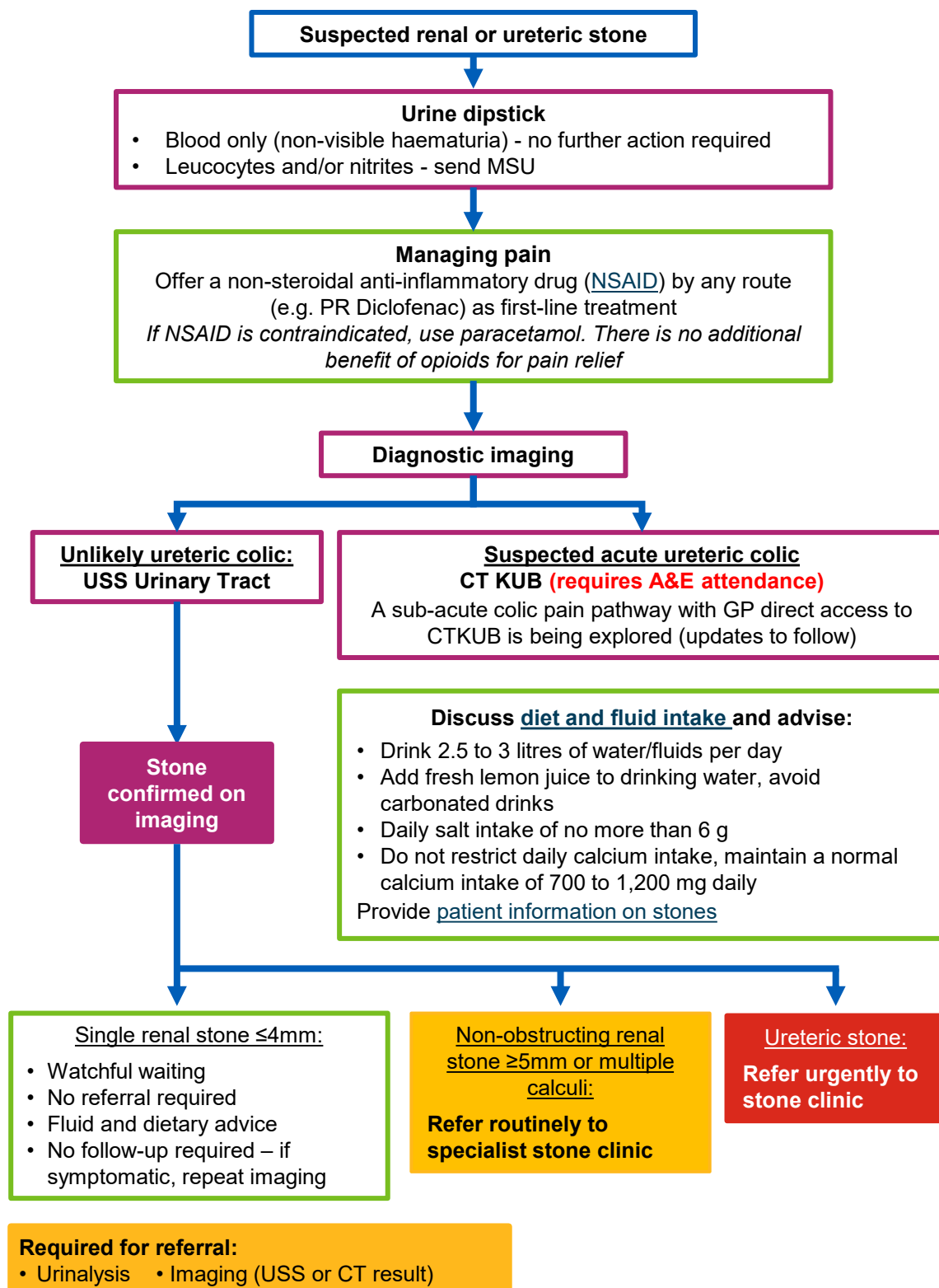
11. Guidelines for Scrotal Lumps and Acute Pain

For more information see [NICECKS](#)



12. Guidelines for Suspected Renal and Ureteric Stones

For more information see [NICE CKS](#)



13. Guidelines for Non-neuropathic Female Lower Urinary Tract Symptoms / Incontinence

Overactive Bladder (OAB): Urgency, urgency incontinence, frequency and nocturia

Stress Incontinence (SUI): Incontinence associated with coughing, laughing, sneezing, exercise

Mixed Incontinence: All of the above symptoms

Examinations

- Examine abdomen and perform pelvic exam to exclude pelvic mass, palpable bladder, prolapse, vaginal atrophy and constipation.
- Urine dipstick - for UTI & haematuria (see guideline for this)
- Post void residual (e.g. bladder scan) if available

Primary Care Management

- Advise weight loss if appropriate
- Bowel management - manage constipation
- **OAB:** trial of caffeine reduction, fluid intake advice
- **SUI:** Provide [self-help resources](#) & [pelvic floor exercises](#)
- **Mixed UI:** Focus treatment on the predominant type of incontinence but conservative / basic measures can be helpful for both

Overactive Bladder (OAB)

(Self) Refer* to Community Bladder & Bowel service for bladder retraining

With a 3 day bladder diary
OR Consider treatment

Mixed Incontinence

(Self) Refer* to Community Bladder & Bowel service for specialist advice

With a 3 day bladder diary

Stress Incontinence (SUI)

Refer to Physiotherapy or (Self) Refer* to Community Bladder & Bowel service for supervised pelvic floor exercises

With a 3 day bladder diary

Consider medical treatment / review polypharmacy

Review response after 4 weeks and then every 6 -12 months

1st Line: Offer an Anticholinergic (see [cost table**](#)) **[BNF]**

e.g. [Solifenacin](#). If elderly Fesoterodine MR / Trospium. Avoid Oxybutynin IR in older women at risk of sudden deterioration in their physical or mental health. Transdermal if unable to take PO.

If an anticholinergic is unsuitable (e.g. Contraindicated or [anticholinergic burden](#) or dementia risk) consider [Vibegron](#) or [Mirabegron](#).

If lack of Anticholinergic efficacy, increase dose or consider an alternative anticholinergic.

2nd Line: [Mirabegron](#) [BNF] or [Vibegron](#) .

or Contraindicated in severe uncont-rolled hypertension (Systolic >180mmHg, Diastolic > 110mmHg)

3rd Line: Consider Combination therapy i.e. anticholinergic + beta 3 agonist e.g. Solifenacin 5mg and Mirabegron 50mg

Refer patients who are prescribed one or more anticholinergic agents and are concurrently managed with urinary catheters and/or continence products for specialist review

If post-menopausal, with vaginal atrophy; Estriol 0.1% cream OR [Estradiol](#) 10mcg pessary. Use daily for 2 weeks (3 weeks if Estriol) then twice weekly indefinitely **[BNF]**

For more information see [NICECKS](#)

Urgent 2WW referral:

- > 45yrs & unexplained visible haematuria or recurrent / persistent post UTI treatment
- Non visible haematuria > 60yrs with dysuria or raised WCC

Refer (urgently if appropriate) or admit:

- Acute cauda equina / neurology
- Suspected urogenital mass (benign) or fistula
- Palpable bladder post voiding
- Persistent bladder /urethral pain
- Deterioration in renal function
- Suspected neurological disease
- Recurrent/persistent UTI ≥60yrs
- Voiding dysfunction
- Previous incontinence surgery, pelvic cancer surgery, or radiation

If no improvement after 3 months consider referral to Urology / Urogynaecology

Required for referral:

- Examination
- Urinalysis
- 3 day bladder diary

Recommended:

- Post void residual (if available)

Patient information links:

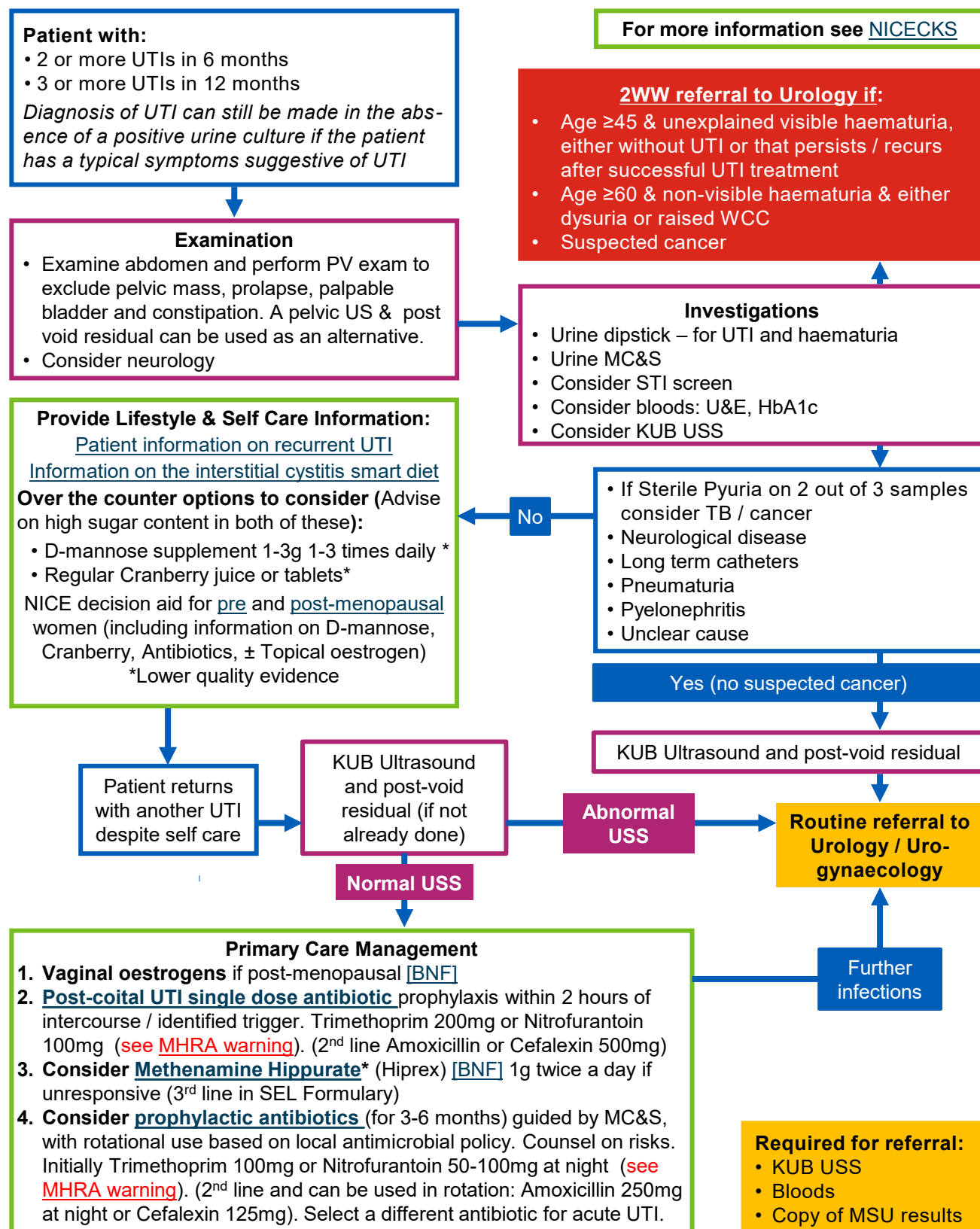
[Bladder Training Leaflet](#)
[Pelvic floor exercises](#)
[Anticholinergic Cognitive Burden scale](#)

13. Guidelines for Non-neuropathic Female Lower Urinary Tract Symptoms / Incontinence

** Anticholinergic Medications: Start with the lowest dose and titrate up if required every 2-4 weeks			
Drug Name	Dose	Monthly cost (July 2023)	
Oxybutynin hydrochloride immediate release	2.5mg twice daily to 5 mg four times daily	56 Tabs	£1.37- £1.47
Solifenacin Succinate	5 – 10mg once daily	30 tabs	£1.65 -£1.81
Tolterodine tartrate immediate release	1 – 2mg twice daily	56 Tabs	£2.82- £3.56
Fesoterodine fumarate modified release	4 – 8mg once daily	28 Tabs	£3.48-£4.48
Trospium chloride immediate release	20mg twice daily	60 Tabs	£11.39
Tolterodine tartrate (modified release)	4 mg once daily	28 Tabs	£12.89
Oxybutynin hydrochloride (modified release)	5 – 20mg once daily	30 Tabs	£14.61-£29.22
Trospium chloride (modified release)	60mg once daily	28 Tabs	£23.05
Darifenacin hydrobromide modified release	7.5 -15mg once daily	28 Tabs	£25.48
Oxybutynin hydrochloride 3.9mg/24hrs transdermal delivery system (patch)	1 patch twice weekly	8 Patches	£27.20
Mirabegron modified release	50mg once daily. 25mg once daily if patient has renal or hepatic impairment	30 Tabs	£29.00
<i>Offer the anticholinergic medicine with the lowest acquisition cost (NICE NG123)</i>			

SEL Continence Services Contact Details	
Bexley	T: 020 8320 3550 ○ E: bexleycare.spc@nhs.net Patients can self refer by phone
Greenwich	T: 020 8320 3550 ○ E: oxl-tr.CentralAccessTeam@nhs.net Patients can self refer by phone
Bromley	T: 0300 3305777 ○ E: bromh.cccpod2refs@nhs.net Patients can self refer by phone
Lambeth and Southwark	T: 020 3049 8810 ○ E: gst-tr.dnreferrals@nhs.net New referrals by GP patients can only self refer by phone (above) if seen by the service in the last 6 months.
Lewisham	T: 020 3049 3446 ○ E: lg.bbphealth@nhs.net Patients can self refer by phone or email

14. Guidelines for Non-neuropathic Female Recurrent UTI / Cystitis (non-pregnant, no catheter)



15. Guidelines for Pelvic Organ Prolapse (POP)

For more information see [NICE NG123](#)

History:

- POP symptoms (mechanical symptoms, lump, bulge, obstruction, pressure, backache)
- Urinary symptoms (frequency, nocturia, urgency, stress incontinence, urgency incontinence, voiding symptoms, UTI's)
- Bowel symptoms (constipation, digitation/ splinting, faecal incontinence, tenesmus)
- Sexual function (sexual activity, dyspareunia, obstruction, coital incontinence)
- Obstetric / gynaecological / surgical history
- Past medical history, co-morbidities and BMI

Examination:

- Abdominal, speculum and bimanual examination of the pelvis to exclude pelvic masses
- Assessment of prolapse (supine and standing) and pelvic floor muscles
- Consider rectal examination to exclude constipation and sphincter weakness

Investigations:

- As per [Female LUTS pathway](#) if urinary symptoms

Conservative management in Primary Care

- Weight loss, address co-morbidities and precipitants
- Manage [constipation](#)
- Prescribe [vaginal oestrogen \[BNF\]](#) if atrophy or recurrent UTI's
- If bladder symptoms manage as per [SEL Female LUTS pathway](#)
- Provide [patient information on pelvic organ prolapse](#)
- Referral to community physiotherapy or bladder and bowel service
- Consider a pessary (if trained practitioner available)

In cases or severe prolapse or procidentia (carries risk of ureteric obstruction):

- **Urgent referral to Urology / urogynaecology**
- Consider FBC, U&E's and USS KUB if renal function abnormal

Follow up after 3 months. Continue management if effective

Referral to Urogynaecology if:

- Persistent symptomatic POP with reduced quality of life despite conservative management
- POP beyond the introitus or worsening POP despite conservative measures
- Previous surgical repair of POP
- Recurrent UTI's associated with incomplete bladder emptying

Required for routine referral:

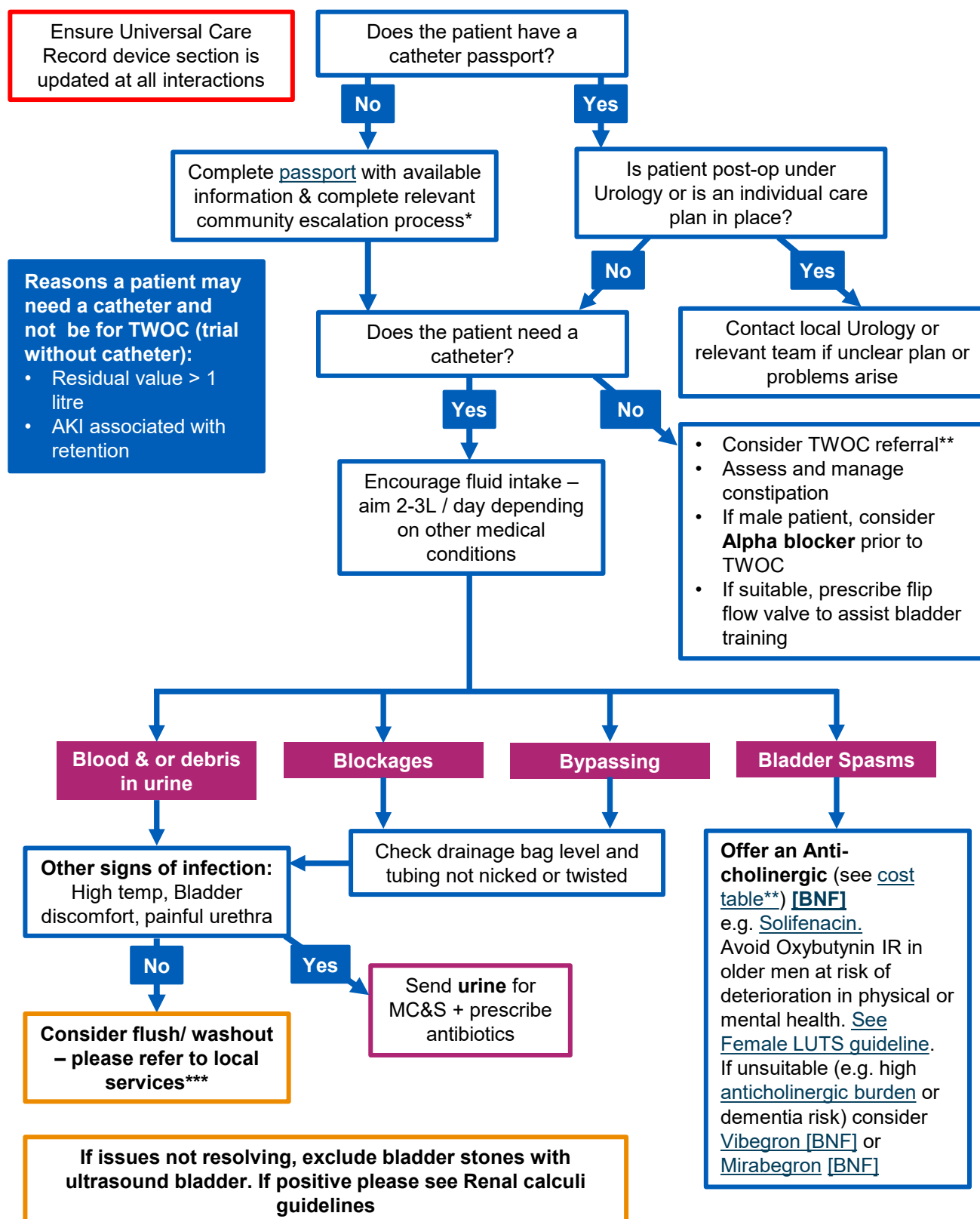
- Examination
- Trial of conservative management (where appropriate)

SEL Continence Services Contact Details

Bexley	T: 020 8320 3550 ○ E: bexleycare.spc@nhs.net Patients can self refer by phone
Greenwich	T: 020 8320 3550 ○ E: oxl-tr.CentralAccessTeam@nhs.net Patients can self refer by phone
Bromley	T: 0300 3305777 ○ E: bromh.cccpod2refs@nhs.net Patients can self refer by phone
Lambeth and Southwark	T: 020 3049 8810 ○ E: gst-tr.dnreferrals@nhs.net Patients can self refer by phone (above) if seen in the last 6 months
Lewisham	T: 020 3049 3446 ○ E: lg.bbphealth@nhs.net Patients can self refer by phone or email

16. Guidelines for Catheter Care

For more information see [NICECKS](#)



Abbreviations

2WW	Urgent Suspected Cancer '2 week wait' referral
ACR	Albumin Creatinine Ratio
AMH	Anti-Mullerian Hormone
BASHH	British Association for Sexual Health & HIV
BAUS	British Association of Urological Surgeons
BMI	Body Mass Index
BP	Blood Pressure
Ca	Cancer
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CBP	Chronic Bacterial Prostatitis
CP	Chronic Prostatitis
CPPS	Chronic Pelvic Pain Syndrome
CT	Computed Tomography
CVA	Cerebrovascular Accident
DRE	Digital Rectal Examination
ED	Erectile Dysfunction
FBC	Full Blood Count
FSH	Follicle Stimulating Hormone
Hb	Haemoglobin
HbA1c	Glycated Haemoglobin
HCM	Hypertrophic Obstructive Cardiomyopathy
INR	International Normalised Ratio
IPSS	International Prostate Symptom Score
KUB USS	Ultrasound Scan of the Kidneys, Ureters & Bladder
LH	Luteinising Hormone
LUTS	Lower Urinary Tract Symptoms

LVF	Left Ventricular Failure
Max	Maximum
MC&S	Microscopy Culture & Sensitivity
MI	Myocardial Infarct
MSU	Mid Stream Urine
NSAID	Non Steroidal Anti Inflammatory Drug
NVH	Non Visible Haematuria
NYHA	New York Heart Association
OAB	Overactive Bladder
OD	Once Daily
PDE-5	Phosphodiesterase-5
POP	Pelvic Organ Prolapse
PSA	Prostate Specific Antigen
PRL	Prolactin
PRN	As required
SEL	South East London
SHBG	Sex Hormone Binding Globulin
SLS	Selected List Scheme
SUI	Stress Incontinence
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFT	Thyroid Function Test
TIA	Transient Ischaemic Attack
UI	Urinary Incontinence
UTI	Urinary Tract Infection
U&E	Urea & Electrolytes
VH	Visible Haematuria

Glossary

WCC	White blood Cell Count
Non-Visible Hematuria	Blood in the urine detected on urinalysis (1+ or above) or microscopy. In SEL microscopy reports show '+' if >10 red blood cells per litre are present (reporting format varies by borough).
Sterile pyuria	The presence of white blood cells in the urine in the absence of bacteria or other infectious agents
Visible Hematuria	Blood in the urine seen with the naked eye