South East London Acute Provider Collaborative

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS Lewisham and Greenwich NHS Trust

South East London Urology Adult Primary Care Guidelines

November 2023

Due for review 2025

South East London Integrated Care System

South East London Acute Provider Collaborative

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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.

All prescribing should be in line with the SEL Joint Medicines Formulary. The guidelines for Erectile dysfunction & Female Urinary Tract Symptoms were drawn up 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, the later using established communication channels (e.g. Consultant Connect and e-RS Advice and Guidance)

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.

Version	Date signed off	Date of next review
2	November 2023	November 2025

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Guidelines for Haematuria

For more information see NICECKS suspected cancer and UTI with non/ visible haematuria

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

"Visible" VH

Is the patient:
- On anticoagulants
- Passing large clots
- Retention of urine
- INR high

Yes → **EMERGENCY REFERRAL**

No → **Investigations**
- Urine dip
- MSU

Is there a history of infection?

Yes → **Treat Infection Retest for haematuria after antibiotics complete**

If "Visible Haematuria" persists or recurs after successful treatment for UTI

No → Patient under 45 years / Patient over 45 years

Referral for Haematuria non-2WW
Assess as per NVH pathway

If Non-Visible haematuria persists consider underlying causes
See NVH pathway

Refer to Urology 2WW *

*** Consider endometrial cancer if age ≥55 and visible haematuria with:**
Low Hb or Thrombocytosis or High blood glucose or Unexplained vaginal discharge

"Non-Visible" NVH

Unexplained Non-Visible Haematuria:
(2 of 3 dipstick tests positive on 3 separate occasions)

Reduce referral threshold if risk factors for urological cancer are present:
- Smoking history
- Family history of urological cancer

Investigations
- Blood Pressure
- PSA
- FBC, U&E, ±INR
- Consider urine cytology
- MSU
- ACR
- KUB USS

Suspected Cancer
OR
Patient ≥60 years with Dysuria OR Raised WCC

No → Patient under 45 years / Patient over 45 years

Routine Nephrology referral / advice

Routine Urology referral

Yes

Refer to Urology 2WW if:
- **≥60 with NVH and either dysuria or raised WCC**
- **Suspected cancer**

Required for routine referral:
- Bloods including PSA
- ACR • MSU

Recommended: KUB USS

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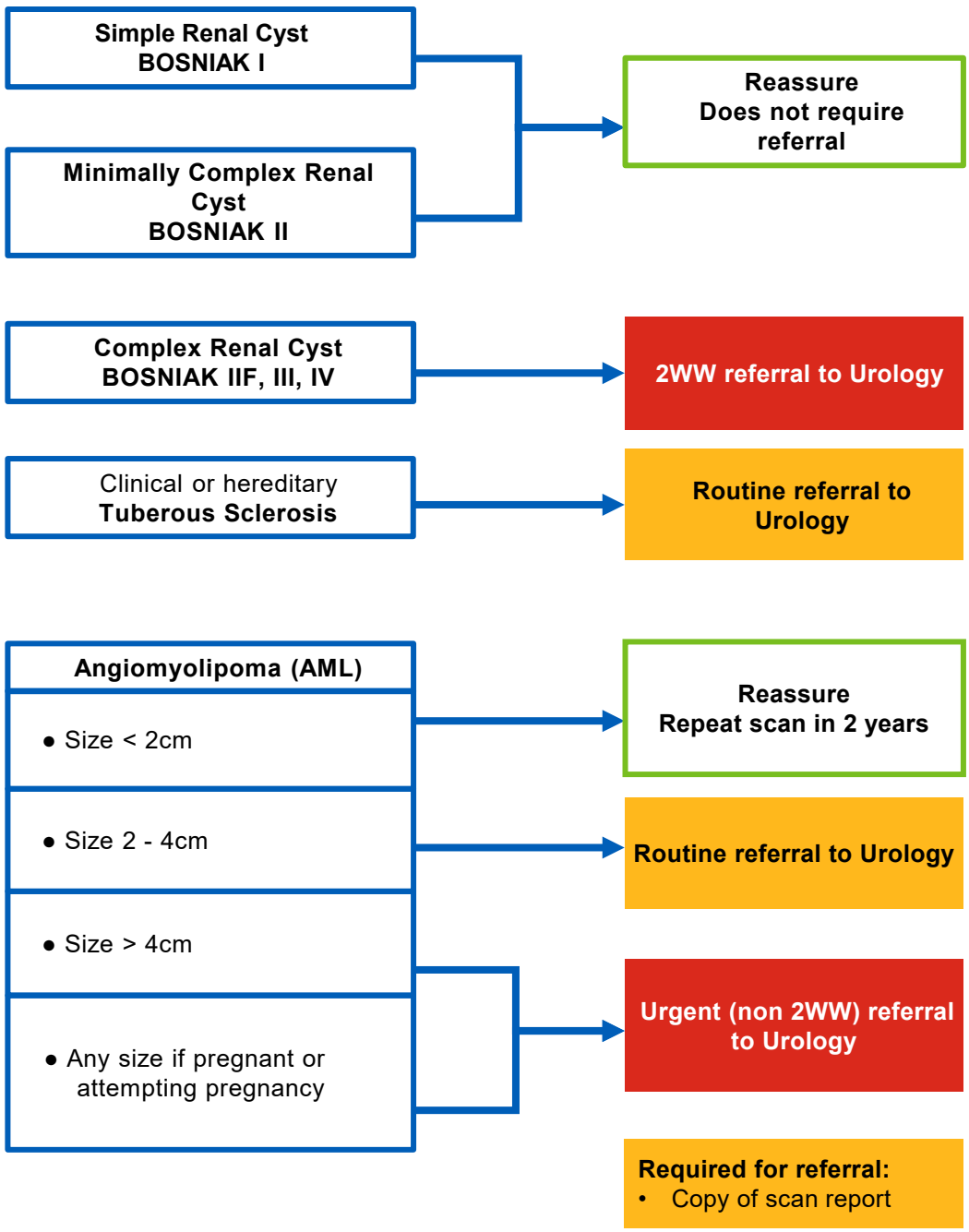
Guidelines for Incidental Renal Mass or Cyst

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.



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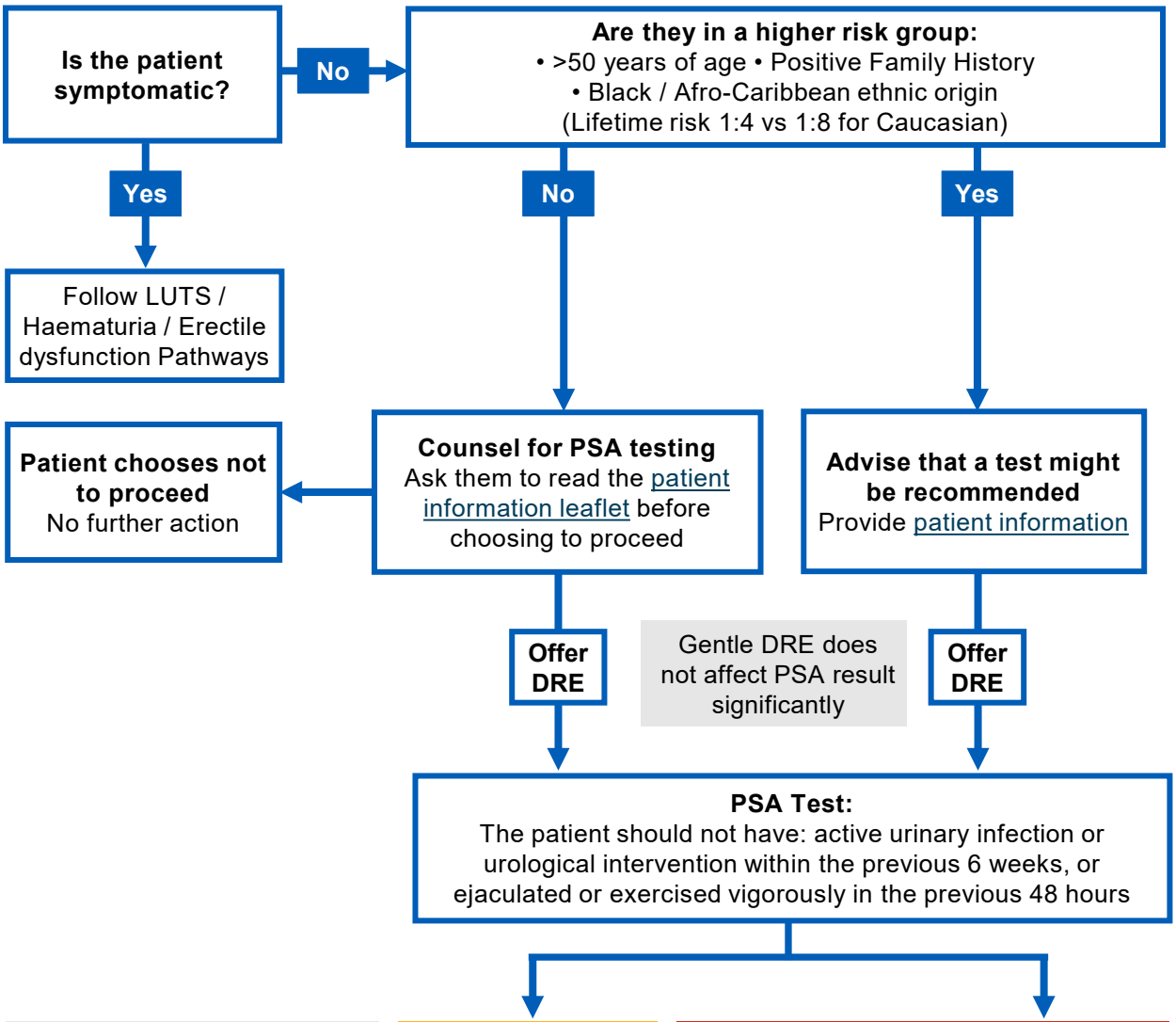
Guidelines for patients requesting routine PSA testing

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



If the patient has been on a 5-alpha reductase inhibitor (Finasteride or Dutasteride):

Double the reported PSA result to get the corrected PSA value and compare with any previous PSA tests.

No benefit of repeating PSA before 6 months of stopping

If PSA normal:

Consider routine referral to urology if there is continuing clinical concern

Refer 2WW if elevated PSA:

AGE	PSA THRESHOLD
<40	Use clinical judgement
40 – 49	> 2.5
50 – 59	> 3.5
60 – 69	> 4.5
70 – 79	> 6.5
>79	Use clinical judgement

NICE NG12

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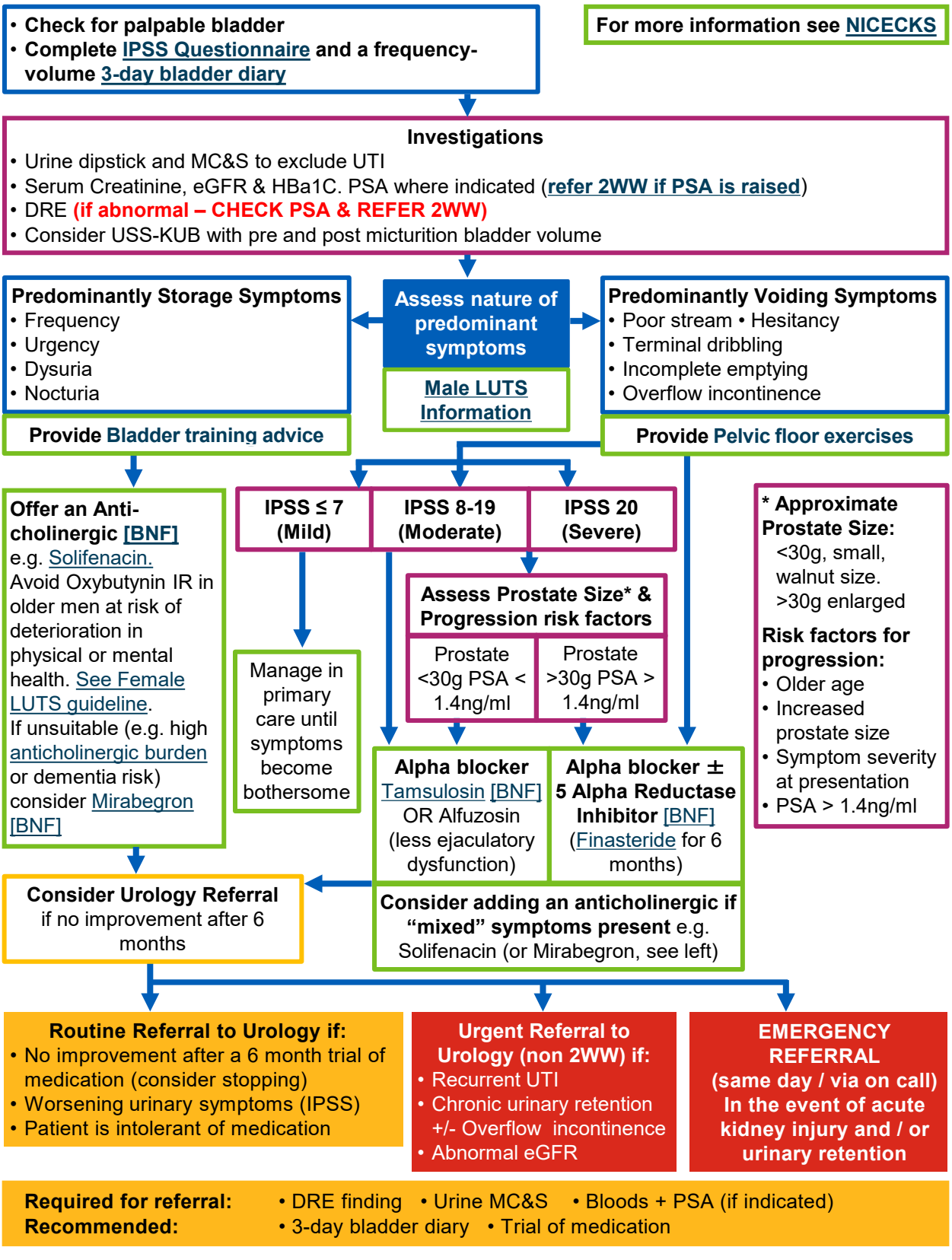
Guidelines for Male Lower Urinary Tract Symptoms (LUTS)



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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**)
- Haematospermia- 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

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Guideline for Erectile Dysfunction (ED)

For more information see NICECKS

History
Vascular risk factors
Symptoms of hypogonadism
Alcohol, tobacco & drugs
Psychosexual history
Pelvic / genital surgery

Examination
BP BMI Pulse
Androgenisation
Genital exam
DRE (>50 or risk factors)

Investigations
Pre 9:30am fasting
Testosterone & SHBG
HbA1c & lipids
Consider PSA

Testosterone >12

Testosterone ≤12

Raised PSA

Psychosexual referral
If appropriate

Primary Care Management:
- Cardiovascular risk factors
- Alcohol, tobacco, drugs.
- Review medications
- Patient information leaflet

Repeat morning Testosterone + FSH, LH, PRL

Testosterone <8

Testosterone 8-12

Intermediate risk:
Specialist evaluation
Following this they may move to a Low or High risk group

High risk:
Refer to Cardiology
Defer sexual activity

Cardiovascular Risk Stratification (overleaf)

Refer to Endocrinology

Refer 2ww

Low risk

Treatment (**Phosphodiesterase-5 (PDE-5) Inhibitors** [BNF]):
Minimum trial 8 doses. Counsel on side effects e.g. priapism
1st Line: Sildenafil 50mg/dose/day PRN *(max dose 100mg)*
2nd Line: Tadalafil 10mg /dose/day PRN *max dose 20mg)*
Patient-funded unless SLS. Daily Tadalafil is not recommended for prescribing in SEL, in line with national guidance

No benefit

Refer to Urology*

Second line treatment: (Training and initiation by specialist. Maintenance prescribing in primary care)

Alprostadil Titrated to maximum dose (max OD, up to 3 times weekly) Minimum trial 2-4 doses. Route as per patient preference

Transurethral:
Muse® 500-1000 micro grams urethral sticks
Vitaros® topical cream

Intracavernosal:
Viridal® 5-40 micrograms
Caverject® 5-40 micrograms

If unable to use intracavernosal Alprostadil due to pain or no response from 40 micrograms Alprostadil start:
Invicorp® 25/2000 micro-grams intracavernosal injection (max OD up to 3 times weekly)

Third line treatment:

Penile prosthesis
Malleable implant (suitable for those with poor manual dexterity, acute priapism)
Inflatable hydraulic system

At any stage:

Vacuum Erection Device (VED):
Initiated in hospital after suitable training. Can be used alone or in conjunction with pharmacological management

GP to only prescribe constrictor rings & replacement pump PRN. Lubricant should be purchased over the counter.

Required for referral:
- Examination
- Bloods
- Trial of two PDE-5 inhibitors consecutively

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Guideline for Erectile Dysfunction (ED)

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 e.g. priapism.

1st Line: Sildenafil 50mg/dose/day PRN (increase to max 100mg 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/dose/day PRN (max 20mg)
(Patient-funded unless SLS criteria met)

4 tablets per month PRN are recommended. In certain circumstances more e.g. 8 Tadalafil tablets per month after radical prostatectomy. Daily Tadalafil is not recommended.

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
Lewisham - John Miell, Aarthi Surendran
Greenwich - Jennifer Tremble
QM Sidcup – Serife Mehmet

Psychosexual services:
KCH – Leonor Herrera Vega
GSTT – Leila Frodsham

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Guideline for Erectile Dysfunction (ED)

****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.

'SLS' Selected List Scheme Criteria

Viagra, tadalafil 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**

Low Cardiac Risk:	Intermediate Risk:	High Cardiac Risk:
• Controlled BP • Asymptomatic & <3 CAD risk factors (excluding gender) • Mild valve disease • LVF/CHF NYHA class I • Successful CABG / stenting/angioplasty	• ≥3 CAD risk factors (excluding gender) • Mild or moderate stable angina • Recent MI (2–8 weeks) • LVF/CHF NYHA class II/III • Previous CVA/TIA**** • PVD****	• Uncontrolled BP • Severe /unstable/ refractory angina • LVF/CHF NYHA class IV • Recent MI (<2 weeks) • High-risk arrhythmia • Obstructive HCM • Moderate valve disease
↓	↓	↓
Manage in primary care	Refer to Cardiology	Refer to Cardiology & defer sexual activity until stabilized

↑ Following this patient may move to a Low or High risk group ↑

*** Risk stratification based on: BSSM & EAU guidelines & adapted from the Third Princeton Consensus.

**** Additional tests may be required

Guidelines for Haematospermia

For more information see NICECKS

Reassure patient that the majority of Haematospermia does not indicate a serious underlying cause (non-recurrent Haematospermia does not require investigation)

Examination and Investigation of Recurrent Haematospermia

- BP
- Scrotal, urethral orifice, abdominal examination & DRE
- Urinalysis & Urine MC&S
- STI screen
- PSA if age over 40 years, family history or at risk group
- Consider FBC ±coagulation (Urgent FBC within 48 hours if considering haematological malignancy)

Identify Treatable Causes:

- UTI
- Uncontrolled hypertension
- Use of oral anticoagulants
- Ca Prostate (consider family history)
- Suspected prostatitis (pelvic / perineal pain / ejaculatory discomfort) See SEL prostatitis guideline
- Recent trauma or instrumentation (such as prostatic biopsy) — reassure that symptoms normally settle within 3 months
- STI
- TB / Schistosomiasis infection (rare but take a travel history)

If treatable cause identified – give treatment

If treatable cause not identified – advise 15-20 ejaculations to clear haematospermia

Consider routine referral to Urology if:

- Haematospermia recurs more than 3 months after the first incident

OR

- Haematospermia is persistent despite 15-20 ejaculations

Urgent referral to Urology if

- Painful
- Associated infection not responding to antibiotics

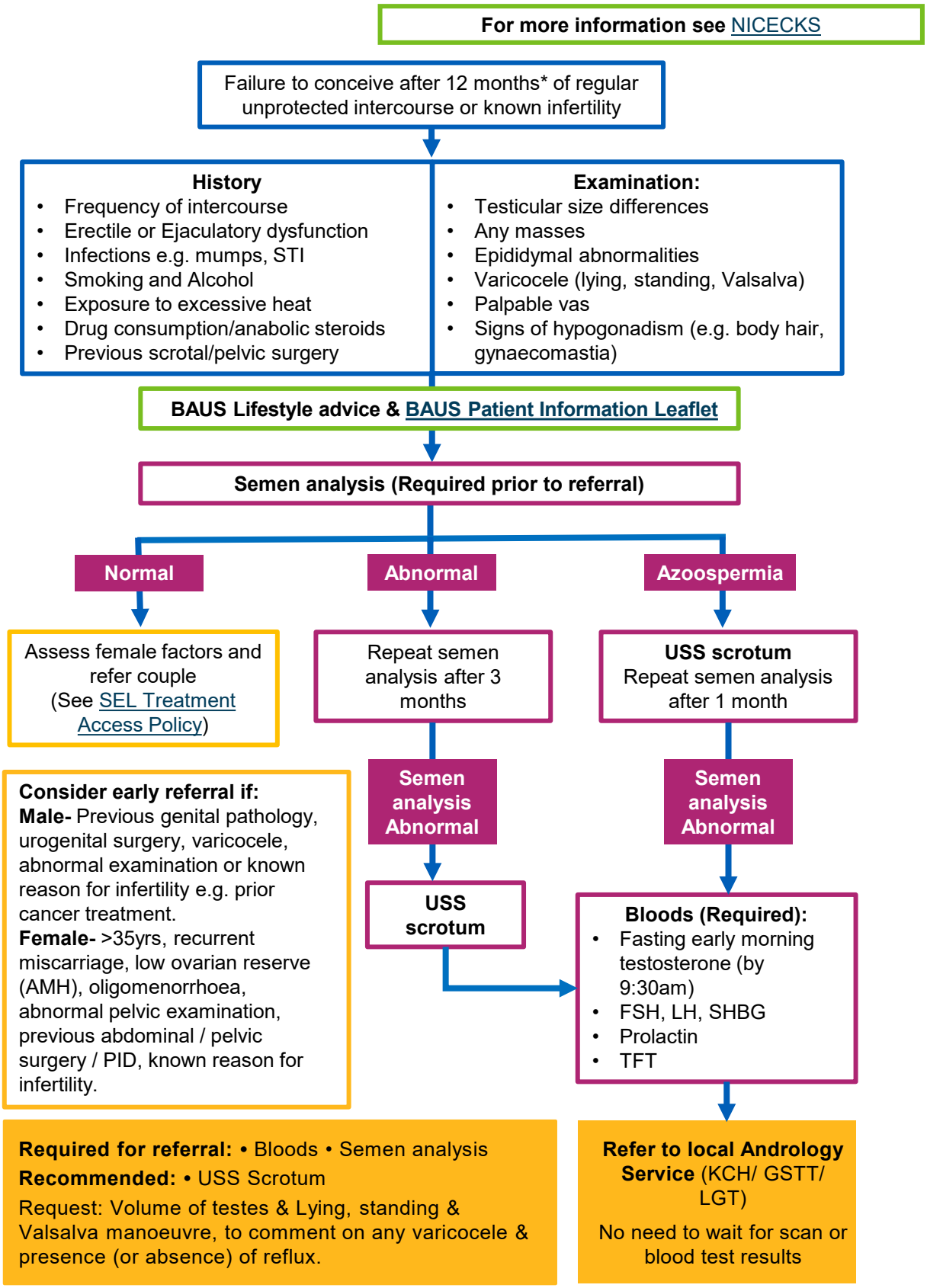
Refer to 2WW Urology if:

- Raised PSA
- Abnormal DRE
- Signs / symptoms of other urological malignancy

Required for referral:

- BP & examination
- Urinalysis & Urine MC&S
- STI screen
- PSA if appropriate

Guidelines for Male Infertility



Guidelines for Penile Deformity

Peyronie's Disease

Palpable lump / thickening in the shaft of the penis

Ask about:

- Pain
- Change in penile shape (curvature/ indentation/ hourglass)
- Change in penile length
- Change in erectile hardness
- Ability to penetrate

Acute phase:
Typically painful with changing shape of erection.
Lasts 6 months on average.
Self-limiting pain.

Chronic phase:
Established change in the penis. Pain settles.

Management in primary care

- Reassure of benign pathology & discuss the natural history
- Provide the **BAUS Patient Information** Leaflet
- Analgesia if required
- If erectile dysfunction is present, consider prescribing a PDE-5 inhibitor (BNF caution). See SEL Erectile dysfunction guideline.

Routine referral to Urology if:

- Causing distress or interfering with sexual function (e.g. poor quality or unstable erection, or affecting ability to penetrate)

Ask patient to take 3 or 4 images of the erect penis from different angles to bring to appointment with the Urologist

Sign post to an advice video by Manchester University NHS Trust on 'How to take Digital Images of your Penile Curvature'

- **N.B** Peyronie's does not require 2WW referral.
- **Penile cancer is a lesion visible on the surface of the skin and should be referred as a 2WW to Urology**

Guidelines for Chronic Scrotal Pain

For more information see NICECKS

Patient presents with over 6 months of scrotal pain

RULE OUT ACUTE CAUSES NEEDING HOSPITAL ASSESSMENT:

- For possible torsion or epididymo-orchitis see SEL Scrotal Lumps and Acute pain guideline
- For possible acute prostatitis see SEL Prostatitis guideline
- Acute extra-scrotal pathology e.g. hernia, renal stones (see below)

Refer 2WW to Urology if concerned about possible tumour:

- See SEL Scrotal Lumps and Acute pain guideline

Consider other non acute urological cause:
Varicocele, hydrocele. If post-operative cause e.g. post-vasectomy pain, persistent haematoma - inform surgical team
Consider non acute extra-scrotal pathology:
Hernia, active back/hip pain, renal stones, history of trauma

1. **Has an infection screen (below) been done?** If not, then request these:
   - STI screen
   - MSU
   - Semen culture (if available) or Post ejaculatory urine culture (see SEL Prostatitis guideline)
2. **Has a Scrotal Ultrasound scan (USS) been done** in the last 6 months with a normal result?
   If not, refer for USS.
   Manage findings as per SEL Scrotal lumps and Acute Pain guideline

NSAIDs or other analgesia ± scrotal support (supportive underwear)

- Is the patient requiring daily analgesia?
- Is the pain affecting quality of life or daily activities?

Yes to the above

Referral to Urology
With a copy of the results

Required for referral: • Ultrasound scan
• Infection screen (MSU, STI screen)
Recommended before referral:
• Semen (or Post ejaculatory urine) culture

No to the above or concerns

Investigate (if not done)
Seek advice and guidance from Urologist if needed

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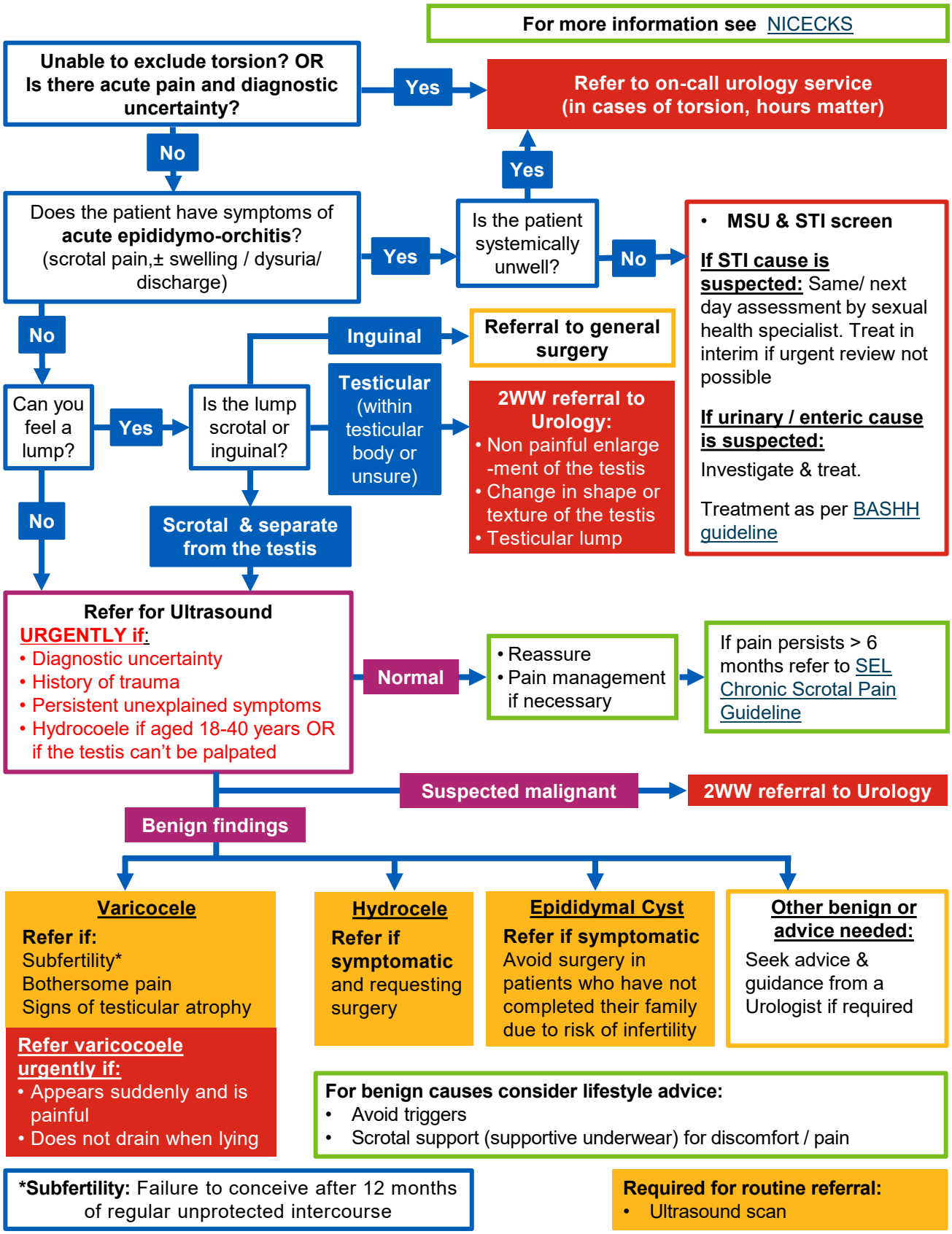
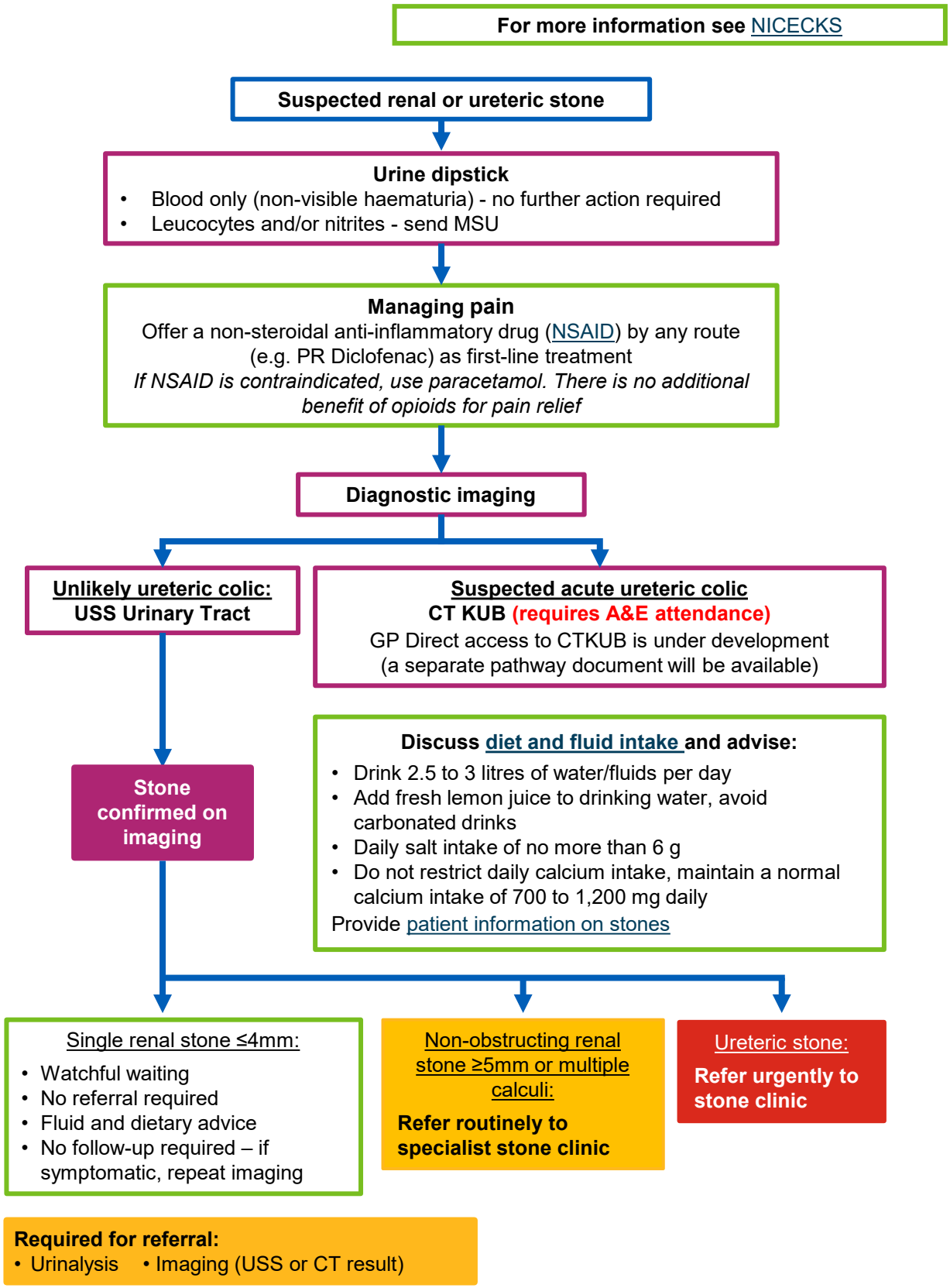
Guidelines for Scrotal Lumps and Acute Pain



Guidelines for Suspected Renal and Ureteric Stones



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

For more information see NICECKS

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

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

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 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. anticholingeric burden or dementia risk) consider Mirabegron.
If lack of Anticholinergic efficacy, increase dose or consider an alternative anticholinergic.
2nd Line: Mirabegron [BNF]. *Contraindicated in severe uncontrolled hypertension (Systolic >180mmHg, Diastolic > 110mmHg)*
3rd Line: Consider Combination therapy i.e. anticholinergic + beta 3 agonist e.g. Solifenacin 5mg and Mirabegron 50mg

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]

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

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

** Anticholingeric 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 tatrate (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 hyrochloride 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
Offer the anticholinergic medicine with the lowest acquisition cost (NICE NG123)			

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**

South East London Acute Provider Collaborative

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

Patient with:
- 2 or more UTIs in 6 months
- 3 or more UTIs in 12 months

Diagnosis of UTI can still be made in the absence of a positive urine culture if the patient has a typical symptoms suggestive of UTI

For more information see NICECKS

2WW referral to Urology if:
- Age ≥45 & unexplained visible haematuria, either without UTI or that persists / recurs after successful UTI treatment
- Age ≥60 & non-visible haematuria & either dysuria or raised WCC
- Suspected cancer

Examination
- Examine abdomen and perform PV exam to exclude pelvic mass, prolapse, palpable bladder and constipation. A pelvic US & post void residual can be used as an alternative.
- Consider neurology

Investigations
- Urine dipstick – for UTI and haematuria
- Urine MC&S
- Consider STI screen
- Consider bloods: U&E, HbA1c
- Consider KUB USS

- If Sterile Pyuria on 2 out of 3 samples consider TB / cancer
- Neurological disease
- Long term catheters
- Pneumaturia
- Pyelonephritis
- Unclear cause

No

Yes (no suspected cancer)

Provide Lifestyle & Self Care Information:
Patient information on recurrent UTI
Information on the interstitial cystitis smart diet
Over the counter options to consider (Advise on high sugar content in both of these**):**
- D-mannose supplement 1-3g 1-3 times daily *
- Regular Cranberry juice or tablets*

NICE decision aid for pre and post-menopausal women (including information on D-mannose, Cranberry, Antibiotics, ± Topical oestrogen)

* Lower quality evidence

KUB Ultrasound and post-void residual (if not already done)

Patient returns with another UTI despite self care

KUB Ultrasound and post-void residual (if not already done)

Abnormal USS

Routine referral to Urology / Uro-gynaecology

Normal USS

Primary Care Management
1. **Vaginal oestrogens** if post-menopausal [BNF]
2. **Post-coital UTI single dose antibiotic** prophylaxis within 2 hours of intercourse / identified trigger. Trimethoprim 200mg or Nitrofurantoin 100mg (see MHRA warning). (2nd line Amoxicillin or Cefalexin 500mg)
3. **Consider prophylactic antibiotics** (for 3-6 months) guided by MC&S, with rotational use based on local antimicrobial policy. Counsel on risks. Initially Trimethoprim 100mg or Nitrofurantoin 50-100mg at night (see MHRA warning). (2nd line and can be used in rotation: Amoxicillin 250mg at night or Cefalexin 125mg). Select a different antibiotic for acute UTI.
4. **Consider Methenamine Hippurate*** (Hiprex) [BNF] 1g twice a day if unresponsive (3rd line in SEL Formulary)

Further infections

Required for referral:
- KUB USS
- Bloods
- Copy of MSU results

South East London Acute Provider Collaborative

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
- Consider USS for post void residual and to assess pelvic organs

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)

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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
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
H	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
WCC	White blood Cell Count

Glossary

Non-Visible Hematuria	Blood in the urine detected on urinalysis or microscopy. In SEL microcopy 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