



Dr Anna Lawrence

Urologist

Auckland Surgical Centre



Mr Simon Van Rij

Urologist

OneSixOne Urology

Auckland

Saturday, June 10, 2017

FULLY BOOKED
(Room 11)

11:00 - 11:55 WS #121: Case Studies of Common Urologic Problems in General Practice

12:05 - 13:00 WS #133: Case Studies of Common Urologic Problems in General Practice
(Repeated)

SMALL LEAKS & LARGE SWELLINGS: UROLOGY AT THE COAL FACE

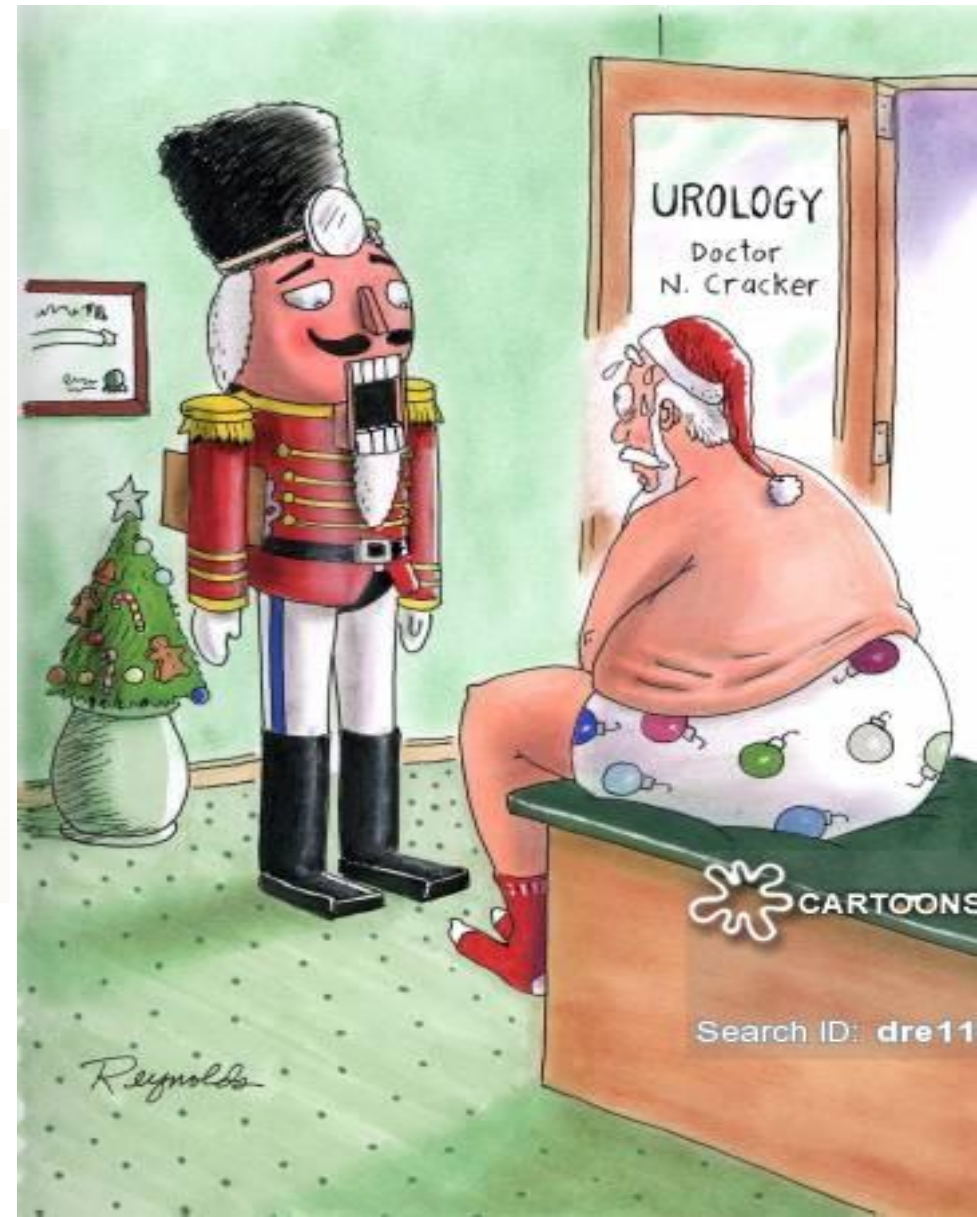


Anna Lawrence – Urologist, Auckland & North Shore

Simon van Rij – Urologist, Auckland & North Shore

WHAT IS THE COAL FACE.....

- No Robots
- No lasers
- No fancy figures
- No overseas graphs



DISCLOSURES / CONFLICTS OF INTERESTS

- **My wife is a General Practitioner**
- **Paid Speaker for Biogen Ltd NZ**

WHAT YOU ACTUALLY SEE IN GENERAL PRACTICE

- **What you can start managing today**

Dr. Anna Lawrence

- Only NZ Urologist with Fellowship in:
Reconstruction, Stricture, Spinal, Incontinence
Urology
UC Davis, California
Pune, India
- Auckland and Counties DHB
- Spinal Unit
- Private practice North Shore and Auckland

COMMON PROBLEMS....

- Molly
- 35yrs
- 2 children
- Presenting again with symptoms:
 - Frequency
 - Urgency
 - pain



RECURRENT UTIS....

- **Defined as 3 + UTIs in 12months**
- **Dx clinically with:**
 - Dysuria
 - Frequency
 - Hematuria
 - Urgency
 - New onset incontinence

RECURRENT UTIS.....

- **50% of females** will experience a UTI
- **25% of woman with a UTI will go on to develop recurrent UTIs**
- If the first UTI is an E.Coli = 44% chance of developing recurrent UTIs

RECURRENT UTIS.....

- Indications for early referral:

- Previous abdo-/perineal surgery
- Previous stone disease
- Gross hematuria after infection resolution
- Bacterial persistence despite appropriate ABS
- Previous urological trauma / surgery
- Immunocompromised
- Urease splitting bacteria –proteus/
pseudomonas
- Pneumaturia/ feacaluria

RECURRENT UTIs.....

- **MANAGEMENT:**

- **No good evidence** for behavioral management
- Fluids
- Voiding after intercourse
- Spermicides
- Showers
- Front to back
- Void q4hourly

- **ALTERNATIVES.....**

- If ex/ smoker – test cytology/ Cx bladder
- ?TB exposure
- **BLADDER PAIN SYNDROME/ IC**
 - Persistent pain
 - Relieved by voiding
 - All day + night

RECURRENT UTIS.....

- **MANAGEMENT:**
 - LOW DOSE CONTINUOUS ABS
 - BETTER THAN NO ABS
 - REVERT TO PREVIOUS FREQUENCY ONCE DISCONTINUED
 - MINIMAL RISK OF SE
- **POST COITAL ABS**
 - NO DIFFERENCE TO CONTINUOUS
 - TAKEN WITH 2HOURS

RECURRENT UTIS.....

- **CRANBERRY:**

- Proanthocyanidins - that prevent bacteria from sticking to the bladder wall and beginning the growth process.
- Need at least 36 mg/g proanthocyanidins

- **D-Mannose:**

- Regular use significantly reduced the risk of recurrent UTI
- No different than in Nitrofurantoin group in recent study but higher compliance to therapy
- 1 -2g/day

RECURRENT UTIS.....

- UROMUNE:
 - SUBLINGUAL IMMUNOMODULATION
 - SPANISH
 - 3 MONTHS OF X2 DAY SPRAY FOR 15+ PROTECTION
- INSTALLATIONS
- HIPREX

Mr. Simon van Rij

- @sivanrij 
- Fellowship training:
- Prostate cancer, Robotics, Lasers, Kidney cancer, LUTS
- Auckland Hospital
- Private: North Shore and Auckland

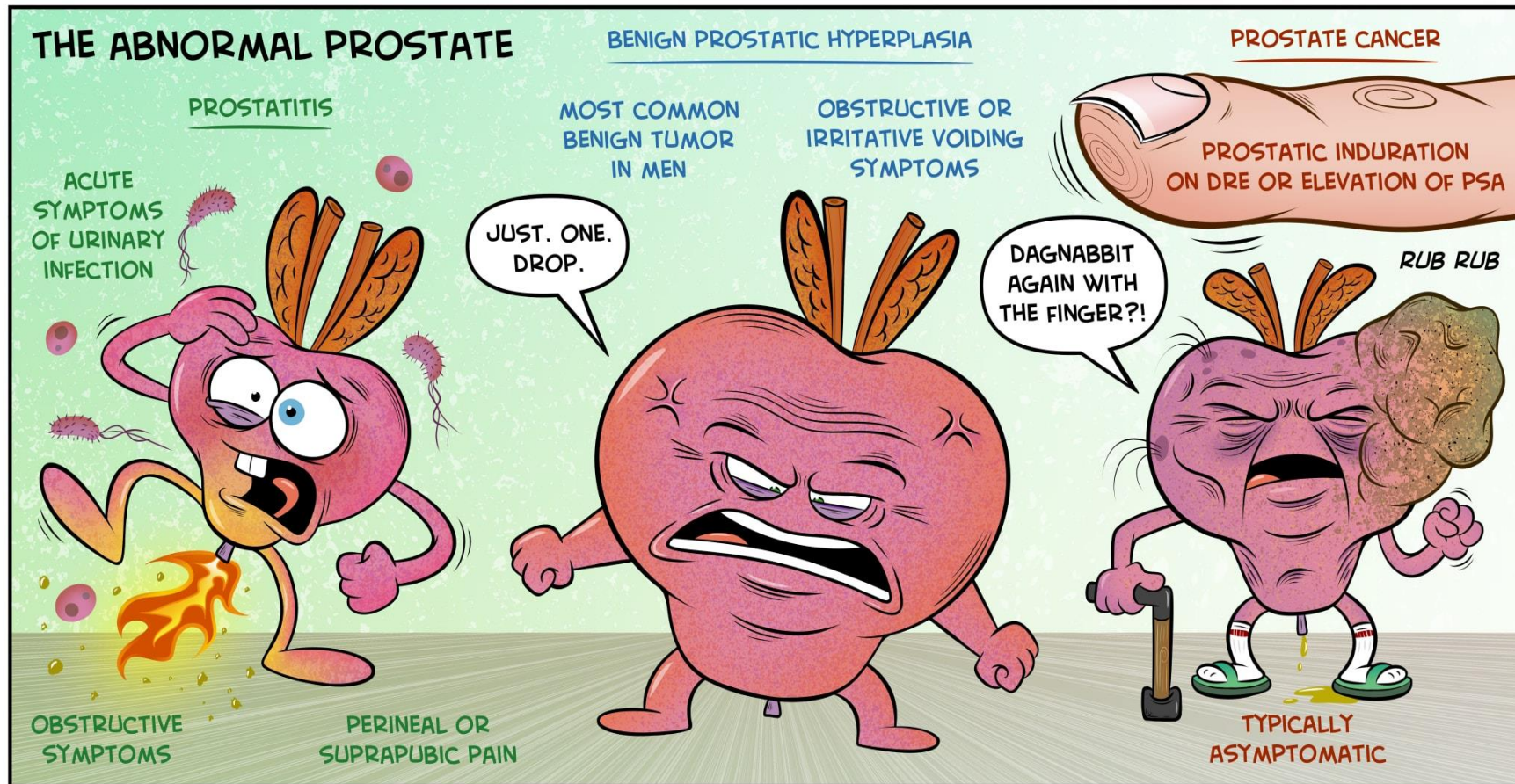
MR. T

- 76y
- “I’m not sleeping well, it is frustrating the number of times at night I need to get up to pass urine”



SO ITS JUST A PROSTATE PROBLEM, RIGHT?

- So this is just a prostate problem isn't it?



QUESTIONS TO ASK..

- Urinary flow “How would you describe your flow”
- Urinary symptoms during day
- Urinary symptoms during the night:
 - “how much bother does it cause?”
 - “Is it worth getting out of bed for?”
 - “What wakes you up?”
- Incontinence/leakage
- Fluid intake during day and night

BOTHER, BOTHER, BOTHER..

- Measure of level of bother

- Qualitative measure

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ TODAY'S DATE: _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. TOTAL: _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Figure 1: An Example of a Bladder Record at:
<http://kidney.niddk.nih.gov/KUDiseases/pubs/diary/pages/page1.aspx>

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble. The “sample” line shows you how to use the diary.

Your name: _____

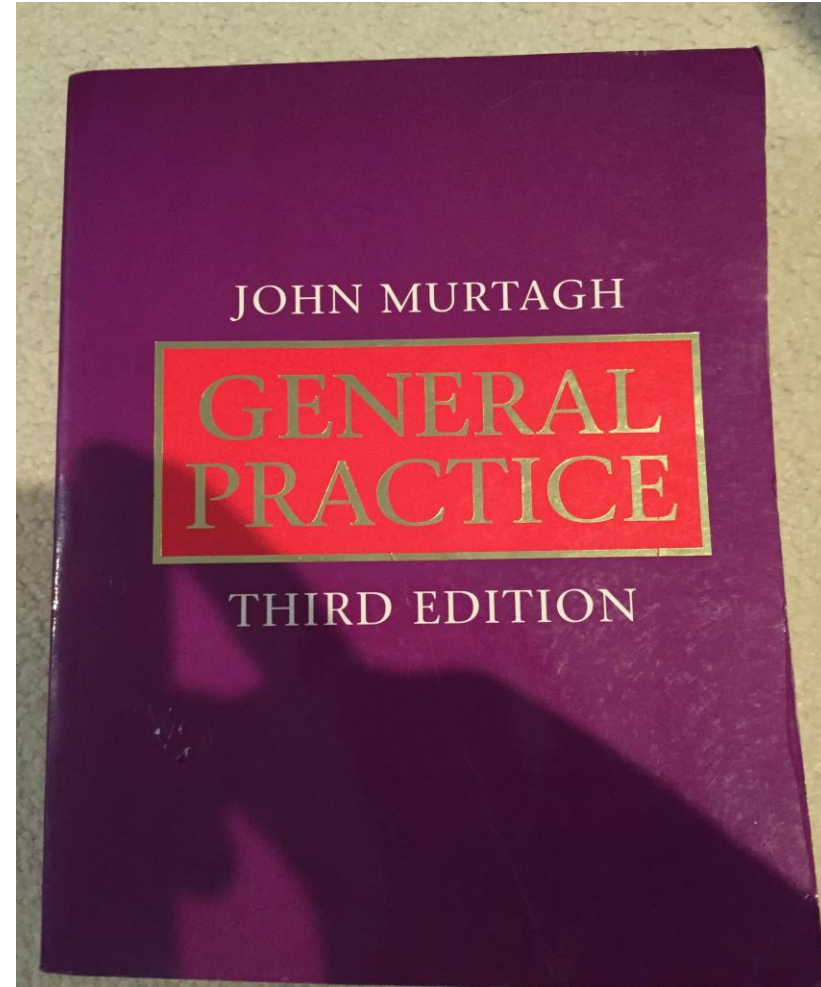
Date: _____

Time	Drinks		Trips to the Bathroom			Accidental Leaks			Did you feel a strong urge to go? Circle one	What were you doing at the time? <i>Sneezing, exercising, having sex, lifting, etc.</i>
	<i>What kind?</i>	<i>How much?</i>	<i>How many times?</i>	<i>How much urine? (circle one)</i>	<i>How much? (circle one)</i>					
Sample	Coffee	2 cups	✓✓	☒ sm ☐ med ☐ lg	☐ sm ☒ med ☐ lg	Yes	☒ No	Running		
6-7 a.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
7-8 a.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
8-9 a.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
9-10 a.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
10-11 a.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
11-12 noon				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
12-1 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
1-2 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
2-3 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
3-4 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
4-5 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
5-6 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			
6-7 p.m.				☐ ☐ ☐	☐ ☐ ☐	Yes	No			

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

MURTAGH RED FLAGS

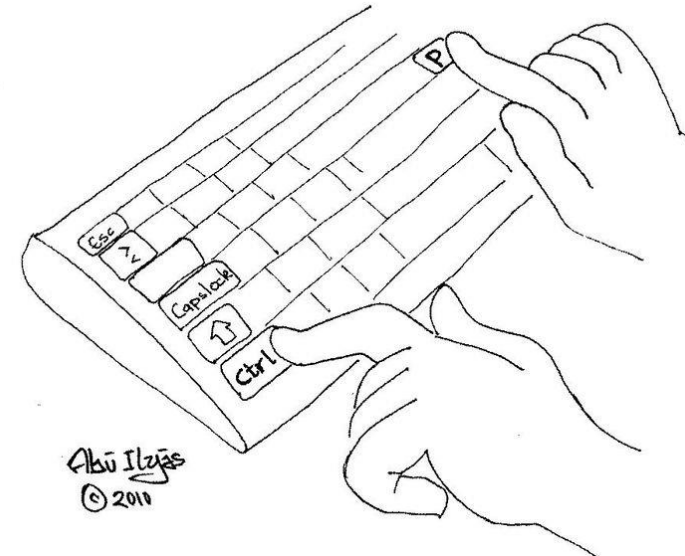
- Blood in urine
- New back pain /neurological
- Wetting the bed at night
(overflow incontinence)



BACK TO OUR PATIENT....

- “Urine dribbles a bit”
- Past Med Hx:
 - No urological history
 - Hypertension – on ACE
 - AF on Dagabatrín
 - No other medications

*The Urologist's favourite
keyboard short cut*



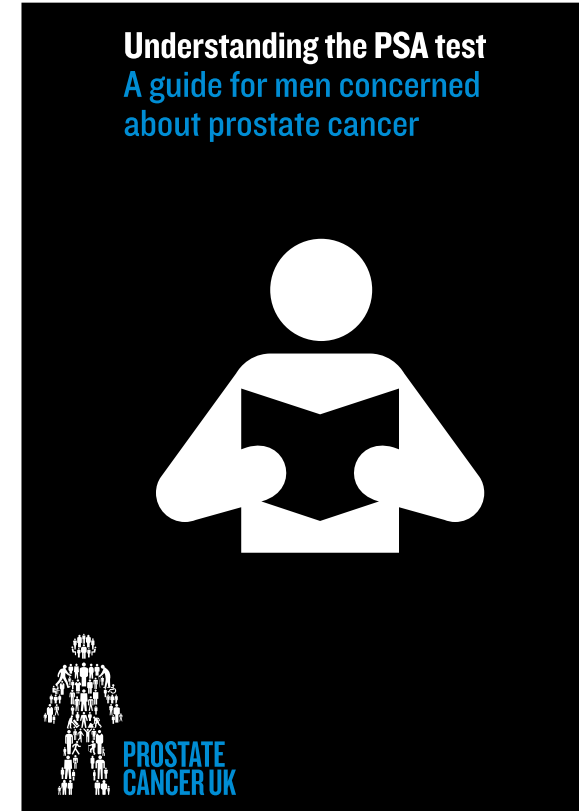
IS AN EXAM HELPFUL???

- PR exam?
- Anything else?



TREAT EMPIRICALLY OR DO INVESTIGATIONS?

- Dipstick
 - Negative
- Blood tests
 - PSA - ? Can of worms



SO IT'S A PROSTATE PROBLEM

- Alpha blocker
- Which one?
- Which dose?



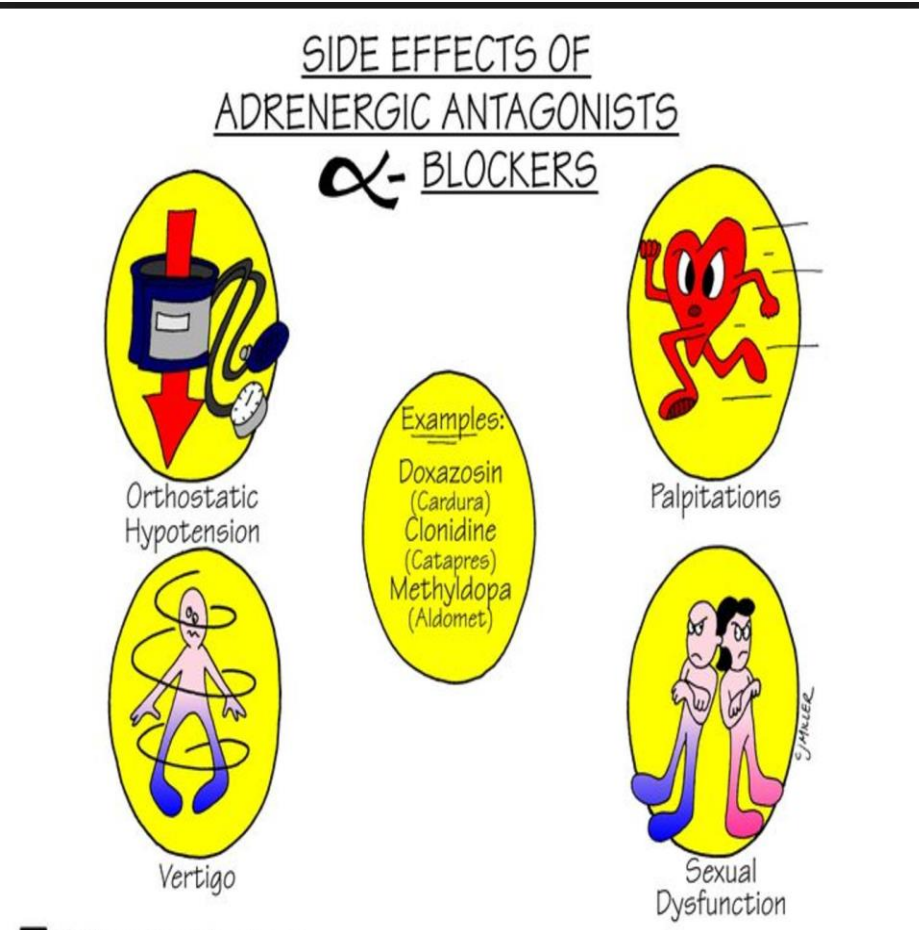
ALPHA -BLOCKERS

- Non-selective:
 - Doxazosin
 - Terazosin
 - Similar efficacy, need to titrate dose
- Selective (therefore no postural hypotension):
 - Tamsulosin 0.4mg OD
 - Special Authority, no titration



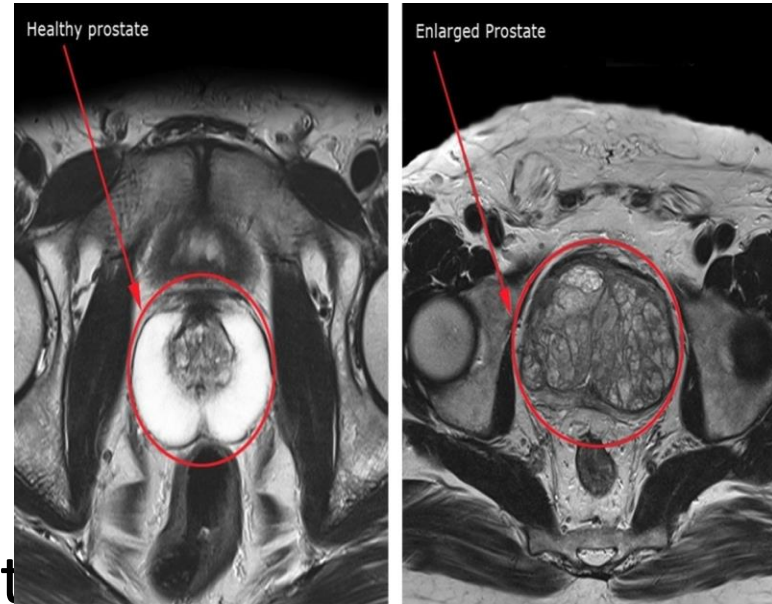
BE WARY OF SIDE EFFECTS..

- We all know postural hypotension
- Sexual function
 - Anejaculation
 - Retrograde ejaculation



WHERE DOES FINASTERIDE FIT IN?

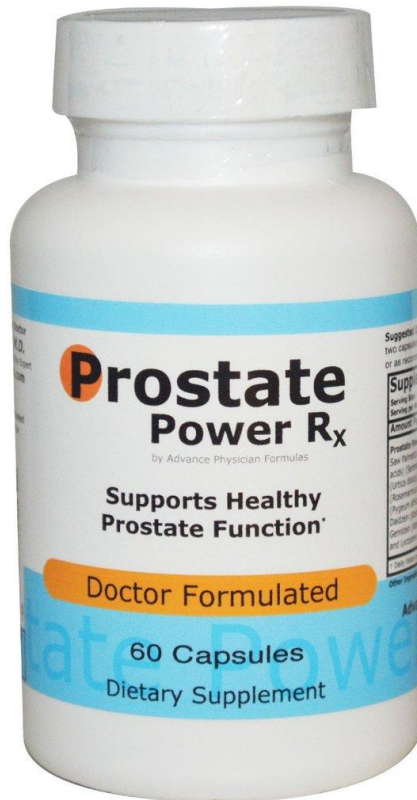
- 5 alpha reductase inhibitor – testosterone metabolism
- Special Authority in NZ
- Doesn't work if prostate <40ml
- Decreases PSA levels
 - effect on surveillance
- Conflicting data around high risk prostate



HOW DO I USE FINASTERIDE?

- Second line agent once alpha-blocker not working
- Generally avoid in young men
 - Sexual side effects, small prostates
- Advise will take 3-6 months to take effect.

“But what about going natural Doc”



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★★★★★

The #1 "five-star rated" doctor formulated prostate supplement on Amazon.com for a reason - it works!

ALTERNATIVE OPTIONS..

- Saw Palmetto and other compounds have been shown to improve urinary symptoms
- Expensive
- Still has side effects
- Empowering the patient



3 MONTHS LATER..

- No improvement in his night time symptoms
- Flow maybe slightly better
- “Have I just got a weak bladder?”



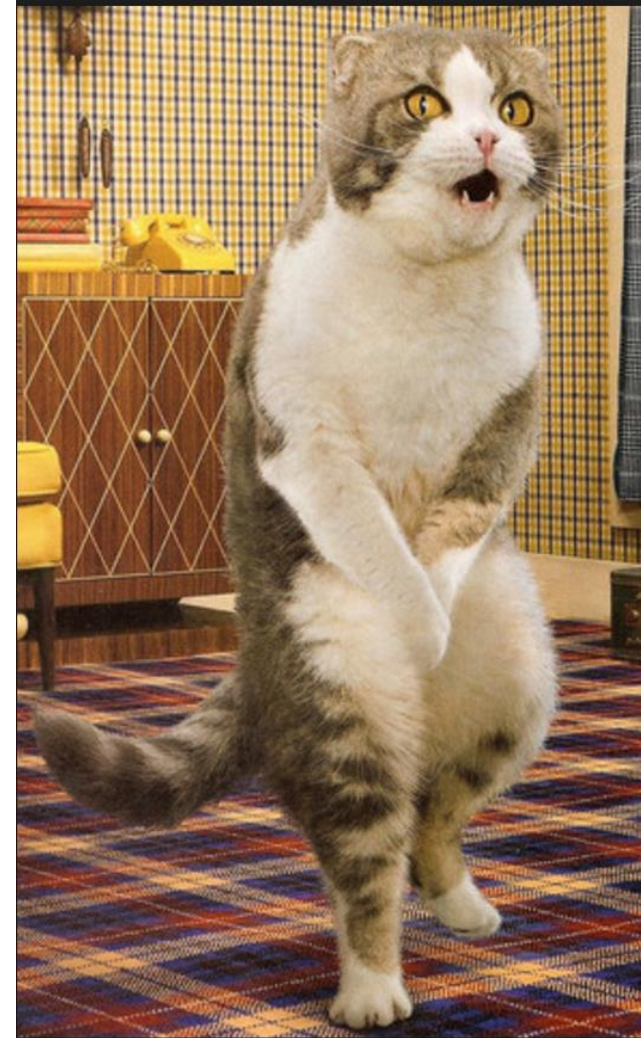
OPTIONS...

- Further treatment?
- Refer to specialist?



IS THERE SUCH A THING AS A “WEAK BLADDER”?

- Oxybutynin
 - Anticholinergic
 - Dull down the sensation
 - Archaic medication – be wary in elderly
- 2.5mg OD or BD can titrate to 5mg TDS



ALTERNATIVES TO ORAL OXYBUTYNIN...

1. SOLIFENACIN

- Special authority:
 - Intolerant to oxybutynin
- Start at 5mg can increase to 10
- Should be standard treatment

3.TOLTERODINE

- 4. TOPICAL OXYBUTYNIN

SIDE EFFECTS



SAFER ALTERNATIVES..

- Advocating for “Betmiga”
- Beta 3 antagonist for NZ

astellas

Why have your usual OAB consultation... ...when you can have a Betmiga conversation?

Typical side effects like dry mouth can make antimuscarinic treatment hard to live with.^{1,2} But why let those issues dominate patient consultations when you can talk about something else? Betmiga relaxes the bladder via [], adrenoceptors in the sympathetic nervous system.³ The result: a level of efficacy you might expect of an antimuscarinic, but more patients staying on treatment through 12 months.^{3,4}

Sympathetic treatment for overactive bladder

Betmiga™ ▼ (mirabegron) Prescribing Information
Presentation: Betmiga™ prolonged-release film-coated tablets containing 50mg or 25mg mirabegron. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence in non-neurotic adult patients with overactive bladder (OAB) syndrome. **Dosage:** Adult (including the elderly): Recommended dose: 50mg once daily. Children and adolescents: Should not be used. **Contraindications:** Hypersensitivity to either substance or one of the excipients. Severe uncontrolled hypertension. **Warnings and Precautions:** Should not be used in patients with and signs and/or symptoms of severe hepatic impairment (or severe hepatic impairment in patients requiring immediate or severe hepatic impairment). Not recommended in patients with severe renal impairment and/or moderate hepatic impairment concurrently receiving strong CYP2D6 inhibitors. Dose adjustment to 25mg is recommended in patients with mild/moderate renal and/or mild hepatic impairment receiving strong CYP2D6 inhibitors concurrently and in patients with severe renal and/or moderate hepatic impairment. Moderate to severe dry mouth may occur. Blood pressure should be monitored at baseline and periodically during treatment, especially in hypertensive patients. Caution in patients with a known history of QT prolongation as in patients taking medicines known to prolong the QT interval. Use with caution in patients with clinically significant bradycardia under observation (BOS) and in patients taking anticholinergics for OAB. Not recommended during pregnancy and in women of childbearing potential not using contraception. Not recommended during breastfeeding. **Interactions:** Clinically relevant drug interactions between Betmiga™ and medicinal products that inhibit, induce or are a substrate for one of the CYP isoenzymes or transporters are not expected, except for inhibitory effect on the metabolism of CYP2D6 substrates. Betmiga™ is a moderate and time-dependent inhibitor of CYP2D6 and weak inhibitor of CYP3A. No dose adjustment needed when administered with CYP2D6 inhibitors or CYP3A poor metabolizers. Caution if co-administered with medicines with a narrow therapeutic index and significantly metabolized by CYP2D6. When initiating a combination with digoxin, the lowest dose for digoxin should be prescribed and serum digoxin levels should be monitored and oral therapy of digoxin discontinued if there are indications of CYP2D6 or P-gp decrease the plasma concentrations of Betmiga™. No dose adjustment is needed for Betmiga™ when administered with theophylline doses less than 400mg or after CYP2D6 or P-gp induction. The potential for inhibition of P-gp by Betmiga™ should be considered when combined with sensitive P-gp substrates; increase in mirabegron exposure due to slowing down excretion may be associated with increases in plasma concentrations. **Effects:** Dryness: dry mouth, nasopharynx, nose, conjunctiva, throat, headache, dizziness, nasal infection, cystitis, vaginitis, uterine infection, dyspareunia, genital, urinary tract, rash, eczema, skin papules, pruritus, joint swelling, subconjunctival injection, blood pressure increase, low myopia, lacrimation, eyelid edema, eye infections, leukocytoclastic vasculitis, prostatic enlargement, urinary retention, hypertensive crisis and ischemia. **Precaution:** Should consult the Summary of Product Characteristics in relation to other side effects. **Pack and prices:** Betmiga™ 50mg and Betmiga™ 25mg each pack of 30 tablets/30 days. **Legal Category:** POM. **Preparation:** April 2016. **Further information available from:** Astellas Pharma Ltd., 2000 Wilford Drive, Cheshire, Skelton, M11 0NS, UK. Betmiga™ is a registered trademark. All IP prescribing information please refer to the Summary of Product Characteristics. For Medical Information phone 0800 783 5018.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Astellas Pharma Ltd. Please contact 0800 783 5018

References: 1. Surveys 75 of all HRP 2009, 105, 1216–122. 2. Hannon J et al. Eur Urol 2014, 65, 755–65. 3. Betmiga Summary of Product Characteristics, April 2016. 4. Amato data on file. BET140470R, February 2016.

Date of preparation: September 2016

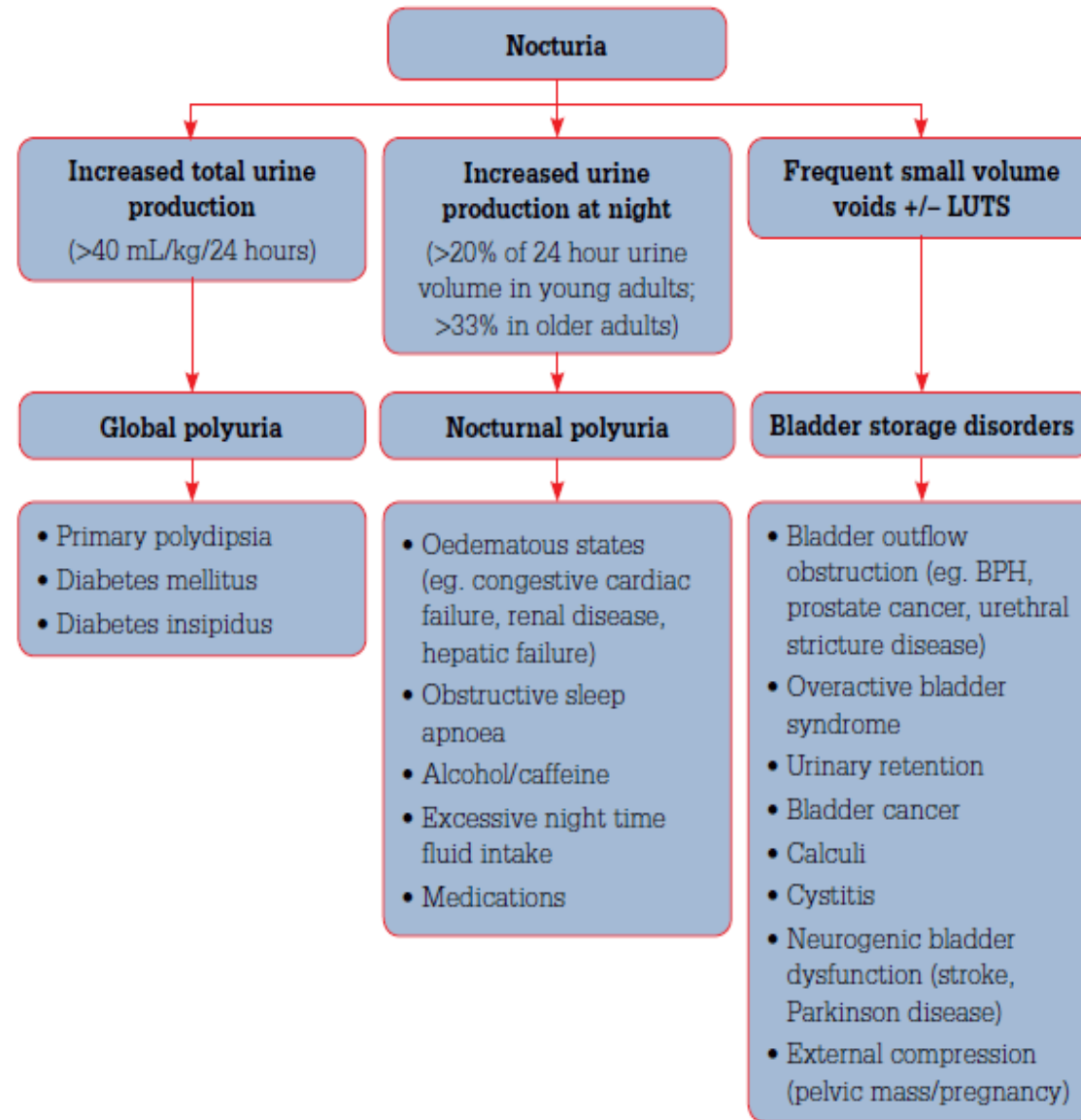
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BACK TO THE PATIENT AT HAND..

- Despite all this he is still getting up in the night.
- Is there anything else or resigned to this for life?
- Nocturia is difficult to treat because it is of multi-factorial cause

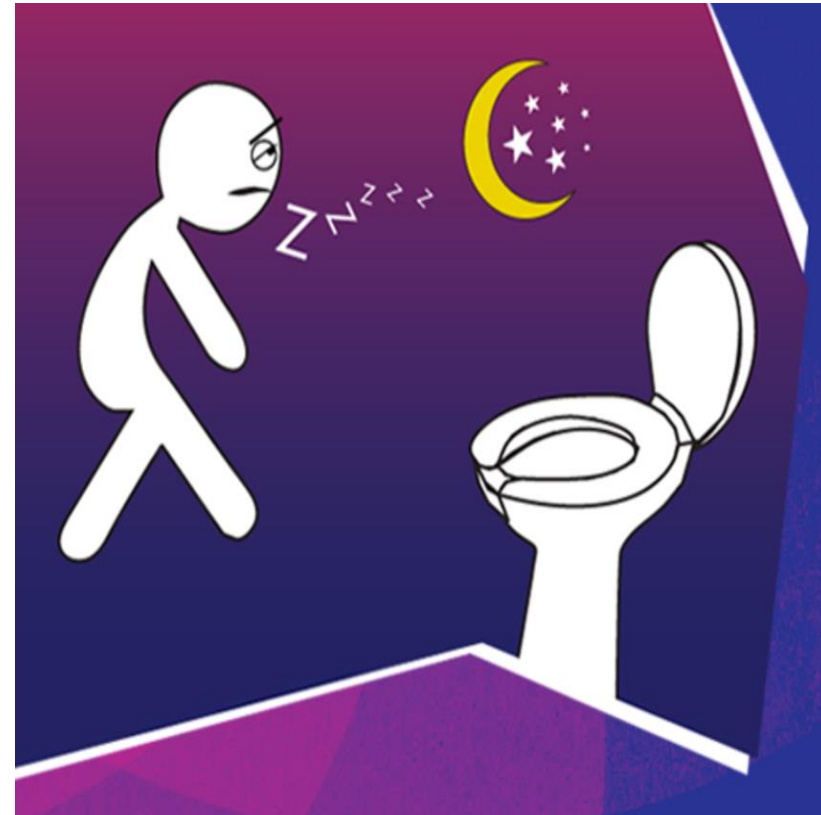


NOCTURIA



NOCTURIA : MULTIFACTORIAL

- General Practitioners:
 - Often better at treating as have expertise to manage all of the potential causes and provide continuity of care in terms of side effect profiles.
- NICE guidelines on Nocturia – written by General Practitioners



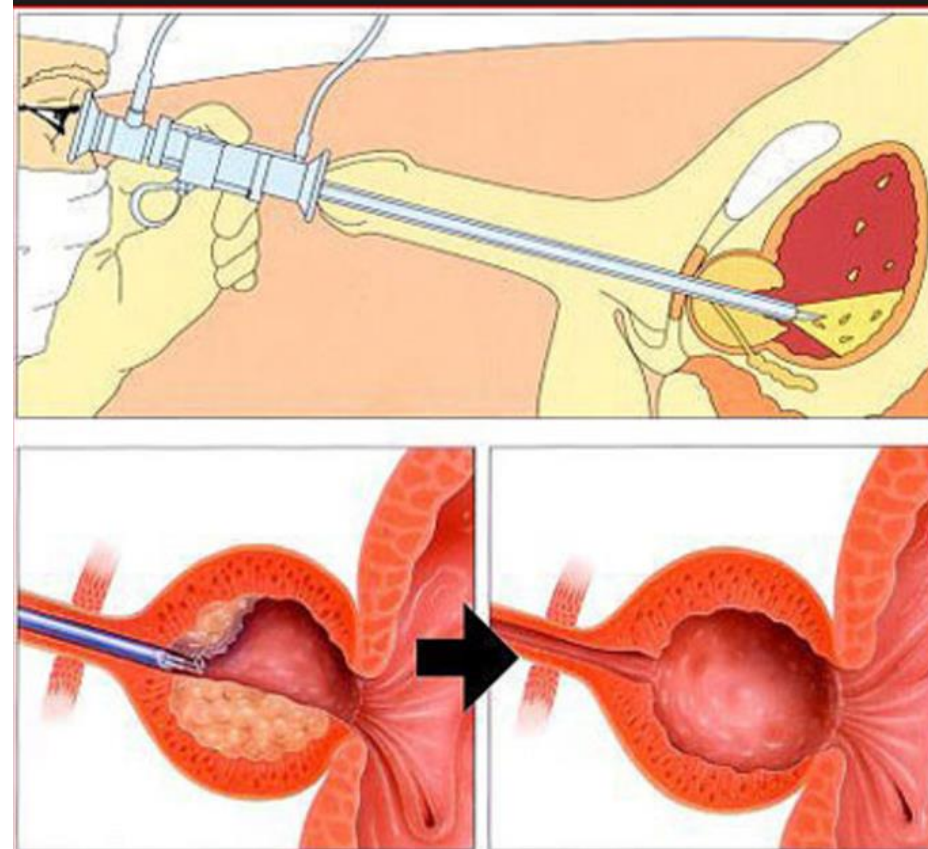
OUTSIDE THE BOX...

- Frusemide?
- Lifestyle changes?
- Surgery?
- Desmopressin?



BPH: SURGICAL OPTIONS

- All Endoscopic (no cuts, telescope via penis)
- TURP stands for:
 - Transurethral resection of prostate
- Is the laser any better?
 - Less bleeding, less irrigation
 - Best for large prostates
 - Anticoagulation

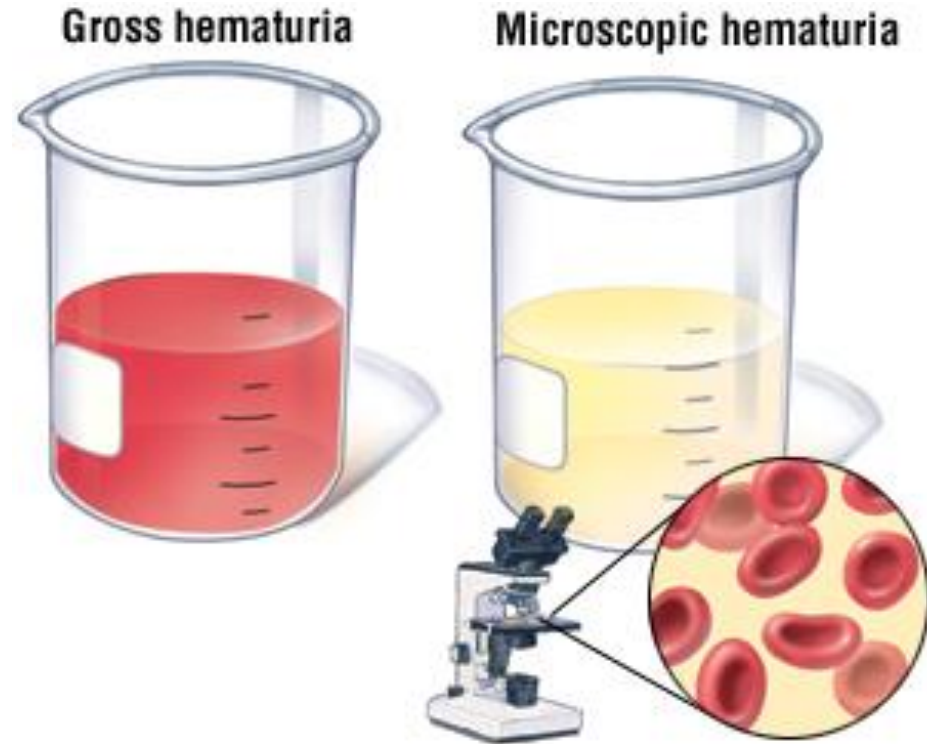


COMMON PROBLEMS....

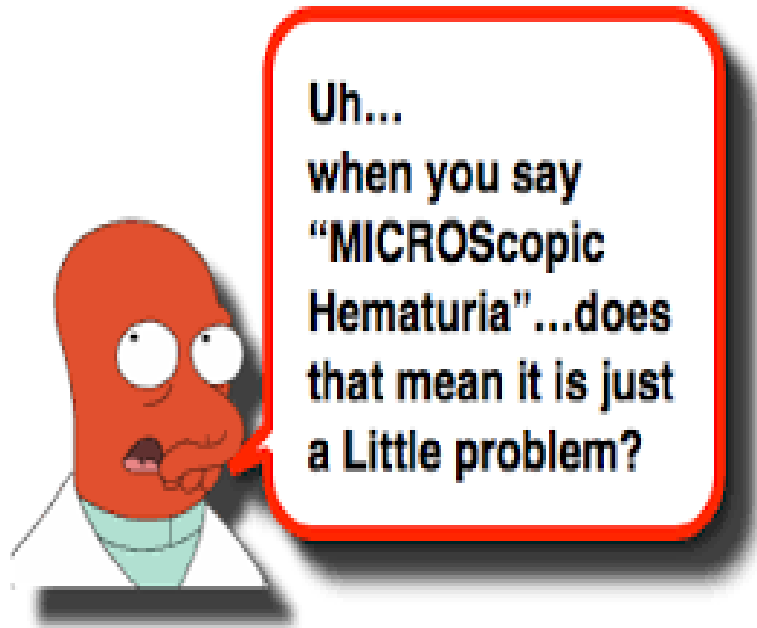


MACROSCOPIC / GROSS HAEMATURIA

- VISIBLE HAEMATURIA
 - PINK
 - RED
 - COLA COLOUR
- REFER!!
 - OUTSIDE OF TRANSIENT CAUSES
 - If in Retention – straight to ED



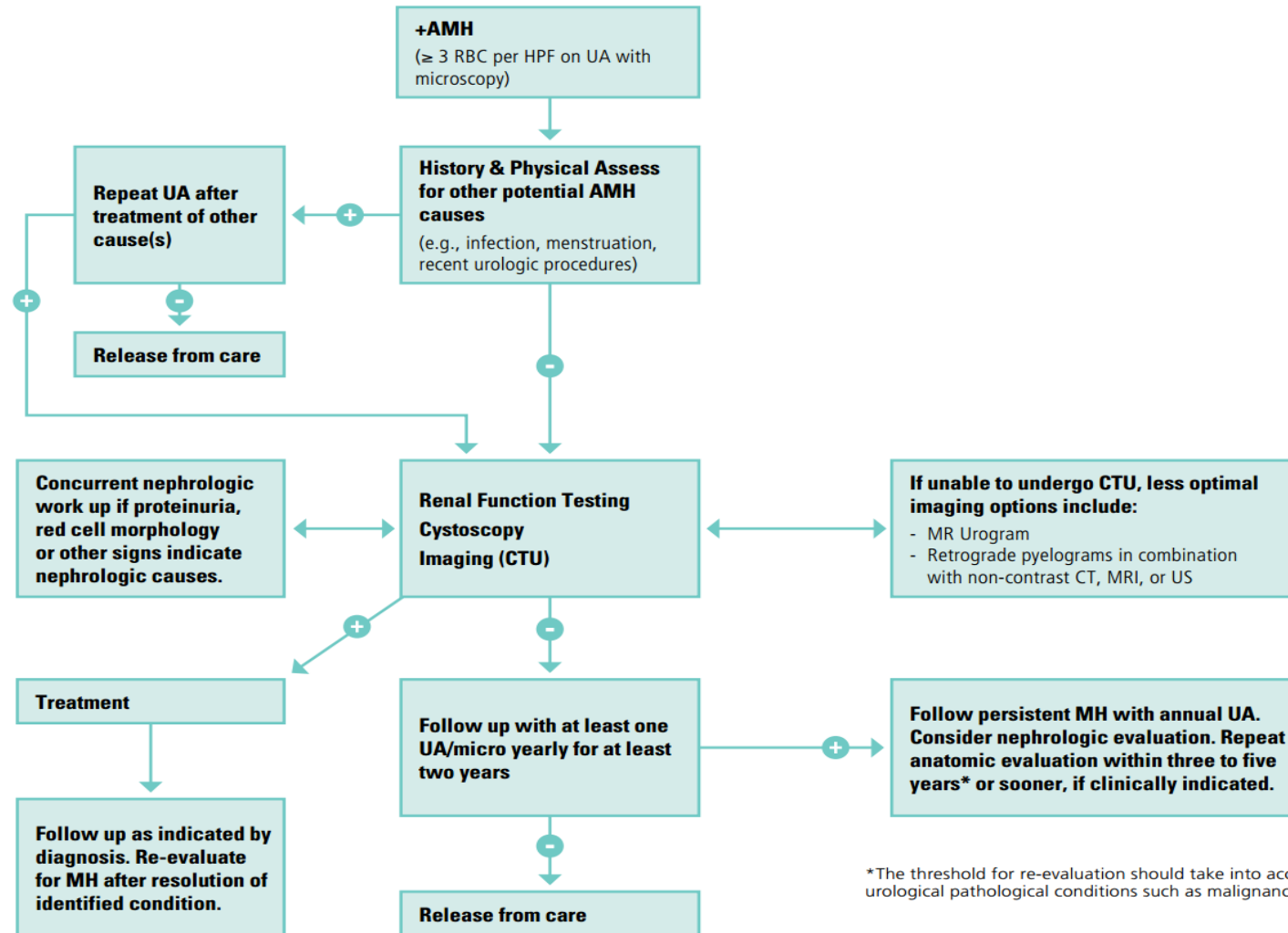
MICROSCOPIC HAEMATURIA



- **MICROSCOPIC :**
 - Urine positive (1+) on two out of three consecutive dipsticks (2/52 period)
 - 3 or greater red blood cells per high powered field

PATHWAY

Diagnosis, Evaluation and Follow-up of AMH



*The threshold for re-evaluation should take into account patient risk factors for urological pathological conditions such as malignancy.

TAKE HOME MESSAGES....

- **MACROSCOPIC HAEMATURIA:** WITHOUT INFECTION – **IMMEDIATE REFERRAL**
- **MICROHAEMATURIA:** FOLLOW PATHWAYS BUT AWARE OF PATIENT RISK FACTORS
- **FEMALE PATIENTS:**
 - REMEMBER THE URINARY TRACT WHEN NO CAUSE OF POST MENOPAUSAL/ PERI-MENOPAUSAL BLEEDING IS FOUND

Mrs B 40y

- “I am very concerned about my son Tom’s penis. The foreskin won’t retract and he is about to start school swimming”

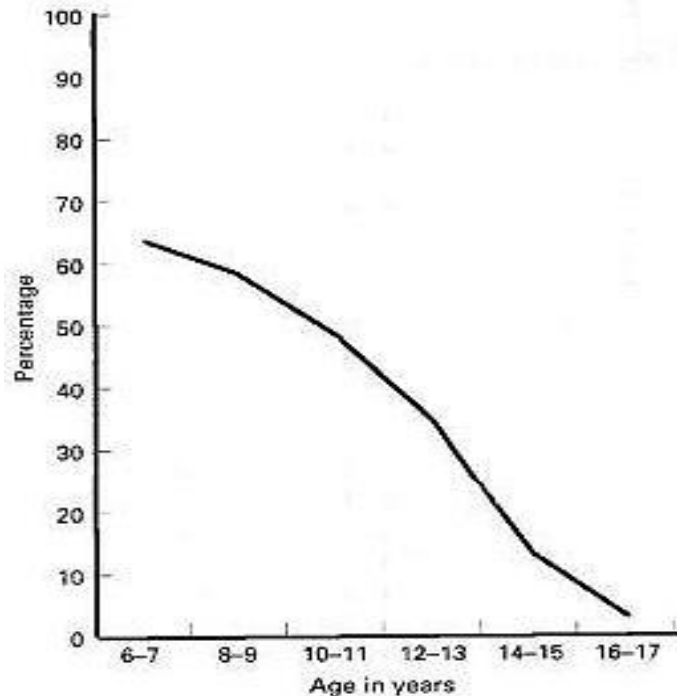


PHIMOSIS

- Inability to retract the foreskin
- Physiological vs pathological
- Social, Religious and cultural factors

CHILDREN

- Physiological process
 - 40% at 1 year
 - 90% at 4 years
 - 99% at 15 years.



- Don't force it
- Trial steroid cream:
 - 0.05% betamethasone cream should be used twice daily for 2 to 4 weeks.
- Circumcision if complications:
 - Pain
 - Ballooning
 - Recurrent infection
 - Other medical condition

YOUNG ADULTS

- “Always had it but now that I am sexually active it is causing ripping and pain”
- Trial steroid cream
- Discuss options
- Frenuloplasty
- Circumcision – websites for this

OLDER MEN

- Hygiene issues
 - Risk of penile cancer extremely rare
 - Lichen Sclerosus – can invade the meatus and urethra
 - Catheter management
-
- Treat under local – dorsal slit or circumcision

PENILE LESIONS: WHAT IS WHAT

- GPs see more lesions than urologists
- Sexual health
- Sexually transmitted infections

BENIGN OR MALIGNANT?



MALIGNANT: PENILE CANCER



BENIGN OR MALIGNANT?



MALIGNANT: PENILE CANCER



BENIGN OR MALIGNANT?



PRE-MALIGNANT – BXO (Lichen Sclerosus)



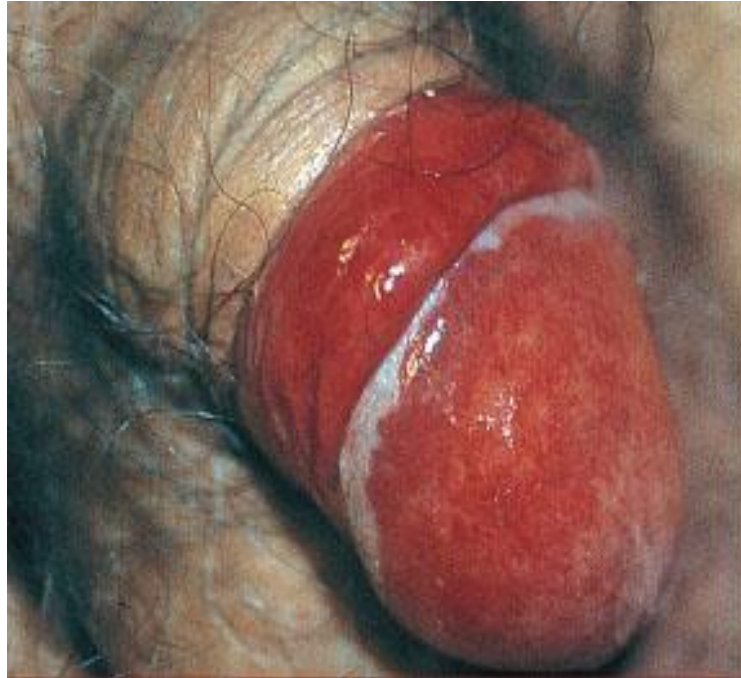
BENIGN OR MALIGNANT?



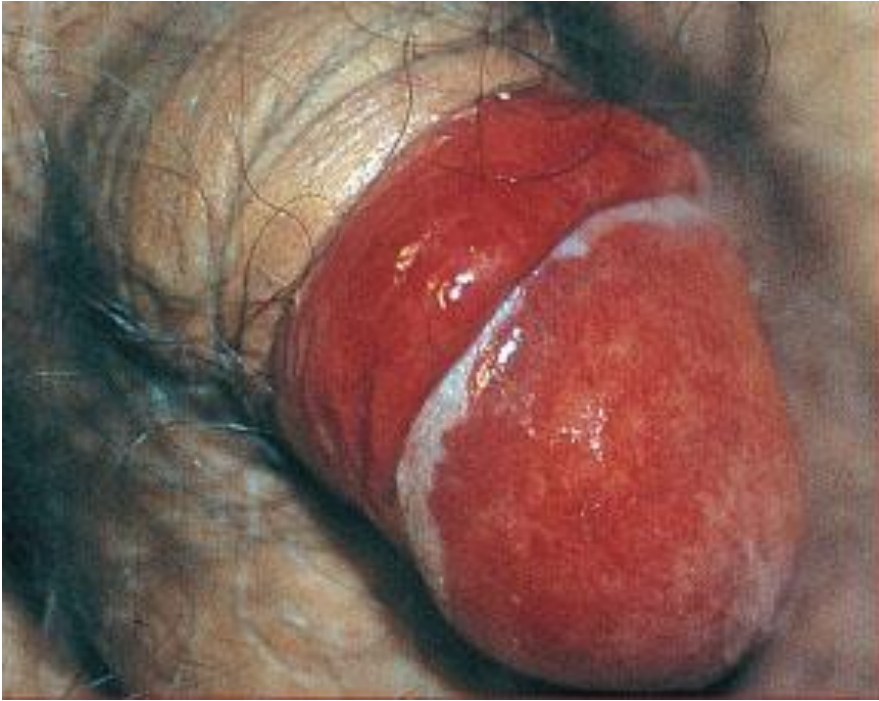
PRE-MALIGNANT -BOWENS /CIS



BENIGN OR MALIGNANT?



BENIGN – ZOON'S BALANITIS



BENIGN OR MALIGNANT?



BENIGN –GENITAL WARTS



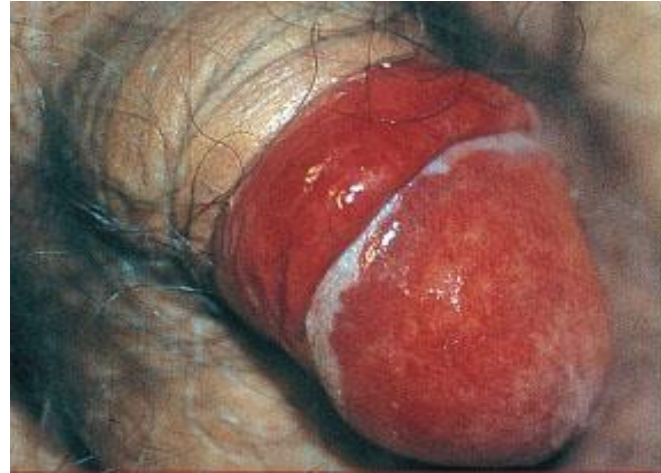
BENIGN OR MALIGNANT?



BENIGN – PEARLY PENILE PAPULES



BENIGN



PRE-MALIGNANT



MALIGNANT



PENILE LESIONS –TAKE HOME MESSAGES

- Age appropriate – young vs old
- STI check if appropriate
- Unsure refer for biopsy

Questions???

- DR. ANNA LAWRENCE
- 022 048 9661 /09 320 0640
- anna@urologyspecialist.co.nz
- MR SIMON VAN RIJ
- Simon.vanrij.co.nz
- 09 623 0161



ZOLADEX

- Hormonal therapy for prostate cancer
- Now the only drug funded by PHARMAC
- Zoladex 10.8mg Inj 3 month supply -
- Safe to transfer over from LUCRIN or ELIGARD
- 0800ZOLADEX – if patients have questions or side effects
- **Breaking news:**
- Hormonal therapy will change very soon and the drug monitoring will get more onerous

OBESITY AND THE DISAPPEARING PENIS

- MY PENIS IT HAS DISAPPEARED
- 31% = Obese
- 35% = Overweight
- ADULT BURIED PENIS IS AN INCREASING PROBLEM...

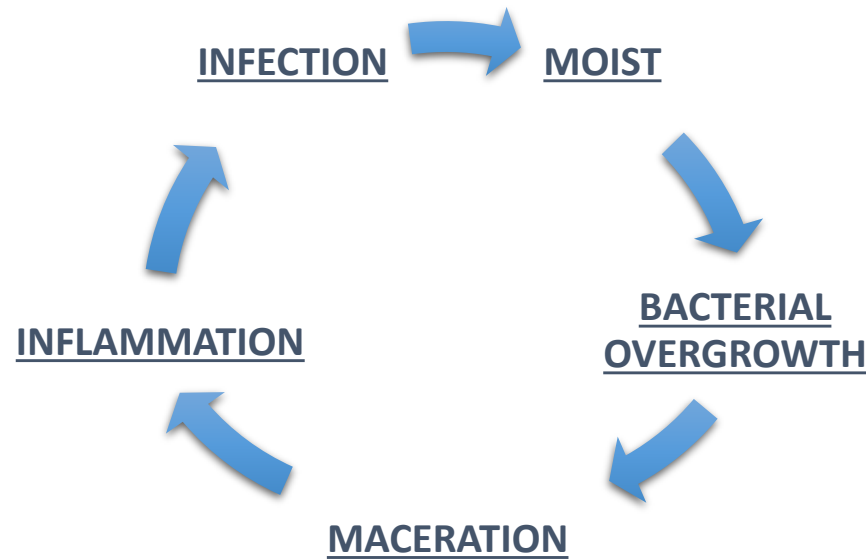


OBESITY AND THE DISAPPEARING PENIS..

- WHY IS THIS A PROBLEM??
- HYGIENE
- SKIN BREAK DOWN
- PHIMOSIS
- INCONTINENCE
- “MISDIRECTED FLOW”
- URINARY RETENTION
- SEXUAL DYSFUNCTION
- ERECTILE DYSFUNCTION
- ? POSSIBLE PRECURSOR TO SCC AS SITTING IN MOIST ENVIRONMENT CAUSING MALADAPTIVE SKIN CHANGES
- PSYCHOLOGICAL HEALTH

OBESITY AND THE DISAPPEARING PENIS

- SO WHY DOES THIS HAPPEN...
 - WITH INCREASED WEIGHT



OBESITY AND THE DISAPPEARING PENIS

- WHAT CAN I DO DOC?
 - WEIGHT LOSS AND EXERCISE!!
 - NO MEDICAL THERAPIES



"No, it's not water. You seem to be retaining food."

OBESITY AND THE DISAPPEARING PENIS

- **SURGERIES:**

- MULTIPLE DIFFICULT OPERATIONS AVAILABLE
- LIPOSUCTION , SKIN GRAFTING, TRANSPOSITIONS.....
- RESULTS WITH UROLOGICAL RECONSTRUCTION SURGEONS ARE GOOD

OBESITY AND THE DISAPPEARING PENIS



anna@urologyspecialist.co.nz EDI: urospecl

OBESITY AND THE DISAPPEARING PENIS

- **Unfortunately:**
 - **Increasing epidemic**
 - **Increasing number of patients effected**
 - **Important to try and alter diet and fluid for prevention as easier than treatment**

Mr I 40y

- “I really feel my scrotal sac dragging every time I go biking on the weekend, is there something I can do about it”



Or maybe you get this radiology report

- Conclusion:
 - A moderate sized hydrocele on the left



Questions to ask

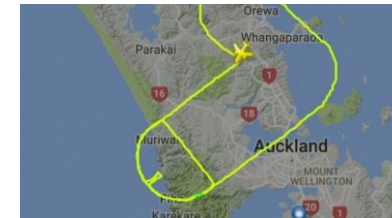
- History
 - Pain questions
 - Social impact
 - Sexual function
- Past hx
- Opportunistic health screening?

Exam

- Consider Chaperone
- Normal side first
- Have a picture of the anatomy in your head
- One hand to fixate the other to palpate
- The scrotum is a sensitive area

Red Flags

- Testicular cancer:
 - 20-40y peak
 - Lump is on teste itself
 - USS and urgent referral if it was found
- 1 out of every 500-1000 scrotal USS



Ultrasound

- Needs a Question:
- ? Cancer
- ? Structural abnormality
- Everything else is benign
- Varicocele 1 in 7 males on left side (feels like can of worms)
- Hydrocele – fluid collection
- Epididymal cyst

Treatment

- Only if symptomatic and causing impact on quality of life
- You can't just aspirate a cyst or a hydrocele as they will just come back
- Surgery not without risks

But what about the
man with ongoing
pain and a normal
ultrasound?



Pain management

- ? Referred pain
- All pain is real
- Pain ladder
- Consider neuromodulation
 - Amitryptiline
 - Gabapentine
- Multidisciplinary approach