Dr Anna Lawrence

Urologist

Auckland Surgical Centre

Mr Simon Van Rij

Urologist

OneSixOne Urology

Auckland

FULLY BOOKED

Saturday, June 10, 2017 (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)

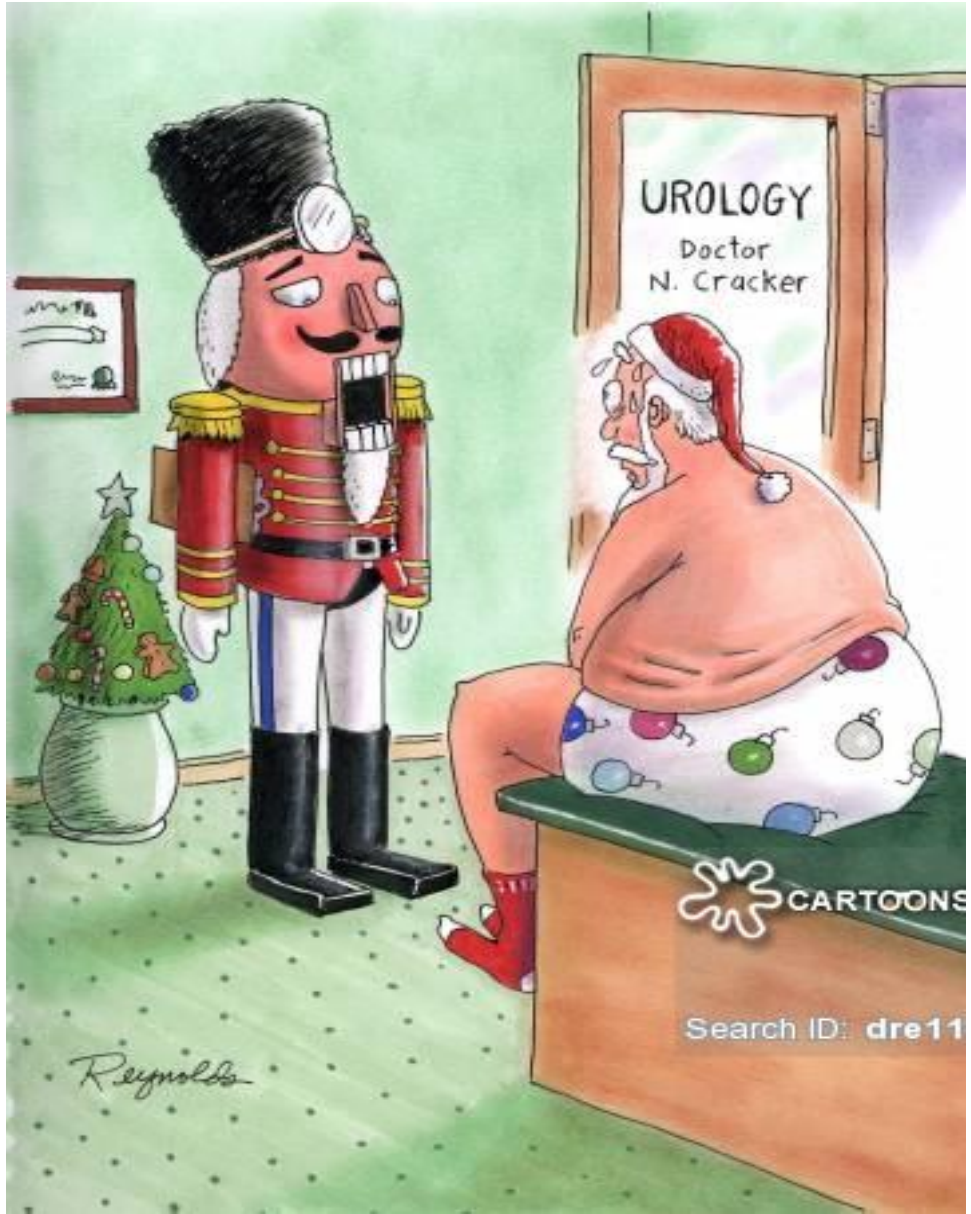
SMALL LEAKS & LARGE SWELLINGS: UROLOGY AT THE COAL FACE

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

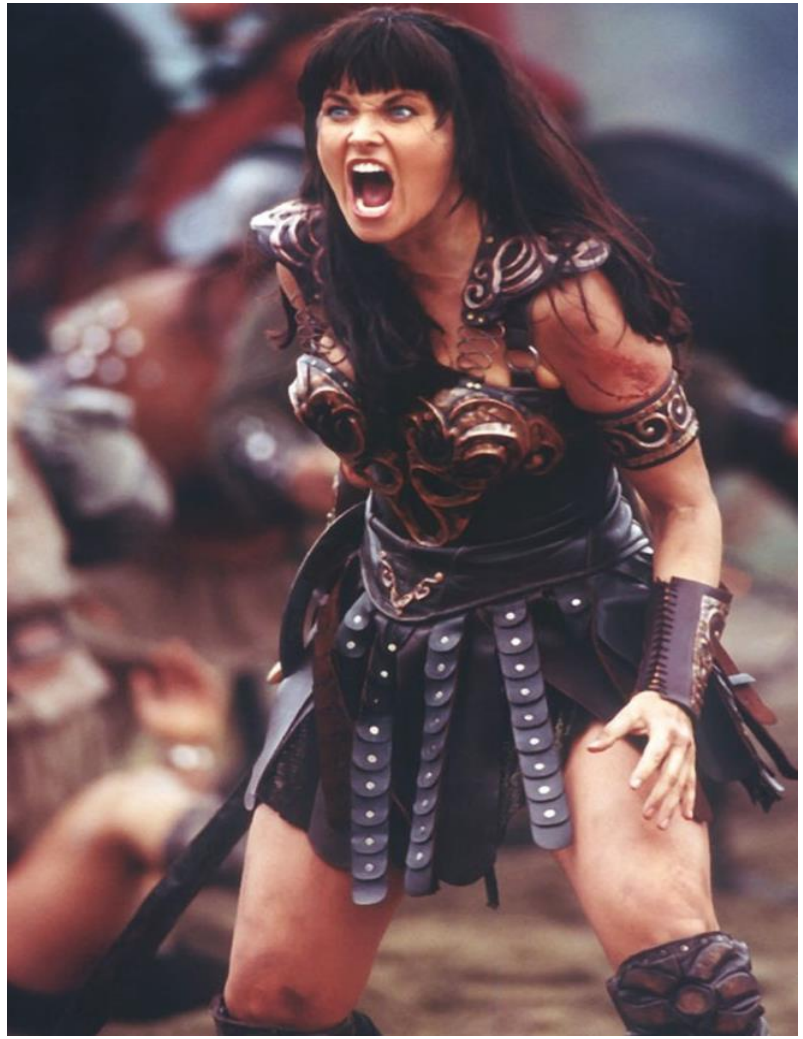
  UC Davis,California

  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
    - Heamaturia
    - 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…….

- **<u>Indications for early referral:</u>**

  - 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 CONTINOUS 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…..

- **<u>UROMUNE:</u>**
  - SUBLINGUAL IMMUNOMODULATION
  - SPANISH
  - 3 MONTHS OF X2 DAY SPRAY FOR 15+ PROTECTION

- **<u>INSTALLATIONS</u>**
- **<u>HIPREX</u>**

Mr. Simon van Rij

- @sivanrij 
- Fellowship training:
- Prostate cancer, Robotics, Lasers, Kidney cancer, LUTS

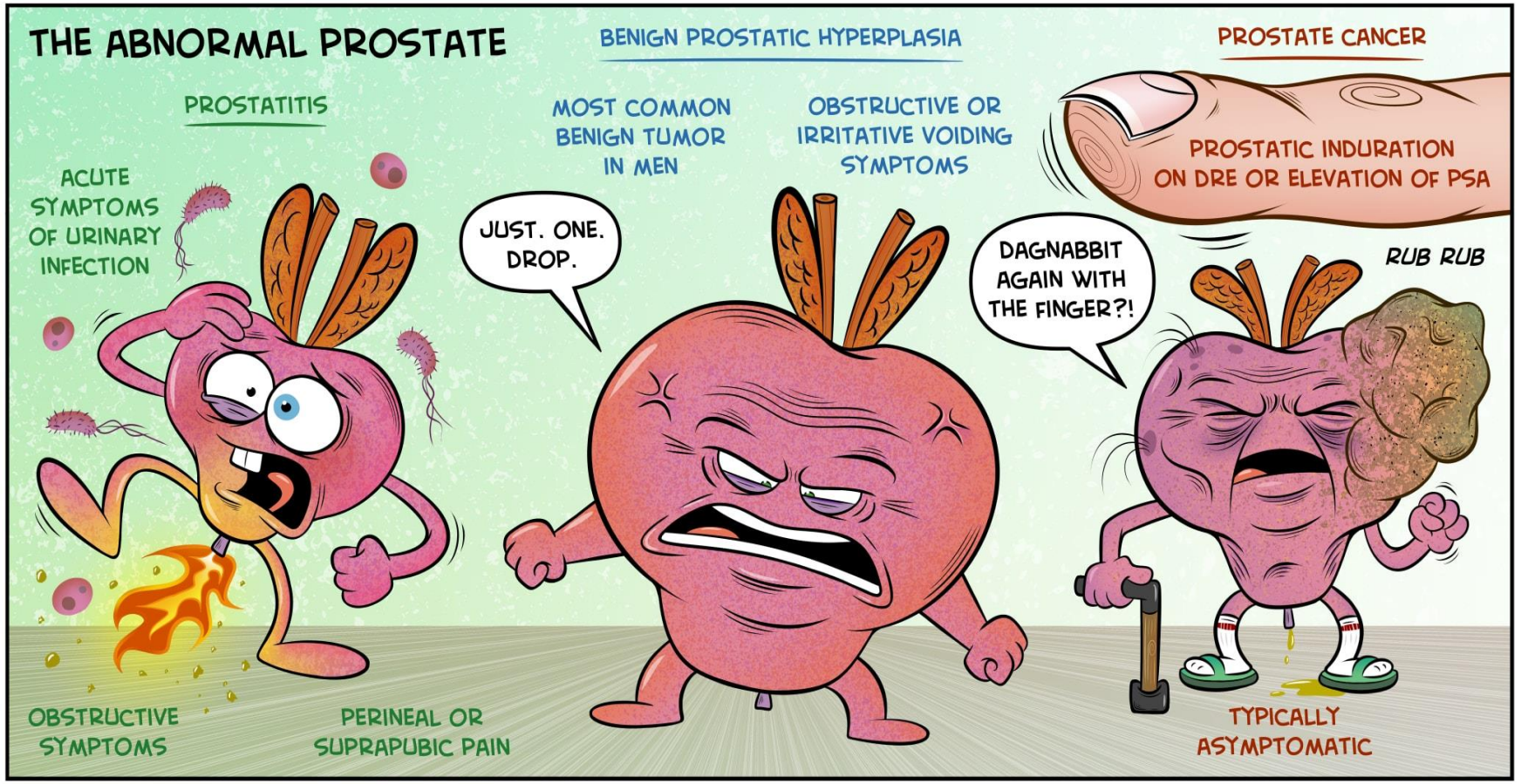
- Auckland Hospital
- Private: North Shore and Auckland

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	LessThan 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: _____

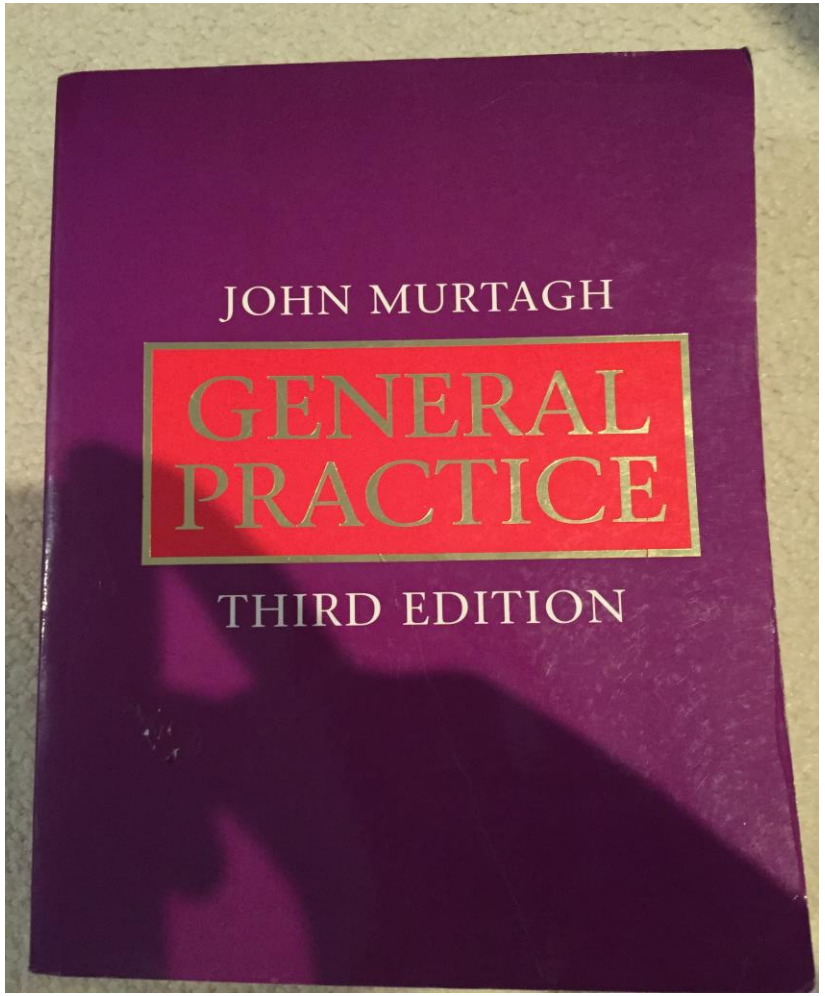
Date: _____

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

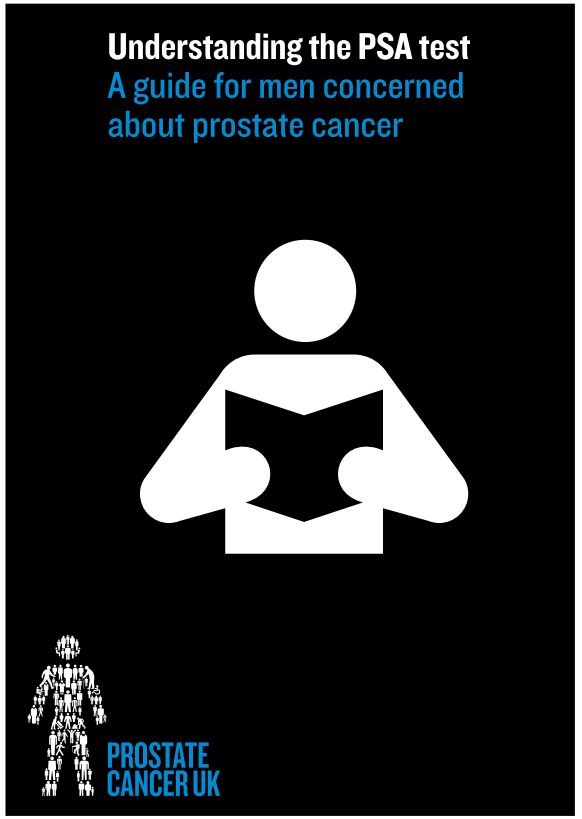
- Past Med Hx:
  - No urological history
  - Hypertension – on ACE
  - AF on Dagabatrin
  - No other medications

IS AN EXAM HELPFUL???

- PR exam?
- Anything else?

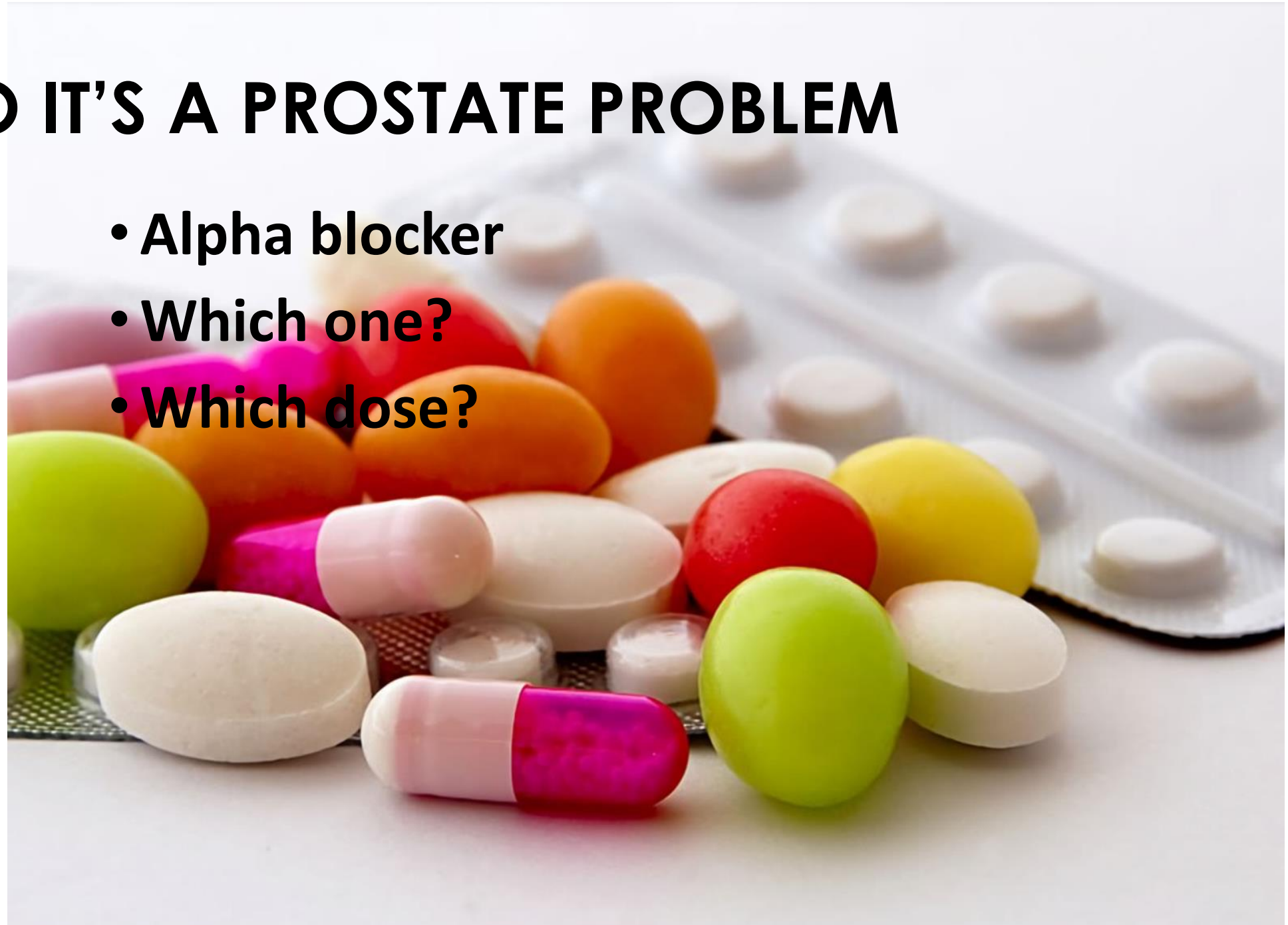
TREAT EMPIRICALLY OR DO INVESTIGATIONS?

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



SO IT'S A PROSTATE PROBLEM

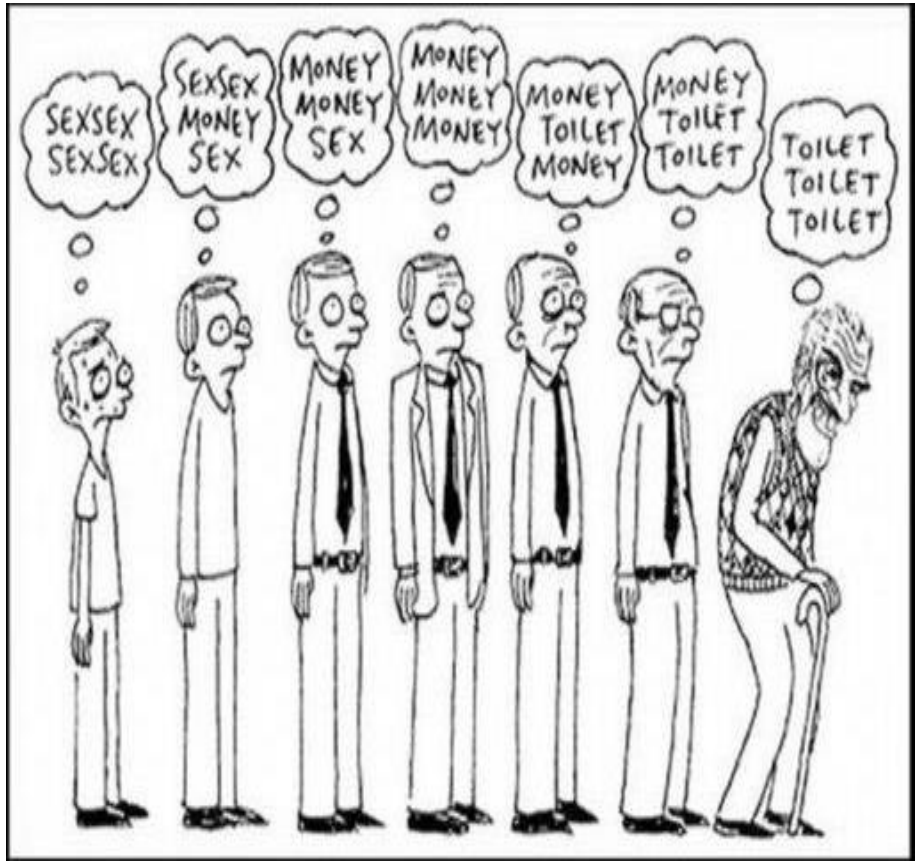
- Alpha blocker
- Which one?
- Which dose?



ALPHA -BLOCKERS

- Non-selective:
  - Doxazosin
  - Terazosin
    - Similar efficacy, need to titrate dose

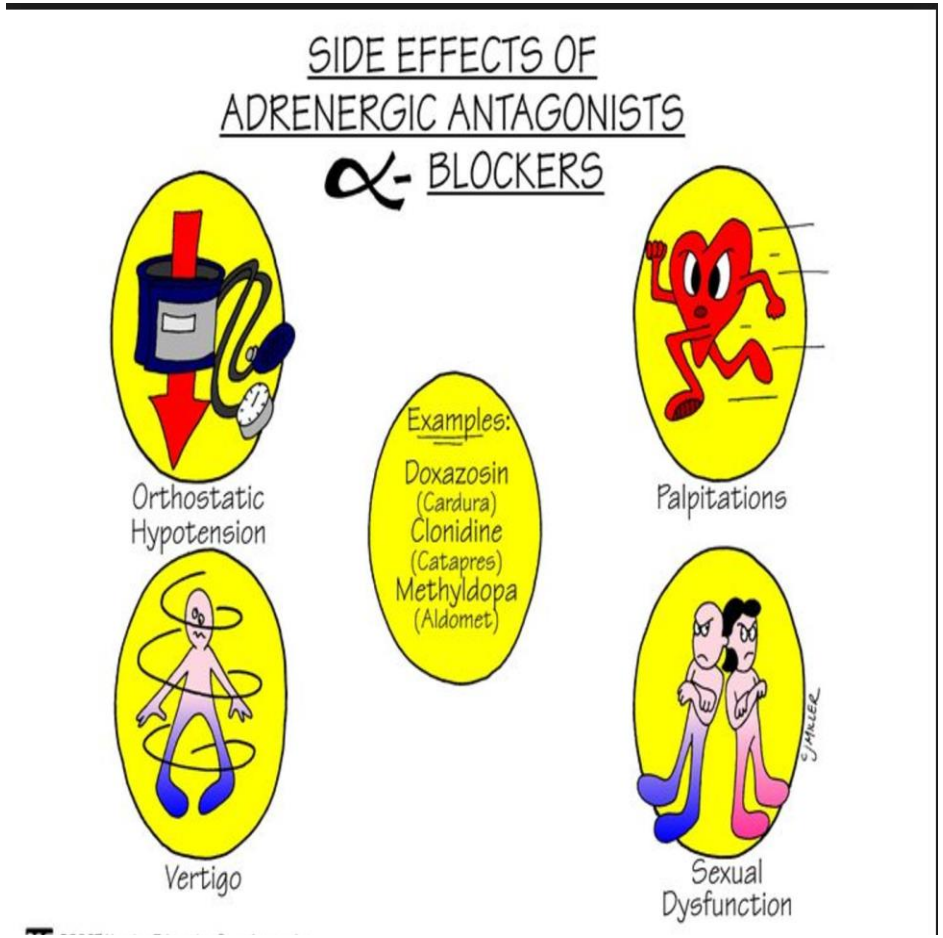
- Selective (therefore no postural hypotension):
  - Tamsulosin 0.4mg OD
    - Special Authority, no titration



BE WARY OF SIDE EFFECTS..

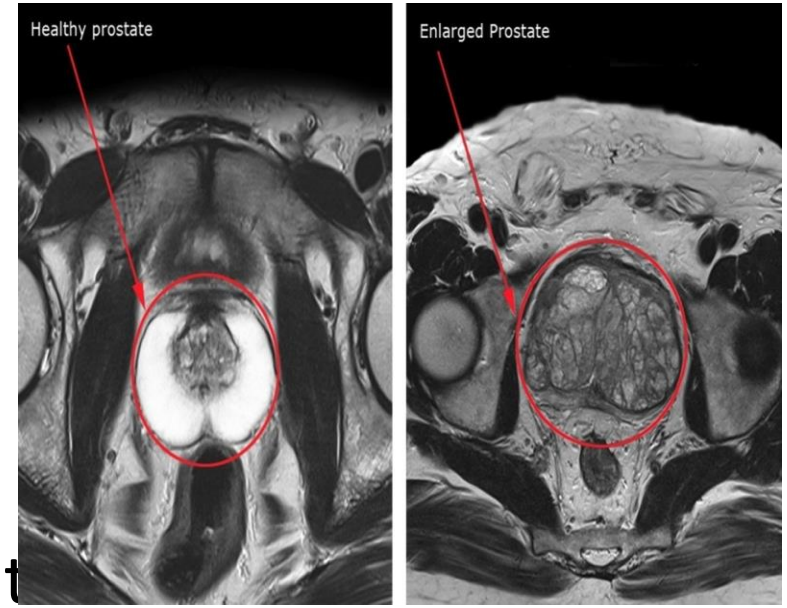
- We all know postural hypotension

- 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 prostat



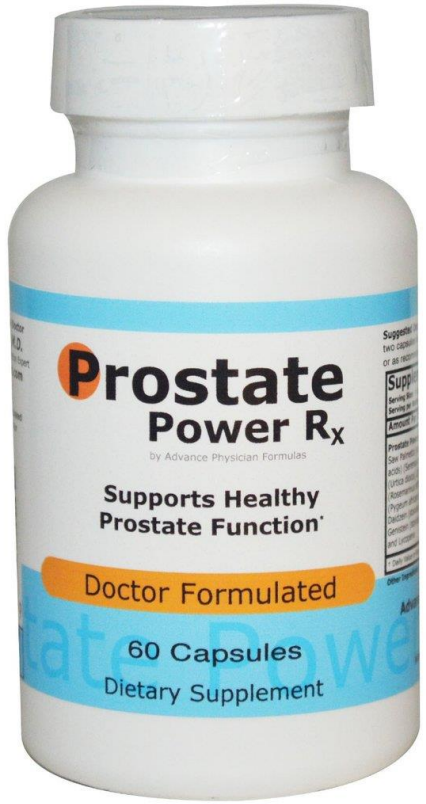
HOW DO I USE FINASTERIDE?

- 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”



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..

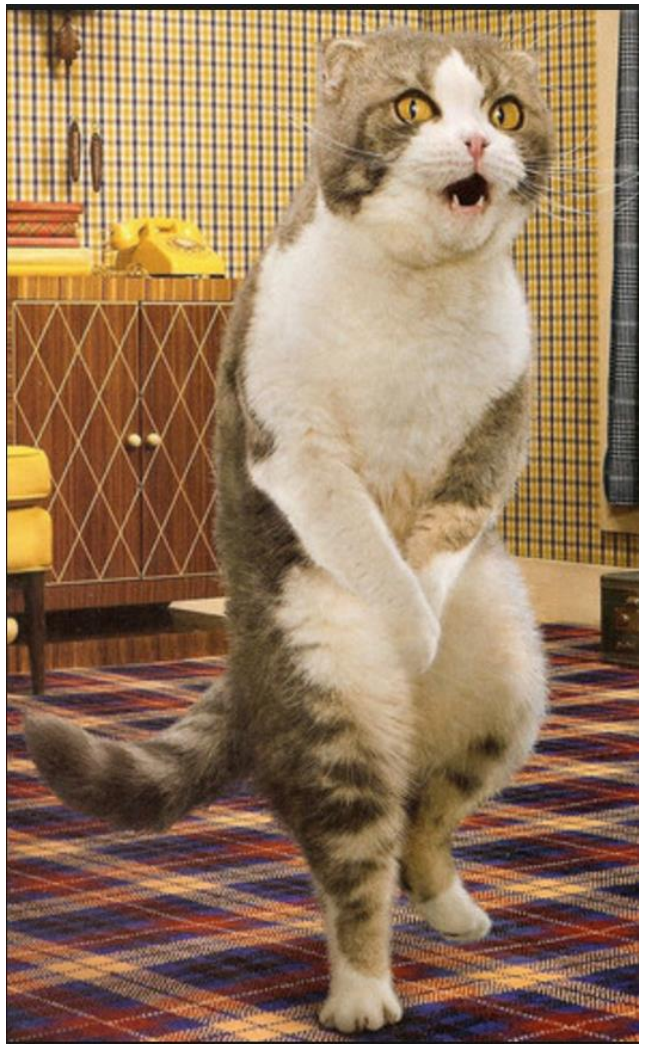
- No improvement in his night time symptoms
- Flow maybe slightly better
- “Have I just got a weak bladder?”

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…

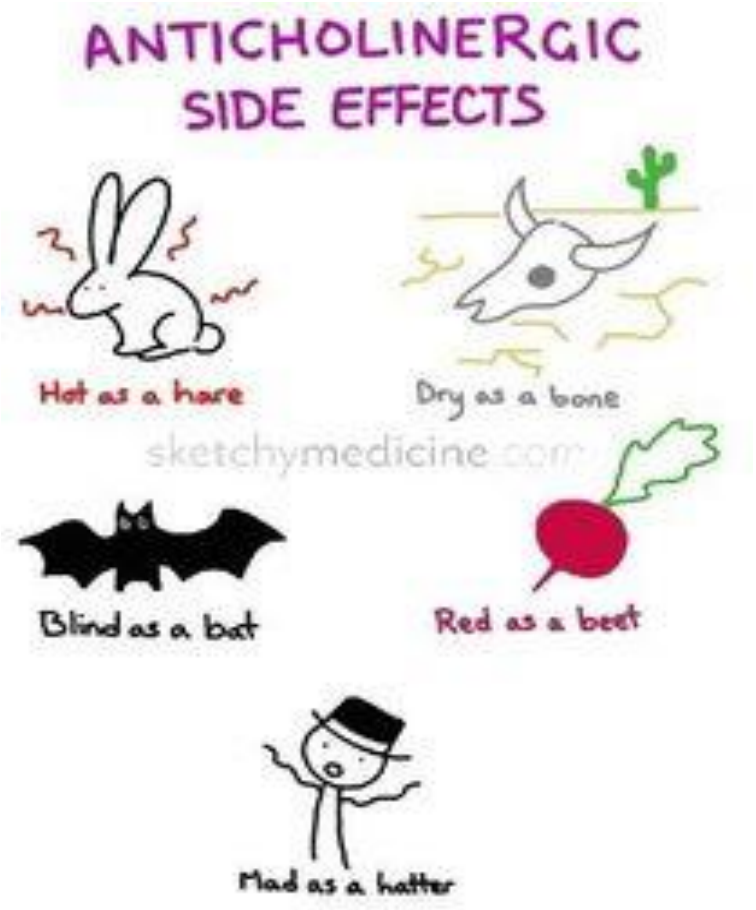
1. SOLIFENACIN

- 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

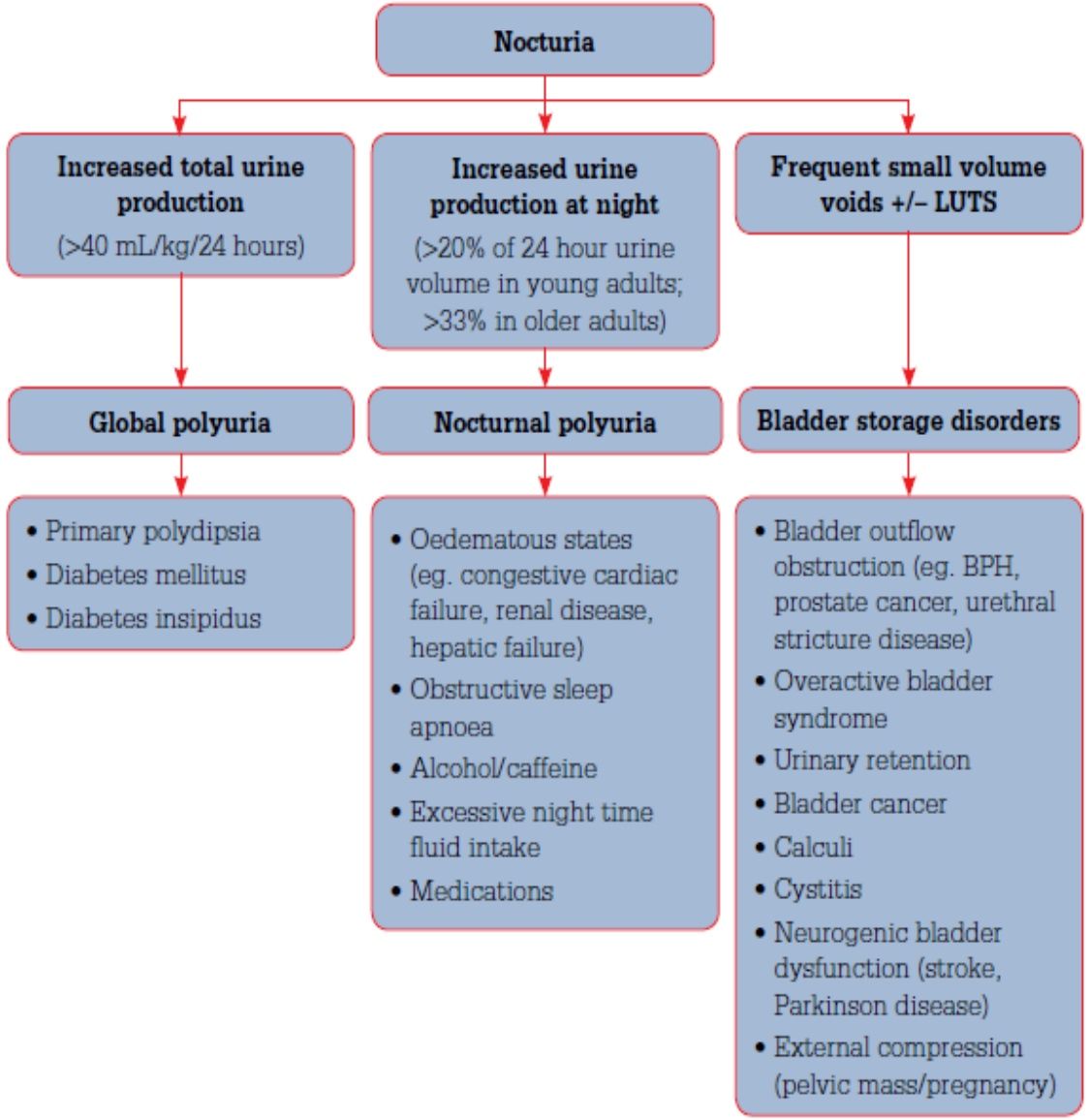
BACK TO THE PATIENT AT HAND..

- 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
Increased total urine production
(>40 mL/kg/24 hours)
Increased urine production at night
(>20% of 24 hour urine volume in young adults; >33% in older adults)
Frequent small volume voids +/– LUTS
Global polyuria
Nocturnal polyuria
Bladder storage disorders
• Primary polydipsia
• Diabetes mellitus
• Diabetes insipidus
• Oedematous states (eg. congestive cardiac failure, renal disease, hepatic failure)
• Obstructive sleep apnoea
• Alcohol/caffeine
• Excessive night time fluid intake
• Medications
• Bladder outflow obstruction (eg. BPH, prostate cancer, urethral stricture disease)
• Overactive bladder syndrome
• Urinary retention
• Bladder cancer
• Calculi
• Cystitis
• Neurogenic bladder dysfunction (stroke, Parkinson disease)
• External compression (pelvic mass/pregnancy)

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

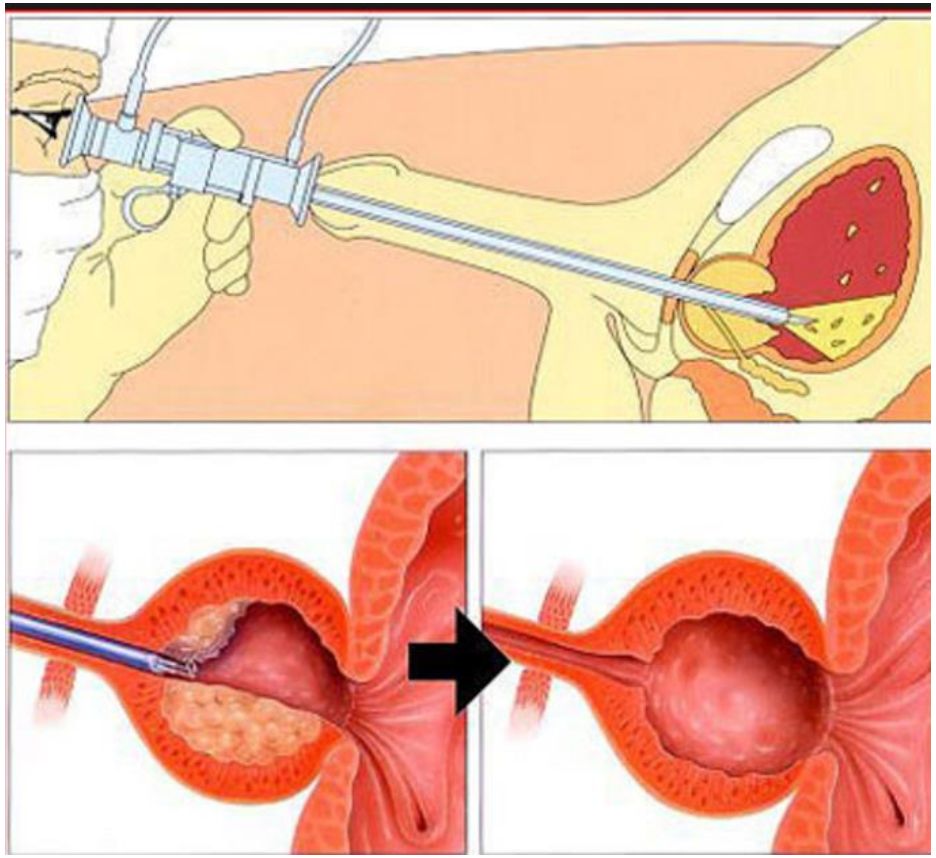
OUTSIDE THE BOX…

- 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

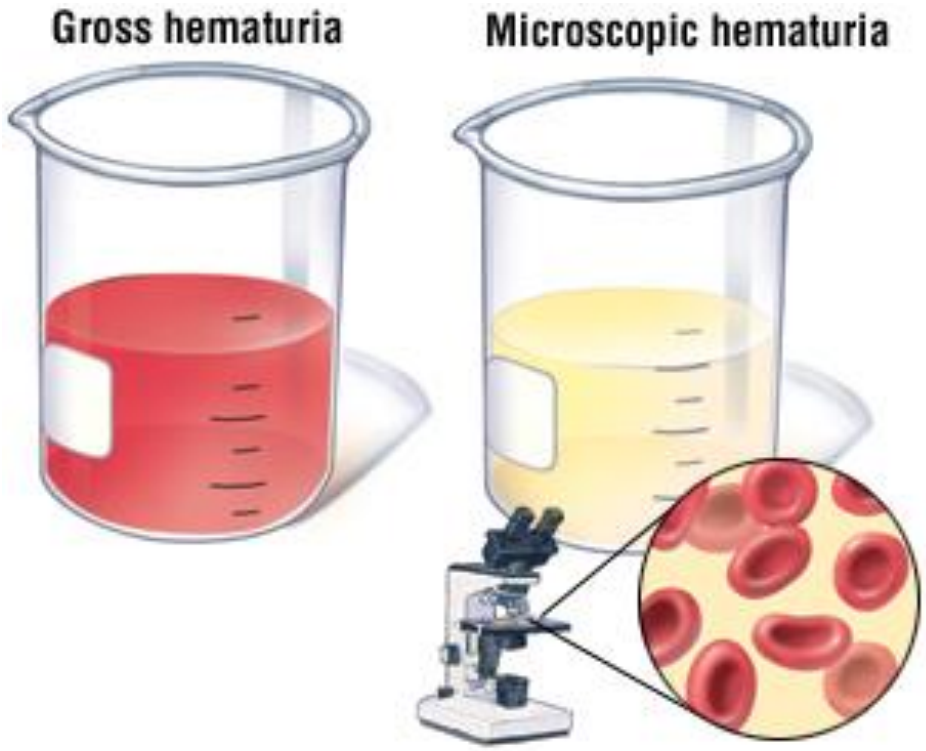


COMMON PROBLEMS….

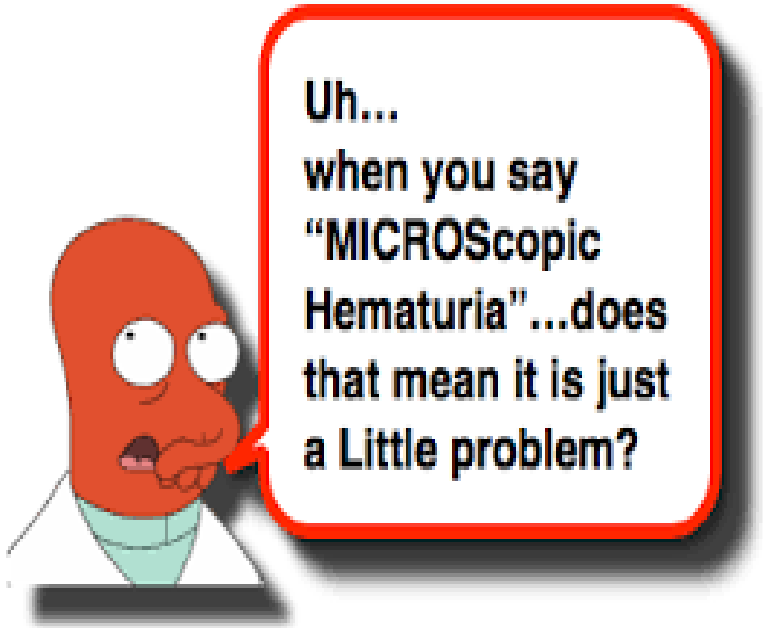
MACROSCOPIC / GROSS HAEMATURIA

- VISIBLE HAEMATURIA
  - PINK
  - RED
  - COLA COLOUR

- <u>REFER!!</u>
  - OUTSIDE OF TRANSIENT CAUSES
  - If in Retention – straight to ED

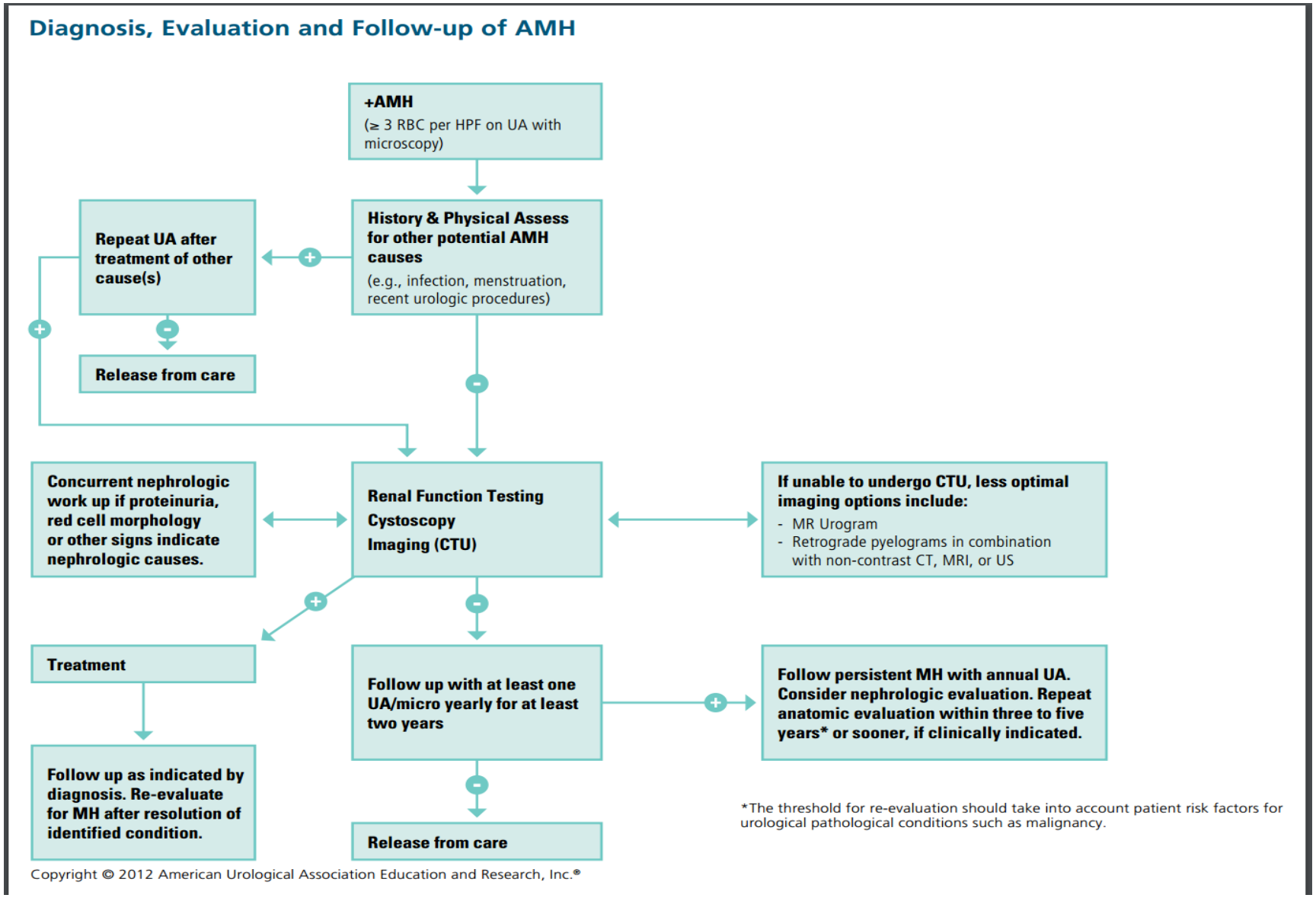


MICROSCOPIC HAEMATURIA



- **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
+AMH
(≥ 3 RBC per HPF on UA with microscopy)
History & Physical Assess for other potential AMH causes
(e.g., infection, menstruation, recent urologic procedures)
Repeat UA after treatment of other cause(s)
Release from care
Concurrent nephrologic work up if proteinuria, red cell morphology or other signs indicate nephrologic causes.
Renal Function Testing
Cystoscopy
Imaging (CTU)
If unable to undergo CTU, less optimal imaging options include:
- MR Urogram
- Retrograde pyelograms in combination with non-contrast CT, MRI, or US
Treatment
Follow up as indicated by diagnosis. Re-evaluate for MH after resolution of identified condition.
Follow up with at least one UA/micro yearly for at least two years
Follow persistent MH with annual UA. Consider nephrologic evaluation. Repeat anatomic evaluation within three to five years* or sooner, if clinically indicated.
Release from care
*The threshold for re-evaluation should take into account patient risk factors for urological pathological conditions such as malignancy.
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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

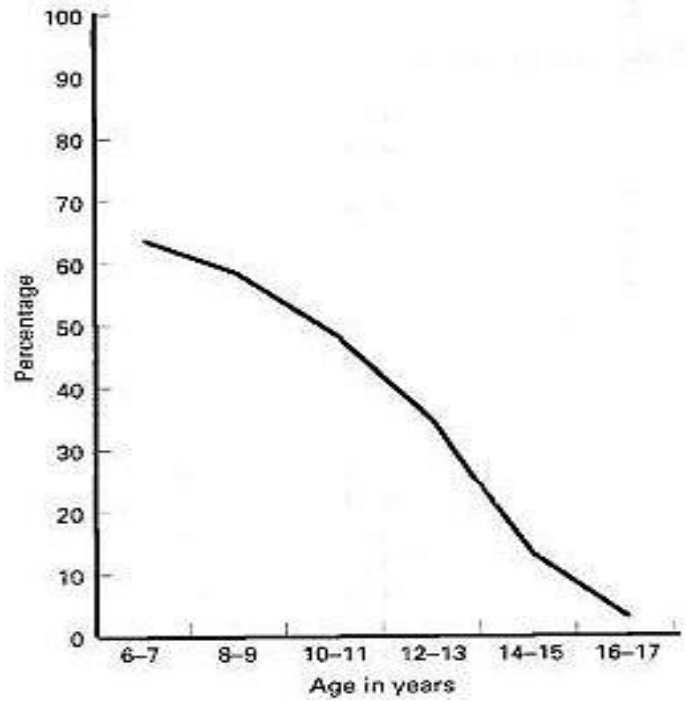
- “I am very concerned about my son Tom’s penis. The foreskin won’t retract and he is about to start school swimming”

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
- Frenuluoplasty
- 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

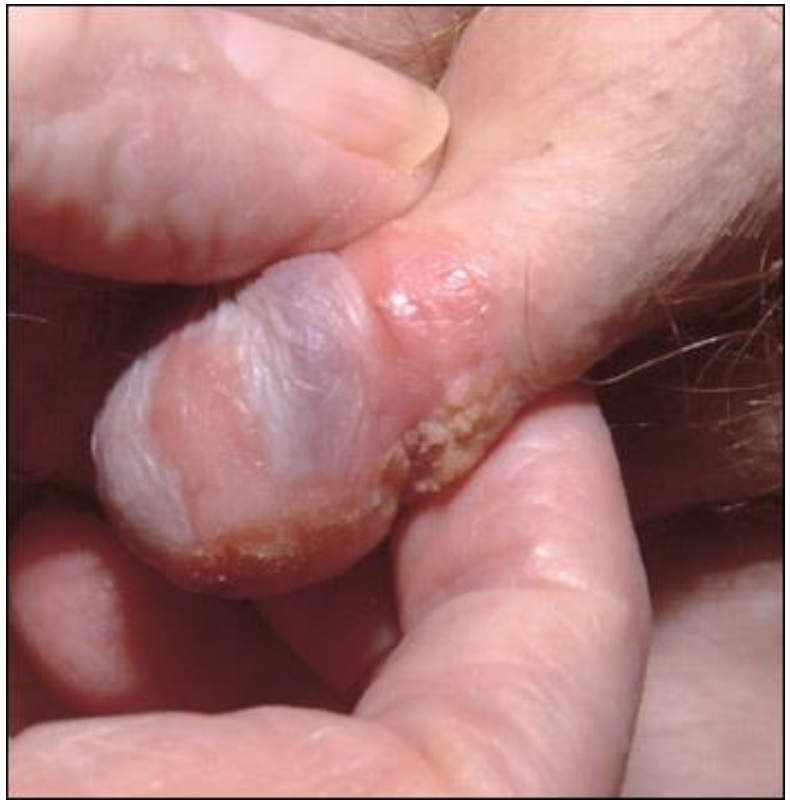
PENILE LESIONS: WHAT IS WHAT

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

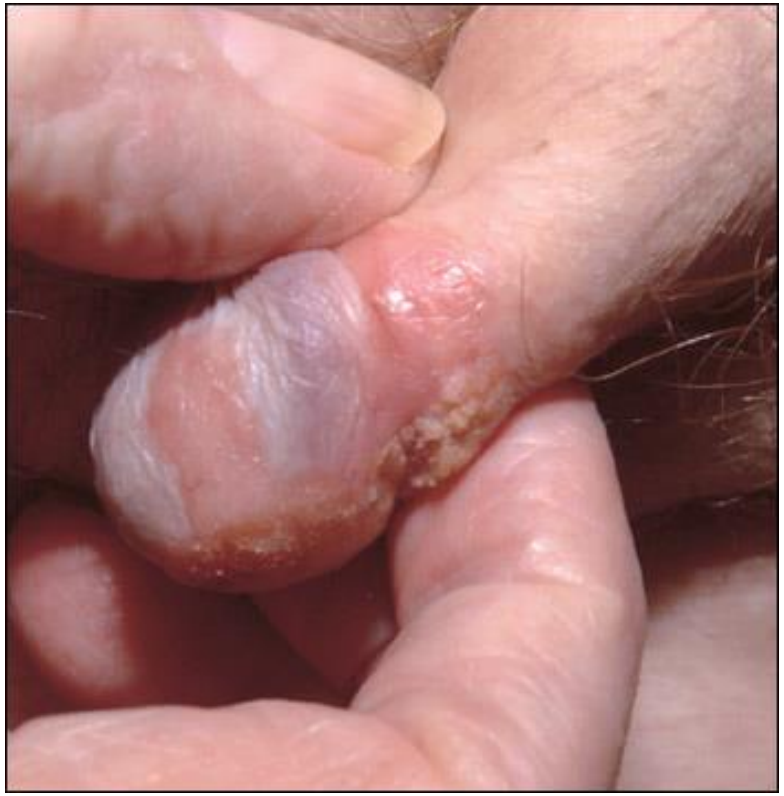
BENIGN OR MALIGNANT?

MALIGNANT: PENILE CANCER

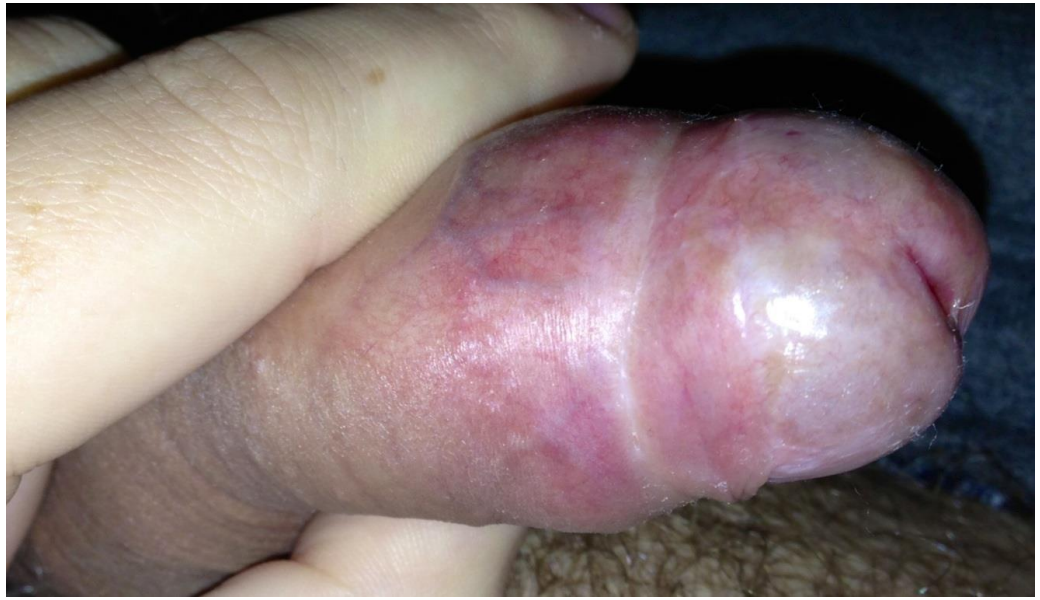
BENIGN OR MALIGNANT?



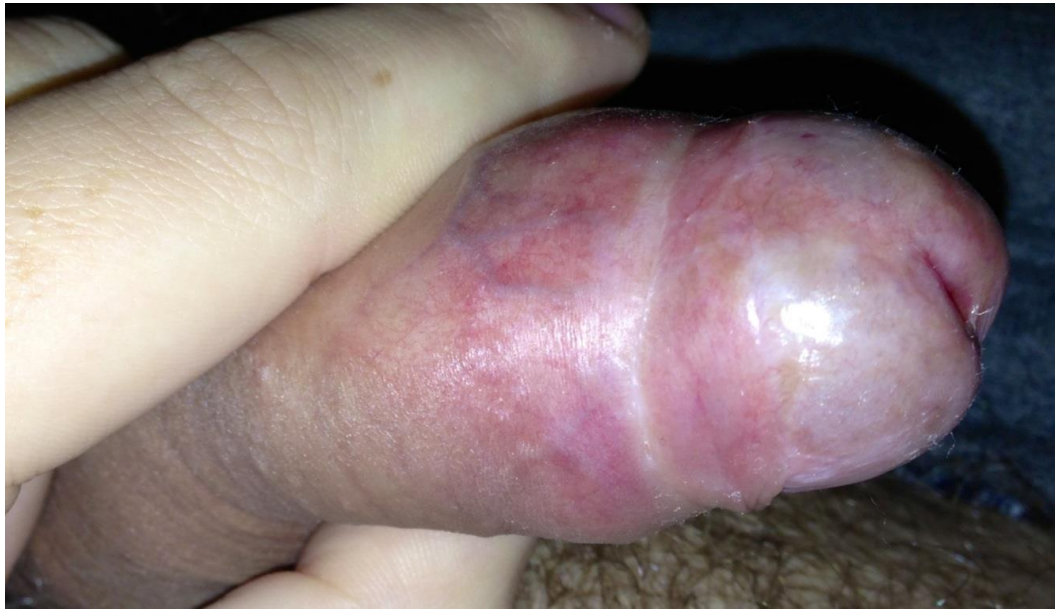
MALIGNANT: PENILE CANCER



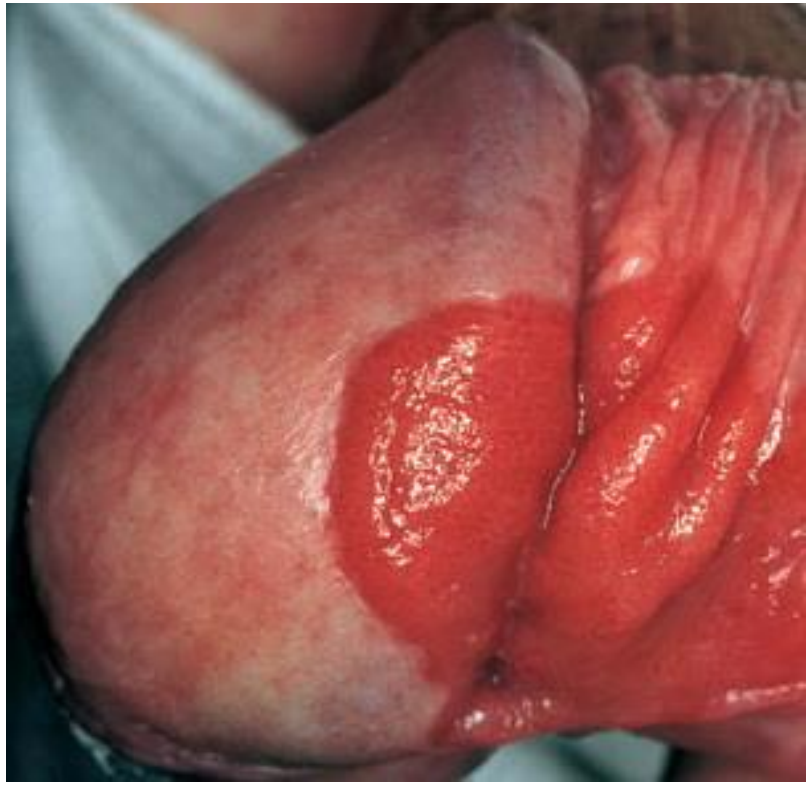
BENIGN OR MALIGNANT?



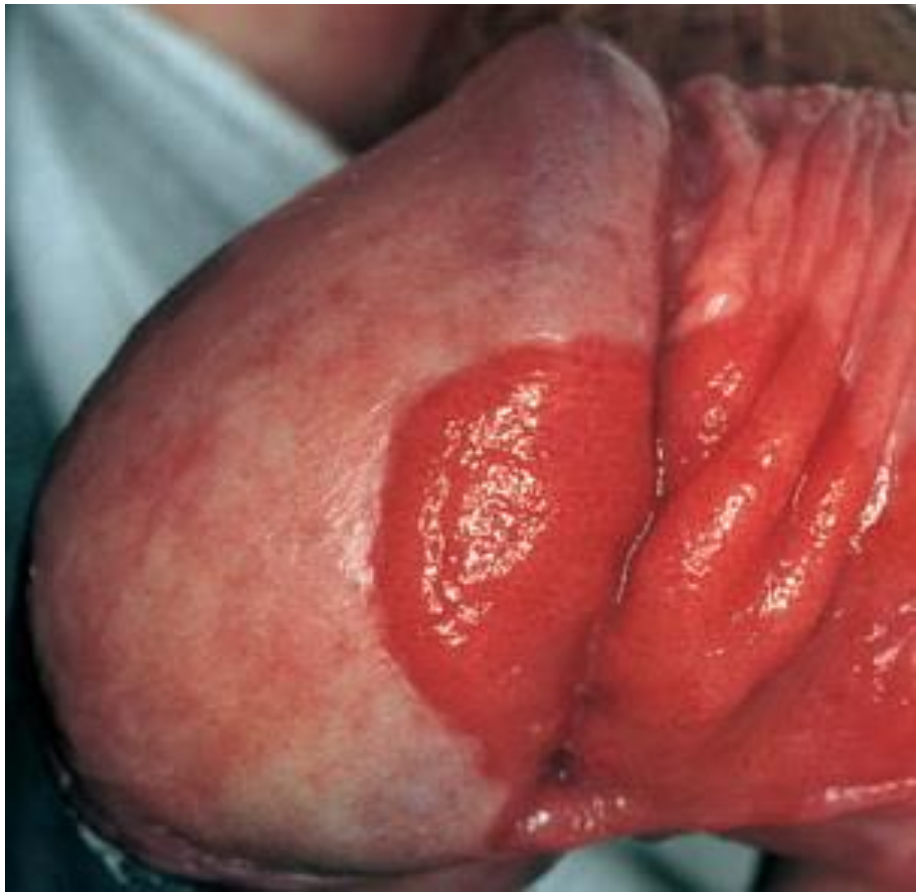
PRE-MALIGNANT – BXO (Lichen Sclerosis)



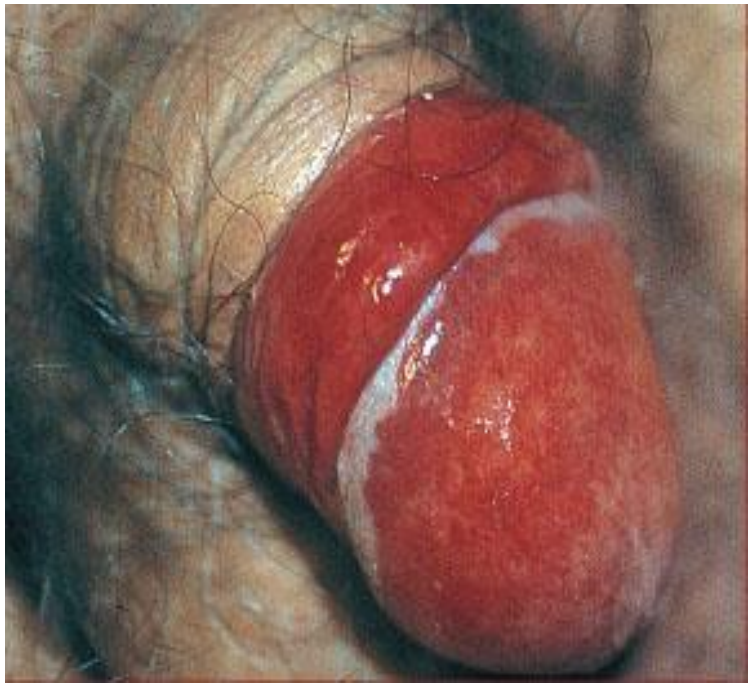
BENIGN OR MALIGNANT?



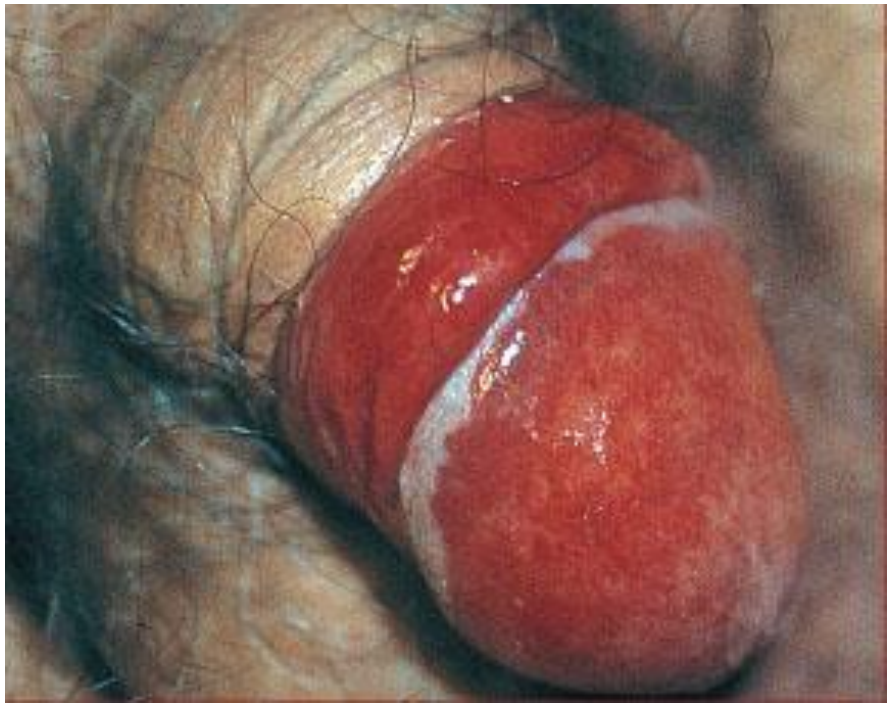
PRE-MALIGNANT
-BOWENS /CIS



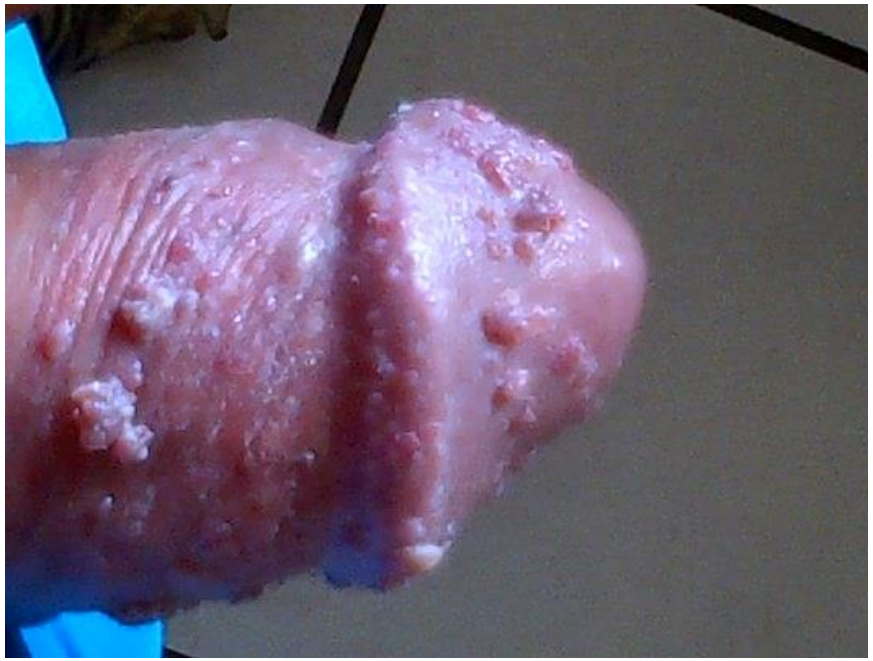
BENIGN OR MALIGNANT?



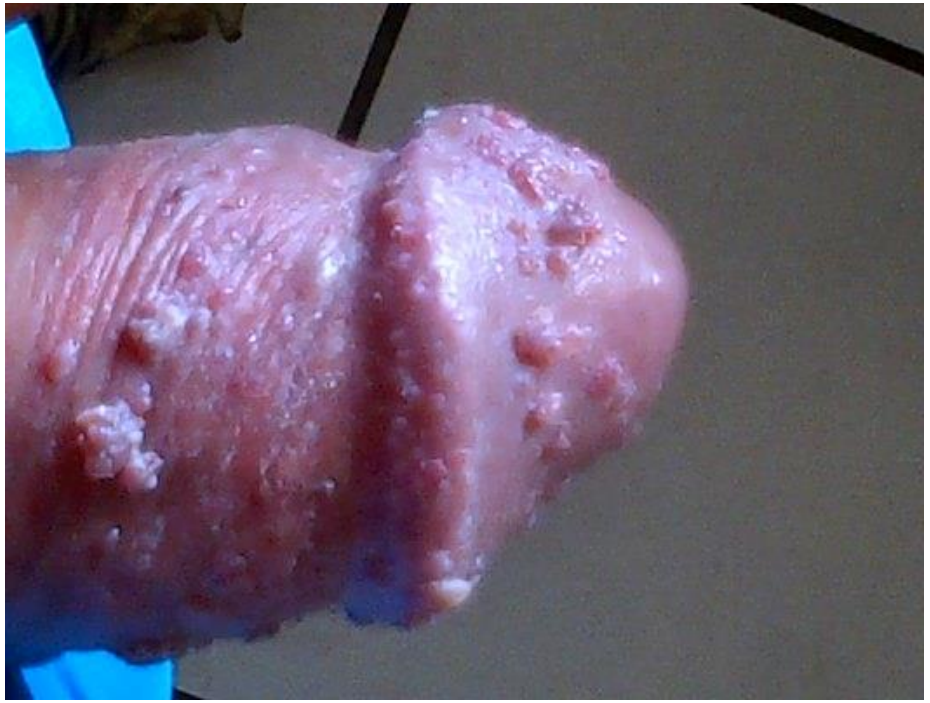
BENIGN –ZOON'S BALANITIS



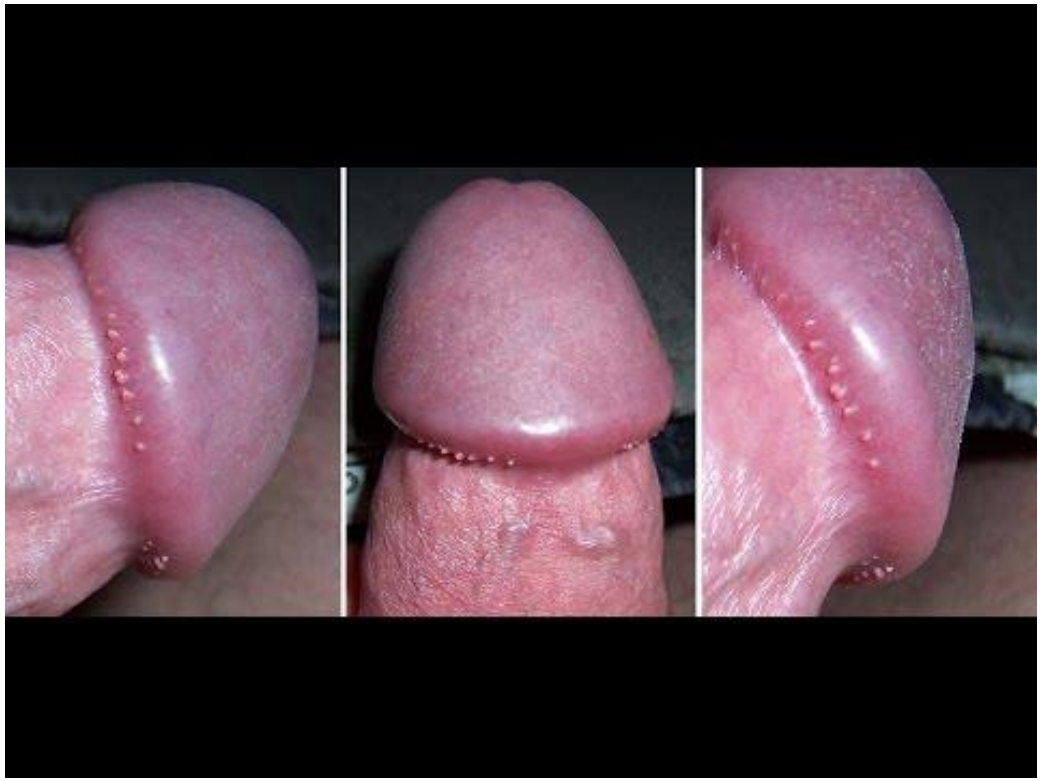
BENIGN OR MALIGNANT?



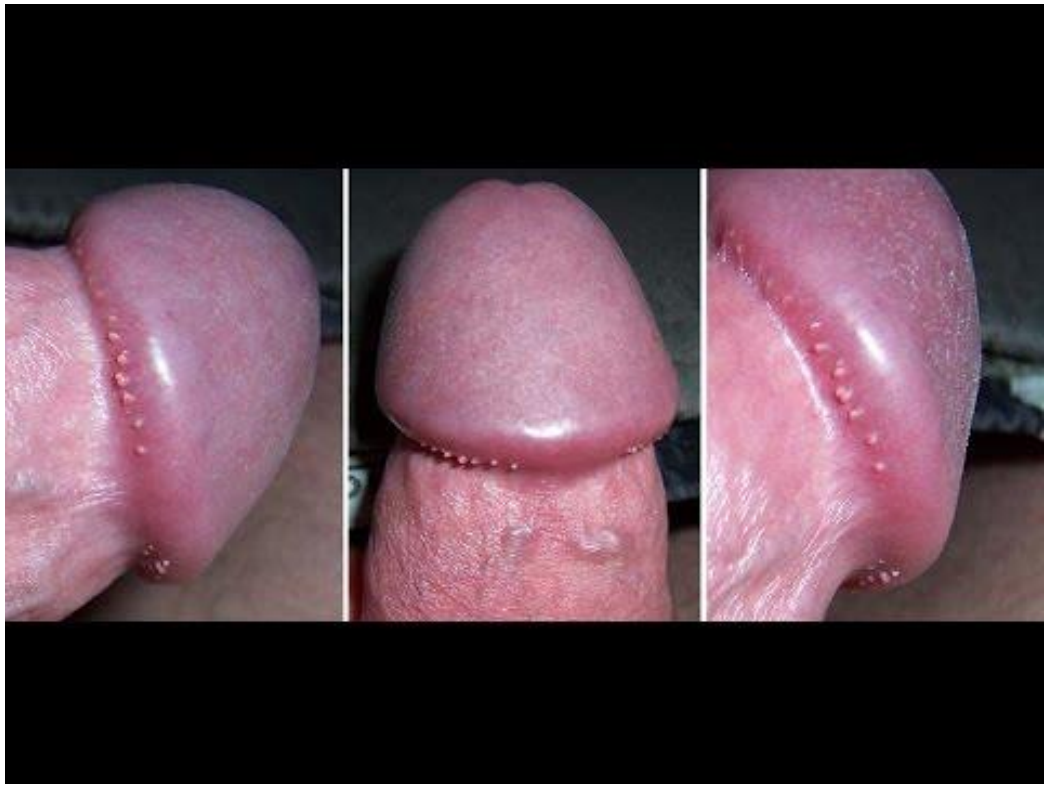
BENIGN –GENITAL WARTS



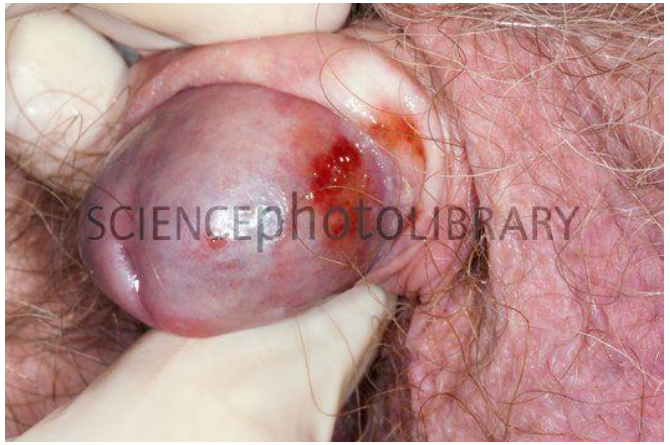
BENIGN OR MALIGNANT?

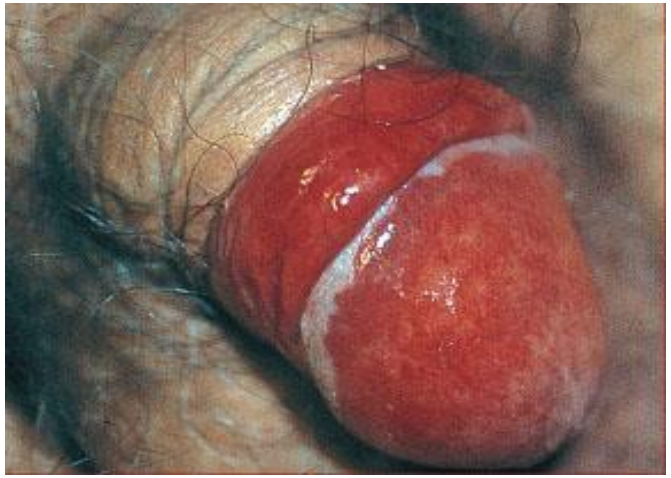


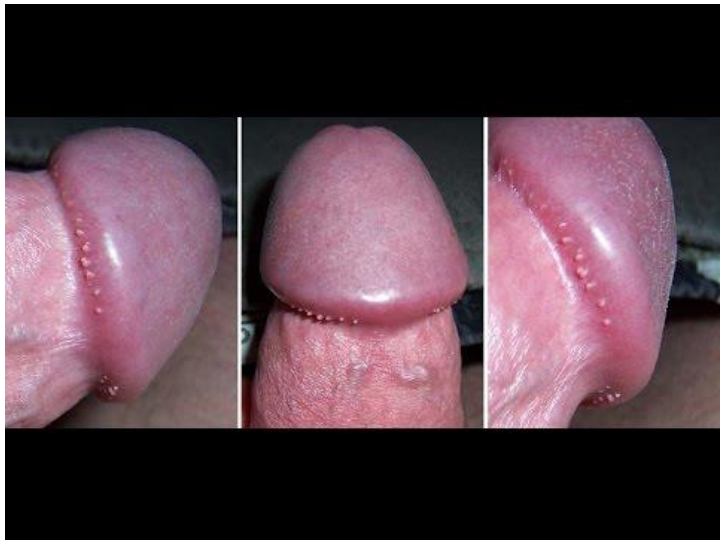
BENIGN – PEARLY PENILE PAPULES

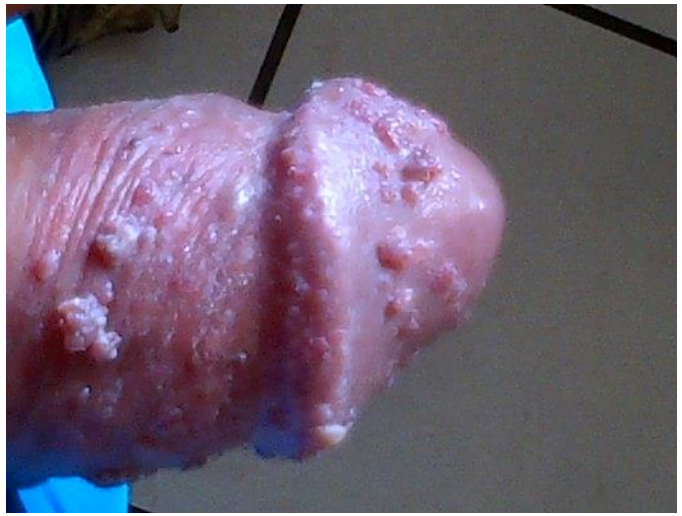


BENIGN

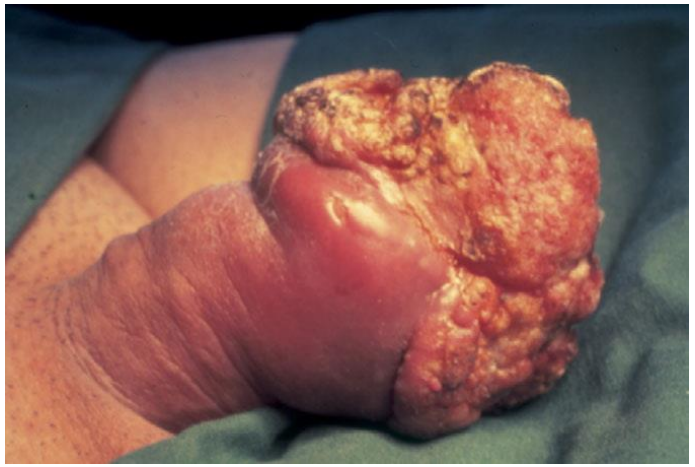


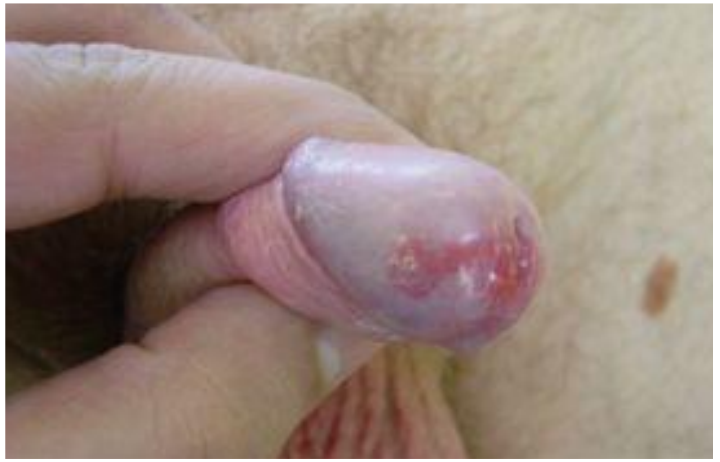


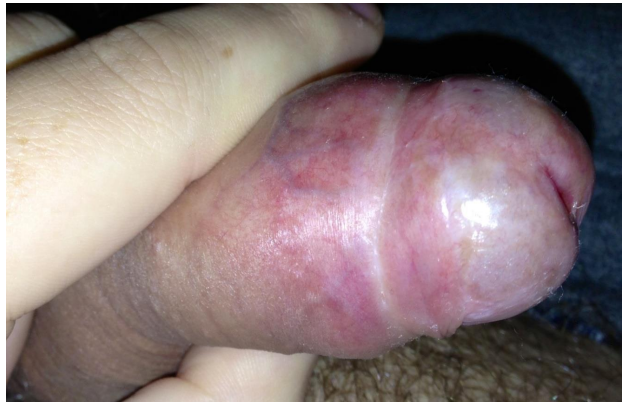


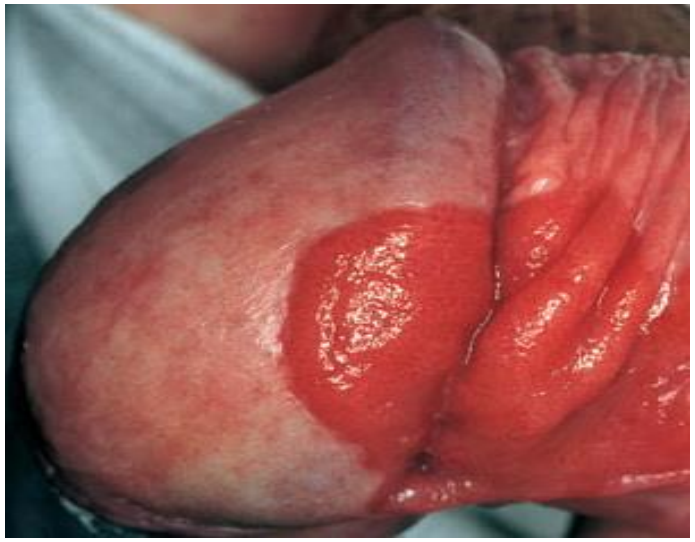


PRE-MALIGNANT

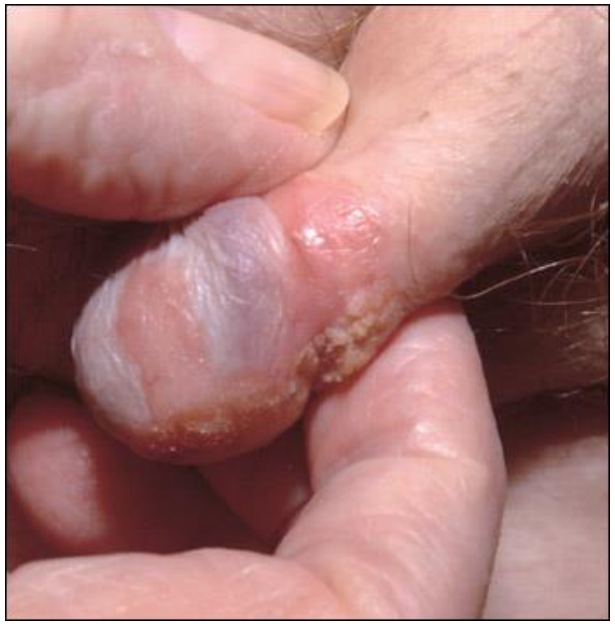








MALIGNANT



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

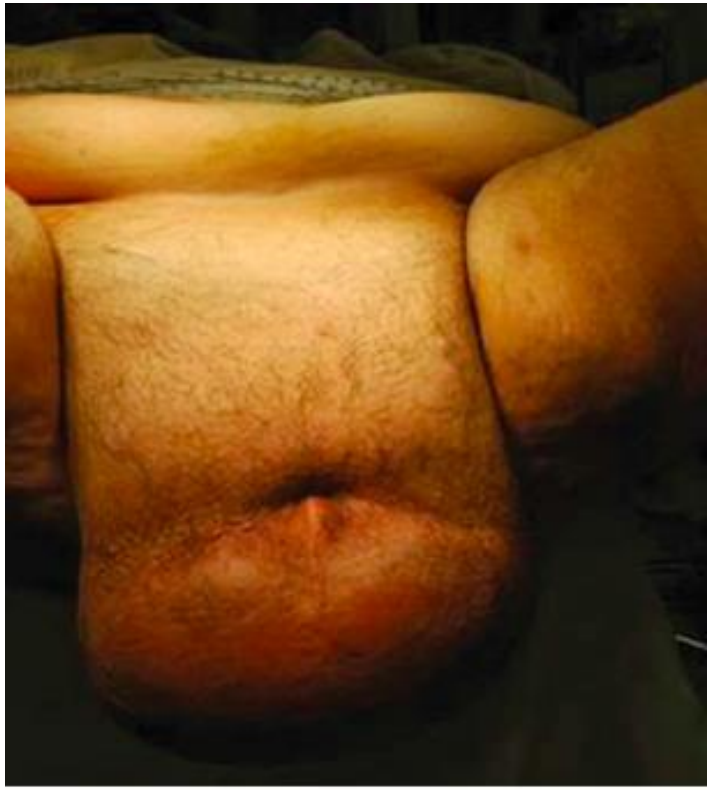
- Hormonal therapy for prostate cancer
- Now the only drug funded by PHARMAC
- Zoladex 10.8mg Inj 3 month supply -
- Safe to transfer over from LUCRIN or ELIGARD
- 0800ZOLADEX – if patients have questions or side effects
- **Breaking news:**
- Hormonal therapy will change very soon and the drug monitoring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



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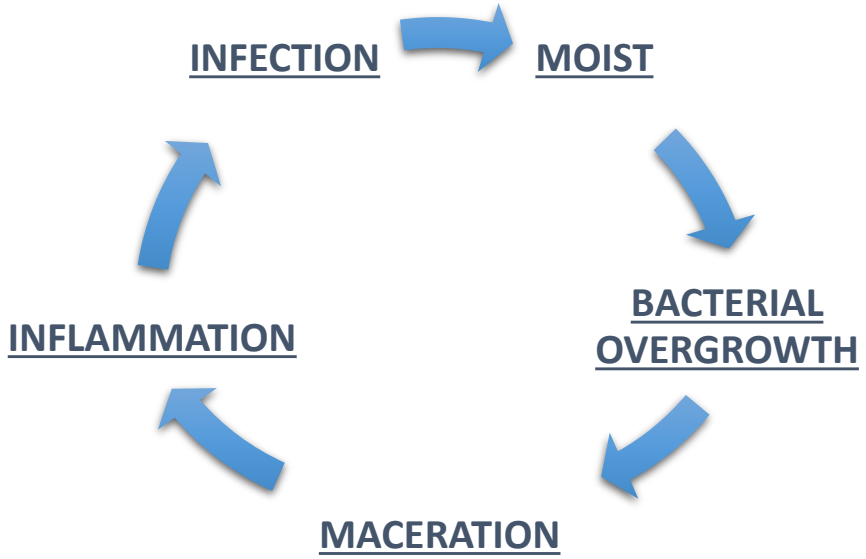
OBESITY AND THE DISAPPEARING PENIS..

- **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**

anna@urologyspecialist.co.nz EDI: urospecl

OBESITY AND THE DISAPPEARING PENIS

- **SO WHY DOES THIS HAPPEN…**
  - **WITH INCREASED WEIGHT**



anna@urologyspecialist.co.nz EDI: urospe

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."

anna@urologyspecialist.co.nz EDI: urospecl

OBESITY AND THE DISAPPEARING PENIS

- **SURGERIES:**

  - **MULTIPLE DIFFICULT OPERATIONS AVAILABLE**
  - **LIPOSUCTION , SKIN GRAFTING, TRANSPOSITIONS…..**

  - **RESULTS WITH UROLOGICAL RECONSTRUCTION SURGEONS ARE GOOD**

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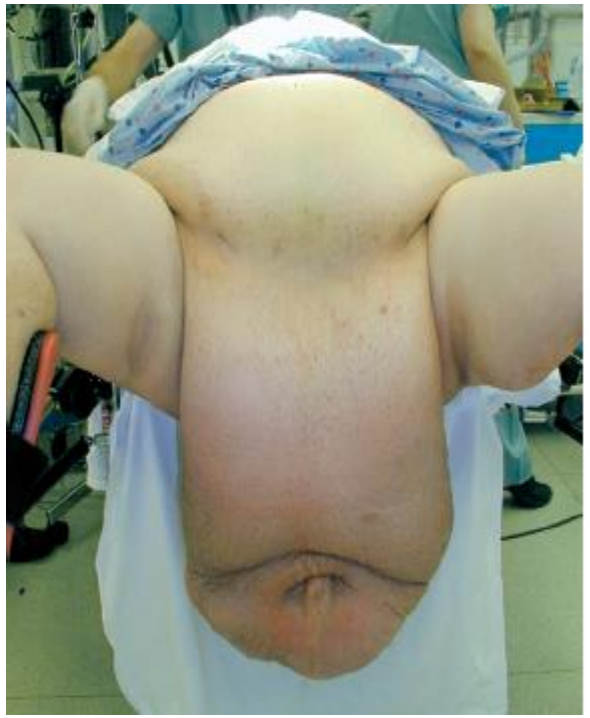
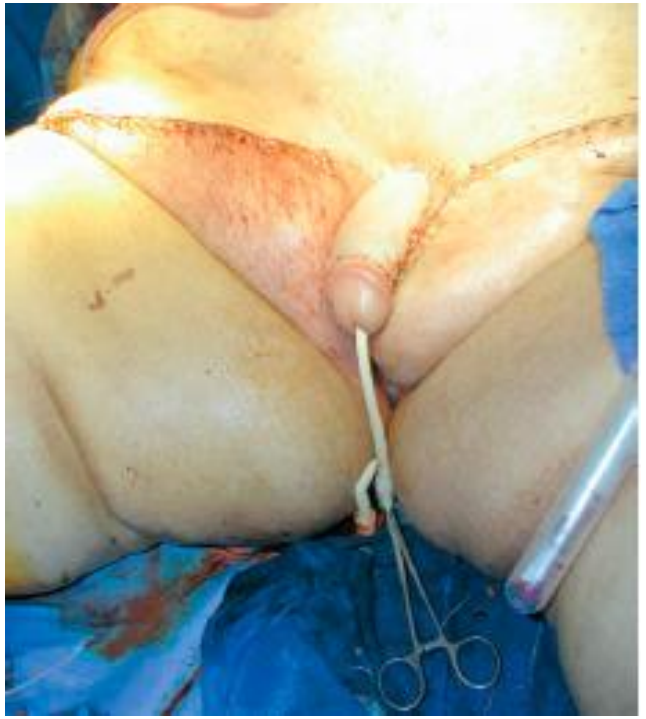
OBESITY AND THE DISAPPEARING PENIS





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OBESITY AND THE DISAPPEARING PENIS

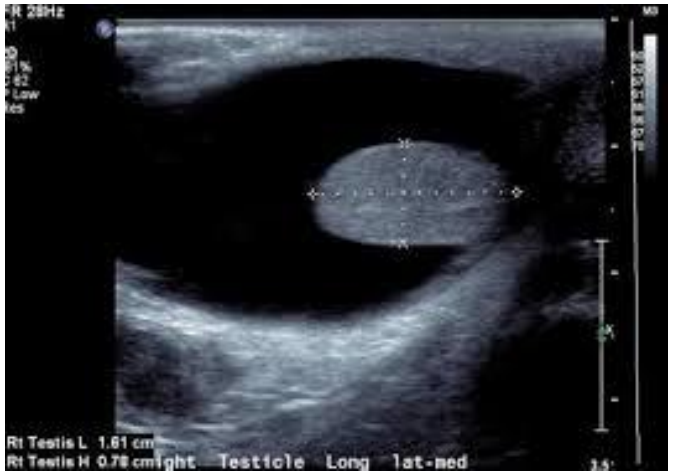
- **Unfortunately:**
  - **Increasing epidemic**
  - **Increasing number of patients effected**
  - **Important to try and alter diet and fluid for prevention as easier than treatment**

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
- Variocele 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 with out 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