Acute Urinary Retention

A proper discharge plan is vital if community treatment planned!
Always record residual volume and check PSA

Three questions about managing AUR:

Can the patient be managed at home?
Yes: only if

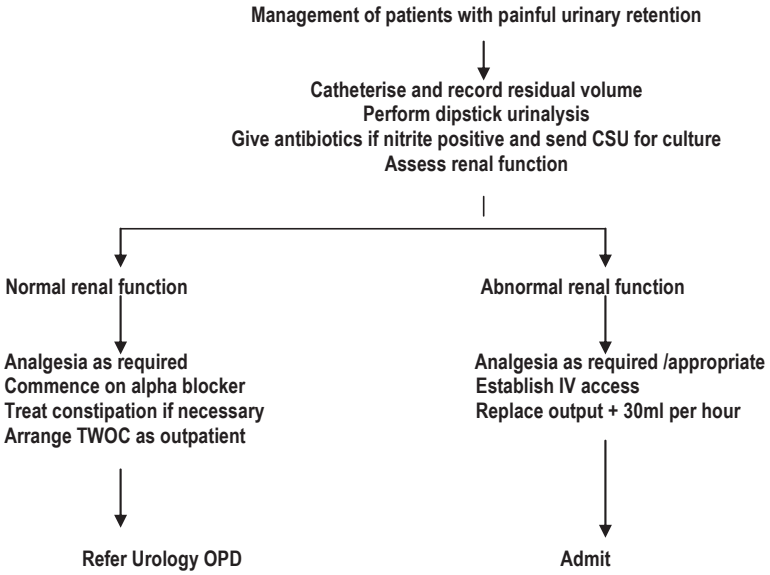
- **reasonable general health,**
- **happy to be discharged (or to take a nursing home place),**
- **normal renal function.**
- **Residual <1000mls**
- **Patient does not develop polyuria during period of observation if residual >1000mls**

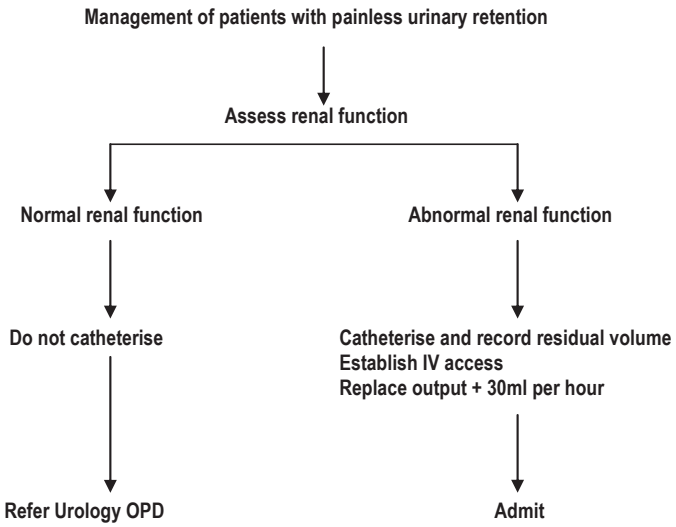
***Should I arrange a trial without catheter (TWOC) before discharge*?**
Yes : only if residual was less than 600mls and there was an obvious cause of this episode (eg binge drinking)

***Should I arrange a trial without catheter (TWOC) after discharge*?**
Yes: only if there was a temporary reason for this episode, e.g.–UTI, drinking binge, long wait to get to the toilet and if patient did not have marked prostatic symptoms prior to episode. The TWOC can be done straight away by withdrawing catheter or follow up can be arranged by ACAHT. "XATRAL XL" for 3-4 days reduces recurrence so it should be prescribed if there are no contra-indications – first dose can be given in Emergency Department (see BNF).

If the patient is discharged with a catheter in you must make very secure follow-up arrangements with him-usually by referring to ACAHT. One of our advice leaflets about catheter care must be given to the patient. Write a referral letter to the Urologist on call ask the clerical staff to forward to his/her secretary– the patient should be advised to contact his GP. Management plan must be carefully outlined on flimsy

Urology referral is based on post code please ask secretarial staff for advice





Renal colic

Patients with renal colic will have their temperature, urinalysis, abdominal signs and KUB recorded. Diclofenac is usually the analgesic of choice and most cases can be investigated via GP. Reconsider the diagnosis if there is no haematuria.
Patient should be admitted to obs ward if:

- **Severe pain persists despite adequate analgesia**
- **UTI**
- **Stone >6mm on KUB plain film**
- **Single Functioning Kidney**
- **Diagnosis in doubt (but first rule out AAA in any patient if first presenting age >60years)**
- **Frail/ very elderly**

If diagnosis confirmed by CTKUB refer to urology URGENTLY : If there are signs of back pressure, evidence of infection deranged renal function or pain not easing with medications given.
All other patients send written referral to the urologist on call.
Commence on an alpha blocker and dispense suitable analgaesia and advise to return if exacerbation of condition

If diagnosis not confirmed by CTKUB find alternative diagnosis.

Management of patients with frank haematuria

Record pulse and blood pressure
Perform dipstick urinalysis
Send MSSU if nitrite positive and commence on appropriate antibiotic
Perform full blood picture and renal function tests

If patient is unable to PU catheterise with a 3 way catheter and record residual volume.
Commence bladder irrigation with normal saline
Admit patient to urology service (surgical if OOH)
Commence on antibiotics if signs of sepsis
X-match if anaemic/ haemodynamically unstable

Refer to Urology clinic if:
Haemodynamically stable
Not anaemic
No evidence of sepsis
Able to PU
Not on warfarin or equivalent

TESTICULAR PAIN

Testicular pain is a common presentation to the Emergency Department. Testicular torsion should be considered in the differential diagnosis of any male presenting with abdominal pain. Boys and learning-disabled young men are at special risk of occult torsion.

	Testicular torsion	Epididymo-orchitis
Pain	Acute onset 20-30% have abdominal pain	Develops gradually
Age range	Pubescent boys Can affect neonates and adults	Post-pubescent 19-40 Can affect younger and older
History	Acute onset 50% report one episode of self resolving pain	Sexual activity Urethral instrumentation UTI
Urinary symptoms	90% urine NAD	Dysuria / freqency Pyuria present in most
On palpation	Testis enlarged, exquisitely tender Unable to distinguish epididymis Testis high riding and horizontal lie	Possible to distinguish the epididymis from the testis. Epidiymis is often enlarged and early on tenderness is localised.
Cremasteric reflex	Absent in most	Present
Prehn's test	Elevation of scrotum does not relieve pain	Elevation of scrotum does relieve pain

- Testicular torsion is a surgical emergency and requires immediate referral to the surgical team on-call.
- Epididymo-orchitis requires appropriate antibiotics and analgesia. Admission may be required for toxic patients or for analgesia.
- A normal USS of testes does not exclude torsion. Self resolving intermittent torsion may look like epididymo-orchitis on USS
- Late-presenting torsion mimics epididymo-orchitis – request scan if pain had sudden severe onset of symptoms

Advice for ED doctors regarding renal patients

If a patient known to the renal unit attends please consider asking at an early stage for expert advice from one of the renal consultants particularly if the presentation relates to a complication of their renal disease or the treatment of this. Examples of this would include:

- **Haemodialysis patient with fluid overload, hyperkalaemia or haemodialysis line sepsis**
- **Peritoneal dialysis patient with peritonitis or inability to perform dialysis**
- **Transplant patient with opportunistic infection or where immunosuppression prescription is being altered.**

Local renal physicians may be contacted by bleep during working hours and via switchboard at other times. If no renal physician is on call, consider contacting the renal registrar on-call at the regional nephrology unit in BCH.