North Central London (NCL) STP
Urology Pathways

Version 11.0 June 2021
Review Date: June 2023

Welcome to the UROLOGY Primary Care Pathway Suite. These pathways have been specially designed by Primary Care GPs along with Specialist Consultant Urologists along with Specialist Allied Healthcare Professionals in the wider multi professional team.
All pathways use a key:

North Central London Urology Lead

Primary Care (Co-Chair): Dr Nick Dattani (North Central London Clinical Commissioning Group)
Secondary Care (Co-Chair): Mr Paul Erotocritou (Whittington Hospital, London)

Frist Release
April 2018

Second Release
April 2019

Third Release
November 2019

Fourth Release
June 2021

PROSTATE CANCER

Refer men using a suspected cancer pathway referral (2ww) for prostate cancer if:
- Prostate feels malignant on digital rectal examination
- PSA levels are above the age-specific reference range. For patients with a slightly elevated PSA, a suspected cancer referral is still recommended.

TESTICULAR CANCER

Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for testicular cancer if they have:
- A solid intra-testicular lump
- Non-painful enlargement or change in shape or texture of the testis
- Abnormal ultrasound scan suggestive of testicular cancer

BLADDER CANCER

Refer using a suspected cancer pathway referral (2ww) for bladder cancer if

Adults aged .45 with:
- UNEXPLAINED visible haematuria without urinary tract infection
- Visible haematuria that persists or recurs after successful treatment of urinary tract infection

Adults aged .60 with:
- UNEXPLAINED non-visible haematuria and either dysuria or a raised white cell count

RENAL CANCER

Refer patients using a suspected cancer pathway referral (2ww) for renal cancer if:
- Abnormal ultrasound scan suggestive of renal cancer

Adults .45 with:
- UNEXPLAINED visible haematuria without urinary tract infection
- Visible haematuria that persists or recurs after successful treatment of urinary tract infection

Asymptomatic renal cysts described as simple in the radiology report do not require referral.

PENILE CANCER

Refer using a suspected cancer pathway referral (2ww) for penile cancer if:
- Penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded as a cause
- Persistent penile lesion after treatment for a sexually transmitted infection has been completed
- Unexplained or persistent symptoms affecting the foreskin or glans

Erectile Dysfunction Primary Care Protocol

Version 11.0 June 2021
Review Date: June 2023

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Patient presents with erectile dysfunction (part of the metabolic syndrome until proven otherwise)

Lifestyle and exercise advice

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀ ♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Cycling advice
(≤ 3hours/week)

History
- Medical history – CVD, hypertension, DM
- History of pelvic / genital surgery
- Psychosexual history
- Any medications that could cause ED *
- Risk factors for metabolic syndrome e.g. sedentary lifestyle, obesity, smoking, ETOH
- Problem getting an erection / keeping an erection / both?
- Energy levels – loss of libido, body hair

Examination

BP, weight, HR. Peripheral Pulses, External genitalia. If indicated Body hair, gynecomastia consider DRE

Investigate for metabolic syndrome
HbA1C, Lipids, U&Es

Consider PSA in men >40

Consider testosterone. If testosterone ≤12nmol/l, check FSH, LH, TSH, prolactin, TFTs, FBC
ASK PATIENT TO ARRANGE BLOOD TEST BETWEEN 8AM-11AM

ONLY refer to endocrinology if hypogonadism (characterised by abnormal testosterone, TSH, LH, prolactin)

Information leaflet

Patient and partner education if required
Modify lifestyle factors
Management of CVD / CHD - QRISK
Management of diabetes

Psychosexual issues

Psychosexual counselling

Barnet: Vale Drive Clinic/Sexual Health Clinic & Royal Free Hospital
Enfield: North Middlesex Hospital
Camden: SPATS
Haringey: IAPT Haringey
Islington: C&I Mental Health Trust Sexual Problems Clinic

Does the patient have CHD?

No

Yes

Use eRS or Consultant Connect A&G with cardiologist

Yes

Does the patient have any of the below?

- Unstable heart disease
- History of recent MI
- Poorly decompensated heat failure
- Unstable dysrhythmia
- Taking nitrates

No

(patient can resume sexual activity and use PDEI)

Treatment
Medication review
PDEI: 1st line = Sildenafil (50mg starting dose. If no improvement 100mg, as required). Minimum trial 4 weeks - offer minimum of 8 tablets
2nd line = Tadalafil (10/20mg). Minimum trial 4 weeks - offer minimum of 8 tablets. SLS
3rd line = Topical prostaglandins e.g., Alprostadil cream (Vitaros ®)

- Refer to urology if no response after 8 weeks of medication ONLY IF PATIENT WISHES to consider MUSE, vacuum device or caverject injections in nurse led clinic.
- Alprostadil cream 300mcg (Vitaros®) may be initiated and continued in primary care as a second-line treatment option for patients who cannot use intracavernosal injection or intraurethral stick due to dexterity issues
- Referrals also accepted if trial of medication is contraindicated (please state this on the referral)

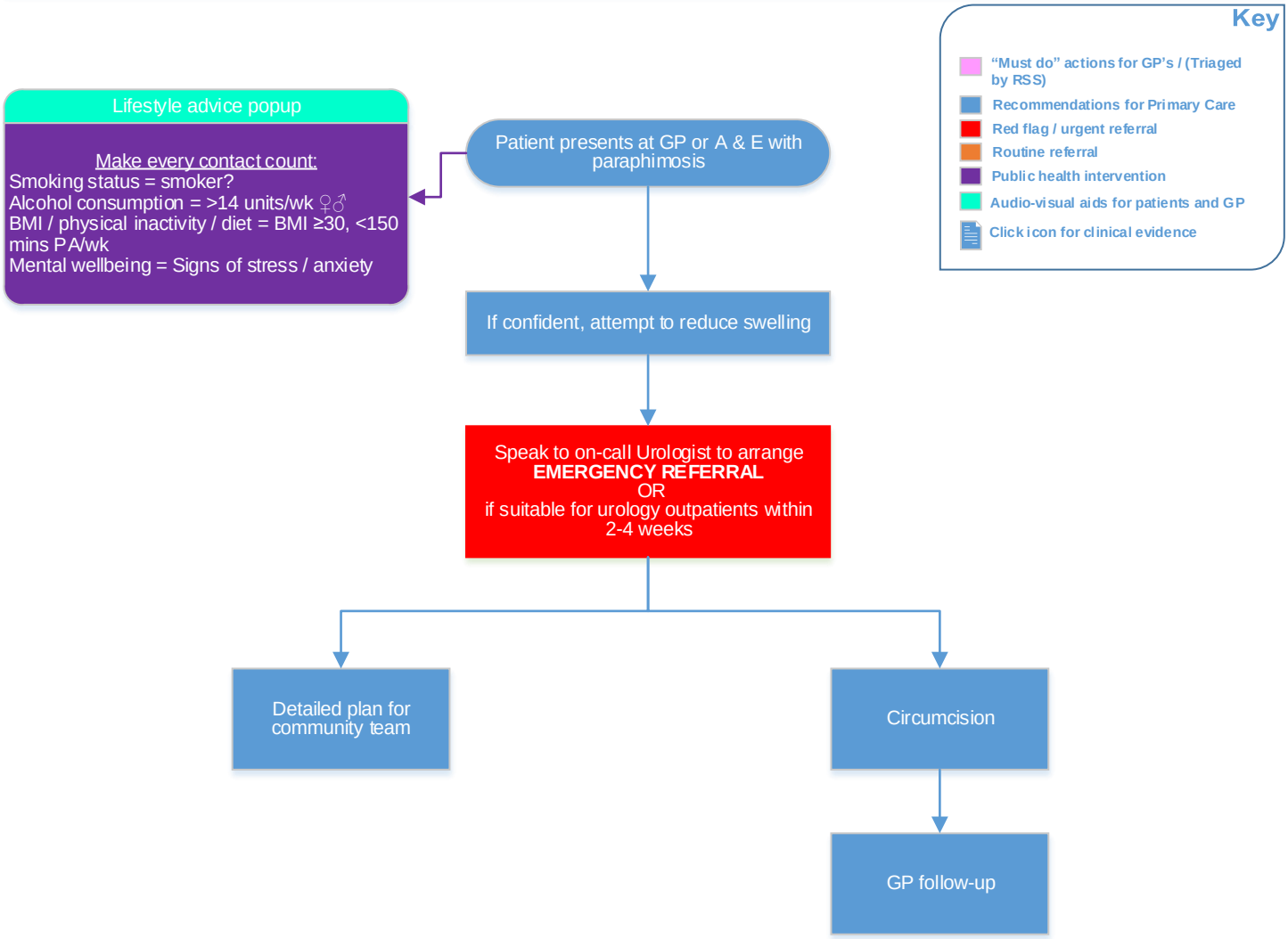
GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

* Medication that can contribute to Erectile Dysfunction : Diuretics, blood pressure medication, anti depressants, antiepileptic medications, NSAIDs, Parkinson's medications, muscle relaxants, prostrate cancer medications, Chemotherapy medicines.

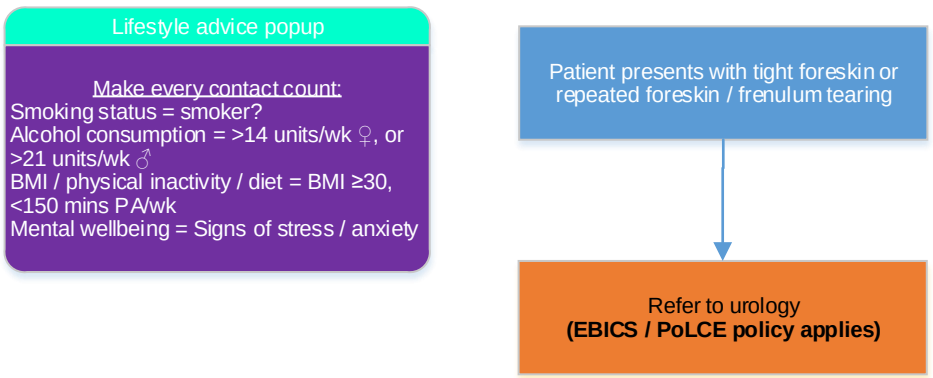
Foreskin Problems Primary Care Protocols

Version 11.0 June 2021
Review Date: June 2023

Paraphimosis Primary Care Protocol



Adult Phimosis Primary Care Protocol



GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Haematospermia Primary Care Protocol

Version 11.0 June 2021
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Haematospermia

Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Urine dip stick (check for haematuria) and send mid stream urine to lab

Consider PSA in men at any age with suspicion or FHx of prostate cancer, especially those >40
Consider DRE and other physical examination
Consider FBC, UE, LFT, Coag screen and/or STI screen

Exclude Identifiable Causes:

- ?UTI;
- ?Oral Anti Coagulants
- ?Ca Prostate(Consider family history)
- ?Testicular cancer
- ?Suspected benign prostatic hypertrophy — refer to male LUTS guidance
- ?Suspected prostatitis (patient may have pelvic pain);
- ?Trauma or instrumentation (such as prostatic biopsy) — reassure him that symptoms normally settle within 3–4 weeks.
- ?STI - Suspected sexually transmitted infection — refer the patient to a service specializing in sexual health for further investigation and management.
- ?An acquired bleeding disorder (secondary to suspected haematological cancer, or liver or kidney failure) — refer for further assessment to the appropriate specialist.
- ? TB/Schistosomiasis infection (take traveller history)

2WW Cancer pathway if raised PSA, suspicious DRE or symptoms of testicular/urological cancer

No Identified Cause

Age ≤ 40 years

PSA, FBC, U&E, LFT, Coag, DRE

(Exclude hepatosplenomegaly and testicular mass)

> 3 episodes within 1 month

Yes

Urology Referral

No

Consider STI Screen and Ultrasound of testes if swelling whilst awaiting referral

Persistence > 1 month or GP has clinical concern

Age ≥ 40 years

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Haematuria Primary Care Protocol

Version 11.0 June 2021
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Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk♀♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Patients presents with haematuria

Is the haematuria visible or non-visible?

Visible

Are any RED FLAGS present?
- On anticoagulants or raised INR
- Passing large clots
- Retention

Yes → Emergency referral (contact Urology on-call)

No

Urine Dip/MSU.
Is there a history of infection (fever, dysuria)

Yes → Treat infection appropriately and review patient after treatment completed

Visible haematuria without UTI or persistent after treatment

Yes

Patient >45 years old

Yes → Refer to 2WW Cancer Pathway (especially with >60 with non-visible haematuria if patient has either dysuria or raised WCC in full blood count)

No, under 45

If no improvement, ROUTINE referral to Haematuria Clinic on Urology Referral Form

If all urological tests are negative consider other diagnosis with management plan and/or consider nephrology referral

Re-bleed

Non-visible

Does the patient have symptoms e.g. voiding, LUTS, (hesitancy, frequency, dysuria)

No → Repeat urine dip stick

Are at least 2 of 3 dipstick tests positive (not trace)? (on 3 separate occasions)

Yes

Symptomatic or confirmed microscopic haematuria without UTI or which persists after UTI treatment in all patients please organise:
Blood pressure
FBC, U&E's, Clotting (if on anti coagulants)
Send urine for ACR

No

Is there isolated proteinuria?

No

Reassure Patient
(No routine follow-up required)

Yes

Yes

Is the patient > 60 years?*

Yes → Refer to 2WW Cancer Pathway (especially with >60 with non-visible haematuria if patient has either dysuria or raised WCC in full blood count)

No, under 60

Yes

If UTI present/suspected, treat infection appropriately and review patient after treatment completed

Where the tests normal or abnormal?

Abnormal if any one of:
- eGFR <60mls/min
- ACR >30 or PCR >50
- BP >140/90

Normal

No cause established

Arrange U/SKUB

Normal

Abnormal

Refer for nephrology for assessment

Cause established and treatment plan

Primary Care Monitoring

Annual assessment (while haematuria persists) of BP, eGFR and ACR / PCR

Refer or re-referral to urology if development of VH or symptomatic microscopic haematuria

Referral to nephrology if:
- Significant or increasing proteinuria (ACR >30 or PCR >50)
- eGFR <30ml/min (confirmed on at least 2 readings and without an identifiable reversible cause)
- Deteriorating eGFR (by >5ml/min fall within 1 year, or >10ml/min fall within 5 years

Consider endometrial cancer in women aged 55 and over with unexplained vaginal discharge who are presenting with the first episode of haematuria and/or low Hb levels.

GP's can access ADVICE & GUIDANCE for Urology or Nephrology via e-RS. Specialists/Consultants should reply within 3-5 working days.

*Consider examination of vulva in female patient to rule out gynaecological cause

Male LUTS Primary Care Protocol

Version 10.8 November 2019
Review Date: November 2020

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
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- Routine referral
- Public health intervention
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Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety
Discuss caffeine and fluid intake and alcohol volume/timings

Patient presents with lower urinary tract symptoms, hesitancy, weak flow, dribbling, staining, frequency, urgency, nocturia, intermittent incomplete emptying

Urine dipstick and DRE
Offer information and time to decide whether to have a PSA test,
U&E, HbA1C

Is there:
- Visible haematuria
- Persistent / recurrent UTI, with haematuria >45 years
- Non visible microscopic haematuria age >60 years (1+ dips or more not trace)
- Raised PSA?

Yes → 2 Week Wait referral

No

Do you suspect acute kidney injury?

Acutely abnormal renal function → Urgent referral (either same day admission or Urgent Referral via RMS depending on clinical scenario

Normal renal function

Does the patient have palpable bladder, nocturnal enuresis, recurrent UTIs or history of renal stones?

Yes → Consider **URGENT** urology referral where appropriate

No

Are the symptoms bothersome?
Consider calculating IPSS

No → Podcast non-bothersome LUTS
Conservative Management: Give reassurance and advice on lifestyle intervention

Yes

Medication review
Is the patient taking diuretics?

Yes → Medication management

Give international prostate symptom score

No improvement

No

Are the LUTS severe (Consider IPSS>20)?

Yes → Start Tamsulosin and then refer to urology
Organise US KUB whilst awaiting referral

No

Does the patient have voiding or storage symptoms?
Tick all that apply

Voiding	Storage
Poor stream	Urinary frequency
Hesitancy	Urgency
Terminal dribbling	Dysuria
Incomplete voiding	Nocturia
Overflow incontinence (occurs in chronic retention)	Other
Other	

Voiding → Lifestyle Counselling
Offer medication where patient is symptomatic –
8 week trial α Blocker
(e.g. alfuzosin or tamsulosin MR capsules)
+/- alpha reductase inhibitor
e.g. Finasteride 5mg OD

These medications could falsely reduce PSA values by up to 50%
Consider annual PSA Testing in these Patients

8 week review

Better → Continue medication
Review 6-monthly via IPSS score or other measurement and then annually

No improvement → US KUB (pre-post micturation)

Continue medication / switch 1st → 2nd line while awaiting referral

Refer to urology. Navigator will organise Uroflow studies before patient is seen in clinic

Storage → Is it mainly night time?

No → Refer to continence service (if available) who will offer lifestyle management, pelvic floor exercises and will prescribe medications if required *
OR
Offer anti-cholinergic:
1st Line: Oxybutynin immediate release (not frail/elderly)
OR Tolterodine immediate release
2nd Line: Solifenacin OR Mirabegron (GP to review cautions)
Review the man every 6 weeks until symptoms are stable, then every 12 months

No improvement → US KUB (pre-post micturation)

Yes → Treat for any co-morbidities which could explain LUTS

Review in 6 weeks

Better → Continue medication
Review 6-monthly via IPSS score or other measurement and then annually

No improvement → US KUB (pre-post micturation)

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Speak to your relevant CCG to get help with this service if you are not already familiar with it. Specialists/Consultants should reply within 3-5 working days.

Link to IPSS Score
http://www.urospec.com/uro/Forms/ipss.pdf

Penile Deformity Primary Care Protocol

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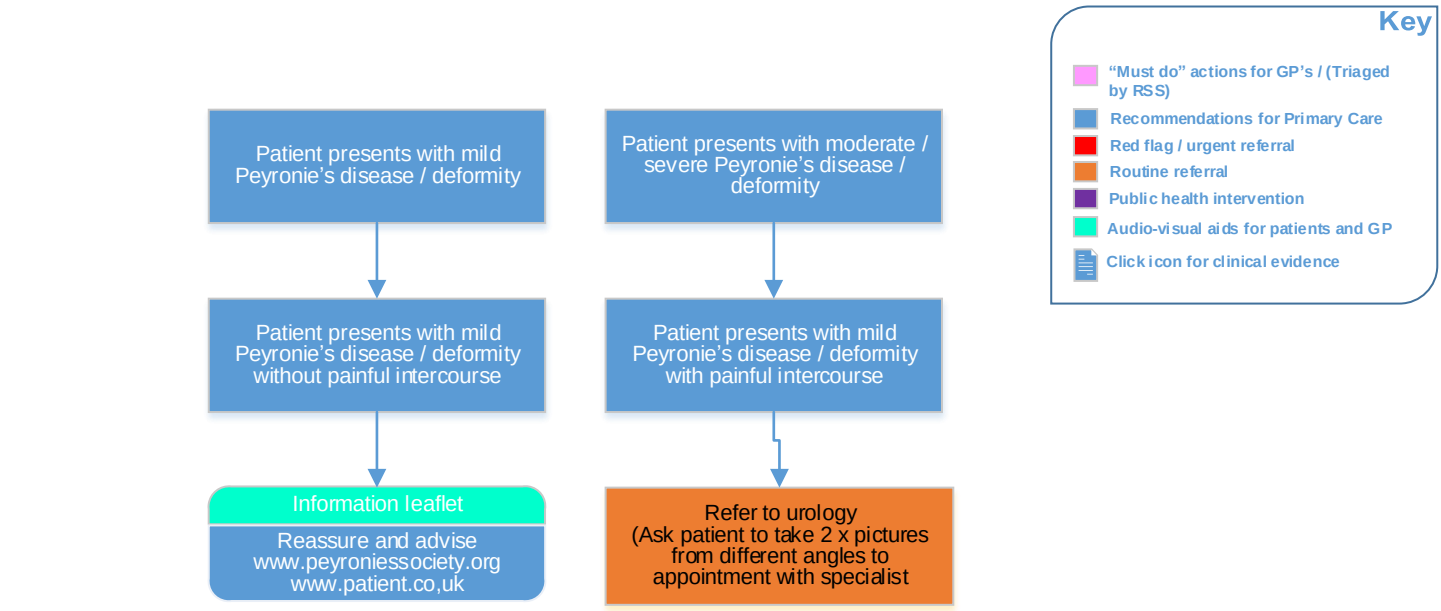
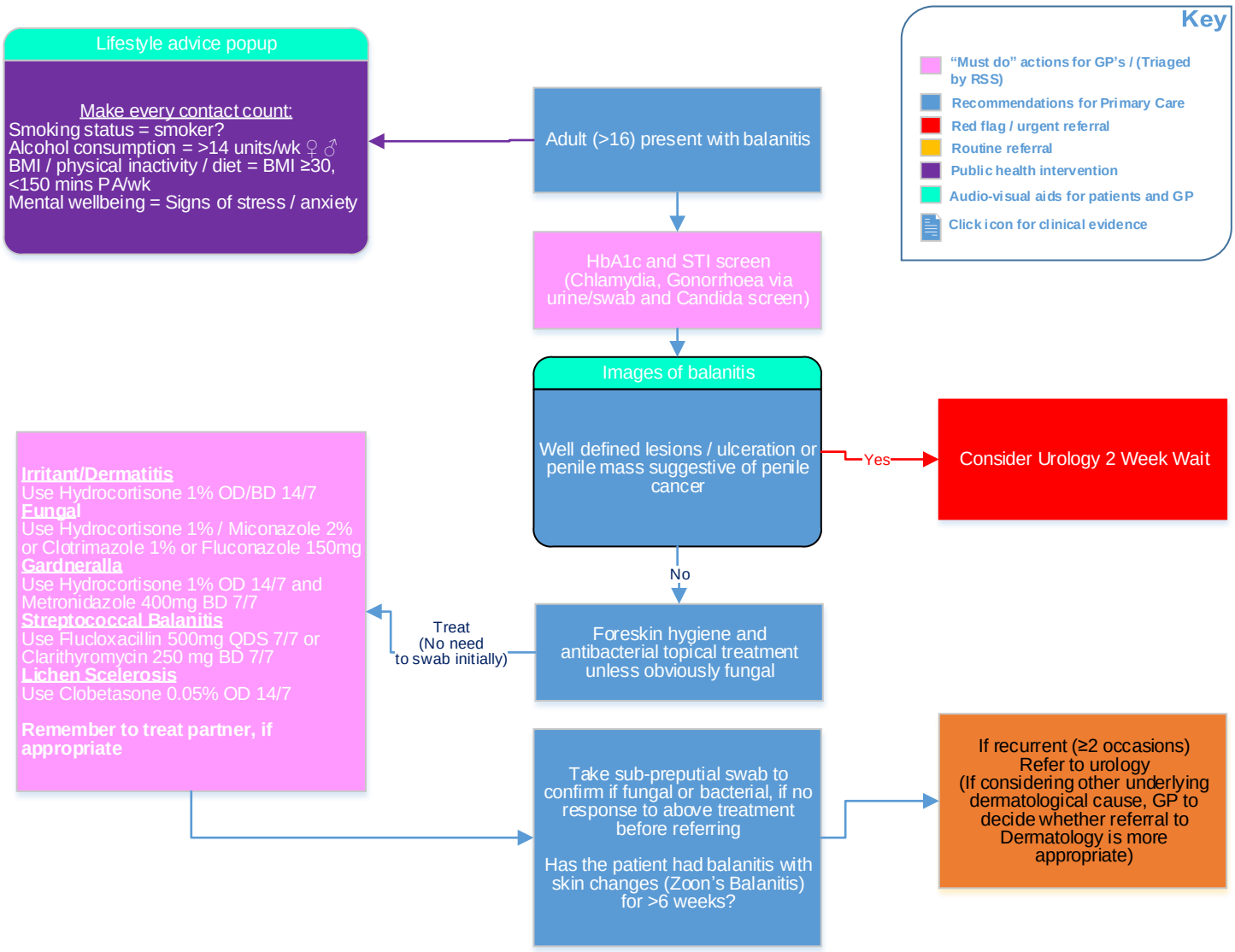
Review Date: June 2023



GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Adult Balanitis Primary Care Protocol



PSA Primary Care Protocol

Version 101.0 June 2021
Review Date: June 2023

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
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Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀ ♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Patient requests a PSA test

Does the patient have a history of clinically malignant prostate or do they have bone pain or unexplained urological symptoms?

Yes → Recommend PSA check and DRE

No → Symptomatic?

Yes → UTI / LUTS / Haematuria

UTI → Treat for infection

LUTS → Refer to LUTS primary care protocol

Haematuria → Refer to haematuria primary care protocol

Recommend PSA check and DRE → Is the PSA high according to the patient's age or is DRE abnormal PSA?

London Cancer PSA Age specific thresholds

Age	PSA Value (ng/ml)
40-49	>2.5
50-69	>3
Over 70	>5

Yes → 2 Week Wait referral to urology

No → Offer PSA blood test and counsel patient * to have test done at least
- 72 hours after ejaculation and
- 6 weeks post resolution of UTI symptoms
± DRE

Patient does not wish to proceed → No further action

* Provide information and counselling to patient regarding PSA testing. Offer leaflet (https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/PSA%20advice.pdf

Is the PSA high according to the patient's age or is DRE abnormal PSA?

London Cancer PSA Age specific thresholds

Age	PSA Value (ng/ml)
40-49	>2.5
50-69	>3
Over 70	>5

Yes → Manage in primary care and consider repeating PSA in 6 weeks in symptomatic patients → Refer to Urology if clinical concern

No → 5-alpha reductase inhibitors could falsely reduce PSA values by up to 50%.

2 Week Wait referral to Urology

Note: There is an NCL-wide prostate cancer follow-up pathway

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Prostatitis

Version 11.0 June 2021
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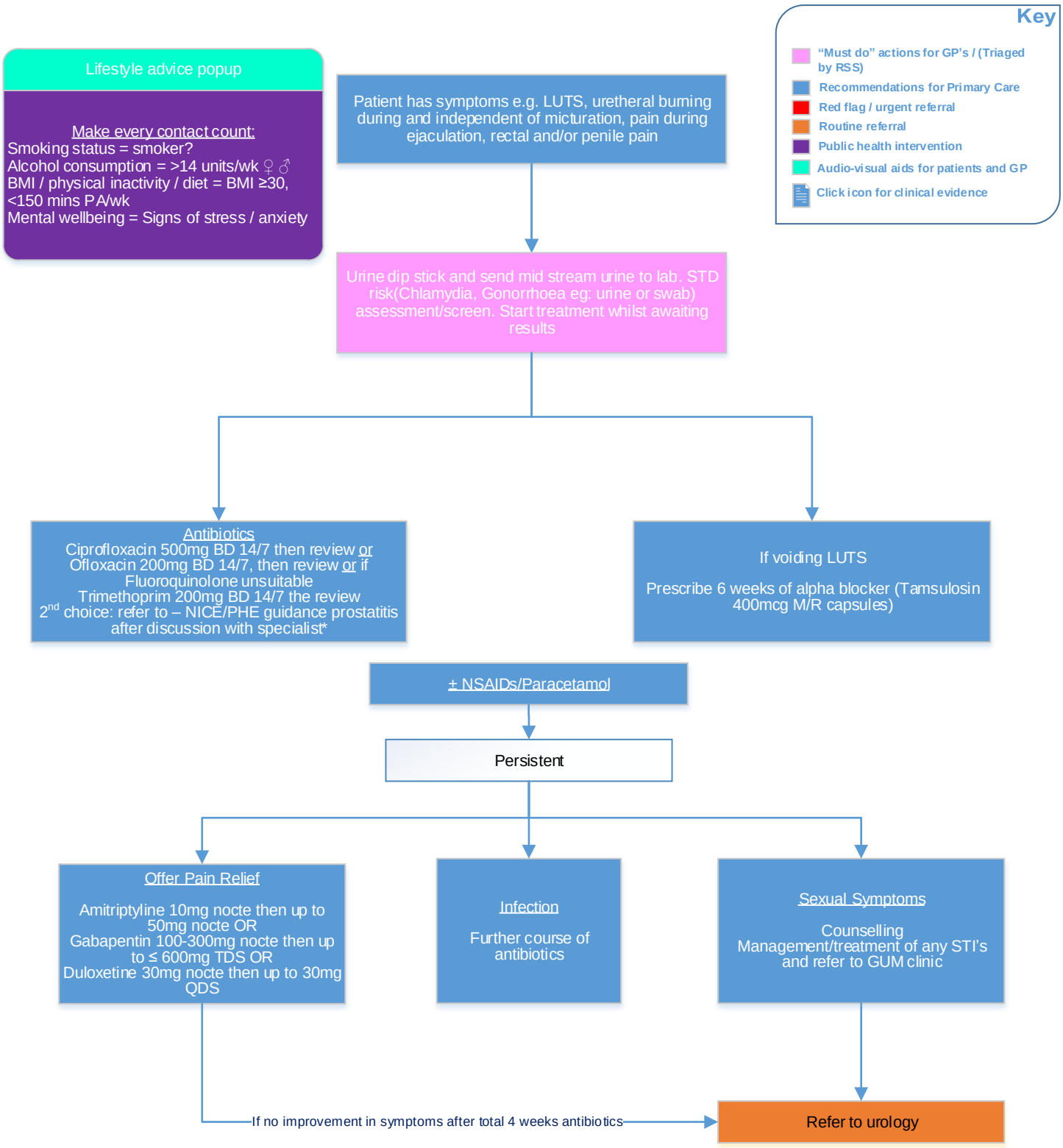

* 2nd choice after discussion with specialist may include to prescribe Levofloxacin 500mg OD 14/7 OR Co-Trimoxazole 960mg BD 14/7

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Women (under 65 years) with suspected UTI

Version 11.0 June 2021
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URINARY SYMPTOMS (e.g. dysuria, frequency, urgency) IN ADULT WOMEN under 65
This guide excludes patients with recurrent UTI (2 episodes in the last 6 months, or 3 episodes in months) or urinary catheter

YES

Consider other causes of urinary symptoms:
- ❑ Vaginal symptoms or discharge – 80% do not have UTI
- ❑ Urethritis – inflammation post sexual intercourse, irritants
- ❑ Check sexual history to exclude sexually transmitted infections
- ❑ Genitourinary symptoms of menopause (vulvo/vaginal atrophy)

YES → Follow relevant diagnostic guide and safety netting

YES → **Consider pyelonephritis or suspected sepsis:**
- ❑ Send urine for culture.
- ❑ Immediately start antibiotic for upper UTI/sepsis using NICE/PHE guidance on pyelonephritis or local/ national guidelines for sepsis.
- ❑ Refer is signs/symptoms of serious illness or condition

❑ **THINK SEPSIS - check for signs/symptoms using local/national tool** such as NICE, RCGP or NEWS2

❑ **Check for any new signs of pyelonephritis** ***see box at bottom of page*

NO

Does patient have any of the 3 key diagnostic symptoms/signs?
- ❑ Dysuria (burning pain when passing urine)
- ❑ New nocturia (passing urine more often at night)
- ❑ Urine cloudy to the naked eye

2 or 3 symptoms	1 symptom	No symptoms

YES (1 symptom) → Perform Urine Dipstick Test

YES (No symptoms) → **Other severe urinary symptoms:**
- ❑ Urgency
- ❑ Visible haematuria
- ❑ Frequency
- ❑ Suprapubic tenderness

YES (2 or 3 symptoms) → UTI likely

Perform Urine Dipstick Test:

- Positive Nitrite OR Leukocyte and RBC positive → YES → UTI likely
- Negative Nitrite Positive leukocyte → YES → UTI equally likely to other diagnosis
- ALL Nitrite, WBC, RBC negative → YES → UTI LESS likely

Other severe urinary symptoms: → NO → UTI LESS likely

UTI likely
- ❑ Send urine culture if risk of antibiotic resistance.
- ❑ If not pregnant and mild symptoms, watch and wait with back up antibiotic
  OR
- ❑ consider immediate antibiotic for lower UTI

NICE/PHE guidance on lower UTI

UTI equally likely to other diagnosis
- ❑ Review time of specimen (morning is most reliable)
- ❑ Send urine for culture to confirm diagnosis
- ❑ Consider immediate or back-up antibiotic (if not pregnant) depending on symptom severity using antibiotic for lower UTI

NICE/PHE guidance on lower UTI

UTI LESS likely
- ❑ No urine culture
- ❑ Consider other diagnosis
- ❑ Reassure that UTI less likely

Give and discuss TARGET UTI leaflet with safety netting advice
If pregnant always send urine culture – follow national treatment guidelines if any bacteriuria

*** Signs/symptoms of moderate risk of sepsis:**
- New alteration in mental state or decreased functional ability
- New heart rate above 90 beats/min at rest or dysthymia
- New dyspnoea or respiratory rate above 20 breaths/min
- New low blood pressure (systolic <100mm Hg)
- No urine passed in 12 hours (≤0.5 – 1ml/kg urine per hour if catheter)
- Tympanic temperature 36ºC or below
- Impaired immune system (except if chemotherapy)

**** Signs of pyelonephritis:**
- Kidney pain/tenderness in back under ribs
- New/different myalgia, flu like illness
- Shaking chills (rigors) or temperature 37.9ºC or above
- Nausea/vomiting

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

PSA Testing Advice for Well Men Age >50

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Potential benefits and risks of PSA testing

	Having the PSA test	Not having the PSA test
Health 	If you have the PSA test and follow-on treatment you are less likely to die of prostate cancer than men who do not have the test. Having an abnormal PSA test result means you may be offered further tests and treatments, which may harm your health.	If you do not have the PSA test you are more likely to die of prostate cancer than men who do have the PSA test. You are also more likely to experience the complications of advanced incurable prostate cancer.
Test results 	The PSA test may reassure you if the result is normal. But it can miss cancer and provide false reassurance. If you have prostate cancer, you are more likely to be diagnosed and treated early. But an abnormal test result may also lead to unnecessary worry and medical tests when there is no cancer. The test cannot tell the difference between fast-growing cancers and slow-growing cancers that may not cause symptoms or shorten your life.	If you do not have the PSA test you may avoid unnecessary worry and tests after an abnormal result when there is either no cancer or a slow-growing cancer. If you have prostate cancer, you are less likely to be diagnosed and treated early.
Accuracy 	About 75 out of every 100 men who have an abnormal PSA test result do not have prostate cancer. This is called a false positive result. About 15 out of every 100 men who have a normal PSA test result do have prostate cancer. This is called a false negative result.	If you do not have a PSA test, you will not get a false positive or a false negative result but the chance of early detection may be missed.
Follow-up 	About 17 out of every 100 men who are tested have an abnormal test result. About 82 out of every 100 men who have an abnormal result will have a biopsy. Some men have problems or complications after a biopsy for prostate cancer. The most common complications are bleeding and infections.	If you do not have a PSA test, it is unlikely you will need to have a biopsy unless you get symptoms of prostate cancer, at which stage the cancer might be more advanced.
Treatment 	If you are diagnosed with prostate cancer, you will need to decide about treatment. Potential treatments can include surgery, radiotherapy and hormone therapy. Side effects of treatments for prostate cancer can include problems with erections, loss of fertility and incontinence.	If you choose not to have a PSA test, it is unlikely you will need treatment for prostate cancer, unless you get symptoms. This means you are less likely to have any complications from treatments.

Older person (Over 65 years) with suspected UTI

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Urinary signs/symptoms, abnormal temperature, non-specific signs of infection

YES

Do not perform urine dipstick: not recommended if over 65 years. Up to half of older adults and most with a urinary catheter will have bacteria present in the bladder/urine without an infection. This "asymptomatic bacteriuria" is not harmful and although it causes a positive urine dipstick antibiotics are not beneficial and may cause harm

ALL

THINK SEPSIS (below) check for signs/symptoms using Local or National Tool such as NICE, RCGP or NEWS2

CHECK for Signs/symptoms of pyelonephritis:
- ❑ Kidney pain/tenderness in back, under ribs
- ❑ New/different myalgia, flu-like Illness
- ❑ Nausea/Vomiting
- ❑ Shaking chills (rigors) OR temperature >37.9ºC OR ≤36ºC

YES →

Consider pyelonephritis or possible sepsis:
- ❑ Send urine for culture before antibiotics are taken
- ❑ Immediately start antibiotics Management for upper UTI/sepsis using - ***NICE/PHE guidance on pyelonephritis or local/national guidelines for sepsis.***
- ❑ If urinary catheter: consider removing Or changing as soon as possible
- ❑ Refer if signs/symptoms of serious illness or condition

NO

CHECK ALL FOR symptoms/signs of UTI:
- ❑ NEW onset dysuria alone
  OR two or more
- ❑ Temperature 1.5ºC above patient's normal twice in last 12 hours
- ❑ New frequency or urgency
- ❑ New incontinence
- ❑ New or worsening confusion/delirium/debility
- ❑ New suprapubic pain
- ❑ Visible haematuria

If fever and delirium/debility only: consider other causes before treating for UTI (*see box below)

YES →

UTI LIKELY: share self-care and safety-netting advice using TARGET UTI leaflet
- ❑ Always send urine culture if feasible, before antibiotics are taken as greater resistance in older adults
- ❑ If mild symptoms, consider backup antibiotics in women without catheters and low risk of complications
- ❑ Offer immediate antibiotics using - NICE/PHE guidance on lower UTI

- ❑ **OR** NICE/PHE guidance on catheter associated UTI
- ❑ If urinary catheter for >7 days, consider changing (if possible remove) as soon as possible, but do not delay antibiotics.
- ❑ Review antibiotic choice and culture result, use narrow spectrum antibiotics if possible

If urinary catheter: also check for catheter blockage AND consider catheter removal Or replacement

Consider if genitourinary syndrome or Menopause (vulvovaginal atrophy), urethritis, sexually transmitted infections, and prostatitis.

NO

CHECK for other causes of delirium if relevant (PINCH ME):
P: **P**ain
I: other **I**nfection
N: poor **N**utrition
C: **C**onstipation
H: poor **H**ydration

M: other **M**edication
E: **E**nvironment change

YES →

Consider other local/national resources for delirium management
Give safety-netting advice about consulting if:
- ❑ Worsening symptoms
- ❑ No improvement 48 hours after starting antibiotics
- ❑ Signs of pyelonephritis
- ❑ Any symptom/sign of sepsis

CHECK ALL for other localised symptoms/signs:
Two or more symptoms or signs in:
- ❑ Respiratory tract infection
- ❑ Gastrointestinal tract infection
- ❑ Skin and soft tissue infection

YES →

Follow local diagnostic and treatment guidance

ALL

NO

Advise "watchful waiting" with further investigation for other causes.

ALL →

If worsening signs or symptoms:
Consider admission or start/change antibiotic

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Public Health England

Urinary tract infection (UTI) information leaflet

For women outside care homes with suspected uncomplicated Urinary Tract Infections (UTIs), or uncomplicated recurrent UTIs

Possible urinary symptoms

Frequency: Passing urine more often than usual

Dysuria: Burning pain when passing urine

Urgency: Feeling the need to pass urine immediately

Haematuria: Blood in your urine

Nocturia: Needing to pass urine in the night

Suprapubic pain: Pain in your lower tummy

Other things to consider

Recent sexual history

- Some sexually transmitted infections (STIs) can have symptoms similar to those of a UTI.
- Inflammation due to sexual activity can feel similar to the symptoms of a UTI.

The outcome

☐ **Mild, or 1 to 2, symptoms and/ or vaginal discharge**

- Antibiotics less likely to help.
- Usually lasts 5 to 7 days.

☐ **Severe, or 3 or more, symptoms and no vaginal discharge**

- Antibiotics are likely to help.

With antibiotics:

- Symptoms should start to improve within 48 hours.
- Symptoms usually last 3 days.

Recommended care

☐ **Self-care and pain relief**

- symptoms are likely to get better on their own.

Antibiotic prescription

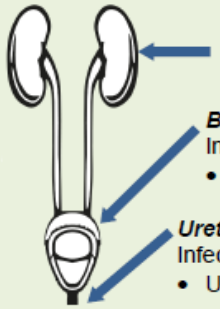
☐ **Immediate** treatment with antibiotics, plus self-care.

☐ Start **delayed or backup** treatment with antibiotics:

- if symptoms get worse
- if symptoms do not get a little better with self-care after 24 to 48 hours

Types of urinary tract infection (UTI)

UTIs are caused by bacteria getting into your urethra or bladder, usually from your gut. Infections may occur in different parts of the urinary tract:



Kidneys (make urine)
Infection in the upper urinary tract
- Pyelonephritis *(pie-lo-nef-right-is)*

Bladder (stores urine)
Infection in the lower urinary tract.
- Cystitis *(sis-tight-is)*

Urethra (takes urine out of the body)
Infection or inflammation in the urethra
- Urethritis- *(your-ith-right-is)*

Self-care to help yourself get better more quickly

- Drink enough fluids to stop you feeling thirsty. Aim to drink 6 to 8 glasses including water, decaffeinated and sugar-free drinks.
- Take paracetamol or ibuprofen at regular intervals for pain relief, if you've had no previous side effects.
- You could try taking cranberry capsules or cystitis sachets. These are effective for some women. There is currently little evidence to support their use.
- Consider the risk factors in the 'Options to help prevent UTI' column to reduce future UTIs.

When should you get help?

Contact your GP practice or contact NHS 111 (England,), NHS 24 (Scotland dial 111), or NHS direct (Wales dial 0845 4647)

The following symptoms are possible signs of serious infection and should be assessed urgently.

Phone for advice if you are not sure how urgent the symptoms are.

1. You have shivering, chills and muscle pain.
2. You feel confused, or are very drowsy.
3. You have not passed urine all day.
4. You are vomiting.
5. You see blood in your urine.
6. Your temperature is above 38˚C or less than 36˚C.
7. You have kidney pain in your back just under the ribs.
8. Your symptoms get worse.
9. Your symptoms are not starting to improve a little within 48 hours of taking antibiotics.

Options to help prevent a UTI

It may help you to consider these risk factors:

Stop the spread of bacteria from your gut into your bladder: Wipe from front (vagina) to back (bottom) when you go to the toilet.

Avoid waiting to pass urine: Pass urine as soon as you need a wee.

Wee after having sex to flush out any bacteria that may be near the opening to the urethra

Wash the external vagina area with water before and after sex to wash away any bacteria that be near the opening to the urethra

Drink enough fluids to make sure you wee regularly throughout the day, especially during hot weather.

If you have a recurrent UTI, also consider the following

Cranberry products: Some women find these effective, but there is currently little evidence to support this.

After the menopause: You could consider topical hormonal treatment, for example, vaginal creams.

Antibiotic resistance

Antibiotics may not always be needed, only take them after advice from a health professional. This way they are more likely to work if you have a UTI in the future.

Antibiotics taken by mouth, **for any reason,** affect our gut bacteria. These bacteria become resistant to antibiotics we take.

Antibiotic resistance means that the antibiotics **cannot kill that bacteria.**

The gut bacteria that cause UTIs are twice as likely to be antibiotic resistant for **at least 6 months** after you have taken any antibiotic.

Common **side effects** to taking antibiotics include thrush, rashes, vomiting and diarrhoea.

www.antibioticguardian.com

ANTIBIOTIC GUARDIAN

RCGP Royal College of General Practitioners

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

BIA British Infection Association

ROYAL PHARMACEUTICAL SOCIETY

SCOTTISH UTI NETWORK

Recurrent UTIs Primary Care Protocol

Version 11.0 June 2021
Review Date: June 2023

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Patient presents with recurrent separate UTIs (≥2 in 6 months or ≥3 in 12 months)

Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀ ♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Urine dip stick (if <65) and treat for infection if positive symptoms (see UTI protocol)

Is there blood in urine?

Yes → Is there blood in the urine or >1 out of 3 dipsticks (no trace) after treatment?

Yes → Haematuria primary care protocol

No → Organise blood tests: U&E, TFT, HbA1C AND pre and post micturation US KUB

Consider STI screen where appropriate

Normal → **Information Leaflet**

Non-pregnant women may wish to try D-mannose
Non-pregnant women may wish to try cranberry products (evidence uncertain)
Under 16s may wish to try cranberry products with specialist advice (evidence uncertain)
Advise people taking cranberry products or D-mannose about the sugar content of these products
Inconclusive evidence for probiotics

Abnormal → **Refer to urology**

Refer or seek specialist advice on further investigation and management for men, people with recurrent upper UTI, people with recurrent lower UTI when the underlying cause is unknown & pregnant women

If fails

If atrophic vaginitis:
1st Line: Ovestin® cream
2nd Line: Vagifem® pessary
Use once daily for 14/7 then twice weekly

Consider use of antibiotic as per *NICE/ PHE recurrent urinary tract infection guidance*

1st Line = Trimethoprim (200 mg single dose when exposed to a trigger or 100 mg at night) OR Nitrofurantoin—if eGFR >=45 ml/minute (100 mg single dose when exposed to a trigger or 50 to 100 mg at night)
2nd Line = Amoxicillin (500 mg single dose when exposed to a trigger or 250 mg at night) OR Cefalexin (500 mg single dose when exposed to a trigger or 125 mg at night)

Or → Ensure that any current UTI has been adequately treated then consider single-dose antibiotic prophylaxis for use when exposed to an identifiable trigger e.g. post-coital antibiotics e.g. Nitrofurantoin 50mg/100mg stat

Or → Consider use of standby packs of antibiotics* with GPs as per NICE guidelines

Review at least every 6 months should include:
assessing prophylaxis success
reminders about behavioural and personal hygiene measures, and self-care
discussing whether to continue, stop or change antibiotic prophylaxis

Review after 6 months → If symptoms fail to respond/settle refer to urology ← Review after 6 months

Constipation is a common cause of UTI's. Please refer to Constipation Primary Care Pathway (within GI protocols)

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Renal Colic Primary Care Protocol

Version 11.0 June 2021
Review Date: June 2023

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Lifestyle advice popup

Make every contact count:
Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀ ♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk
Mental wellbeing = Signs of stress / anxiety

Abrupt onset unilateral abdominal pain in loin/flank radiating to labia ♀ or groin ♂
Lasts minutes/hours in spasms, restless, associated nausea/ vomiting, urine frequency, dysuria, haematuria, fever.

If patient systemically well

If patient systemically unwell, refer to A&E

"Renal Colic" Test group on TQuest

Non contrast CT KUB
Urine Dip + MSU
FBC, U&E, Calcium, Urate, Phosphate, CRP

↑ Fluids
Analgesia ± Antiemetic

CT Results

If <5mm = 80% pass spontaneously
5 -10mm = 50% pass spontaneously

Obstruction
Speak to on-call surgeon and decide route for urgent referral

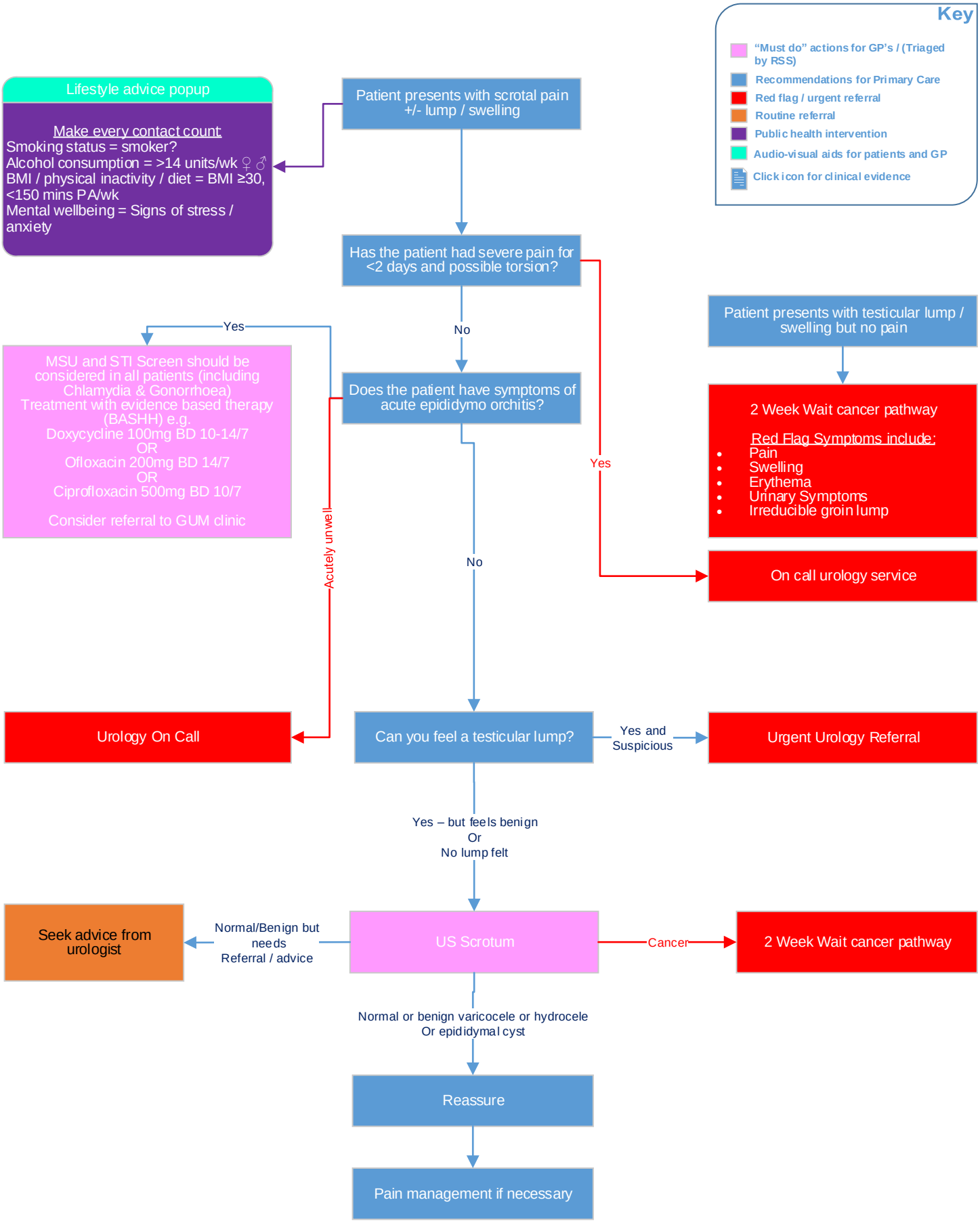
Kidney stone: refer to urology if kidney stone of 5mm or more for 8/52
Ureteric stone: refer to urology where patient has ureteric stone of any size for a period of time

If Kidney stone <5mm but symptomatic after 8/52

GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Scrotal Problems Primary Care Protocols

Version 11.0 June 2021
Review Date: June 2023



GP's can access ADVICE & GUIDANCE for Urology via e-RS. Specialists/Consultants should reply within 3-5 working days.

Urinary Incontinence Primary Care Protocol

Version 11.0 June 2021
Review Date: June 2023

Key

- "Must do" actions for GP's / (Triaged by RSS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Female patient presents with urinary or bladder symptoms

Urgency, frequency and nocturia indicate an **overactive bladder**.
Loss of small amounts of urine associated with coughing, laughing, sneezing, exercising indicate **stress incontinence**.
Both of the above symptoms indicate a **mixed incontinence**

Examine abdomen and perform PV exam to exclude pelvic mass. BMI, avoid Genuine Stress Incontinence (GSI). Arrange US Pelvis if any doubt to exclude a mass.
Undertake a urine dipstick to detect presence of blood, glucose, protein, leucocytes and nitrites. Treat any infection with appropriate antibiotics.
Consider U/S KUB to measure post-void residue of volume in women with symptoms suggestive voiding dysfunction or recurrent UTI

Red Flag Symptoms

Visible Haematuria >45
Non Visible Haematuria >60
Suspected mass from urogenital organs
Acute history of sphincter disturbance + lower back pain ± saddle anaesthesia
Recurrent UTIs with or without recurrent catheter blockages
Biochemical evidence of renal deterioration

Lifestyle Intervention

Caffeine – trial of caffeine reduction with over active bladder.
Fluid – advise modifications of high or low fluid intake in urinary continence or over active bladder
Weight – advise weight loss where BMI is >30

For Overactive and Urgency

Refer into Continence Service (community based) for bladder training for 6/52
Continence Service can prescribe medication if needed

Or

If Patient declines, start medical treatment

1st line: Immediate release oxybutynin (not frail/elderly) or tolterodine immediate release. Offer Mirabegron (if anti-cholinergics are contra-indicated). Trial 1st line medication for 4-6 weeks. **THEN**

2nd line: Solifenacin or Mirabegron if anti-cholinergic not tolerated or more than 2 anti-cholinergic ineffective.
Offer transdermal Oxybutynin to patients unable to take oral medication. Trial 2nd line medication for 4-8 weeks.

Offer the anticholinergic medicine with the lowest acquisition cost to treat overactive bladder or mixed urinary incontinence in women. When offering anticholinergic medicines to treat overactive bladder, take account of the woman's risk of adverse effects, including cognitive impairment

If post-menopausal, vaginal atrophy;
1st Line: Ovestin® cream
2nd Line: Vagifem® pessary
Use once daily for 14/7 then twice weekly

If troublesome Nocturia;
Consider desmopressin, 200mcg OD increasing to 400mcg if needed.
Avoid >65 with hypertension or CVD *(see BNF for contra-indications and cautions)*

For stress incontinence

Exercise Management

Offer Pelvic floor exercise in primary care + Bladder diary for 3 months

Refer to physiotherapy for pelvic floor exercise

Consider duloxetine second line only if women prefer pharmacological treatment or are not suitable for surgical treatment.

If patient has Mixed Incontinence follow the arm for most predominant feature (if overactive bladder is more predominant follow the left arm, if stress incontinence is more predominant follow the right arm).

If no improvement after three months
Refer to Gynaecology or Urology or Urogynaecology
Urology will see patients with a history of post bladder surgery, radiotherapy, complex pelvic surgery.
If stress incontinence is the predominant symptom in mixed urinary incontinence, discuss with the woman the benefit of non-surgical management and medicines for overactive bladder before offering surgery

Alternative Conservative Management

Consumables – absorbent products and toileting aids as a coping strategy *(as per local CCG availability)*

Catheters – Consider in patients with persistent urinary retention causing incontinence, symptomatic infections and renal dysfunction *(as per local CCG availability)*

Reference – NICE Clinical Guideline NG123

Incontinence support services available to patients

Version 11.0 June 2021
Review Date: June 2023

SUPPORT	SUPPORT TYPE	TARGET GROUP	ACCESS	SUPPORT
CCG Community Continence and Stoma service Provider Barnet: *CLCH District Nurses* Camden: *Whittington Community Bladder & Bowel Service* Enfield: *BEH-MHT* Haringey: *Whittington Community Bladder & Bowel Service* Islington: *Whittington Community Bladder & Bowel Service*	Community Healthcare	All	Referral	It offers a comprehensive range of support to help people self-manage and remain independent, or to adapt and modify their lifestyles to adjust to increasing dependence. Housebound patients are seen by district nurses in the first instance. Help with catheter changes and continence pads, etc. *Barnet: CLCH District Nurses - 0845 389 0940 / 0203 209 7920* *Camden: Whittington Community Bladder & Bowel Service - 020 3316 8401** *Enfield: 020 8702 5820*** *Haringey: Whittington Community Bladder & Bowel Service - 020 3316 8398** *Islington: Whittington Community Bladder & Bowel Service - 020 3316 8401** **https://www.whittington.nhs.uk/default.asp?c=10154* ***http://www.beh-mht.nhs.uk/enfield-community-services/ecs-services/continence-service.htm*
Age UK	Web-based information	Older people	Any	Age UK have pages dedicated to information about incontinence https://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIG15_Managing_incontinence.inf.pdf?dtrk=true They also have produced a guide on common bladder and bowel problems and how to manage them. https://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIG15_Managing_incontinence.inf.pdf?dtrk=true
NHS Choices	Web-based information	All	Any	With more than 48 million visits per month, It is the UK's biggest health website, accounting for a quarter of all health-related web traffic. Has pages explaining incontinence conditions, and how to access services.
The Chartered Society of Physiotherapy	Professional Body	Pregnant women	Any	The Chartered Society of Physiotherapy (CSP) has lots of useful information about pregnancy-related incontinence. You can also use the CSP's Physio2U service to find a local practitioner or contact the Pelvic Obstetric and Gynaecological Physiotherapy group.
Squeezy	App	Women	Any	Squeezy helps women with their pelvic floor muscle exercises as part of a physiotherapy programme.
Squeezy for men	App	Men	Any	For men to manage their pelvic floor muscle exercises
Tät	App	Women	Any	Tät is a training program for your pelvic floor. It guides you through progressively challenging exercises to build up strength; when you master one, you move on to the next. And for each exercise, graphics illustrate how long, and how intensely, you should contract your muscles. The app also offers lifestyle advice, and lets you set reminders so you stick to your regular "workouts."
Bladder & Bowel UK	Web-based information	All	Any	Bladder and Bowel UK offer specialist clinical and product advice, support and practical help. We have a team of Specialist Nurses and Continence Product Information staff, who can be contacted on the National Confidential Bladder and Bowel UK help line (0161 607 8219) or via email at bladderandboweluk@disabledliving.co.uk
ERIC (Childrens bladder and bowel charity)	Helpline Web-based information	Children	Children	Charity dedicated to the bowel and bladder health of all children and teenagers in the UK. Our vision is that every child and teenager with a bowel or bladder condition can access support and live free from embarrassment, shame, isolation and fear.
Bladder & Bowel Community	Support website Online Forum Carers information and advice	All	Any	The Bladder and Bowel Community (B&BC) is the UK wide service for people with bladder and bowel control problems. B&BC provides information and support services, including a confidential helpline, for anyone affected by these conditions as well as their families, carers and healthcare professionals.
Prostate Cancer UK	Web-based information Helpline Online chat with specialist nurse	Men with prostate cancer	Any	Website has a section on Urinary problems after prostate cancer treatment. https://prostatecanceruk.org/prostate-information/living-with-prostate-cancer/urinary-problems
General Practice	Clinical	All	Any	Can provide treatment options including prescribed medicines
Midwives and Health Visitors	Community	Pregnant and Post-natal women	Pregnant and Post-natal women	What UI support is given by midwives during pregnancy? What UI support is given by health visitors?
Carers UK	Web-based information and advice helpline	Carers	Any	Our expert telephone advice and support service is here if you want to talk about caring. If you're looking for answers, our online information and support is the best place to start.
Barnet Carers Centre	Carers centre	Carers	Any	The Centre offers advice, information, emotional and practical support for all informal carers who live or work in the London Borough of Barnet.
Association for continence advice	Professional body	Health professionals	Health professionals	Multidisciplinary group of health care professionals providing information about all aspects of incontinence. Continence adviser provides telephone advice and answers letters.

Pelvic Floor Exercises for Men

Version 11.0 June 2021
Review Date: June 2023

Introduction

Many men may experience urinary leakage caused by a variety of problems and conditions. Some also have difficulty controlling wind or leakage from the bowels. This may be due to weakness of the muscles of the pelvic floor, which have an important function in preventing these troublesome symptoms.

What is Pelvic Floor?

The floor of the pelvis is made up of layers of muscle and other tissues. These layers stretch from the tailbone at the back to the pubic bone in front. A man's pelvic floor supports the bladder and the bowel. The urethra (bladder outlet) and the rectum (back passage) pass through the pelvic floor. The pelvic floor muscles play an important role in bladder and bowel control. The pelvic floor also plays a role in maintaining an erection.

Why the Pelvic Floor Muscles get weak

The pelvic floor muscles can be weakened by:

- Surgery for an enlarged prostate gland
- Continual straining to empty the bowels, usually due to constipation
- Persistent heavy lifting
- A chronic cough, such as smoker's cough or chronic bronchitis and asthma
- Being overweight
- Lack of general fitness

Neurological damage (e.g. after a stroke or spinal injury, or resulting from other neurological conditions such as multiple sclerosis) can also result in poor pelvic floor muscle function. People in this group should seek advice from a healthcare professional.

Pelvic Floor exercises

You can improve control of your bladder and bowel by doing exercises to strengthen your pelvic floor muscles. These exercises may also be used in conjunction with a bladder training programme aimed at improving bladder function in people who experience the urgent need to pass urine frequently and who may not always "make it in time". Bladder training is explained in B&BC's booklet 'A Healthy Bladder'.

How to contract the Pelvic Floor Muscles

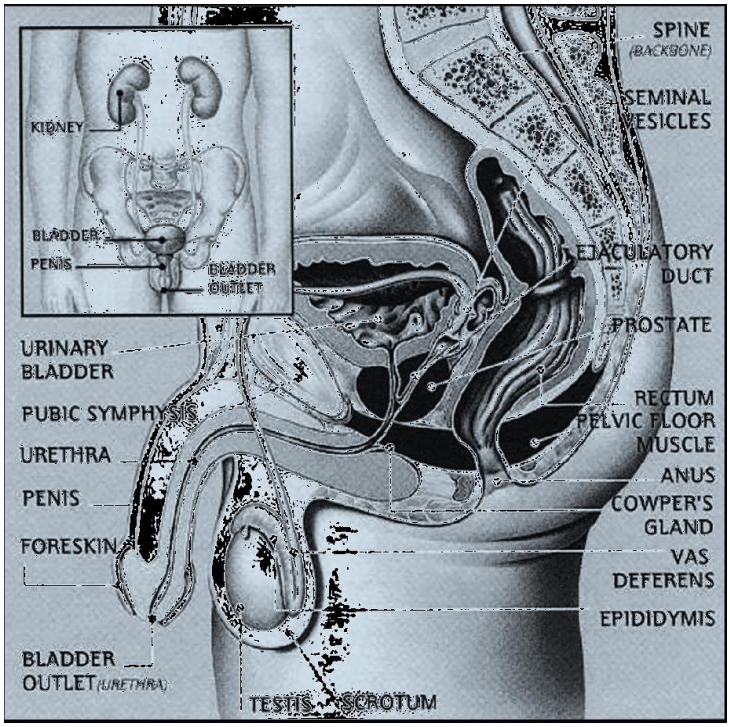
The first thing to do is to correctly identify the muscles that need to be exercised.
1. Sit comfortably or lay on your bed with the muscles of your thighs, buttocks and abdomen relaxed.
2. Tighten the ring of muscle around the back passage as if you are trying to control diarrhoea or wind. You should be able to feel the muscle move. Don't try too hard otherwise you will start to squeeze your buttocks, thighs and/or your tummy muscles inappropriately.
3. Now imagine trying to draw your penis inside your body to shorten it, whilst at the same time lifting your scrotum upwards towards your tummy button. If your technique is correct, each time that you tighten your pelvic floor muscles you may feel a dip at the base of your penis, and scrotum move up slightly.

If you are unable to feel a definite squeeze and lift action of your pelvic floor muscles, you should seek professional help to get your pelvic floor muscles working correctly - see the final section of this factsheet. Even men with very weak pelvic floor muscles can be taught these exercises by a physiotherapist or continence advisor with expertise in this area.

Doing Pelvic Floor exercises

Now you can find your pelvic floor muscles, here are the exercises to do:
1. Your pelvic floor muscles need to have stamina. To train for improved endurance sit stand or lie with your knees slightly apart. Gradually tighten and pull in the pelvic floor muscles. Keep shortening and lifting them for as long as you can. Rest for 4 seconds and then repeat the contraction. Build up your ability and strength until you can do 10 slow contractions at a time, holding them for 10seconds each with rests of 4 seconds in between.
2. Your pelvic floor muscles also need to react quickly to sudden stresses from coughing, laughing or exercise that puts pressure on the bladder. Practice some quick contractions, drawing in the pelvic floor quickly and strongly and then holding it for a few seconds before relaxing. If you are sneezing or coughing, you need to be able to squeeze quickly as well as holding onto the squeeze until the sneeze or cough has subsided.

Aim to do a set of both slow contractions (exercise 1) and quick contractions (exercise 2) at least 3 times each day.
It takes time for exercise to improve muscles function. You are unlikely to notice any improvement for several weeks, so stick at it! You will need to exercise regularly for at least 3 months before the muscles gain their full strength.



Make the exercises a daily routine

Once you have learnt how to do these exercises, they should be done regularly, giving each set your full attention. It may be helpful to have regular times during the day for doing the exercises; for example, after going to the toilet, when having a drink, when lying in bed.
Also you need to tighten your pelvic floor muscles while you are getting up from a chair, coughing or lifting. Some men find that tightening before they do such things helps them to regain control.
Remember good results take time. In order to rehabilitate your pelvic floor muscles you will need to work hard at these exercises. You may not notice an improvement for several weeks and you will not reach your maximum performance for a few months.
When you have recovered control of your bladder or bowel you should continue doing the exercises twice a day for life.

Other tips to help your Pelvic Floor

- Share the lifting of heavy loads
- Avoid constipation and prevent any straining during a bowel movement
- Seek medical advice for hay fever, asthma and bronchitis to reduce sneezing and coughing
- Keep your weight within the right range for your height and age

Seeking help

To achieve your best results you may need to seek help from a specialist physiotherapist or continence advisor. They will have a range of treatments available that can help you learn how to improve your pelvic floor muscles functions.
You can get the details of your nearest Continence Clinic by phoning B&BC or visiting our website. Our contact details are below.

Prostate problems

B&BC also has a fact sheet on 'Your Prostate and You' which gives information and advice on prostate concerns

Bladder and Bowel Community

The Bladder and Bowel Community
7 The Court, Holywell Business Park, Northfield Road
Southam, CV47 0FS
General enquiries: 01926 357220
Email: help@bladderandbowelfoundation.org
Web: www.bladderandbowelfoundation.org

Pelvic Floor Exercises for Women

Version 11.0 June 2021
Review Date: June 2023

Introduction

Physiotherapists, doctors and nurses know that exercising the pelvic floor muscles can help you to improve your bladder control. When done correctly, these exercises can build up and strengthen these muscles and so help you to control your bladder and bowel.

What is a pelvic floor?

The pelvic floor consists of layers of muscle and ligaments that stretch from the pubic bone to the end of the backbone (coccix) and from side to side (see diagram). Firm, supportive pelvic floor muscles help support the bladder, womb and bowel, and to close the bladder outlet and back passage.

How does pelvic floor work?

The muscles of the pelvic floor are kept firm and slightly tense to stop leakage of urine from the bladder and wind or faeces from the bowel. When you pass water or have a bowel motion the pelvic floor muscles relax. Afterwards, they tighten again to restore control. The muscles actively squeeze when you laugh, cough, lift or sneeze to help prevent any leakage. They also have an important sexual function, helping to increase sexual awareness for both yourself and your partner during intercourse.

How can exercising the pelvic floor muscles help?

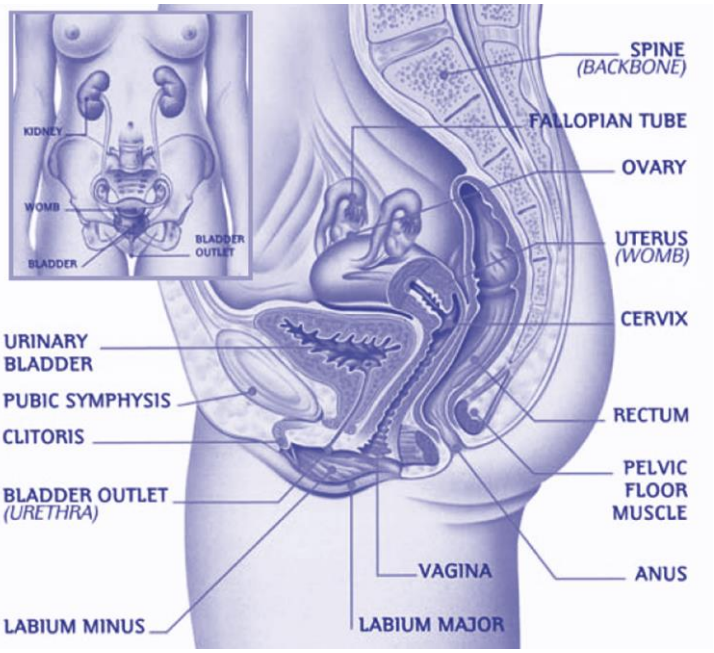
Exercising the pelvic floor muscles can strengthen them so they give the correct support. This will improve your bladder control and improve or stop leakage of urine. Like any other muscles in the body, the more you use and exercise them, the stronger the pelvic floor muscles will be.

Finding your pelvic floor muscles

It is not always easy to find your pelvic floor muscles. Exercising them should not show at all 'on the outside'.
You should not pull in your tummy excessively, squeeze your legs together, tighten your buttocks or hold your breath!
Here is what to do:
1. Sit comfortably with your knees slightly apart. Now imagine that you are trying to stop yourself passing wind from the bowel. To do this you must squeeze the muscles around the back passage. Try squeezing and lifting that muscle as if you really do have wind. You should be able to feel the muscle move. Your buttocks and legs should not move at all. You should be aware of the skin around the back passage tightening and being pulled up and away from your chair. Really try to feel this squeezing and lifting.
2. Now imagine you are sitting on the toilet passing urine. Picture yourself trying to stop the stream of urine. You should be using the same group of muscles that you used before, but don't be surprised if you find this harder. (Do not try to stop the stream when you are actually passing water as this may - if repeated – cause problems with correct emptying).
3. Now try to tighten the muscles around your back passage, vagina and front passage and lift up inside as if trying to stop passing wind and urine at the same time. It is very easy to bring other incorrect muscles into play, so try to isolate your pelvic floor as much as possible by not squeezing your legs together, not tightening your buttocks and not holding your breath.
The lower tummy can very gently be drawn in as if pulling away from the zip of tight trousers. In this way most of the effort should be coming from the pelvic floor muscles.

Practising you exercises

Now you can find your pelvic floor muscles, here are the exercises to do:
1. Your pelvic floor muscles need to have stamina. So sit, stand or lie with your knees slightly apart. Slowly tighten and pull up the pelvic floor muscles as hard as you can. Try lifting and squeezing them as long as you can. Rest for 4 seconds and then repeat the contraction. Build up your strength until you can do 10 slow contractions at a time, holding them for 10 seconds each with rests of 4 seconds in between.
2. Your pelvic floor muscles also need to react quickly to sudden stresses from coughing, laughing or exercise that puts pressure on the bladder. So practise some quick contractions, drawing in the pelvic floor and holding it for just one second before relaxing. Try to achieve a strong muscle tightening with up to ten quick contractions in succession.
Aim to do a set of slow contractions (exercise 1) followed by a set of quick contractions (exercise 2) 3-4 times each day.
It takes time for exercise to make muscles stronger. You are unlikely to notice any improvement for several weeks- so stick at it! You will need to exercise regularly for at least 3 months before the muscles gain their full strength.



Tips to help you

1. Get into the habit of doing your exercises during normal day to day activities. For example, whilst cleaning your teeth or waiting for a kettle to boil.
2. If you are unsure that you are exercising the right muscles, put your thumb into the vagina and try the exercises to check. You should feel a gentle squeeze as the pelvic floor muscle contracts.
3. Tighten your pelvic floor muscles when you feel you might be about to leak - pull up the muscles before you cough, laugh, sneeze or lift anything heavy. Your control will gradually improve.
4. Drink normally - about 6-8 large glasses of fluid a day, avoiding caffeine if you can. Water is best! And don't get into the habit of going to the toilet 'just in case'. Go only when you feel your bladder if full.
5. Watch your weight - extra weight puts extra strain on your pelvic floor muscles.
6. Once you have regained control of your bladder, don't forget your pelvic floor muscles. Continue to do your pelvic floor exercises a few times each day to ensure that the problem does not come back.
Remember: you can exercise your pelvic floor muscles wherever you are - nobody will know what you are doing!

Do you have any questions?

This information sheet is designed to teach you how to control your bladder, so that you'll be dry and comfortable. If you have problems doing the exercises, or if you don't understand any part of this information sheet, ask your doctor, nurse, continence advisor or specialist continence physiotherapist for help. Do your pelvic floor muscle exercises every single day. Have faith in them. You should begin to see results in a few weeks if you are exercising correctly - but don't stop then: make the exercises a permanent part of your daily life.

Pelvic floor exercises for men

Men have the same sling of pelvic floor muscles as women, and if they have 'weak bladders' (particularly after treatment for an enlarged prostate) they too can benefit from pelvic floor muscle exercises.

Bladder and Bowel Foundation

SATRA Innovation Park
Rockingham Road
Kettering
Northants NN16 9JH
General enquiries: 01536 533255
Nurse helpline: 0845 345 0165
Counsellor helpline: 0870 770 3246
Email: info@bladderandbowelfoundation.org
Web: www.bladderandbowelfoundation.org

Bladder Diary

Version 11.0 June 2021

Review Date: June 2023

Date: **I woke up at:** **I went to sleep at:**

Time	Record drinks (type and amount)	Each time you use the toilet to pass urine *(please tick below)*	When you changed a pad/ panty liner *(please tick below)*	Each time you leak urine, circle whether you were:			
12am				Almost Dry	Damp	Wet	Soaked
1am				Almost Dry	Damp	Wet	Soaked
2am				Almost Dry	Damp	Wet	Soaked
3am				Almost Dry	Damp	Wet	Soaked
4am				Almost Dry	Damp	Wet	Soaked
5am				Almost Dry	Damp	Wet	Soaked
6am				Almost Dry	Damp	Wet	Soaked
7am				Almost Dry	Damp	Wet	Soaked
8am				Almost Dry	Damp	Wet	Soaked
9am				Almost Dry	Damp	Wet	Soaked
10am				Almost Dry	Damp	Wet	Soaked
11am				Almost Dry	Damp	Wet	Soaked
12pm				Almost Dry	Damp	Wet	Soaked
1pm				Almost Dry	Damp	Wet	Soaked
2pm				Almost Dry	Damp	Wet	Soaked
3pm				Almost Dry	Damp	Wet	Soaked
4pm				Almost Dry	Damp	Wet	Soaked
5pm				Almost Dry	Damp	Wet	Soaked
6pm				Almost Dry	Damp	Wet	Soaked
7pm				Almost Dry	Damp	Wet	Soaked
8pm				Almost Dry	Damp	Wet	Soaked
9pm				Almost Dry	Damp	Wet	Soaked
10pm				Almost Dry	Damp	Wet	Soaked
11pm				Almost Dry	Damp	Wet	Soaked

Managing Urology patients in Primary care - Practical steps for GPs on getting the most out of Advice and Guidance

1. Check the primary care urology pathways – We have urology pathways for the following common problems:

- Erectile dysfunction
- Foreskin problems
- Haematospermia
- Haematuria
- Male LUTS
- Penile Deformity
- Prostatitis
- PSA
- Recurrent UTIs
- Renal Colic
- Scrotal Problems
- Suspected Lower UTI (age >16)

If the patient is already known to a particular hospital or has had previous investigations there particularly for PSA related questions and results of scans submit your question to that hospital so that all the information is available to the consultant responding.

For infertility Advice & Guidance queries please select UCLH, e.g. patient with abnormal semen analysis

If scans have been done with InHealth please ensure full report is attached to the advice and guidance request.

A number of common GP queries not covered in the primary care pathways are addressed below.

Frequently Asked Questions (FAQs) in Urology

Version 11.0 June 2021
Review Date: June 2023

Incidental Ultrasound Findings on Abdominal/KUB Ultrasounds	
Simple renal cysts	These are common, 50% of 50 year olds will have one on imaging. They rarely cause pain and do not undergo malignant transformation with time. These will rarely will result in deterioration of a patients' renal function. These patients do not need referral unless you are convinced that the cyst is the cause of patients' pain.
Complex renal cysts	Not all complex renal cysts on ultrasound will be a cancerous. However without further radiological imaging GPs should assume this a potential diagnosis and refer the patient via 2ww urology cancer referral form.
Angiomyolipoma	Benign finding consisting of blood vessels, smooth muscle and fat. If small, < 1 cm = NO follow up. If between 1-3cm = repeat annually, where clinically appropriate. If > 4cm OR if the patient is female of child bearing age refer to Urology
Mild hydronephrosis	Repeat ultrasound scan and arrange baseline renal function. Refer to secondary care if no change OR arrange a CT KUB non-contrast in primary care. CT will usually be normal, if so reassure. If abnormal, refer to urology.
Bilateral Hydronephrosis	Discuss with on call urology registrar
Findings on Testicular Ultrasound	
Epidiymal Cysts	Common finding on scrotal ultrasound. If <2 cm this will rarely will cause symptoms. Torsion of the cyst is extremely rare and do become infected. If >2cm and patient is symptomatic, refer patient to urology if they wish to have surgical intervention. **Complications of surgery** • Risk of chronic pain with surgery • Risk of affecting sperm transportation. Important in younger men no children as rarely would surgical intervention be offered.
Varicocoele	Not all varicocele's cause symptoms. If not clinically palpable unlikely to be of significance. Not routinely operated on prophylactically for the sake of fertility. Do not do semen analysis on patients with a varicocele who do not have a partner Only refer if patient is experiencing pain OR documented infertility (do not routinely test.)
Hydrocoele	Benign finding. Important to ensure when a hydrocele is found that the testis is normal. If patient symptomatic to refer for treatment. Refer urgently to exclude a tumor IF; Man >40 has a varicocele, which appears suddenly and it remains tense when the patient is lying down OR the patient has a solitary right sided varicocele.

<table>
<tr><td>Intra-testicular cysts</td><td>Providing it is said to be a simple cyst no further intervention.
Advise patient on testicular self-examination.
https://www.macmillan.org.uk/information-and-support/testicular-cancer/understanding-cancer/testicular-self-examination.html</td></tr>
<tr><td>Testicular microlithiasis</td><td>Not a pathological finding.
Consider referral to secondary care/repeat ultrasound at 6 months if risk factors for testicular cancer: family history testicular cancer, undescended testicle.
Patient should be reassured and advised to continue to perform regular self-testicular examination
https://www.macmillan.org.uk/information-and-support/testicular-cancer/understanding-cancer/testicular-self-examination.html</td></tr>
<tr><td colspan="2">PSA Testing</td></tr>
<tr><td>Prostate cancer mainly affects men over 50, with the average age at diagnosis of 65-69 years old.</td><td>It is exceptionally rare in men under the age of 40.
Patients with a first degree relative who was diagnosed with prostate cancer should have their PSA checked 10 years before that relative's diagnosis.

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/PSA%20advice.pdf</td></tr>
<tr><td colspan="2">PSA Questions</td></tr>
<tr><td>The BPAS/London Cancer PSA ranges are different to those of NICE (not CKS). Although according to BPAS the PSA is normal, the patient has contacted me to discuss their results against NICE. Should I refer them to Urology?</td><td>No. The London Cancer guidelines are constantly assessed and updated from evidence available, trying to ensure that cancer is picked up in those who need it treated whilst at the same time trying not to put patients through unnecessary tests and worry. Hence there are published age specific PSA ranges on London cancer.

<table>
<tr><th colspan="2">BAUS PSA AGE-SPECIFIC THRESHOLDS</th></tr>
<tr><th>AGE (years)</th><th>PSA Value (ng/ml)</th></tr>
<tr><td>40-50</td><td>>2.5</td></tr>
<tr><td>50-69</td><td>>3</td></tr>
<tr><td>≥70</td><td>>5</td></tr>
</table>
</td></tr>
<tr><td>The patient has urinary symptoms (e.g. frequency or nocturia), their PSA Is borderline normal. DRE is normal. No red flags. Should I refer?</td><td>PSA should be repeated.

https://myhealth.london.nhs.uk/wp-content/uploads/2019/04/Pan-London-Suspected-Cancer-Referral-Guide-Urology_0.pdf</td></tr>
<tr><td>Patient to be referred back if symptomatic despite maximal dual therapy (Tamsulosin and finasteride) and understands next step is likely to be surgical.</td><td>If PSA elevated for age needs to be referred as a target, unless previously investigated and a higher PSA has been set as acceptable for this patient by secondary care.

https://www.baus.org.uk/patients/conditions/10/raised_psa</td></tr>
</table>