# Countess of Chester

**Department of Urology**

Induction manual for junior doctors

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Welcome to Urology. I hope the following information will be useful.

## General Information

Urology patients are mainly located on wards 52/53 and 41. However we commonly have outliers on other wards.

It is the responsibility of the F1/SHO to liaise each morning with the night on-call SHO or day on-call general surgical team to obtain a list of new urology patients admitted from the previous day. In addition please have a list of all urology inpatients for the daily ward rounds.

## SpR/ Specialty doctor ward rounds are at 8am daily.

Monday – Specialty doctor

Tuesday SPR

Wednesday – MDT 08.30 – 09.30 (radiology seminar room), Ward round following - Consultant (Awsare/ Somov) / SPR / Staff grade

Thursday – SPR /Alt weeks Staff grade

Friday - SPR

## Consultants do ward rounds at various times depending on their other commitments. However in general Mr Awsare will do a ward round after the MDT on Wednesdays and on a Friday afternoon.

**The team**

**Consultants:**

Mr Awsare (Lead Clinician)

Mr Dev Gulur (Governance & Audit Lead, Rota co-ordinator)

Mr Pavlo Somov (Cancer Lead)

**Locum Consultant:**

Mr Sanjay Das

**Specialty doctor:**

Mr Murshed Khandker

**Speciality registrar:**

Ms Emma Fishleigh (starting Feb 2021), bleep 2857

**Duties and Responsibilities of F1s**

Your typical day would start with a ward round (usually registrar/ Specialty doctor led) at 8 AM. It is usually the F1’s responsibility to document the ward rounds in patient case notes and date/time the entries. This is a good time to check management plan for individual patients and clarify any doubts, including timely antibiotic prescribing review.

Typically there would be a list of jobs at the end of the ward round comprising usually of blood investigations, radiology investigations, interdepartmental consultations and referrals.

Radiology investigations need to be ordered on *meditech* and the urgent ones need discussing with the on-call radiologist/interventional radiologist**. (Please see relevant section for radiological investigations)**

It is also your responsibility to chase up the investigations at the end of your working day, document them in the notes and highlight concerns to your seniors.

If you have clinical concerns regarding any patients then come and find a senior member of the team to discuss.

Contacting Seniors: Registrars/Consultants may be scrubbed in theatre if the bleep is not being answered; so try again. In urgent cases, it may be easier to actually come over to theatres/clinics to discuss.

Important unfinished jobs and patients needing overnight medical attention should be handed over to the on call team surgical team at the end of your working day.

At the weekend there is a regular urology ward round by The Consultant and/or Middle-grade doctor and an inpatient list needs to be updated on Friday afternoon. Patients that need any additional review need to be handed over to the on-call general surgery team (usually SHO).

During your placement, you should attempt to attend a few of the clinic/endoscopy/theatre sessions to get the maximum out of your stay with us. It is only polite to introduce yourself to staff in these areas on your first visit. Timetables of all sessions are in urology secretary’s office.

**Duties and Responsibilities of SHO**

You must attend and gradually lead the 8am ward rounds. You should also support F1s in fulfilling their duties and help them as and when appropriate. You should be in regular contact with them each working day to direct ongoing patient management. If the F1 is flat out and their F1 colleagues are busy, you are expected to assist them; in the same way that Specialty trainees should help you.

You should attend theatre / endoscopy and clinics provided there are no outstanding issues on the ward and the F1 does not need assistance.

**F1s and SHOs general advice**

You are never without help. If you cannot contact any of your more senior colleagues and need help or advice, seek the Consultant, even if this means ringing him at home at night. Any of the other consultants will be willing to help, even if they are not on call. Failing this please contact the general surgical oncall SPR / consultant.

Requests to see patients should be dealt with positively. No junior member of staff may decline to see a patient under any circumstances without contacting the next‑on‑call or the Consultant.

**Good Note Taking**

Accurate note taking is one of the essential skills to be learnt as they are the only consistent guide to a patients’ management plan; and it is a legal document. Any patient consultation that occurs must be noted and should be legible, signed, dated and timed. It should identify who has made the management decision and what the plan is.

***An example:*** Continuation sheet with correct patient details.

10/01/2015 0800 WR Mr. Awsare

Report how patient feeling – In pain or much better etc

Summarise test results already written – WCC down, APPT ratio 2.0

Note observations – P 80 BP 120/70 T 37.5 RR 12

Specific post op – post nephrectomy, abdo soft, Drain – 250ml last 24 hours

Plan: Analgesia IV analgesia, keep epidural today

 Fluid management NBM 3 days or until passing flatus

 Medications and oxygen 2 litres nasal specs overnight, normal meds

 Investigations FBC, U&E, CXR

**Each note must be signed, then name printed, bleep number and designation**

 **-** Signature; JONES F1 BLEEP 5867

**Emergency theatre**

If patients require inpatient emergency theatre, this needs to be booked on *meditech (****under review orders – emergency theatre bookings****).*Please speak to seniors if unsure of operation / side surgery / general or local anaesesthisia etc.

If patient is having JJ stent or ureteroscopy an x-ray request on *meditech* will also be needed. (**review orders - theatre radiography for retrograde pyelogram**)

**Handover arrangements**

To ensure continuity of care, junior staff are expected to carry out a formal handover to the on-call surgical team of any outstanding important investigations / tests at the end of the day.

On Fridays, patients of concern need to be handed over for review by the weekend on-call team.

For handover, briefdetails should be informed to team such as :‑

• diagnosis and current treatment of acutely ill patients

• requests made by senior staff for new investigations

• patients expected to die

• emergency admissions for whom a theatre booking has been made

 • unexpected illness in previously well patients

**Prescribing**

If you are asked to prescribe any drug and you are not familiar with the dosages, administration or side‑effects, you should seek advice from a senior member of staff.

Specific details on antibiotic prophylaxis and DVT prevention are given in the trust Guidelines. Patients must have a VTE assessment completed on admission. It is very important that these instructions are carefully followed. Failure to do so may lead to unnecessary morbidity or mortality.

**Urological referrals from other wards**

The registrar may be asked to see patients on other wards.

If you are contacted regarding a urology opinion on a patient under a different speciality - a referral letter must be sent through *meditech* as a consultation request. It may sometimes be helpful if the SHO can visit to assess the urgency of the situation, and report back.

However if the referring team needs an urgent urological opinion then they must contact a senior member of the urology team directly.

Inter-hospital transfers must be discussed with senior member of the team.

**Medical students**

Medical students are commonly assigned to the urology team. Please encourage them to attend ward rounds, clinics, endoscopy and theatre. Please note - **If medical students are present in theatre they are not allowed to perform any intimate examinations.**

**Reporting a death to the coroner**

As per trust guidance. If you are unsure regarding a patient’s cause of death then please discuss with a senior member of the team in the first instance.

**Urology discharge summaries**

Remember that a department is judged by its written output. This is also a mandatory requirement and forms part of the contract between the CCG and the Hospital. A report on outstanding e-discharges are sent to the Consultants twice a day.

Most complaints relate to poor communication. GPs need to know about their patients’ in-hospital treatment, including any changes to medication and follow up plan.

All patients need a discharge summary completing prior to discharge. This is essential information for the GP. The main aspects are primary diagnosis, inpatient management (**If patient underwent an operation this must be included)**, discharge medication and follow up plan.

If the patient had a serious complication or secondary diagnosis this should be included (E.g Chest infection/Myocardial infarction post op)

***An example*** of information to be included in discharge summary:

**Diagnosis** - Admitted Right renal colic

**Investigations** – Blood parameters normal apart mildly raised WCC 13. CT KUB demonstrated a 5mm right ureteric calculus with mild hydronephrosis

**Brief summary of management** – Given analgesia. Patient managed conservatively as pain settled. Commenced on medical expulsive therapy.

**Discharge medication** -Tamsulosin 400mcg OD for 28 days including changes to regular medication)

**Follow up** – Urology OPC 3/52 with KUB Xray on arrival. Patient advised to return to A&E if any uncontrolled pain or fever.

If you are unsure regarding a patients diagnosis / management / follow up then please ask a senior for advice.

For patients that have a prolonged admission only the essential information needs to be included. Think about what might be important for the GP to know if the patient attended their surgery shortly after discharge.

**Follow-up OPC / Procedures / Operations**

**Booking further investigations/procedures**

The doctor filling out the discharge summary needs to ensure that follow-up investigations have been ordered on meditech or request made to GP in discharge summary.

Please ensure that when ordering investigations that this is on the urology **admission account** on *meditech* or the reports will go to another consultant/department. As below -

 

**Listing patients for surgery / procedures / endoscopy**

For patients being listed for operations / procedures – please fill out a waiting list form (in secretaries office) and take in person to the urology secretaries office. If in any doubt regarding the urgency or name of procedure please clarify with seniors. All patients undergoing planned daycase/ inpatient procedures (other than flexible cystoscopy) are required to sign their consent BEFORE their actual surgery date. Wherever possible therefore, please consent patients prior to discharge. Please write on the form **ACTIVE FORM: DO NOT SCAN. If consenting is not done, we will need to make an outpatient appointment for the patient to sign their form as per Trust policy.**

***PLEASE INDICATE ON THE DISCHARGE SUMMARY THAT YOU HAVE FILLED IN THE WAITING LIST FORM***

E.g. Follow-up – Patient listed for elective TURP – waiting list form/ Consent completed

****

**Trial without catheter / Intermittent self catheterisation training / 1st change suprapubic catheter**

Unlike most hospitals, uncomplicated TWOCs for patients going home with catheters are performed in the **community** (even for Urology patients). The guidance for this is located in the COCH Documents library under “Trial without Catheter”. A copy of this is available at the end of this document.

The exceptions to this are:

**Patients NOT suitable for a Community TWOC:**

* Urology specific radiotherapy within previous 3 months.
* Post-operative radical prostatectomy Urethrotomy within previous month.
* Suspicion of bladder cancer e.g. Visible Haematuria of unknown cause (exclude UTI).
* Difficult catheterisation requiring Hospital admission
* First insertion of suprapubic catheter.

These are performed in the urology unit. Urology unit TWOCs are booked via Meditech (the same as making an inpatient referral). The unit needs to know how soon the appointment needs to be made, for TWOC this is normally 2/52 following discharge unless otherwise stated.

Teaching ISC and 1st change of SPC are performed in the Urology Unit.

**External shock wave lithotripsy**

This is booked on a waiting list form. Please indicate the side / location of the calculus. ESWL sessions are once or twice a month in the urology unit. For further information regarding booking / dates please liaise with the urology unit.

**Outpatient clinic**

Please make it clear in discharge summary the OPC follow up, if any. If unsure please ask senior. Common follow-up following elective surgery is in elective procedures section.

**Educational Opportunities**

All trainees have a designated educational supervisor. Trainee and trainer must meet formally to discuss learning needs, performance and career prospects at the beginning of the post, halfway through and towards the end.

MDT meeting: Wednesday morning 08.30 – 09.30. All team expected to come unless needed on ward.

**Theatres:** You are encouraged to attend clinics/theatre/day case. There is a rota for SHOs in the secretary’s office.

**Audit meetings:** Monthly on rolling half day. All junior members of team should try to be involved in at least one audit during their time in urology department. In addition morbidity and mortality data will be presented at these meetings.

**Friday lunch** – This is often sponsored by a pharmaceutical rep, and is held in secretary office from 12.30. A diary of booked dates is with the secretaries. All welcome.

**Radiological Investigations**

Urology is very dependent on radiological imaging, and we work very closely with our colleagues in radiology/interventional radiology.

A request for an X‑ray is a request for a Consultant opinion, and you should treat the radiologists as colleagues. You will get the best results if you go along and discuss difficult or complicated cases before completing the request. Before doing this it is important that you understand the clinical details, why the investigation is necessary and what changes to management the result might make. If you are unsure why you are requesting an investigation please discuss with a senior member team first.

You may initiate requests for straightforward X‑rays and ultrasounds according to your own clinical judgement.

Investigations involving contrast media and CT scans will be initiated by the senior staff, but you are responsible for liaising with the X‑ray Department and completing the request form.

Contact your seniors if the radiographer or the radiologist remains unconvinced.

**Common urology investigations**

**Ultrasound**

**U/S ( Ultrasound of renal tract )**

A common investigation, particularly for patients admitted with AKI, pyelonephritis and initial assessment of haematuria. If the patient is not catheterised then they should attend with a full bladder. It is often useful to ask for a post void residual on the request. Catheterised patients can have the catheter clamped prior to scan provided there is no contraindication to this.

*Please include on request side symptoms, hx urological surgery if relevant, relevant abnormal blood parameters.*

**U/S ( Testis )**

Normally this investigation is for testicular pain or potential testicular malignancy. Not indicated for a potential diagnosis of testicular torsion (these patients should have immediate scrotal exploration in theatre. An U/S testis is useful in patients with suspected epididymo-orchitis to excude an abcess that may need surgical drainage.

*Please state side of symptoms, clinical suspected diagnosis (In emergency patients this would normally be orchitis ? abscess )*

**CT**

**CT (CT KUB)**

This is one of the most common investigations that will be requested. This is a non-contrast scan looking at the kidneys, ureters and bladder. It is for investigation of renal colic / urinary calculi.

*Please include on request side symptoms, hx urological surgery if relevant and past Hx calculi, relevant abnormal blood parameters.*

**CT Urogram**

A CT urogram or CT IVU is a contrast scan. Therefore patients with significantly impaired renal function are contraindicated ( An eGFR > 40 normally ok, if doubt discuss with senior). In addition care must be taken with patients taking metformin or a history contrast allergy. This scan is primarily used as investigation of haematuria. The contrast will fill the collecting systems, ureters and bladder to exclude filling defects ( i.e. cancer ).

*Please include on request side symptoms, hx urological surgery if relevant and past Hx calculi, relevant abnormal blood parameters. Patients will require a cannula for IV contrast.*

**MRI**

**MRI (Prostate / Bladder / Renal )**

MRI scans are most often used to image the prostate or bladder for malignancy.

*It is useful for the radiologist to have information such as whether known suspected malignancy / stage cancer / PSA / examination findings / recent surgery etc.*

**Nuclear medicine**

Nuclear medicine scans are more common in outpatients. If an inpatient nuclear medicine scan is required please speak to the technicians following requesting the scan. There is often a long waiting list but the department will normally prioritise inpatients if discussed.

**Nuclear medicine MAG3 dynamic renogram**

A renogram is performed in department of nuclear medicine. It is called a dynamic scan because it gives functional information regarding the kidneys. This scan is normally requested to assess drainage of kidney / kidneys if obstruction is suspected. This is commonly after a CT o U/S showing hydronephrosis. Commonly this is used to investigate a condition called PUJ obstruction. The patient will have a IV radionucleotide injection then using a gamma camera the excretion will be analysed.

*Please include side symptoms or suspected obstruction if relevant including previous imaging findings. Patients will require a cannula.*

**Nuclear medicine Bone scan**

This scan is to look for bone metastasis, most commonly in prostate cancer but also occasionally in renal or bladder cancer. Again this is performed in nuclear medicine department. The patient has a radionucleotide injection the scan is then performed ~3 hours following the injection.

*Please include pts PSA (if prostate metastasis suspected), any sites of pain or abnormalities on plain xray or MRI suspicious of bone metastasis. Patients will require a cannula.*

**Nuclear medicine DMSA renogram**

Similar to MAG3 renogram; however the radionucleotide injection is taken up by the kidneys not excreted. This therefore gives information regarding the split function of the kidneys and any areas of renal scarring. It does not give any information on obstruction. In adults it is often used if a kidney is thought to be poorly functioning in a work-up prior to potential nephrectomy.

*Patients will require a cannula.*

**Interventional radiology**

We work very closely with the interventional radiology department and often have several inpatients every week requiring their services. More than any other investigation patients requiring IR are best discussed in person with the interventional radiologist. They are all friendly and approachable and would much rather a case is discussed with them particularly if not straightforward. There is normally a different radiologist every day and following ward round if a patient requires IR it is best to prioritise these patients.

*Patient for IR will require up to date bloods including FBC, U+Es and coagulation. Please state side on request. In majority of cases it is the responsibility of the team to ensure patients are consented and the side marked.*

**Nephrostomy**

A percutaneous tube placed through the loin into the patients renal collecting system. Most commonly used for patients with obstructed kidney. The nephrostomy is then fixed to skin with dressing an connected to drainage bag. If nephrostomy is not draining must common problem is blockage with blood clot or debris. Can be flushed with 5-10mls normal saline.

**Nephrostogram (Antegrade pyelogram)**

Contrast is injected through the nephrostomy tube under screening. This is normally done for anatomical information / look for the site of obstruction. If a nephrostomy is not draining despite flushing then a nephrostogram will be requested to check correct position of nephrostomy (i.e. to see if it has fallen out of the collecting system)

**Antegrade stent**

JJ stents are used for internal drainage between the kidney and bladder. They can be inserted in theatre cystoscopically from the bladder (retrograde JJ stent). Alternatively the JJ stent can be inserted through the nephrostomy tract into the kidney then down to the bladder in IR (antegrade JJ stent).

JJ stents are normally either removed following correction of the cause of obstruction or left insitu long term. However if left insitu long term they need to be changed every 6/12 in most cases. Major comorbidity can result from a forgotten stent.

**Therefore in patients that have had a JJ stent inserted during their admission (retrograde or antegrade) please ensure on discharge that some follow-up arrangements have been made (either listed for operation / change JJ stents / removal JJ stent ) If in any doubt regarding plan discuss with senior.**

**Permanent metallic ureteric stents**

These are usually inserted in patients with certain pelvic/ gynaecological or retroperitoneal cancers as an alternative to frequent JJ stent changes. These are performed in IR, usually following an initial nephrostomy.

**Fluoroscopy**

This is commonly used post operatively to check for a leak. Investigations are requested under fluoroscopy on *meditech*. Please always check at what time interval the team want the investigation performing.

**Cystogram**

Contrast is injected through patients catheter to check if bladder has a leak (normally after bladder has been opened at time surgery). Most commonly patients require this 2/52 after operation as an outpatient.

*Discuss request with x-ray prior to patients discharge to confirm a date for procedure. Then inform the urology unit with patient’s details/ date cystogram, the patient will then attend urology unit immediately following cystogram for review by a member of the team.*

**Urethrogram**

Similar to a cystogram although the test is looking at urethra.

*Discuss request with x-ray prior to patients discharge to confirm a date for procedure. Then inform the urology unit with patient’s details/ date urethrogram, the patient will then attend urology unit immediately following urethrogram for review by a member of the team.*

# ROUTINE UROLOGY ADMISSIONS

All patients who are to be admitted for routine surgery are seen in the Pre-Admission Assessment Clinic prior to their admission date. You may occasionally be asked to prescribe bridging LMWH for patients on anticoagulation (please correlate with pts weight), or prescribe antibiotics id their pre-operative mid-stream urine is positive for a UTI.

Patients admitted for elective surgery preoperatively normally go to theatre admissions lounge (TAL) or jubilee day surgery admissions unit.

It is the responsibility of the operating surgeon to consent patients.

However the SHOs are expected to be involved in consenting patients for theatre and interventional radiology procedures (within their competency).

**\*Common procedure consent forms present in appendix\***

F1s are not expected to consent patients.

**Protocols/follow-up for common elective procedures**

### DVT prophylaxis Please check with seniors if you are unsure what to do

All patients undergoing **abdominal or pelvic surgery** require DVT prophylaxis i.e. TED stockings and prophylactic LMWH. TURPs, TURBTs, BNIs, optical urethrotomies, radical inguinal orchidectomies, epididymal cyst excisions, hydrocoele repairs and circumcisions do not require prophylactic Tinzaparin but should have TEDS unless contraindicated.

**TURP/BNI**

Patients have 3 way catheter post op with irrigation. This is normally removed day 2 post op. Patients require FBC, U+Es days 1 post op.

Need to watch for TUR syndrome (1-2% risk). (low Na / fluid overload / glycine toxicity ) post operatively. Presents with confusion, blurred vision. If suspected inform senior ASAP. May need HDU/ITU.

Follow-up – 3/12 OPC unless stated otherwise.

**TURBT**

Patients have 3 way catheter post op with irrigation. This is normally removed day 1 post op. Patients require FBC, U+Es days 1 post op.

Follow-up – 2/52 OPC for histology results as cancer case

**Optical urethotomy**

Catheter 24- 48 hours post op.

Follow-up – OPC 3/12 with Uroflow rate and bladder scan on arrival

**Ureteroscopy**

May be daycase or overnight stay. Patients will often have a JJ stent left insitu. It is essential that follow-up plans are made for patients with stents. Usually removed with flexible cystoscopy after 2/52 (needs waiting list form) If in any doubt and not clear from operation note please clarify with senior.

### PCNL

Patients have nephrostomy tube and catheter post op. A nephrostogram (please see radiology section) needs to be booked for usually post op day 1. Following this a senior member of team will make a decision regarding nephrostomy removal.

Follow-up – OPC 3/12 unless otherwise stated.

### Nephrectomy

Post op catheter( removed when mobile). Post op drain (if present) normally removed when less < 50 mls in 24 hrs.

Follow-up – 4/52 for histology results

**Radical inguinal orchidectomy**

Usually overnight stay, occasionally daycase. Often need staging CT scans, follow up tumour markers 1 week post op. (Please check op note)

Follow-up – OPC 2/52

**Circumcision/Hydrocele repair/epididymal cyst removal/rigid cystoscopy + biopsy**

Daycase procedures, for follow up please check op notes. Normally no follow-up for above except rigid cystoscopy and biopsy.

**Upper tract FU of TCC bladder patients:**

G3 pT1 (High risk) needs yearly upper tract imaging with CTU.

Intermediate risk TCC (G2, 3 pTa and CIS) patients need upper tract imaging with CTU every 3 years unless they have dipstick or visible haematuria. Consider USS in between if develops recurrent UTIs.

Low risk (G1pTa) do not need upper tract follow unless they have dipstick haematuria or visible haematuria. Consider USS in between if develops recurrent UTIs.

**EMERGENCY ADMISSIONS**

Emergency admissions are either admitted via A&E or from the GP. The surgical SHO on-call will see all admissions for urology. OOH the general surgical SPR will supervise the SHO. There is a urology consultant on-call at all times. The Urology StR and middle grade are on-call on the weekends (currently 1 in 4)

The following are some of the common emergencies under urology. If you have any questions, or are unsure what to do, speak to senior.

### Retention of urine

If the residual is <800mls, there is no diuresis and U&E normal they do not need to be admitted (unless the referrer thinks there is a reason to). Send CSU and U&E and treat possible precipitating factors (e.g. UTI, constipation) and consider commencing an α-blocker if not contra-indicated (Tamsulosin 400mcg OD). Community TWOC (unless contra-indicated)

If residual >800mls, U&E deranged, frank haematuria has developed or patient is diuresing, they need admission. Check FBC, U&E, CRP. Treat any precipitating factors as above. If Creatinine raised above baseline do not commence α-blocker. Observe for diuresis with hourly urine output (UO) monitoring – if UO >200mls/hr replace with IV fluids (Normal Saline) at 50% of hourly output. Will need daily U&Es and lying and standing BP check (can also do daily weights).

 **Minimising risks of suprapubic catheter insertion (adults only)**

As clinicians, there are six questions you can ask to keep your patients safe:

|  |  |
| --- | --- |
| **Question** | **Guidance** |
| 1. **Does this**

**procedure need to****be done?** | * Insertion of suprapubic catheter carries a risk to the patient.
* Indications for the procedure are: the relief of urinary retention
* where urethral route is contraindicated or not technically possible.
* Record in patient notes why this procedure was done and any
* problems
 |
| 1. **Am I competent to do this?**
 | * You should not undertake this procedure if not competent.
* You need to be trained in the procedure.
* You need to be familiar with local equipment and guidelines.
* Senior supervision should be available, if needed.
 |
| 1. **Does this need to be done now?**
 | * Emergency procedures and those performed out of hours present
* more risk.
* Seek advice from the on-call urology team and consider other

options, e.g. fine needle aspiration, as an interim measure. |
| 1. **Is it the right procedure for this patient?**
 | **Absolute** contraindications:* non-palpable bladder;
* non-visualisable distended bladder by ultrasound.

**Relative** contraindications:* coagulopathy (until the abnormality is corrected);
* prior abdominal or pelvic surgery (potential bowel adherence to the
* bladder or anterior abdominal wall. In such cases you should

consider requesting a urological surgeon to perform an opencystostomy;* pelvic cancer with or without radiation (increased risk of adhesions).
 |
| 1. **Have I got access to an ultrasound?**
 | Ultrasound should be used wherever possible to visualise the bladderand guide insertion of the catheter |
| 1. **Do I know what to look for in the case of bowel perforation?**
 | * Monitor patients carefully.
* Urology team should carry out the first change of catheter.
* Have a high index of suspicion for signs of bowel perforation

including:* + patient has abdominal pain;
	+ patient has signs of localised peritonitis;
	+ patient is systemically unwell.
 |

### Acute testicular pain

### Acute testicular pain = torsion until proven otherwise, and must be seen immediately. If a GP referral, advise immediate admission and to be kept NBM. If a child, send them to Paediatric A&E (and inform Paeds A&E you are expecting them).Need clinical assessment, temp, urinalysis +/- bloods and prompt review by StR – keep NBM until then.

### Blocked catheter

Usually seen by DN/A&E/GP in the first instance and flushed or changed. If successful continue home management, can refer to Urology as O/P if necessary. Occasional patients need admission for social reasons- consider admission under care of the elderly team for multi-disciplinary care. If unsuccessful , discuss with the on-call team. (N.B. If suprapubic catheters are removed the tract can close up quickly, therefore patients whose suprapubic catheter is out should be brought in and seen ASAP). Replace with long-term catheters.

### Renal colic

Initially should be referred to general surgical SHO for initial assessment of abdominal pain and appropriate imaging (CT KUB). If urological pathology found on imaging can then be admitted under Urology if necessary. If patient has frank haematuria or known recent stones and pain sounds typical of renal colic can be admitted straight to Urology. All stone patients should have a serum calcium and urate. (Please see updated Renal colic pathway in A&E )

### Frank haematuria

If clots ++, in clot retention or patient unwell/anaemic requires admission. Do bloods (FBC, U&E, coag, G+S). 3-way catheter and irrigation as necessary. If no clots; patient not in retention and otherwise well; consider referring to local haematuria clinic (2 week rule).

**3 way catheters**

3 way catheters are used for haematuria associated with clot retention or in a post operative setting (TURP/TURBT). They are inserted exactly the same as normal 2 way catheters but the balloon is normally inflated with 20-30 mls water. If inserted for clot retention then a washout of clots is done with a bladder syringe following insertion, after this irrigation can be commenced.



3 way catheters can have straight tip or a curved coude tip. Irrigation is connected to the smaller port and a urine drainage bag to the larger port. Irrigation is continued until the urine is clear, the rate or speed of irrigation is altered depending on the severity of the haematuria, with the aim to prevent clot formation and the catheter blocking. Once irrigation has been stopped a spigot can be used in the smaller port prior to TWOC.

### Spinal cord compression

Should be seen immediately, and need a full neurological examination including a DRE, noting anal tone and sensation. Inform senior and commence Dexamethasone (with PPI cover). They will need an **urgent** MRI scan. Please refer to the **metastatic spinal cord compression** guideline under COCH Documents folder.

### Trauma

## Should be assessed by A&E and discussed with senior ASAP.

ANNUAL AND STUDY LEAVE

**Please note that it is your responsibility to ensure that all leave is sanctioned in good time. Please follow Trust and HEENW guidelines, ensuring that the appropriate forms are completed.**

**Leave must be requested at least *six weeks* in advance**, so you should plan and request your leave as soon as possible. It may not be possible to grant leave requested less than six weeks in advance.

The StR is the rota organiser for junior and middle grade doctors. Leave request forms must be given to StR / staff grade initially to check appropriate ward cover. Following this they can be signed by the consultant.

Study leave forms must given to the Education Centre after signing.

All annual and study leave needs to be written on the calendar above the SPRs desk in the urology secretaries office.

**Please can F1s also include post oncall / weekend days that are off on the calendar.**

**Can SHOs include all their night shifts and post oncall time off.**

Foundation Doctors should organise their leave as soon as possible after they arrive to avoid difficulties at the end of the post and spread their leave evenly throughout surgery and urology. This requires careful forward planning.

We must have at least one F1 or SHO present on all days.

Any changes to the on‑call rota (for example swapping nights) must be notified to the Registrar/ staff grade. These changes also need to be made on the calendar in urology secretaries’ office.

## Study Leave

Study leave forms to be initially validated by SPR / staff grade. Following this they will be signed by consultant.

**Sickness**

In the event of sickness you are required to firstly contact your team and medical staffing (preferably before 10 am) in order for cover arrangements to be made.

**Consent**

Please find below example consent forms for some common urological procedures.

 (Taken from BAUS consent forms)

**Circumcision**

OCCASIONAL

 BLEEDING OF THE WOUND OCCASIONALLY NEEDING A FURTHER PROCEDURE

 RARELY, INFECTION OF INCISION REQUIRING FURTHER TREATMENT

 PERMANENT ALTERED OR REDUCED SENSATION OF PENIS

 PERSISTENCE OF ABSORBABLE STITCHES AFTER 3 / 4 WEEKS REQUIRING REMOVAL

RARE

 SCAR TENDERNESS, RARELY LONG TERM

 YOU MAY NOT BE COMPLETELY COSMETICALLY SATISFIED

 OCCASIONAL NEED FOR REMOVAL OF EXCESSIVE SKIN AT A LATER DATE.

 PERMISSON FOR BIOPSY OF ABNORMAL AREA ON GLANS IF MALIGNANCY A CONCERN

ALTERNATIVE THERAPY: DRUGS TO RELIEVE INFLAMMATION LEAVE UNCIRCUMCISED

**Epididymal cyst removal**

OCCASIONAL

 RECURRENCE OF FLUID COLLECTION CAN OCCUR

 BLOOD COLLECTION AROUND TESTES WHICH RESOLVES SLOWLY OR REQUIRES SURGICAL REMOVAL.

 POSSIBLE INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

RARE

VERY RARELY THE SCARRING CAN DAMAGE THE EPIDIDYMIS CAUSING SUBFERTILITY

ALTERNATIVE THERAPY: OBSERVATION, REMOVAL OF FLUID WITH A NEEDLE, VARIOUS OTHER SURGICAL APPROACHES

**Repair of hydrocele**

OCCASIONAL

 RECURRENCE OF FLUID COLLECTION CAN OCCUR

 BLOOD COLLECTION AROUND TESTES WHICH RESOLVES SLOWLY OR REQUIRES SURGICAL REMOVAL.

 POSSIBLE INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

ALTERNATIVE THERAPY: OBSERVATION, REMOVAL OF FLUID WITH A NEEDLE, VARIOUS OTHER SURGICAL APPROACHES

**Orchidopexy**

OCCASIONAL

 RARELY, INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

 OCCASIONALLY THE TESTIS WILL REMAIN HIGH IN THE SCROTUM AFTERWARDS

 OCCASIONALLY NOT POSSIBLE TO BRING DOWN

RARE

 BLEEDING REQUIRING FURTHER TREATMENT

 RARELY, THE TESTIS CAN SHRINK DUE TO POOR BLOOD SUPPLY AFTER THIS CONDITION

VERY RARE

 WE CAN NOT GUARANTEE FUTURE FERTILITY

 VERY RARELY THE PROCEDURE NEEDS TO BE REPEATED

ALTERNATIVE THERAPY: OBSERVATION

**Radical inguinal orchidectomy**

OCCASIONAL

 CANCER, IF FOUND, MAY NOT BE CURED BY THIS ALONE

 NEED FOR ADDITIONAL PROCEDURES OR TREATMENTS SUCH AS SURGERY, RADIATION OR CHEMOTHERAPY

 LOSS OF FUTURE FERTILITY

 PERMISSION TO BIOPSY OTHER SIDE IF SMALL, ABNORMAL OR HISTORY OF MALDESCENT

RARE

 REMOVAL OF TESTES ONLY TO FIND THAT CANCER WAS NOT PRESENT

 POSSIBILITY THAT PATHOLOGIC DIAGNOSIS WILL BE UNCERTAIN

INFECTION OF INCISION REQUIRING FURTHER TREATMENT (&POSSIBLE REMOVAL OF IMPLANT) BLEEDING REQUIRING FURTHER SURGERY

(&POSSIBLE REMOVAL OF IMPLANT)

IF INSERTION OF TESTICULAR PROSTHESIS

 PAIN, INFECTION OR LEAKING REQUIRING REMOVAL OF IMPLANT.

 PATIENT COSMETIC EXPECTATIONS NOT ALWAYS MET

 IMPLANT MAY LIE HIGHER IN SCROTUM THAN NORMAL TESTIS

 PALPABLE STITCH AT ONE END WHICH YOU MAY BE ABLE TO FEEL

 LONG TERM RISKS FROM USE OF SILICONE PRODUCTS UNKNOWN

**Exploration of scrotum for suspected testicular torsion**

COMMON

 FIXATION OF BOTH TESTES IF TORSION IS DISCOVERED VIA SAME INCISION

 I AGREE TO REMOVAL OF TESTIS DURING SURGERY IF DAMAGE CAUSED BY TWISTING IS THOUGHT IRREVERSIBLE

OCCASIONAL

 YOU MAY BE ABLE TO FEEL THE STITCH USED TO FIX THE TESTIS

 BLOOD COLLECTION AROUND TESTES WHICH RESOLVES SLOWLY OR REQUIRES SURGICAL REMOVAL.

 POSSIBLE INFECTION OF INCISION OR TESTIS REQUIRING FURTHER TREATMENT

RARE

 LOSS OF TESTICULAR SIZE OR ATROPHY IN FUTURE IF TESTIS IS SAVED

 NO GUARANTEE OF FERTILITY

ALTERNATIVE THERAPY: OBSERVATION RISKS LOSS OF TESTIS.

**Insertion of JJ stent**

COMMON

 MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION

 TEMPORARY INSERTION OF A CATHETER

 TEMPORARY DISCOMFORT FROM TUBE CAUSING PAIN, FREQUENCY AND OCCASIONAL BLOOD IN URINE

 FURTHER PROCEDURE TO REMOVE STENT IF INSERTED

 USE OF XRAY IMAGING TO HELP IN THE CORRECT PLACEMENT OF THE STENT

OCCASIONAL

 INFECTION OF BLADDER REQUIRING ANTIBIOTICS

 OCCASIONALLY WE CAN NOT PASS THE STENT REQUIRING ALTERNATIVE TREATMENT

 PERMISSION FOR TELESCOPIC REMOVAL/ BIOPSY OF BLADDER ABNORMALITY/STONE IF FOUND

RARE

 DELAYED BLEEDING REQUIRING REMOVAL OF CLOTS OR FURTHER SURGERY

 INJURY TO URETHRA CAUSING DELAYED SCAR FORMATION

ALTERNATIVE THERAPY: OBSERVATION, PLACEMENT OF TUBE DIRECTLY INTO KIDNEY FROM BACK (CALLED A

NEPHROSTOMY), OPEN SURGICAL TREATMENT

**Ureteroscopy**

COMMON

 MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION

 TEMPORARY INSERTION OF A BLADDER CATHETER

 INSERTION OF URETERIC STENT WITH FURTHER PROCEDURE TO REMOVE IT

 NO GUARANTEE OF CURE AS OFTEN DIAGNOSTIC PROCEDURE ONLY

OCCASIONAL

 KIDNEY DAMAGE OR INFECTION NEEDING FURTHER TREATMENT

 FAILURE TO PASS TELESCOPE IF URETER IS NARROW

RARE

 FINDING CANCER REQUIRING ADDITIONAL THERAPY

 DAMAGE TO URETER WITH NEED FOR OPEN OPERATION OR TUBE PLACED INTO KIDNEY DIRECTLY FROM BACK TO

ALLOW ANY LEAK TO HEAL

 VERY RARELY, SCARRING OR STRICTURE OF URETER REQUIRING FURTHER PROCEDURES

ALTERNATIVE THERAPY: OPEN SURGERY, OTHER X-RAY INVESTIGATIONS, AND FURTHER OBSERVATION

**TURP / Bladder neck incision**

COMMON

 TEMPORARY MILD BURNING, BLEEDING AND FREQUENCY OF URINATION AFTER PROCEDURE

 NO SEMEN IS PRODUCED DURING AN ORGASM IN APPROX: 20%if INCISION or 75% if RESECTION

 MAY NOT RELIEVE ALL PROSTATIC SYMPTOMS

OCCASIONAL

 POOR ERECTIONS POSSIBLE (IMPOTENCE IN APPROX 5-10%)

 INFECTION OF BLADDER OR KIDNEY REQUIRING ANTIBIOTICS

 BLEEDING REQUIRING RETURN TO THEATRE AND/OR BLOOD TRANSFUSION.

 POSSIBLE NEED TO REPEAT TREATMENT LATER DUE TO REOBSTRUCTION (APPROX 10%)

 MAY NEED SELF CATHETERISATION TO EMPTY BLADDER FULLY IF BLADDER WEAK

 FAILURE TO PASS URINE AFTER SURGERY REQUIRING A NEW CATHETER

RARE

 FINDING UNSUSPECTED CANCER IN THE REMOVED TISSUE AND THIS MAY NEED FURTHER TREATMENT

 INJURY TO URETHRA CAUSING DELAYED SCAR FORMATION

 LOSS OF URINARY CONTROL (INCONTINENCE), TEMPORARY OR PERMANENT

 ABSORPTION OF IRRIGATING FLUIDS CAUSING CONFUSION, HEART FAILURE (TUR SYNDROME) VERY RARELY, PERFORATION OF THE BLADDER REQUIRING A TEMPORARY URINARY CATHETER OR OPEN SURGICAL REPAIR

ALTERNATIVE THERAPY: DRUGS, USE OF A CATHETER OR STENT, OBSERVATION OR OPEN OPERATION

**TURBT**

COMMON

 MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION

 TEMPORARY INSERTION OF A CATHETER FOR BLADDER IRRIGATION

 NEED FOR ADDITIONAL TREATMENTS TO BLADDER IN ATTEMPT TO PREVENT RECURRENCE OF TUMOURS

INCLUDING DRUGS INSTALLED INTO THE BLADDER

OCCASIONAL

 INFECTION OF BLADDER REQUIRING ANTIBIOTICS

 NO GUARANTEE OF CANCER CURE BY THIS OPERATION ALONE

 RECURRENCE OF BLADDER TUMOUR AND/OR INCOMPLETE REMOVAL

RARE

 DELAYED BLEEDING REQUIRING REMOVAL OF CLOTS OR FURTHER SURGERY

 DAMAGE TO DRAINAGE TUBES FROM KIDNEY (URETERS) REQUIRING ADDITIONAL THERAPY

 INJURY TO URETHRA CAUSING DELAYED SCAR FORMATION

PERFORATION OF THE BLADDER REQUIRING A TEMPORARY URINARY CATHETER OR OPEN SURGICAL REPAIR

ALTERNATIVE THERAPY: OPEN SURGICAL REMOVAL OF BLADDER, CHEMOTHERAPY OR RADIATION THERAPY

**Cystoscopy and hydrodistension**

COMMON

 MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION TEMPORARY INSERTIONOFACATHETER

 OFTEN A BIOPSY OF THE BLADDER IS PEFORMED AT THE SAME TIME

OCCASIONAL

 INFECTION OF BLADDER REQUIRING ANTIBIOTICS

 THERE IS NO GUARANTEE OF RELIEF OF BLADDER SYMPTOMS

 PERMISSION FOR TELESCOPIC REMOVAL/ BIOPSY OF BLADDER ABNORMALITY/STONE IF FOUND

RARE

 DELAYED BLEEDING REQUIRING REMOVAL OF CLOTS OR FURTHER SURGERY

 INJURY TO URETHRA CAUSING DELAYED SCAR FORMATION PERFORATION OF THEBLADDER REQUIRING A TEMPORARY URINARY CATHETER OR RETURN TO THEATRE

FOR OPEN SURGICALREPAIR

ALTERNATIVE THERAPY:

VARIOUS MEDICATIONS TAKEN ORALLY OR INSTALLED INTO BLADDER. AUGMENTATION

(ENLARGEMENT) OF BLADDER WITH INTESTINE, OBSERVATION

**Insertion of SPC**

COMMON

 TEMPORARY MILD BURNING OR BLEEDING AFTER PROCEDURE

 REGULAR CHANGES OF CATHETER EVERY 3 / 4 MONTHS

OCCASIONAL

 INFECTION OF BLADDER REQUIRING ANTIBIOTICS (OCCASIONALLY RECURRENT INFECTIONS)

 BLOCKING OF CATHETER REQUIRING UNBLOCKING

 BLADDER DISCOMFORT OR PAIN OR BLADDER STONE FORMATION

RARE

 BLEEDING REQUIRING IRRIGATION OR ADDITIONAL CATHETERIZATION TO REMOVE BLOOD CLOT

 VERY RARELY DAMAGE TO SURROUNDING STRUCTURES, SUCH AS BOWEL OR BLOOD VESSELS REQUIRING

ADDITIONAL SURGERY

ALTERNATIVE THERAPY: CATHETER THROUGH URETHRA, PERMANENT URINARY DIVERSION

**Optical urethotomy**

COMMON

 MILD BURNING OR BLEEDING ON PASSING URINE FOR SHORT PERIOD AFTER OPERATION

 TEMPORARY INSERTION OF A CATHETER

 NEED FOR SELF CATHETERISATION TO KEEP THE NARROWING FROM CLOSING DOWN AGAIN

OCCASIONAL

 INFECTION OF BLADDER REQUIRING ANTIBIOTICS

 PERMISSION FOR TELESCOPIC REMOVAL/ BIOPSY OF BLADDER ABNORMALITY/STONE IF FOUND

 RECURRENCE OF STRICTURE NECESSITATING FURTHER PROCEDURES OR REPEAT INCISION

RARE

 RARELY, DECREASE IN QUALITY OF ERECTIONS REQUIRING TREATMENT, INCONTINENCE

ALTERNATIVE THERAPY: OBSERVATION, URETHRAL DILATION, OPEN (NON-TELESCOPIC) REPAIR OF STRICTURE

**Department of Urology: Local Induction checklist for new starters (ST/ CT/F2)**

**Name:**

1. **Annual/ Study leave**
	1. Notice period 6 weeks

* 1. At least 1 person of same grade available for ward cover
	2. Rota co-ordinator (ST) to confirm availability in writing
	3. Final approval by Rota co-ordinator (Mr Gulur) ONLY
1. **Hand-over**
	1. Weekend plans in notes
	2. Ill patients to be handed over to night team during weekdays at weekends

verbally and in writing

* 1. Afternoon round on Friday
	2. Should receive proper handover from General Surgery in the morning- if inappropriate, keep record to feedback
1. **Ward rounds**
	1. Daily
	2. Co-ordinate with Mr Khandker /StR
2. **Referrals**
	1. All in patient referrals to be dealt with promptly
	2. Co-ordinate with Mr Khandker/ StR
	3. Dictate letter to referring clinician and GP
3. **E-discharges**
	1. Start filling ASAP
	2. Patients to be discharged over weekend need e-discharges partially

complete

* 1. Financial penalty to the department

1. **Anti-coagulation and anti-platelet medication**
	1. Follow Trust Guidelines
	2. Be alert for patients with history of severe angina or drug eluting stents
	3. Elective patient will usually have plan put in by pre-assessment
	4. For emergency patients (especially with **drug eluting stents**) **do NOT stop anti-platelet** medication without consulting Cardiology and recording outcome of referral in notes
2. **Medical students and intimate examination of patients**
	1. Allowed if patient is awake and gives consent
	2. NOT allowed under anaesthetic/ sedation even if patient gives consent
	3. Students should refuse to perform if asked by senior doctors

Enjoy your time with us and don’t hesitate to ask if in doubt!