

# Monash Children's Hospital

## Referral Guidelines

### PAEDIATRIC UROLOGY

#### EXCLUSIONS

Services not offered by Monash Children's Hospital

- Monash Children's Hospital does not offer circumcision for cultural/religious reasons
- Children with incontinence or enuresis (bedwetting): [Click here](#) for Continence Clinic
- Patients beyond 16th birthday: [Click here](#) for adult Monash Health Urology guidelines

#### CONDITIONS

##### GENERAL UROLOGIC CONDITIONS

[Ambiguous genitalia](#)  
[Haematuria](#)  
[Hydronephrosis](#)  
[Hypospadias and chordee](#)  
[Renal and ureteric calculi](#)  
[Urinary Incontinence](#)  
[Urinary Tract Infection](#)  
[Voiding dysfunction](#)

##### MALE SPECIFIC CONDITIONS

[Balanitis](#)  
[Foreskin concerns](#)  
[Paraphimosis](#)  
[Phimosis](#)  
[Scrotal pathology – acute](#)  
[Undescended / retractile testes](#)

#### PRIORITY

All referrals received are triaged by **Monash Children's Hospital clinicians** to determine **urgency of referral**.

##### EMERGENCY

For emergency cases please do any of the following:

- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

##### URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

##### ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of Unit:  
A/Prof Chris Kimber

Program Director:  
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Last updated:  
27/06/2019

# Monash Children's Hospital

## Referral Guidelines

### PAEDIATRIC UROLOGY

#### REFERRAL

How to refer to  
Monash Children's  
Hospital

#### Mandatory referral content

##### Demographic:

Full name  
Date of birth  
Next of kin  
Postal address  
Contact number(s)  
Email address  
Medicare number  
Referring GP details  
including **provider number**  
Usual GP (if different)  
Interpreter requirements

##### Clinical:

Reason for referral  
Duration of symptoms  
Management to date and response to  
treatment  
Past medical history  
Current medications and medication  
history if relevant  
Functional status  
Psychosocial history  
Dietary status  
Family history  
Diagnostics as per referral guidelines



[Click here](#) to download the outpatient referral form

#### CONTACT US

##### Medical practitioners

To discuss complex & urgent referrals, call:  
Paediatric Urology Fellow 0466 005 884

For patients not eligible for Medicare cover,  
specialist urologic care can also be  
arranged. Please contact the Department of  
Paediatric Urology to discuss this:

Phone: (03) 8572 3838

Fax: (03) 8572 3647

Email: [paedurology@monashhealth.org](mailto:paedurology@monashhealth.org)

##### Submit a referral

Fax referral form to Monash Children's  
Hospital Specialist Consulting Services:

Fax: 8572 3007

Email [scmonashchildrens@monashhealth.org](mailto:scmonashchildrens@monashhealth.org)

##### General enquiries

Phone: 8572 3004

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## GENERAL UROLOGIC CONDITIONS

### AMBIGUOUS GENITALIA

#### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- Family history of similar conditions
- Concerns at birth

##### Investigations

Nil

#### Routine

Concern about significantly abnormal genitalia

#### Management Options for GP

N/A

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### HAEMATURIA

#### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- Microscopic haematuria
  - Greater than 25 RBC/μl in urine microscopy
- Macroscopic haematuria
  - Visible blood in urine
  - Urinalysis positive for blood

##### Investigations

- Check blood pressure and growth
- Urine tests:
  - Urinalysis with micro
  - Urine culture, protein, creatinine ratio, calcium to urine creatinine ratio
- Serum tests:
  - Creatinine, U&Es
  - FBC
  - For macroscopic haematuria test coagulation studies: APTT, INR
- Urinary tract ultrasound

#### Emergency

Inability to pass urine → immediate referral to Emergency Department

#### Urgent

- Macroscopic haematuria with pain
- Recurrent episodic macroscopic haematuria

#### Management Options for GP

- Perform at least two consecutive urine dipsticks or urinalysis 1-2 days apart
- Refer to [nephrology and continence](#) for:
  - Microscopic haematuria
  - Family history of renal failure
  - Microscopic haematuria in multiple family members
  - Associated symptoms
  - Weight loss, fever, joint pain or rash
  - Poor growth
  - Elevated blood pressure
  - Oedema
  - Elevated serum creatinine/ potassium
  - Red blood cell casts
  - Abnormal renal ultrasound

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## GENERAL UROLOGIC CONDITIONS (cont'd)

### HYDRONEPHROSIS

#### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- Commonly unilateral
- Often identified on pre-natal scans
- May be associated with pathology or be clinically insignificant
- Signs may include:
  - Abdominal, back or flank pain
  - Nausea and vomiting
  - Painful urination
  - Recurrent UTI
  - Fever
  - Cloudy urine

##### Urgent

- Severe hydronephrosis (SFU grade 4)
- Bilateral hydronephrosis (SFU grade 3+)
- Hydronephrosis with associated concerns
  - Single kidney
  - Duplex system
  - Ureteric dilatation
  - Ureterocele
- Hydronephrosis and pain or urinary tract infection

#### Management Options for GP

##### Investigations

- Urine microscopy and culture if unwell
- Urinary tract ultrasound – ensure *images* are available for review at triage

##### Routine

Hydronephrosis without symptoms or associated concerning features above

See relevant fact sheet and guidelines for further information:

- [antenatal hydronephrosis](#) information sheet
- [hydronephrosis](#) information sheet

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### HYPOSPADIAS AND CHORDEE

#### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- **Chordee** – significant downward curvature and angulation of the penis associated with erection
- Asymmetry of the foreskin with a normal urethral meatus
- **Hypospadias** – birth defect in boys where the urethral opening is not located in the normal position this can be anywhere on the under surface of the penis extending down behind the scrotal sac
- Incomplete foreskin forming a hood
- Deflected urinary stream

##### Routine

At 3 months of age

#### Management Options for GP

Refer to urology department for surgical assessment

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## GENERAL UROLOGIC CONDITIONS (cont'd)

### RENAL AND URETERIC CALCULI

### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- May be asymptomatic in children
- Cramping, intermittent abdominal and flank pain with haematuria, nausea or vomiting
  - Risk factors for stones
  - Past or family history of stones
  - Poor fluid intake
  - Ketogenic diet
  - Cystic fibrosis
  - Urinary tract abnormalities
  - Some medications
  - Some inherited disorders

##### Investigations

- Urinary tract ultrasound
- Urine dipstick for blood
- Urine microscopy and culture

#### Management Options for GP

- If the stone is small, the child well and pain is manageable, treat at home. Stones smaller than 5mm often pass on their own.
- Use non-steroidal analgesia
- Advise increase fluid intake
- Advise family to strain urine for a few days until stone passes and save it in a clean container to enable analysis to guide future treatment
- After passing stone arrange urinary tract ultrasound and referral to Urology clinic

#### Emergency

- Severe and uncontrolled pain
- Inability to pass urine
- Immediate referral to emergency department

#### Urgent

Known presence of asymptomatic stones

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## GENERAL UROLOGIC CONDITIONS (cont'd)

### URINARY INCONTINENCE

### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- Consider the following when performing a clinical history and examination:
  - Daytime accidents
  - Frequency
  - Urgency
  - Straining
  - Pain on urination
  - If periods of dryness ask about physical, emotional and social triggers
  - Previous treatments
  - History of constipation
- Consider medical problems that may contribute to bedwetting (diabetes, UTI, faecal soiling, pin worms, renal failure, seizures, sleep problems etc.)

##### Investigations

- Bladder diary (input and output frequency)
- Investigate daytime symptoms before addressing night time enuresis
- Urinalysis only if symptoms suggestive of diabetes, UTI or constipation

#### Management Options for GP

##### Nocturnal enuresis

- Reassurance
- Manage constipation
- Education and reassurance consider the following options:
  - Motivational therapy
  - Enuresis alarms
  - Self-awakening
  - Medications - Desmopressin

##### Urgent

Refer to Urology

- Abnormal urinary tract ultrasound
  - Hydronephrosis
- Associated genital anomaly

##### Routine

Refer the following to [Nephrology Continence Clinic](#)

- Night wetting persistent following failed treatment in child over 7 years of age
- Day wetting persistent after constipation / UTI treated in child over 5 years of age

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## GENERAL UROLOGIC CONDITIONS (cont'd)

### URINARY TRACT INFECTION

### WHEN TO REFER?

#### Initial GP Work Up

#### Clinical history and physical examination

- Dysuria, frequency, haematuria
- Malodorous urine
- Abdominal pain
- Fever
- General malaise
- Failure to thrive

#### Investigations

- MSU for microscopy and culture
- Consider renal and bladder ultrasound to rule out anatomical anomalies

#### Management Options for GP

- Treat acute infection and re-test after completion of treatment to ensure cure
- Education about bladder emptying, hydration and perineal hygiene
- See relevant information sheets:
  - [Urinary tract infection](#) - child
  - [Urinary tract infection](#) – infant

#### Emergency

Infants <6 months of age with signs of sepsis → refer to emergency department

#### Urgent

Refer to Urology if:

- Ultrasound shows anatomical anomaly such as hydronephrosis

Refer to [Nephrology](#) if:

- Associated elevated blood pressure
- Infant with *febrile* UTI
- Child with 2 or more *febrile* UTIs

#### Routine

Refer to [General Paediatrics](#) if:

- Infant with confirmed UTI without fever
- Child with 3 or more UTIs without fever

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## GENERAL UROLOGIC CONDITIONS (cont'd)

### VOIDING DYSFUNCTION

### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

##### Underactive bladder/retention

- Recurrent UTI
- Painful urination
- Bloating or pain in the lower abdomen

##### Overactive bladder

- Incontinence, frequent or urgent urination
- Bladder spasm

##### Obstruction

- Fever, nausea and vomiting
- Pain in lower abdomen
- Urinary hesitancy, dribbling, slow stream
- Incomplete emptying, intermittent or decreased urine flow
- Blood in the urine
- May have a neurological condition, spinal injury or had recent surgery

##### Investigations

- Exclude constipation
- Urinalysis +/- culture
- Bladder diary
- Urinary tract ultrasound with pre and post void bladder volume assessment

#### Management Options for GP

- Treat constipation
- Advise regular toileting and good fluid intake
- Refer to [abnormal bladder function](#) information sheet for initial management options

#### Emergency

Unable to pass urine - immediate referral to emergency department

#### Urgent

- History of neurological condition or spinal injury
- Significant pain

#### Routine

Refer to [Nephrology Continence Clinic](#) with

- Voiding dysfunction with associated UTIs
- Overactive bladder
- Incontinence

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## MALE SPECIFIC CONDITIONS

### BALANITIS

#### Initial GP Work Up

#### Clinical history and physical examination

- May cause dysuria and penile discharge
- Foreskin may become red and swollen

#### Management Options for GP

- Salt bathing can help early on
- Topical antibiotics are not indicated
- Consider oral antibiotics if erythema extends down penile shaft
- See [foreskin concerns](#) information sheet

### WHEN TO REFER?

#### Routine

- Recurrent balanitis
- Preputial ballooning on voiding

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### FORESKIN ADHESIONS / SMEGMA CYSTS

#### Initial GP Work Up

#### Clinical history and physical examination

- Most foreskins are not retractable at birth
- Foreskins do not need to be retracted for cleaning before puberty
- Foreskin adhesions to glans and accumulation of smegma under the foreskin is common and normal

#### Management Options for GP

- Reassurance for family
- Encourage child to retract foreskin for cleaning when this becomes easy

### WHEN TO REFER?

Referral is NOT required as active management is unnecessary

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## MALE SPECIFIC CONDITIONS (cont'd)

### PARAPHIMOSIS

#### WHEN TO REFER?

#### Initial GP Work Up

#### Clinical history and physical examination

- Commonly results from a previous normal foreskin that has been retracted and not been replaced
- Oedema traps foreskin behind glans

#### Emergency

If unable to replace foreskin, refer to emergency department

#### Management Options for GP

- Compression for 5 minutes
- Try to reduce and advise future prevention
- Keep fasted and refer to Emergency Department if unable to replace

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### PHIMOSIS

#### WHEN TO REFER?

#### Initial GP Work Up

#### Clinical history and physical examination

- Most foreskin openings are 'tight' in childhood
- Foreskin retractability is highly variable and not necessary to achieve before puberty
- Pathological phimosis = scarred foreskin opening
- Ballooning on voiding

#### Urgent

Pin hole preputial orifice with poor urinary stream

#### Routine

- Pathological phimosis
- Persistent symptoms and failed conservative treatment with creams

#### Management Options for GP

- If ballooning on voiding +/- or balanitis, consider topical steroid creams e.g. Betnovate 1/5 for 6 weeks

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## MALE SPECIFIC CONDITIONS (cont'd)

### SCROTAL PATHOLOGY

### WHEN TO REFER?

#### Initial GP Work Up

##### Clinical history

- Age of the child
- Previous trauma
- Onset of pain
- Fever
- Consider sexual activity in adolescent
- Prior genito-urinary surgery / known anomaly

##### Physical examination

- Presence or absence of cremasteric reflex (this is usually absent in torsion of the testes)
- Observation of gait and resting positioning
- Transillumination
- Reducible swelling
- Palpate and compare the lower abdomen and inguinal area
- Palpate and compare the scrotum and testes

##### Investigations

- Urinalysis MSU and MCS
- Blood tests are not used in the acute setting
- Ultrasound only if non-acute

#### Management Options for GP

- Acute scrotal pain requires an immediate surgical assessment due to the risk of torsion of the testis and subsequent infarction
- If torsion is suspected, keep child fasted and refer to nearest hospital emergency department

#### Emergency

Immediate referral to nearest hospital's emergency department for any of the following findings:

- Acute uncontrolled pain
- Swelling with pain
- Tender testis
- Absence of cremasteric reflex

#### Urgent

- Firm testicular mass
- Suspected hernia

#### Routine

Suspected hydrocele

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## MALE SPECIFIC CONDITIONS (cont'd)

### UNDESCENDED / RETRACTILE TESTES



### WHEN TO REFER?

#### Initial GP Work Up

#### Clinical history and physical examination

- Diagnostic imaging has no role in the management of undescended testes

#### Retractile testes

- Testis normal in size that reach the bottom of the scrotum without tension
- Usually in scrotum after warm bath

#### Undescended testes

- Cannot be manipulated into the bottom of the scrotum after the age of 3 months

#### Management Options for GP

- Reassure and re-examine if retractile
- Refer if concerned

#### Routine

- Testis not fully descended by 3 months
- Retractile testes may require referral if they become undescended over time ("ascending testis")

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