

Oxfordshire Urology Guidelines for Primary Care

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Approved by Oxfordshire PCT Clinical Executive and ORH – November 2009

<http://opct.oxnet.nhs.uk/GeneralPractice/Document%20Libra>

European Association of Urology Guidelines

www.uroweb.org

Purpose of the ORH Guidelines

- To improve efficiency in treatment pathways
 - To enable GPs to investigate and initiate non-operative treatment for certain routine conditions
 - Encourage appropriate work up prior to being seen in the out patients clinic
 - Aim to offer definitive treatment decisions at the initial consultation
 - Minimize unnecessary follow up appointments
- Safely reduce the number of Urology referrals from primary to secondary care
 - address the “over performance” problem in Oxfordshire secondary care
 - Current deficit for out patients is approx £120,000
 - £145 per referral
 - 827 OP appointments !

Conditions Covered

- Erectile dysfunction
- Curved erection (Peyronie's Disease)
- Haematospermia
- Hydrocele (fluctuant/transilluminable scrotal swelling)
- LUTS (male, over 40, moderate LUTS, no haematuria)
- Phimosi
- Male circumcision
- Recurrent female UTI (adults)
- Urge incontinence (adult females)
- Scrotal pain
- Cancer referral guidelines

ED - Assessment

- Definition – Inability to achieve or maintain an erection sufficient for sexual intercourse
- Massachusetts Male Aging Study on incidence of ED → 15 % mild, 25% moderate, 10% complete.
- History
 - Duration of ED, ? Spontaneous/nocturnal erection, ?ejaculation, ? Penile deformity
 - Identification of risk factors – DM, HT, Dyslipidaemia, previous pelvic surgery, EBRT, neurological conditions
 - SH – smoking, drugs, ETOH,
 - DH – antihypertensives, anti-depressants, anti psychotics
 - Personal/Relationship issues
- Examination
 - External genitalia, Testes, DRE, neurological exam, peripheral pulses
- Investigations
 - IIEF, BP, Morning Testosterone, Glucose, Lipid profile, PSA. If testosterone is abnormal then rpt with FSH/LH +/- prolactin

1. Erectile Dysfunction

DIAGNOSIS

- Clues to psychogenic origin
 - sudden onset, early collapse of erection, good quality self-stimulated or early morning erections, premature ejaculation, relationship problems/changes, major life events, psychological problems
- Clues to organic cause
 - gradual onset, lack of tumescence, normal ejaculation, normal libido, risk factors e.g., vascular, endocrine, neurological, pelvic operations, radiotherapy or trauma, medications, smoking, high alcohol, recreational or body-building drugs
- Drug causes
- Examine:
 - Blood pressure, peripheral pulses
 - Genitalia: testicular size, penile fibrosis, retractable foreskin.

The following drugs may be the cause of ED:

Antihypertensives:

β -blockers/Thiazides/Hydralazine

α -blockers/ACE inhibs/Ca-channel blockers

Diuretics: Thiazides/K sparing/carbonic anhydrase inhibs > Loop diuretics

Antidepressants eg SSRI's, Tricyclics, MAOI's

Antipsychotics eg phenothiazines, carbamazepine, risperidone

Hormonal agents eg CPA, LHRH analogues, oestrogens

Lipid regulators: Gemfibrozil/Clofibrate > statins

Anticonvulsants eg phenytoin/ carbamazepine

Antiparkinsonian eg levodopa

Ulcer healing: H₂ antagonists > Proton pump inhib

Miscellaneous: allopurinol, indomethacin, disulfiram

	Clinical Suspicion	Investigation
MANAGEMENT/ INVESTIGATION	Diabetes	Usual appropriate management
	Heart disease	Usual appropriate management - Chol, BP
	If history (decreased libido) or examination suggests hypogonadism	Testosterone (free and morning (7-11am))
	If testosterone low	LH/prolactin
	If suspected renal impairment	Usual appropriate management - C&E
	If suspected liver impairment	Usual appropriate management - LFTs
	Afro-Caribbean patients	Sickle cell screen
<ul style="list-style-type: none"> ▪ If initial screenings tests indicate significant abnormality, manage as appropriate for underlying condition 		

Risk Stratification

- Recommendation of the European Association of Urology
- Pts should be risk stratified according to cardiovascular risk
 - Low → IHD but asymptomatic, stable angina, HT, previous CABG (stable) → safe to treat
 - Intermediate → angina, LVF (II), recent MI > 6/52, CVA, multiple risk factors → Cardiology consult and re-stratify
 - High → Recent MI < 6/52, arrhythmia, valve disease, unstable angina, LVF, CM → Not safe to treat until cardiac condition is corrected

ED - Treatment

- General
 - Lifestyle – stop smoking, weight loss, exercise
 - Psychogenic ED
 - Psychosexual counselling
 - www.relate.org.uk
 - +/- PDE5i
 - Identify and treat curable causes
 - Vascular cause – needs further inx – duplex+/-contrast imaging → vascular reconstruction
 - If low testosterone → testosterone replacement therapy

ED - Treatment

- Oral agents
 - First line therapy
 - Viagra (sildenafil)
 - 25-100mg
 - Effective 30-60mins. Avoid EtoH, fatty meals prior to ingestion. Efficacious for 12 hrs.
 - Efficacious in 60-80 % of pts. S/E visual disturbance
 - Levitra (vardenafil)
 - 5-20mg
 - Effective after 30 mins. Avoid fatty meals.
 - Efficacious in 60-80% of pts
 - Cialis (Tadalafil)
 - 10-20mg
 - Efficacious after 2hrs. Not affected by food. Effective for 36 hours.
 - Efficacious in 70-80%. S/E Myalgia
 - Can be used as a daily prep at 5mg/day instead of on demand.
- S/E – headache, flushing and dizziness
- Contraindications – **Nitrates**, unstable cardiovascular disease, recent MI, recent CVA

<p>REFER Email Advice</p>	<ul style="list-style-type: none"> ▪ Prior to referral, check whether consultant referral required using e-mail advice service ▪ oxon.urologyadvice@nhs.net
<p>Cost £20</p>	
<p>REFER ONLY</p>	<ul style="list-style-type: none"> ▪ Under Consultant direction, following email advice ▪ Young patients who have always had difficulty ▪ Patients with history of pelvic trauma ▪ Abnormality of testes or penis ▪ Starting hormone replacement therapy (DRE and PSA measurement) <p>NB: All other, less complex, patients will not be seen by ORH consultants</p>
<p>Cost £145</p>	
<p>ADDITIONAL INFORMATION</p>	<p>The investigation and treatment of less complex cases of erectile dysfunction is usually managed in primary care. If specialist NHS services are considered necessary for a patient in this group, a request for prior approval of referral should be made through the PCT's Individual Funding Request process, and sent to:</p> <p>Healthcare Priorities Directorate of Public Health Oxfordshire Primary Care Trust Jubilee House 5510 John Smith Drive Oxford OX4 2LH</p>
<p>Other</p>	<p>Not applicable.</p>

ED Treatment – Non responders

1. Pt re-education
 - Check correct dosing, preparation and useage
1. Switching agents
 - Weak evidence to suggest a benifit in switching to Levitra in Viagra non-responders
 - Maximal dose X3 attempts of all three agents
1. PGE1 therapy
 - Caverject – 5-40 mcg
 - Effective within 5-15 mins. Effective in 70% of pts
 - Risks – Priapism (1-5%), pain 50%, fibrosis 2%
 - MUSE – 125-1000mcg
 - Less effective than Caverject (40% success rate)
 - Pain 40%, bleeding 5%
1. Vacuum pump device

3. Haematospermia

DIAGNOSIS

Primary haematospermia

A benign self-limiting condition – common in the 30s-40s.

- Blood in the ejaculate is the only symptom.
- There is no blood in the urine, macro or microscopically.
- The patient has no evidence of any urinary irritation or infection and physical examination is completely unremarkable.
- The condition is self-limiting.

Primary haematospermia patients have been studied extensively in the past and most studies show no other associated problems. About 15% of patients will have one episode and never have another.

Secondary haematospermia

The cause of bleeding is known or suspected e.g. immediately after a prostate biopsy, or in the presence of a urinary or prostate infection or cancer.

Unusual causes or predisposing factors:

- Prostatitis
- Epididymitis
- Urinary calculi
- TB
- Cirrhosis of the liver
- Arterial hypertension
- Haematological disorders affecting clotting e.g. haemophilia
- Parasitic infections

MANAGEMENT

Consider DRE and PSA in patients with haematospermia if Ca prostate thought to be a risk.
Primary haematospermia usually resolves spontaneously, and reassurance is usually all that is required after full physical examination and investigations of any ancillary symptom or signs.

REFER Email Advice

Cost £20

- Check referral criteria – do not refer unless haematospermia is recurrent over 4-6 months
- Oxon.urologyadvice@nhs.net

REFER ONLY

Consultant

Cost £145

NB

- If the problem is persistent, as above
- Abnormal external genitalia
- Abnormal prostate on digital rectal examination (in absence of symptoms)
- Abnormal PSA if age > 40 years
- Normal age-specific range for PSA used by the ORH is
 - age 40-50 <2.5
 - age 50-60 <3.5
 - age 60-70 <4.5
 - age >70 <6.5
 - age >80 <10

This does not imply routine screening with PSA is recommended. This range is ideal for fit men with at least 5 years' life-expectancy. If the patient is elderly, unfit or frail then clinical judgement should influence decision to refer

ADDITIONAL INFORMATION

- <http://www.nice.org.uk/page.aspx?o=cg027quickrefguide> (page 14 for different PSA thresholds)

4. Hydrocele (fluctuant/transilluminable scrotal swelling)

DIAGNOSIS	<ul style="list-style-type: none">▪ Clinical/ultrasound diagnosis.
MANAGEMENT	<ul style="list-style-type: none">▪ Arrange ultrasound▪ If ultrasound demonstrates a hydrocoele or epididymal cyst with normal testes, the patient should be managed conservatively.▪ Needle aspiration is not recommended unless under sterile conditions, and may only provide temporary help.
REFER Email Advice Cost £20	<ul style="list-style-type: none">▪ Check referral criteria – do not refer unless criteria met▪ Oxon.urologyadvice@nhs.net
REFER ONLY Consultant Cost £145 NB	<ul style="list-style-type: none">▪ considerable discomfort, affecting normal activity e.g. off work because of it▪ so large that directional voiding is becoming difficult▪ so large that clothing no longer fits <p>Patients not meeting these referral criteria will not be treated by the ORH Urology Department</p>
ADDITIONAL INFORMATION	<ul style="list-style-type: none">▪ Not applicable

5. Lower Urinary Tract Symptoms (male 40+ with mild/moderate LUTS/no haematuria)

DIAGNOSIS

- Clinical symptoms of bladder outflow obstruction

MANAGEMENT

- Dip urine to look for infection or blood.
- Do DRE, check renal function and PSA, and consider renal tract ultrasound.
- If referral criteria do not apply, offer trial of alpha-blocker NB continuous usage requires monitoring of renal function.

REFER Email Advice

- Diagnostic difficulty - if the diagnosis is in doubt or for re-assurance - contact Oxon.urologyadvice@nhs.net

Cost £20

REFER ONLY

Consultant
Cost £145

- If symptoms persist and no response to 3 months' alpha blocker
- Palpable bladder
- Abnormal-feeling prostate
- HA creatinine or eGFR
- Postvoid residual on U/S >300mls
- Abnormal kidneys on ultrasound,
 - abnormal PSA for age age 40-50 <2.5
 - age 50-60 <3.5
 - age 60-70 <4.5
 - age >70 <6.5
 - age >80 < 10

ADDITIONAL INFORMATION

- Not applicable

Assessment of LUTS

- Aim to make diagnosis and identify risk factors for progression for BPH
- History
 - Filling/Voiding/Both
 - Warning signs ? Haematuria/Pain
 - Fluid intake – caffeine, EtOH
 - PMH, previous surgery
 - DH
- Examination
 - Bladder, ext genitalia, DRE, neurology
- Inx
 - Urinalysis
 - IPSS
 - Bladder diary 3/7
 - Flow Rate + Residual Volume assessment
 - Creatinine
 - PSA + counseling

Management Options

- **Option 1 WW**
 - Low IPSS/bother or Mod IPSS/low bother score
 - WW is safe option
 - MTOPS – 83% of pts did not progress after 4.5 yrs
 - Risk of retention is less than 1-2% per year
- **Option 2 Herbal Medication (eg Saw Palmetto)**
 - Safe, mode of action and benefit is unclear
 - Most recent Cochrane review suggested no benefit

Management Options

- **Option 3 Alpha blocker monotherapy**
 - All alpha blockers have similar efficacy in terms of:
 - Improved symptoms (30 – 40%)
 - Improved flow (16 – 25%)
 - Tamsulosin, Alfuzosin better tolerated
 - Alfuzosin higher rate of hypotension



Management Options

- **Option 4 5ARI monotherapy**
 - Finasteride and Dutasteride have equal efficacy in terms of volume reduction (27% at 12/12)
- PLESS 4 years of Finasteride for mod/severe LUTS
 - BPH related Surgery - RRR = 55%
 - AUR - RRR = 57%
 - NNT = 25
 - Volume change
 - 32% reduction
 - Symptom Score
 - Placebo 1.3 decrease v Finasteride 3.3 decrease
 - Flow rate
 - Placebo 0.2ml/s increase v Finasteride 1.9 ml/s increase

Management Options

- **Option 5 – Dual Therapy**
- MTOPS
- Progression rates = Placebo 17%, Monotherapy, 10%, Dual 5% (66% RRR)
- Dual Therapy led to a 66% RRR in the incidence of treatment failure
 - Symptom score most common reason for progression
 - Retention rare; 2% placebo comp 1% in treatment arms
- The risks of acute urinary retention and the need for invasive therapy were significantly reduced by combination therapy ($P < 0.001$) and finasteride ($P < 0.001$) but not by doxazosin

MTOPS

- Predictors of Clinical Progression
 - PSA > 1.5
 - Gland volume > 30 mls
- Bottom Line
 - Mod/Severe symptoms with a PSA < 1.5 and gland volume < 30 mls → Alpha blocker alone
 - Mod/Severe symptoms with a PSA > 1.5 and or gland volume > 30mls → combination therapy

8. Recurrent Female Urinary Tract Infection (adult female)

DIAGNOSIS

Recurrent UTI is defined as 3+ laboratory confirmed UTIs in 12 months, with proven clearance of infection between them.

MANAGEMENT

- Patient could be managed conservatively with short courses of appropriate antibiotics for at least 3 months if
 - physical examination is unremarkable +
 - a normal ultrasound +
 - a post void residual is <100 mls
- Consider renal calculus which may only show on a KUB x-ray
- Recurrence may be avoided by high fluid intake, including cranberry juice; advice on perineal hygiene; postcoital voiding; treating constipation promptly.

REFER Email Advice

- Diagnostic difficulty
- Check referral criteria
oxon.urologyadvice@nhs.net

Cost £20

REFER ONLY

- If UTI continue to recur despite treatment actions
- Post void residual volume >100ml
- Unusual patterns of disease

Consultant
Cost £145

ADDITIONAL INFORMATION

- Not applicable

Assessment of UTI/rUTI

- History
 - UTI – frequency, symptoms, fever, loin pain, ? Cultures, ?abs
 - Assc LUTS
 - Fluid intake
 - **Assc with sexual activity**
 - **Type of contraception**
 - Warning sign – haematuria, pain
 - PMH – childhood UTI
- Examination
 - Abdomen – palpable bladder
 - Genitaliae/intritus - ? Urethral diverticulum, atrophy
- Inx
 - Urine dipstick +/- MSU
 - FR + RV
 - USS + KUB
 - If any warning signs = flexi cystoscopy
- Causes of bacterial persistence
 - Urethral diverticulum, chronic prostatitis, boo, bladder stone, VVF, obstructed kidney, chronic pyelonephritis, kidney stones, bladder tumour

Management of rUTI

- Bacterial Persistence
 - Treatment of underlying disorder eg BOO
- Re-infection
 - Difficult to cure
 - Oral Fluid intake 2-3L
 - Avoid spermicidal contraception
 - Topical oestrogen cream if evidence of atrophy
 - Voiding pre/post intercourse
 - Abs post intercourse (x1 Cefalexin 250mg)
 - Cranberry juice
 - Low dose prophylactic Abs
 - Can reduce infections by 90% comp to placebo
 - Options Trimethoprim 100mg, Nitrofurantoin 50mg

9. Urge incontinence of urine (female)

DIAGNOSIS

Urge incontinence (involuntary loss of urine, associated with urgency) and overactive bladder (urgency, without incontinence) are common in postmenopausal women; may be associated with neurological disorders. Symptoms include:

- Urgency
- Frequency
- Nocturia

Exclude UTI/haematuria with stick-test.

If no mass or significant prolapse on abdominal/PV examinations then manage as below.

MANAGEMENT

Lifestyle advice:

- Limit intake of caffeine, spicy food, carbonated drinks
- Limit daily fluid intake to 1.5-2.5 litres
- Weight loss if BMI >30

Bladder training (at least 6 week trial) – prompted, scheduled voids may help reduce leaking episodes

- regular voiding (6-8 times during the day)
- increasing the time between voids to 3-4 hours during the day
- urge suppression between timed voids

Pharmacological therapies (combined with bladder training):

- antimuscarinics: 1st line: Oxybutynin (immediate release); 2nd line: Solifenacin or Tolterodine (modified release). Initial trial for one month.
- topical vaginal oestrogens for postmenopausal women with vaginal atrophy

Urge Incontinence

REFER
Email Advice

- Primary care management unsuccessful
oxon.urologyadvice@nhs.net

Cost £20

REFER ONLY

Refer non-responders after 6-12 weeks.

Consultant
Cost £145

ADDITIONAL
INFORMATION

NICE Clinical Guideline Female Urinary Incontinence

<http://guidance.nice.org.uk/CG40>

Referral protocol for ORH urogynae services:

<http://nww.oxfordshirepct.nhs.uk/GeneralPractice/Document%20Library/Referr>

Assessment of incontinent pt

- As per the NICE guidelines the aim of the initial assessment is to categorize pt into SUI/UUI/MUI which will guide subsequent therapy
- History
 - symptoms, assc LUTS, UTI,
 - PMH – neuroloigal conditions, Past gynae history, past surgical history, DH
- Examination - abdomen (Bladder), introitus (Oestrogen status, urethral diverticulum), PV – pelvic floor tone, Left lateral position – (? Prolapse, ? Demonstrable SUI)
- Investigations – **3/7 Bladder diary, Urinalysis, FR and RV**

-

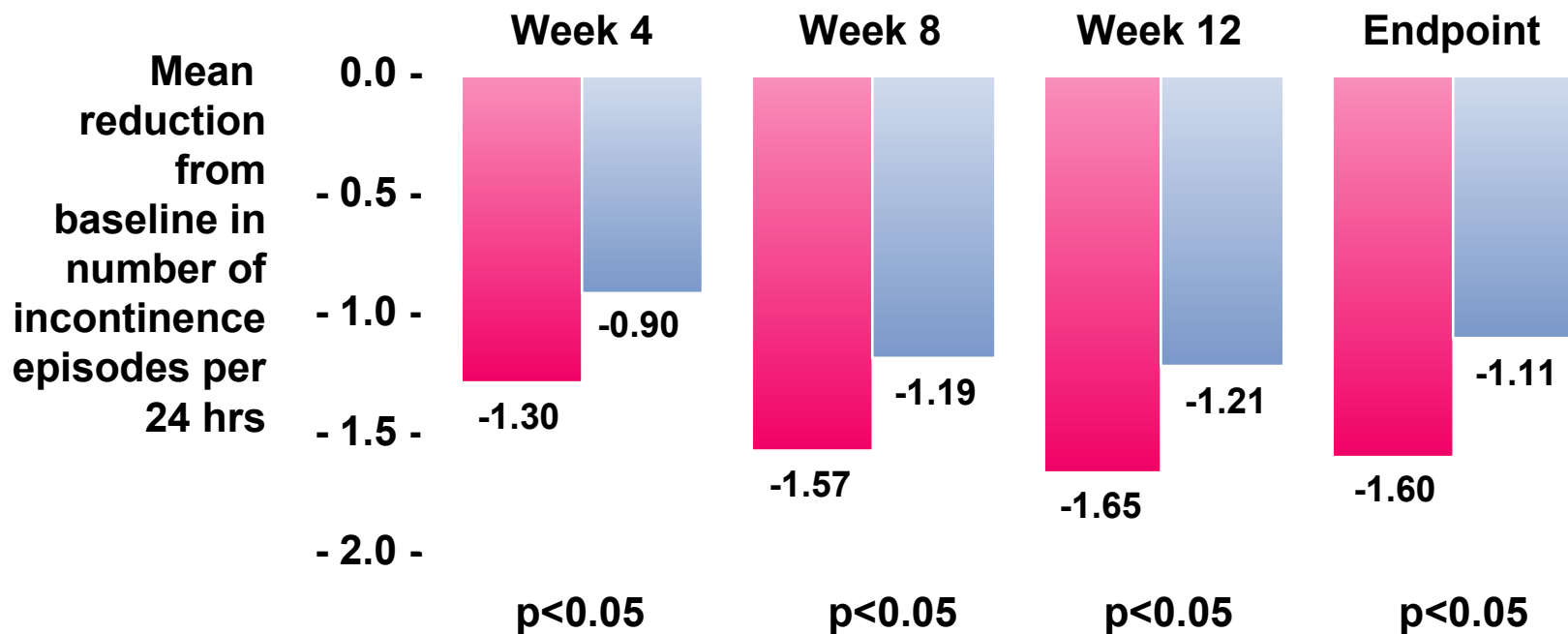
SUI

- Lifestyle modification – weight loss, stop smoking
- A trial of supervised pelvic floor muscle training of at least 3 months' duration should be offered as first-line treatment to women with stress or mixed UI.
 - Min 8 contractions, 3 times/day
 - Benefit in 50-70% of pts
- If PFMT are of no benefit at review then refer
- Urodynamics are only needed if there is a suggestion of OAB or a history of previous surgery.
- Surgical options
 - TVT, rectus fascia sling, open colposuspension, TOT, peri-urethral injections, duloxetine

UUI

- Lifestyle modification – avoidance of caffeine/Etoh
- Bladder retraining – min 6/52
- Anticholinergics – NICE recommend Oxybutinin as 1st line. Switch if S/E intolerable.
- **Topical oestrogens for atrophic vaginitis**
- If no improvement - Urodynamics
- Surgical options
 1. Botulinum toxin A (70% response rate, ISC up to 15%)
 2. Sacral Neuromodulation(50% respond to PNT, of those with a permanent device 60-70% response)
 3. Augmentation cystoplasty (90% response rate)
 4. Loop diversion

Reduction in episodes of incontinence¹



-  solifenacin (5/10mg groups combined) (n=378 at endpoint)
-  tolterodine XL 4mg (n=397 at endpoint)

10. Scrotal pain

DIAGNOSIS

- Common problem in 20-35 yr old men, usually self limiting over several months.
- Often no palpable pathology, nor any findings on USS.

MANAGEMENT

- Conduct examination (lying and standing)
- Investigate using scrotal and renal ultrasounds
- A trial of NSAIDs or antibiotics for epididymo-orchitis (ciprofloxacin and doxycycline) for 2 weeks or more may be worthwhile

DO NOT REFER

- Referral is not needed if:
 - scrotal examination lying and standing is unremarkable +
 - scrotal and renal ultrasounds unremarkable

REFER Email Advice

Cost £20

- Diagnostic difficulty
- Check referral criteria
oxon.urologyadvice@nhs.net

REFER ONLY

Consultant
Cost £145

- Only refer if indicated through email advice
- Treatment above fails

ADDITIONAL INFORMATION

- Not applicable

6. Phimosis (presenting with tight foreskin)

DIAGNOSIS

- In children, usually presented by concerned parents, who need reassuring that foreskin doesn't need to fully retract until 5-6 yrs old.
- Wine bottle phimosis, with reports of ballooning during micturition, may result in recurrent balanitis.
- In adults, mild degrees of phimosis may be treated with steroid cream.

MANAGEMENT

- If the glans is visibly/palpably normal, the patient could be managed conservatively with topical steroids and hygiene advice

REFER Email Advice

Cost £20

- Diagnostic difficulty- if the diagnosis is in doubt or for reassurance
oxon.urologyadvice@nhs.net

REFER ONLY

Consultant
Cost £145

- Recurrent balanitis
- Difficulty voiding
- Recurrent pain, tearing/bleeding during sexual activity
- Suspicion of malignancy

ADDITIONAL INFORMATION

- Not applicable

7. Male circumcision – non therapeutic

MANAGEMENT

Circumcision may be offered for

- Pathological phimosis
- Recurrent UTI
- Balanoposthitis
- Recurrent pain, bleeding or splitting during intercourse after treatment for candidal or other balanitis
- Suspected cancer

Circumcision for religious, cultural or lifestyle reasons is not commissioned.

DO NOT REFER

As above, non therapeutic circumcision is not commissioned.

ADDITIONAL INFORMATION

Treatment threshold statement:

<http://www.oxfordshire.nhs.uk/documents/ITTS2Malecircumcision.pdf>

Phimosis

- The foreskin grows to envelope the glans by Wk 16.
- The lining of the prepuce and glans are initially contiguous. Separation occurs via desquamation
- Evidence comes from the work of Oster + Gardner.
- Incidence of physiological phimosis
 - 30% 1 year
 - 10 % 3 years
 - 1 % 16 years
- Management
 - Reassurance + Conservative
 - Topical steroids (Betnovate 0.025% bd for 2/12 = 70-80%)
 - Circumcision
 - Risk – infection, bleeding, meatal stenosis, altered sensation, perceived poor cosmesis

2. Curved Erection (Peyronie's Disease)

DIAGNOSIS

Patients may first notice a tender lump in the penis, and complain of painful curvature of the erect penis, usually making intercourse difficult or impossible. The symptoms are:

- **a plaque on the concave surface of the flaccid penis:** this can develop slowly, taking 12 -18 months to reach its full extent. Usually the plaque forms on the top of the shaft, making the penis bend upwards, but if the plaque is on the underside it will bend downward. In some cases, the plaque develops on both top and bottom, leading to indentation and shortening of the penis. In the worst cases, the hardened plaque reduces flexibility and causes pain, bending, and emotional distress such that sexual intercourse becomes impossible.
- **pain in the shaft of the penis:** two-thirds of men with Peyronie's disease will experience pain in the penis. In most cases, it will gradually settle down and disappear without treatment in a few months.
- **abnormal angulation of the erect penis:** during the 12-18 months that the plaque or lump is developing, the deformity of the erect penis can change. During that time 30-40% get worse; 10-20% get better; and 50% remain the same.

There is an association with Dupuytren's and heavy alcohol intake. The degree of erectile dysfunction as a consequence of Peyronie's can vary from a complete inability to attain and/or maintain an erection adequate for satisfactory sexual experience, to a slight reduction in penile rigidity.

The main aims of treatment of Peyronie's are to help the man stay sexually active, and reduce pain.

Mild cases

As the plaque of Peyronie's disease often shrinks or disappears without treatment, it may be appropriate to have a period of surveillance of 1-2 years, or longer. If the problem has been present for a long time, is not changing, and is not causing the patient much trouble, no treatment is needed. The patient should be reassured and asked to return if the condition worsens.

Moderate/severe cases

•Surgery

If the problem does not resolve with time, surgery to correct the deformity may be warranted.

Indications for surgery are:

- unacceptable difficulty with penetration during sex
- pain during sex for either partner that is a consequence of the penile deformity

The 3 most common operations are:

- Removal/expansion of the plaque followed patching with skin/artificial material. [This can involve partial loss of erectile function, especially rigidity].
- Removal/pinching of tissue from the side of the penis opposite the plaque, which cancels out the bending effect. [This causes a shortening of the erect penis].
- Implantation of a device that increases rigidity of the penis. An implant alone may straighten the penis adequately, or sometimes implantation is combined with incisions/ grafting/plication

Surgery is usually combined with circumcision, and almost always results in 1cm or more of shortening.

NB Surgery is not warranted solely for cosmetic reasons. Surgery does not guarantee that the penis will be perfectly straight afterwards, and some men will develop erectile dysfunction or even numbness of the penis following surgery.

•Drug and other therapies

A number of drug treatments and other therapies are sometimes used (eg, Vit E; para-aminobenzoate tablets; injections of collagenase, dimethyl sulfoxide, steroids and calcium channel blockers directly into the plaques) but currently these are of unproven benefit.

**REFER
Email Advice**

Cost £20

- Prior to referring, check whether consultant referral required using e-mail advice service.
- oxon.urologyadvice@nhs.net

REFER ONLY

Consultant
Cost £145

Patient unable to have intercourse, meet the criteria for surgery, and are aware of the likely outcome.

Peyronie's disease

- Penile curvature secondary to the development of fibrous plaques within the tunica albugenia
- Pathophysiology – minor trauma leads to microvascular injury. Subsequent inflammation/fibrosis
- History
 - History of trauma, pain, distal flaccidity, erectile dysfunction.
 - Aim to determine if in the acute or quiescent phase of the disease
- Assessment
 - Ext genitalia. ? Palpable plaque. Assc dupuytron/PF
 - **Patient photographs** are invaluable at the time of a consultation to demonstrate deviation

Peyronie's disease

- Management
 - Active phase – Observation
 - Medical therapies; Vit E (1000IU), Tamoxifen 20mg bd, Colchicine 600mcg bd.
 - Acetyl L carnitine RCT better than tamoxifen
 - Intralesional therapy – Verapamil every 2/52
 - No definite proven benefit of any of these treatments
 - Surgery only indicated during the quiescent phase
 - Usually only appropriate if sexual intercourse is no longer possible
 - Risk of surgery
 - Shortening, Erectile, Dysfunction, Altered sensation, recurrent/persistent curvature

Hyperlinks to NICE Referral Guidelines for Suspected Cancer

Quick Cancer Referral Reference Guide

<http://www.nice.org.uk/page.aspx?o=cg027quickrefguide>

Larger Cancer Referral Document

<http://www.nice.org.uk/page.aspx?o=cg027niceguideline>

All Cancer referral Guidelines

<http://www.nice.org.uk/page.aspx?o=cg027>

- This presentation is a combination of my own views and the referral guidelines issued by the department of Urology at the Churchill Hospital.