CYSTITIS, ACUTE (595.0), CHRONIC (595.2), INTERSTITIAL (595.1)

CRITERIA	→ 1) Male single episode. Anatomic abnormality ruled out (IVP, etc) → 2) Female, uncomplicated single or recurrent episodes. No recurrence since change in hygiene/lifestyle or with appropriate use of prophylactic antibiotics. → 3) Urologic abnormality resolved, no infections for 3 mos.	→ N/A	→ 1) Current → 2) Assoc. with urologic abnormality: bladder-neck obstruction, diverticulum of bladder, stricture of meatus, or post menopausal.	→ 1) Assoc. urologic abnormality unrepairable. → 2) Interstitial cystitis, within 5 yrs.
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICTIONS/ DEFER			UNTIL: 1) Resolved 2) Urologic abnormality repaired and infection resolved for 3 mos.	
RATIONALE	Recurrent cystitis in females is assoc. with diaphragm use, urethral stenosis, stricture or diverticulum, or is assoc. with menopause.	Chronic cystitis in males frequently assoc. with chronic prostatitis. Low dose antimicrobials prevent recurrence in susceptible individuals. Often used post coital.		

MEDICAL INFORMATION NEEDED:

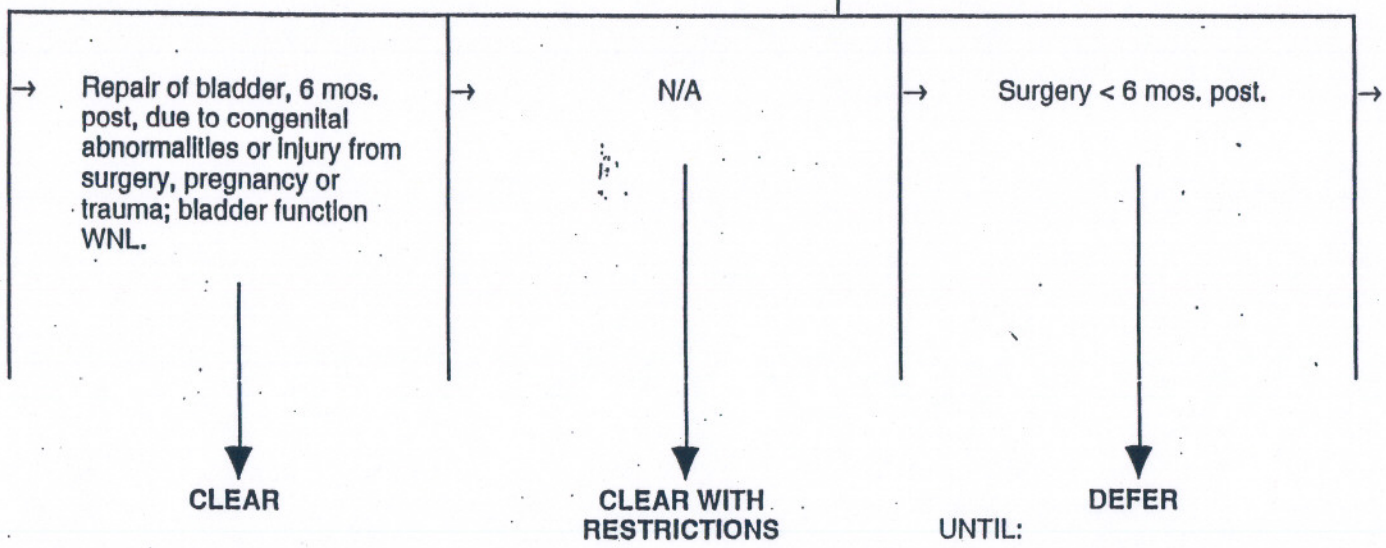
Generic Information

Microscopic U/A if multiple episodes;

Urologic work up for all males and for females with complications.

3/7/94

CYSTOPLASTY (57.89)



RESTRICTIONS/ DEFER

UNTIL:

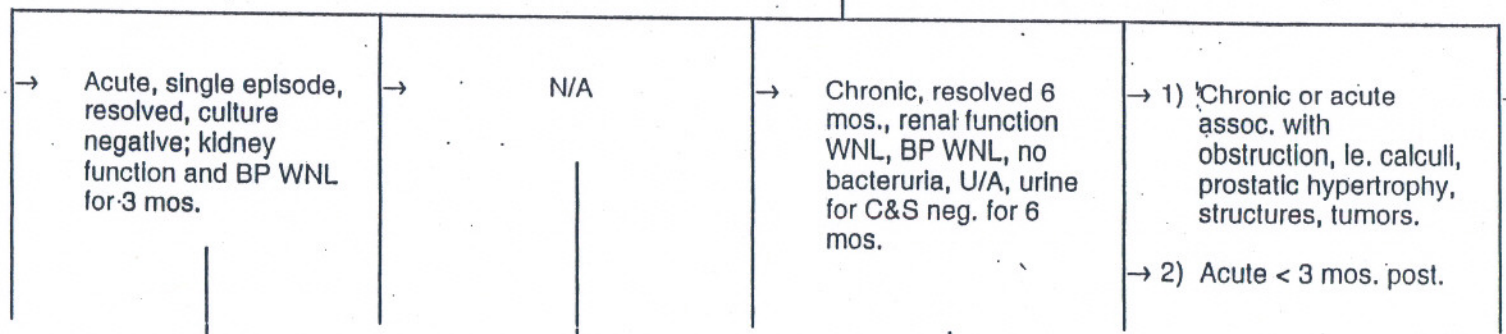
Post surgery 6 mos., bladder function WNL.

RATIONALE

MEDICAL INFORMATION NEEDED: Urologist evaluation.

5/4/93

PYELONEPHRITIS, ACUTE (590.1), CHRONIC (590.0)



ACTION

CLEAR

CLEAR WITH RESTRICTIONS

MRB/ MED ADVISOR

DEFER

UNTIL:

1) Assoc. cause is treated and Infection resolved 6 mos.; BP and kidney function WNL (See appropriate diagnosis)

2) Three mos. post, U/A, C&S neg. X 3 mos., kidney function and BP WNL.

MNQ

RESTRICTIONS/ DEFER

RATIONALE

Acute is usually cured without complications.

Chronic progresses very slowly with patients having adequate renal function for > 20 yrs. after onset of disease.

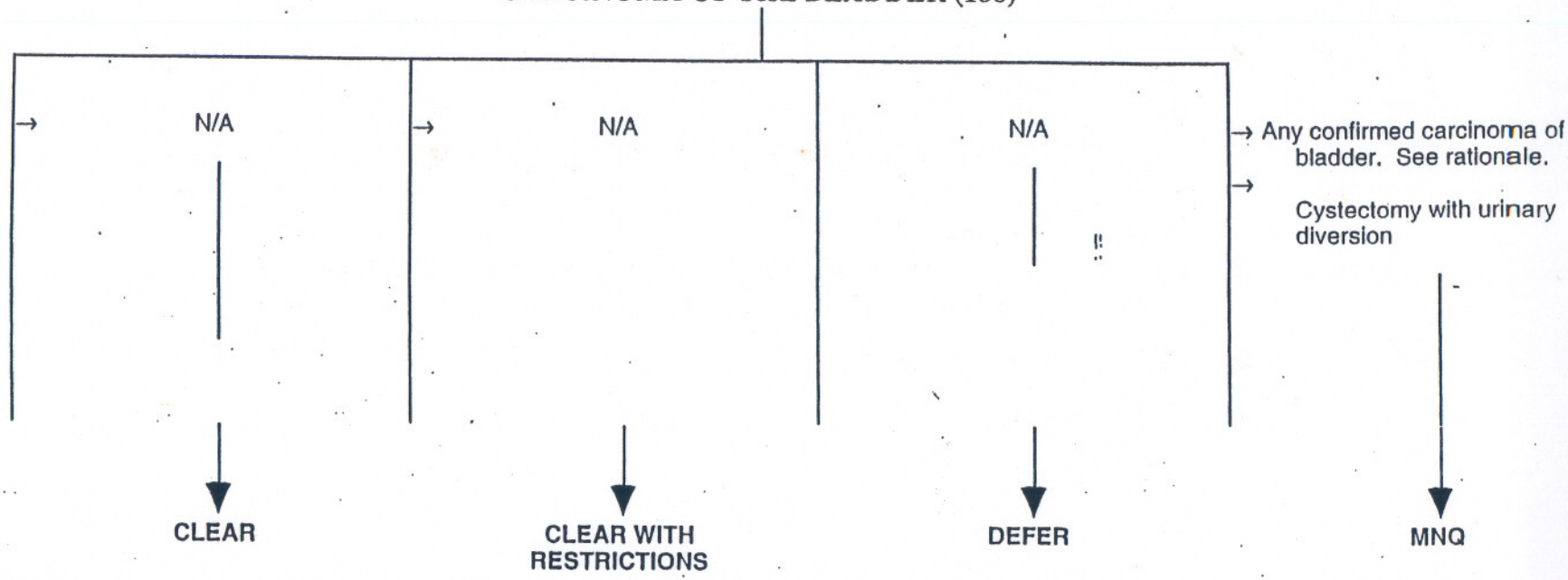
MEDICAL INFORMATION NEEDED:

Generic information

Microscopic U/A

Nephrologist evaluation if chronic pyelonephritis (resolved).

CARCINOMA OF THE BLADDER (188)



RESTRIC-TIONS/ DEFER

RATIONALE

Bladder CA has lifelong recurrence, never considered cured. 25-30% of superficial progress to invasive, requires cystoscopy q 3 mos. X 2 yrs., then q 4 mos. X 2 yrs., then Q 6 - 12 mos. Cannot accomodate F/U overseas, complications = perforation, bleeding, infection, anesthegic risks.

Urinary diversion not appropriate for developing country.

Prognosis is poor.

MEDICAL INFORMATION NEEDED:

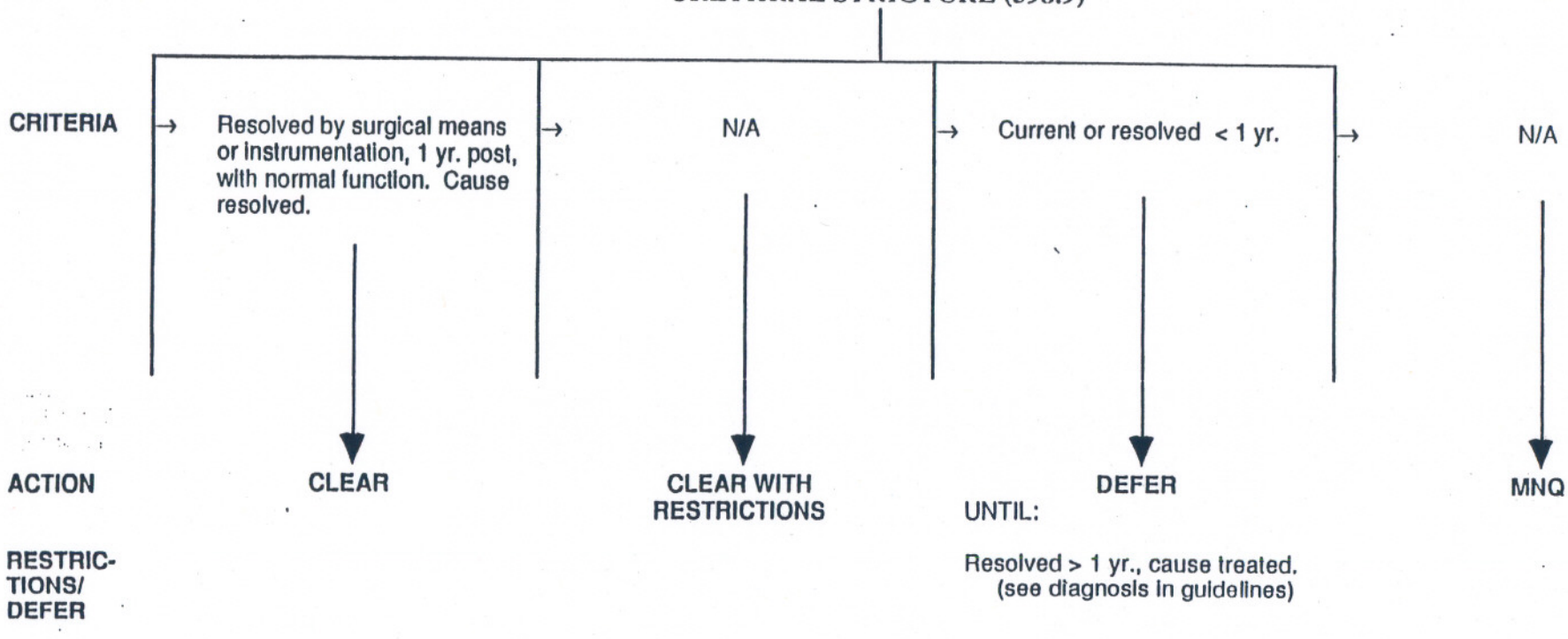
Generic Information

Specific Information: urologist evaluation

F/U needed.

9/19/94

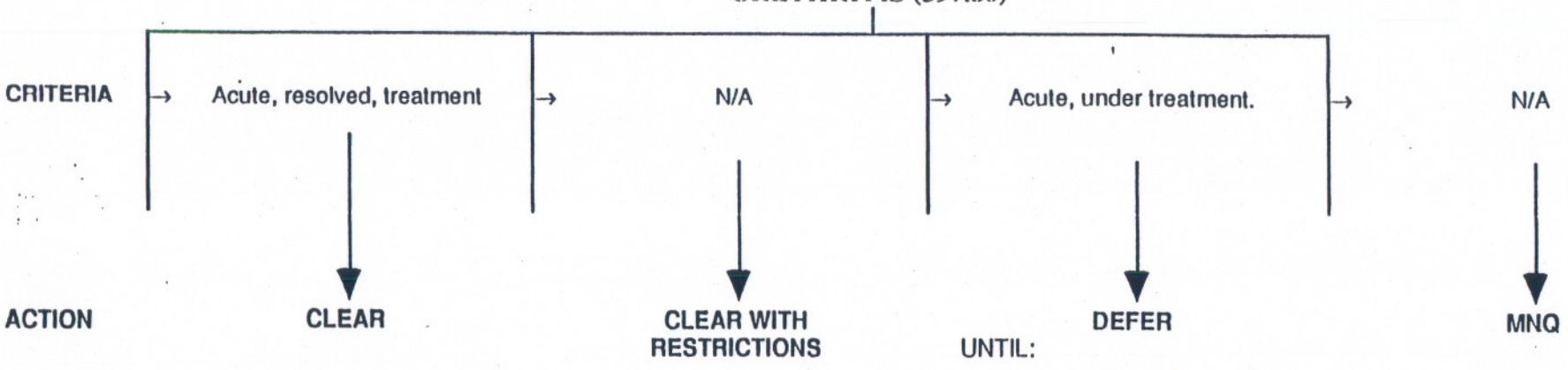
URETHRAL STRICTURE (598.9)



RATIONALE In males, obstruction or stricture can be due to benign prostatic hypertrophy, prostatic cancer, prostatitis, or can be congenital or caused by infection and frequently recurs. In females, urethral obstruction is rare. (see particular diagnosis, if necessary).

MEDICAL INFORMATION NEEDED: Generic information

URETHRITIS (597.80)



UNTIL: resolved

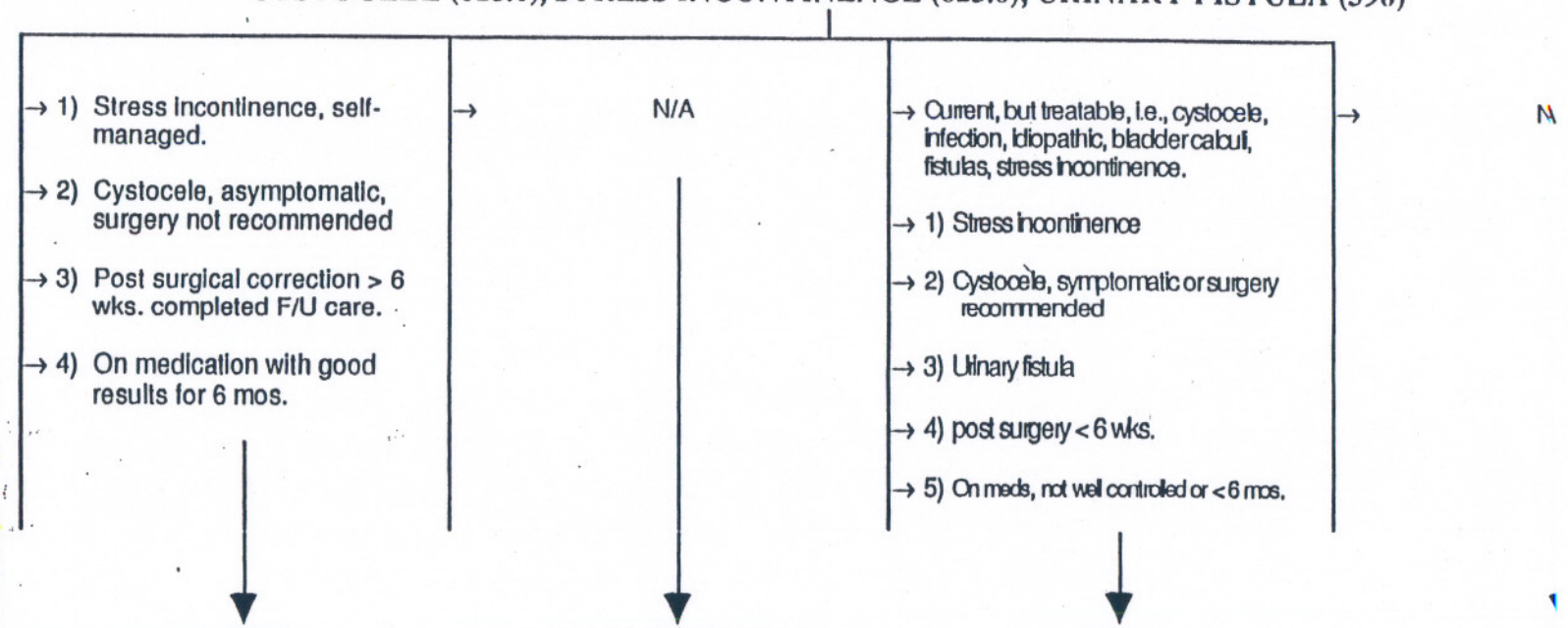
RESTRIC-TIONS/ DEFER

RATIONALE Urethritis can be assoc. with UTI (in women) or in males it frequently is due to gonorrhea or chlamydia.

MEDICAL INFORMATION NEEDED: Generic Information

5/4/93

CYSTOCELE (618.0), STRESS INCONTINENCE (625.6), URINARY FISTULA (596)



UNTIL:

1) Well controlled

2-3) Post surgery

4) Period > 6 wks.

5) Period > 6 mos., well controlled.

80% of patients with urinary incontinence can be cured or well controlled.

Meds. include Sudafed and alpha-blockers, Di-tropan, tricycles. Do not require special F/U.

Generic Information

ON

Cystocele: Urologist or Gynecologist.

y

5/4/9

ADDENDUM

GENITOURNIARY

Testicular Cancer/
Orchiectomy: An individual with Testicular Cancer needs Alphafeta protein and Beta HCG levels every year and a CXR q 6 months as f/u to r/o recurrence. Three years post surgery the recurrence rate is low.

Benign Prostatic
Hypertrophy (BPH): The severity of the disease of BPH is not based on the size of the prostate. The symptoms are a better criteria. A Urology evaluation is recommended for all men with enlarged prostates. Attached is a questionnaire from the American Urological Association to help in the evaluation of symptoms. More than half the men in the US over 50 suffer from BPH.

Carcinoma of the
Prostate: Accounts for 19% of all male cancers. It is rarely diagnosed in men under 55. The average age of diagnosis is 70. Every man over 40 should have a yearly rectal exam as a screening procedure. No sensitive or specific tests have been developed for Ca of the Prostate. PAP (prostatic acid phosphatase) is elevated in a large percentage of individuals with cancer spread beyond the prostate. PSA (prostate specific antigen) is elevated in men with prostate cancer and other diseases of the prostate. The PSA is more valuable in assessing the effectiveness of treatment of the cancer than as a diagnostic tool. The PSA should return to normal (0) after effective therapy. If the PSA remains elevated, the individual requires additional treatment.

Prostatitis: Chronic Nonbacterial Prostatitis frequently responds to Tetracycline. It is frequently associated with stress.

Abnormal Renal
Function, Nephrotic Syndrome,
Nephritis (Acute and Chronic), and
Glomerulonephritis: Renal Disease is variable with each individual. All these conditions should be evaluated by a Nephrologist.

Cancer of the
Kidney: Localized tumors that have not spread beyond the kidney have an excellent prognosis. Cancer of the Kidney has been known to recur 20 years later. The standard treatment is Nephrectomy. Standard f/u is a chest xray every 6 months for 2 years, then annually.

Nephrolithiasis,
Urolithiasis : Urinary Tract Calculi are common. They are also extremely painful. Airplane pilots are barred from flying with untreated calculi. Tea and hot climates, where the body passes large amounts of fluid in sweat, contribute to stone production. 10% repeat incidence exists.

Cystic Diseases of the
Kidney: One cyst or multiple cysts not compressing the kidney usually do not cause renal damage. The cyst consists of "trapped" urine components. The cysts are usually painless and do not affect kidney function.

Pa[illegible]ne: _____ DO[illegible] ___ ID #: _____ Date of assessment: ___
In[illegible]nonitor ( ) during _____ after ( ) ___ therapy. Physician/office: _____

WHOPSS / AUA

	not at all	less than 1 time in 5	less than half the time	about half the time	more than half the time	almost always	
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	none	1 time	2 times	3 times	4 times	5 or more times	
7. Over the past month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	

Total WHOPSS Score S = ___

QUALITY OF LIFE DUE TO URINARY SYMPTOMS

	delighted	pleased	mostly satisfied	mixed about equally satisfied and dissatisfied	mostly dissatisfied	unhappy	terrible
1. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Quality of Life assessment index L = ___

URINALYSIS

COMPONENT	NORMALS	CRITERIA
Specific Gravity Color Character pH	1.005-1.020 Straw Clear, odorless 4.5-8.0	Any deviations should be reviewed in context of other U/A findings and history and physical. May ask for repeat or take action based on underlying cause.
Glucose (sugar):	Negative	Negative---------- Clear Present ---------- Defer: Diabetes, drug therapy
Protein (Albumin):	Negative to Trace	Negative to trace-(except diabetics) Clear > Trace ---------- Defer:MD evaluation for kidney disease
Ketones (acetone):	Negative	Negative ---------- Clear Trace or 1+ & no glucose ---- Clear > 1+ & positive glucose ----- Defer: MD evaluation
Urobilinogen:	Negative/Small Amounts	Negative to trace ---------- Clear > Trace ---------- Repeat and evaluate
Bilirubin:	Negative	Negative---------- Clear Positive---------- Refer: MD R/O liver disease
Nitrite:	Negative	Negative---------- Clear Positive---------- R/O UTI
Ascorbic Acid:	No importance	N/A---------- ---------- N/A
Blood (Occult Blood):	Negative dipstick, o-3 RBC/HPF	Negative-or < 0-3 RBC/HP---------- Clear Positive---------- Defer: R/O > 3 RBC/HPF Urologic dysfunction

10/4/93

Polycystic Kidney
Disease: is a familial disease that causes renal failure. Individuals with this disease can be diagnosed as early as childhood. Usually, their kidney function is not affected until their 40-50's. Deterioration in kidney function is very slow, usually over a 40 year period. They are excellent kidney transplant candidates. However, they are at risk for a ruptured renal cyst if they are hit in the kidney area. They should be barred from playing contact sports or motorcycle riding.

Carcinoma of the
Bladder: Superficial, intravesicular bladder cancer has a good prognosis. Treatment is excision of the lesion via cystoscope. F/u consists of a cystoscope q 3 mo for 2 years, then cystoscope q 4 mo. for 2 years, then cystoscope q 6-12 months. There is as yet no cure. The lesions have been known to recur many years later. Approximately 25-30% of the superficial lesions progress to invasive Carcinoma. Invasive Carcinoma has a poor prognosis.

Cystoplasty: Is rarely down now. It is sometimes done for Interstitial Cystitis.

Hematuria: Hematuria is almost always a sign of pathology. Ca of the Bladder causes bleeding intermittently. One urine specimen without RBC's after a urine with RBC's does not r/o pathology. < 4-6 RBC's must have 2 additional clear urine specimens, spaced four weeks apart, to r/o a problem. If bleeding persists, a Urology/Nephrology work up must be done. With >10-20 RBC's, a work up is indicated regardless of a subsequent clear urine specimen.

Urinary
Incontinence: Can be treated with many different medications: Sudafed, Alpha Blockers (Minipress), Imipramine, Ditropan, and Propantheline. They require no special f/u.