MALE URINARY RETENTION/ INCOMPLETE BLADDER EMPTYING REFERRAL GUIDELINE

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HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Complete inability to void

Distended / painful bladder

Palpable bladder distension

Obstructive acute renal insufficiency

Gross hematuria with passage of solid clots

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Obstructive urinary symptoms (weak stream, straining to void), and poor response to alpha blockers

"Overflow" incontinence

History of prior urological instrumentation (catheters, urologic surgery, trauma)

Neurological disease (MS, diabetic neuropathy, Parkinson's)

Elevated post-void bladder volume (PVR): greater than 200 ml (adult)

Able to void, but with sensation of residual urine in bladder

Recurrent culture-proven UTI

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Obstructive urinary symptoms (weak stream, straining to void)

Single episode of culture-proven UTI

SUGGESTED PREVISIT WORKUP

Bladder scan if available

Urinalysis

Catheter placement

Renal and Bladder ultrasound (if will not delay treatment)

If febrile / toxic, send to ED

SUGGESTED WORKUP

Bladder scan if available

Urinalysis

Consider starting a 5-alpha reductase and maximize dose of alpha blockers

inhibitor if enlarged prostate on exam

SUGGESTED MANAGEMENT

Bladder scan if available

Urinalysis

Elimination of causative agents (antihistamines, anticholinergics, opiates, alpha agonists)

Treatment of fecal impaction

Treatment of any UTI

Trial of empiric alpha blockers; if no improvement in 1-2 weeks, consider urology referral

CLINICAL PEARLS

- Alpha blockers and 5-alpha reductase inhibitors are not mutually exclusive; many patients require combination
- 5-alpha reductase inhibitors take up to 6 months for appreciable efficacy
- Of patients with acute urinary retention, after 5 days with a urethral catheter, 40% will be able to pass a voiding trial
- After catheter placement, treat constipation aggressively prior to initiating a voiding trial

Maine Medical
PARTNERS

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.