UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

Guidelines

Urological Prioritisation During COVID-19

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Subject:	Patient Care	**Distribution:**		Members Only	
Authorised by:	Board of Directors	**Approved Date:**	25/03/20	**Review Date:**	As needed

Purpose and Scope

In Australia and New Zealand all elective surgery has been suspended until further notice, with the exception of Cat 1 and urgent Cat 2 cases.

These guidelines were developed by the USANZ Board of Directors as a general guide only to assist our members and medical directors to make decision during this unprecedented crisis.

We recognise these unusual times require flexibility in patient care and hope the public health measures implemented are successful allowing us all to return to some normality in the near future.

Decision Making

Each urologist will need to base their individual decisions on their own local and personal circumstances. Each hospital may be approaching their COVID-19 strategies differently, and the advice is highly likely to vary over the coming days and weeks. These differences between hospitals/health districts/countries/states and territories need to be taken into account when urologists are making prioritisation decisions regarding patient care.

It is also recommended that a shared decision-making approach be taken with patients and their families where practicable.

As the peak is likely to start by next week (commencing 30/3/2020), it is strongly recommended that all urologists formulate a robust plan that protects their patients, junior medical staff, office and hospital staff as well as themselves with some urgency this week.

Consultations

Clinicians should at this stage be limiting movements of patients in and out of offices to protect patients, their families, your staff and yourselves.

Consider carefully whether patients acutely require investigations such as pathology and radiology at this time or if it can be deferred for a period of time safely.

Transition to telehealth platforms as soon as possible and for as many people as possible – phone, or videoconferencing with Skype, Zoom or Doxy platforms.

Urological Surgery

There is a need to re-define urgent urological surgery from those procedures that relatively safely could be deferred for several months. Ventilators and anaesthetists will be in high demand to look after COVID-19 patients and as a group of ethical professionals we must at all times ensure that scarce resources are directed appropriately.

Below is an indicative list of conditions which may warrant urgent surgical intervention during the COVID 19 crisis. The list is not exhaustive but acts a guide for clinicians. ICU availability may be compromised at times and access to this level of care may be required in some cases.

Testis cancer: Inguinal orchidectomy, RPLND for progressive residual mass post chemotherapy (consider deferral if suggestive of slowly growing mature teratoma)

Renal cancer: Large renal cell carcinoma > 7 cm, or complicated with venous thrombus (consider immunotherapy/chemotherapy options as initial treatment in metastatic setting with secondary delayed cytoreductive nephrectomy) , upper tract urothelial cancers (consider neoadjuvant chemotherapy)

Prostate cancer: A proportion of high risk prostate cancers (viz., some select Gleason 8-10 cancers only)

Intermediate and some high risk cancers may in many circumstances be safely managed with initial ADT and deferred definitive treatment.

Low risk cancers should be initially managed with active surveillance.

Bladder cancer: Cystectomy for MIBC (ideally prior neoadjuvant chemotherapy and delay surgery after discussion with medical oncology colleagues), surveillance cystoscopy +/-TURBT for high risk NMIBC only e.g., CIS and G3T1

Cystoscopy for macroscopic haematuria: We recommend that a diagnostic cystoscopy should be undertaken with abnormal radiology or abnormal cytology. If these investigations are normal a delay of 1-2 months for a diagnostic cystoscopy is a low risk to the patient.

Prostate biopsies: Only for suspicious prostate lesions or PIRADS 4/5 on prior MRI (not for lower PIRADS nor for protocol based AS evaluation which should be followed biochemically in 3 months)

TURP: For chronic or acute urinary retention if not suitable for self-catheterisation or indwelling IDC.

Endourology: Symptomatic stones, obstructed +/- infected kidneys, stents in situ

Scrotal: Testicular torsion

Trauma: Including penile, urethral.

Superseded documents

- None

Revision history & Review date

These guidelines will be monitored and reviewed by the Board as the health crisis develops.

Version	Date	Notes	By
1.0	25/03/2020	Approved	Board of Directors

Contact

USANZ President, Email: president@usanz.org.au