GENITOURINARY HISTORIES

Common Presentations
UTI / Pyelonephritis
Kidney Stones
Stress versus urge incontinence
Haematuria – UTI / Ureteric Stones / Renal / Bladder or Prostatic Cancer
Prostatism (BPH vs Prostate cancer)
Menorrhagia / Oligomenorrhoea / Dysmenorrhoea / Postcoital bleeding
Menopause and Postmenopausal Bleeding (Endometrial and Ovarian Cancer)
STIs / Pelvic Inflammatory Disease
Infertility

Urinary History Common Symptoms
Frequency, Dysuria, Suprapubic or Renal pain +/- fever
Polyuria versus oliguria
Haematuria
Urinary incontinence (stress vs urgency)
Prostatic symptoms (frequency, nocturia, hesistancy and incomplete bladder empyting, post-micturition dribbling, weak stream…)

Menopause (age of onset – last period (more than 1yr no period)
Associated symptoms – flushing / sweats, vaginal dryness, mood changes

Sexual health
Dyspareunia
Vaginal discharge
Penile discharge

Consultation Skills: Check Moodle on Addressing Embarrassing Problems with Patients for more detail on asking a sexual history

CASE SCENARIO 1 – STUDENT DOCTOR

You are asked to see a 44 year old woman Farah who presents to the emergency department in Prince Hamza hospital with right sided loin pain. Take a history from her and ask differentiating questions to determine the cause of her pain. Pick up any patient cues that may present in the history.

CASE SCENARIO 1 – PATIENT HISTORY

Name: Farah Haddad
Age: 44 years
Occupation: Housewife
Residence: Tababour

PC: Severe right sided loin pain

HPC: 2 days right sided abdominal / loin pain – worse today not relieved by ibuprofen
Radiates to right groin
Sharp / stabbing in nature
Severe 9/10 pain scale – difficult to get comfortable – writhing around
Noticed some blood in your urine today – `alarmed', worried

If picks up cue `alarmed' and `worried': `With the severe pain and blood I thought it was something serious like cancer or something'

If asked directly: No fever, no dysuria and no frequency

Drinks water from the tap without a filter
Eats lots of spinach

PMSH: Hypertension

DH: Bendroflumethiazide 2.5mg
Ibuprofen 400mg

FH: None

SH: Non-smoker and doesn't drink alcohol

NOTES ON CASE SCENARIO 1 – RENAL COLIC

Feedback on consultation skills – active listening, open to closed questions, targeted questioning, structure of consultation, did they pick up the patient cue?

What differentials of haematuria do they know?

- Renal / ureteric stones
- UTI / Pyelonephritis
- Renal / Bladder or Prostatic cancer
- Glomerulonephritis….

Differentiating (targeted) questions:

- Fever, dysuria, frequency to exclude infection
- Renal colic – sharp stabbing pain in loin (ask patient to point where) radiating to groin, severe, can be like waves

Different types of stones – calcium oxalate, uric stones

- Consider risk factors for uric stones – red meat or certain types of seafood (purine rich food), alcohol, thiazide diuretics
- Calcium oxalate – hard water (unfiltered water in Jordan), spinach and other foods

Management of renal colic / stones

- Analgesia – strong nsaids best choice
- Increase fluid intake to wash out
- Check renal function ?iv fluids
- If small stone less than 1cm usually passed spontaneously otherwise need to consider lithotripsy or surgery if not being passed

CASE SCENARIO 2 – STUDENT DOCTOR

You are a fourth year medical student at Prince Hamza Hospital working in the urology clinic and you have a new GP referral of a 76 year old gentleman who is struggling with frequency of passing urine. Take a complete history and summarize your history back to the patient at the end.

CASE SCENARIO 2 – PATIENT HISTORY

Mohammed Hamza
76 years
Retired shopkeeper
Lives in Hashmi Shamali

PC: Struggling with going every 1-2 hours to pass urine
Feeling tired as getting up in the night too

HPC: 4-6 month problem with frequency
Getting up in the night 2-3 times to pass urine
Feeling tired as poor sleep

If asked directly:
Weak urinary stream
Difficulty getting started passing urine (hesistancy)
After finished passing urine sometimes dribble afterwards (post-micturition dribble)
No fever, dysuria, pain or haematuria
No weight loss, lower back pain

Patient Ideas: I think it's my prostate doctor
Patient Concerns: Wants to get more sleep and get some treatment to stop having to go to the toilet so frequently. Hoping he doesn't need surgery
Patient Expectation: Trial of a medication

PMSH: Heart Failure
Hypertension
Atrial Fibrillation

DH: Furosemide 40mg once daily
Bisprolol 5mg once daily
Digoxin 62.5mcg once daily
Aspirin 100mcg

No allergies

FH: Father had prostate cancer aged 75 years

SH: Ex smoker – gave up 10 years ago, smoked for 50 years, 30 cigarettes a day. Doesn't drink alcohol but drinks 5 coffees a day.

NOTES ON CASE SCENARIO 2 – PROSTATISM

Feedback on consultation skills – opening question? What specific prostatic questions did they ask about? Did they gather the patient perspective?

International Prostatic Scoring System (IPSS) questions are listed below:

- Incomplete Emptying: How often have you had the sensation of not emptying your bladder?
- Frequency: How often have you had to urinate less than every two hours?
- Intermittency: How often have you found you stopped and started again several times when you urinated?
- Urgency: How often have you found it difficult to postpone urination?
- Weak Stream: How often have you had a weak urinary stream?
- Straining: How often have you had to strain to start urination?
- Nocturia: How many times did you typically get up at night to urinate?

Differentiating questions for urinary frequency

Rule out infection – fever, dysuria, suprapubic pain, cloudy / smelly urine…

Anything else in the medications that could be contributing to the symptoms?

Furosemide – diuretic – dilemma as used for heart failure – need to discuss with patient balancing act of treating heart failure versus side effect of urinary frequency. Also don't forget caffeine as a stimulant

Family history of prostate cancer – what other questions would you ask regarding screening for prostatic cancer?

Haematuria, lower back or pelvic pain (metastatic bone disease), weight loss

Remember can't tell if BPH or Prostatic cancer at this stage – need further testing – prostate examination, PSA and possible prostate biopsing

CASE SCENARIO 3 – STUDENT DOCTOR
You are in a family medicine clinic in Tababour and you are asked to see a 28 year old newly married woman Malak who has developed some irregular vaginal bleeding and vaginal discharge. She seems upset and nervous.

CASE SCENARIO 3 – PATIENT HISTORY
Malak Darwish
28 year old
Housewife living in Tababour

PC: Developed some vaginal bleeding between periods that you have noticed after close relations with your husband and vaginal discharge

HPC: Married 3 months ago and since then developed new vaginal discharge and some bright fresh blood after intercourse
Vaginal discharge – smells (not fishy odour), thick and pussy (purulent)
No lower abdominal (pelvic) pain or pain during sexual intercourse
No fever
No pain on passing urine (dysuria)

Sexual History
No previous sexual partners prior to marriage
Trying to get pregnant not used condoms (unprotected intercourse)

Upset and start to cry – if doctor picks up on cue or shows empathy
`I'm really angry as I'm not sure I can trust my husband. I come from a religious family and can't speak to anyone about this. Could this be an infection from him?'

Patient concern: as above – patient worried acquired infection from husband as has penile discharge
Patient expectation: to keep confidentiality but do some swabs

PMSH: Nil significant
DH: Taking Folic Acid
Allergies: Penicillin – rash if takes it
SH: Non-smoker, doesn't drink alcohol

CASE SCENARIO 3 – POSTCOITAL BLEEDING AND VAGINAL DICHARGE
Challenging consultation and needs empathy and sensitivity – can discuss cultural aspects of this case, medical ethics of patient confidentiality…

Do you know any causes of postcoital bleeding (spotting or bleeding)?

Ectropion
Cervical polyps
CIN or Cervical cancer (therefore need to pass a cervical speculum +/- colposcopy for smears as well as taking swabs)
Cervicitis – N. gonorrhea, C tachomatis, Trichomonas Vaginalis

Do you know some causes of vaginal discharge? What other questions are appropriate to ask?

Normal – increases during ovulation, pregnancy or breastfeeding, douching
Vaginal Candidiasis – thick, whitish or yellowish discharge with itching. Can be recurrent often worse prior to period
Bacterial vaginosis – white, fishy odour
Gonorrhoea – cloudy or yellow with intermenstrual bleeding
Trichomanosis – pain and itching whilst urinating
Possible cervical or endometrial cancer

Taking a Sexual History
How to introduce the topic?

- Warning shot – `I am going to ask you a few questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health.'
- Asking their permission - `Are you OK if I proceed?' Do you have any questions before I ask these questions?' `Is that OK with you?'
- Normalising - `Just so you know, I ask these questions to all of my adult patients, regardless of age, gender, or marital status.'
- Framing the topic / question - `Because of the symptoms (e.g. vaginal discharge) you describe I need to ask you some questions to know how best to help you. Is that OK?'
- Building patient trust and maintaining patient confidentiality – `Like the rest of your information, this information is kept in strict confidence.'

Specific Sexual History questions

- Do you have a regular sexual partner at the moment?
- Is your partner male or female?
- Can I ask if you have had any (other) sexual partners in the last 12 months?
- How many were male? How many female?
- Do you use barrier contraception (condoms) – sometimes, always or never (particularly ask this if they have had more than 1 partner in the last 12 months)?
- Can I ask what kind of sexual contact you have had? (genital, anal or oral?)
- Have you ever had a sexually transmitted infection? (when, how treated, any recurrence, ask specifically about HIV testing)

CASE SCENARIO 4 STUDENT DOCTOR

You area 4th year medical student who is in an outpatient clinic at Prince Hamza Hospital. You are asked to see a 53 year old Nour Beni Hassan with problems with urinary incontinence. Make an assessment of her problem and explore any patient cues.

CASE SCENARIO 4 PATIENT HISTORY

Nour Beni Hassan
53 years old
Married with 8 children

PC: Several episodes a day of urinary incontinence – embarrassing and `stopping me going out'

HPC: If picks up on the cue `stops me going out' – disclose concern about knowing where there are public toilets as if I need to go I need to go very quickly and can get caught out. Plus the embarrassment of having urinary incontinent episodes and the smell.

Long standing urinary incontinence since last vaginal birth 10 years age but worse in last year since periods stopped and feel a lump `down below' (vaginal)

If asked directly:
Urgency – need to go immediately when need toilet – get caught out often
Stress symptoms – leak urine if I cough, carry something heavy or laugh
Last period 14 months ago
Flushing
Vaginal dryness
No fever, dysuria

Patient Ideas: Thinks on the menopause and this has caused worsening lump in vagina that seems to have affected urinary continence

Patient concerns: Going out and stopping me going out due to embarrassment of getting caught and not knowing if a public toilet is available

Patient Expectations: Check this vaginal lump on examination and offer advice on what to do for her symptoms and offer treatment options

PMSH: 8 vaginal births – eldest 23 years old youngest 8 years old
Prolonged labour in first 2 children
Haemorrhoidectomy for haemorrhoids
Obesity and Diabetes
Leg swelling in summer months when the weather is hot

DH: Takes Furosemide 40mg in summer. Metformin 500mcg twice daily
SH: Drinks lots of caffeine – 5 cups of tea daily and 3 coffees
No smoking or alcohol consumption

CASE 4 SCENARIO – MIXED URGE AND STRESS INCONTINENCE

Feedback on consultation skills – did they find out patient perspective? Did they pick up the cue of the affect of the problem on the patient's social life?

Urge versus stress incontinence?
Urge incontinence – not being able to hold urine and get to toilet in time – sense of urgency (need to go suddenly) but unable to maintain bladder control
Stress incontinence due to weak pelvic floor muscles – secondary to childbirth (8 vaginal childbirths in this case) and if prolonged labour greater risk
Postmenopausal risk factor - `lump in vagina' ?uterine prolapse
Provoking factors (increase in intra-abdominal pressure) – coughing, laughing, obesity, sneezing, carrying heavy bags…

Need to rule out UTI – ask about frequency, fever, dysuria, pain…

Worth trying to stop use of Furosemide and reduce caffeine consumption in this case and advice on pelvic floor exercises