

# kidney news

Volume 2, Issue 1

March 2000

The problem is isolated microscopic haematuria.

1. Asymptomatic. Although Peter has symptoms of prostatism, what is discussed here is the same for any person with asymptomatic isolated microscopic haematuria. The fact Peter has symptoms of prostatism, and an enlarged prostate on examination, the management doesn't vary. He needs to see a urologist.
2. Isolated. Means absence of other significant urinary abnormalities. That is no proteinuria, or casts. If there is any other urinary debris apart from the haematuria, referral should be to a renal physician in the first instance.
3. Microscopic. Not seen by the patient's eye. Usually macroscopic haematuria implies large bleeding that is from a surgically associated urinary tract lesion – tumour, trauma, or stones in particular. Macroscopic isolated haematuria may require referral to a renal physician (usually requiring a renal biopsy) when urological investigations are fruitless; or the haematuria is associated with infection, haematological abnormality (eg. bleeding diathesis), or metabolic investigation of renal stone causes is necessary.

In this case, Peter, needs initial referral to a urologist because of the haematuria. The urologist will arrange for cytology, and IVU and renal tract ultrasound, and cystoscopy. If all these investigations are normal, or do not explain the haematuria; referral to a renal physician is necessary.

In Peter's case the urologist can also address the prostatism symptoms if Peter wants to have surgical management rather than medical management (eg. doxazosin or terazosin) – which he may not tolerate since his BP is low/normal.

## Case Study

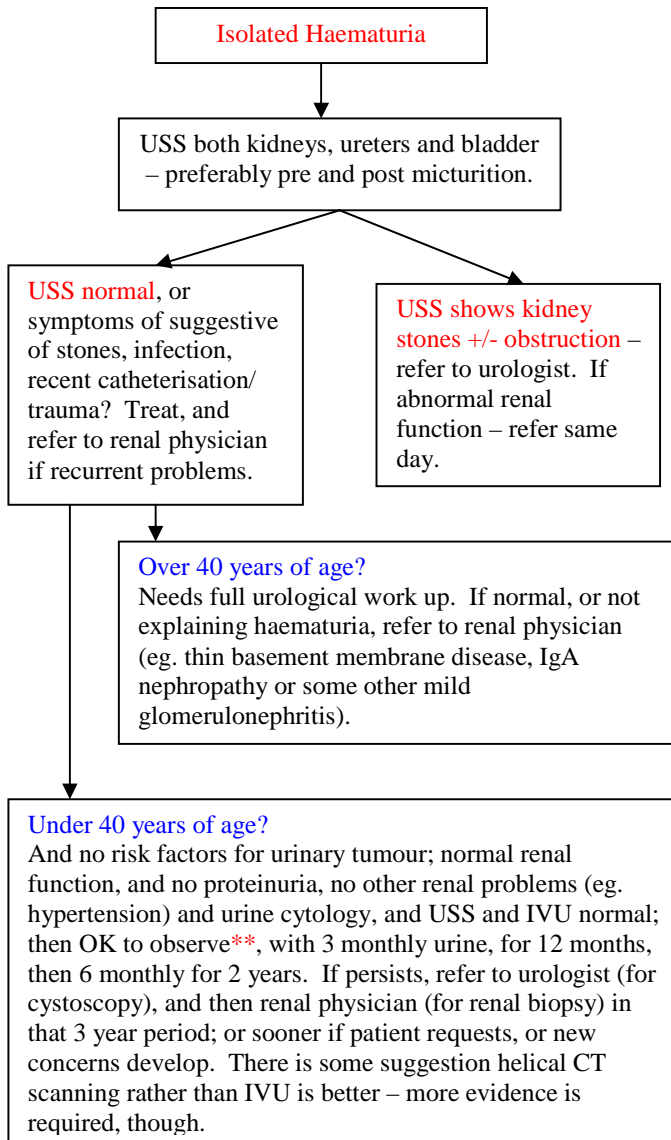
Peter, a 52 year old with no previous ill-health presents with symptoms of prostatism. System enquiry adds little else. Previous history adds no more. Only examination abnormality reveals large prostate on PR. BP 138/82. As part of the routine work-up you request MSU. Result is no protein, no WBCs, and 50/ccm RBCs. No casts, and no epithelial cells. A repeat MSU shows the haematuria persists, but 100/ccm.

What now?

## WHAT'S IN HERE THIS TIME?

- 1 Introduction
- 1 Contents
- 1 Case study – haematuria
- 2 Approach to the patient with haematuria
- 2 How to contact me, and my locum

It is generally accepted little pathology will be found in any person under the age of 40 years with isolated microscopic haematuria; and investigation for tumour must be undertaken for over 45 year olds. Note the 40-45 year old grey zone! The debate continues. Although there is adequate evidence to support the general approach below, we can argue over the under 40 year olds being over-investigated with this approach:



**\*\*Monitoring: Should include:**

1. MSU – for blood and protein.
2. Serum creatinine and urea for renal function.
3. cytology at 6 monthly intervals (if cystoscopy not done).
4. BP, and general health questions aimed at urinary symptoms – infections, pain, colour, odour, frequency etc.
5. If radiology normal – no value in repeating on a regular basis

## Dr David Voss ED

Specialist Physician  
Renal and Internal Medicine

### Rooms

15 Aberfeldy Avenue, Highland Park, Auckland

### Residence

13 Sprott Road, Kohimarama, Auckland 5

### Contact on cellular phone

021 664664

### Appointments

phone 09 5373578

### Facsimile

021 699664

### E-mail:

[kidney@clear.net.nz](mailto:kidney@clear.net.nz)

### Qualifications

BSc (Biochemistry, Otago) 1981

MBChB (Otago) 1984

FRACP 1992

MRCP(UK) 1993

### Interests

Investigation of renovascular disease and hypertension

Management of urinary tract infections

Investigation of urinary calculi

Investigation of proteinuria and haematuria

Investigation and management of impaired renal function.

Nutrition in renal failure