

The Urology practice at Valley Children's provides specialized care for infants, children and adolescents with genital and urological problems. In addition to pediatric urologists, the practice is staffed with dietitians, social workers and nurses. A urologist is on-call 24 hours a day for emergencies.

### Access Center

24/7 access for referring physicians  
(866) 353-KIDS (5437)

### Outpatient Referral

Referral forms online at [valleychildrens.org/refer](https://valleychildrens.org/refer)  
FAX: (559) 353-8888

### Urology Office Numbers

Main: (559) 353-6195  
FAX: (559) 353-6196  
Physician Line: (559) 353-6451

### Physician Liaison

(559) 353-7229

A pediatric urologist has completed a residency in urology, is certified by the American Board of Urologic Surgery and boarded in the sub-specialty of Pediatric Urology, and has completed additional training in a pediatric urology fellowship. In select situations, a urologist may have gained a lifetime of pediatric experience but started practice before such fellowships were available. For purposes of developing these guidelines, the following group definitions are used: infant (0–1 year), child (2–12 years), and adolescent (13–18 years).

- Undescended testicles and elective congenital hydrocele/hernia are optimally corrected in infancy or early childhood.
- Hypospadias: chordee, buried penis, COMPLEX congenital urologic conditions: epispadias, prune belly syndrome, urachal remnants are usually repaired in infancy or early childhood; the operation should be performed by a pediatric urologist.
- Complex congenital urologic problems (eg, duplex systems, ureterocele, bladder exstrophy, moderate or severe vesicoureteral reflux, posterior urethral valves) should preferably be managed by a pediatric urologist.
- Solid malignancies: childhood solid/cystic benign or malignant tumors of the bladder/prostate, kidney, testicles should be treated from the outset by a pediatric urologist in conjunction with a pediatric medical cancer specialist.
- Disorders of sexual development (ambiguous genitalia) conditions should be co-managed from the outset by the primary care pediatrician and a pediatric urologist. The management team should include a pediatric endocrinologist and a psychologist in consultation with the primary care pediatrician and pediatric urologist.
- Cystoscopic procedures in infants and children preferably should be performed by a pediatric urologist.
- A pediatric urology consultation should be considered when a child has prolonged, severe daytime voiding difficulty.
- A pediatric urologist should be involved in the care of children with spinal cord disorders (eg, spinal cord injuries, myelomeningocele).
- Infants or children with major urologic injuries should be stabilized at the nearest medical center and then transported to a pediatric trauma center.
- Infants or children with testicular torsion should be evaluated and operated on promptly at the nearest medical center.

When a urinary tract abnormality has been identified prenatally, a pediatric urologist should be consulted as a member of the fetal treatment team.

# Pediatric Urology Consultant Reference Guide

| Disease State                                | Suggested Work-up and Initial Management  | When to Refer  |
|--|---|--|
| Febrile UTI - boy/girl < 2 mo.               | Ucx, UA, Chem 7/Basic Metabolic Panel, Renal/Bladder Ultrasound and VCUG. Prophylactic antibiotics  | After Imaging Studies  |
| Febrile UTI - boy/girl 2-24 mo.              | Ucx, UA, Chem 7/Basic Metabolic Panel, Renal/Bladder Ultrasound and VCUG only if Renal/Bladder Ultrasound abnormal. Prophylactic antibiotics            | After Imaging Studies  |
| Primary Nocturnal Enuresis                   | Enuresis Alarm, DDAVP, Reassurance  | No Response to initial Rx, >6 yr. old                          |
| Diurnal Urinary Incontinence +/- UTI         | Ucx, UA, Renal/Bladder Ultrasound, Timed Voiding, Bowel Management, Prophylactic Antibiotics for recurrent UTI  | If imaging studies abnormal or no response to initial therapy  |
| Spina Bifida/Neurogenic Bladder of any cause | Renal/Bladder Ultrasound, VCUG, Chem 7/Basic Metabolic Panel  | Upon diagnosis   |
| Urinary Stones                               | CT A/P w/o contrast, KUB, UA, Ucx   | Upon diagnosis   |
| Microscopic Hematuria                        | UA, Ucx, random urinary calcium and creatinine (NL<0.18), +/- Renal/Bladder Ultrasound  | To Nephrology, Urology for abnormal ultrasound                 |
| Prenatal Hydronephrosis                      | Renal/Bladder Ultrasound, VCUG at birth. Repeat Renal/Bladder Ultrasound in 2wks (MAG-3 renal scan with Lasix at 1 month). Chem 7/Basic Metabolic Panel | Prenatal counseling for parents. Baby post-birth after studies |
| Hydronephrosis                               | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Any abnormality  |
| Multicystic Renal Dysplasia                  | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Prenatal counseling for parents. Baby post-birth after studies |
| Kidney Tumor                                 | CT A/P w/ AND W/o IV Contrast   | Immediately after confirmation                                 |
| Vesicoureteral Reflux                        | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Upon diagnosis   |
| Ureterocele                                  | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Upon diagnosis   |
| Ectopic Ureter                               | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Upon diagnosis   |
| Megaureter                                   | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Upon diagnosis   |
| Renal/Ureteral Duplication                   | Renal/Bladder Ultrasound and VCUG   | Upon diagnosis   |
| Frequency/Urgency w/o UTI                    | UA, Ucx. Timed Voiding, Bowel Management  | UTI, Sx. 2 mo, severe Sx                                       |
| Posterior Urethral Valves                    | Renal/Bladder Ultrasound, VCUG, Ucx, UA, Chem 7/Basic Metabolic Panel   | Upon diagnosis (Urgent)  |
| Hypospadias                                  | Renal/Bladder Ultrasound if opening is at or more proximal than penoscrotal junction. Endocrine workup if at least one testis is undescended            | Early Parental Counseling. At 6 mo. to plan for surgery        |
| Meatal Stenosis                              | Observe Urine Stream, will deviate laterally or upward/thin stream  | Upon diagnosis   |
| Urethrocutaneous Fistula                     | Observe Urine Stream  | Upon diagnosis   |

# Pediatric Urology Consultant Reference Guide

| Disease State              | Suggested Work-up and Initial Management  | When to Refer                                     |
|----------------------------|---|---|
| <b>Penis</b>               |   |   |
| Phimosis                   | Betamethasone cream 0.05 or 0.1% BID to gently stretched opening of the foreskin                              | Persistent symptomatic phimosis                   |
| Paraphimosis               | Circumferential compression to reduce edema, then pull foreskin forward while pushing in glans simultaneously | At occurrence or post reduction for possible circ |
| Chordee                    | Check for hypospadias   | Upon diagnosis                                    |
| Post-Circumcision Adhesion | Betamethasone 0.05% cream BID on gently stretched foreskin x 6-8 weeks. Push back on fat pad                  | No response to medical treatment                  |
| Ambiguous Genitalia        | Karyotype, endocrine w/u  | Upon diagnosis                                    |
| Micropenis                 | Endocrine workup. Avoid Circumcision  | After endocrine evaluation                        |

## When Not To Do Newborn Circumcision

Buried, concealed, inconspicuous penis. Penoscrotal fusion/webbed penis, penile torsion, micropenis, hypospadias, epispadias, chordee

## Testis/Scrotum

|   |  |   |
|---|--|---|
| Undescended Testis  | Imaging studies not necessary unless both testes are not palpable                        | Early Parental Counseling. At 6 mo. to plan for surgery   |
| Testis Mass   | Scrotal US w/Doppler. Tumor Markers (HCG, AFP, LDH, Testosterone)                        | At diagnosis or suspicion                                 |
| Testis Torsion  | ER referral for immediate scrotal US w/ Doppler. Pain Control                            | At Presentation (Emergent)                                |
| Torsion of testicular appendages (confirmed on US, testicular blood flow normal or increased) | Ibuprofen, 10mg/kg QIDx 2wks. Scrotal elevation. +/- ice packs. Light activity           | Persistent swelling or recurrent pain                     |
| Epididymorchitis (+ UA or Ucx)  | Scrotal US, Renal/Bladder Ultrasound, VCUG   | After studies   |
| Varicoceles   | Scrotal US. Observe if testes same size and pt asymptomatic                              | Testis size asymmetry, pain, visible or large varicoceles |
| Hydrocele (communicated or located)   | Scrotal/inguinal US if mass or testis not palpable. Treat constipation/asthma if present | 6 mo. if asymptomatic. At diagnosis if symptomatic        |

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|-------------------------|---|--|
| <b>Female Genitalia</b> |   |  |
| <b>Labia Fusion</b>     | Generally does not require treatment unless UTI/severe rash. Premarin cream 0.625 mg/g directly on the fused line ghs x 6 weeks | Not responding to medical Rx. H/O UTI or recurrent severe rash |

Note: If child is toilet-trained, renal bladder ultrasound should include before and after bladder voiding images.