AED Management of Suspected Renal Colic

Exclude AAA! (RCEM safety Guidance in over 50s)

Discuss with Middle Grade or Consultant to perform USS

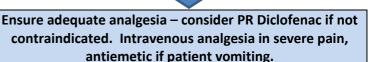


Ensure full set of observations taken, including temperature. Bloods including FBC, U&Es, LFTs, amylase and clotting. VBG (lactate) if pyrexial

Obtain WTU to confirm presence of dipstick haematuria (absence makes diagnosis very unlikely – discuss with senior



If signs of sepsis to follow sepsis pathway



If unable to get pain under control – urgent referral to Urology (between 9 – 17) or Surgeons (out of hours)



Review of Results and Patient

Ensure normal renal function on U&Es – if in renal failure needs urgent referral

Signs of sepsis (fever, tachycardia, hypotension, lactate >4) requires urgent referral

Ensure adequate pain control – if not requires urgent referral.



AEC Investigations

If conditions for AEC discharge met, book next day CTKUB* - ring Emergency CT (1435) to check availability and book a slot. Ensure details of appointment given to patient, along with AEC renal colic patient information leaflet. Provide TTO for analgesia. Document time slot in AEC diary and send patient to reception prior to discharge, where reception will create a slot in EDAEC for review the next day post scan. Ensure Renal Colic leaflet (on intranet) provided to patient and ensure patient reports to ED reception post scan



CTKUB Results

Patient returns to ED after CTKUB. Reception direct patient to ED AEC and inform AEC Doctor / Nurse.

Reception provide patient notes ICE discharge to be completed by Doctor

ED doctor to review patient and CTKUB report. If renal stone confirmed and no hydronephrosis can refer patient to Urology Stones Clinic. Complete Stone Clinic Referral Form and ask Reception to scan and e-mail to stone.clinic@sthk.nhs.uk. If CTKUB normal – not for Urology referral! Discuss with senior.



Renal Colic

A&E Attendance:

- 1) Exclude AAA (note RCEM Safety Guidance in over 50 age group)
- 2) Presence of dipstick haematuria (if absent then diagnosis very unlikely). Remember dipstick haematuria does not exclude AAA or other surgical diagnosis however!

Indications for immediate urology on call attendance & admission.

- 1) Fever or other signs of sepsis
- 2) Uncontrolled pain or requiring repeat opiate analgesia

Initial investigations:

- 1) WTU
- 2) U&E / FBC

Imaging:

Unenhanced CT KUB (this is a low dose CT not sensitive enough to exclude AAA)

<u>Unless</u> recurrent stone presenter. Then KUB x-ray & USS kidneys will suffice especially if young female and CT KUB has been performed within previous 12 months.

Timing of imaging:

Immediately from A&E where possible during working hours and also weekend daytime.

Otherwise next day as per current protocol (A&E arrange for patient to re-attend)

Remember to document this in the AEC diary and provide patient with a card to book in as a reattender Please note that AEC has 2 fixed time slots for CTKUB and 2 for USS – please refer to the diary for this

Unless sepsis - urgent (day or night) USS or CT to confirm hydronephrosis and need for immediate intervention.

AEC reviews & Documentation

Before discharge on the first attendance, send the patient reception to confirm their appointment slot in AEC in booked. This enables the receptionists to create a set of patient notes for their return the next day. When the patient returns post scan reception should direct the patient to ED AEC and inform the AEC Dr / Nurse to ensure timely review. An ICE discharge needs to be completed.

Discharge plan for confirmed <u>ureteric</u> calculus:

- 1) Simple analgesia. NSAID (unless C/I)
- 2) Tamsulosin 400mcg daily (unless C/I) Indicated for lower ureteric stone
- 3) No role for antibiotics (stone and infection = admission)

Follow up arrangements for those not requiring admission:

- Normal CT no urology!
- 2) Imaging confirms stone / hydronephrosis complete **proforma** for urgent stone clinic appointment.