



West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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Dear Andrew

RE Official Information Act request WCDHB 9644

I refer to your four emails dated 25 November 2021 to the Ministry of Health which they subsequently transferred to us on 9 December 2021 requesting the following information under the Official Information Act from West Coast DHB. Specifically:

1. *Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR)*

Depending on the nature and seriousness of the condition, our procedural guidelines are to request acute urology assessment by a speciality (either general surgeon or urologist, depending on severity) if the patient has signs of sepsis (e.g. fever) after any urologic procedure (especially post-TRUS prostate biopsy).

Referral for a non-acute urology assessment by a specialist is the guideline protocol if the patient has:

- persistent macroscopic haematuria resulting in a haemoglobin decrease of greater than 10 g/L.
- flow reduction symptoms persist.
- bladder overactivity symptoms persist,

and to seek specialist urology service phone advice if ongoing concern or considering starting finasteride or tranexamic acid in a patient with haematuria.

The Urology service accepts referrals from any medical or nurse practitioner, including private specialists, rural nurse specialists and practice nurses, using processes that ensure fairness and equity.

Acute urinary retention is initially managed by the emergency department or inpatient medical and surgical teams for patients at the Te Nikau facility. A referral to urology services is made for further management after the initial treatment.

See **Appendix 1** (attached) for guidelines for general practice and emergency department for patients presenting with post-operative urinary retention issues.

2. Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain”

There are no service specific guidelines for the management and prevention of post-surgical pain that can answer this question. The management of acute and postoperative pain is a core role of anaesthetists. These specialists discuss pain management with individual patients and develop a plan as part of the overall anaesthesia care. Prevention of post-surgical pain may be mitigated through a wide range of anaesthetic and analgesic medications which may include local anaesthetic agents, strong opioid based medications and a large range of non-opioid drugs. Early persistent post-surgical pain is managed collaboratively between anaesthesia and surgical services. Persistent or chronic pain after surgery requires a multidisciplinary approach through a chronic pain service and management is dependent on the type and location of surgery and severity of pain relating to each individual patient in their own right.

Given the extremely wide range and scope of clinical treatment options that may be used in response to individual cases in all of the various surgical disciplines, we are unable to refine this further, as this is the subject of many years of study and training of doctors, nurses, and allied health professionals in their respective surgical and medical fields. We therefore decline to provide further information under Section 18 (f) of the Official Information Act i.e. *“... that the information requested cannot be made available without substantial collation or research.”*

3. Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation”

An individualised approach is taken when providing care to a person who has attempted suicide. This is because we need to respond to the diverse reasons people have for attempting suicide, different life circumstances, levels of whānau support, and their differing needs. For instance, some suicide attempts occur in the context of a major life event and there may be less ongoing risk afterwards, compared with someone who has constant symptoms of severe depression or psychosis.

However, in general the following steps are taken:

- Any potentially life-threatening injuries or conditions are given immediate priority
- An assessment is then undertaken which includes the person’s clinical presentation, circumstances, level of risk, and wishes
- A plan is established in conjunction with the person and their whānau
- Information on managing mental illness and/or addictions, and support services available, is then provided.

The plan developed for an individual may or may not include follow up by Specialist Mental Health Services (SMHS), but SMHS will be involved in a person’s ongoing care if they show signs of moderate to severe mental illness. This could take the form of an inpatient admission, or outpatient care in the community. Care for mild to moderate mental illness is available through primary care and NGO providers.

4. Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation”

We do not have separate guidelines or management pathways that differentiate for subtypes of constipation. Classification into slow transit constipation, normal transit constipation and defecatory disorders requires specialist assessments (Gastroenterology or Colorectal Surgery) and would be beyond the scope of our primary care teams.

There are community health pathway guidelines covering constipation and include referral from primary care for child and adult patients. Constipation has a vast range of causes and importance is placed on identifying “red flags” which may indicate an underlying serious illness. See **Appendix 2**

(attached) for generic guidelines for general practice and emergency department for child and adult patients presenting with constipation.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Tracey Maisey', with a stylized flourish extending to the right.

Tracey Maisey
Executive Director
Planning, Funding & Decision Support

Appendix 1: Guidelines for General Practice for Postoperative Urologic Complications

Guidelines for the most common complications presenting to general practice or the emergency department after [urologic procedures](#) are as follows:

1. Haematuria

1. Assess whether the bleeding is mild (rose-coloured urine) or severe (dark red urine, often with clots), and whether there are signs of severe anaemia. Bleeding is common in the first 6 weeks after urologic intervention, especially TURP.
2. If signs of urinary retention, manage according to the [Acute Retention](#) pathway, using a 3-way catheter.
3. Consider checking the haemoglobin level.
4. Stop or reduce anticoagulants if able to do this safely.
5. If persistent macroscopic haematuria resulting in a haemoglobin decrease of greater than 10 g/L, request [non-acute urology assessment](#).
6. If ongoing concern, or if considering starting [finasteride](#) or [tranexamic acid](#), seek [urology phone advice](#). Advise the patient:
 - to decrease physical activity and increase fluids.
 - that it may take a few weeks to settle.
 - to see their general practitioner if it is not improving over 5 to 7 days.

1. Infection

1. If the patient has signs of sepsis (e.g. fever) after any urologic procedure (especially post-TRUS prostate biopsy), request [acute urology assessment](#).
2. Dysuria may be due to urethral irritation after the procedure – consider urinary alkalinisers, e.g. [citrate sodium anhydrous + citric acid anhydrous + sodium bicarbonate + tartaric acid](#) (Ural sachets).
3. If urinary alkalinisers do not relieve the symptoms, manage according to the [UTI in Adults](#) pathway.

2. Flow Reduction

1. Rule out a urinary tract infection.
2. Severe flow reduction suggests a significant obstruction. If there is a severe feeling of incomplete emptying, or an inability to pass urine, see [Acute Urinary Retention](#) pathway.
3. If flow reduction is associated with significant frequency (small volume voiding) and urgency, consider overactive bladder (especially if there is urinary leakage or [incontinence](#)).
4. If symptoms persist, request [non-acute urology assessment](#).

3. Bladder overactivity

Frequency, urgency, and mild urge incontinence are common following urinary tract surgery, and will mostly settle with time and reassurance.

1. Rule out a urinary tract infection and check for urinary retention.
2. Consider using [solifenacin succinate](#), which may help symptoms. Slowly increase the dose due to medication side-effects.
3. If symptoms persist, request [non-acute urology assessment](#).

4. Catheter management problems – Post-procedure

The most common problems are:

- leakage.
- blockage and encrustation

Management and referral:

1. Clearly [document key information](#).
2. Make a clear plan for catheter removal or change:

- Remove urinary catheters as soon as possible, although this will vary according to the circumstances.
 - If retention was precipitated by an acute event, e.g. constipation, medical illness, or surgery, remove catheter in 3 to 5 days. See [Catheter Change or Trial of Void](#) pathway.
 - If prior symptoms of [benign prostatic hypertrophy](#), treat with an [alpha-1-blocker](#) and arrange a [trial of void](#) in 2 to 3 days.
 - If the catheter is removed prematurely, consider whether [trial of void](#) is appropriate or if catheter should be reinserted.
 - Organise prophylactic antibiotic supply if indicated for future catheter change.
3. Manage possible post-procedure problems:
- Leakage around the catheter may be caused by catheter blockage, bladder spasm, or straining at stool.
 - [Blockage and encrustation](#)
 - [Catheter-acquired UTI](#)
 - Treat a UTI in a catheterised patient if fevers, pain, systemically unwell. Change in appearance or odour of the urine is not an indication for antibiotics. Change of catheter is not required.
 - When an organism has been identified, check the [local antimicrobial susceptibility patterns](#).
 - If patients with an indwelling catheter (IDC) develop haematuria or a marked change in urinary symptoms, consider other urological problems including bladder cancer.
4. Arrange change of catheter, catheter care, and provision of catheter supplies via [district nursing](#).
5. Give the patient [written catheter care information](#).
- Request [acute urology assessment](#) if possible urethral trauma.
 - If unable to insert a urethral catheter in general practice, e.g. due to time or equipment limitations, arrange insertion via the emergency department or district nursing providers that can insert catheters acutely, depending on skill and experience
 - Seek [acute urology advice](#):
 - before urethral catheterisation if urethroplasty or radical prostatectomy within the preceding 6 weeks.
 - if catheter insertion is unsuccessful.
 - If recent vaginal surgery, seek [acute gynaecology advice](#) or [acute urology advice](#).
 - Request [district nursing services](#) for catheter care and provision of catheter supplies.

APPENDIX 2: Guidelines for General Practice for Constipation

Guidelines for adults and children presenting to general practice for constipation are as follows:

1. Constipation in Adults

Red Flags

- Weight loss
- Abdominal mass
- Iron deficient anaemia
- Blood mixed with stool
- Palpable or visible rectal mass

Background: About Constipation

Constipation is difficult to define. It may relate to one or more of the following:

- infrequent passage of stools
- difficulty in passing a stool
- passage of hard stools
- Most patients with idiopathic constipation are otherwise asymptomatic.

Assessment

1. History – assess constipation and associated features.
 - Frequency and consistency of motions, presence of [alternating diarrhoea](#)
 - Blood, lumps, pain, soiling of underwear
 - [Medications](#)
 - Symptoms of [hypothyroidism](#) or depression
2. Assess for red flags and consider secondary causes.
3. Examine abdomen and rectum. Consider bimanual pelvic examination.
4. Investigations
 - Plain abdominal X-rays are generally not useful in the diagnosis of chronic constipation.
 - Bloods are not usually necessary but will depend on differential diagnosis.
 - Further investigations, including [colonoscopy](#) or CT colonography, may also be indicated depending on likely differential diagnosis.

Management

1. If red flags are present, consider referral according to the [Colorectal Symptoms](#) pathway.
2. Patient education is important to prevent laxative dependence.
 - Avoid [constipating drugs](#) if possible.
 - Advise about [simple measures](#) to relieve and prevent recurrence of idiopathic constipation.
3. Medications
 - Consider an initial trial of [docusate + senna](#) orally 50 mg + 8 mg, 1 to 2 tablets at night.
 - If constipation is due to opiates, see the management of [constipation](#) associated with opioid use.
 - If hard stool is filling the rectum, consider suppositories or enemas:
 - [Glycerol suppositories](#)

- [Bisacodyl suppositories](#)
 - [Micolette or Microlax enema](#)
 - [Phosphate enema](#) – should usually be avoided in the elderly or those with chronic kidney disease as there have been cases of phosphate nephropathy and acute kidney injury, some of which have been fatal. However, if non-phosphate enema products are not available, phosphate enema may be used with precautions, including ensuring adequate hydration and minimising the number of doses used.
 - Other options include:
 - [Bulk-forming laxatives](#)
 - [Stimulant laxatives](#)
 - [Osmotic laxatives](#)
 - [Stool-softening agents](#)
4. [Pregnancy](#)
- If dietary and lifestyle changes fail to control constipation in pregnancy, moderate doses of poorly absorbed laxatives may be used.
 - A bulk-forming laxative should be tried first.
 - An osmotic laxative, such as [lactulose](#), can also be used.
 - [Bisacodyl](#) or [senna](#) may be suitable, if a stimulant effect is necessary.

Request

If any red flags, request [non-acute general surgery assessment](#).

2. [Constipation in Children](#)

Background: About Constipation in Children

- Constipation is the difficult, delayed, or distressing passage of stools. It is a common problem, occurring in up to 30% of children.
- Childhood functional constipation may present with:
 - 2 or fewer bowel motions per week
 - Large stools in the rectum palpable on abdominal examination
 - Retentive posturing and withholding behaviour
 - Painful defecation or hard bowel movements
 - Large diameter stools
 - Soiling
- The child may also be irritable, show malaise or lethargy, and have decreased appetite or early satiety, symptoms which often resolve after the passage of a large stool.
- Constipation can be a significant risk factor for urinary tract infections (UTIs), urinary frequency and urgency, and recurrent abdominal pain.
- It can be present despite a daily bowel motion – where daily stool is reflective of overflow from a rectum filled to capacity.
- Soiling is caused by soft stool leaking around the hard stool of constipation. It is often referred to as overflow or "sneaky poos".
- Encopresis occurs when a child is not constipated and is aware of passing stool but passes stools somewhere other than on the toilet or into a nappy.
- It is normal for babies aged younger than 1 year to vary greatly in the frequency and consistency of bowel motions:

- Breastfed babies may defecate following each feed but some breastfed babies only defecate every 7 to 10 days.
- Formula-fed babies will usually defecate at least every 2 to 3 days.
- Babies can appear distressed for some time prior to a bowel motion. Straining, facial flushing, or crying for a short period before passing soft stool can be normal in infants and is not constipation.
- Children aged older than 1 year usually defecate at least every 2 days.
- Constipation in childhood is almost always functional.
- Organic problems are rare and are usually only sought if standard treatment fails or in the setting of obvious abnormality, e.g. anorectal anomaly, neurological abnormality. Medical causes could include Hirschsprung's disease, slow colonic transit, coeliac disease, hypothyroidism, and hypercalcaemia.

Assessment

1. [Take a history](#).
2. Examination:
 - Weight and height.
 - Palpation of abdomen. Examination is often normal but a palpable stool in the descending colon is suggestive of faecal impaction.
 - [Inspection of anus](#), especially in infants.
 - Check spine for deep cleft or tuft of hair and lower limb neurology.
 - Rectal examination is not necessary in general practice.
3. Consider [faecal impaction](#) if:
 - palpable mass.
 - soiling or loss of awareness.
 - abdominal pain and vomiting.
 - urinary retention.
 - lack of result or increasing abdominal pain when using maintenance laxative therapy.
4. Investigations are not necessary as diagnosis is made by history and examination.

Management

1. Provide [education](#) and arrange follow-up and support to achieve patient compliance.
2. General measures:
 - [Adequate fluid intake](#)
 - Adequate exercise
 - [Adequate fibre](#)
 - Fruit juice containing sorbitol (e.g. prune, pear, or apple) or kiwifruit (e.g. KiwiCrush), may be sufficient to soften the stool. Do not give fruit juice to infants aged younger than 1 year.
 - [Regular toileting](#)
3. If a child is symptomatic or has longstanding constipation, abdominal pain, or soiling, start [maintenance laxatives](#) as well as general measures.
4. If faecal impaction, consider [disimpaction](#).
5. [Anal fissures](#).
6. Arrange [follow-up](#).

Request

- Request [non-acute paediatric medical assessment](#) if:
 - suspected organic cause.
 - faecal impaction which has not responded to disimpaction treatments above.
 - the child has been receiving adequate doses of medication but treatment is not effective.
- In your referral, include information on symptoms, duration of symptoms, and treatments trialled.

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