Pediatric Urology

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
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

Pediatric Urology Consultant Reference Guide

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.

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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

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Penis		
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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Disease State	Suggested Work-up and Initial Management	When to Refer
Female Genitalia		
Labia Fusion	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.