BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 STRATEGY FOR TREATMENT OF ANDROLOGY CONDITIONS

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This document is a pragmatic approach to the management of andrology conditions and provides guidance for areas and units with a significant level of COVID-19.

If you are working in a locality where COVID-19 does not have a major impact on your routine hospital work, normal diagnostic and treatment pathways should be maintained.

PRINCIPLES OF CARE

Andrology conditions present no significant risk to life, but they can impact significantly on quality of life (QoL).

Inevitably, they will have a lower priority during the acute and recovery phases from any wave of COVID-19 infections. The aims should be to:

- Minimise the risk of the underlying clinical issue getting worse, whilst awaiting definitive treatment;
- Keep patients well informed of the need for a change in their expected treatment timeline; and
- Ensure that patients whose treatment is delayed do not get "lost" in the system.

GENERAL RECOMMENDATIONS FOR SURGERY

It is important to consider:

- Alternatives to general anaesthetic where possible; and
- Temporising procedures until definitive surgery can be safely offered (e.g. urethral dilatation and CISC if awaiting urethroplasty).

Treatment categories may be influenced by the following factors:

- A change in the patient's condition, requiring re-prioritisation of category (or the partner's fertility status in cases of subfertility);
- Age, co-morbidities and risk factors which determine the timing of elective treatment; and
- The need to ensure that patients are fully aware of the risks associated with COVID-19 infection in the peri-operative period.

EMERGENCY CASES (NHS CATEGORY 1a/1b)

Conditions include:

- Priapism;
- Penile fracture;
- Infected/eroded penile implant;
- Acute testicular torsion;
- Fournier's gangrene;
- Acute retention of urine (or impending retention ± evidence of renal impairment) due to urethral stricture;
- Peno-scrotal abscess; and
- Onco-TESE (simultaneous radical orchidectomy with surgical sperm retrieval).

These cases should continue to be treated as time-sensitive urgent problems, on-call, as per standard guidelines.

HIGH PRIORITY (NHS CATEGORY 2)

These are clinically urgent/time-sensitive issues, including:

- Delayed penile implant for prolonged ischaemic priapism;
- Skin graft reconstruction following Fournier's gangrene;
- Urgent surgical sperm retrieval (SSR) in azoospermic men prior to chemotherapy; and
- Eroded penile implant causing pain (but not septic).

Ideally, these cases should be treated within 4 weeks. * See endnote

INTERMEDIATE PRIORITY (NHS CATEGORY 3)

These are clinically important conditions with a significant impact on activities of daily living (ADL), including:

- Painful, severe phimosis;
- Urethral stricture with a suprapubic catheter in situ; and
- Urethral strictures with significantly worsening LUTS, Qmax less than 5 ml/sec or recurrent UTIs.

Ideally, these cases should be treated within 3 months. * See endnote

LOW PRIORITY (NHS CATEGORY 4)

Tier 1

Conditions not affecting activities of daily living (ADL) but time-sensitive, including:

- Early signs of penile implant erosion (no pain or sepsis);
- Urethral stricture with flow rate less than 10 ml/sec; and
- Surgical sperm retrieval (SSR) in infertile men with female partner within 1 year of funding elapsing, or low ovarian reserve (anti-Müllerian hormone, AMH), dependent on return of assisted conception services.

Ideally, these should be treated within 3 to 6 months. * See endnote

Tier 2

Conditions not affecting activities of daily living (ADL) and not time-sensitive, including:

- Mild phimosis;
- Hydrocele / routine scrotal surgery;
- Vasectomy;
- Peyronie's surgery in men with functional impact;
- Penile implant surgery; and
- SSR in men with a young female partner and normal ovarian reserve (anti-Müllerian hormone, AMH).

Aim for treatment within 6 to 18 months. Patients are NOT at risk of clinical harm if delayed longer. * See endnote

OUTPATIENTS

You will need to consider:

- Reconfiguration of services to minimise hospital visits;
- Use of **face-to-face** consultation where physical examination is essential;
- Use of **video or telephone** contact, depending on the available technology and resources; and
- Use of **patient-generated digital photos** – you must initiate processes to allow safe transfer & receipt, via e-mail or other purpose-built platforms. This will require active co-operation with your local IT and governance structures.

GENERAL SUMMARY

- You will need to develop new guidance and protocols for treatment and triage of andrological conditions; and
- Patient pathways will also need specific attention in order to rationalise patient visits to hospital.

Endnote *

The suggested timelines are a guide only and are subject to local, regional and national factors. These include (but are not limited to) access to theatres, staff availability, backlogs, on-going oncological diagnostics & treatment, competing "benign" conditions and further restrictions due to resurgent COVID-19 infection