

key points

SELECTED BY

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AUR is defined as the sudden inability to pass urine.

The patient presents with a history of reducing urinary output, which may have stopped for hours before seeking medical attention. This is associated with lower abdominal distension. Retention in women is relatively rare. Generally, once the underlying problem is identified and treated, successful voiding is achieved in the majority of cases.

AUR is more than ten times more common in men than

women. In men it tends to occur in the elderly and the risk of AUR is higher in men > 70 years. The causes of AUR in men can be divided into precipitated (induced by an event) or occurring spontaneously. These can be further divided according to the mechanism i.e. obstructive, neurological and myogenic. Spontaneous AUR is caused by progression of BPH leading to a mechanical obstruction of the bladder outlet. It is the most common cause of AUR.

The typical presentation of AUR is a patient complaining

of a sudden inability to urinate associated with progressive abdominal distension which is usually painful. The pain increases in intensity with increasing distension of the bladder. An abdominal examination should reveal a distended bladder which can be confirmed by a dull percussion note. A digital rectal examination is vital to gain information on prostatic enlargement (either benign or malignant), faecal load in rectum, anal tone and presence of other masses.

Urinalysis and culture should be carried out on a sample

obtained after catheterisation to rule out infection. Renal function should be assessed to see if there has been damage to the upper tracts. This is more common in chronic urinary retention. It is better not to perform a PSA test in this situation as it will invariably be raised due to distension of the bladder and catheter insertion. If catheter insertion fails then a urological consultation is required for insertion of a suprapubic catheter.

Admission is essential if the patient is: unwell with urosepsis;

has abnormal renal function needing further investigation and fluid monitoring; has acute neurological problems; or is unable to take care of the catheter. Trial without catheter needs to be planned and the ideal time to do this is within 2-3 days so that the patient can pass urine naturally.

Identifying risk factors for AUR and referring high-risk

patients to a urologist, especially for assessment of prostatic volume and flow rate, and early treatment with alpha-blockers and 5 α -reductase inhibitors can improve symptoms as well as reduce the incidence of AUR.