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CHAPTER 3. SPINAL CORD INJURY (SCI) CARE STANDARDS

3.01 POLICY

The Chief, SCI Service, is responsible for establishing clinical practice guidelines for major aspects of SCI care.

3.02 CREDENTIALING/PRIVILEGING

a. Credentialing and privileging activities in the SCI Service will conform to policies adopted by Department of Veterans Affairs (VA) Central Office.

(1) All clinical staff will be appropriately credentialed/privileged through the medical center and VA approved credentialing/privileging process.

(2) SCI chiefs will be responsible for personally reviewing and sighting evidence of credentials verification prior to the appointment of any physician assigned to SCI Service.

(3) Any and all privileges requested by an SCI clinician will be routed through the Chief, SCI Service, for review, concurrence, and/or recommendations.

b. The Chief, SCI Service, will use information collected in the SCI Quality Improvement (QI) process for reviewing and/or revising staff clinical privileges as governed by appropriate public law and Veterans Health Administration (VHA) regulations.

3.03 CLINICAL PRACTICE GUIDELINES FOR UROLOGY

a. Urinary Diversion

(1) Experience derived from long-term follow-up of SCI veterans points to the conclusion that urinary diversion is seldom indicated.

(2) Any major surgical procedure on the urinary tract of SCI veterans should be performed only at VA SCI centers, unless an emergency situation contraindicates transportation of the patient.

(3) No urinary diversion surgery should be undertaken without previous discussion and concurrence of the Chief, SCI Center. Within 2 weeks post-surgery a written report containing pertinent patient and medical information will be sent to the Director, Spinal Cord Injury Programs (117F), VA Central Office, 810 Vermont Avenue, NW, Washington, DC, 20420, through the Associate Deputy Chief Medical Director (ADCMD) for Clinical Programs (11).

b. Urodynamic Laboratories

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(1) The Chief, SCI Service, is responsible for the planning and administration of the urodynamic laboratory and will provide consultation to other services who request urodynamic studies. The clinical and laboratory records obtained from such examinations will be made an integral part of the patient's treatment file.

(2) All patients shall have a complete urodynamics study during the initial admission. This will include cystometrogram (CMG) with simultaneous sphincteric pressure measurement under fluoroscopy and/or rectal sonography. If concurrent fluoroscopy is not available, separate voiding cystourethrogram (VCU) will be done. A physician

competent in urodynamics/uroradiology shall be present for consultation during the study. Urodynamic studies shall preferably be done 3 to 6 months after injury, or after return of bladder activity, whichever comes first.

(3) An urodynamic workup shall be repeated 1 year after injury, and thereafter, when indicated, except that a complete urodynamic workup shall be performed no less than every 3 years even when patient is asymptomatic. Indications for an urodynamic workup include:

(a) Frequent symptomatic urinary tract infections (UTI), i.e., more than two times per year;

(b) Progressively high residuals;

(c) Autonomic dysreflexia;

(d) Hydroureter, hydronephrosis;

(e) Progressive bladder trabeculation;

(f) New onset vesicoureteral (VU) reflux;

(g) New onset of lithiasis; and

(h) Decreased renal function.

c. Urolithiasis

(1) Frequent and recurrent urinary lithiasis requires systematic and periodic evaluation of the spinal cord injured for stone formations. Uroendoscopy and lithotripsy have markedly decreased the indications and need for open surgery.

(2) No invasive surgical procedures should be undertaken without previous discussion and concurrence of the Chief, SCI Center. Within 2 weeks of post-invasive surgery, a written report containing pertinent patient and medical information will be sent to the Director, Spinal Cord Injury Programs (117F), 810 Vermont Avenue, NW, Washington, DC, 20420, through the ADCMD for Clinical Programs (11).

d. The fact that there is a sixteen-to-twenty fold increased incidence of bladder tumors in SCI veterans, especially in the presence of an indwelling catheter, necessitates a constant vigilance in those patients. Emphasis is placed on monitoring of urinary cytology and, when indicated, cystoscopy and bladder biopsy.