History Taking for Acute Urinary Retention

The majority of patients presenting with retention will be unable to pass urine, have abdominal pain and have a palpable suprapubic mass (**Acute retention**).

Some, who have **chronic retention**, may not have pain and a small number will be found to be in retention incidentally on scan.

The key to the history taking is to **identify the underlying cause**:

Prostatic enlargement: Symptoms of bladder outflow obstruction: Hesitancy, poor stream, intermittent flow, incomplete emptying, terminal dribbling, nocturia.

Infection: Preceding frequency, urgency, dysuria, visible haematuria

Constipation: Usually on the background of obstructive lower urinary tract symptoms.

Clot: Visible haematuria +/- clots usually precedes retention.

Post operative: Epidural and spinal anaesthesia are particularly prone to inducing retention.

Neurological disorder: Ask about lower limb weakness, paraesthesia, saddle anaesthesia, faecal incontinence.

Consider the following as possible causes:

Spinal: back pain (disc prolapsed), spinal injury, surgery, metastases, abscesses.

Pelvic nerve injury: previous pelvic surgery esp AP resection for low rectal tumour. Pelvic trauma, damage during childbirth – instrumentation, prolonged second stage of labour.

Medical conditions: Diabetes – loss of autonomic nerves. MS can present as retention, always consider this important diagnosis particularly in women who present in retention. Shingles can cause retention so ask about painful rashes.

Medication: Anticholinergics for over active bladder (tolterodine, oxybutynine, solifenacin), opiates (inc tramadol), antihistamines (cetirazine), tricyclic antidepressants (amitriptyline).