

## U

**ULCER PCR**

Specimen required: **Dry swab for PCR**  
 Department: Referred test  
 Note: There are several PCR tests now available for Ulcers depending on the site of infection.

Non-genital e.g. eye	Herpes I/II PCR Adenovirus
Genital may include	Herpes I/II Treponema pallidum Haemophilus ducreyi Lymphogranuloma venereum Granuloma inguinale

**UNSTABLE HAEMOGLOBIN**

See HAEMOGLOBINOPATHY STUDIES

**URATE**

See URIC ACID

**UREA BREATH TEST**

See HELICOBACTER BREATH TEST

**UREA**

Specimen required: **Serum (1 x SST)**  
 Department: Biochemistry  
 Reference range: 2.5 - 9.0 mmol/L > 60 years  
 2.5 - 8.0 mmol/L < 60 years  
 Interpretation: HIGH – Renal insufficiency (e.g. CCF, intrinsic renal disease, urinary tract obstruction),  
 gut bleeds.  
 LOW – Liver disease, overhydration.

**UREAPLASMA**

See PCR COLLECTION FIRST VOID URINE

**URIC ACID ( UA ) – SERUM**

Specimen required: **Serum (1 x SST)**  
 Department: Biochemistry  
 Reference range: Male: 0.20 - 0.42 mmol/L  
 Female: 0.15 - 0.36 mmol/L  
 Interpretation: HIGH - "Hyperuricaemia" – not necessarily gout. Renal insufficiency.  
 LOW - Uricosuric drug, renal tubule defect.

**URIC ACID – URINE**

Specimen required: **Urine – 24 hour collection with NO PRESERVATIVE.**  
 Department: Biochemistry  
 Reference range: < 4.0 mmol/day  
 Interpretation: HIGH - Urate overproduction.  
 LOW - Urate underexcretion.

**URINE - ALDOSTERONE**

Specimen required: **Urine – 24 hour collection with NO PRESERVATIVE.**  
 Department: Referred test

**URINE COPPER**

See COPPER

**URINE PROTEIN ELECTROPHORESIS (BENCE JONES PROTEINS)**

Specimen required: **Urine. (Early morning for screening; 24 hour for monitoring treatment).**  
 Department: Biochemistry  
 Interpretation: In multiple myeloma and light chain disease, abnormal proteins may be detected.

**URINE FOR CYTOLOGY**

See CYTOLOGY

**URINE FOR AFB / TB / MYCOBACTERIOLOGY**

See TUBERCULOSIS

**URINE FOR MICRO CULTURE & SENSITIVITY ( MC&S )**

Department: Microbiology

Specimen collection:

**1. Midstream urine: mid stream clean catch specimens are required.**

**Female:** The labia are separated with one hand. If needed a sterile water wipe can be used to prepare labia. Keeping the labia apart, the midstream of the urine is collected into a sterile container.

**Male:** If needed, retract the foreskin, clean the area with a sterile water wipe as required. The midstream of the urine is then collected into a sterile container.

**2. Paediatric urine: mid stream clean catch specimens are optimal if feasible.**

With cooperative toddlers, a 'clean catch' urine specimen is preferred. For babies and smaller children, a collecting bag might have to be used over the child's genitalia and a nappy put on and the child given a drink. The bag should be checked frequently so that it can be removed immediately it is seen to contain urine. The urine is then transferred into a sterile yellow capped container for analysis.

**3. Catheter specimens:** Specimens must be collected from the catheter itself using a sterile syringe, not the collecting bag. If a catheter is being changed, the specimen is taken after insertion of the new catheter, not from the old one. Once a catheter is permanently removed, urine is checked for infection by collecting an M.S.U. 24-48 hours after removal. Indwelling urinary catheters universally become colonised with coliform and other bacteria. Bacteria cultured from IDC urine generally represent colonisers rather than pathogens and results should be interpreted with caution.**4. Ileal conduits:** Ileal conduit urine specimens are likely to be contaminated by colonising bacteria. Bacteria cultured from these specimens generally represent colonisers rather than pathogens and results should be interpreted with caution. Bag specimens are not acceptable as they are contaminated by stomal organisms. A catheter introduced aseptically into the stroma will result in a more reliable specimen.

- Comment:**
- (1) All urines are examined using the Iris automated urine microscopy analyzer. Leucocytes and red cells are reported as the number per litre. Any significant findings on microscopy are reported. When red cell morphology is required, a fresh specimen of urine should be delivered to the Laboratory as soon as possible. Culture results are expressed as number of bacteria per litre of urine. Cut-off values differentiate between bacteria that are likely to represent pathogens and those that are likely to represent contaminants. Contamination of urines may also be indicated by the presence of squamous epithelial cells.
  - (2) Significant bacteriuria occurs when a culture result is  $>10^8$ /L. In older asymptomatic patients, treatment may not be warranted initially. Occasionally, smaller numbers may be relevant in symptomatic ambulatory patients. In pregnant women, any quantity of Group B Streptococcus may be associated with a likely carrier status at delivery.
  - (3) **Where microscopy indicates no evidence of infection, a report will be issued on the same**

day. Where subsequent significant bacterial growth occurs, an amended report will be issued.

Note:

Urines should be refrigerated after collection as bacteria can multiply exponentially and quantitative results will be potentially inaccurate.

## UROBILINOGEN

See PORPHYRIN SCREEN

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