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Lowell General Hospital

Department of Family Medicine November Meeting Minutes

Date: November 14, 2025
Time: 7:00am
Attendees: Dr. Sangita Pillai, Dr. Christen Fragala, Dr. Malina Holmes, Dr. Chong So, Dr. Cara Marshall, Dr. John Ragucci, Dr. Jennifer Wolf, Dr. Roberto Larios, Dr. Marian Younge, Dr. Patrick O'Neil, Dr. Catherine Trinh, AnneMarie Aquino, RN, Clinical Manager, Mary Retman, RN, Quality Improvement Specialist, Maxine Miller
Guests: Dr. Robert Edelstein

I. Call to Order

- Dr. Pillai called the meeting to order at 7:00am.

II. Approval of Minutes

- The department approved the previous minutes of October with edits that Dr. Pillai emailed about.

III. New Business

- Dr. Pillai mentioned an issue that someone in the department had regarding being notified that one of their patients was seen at an Urgent Care.
- She asked the department if anyone has run into similar incidents and it was mentioned that if a patient is seen at a Circle Health Urgent Care, there usually is a notification sent.
- Some physicians disagreed and said they do not get notifications on a regular basis and questioned if it is because they are not a Tufts Medicine employed physician.
- Most get epic notifications for both emergency room visits and discharges and some get epic notifications for urgent care visits.
- Dr. Marshall said that she gets a Tiger Text if a patient is seen at the emergency room but does not receive them for urgent care visits.
- Another suggestion was to see if there is the ability to have these notifications sent to the office rather than through a text message alert or tag.
- Family Medicine privileges are being worked on and will be updated soon. Dr. Pillai is reorganizing the form into specific sections and adding some additional privileges.
- The goal is to have the revised Family Medicine Privilege form approved before the LCHC Residency Program starts.

IV. Old Business

a. Medical Executive Committee

- There were no significant updates from las month's MEC meeting.

b. Labor and Delivery Committee

- Dr. Holmes stated that the Labor and Delivery Committee did not meet last month.

c. Cancer Committee

- No one was on the call to give an update. If anyone is interested in joining the Cancer Committee, please reach out to Dr. Pillai.

d. Credentials Committee

- Dr. Marshall stated there was recent discussion on the amount of peer references needed for initial applicants. The current policy states that only two are needed, but more commonly seen at other facilities, three peer references are required.

e. Morbidity and Mortality Council

- M & M cases have not been relevant to outpatient Family Medicine.

f. Perinatal Committee

- There were a few policies updated because they were outdated.
- C-Section rates continue to decline and stay within national trend.

g. MCH Updates

- No updates were given.

h. DEI Update

- Dr. Lewis said the main update with DEI is just for situational awareness and to look out for updated terms being used since the current administration is targeting institutions that have a focus on diversity, equity, and inclusion.
- Tufts Medicine, as an organization, also had to pivot, so terms like engagement and belonging will start being used which is the new title of the group's work in the same space.
- The mission continues to be the same. It continues to be centered around structures, policies, programs, training, materials.
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i. Family Medicine Residency Program

- Dr. Marshall said that they are amid interviewing and are not halfway through the interview process. There was a total of 1022 applicants. There seems to be a sizable number of applicants that are applying for family medicine residency but also double applying for other specialties.

j. Bridge Clinic

- Dr. O'Neil told the department that Dr. Williams is at an Addiction Medicine Conference in Portland, Oregon.
- We are working hard on trying to get a long acting injectable buprenorphine so that patients could potentially receive their injection prior to their discharge from the hospital.
- When a patient is hospitalized or visits an emergency room, the chance of fatal overdose skyrockets.

- The Clinic is working on getting a Pyxis machine so they can potentially start dispensing methadone using the 72 hour rule.

k. Mass Medical Society

- Dr. Dulac was not at the meeting to give an update.

l. Inpatient Care Update

- Dr. Larios said that Dr. Jaleel is looking for more inpatient family medicine doctors.
- Dr. Larios teaches at UMass and has noticed a lot more doctors being interested in inpatient care.

V. Hematuria Presentation by Dr. Edelstein

- Dr. Pillai invited Dr. Edelstein to the department meeting to discuss Hematuria.
- Dr. Edelstein discussed the nuances of hematuria, emphasizing the importance of following guidelines from the American Urological Association. He explained that 20% of patients referred to urologists may have hematuria, with microscopic hematuria being common. The diagnostic criteria include counting red blood cells per high-powered field, with different risk categories based on age, smoking history, and red blood cell count. Low-risk patients should repeat urine analysis within six months, while high-risk patients require CAT scans with contrast and cystoscopy. Dr. Edelstein also highlighted the need for timely workups to prevent cancer mortality.
- Please see the attached slides for more information on his thorough presentation.

VI. Adjournment & Other Discussion

- The meeting adjourned at 8:05am.

Next Meeting:
Friday, February 13, 2026, at 7:00AM via Zoom

Respectfully submitted,

Maxine M Miller

Maxine Miller
Medical Staff Coordinator

Approved by:

_____ _____

Sangita Pillai, MD — Date
Chief, Department of Family Medicine

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The Lowell General Hospital
Office of Clinical Education

Hematuria update

Rob Edelstein, MD, MHCM, FACS
Medical Education Lead, LGH OCE
Associate Professor, Dept of Urology
Tufts University School of Medicine

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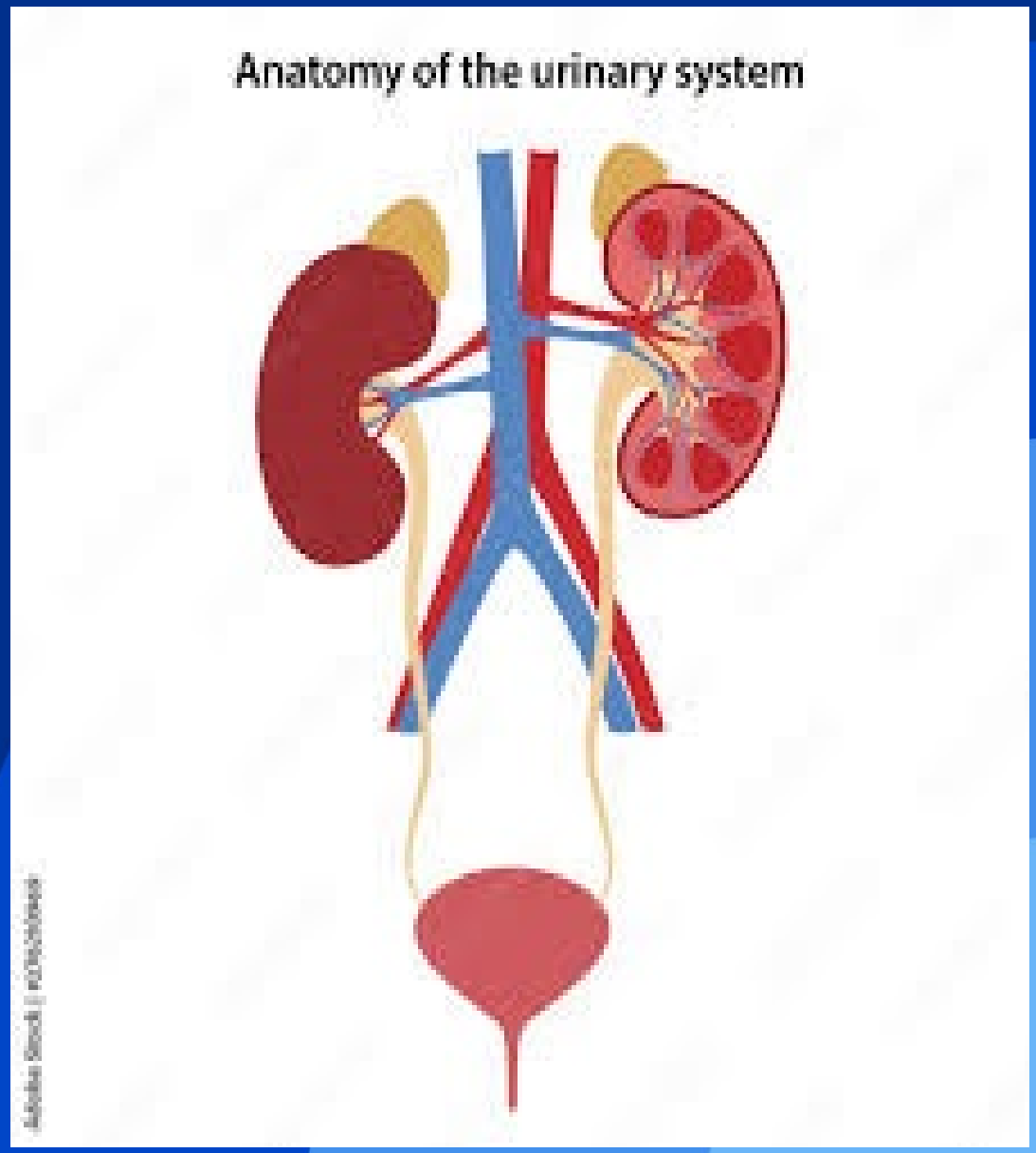
Hematuria update

American Urological Association

The American Academy of Family Physicians references the American Urological Association guidelines for the evaluation of asymptomatic microscopic hematuria



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Hematuria update

Prevalence

Hematuria remains one of the most common urologic diagnoses, estimated to account for over 20% of urology evaluations.
Screening studies have noted a prevalence range of microhematuria (MH) among healthy volunteers of 2.4%-31.1% depending on the specific population evaluated.

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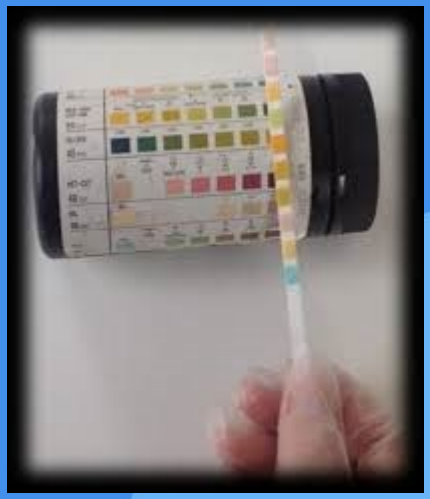
Hematuria update

Diagnosis and Definition of Microhematuria

Clinicians should define microhematuria as ≥3 red blood cells per high-power field on microscopic evaluation of a single, properly collected urine specimen.

Clinicians should not define microhematuria by positive dipstick testing alone. A positive urine dipstick test (trace blood or greater) should prompt formal microscopic evaluation of the urine.



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Hematuria update

Initial Evaluation

Clinicians should perform the same evaluation of patients with microhematuria who are taking antiplatelet agents or anticoagulants (regardless of the type or level of therapy) as patients not on these agents.

In patients with findings suggestive of a gynecologic or non-malignant urologic etiology, clinicians should evaluate the patients with appropriate physical examination techniques and tests to identify such an etiology. However, risk-based urologic evaluation should still be performed.

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Hematuria update

Delays in diagnosis of bladder cancer have been suggested to contribute to a 34% increased risk of cancer-specific mortality and a 15% increased risk of all-cause mortality.

Yet, a 2008 study found that less than 50% of patients with hematuria diagnosed in a primary care setting were subsequently referred for urologic evaluation.

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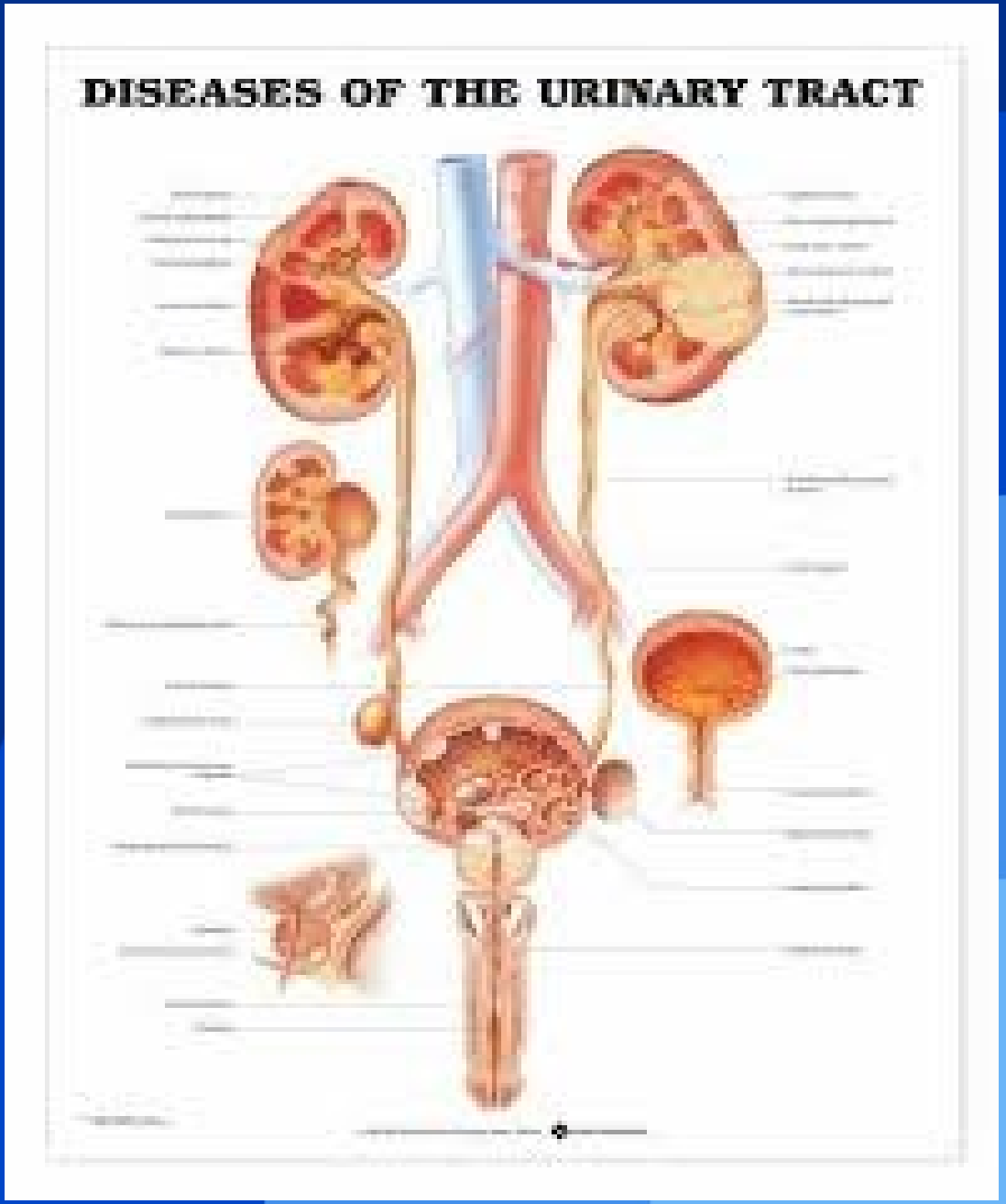
Hematuria update

Urologic etiologies for hematuria include malignancy, infection, inflammation, calculus disease, benign prostatic hyperplasia (BPH), and congenital or acquired anatomic abnormalities

A recent prospective observational study of over 3,500 patients referred for evaluation of hematuria noted a 10.0% rate of urinary tract cancer: 13.2% for patients with gross hematuria (GH) and 3.1% among patients with MH only. The vast majority of cancer in this setting is due to bladder malignancy.



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Hematuria update

Initial Evaluation:

In patients diagnosed with gynecologic or non-malignant genitourinary sources of microhematuria, clinicians should repeat urinalysis following resolution of the gynecologic or non-malignant genitourinary cause. If microhematuria persists or the etiology cannot be identified, clinicians should perform risk-based urologic evaluation.

In patients with hematuria attributed to a urinary tract infection, clinicians should obtain a urinalysis with microscopic evaluation following treatment to ensure resolution of the hematuria.

Clinicians should refer patients with microhematuria for nephrological evaluation if medical renal disease is suspected. However, risk-based urologic evaluation should still be performed.

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Hematuria update

Following initial management, clinicians should categorize patients presenting with microhematuria as low/negligible-, intermediate, or high-risk for genitourinary malignancy

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Hematuria update

Assessment of Risk category

Table 4: AUA/SUFU Microhematuria Risk Stratification System 2025

Risk of malignancy*	Low/Negligible 0-0.4%[21, 22, 24]	Intermediate 0.2-3.1%[21, 22, 24]	High 1.3-6.3%[21, 22, 24]
Number of criteria patient must meet	All	One or more	One or more
Degree of hematuria on a single urinalysis	3-10 RBC/HPF⁺	11-25 RBC/HPF⁺	>25 RBC/HPF⁺
Alternative criteria for degree of hematuria		Previously low/negligible -risk patient with no prior evaluation and 3-25 RBC/HPF* on repeat urinalysis	History of gross hematuria
Age for women	<60 years	≥60 years	*Women should not be categorized as high-risk solely based on age*
Age for men	<40 years	40-59 years	≥60 years
Smoking history	Never smoker or <10 pack years	10-30 pack years	>30 pack years
Presence of additional risk factors for urothelial cancer (see Table 3)	None	Any	One or more plus any high-risk feature

*Risk of malignancy is based on the definition from the 2020 AUA/SUFU Guideline in which women being age < 50 year was a criterion for low-risk, women being age 50-59 years was a criterion for intermediate-risk, and women being age > 60 was a criterion for high-risk. Based on interval studies showing significantly lower risk of urothelial malignancy in women, women being age < 60 years is a criterion for low-risk, women being age > 60 years is a criterion for intermediate-risk, and women cannot be categorized as high-risk based on age alone in the 2025 guideline iteration.

⁺HPF: High-Power Field

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Hematuria update

LOW/NEGLIGIBLE-RISK

In low/negligible-risk patients with microhematuria, clinicians should obtain repeat urinalysis within six months rather than perform immediate cystoscopy or imaging.

INITIALLY LOW/NEGLIGIBLE-RISK WITH HEMATURIA ON REPEAT URINALYSIS

Low/negligible-risk patients with microhematuria on repeat urinalysis should be reclassified as intermediate- or high-risk based on repeat urinalysis. In such patients, clinicians should perform risk-based evaluation in accordance with recommendations for these respective risk strata.

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Hematuria update

My personal recommendation: If the patient is/was a smoker or has a family history of malignancy, I often evaluate these patients as if they are in the high risk category, acknowledging the risks of contrast imaging, radiation and cystoscopy

INTERMEDIATE-RISK

Clinicians should recommend cystoscopy and renal ultrasound in patients with microhematuria categorized as intermediate risk for malignancy.

In appropriately counseled intermediate-risk patients who want to avoid cystoscopy and accept the risk of forgoing direct visual inspection of the bladder urothelium, clinicians may offer urine cytology or validated urine-based tumor markers to facilitate the decision regarding utility of cystoscopy.

Renal and bladder ultrasound should still be performed in these cases. For patients with intermediate-risk microhematuria who do not undergo cystoscopy based on urinary marker results, clinicians should obtain a repeat urinalysis within 12 months. Such patients with persistent microhematuria should undergo cystoscopy.

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Hematuria update

HIGH-RISK

Clinicians should perform cystoscopy and axial upper tract imaging in patients with microhematuria categorized as high-risk for malignancy.

The underuse of cystoscopy, and the tendency to solely use imaging for evaluation, is particularly concerning when one considers that most cancers diagnosed among persons with hematuria are bladder cancers, optimally detected with cystoscopy.

My personal recommendation: There is almost never a reason to deviate from this recommendation

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Hematuria update

Options for Upper Tract Imaging in High-Risk Patients:

1.If there are *no* contraindications to its use, clinicians should perform multiphasic CT urography (including imaging of the urothelium).

2.If there *are* contraindications to multiphasic CT urography, clinicians may utilize MR urography.

3.If there are contraindications to multiphasic CT urography *and* MR urography, clinicians may utilize retrograde pyelography in conjunction with non-contrast axial imaging or renal ultrasound.

Note that U/S alone is not included in this high-risk recommendation

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Hematuria update

In patients with microhematuria who have a family history of renal cell carcinoma, a known genetic renal tumor syndrome, or a personal or family history of (or suspicious for) Lynch syndrome, clinicians should perform upper tract imaging regardless of risk category.

Table 6: Inherited Risk Factors for Renal Cortical Tumors

Known genetic renal tumor syndrome
1. von Hippel-Lindau
2. Birt-Hogg-Dube
3. Hereditary papillary RCC
4. Hereditary leiomyomatosis RCC
5. Tuberous sclerosis

Risk factors for bladder cancer: Smoking, heavy alcohol consumption, exposure to certain organic chemicals, family history of bladder or other cancers, increasing age, male gender, prior radiation therapy to pelvis, exposure to cyclophosphamide and other chemicals

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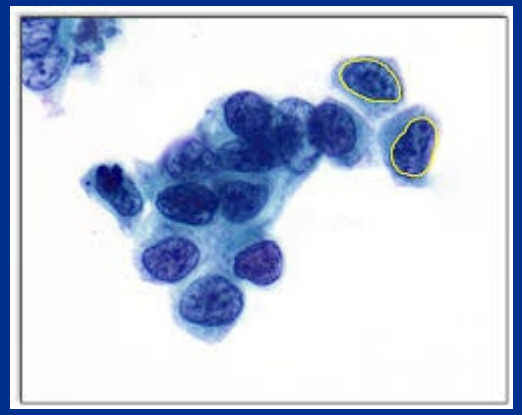
Hematuria update



Cytology and urinary marker tests

Clinicians should not routinely use urine cytology or urine-based tumor markers to decide whether to perform cystoscopy in the initial evaluation of low/negligible- or high-risk patients with microhematuria.

Clinicians should not routinely use cytology or urine-based tumor markers as adjunctive tests in the setting of a normal cystoscopy.

Clinicians may obtain urine cytology for high-risk patients with equivocal findings on cystoscopic evaluation or those with persistent microhematuria and irritative voiding symptoms or risk factors for carcinoma in situ after a negative workup.

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Hematuria update

Follow-Up

In patients with a negative risk-based hematuria evaluation, clinicians should engage in shared decision-making regarding whether to repeat urinalysis in the future.

For patients with a prior negative hematuria evaluation and subsequent negative urinalysis, clinicians may discontinue further evaluation for microhematuria.

For patients with a prior negative hematuria evaluation who have persistent or recurrent microhematuria at the time of repeat urinalysis, clinicians should engage in shared decision-making regarding the need for additional evaluation.

For patients with a prior negative hematuria evaluation who develop gross hematuria, significant increase in degree of microhematuria, or new urologic symptoms, clinicians should initiate further evaluation.

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Hematuria update

Summary:

Always make note of hematuria if present (> 3 RBC/hpf on microscopy). Do not rely on dipsticks alone

Any patient with hematuria should be offered evaluation in shared decision making

Proceed along the recommended guidelines after assessing the risk category of the patient

Consider medical renal disease after anatomic evaluation is complete

Deviation from the guidelines exposes the patient (and clinician) to risk