VCMC/SANTA PAULA HOSPITAL CLINICAL PRACTICE GUIDELINE
Cystography Technique

The contents of this clinical practice guideline are to be used as a guide. Healthcare professionals should use sound clinical judgment and individualize patient care. This CPG is not meant to be a replacement for training, experience, CME or studying the latest literature and drug information.

Cystography Technique

Once urethral integrity is confirmed by RUG and a Foley catheter is in the bladder, two options exist for evaluation of bladder integrity. Accuracy is comparable between the techniques.

Plain Film (conventional) Cystography

1. This is done in the Trauma Bay or Radiology Department after RUG and placement of Foley catheter.
2. A scout film is done prior to contrast injection (the initial pelvis X-ray obtained above is sufficient).
3. Fill bladder with 250-300 mL of 50% dilute water soluble contrast under gravity pressure. Clamp the Foley.
4. Obtain filled bladder AP X-ray.
5. After confirming adequacy of this X-ray, drain the bladder completely and obtain a post-void AP X-Ray.

CT Cystography

1. Alternative to conventional cystography in stable patients.
2. After completion of standard trauma CT of the chest/abdomen/pelvis and TL spine.
3. Instill dilute contrast (mixture of 50 mL of Optiray or other iodinated contrast material and 500 mL of sterile saline). 250-300 mL of this dilute contrast in instilled under gravity, and then Foley is clamped.
4. CT of the pelvis is performed.
5. Note: CT scans performed during the excretion phase of IV contrast and without direct instillation of dilute contrast into the bladder are NOT sufficient to rule-out bladder injury.

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