why would the urologist omit the history of crede, and note the pt takes in very high volumes, but there is no hydronephrosis

The note is using a shortcut that urologists often use, and that shortcut leaves out the part of your history that makes the shortcut unsafe.

What the note is trying to say

Chronic retention is split, in practice, into low-pressure and high-pressure types. High-pressure retention is the one that damages kidneys. Many clinicians treat **hydronephrosis or a falling kidney function** as the bedside marker of that dangerous type, and they treat **normal kidneys and no hydronephrosis** as low-pressure retention.[1] [2]

A very large urine output from high fluid intake can also fill a stretchy bladder without obstruction. A compliant bladder can hold a large volume at fairly low storage pressure and spare the kidneys for years. So “drinks a lot, huge bladder volumes, no hydronephrosis” is a coherent story for **low-pressure, high-capacity retention or high intake**, and it is why the upper-tract finding was written down and the Credé history was not.[3]

Why Credé still should have been written

That classification is only a **proxy**. The actual definition is bladder pressure, not the kidney picture. Low-pressure chronic retention means an end-filling pressure under about 25 cmH2O. High-pressure means above that. Only about half of high-pressure cases develop upper-tract dilatation or reduced kidney function, so **no hydronephrosis does not prove the pressure is low.**[4]

Credé adds a second problem the ultrasound cannot see. Storage pressure can be low while the pressure you create by pressing on the abdomen is high for those 15 minutes. That spike can reflux urine without leaving permanent swelling of the kidneys on one scan. A residual measured after that press also cannot be compared with a normal post-void residual. Canadian guidance on neurogenic bladder is the same idea: high storage pressure often has no symptom you can feel, and urodynamics are required to find it.[5]

High intake also does not explain a catheter that catches and bleeds, or a growing epididymal lump. Those are outlet, urethral, and genital findings. They do not belong in a “you just drink too much” explanation.

Why it was omitted

The most likely reasons are ordinary, not a hidden conclusion:

- The urologist heard “I push to pee,” filed it as straining, and did not treat the word Credé as a pressure problem once the kidneys looked normal.
- The note was written to answer the question they ordered the scan for: are the kidneys being damaged? No hydronephrosis answered that question for them.
- The technologists’ 15-minute wait never reached the radiologist, so the report looks like a standard post-void residual.
- Template notes keep the finding the author thinks is decisive and drop the rest.

None of those reasons makes the omission clinically acceptable. The note can be true as far as it goes — high intake, no hydronephrosis — and still be an incomplete account of how you empty. The missing sentence is what tells the next reader that the residual was produced by abdominal pressure. That is why the addendum is worth requesting, and why the next test should be urodynamics plus a residual after a spontaneous attempt only, not another reassurance based on the kidneys.

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1. https://www.bmj.com/content/366/bmj.l4590
2. https://www.ncbi.nlm.nih.gov/books/NBK558920/
3. https://pmc.ncbi.nlm.nih.gov/articles/PMC12301950/
4. https://tau.amegroups.org/article/view/14668/html
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13. https://www.auanet.org/guidelines-and-quality/quality-and-measurement/quality-improvement/clinical-consensus-statement-and-quality-improvement-issue-brief-(ccs-and-qiib)/non-neurogenic-chronic-urinary-retention-consensus-definition-management-strategies-and-future-opportunities-x22670
14. https://www.scribd.com/presentation/952576055/Acute-Chronic-Urinary-Retention-Detailed-MBBS-MD
15. https://localurology.com/il/conditions/urinary-retention/