Nice guidelines uti child

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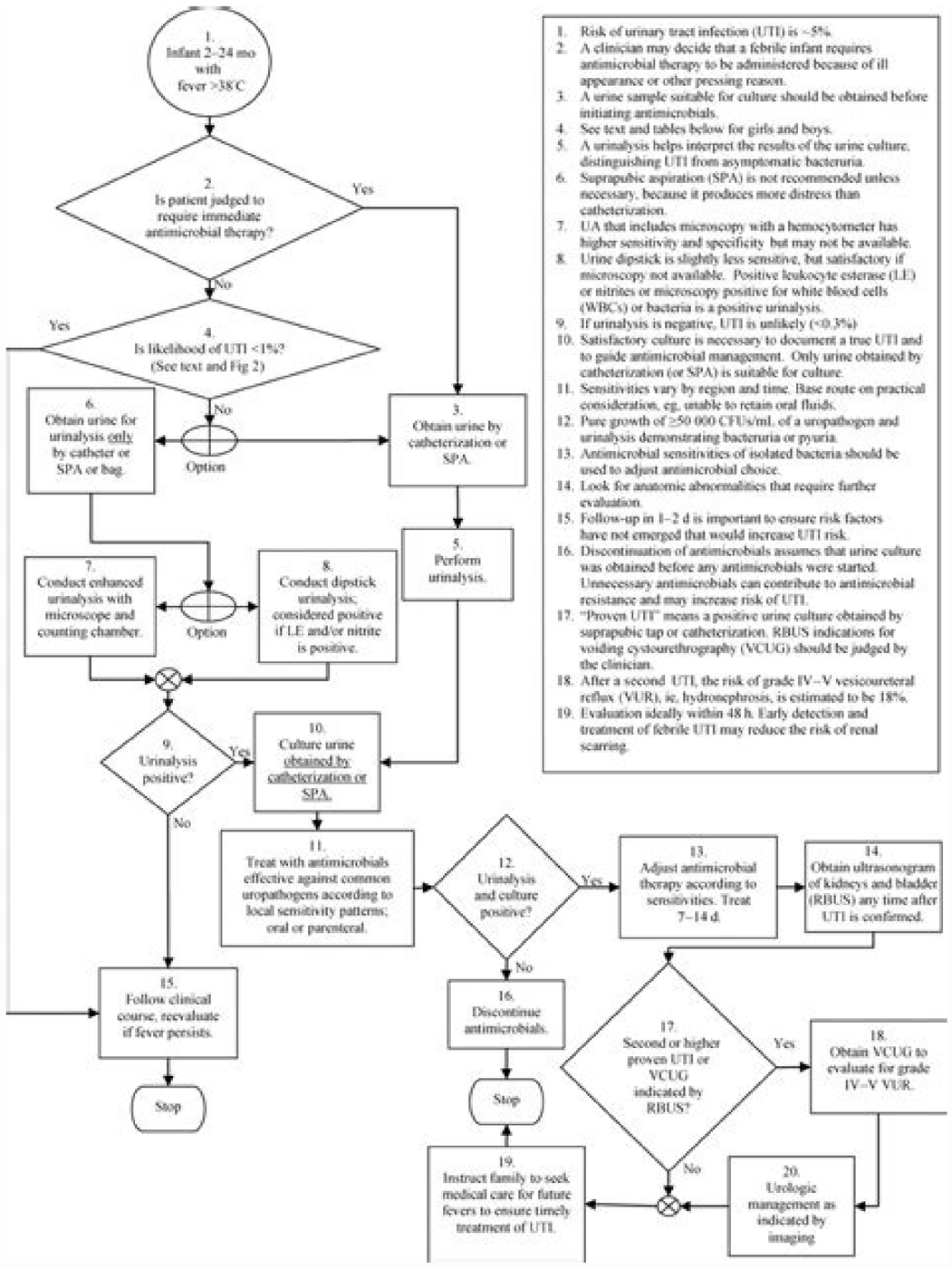
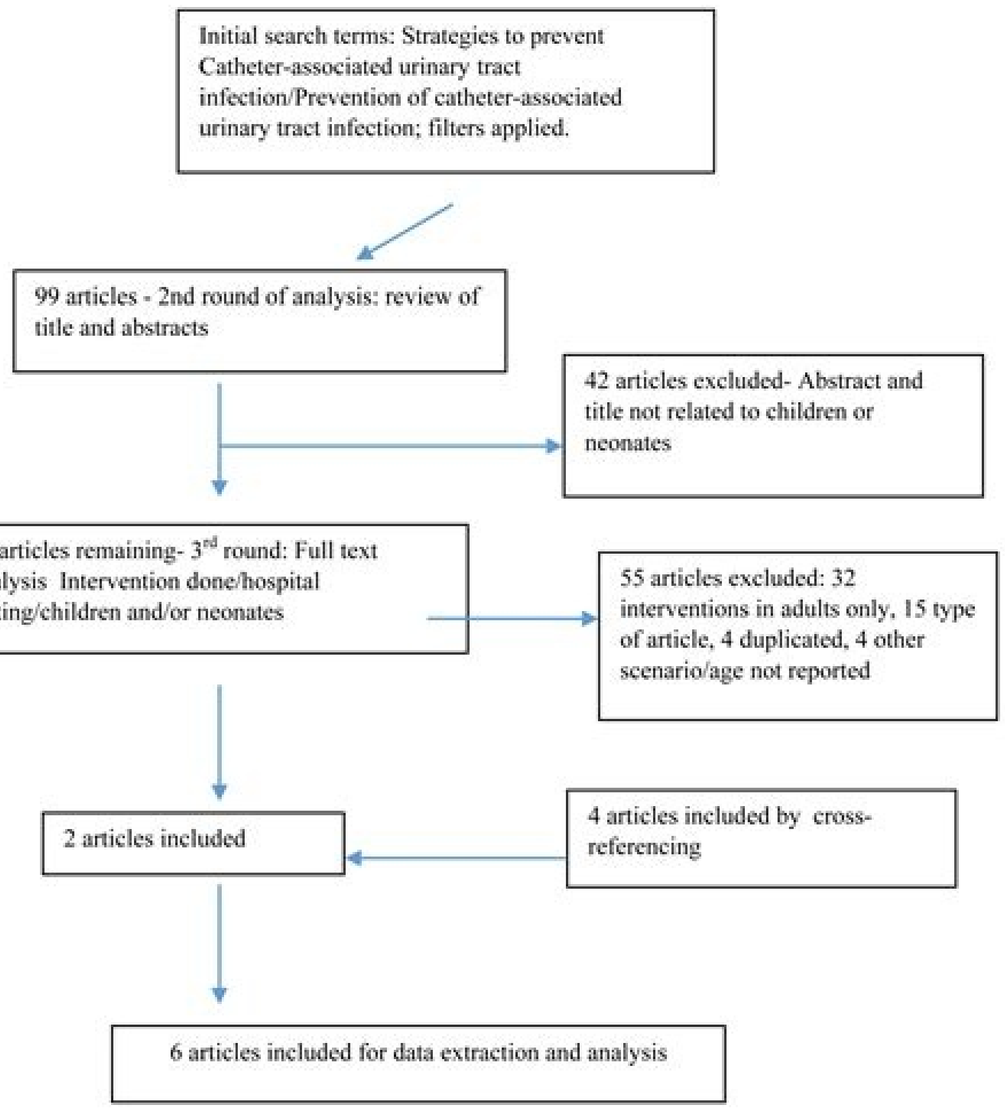
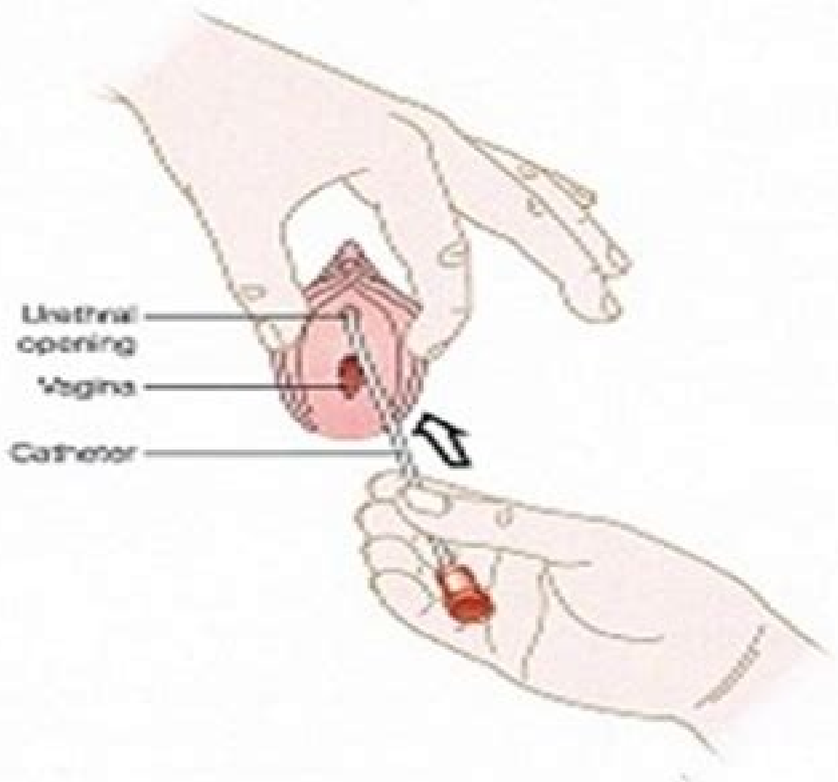
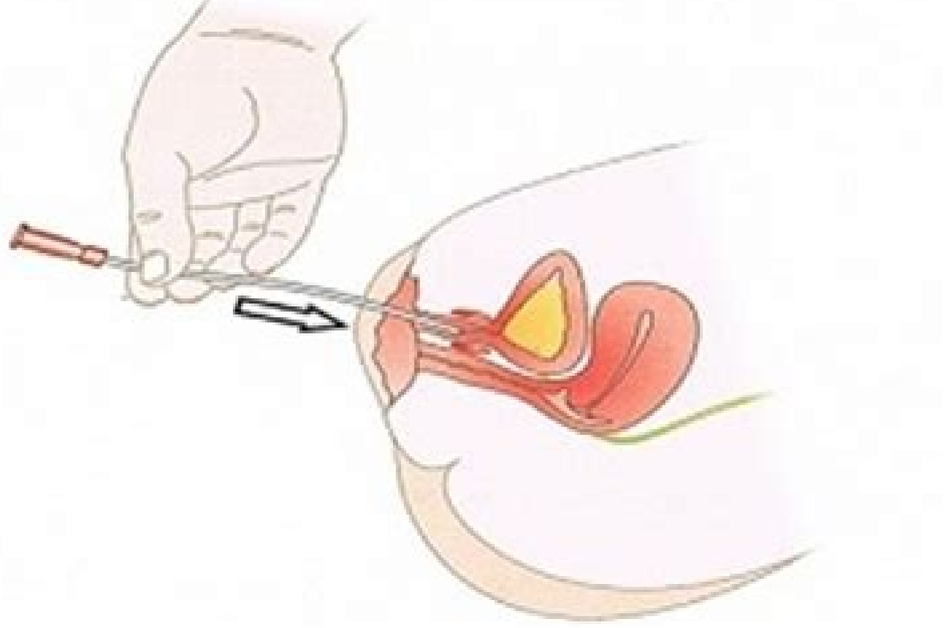


1. Risk of urinary tract infection (UTI) is ~5%.
2. A clinician may decide that a febrile infant requires antimicrobial therapy to be administered because of ill appearance or other pressing reason.
3. A urine sample suitable for culture should be obtained before initiating antimicrobials.
4. See text and tables below for girls and boys.
5. A urinalysis helps interpret the results of the urine culture, distinguishing UTI from asymptomatic bacteruria.
6. Suprapubic aspiration (SPA) is not recommended unless necessary, because it produces more distress than catheterization.
7. UA that includes microscopy with a hemocytometer has higher sensitivity and specificity but may not be available.
8. Urine dipstick is slightly less sensitive, but satisfactory if microscopy not available. Positive leukocyte esterase (LE) or nitrites or microscopy positive for white blood cells (WBCs) or bacteria is a positive urinalysis.
9. If urinalysis is negative, UTI is unlikely (<0.3%)
10. Satisfactory culture is necessary to document a true UTI and to guide antimicrobial management. Only urine obtained by catheterization (or SPA) is suitable for culture.
11. Sensitivities vary by region and time. Base route on practical consideration, eg, unable to retain oral fluids.
12. Pure growth of ≥50 000 CFUs/mL of a uropathogen and urinalysis demonstrating bacteruria or pyuria.
13. Antimicrobial sensitivities of isolated bacteria should be used to adjust antimicrobial choice.
14. Look for anatomic abnormalities that require further evaluation.
15. Follow-up in 1–2 d is important to ensure risk factors have not emerged that would increase UTI risk.
16. Discontinuation of antimicrobials assumes that urine culture was obtained before any antimicrobials were started. Unnecessary antimicrobials can contribute to antimicrobial resistance and may increase risk of UTI.
17. "Proven UTI" means a positive urine culture obtained by suprapubic tap or catheterization. RBUS indications for voiding cystourethrography (VCUG) should be judged by the clinician.
18. After a second UTI, the risk of grade IV–V vesicoureteral reflux (VUR), ie, hydronephrosis, is estimated to be 18%.
19. Evaluation ideally within 48 h. Early detection and treatment of febrile UTI may reduce the risk of renal scarring.



Age		Invetigative strategy	Treatment guidance	
< 3 months		Urgent Microscopy & Culture	If possible await microscopy before tx Paeds R/V Manage as febrile child also	
3mnths – 3 years	Specific symps	Urgent Microscopy preferable	If safe to wait & microscopy avail tx after microscopy results If no microscopy available tx & send for MC&S	
	Non Specific symps		High risk of serious bacterial illness (SBI) = tx and send Intermediate risk SBI = Arrange MC&S if microscopy not urgently available can use urine dip to guide tx Low Risk SBI = Await microscopy and culture results	
> 3 years		Urine dip	Leucs & Nitrite +ve	tx & culture
			Nitirite Only	Tx & culture
			Leucs Only	Await microscopy & culture unless good clinical evidence of UTI / unwell





Clinical features / Imaging & timescale	Responds to antibiotics within 48 hours	Atypical UTI*	Recurrent UTI
USS	No	During acute episode	Within 6 weeks
DMSA (4-6 months following infection)	No	Yes	Yes

* In an infant or child with a non E.coli, Enterococcus or Klebsiella organism UTI, who is responding well to antibiotics and with no other features of atypical infection, USS can be performed within 6 weeks.

MCUG is not routinely indicated in this age group but may be considered is there is dilatation on USS, poor urinary flow, atypical causative organism or family history of vesicoureteric

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The British National Institute for Health and Care Excellence (NICE) published the “Urinary tract infection in under 16s: diagnosis and management” in 2007 as a guideline for pediatric urinary tract infection (UTI) management, including imaging, prophylaxis and follow-up 1. This article intends to summarize only the imaging approach proposed by this guideline. atypical UTI seriously ill reduced urine flow abdominal or bladder mass increased creatinine levels sepsis failure to respond to suitable antibiotics in the first 48 hours infection with non-E. Coli organisms recurrent UTI 2 or more episodes of UTI with acute pyelonephritis, or 1 episode of UTI with acute pyelonephritis and 1 or more episode of lower UTI, or 3 or more episodes of lower UTI Clinical examination and laboratory tests are considered sufficient for UTI diagnosis, and so, routine use of imaging or this purpose is not recommended.Only infants and children with atypical UTI should have an ultrasound of the urinary tract during the acute infection. Imaging will help in identifying structural abnormalities of the urinary tract such as obstruction. ultrasound infants and children who have had a lower urinary tract infection should undergo an ultrasound study within six weeks only if they are younger than 6 months, have had atypical UTI, or have had recurrent infections DMSADMSA scan 4 to 6 months following the acute onset should be considered to detect renal parenchymal defects: younger than 3 years and has had an atypical or recurrent infection older than 3 years and has had recurrent UTI micturating cystourethrogram (MCUG) routine imaging to identify vesicoureteral reflux (VUR) is not recommended for infants and children who have had a UTI, except in particular circumstances, such as: younger than 6 months and has had an atypical or recurrent infection between 6-month-old and 3-year-old, only if : ureteral dilatation / hydronephrosis on ultrasound reduced urine flow non-E. Coli infection family history of VUR for micturating cystourethrogram (MCUG), prophylactic antibiotics should be given orally for 3 days with MCUG taking place on the second day 1. National Collaborating Centre for Women's and Children's Health (UK). Urinary Tract Infection in Children: Diagnosis, Treatment and Long-term Management. London: RCOG Press; 2007 Aug. PubMed PMID: 21290637. The NICE Clinical Knowledge Summaries (CKS) site is only available to users in the UK, Crown Dependencies and British Overseas Territories. CKS content is produced by Clarity Informatics Limited. It is available to users outside the UK via subscription from the Prodigy website. If you believe you are seeing this page in error please contact us. This quality standard covers diagnosing and managing urinary tract infection in infants, children and young people (under 16). It includes new and recurrent infections of the upper or lower urinary tract. It describes high-quality care in priority areas for improvement. NICE has also published a quality standard on urinary tract infections in adults. In July 2022, changes were made to align this quality standard with the updated NICE guideline on urinary tract infections in under 16s. See update information for details. How to use NICE quality standards and how we develop them Quality standards help you improve the quality of care you provide or commission. They apply in England and Wales (see the UK government website and Welsh government website). Decisions on how they apply in Scotland and Northern Ireland are made by ministers in the Scottish government and Northern Ireland Executive. Find out how to use quality standards and how we develop them. We check our quality standards every August to make sure they are up to date. Media Platforms Design TeamIf you’ve had a urinary tract infection before, you know the drill. First, you feel pain and burning when you pee. You head to the doctor, who takes a urine sample and sends it out for a culture. If the results come back positive, you take an antibiotic to fight the bug.But what if you could get better without the drugs—and the side effects, costs, and risks of antibiotic resistance that come with them? A new Dutch study suggests some women with simple infections can, and that more than one-third would be willing to give it a shot. Researchers at the University of Amsterdam studied 176 otherwise healthy women with straightforward UTI symptoms. Doctors asked 137 of them whether they’d wait to take antibiotics until it was absolutely necessary; 51 took their doctors up on the offer.After a week, almost three-fourths of the women felt better, according to results published in the journal BMC Family Practice. Although some of the women who didn’t improve after a week ended up taking antibiotics, 28 didn’t, and 20 got better regardless. And none of the women developed kidney infection—a potentially serious complication of untreated urinary tract infections. This strategy would mark a serious shift from the way doctors in the U.S. treat UTIs right now. “Such a proposal contains much potential to decrease the relatively rampant use of antibiotics as common practice today,” says David Hoenig, MD, a urologist Albert Einstein College of Medicine and Montefiore Medical Center who wasn’t involved in the study. But, he points out, just because the women’s symptoms eased doesn’t mean their infection was cured. Study author Bart Knottnerus, MD, says ongoing research could help guide doctors in spotting women who can safely say no to the drugs. “Although not using antibiotics is safe and many women will get better in a week, many others won’t,” he says. “A next research step might be to investigate whether we can predict which women will benefit from antibiotics (with or without delayed prescription) and which women won’t.”In the meantime, if you’re not pregnant and don’t have a fever, bleeding, pain in your side, or other signs of a more serious problem, you might consider asking your doctor about the benefits and risks of skipping the script. Pain medications such as acetaminophen may relieve symptoms in the meantime, Dr. Knottnerus says.Of course, preventing UTIs altogether will save you even more pain. To do it, drink plenty of water and consider sipping on cranberry juice if you’re prone to frequent infections—it has antibacterial properties and also makes your urine more acidic and hostile to bugs, Dr. Hoenig says.More from Prevention: Do Cranberries Prevent UTIs?Cindy KuzmaContributing WriterCindy is a freelance health and fitness writer, author, and podcaster who’s contributed regularly to Runner’s World since 2013. She’s the coauthor of both Breakthrough Women’s Running: Dream Big and Train Smart and Rebound: Train Your Mind to Bounce Back Stronger from Sports Injuries, a book about the psychology of sports injury from Bloomsbury Sport. Cindy specializes in covering injury prevention and recovery, everyday athletes accomplishing extraordinary things, and the active community in her beloved Chicago, where winter forges deep bonds between those brave enough to train through it. 1National Collaborating Centre for Women's and Children's Health, Royal College of Obstetricians and Gynaecologists, London NW1 4RGFind articles by Rintaro Mori2National Collaborating Centre for Women's and Children's Health, Royal College of Obstetricians and Gynaecologists, and University of Leicester, LeicesterFind articles by Monica LakhanpaulAuthor information Copyright and License information DisclaimerCopyright © BMJ Publishing Group Ltd 2007Although urinary tract infection affects at least 3.6% of boys and 11% of girls, establishing the diagnosis is difficult in early childhood owing to the lack of specific urinary symptoms, difficulty in urine collection, and contamination of samples. Most children have a single episode and recover promptly. Current imaging, prophylaxis, and prolonged follow-up strategies place a heavy burden on patients, families, and NHS resources and carry risks without evidence of benefit. This article summarises the most recent guidance from the National Institute for Health and Clinical Excellence (NICE) on how to provide consistent clinically and cost effective practice for the diagnosis, treatment, and further management of urinary tract infection in childhood.1NICE recommendations are based on systematic reviews of best available evidence. When minimal evidence is available, a range of consensus techniques is used to develop recommendations. In this summary, recommendations derived primarily from consensus techniques are indicated with an asterisk (*).• Consider a diagnosis of urinary tract infection in all infants and children with:(a) unexplained fever of 38°C or higher after 24 hours at the latest(b) symptoms and signs suggestive of urinary tract infection, including:- fever2- non-specific symptoms, such as lethargy, irritability, malaise, failure to thrive, vomiting, poor feeding, abdominal pain, jaundice (in infants)- specific symptoms, such as frequency, dysuria, loin tenderness, dysfunctional voiding, changes to continence, haematuria, and offensive or cloudy urine.• Collect a urine sample:(a) do this preferably by clean catch, but if this is not possible, use a urine collection pad but not cotton wool balls, gauze, or sanitary towels. (b) if non-invasive techniques are not possible, use a catheter sample or suprapubic aspirate with ultrasound guidance.• Test the urine sample: for infants younger than 3 months, refer to a paediatric specialist, who should send urine for urgent microscopy and culture; for children 3 months or older but younger than 3 years, see box 1; for children 3 years or older, see box 2. • Send urine for culture when any of the following apply*:- age younger than 3 years- clinical diagnosis of acute pyelonephritis or upper urinary tract infection- high to intermediate risk of serious illness2- history of recurrent urinary tract infection- single positive dipstick result for leucocyte esterase or nitrite- infection does not respond to treatment within 24-48 hours, if no sample has already been sent- clinical symptoms and dipstick tests do not correlate.Localising site of urinary tract infection* • Consider any child with bacteriuria and fever of 38°C or higher as having acute pyelonephritis or upper urinary tract infection.• Consider any child with fever lower than 38°C, loin pain or tenderness, and bacteriuria as having acute pyelonephritis or upper urinary tract infection.• Consider all other children with bacteriuria but no systemic symptoms or signs as having cystitis or lower urinary tract infection.History, examination, and documentation • Ensure history and examination, and document the presence or absence of features of atypical illness and markers of underlying pathology.*Antibiotic treatment• Children with a high risk of serious illness2 and/or younger than 3 months: refer immediately to secondary care• Children aged 3 months and older with acute pyelonephritis or upper urinary tract infection: - consider referral to secondary care- treat with 10 days of oral antibiotics, or if child is unable to tolerate oral antibiotics, start treatment with intravenous antibiotics until oral intake is possible- repeat culture if no response within 24-48 hours• Children aged 3 month and over with cystitis or lower urinary tract infection:- treat with three days of oral antibiotics according to local guidance- advise carers to return for review if the child remains unwell after 24-48 hours.Preventing recurrence• Do not prescribe antibiotic prophylaxis routinely.Imaging strategies*• Children of all ages with atypical urinary tract infection (box 3): perform ultrasonography of the urinary tract during the acute infection to identify structural abnormalities of the urinary tract.• Infants younger than 6 months with first time urinary tract infection that is responsive to treatment: do ultrasonography within six weeks of the infection.• Children younger than 3 years with atypical and/or recurrent urinary tract infection (box 3): do a DMSA (dimercaptosuccinic acid) scan 4-6 months after the acute infection to detect renal parenchymal defects.• Do not do routine imaging to identify vesicoureteral reflux.Referral and follow-up*• Referral to paediatric care specialist for children with abnormal imaging findings and after recurrent urinary tract infection.• Appropriate information and advice must be provided at each stage, including:- the possibility of a urinary tract infection recurring- the need to be vigilant and seek prompt treatment from a healthcare professional for any suspected reinfection.Specific urinary symptoms• Send urine sample for urgent microscopy and culture; if urgent microscopy is not available, send a urine sample for microscopy and culture• Start antibiotic treatmentHigh risk of serious illness • Refer child urgently to paediatric specialist care• Send urine sample for urgent microscopy and culture• Manage in line with NICE clinical guideline on feverish illness in children2Intermediate risk of serious illness • Consider urgent referral to a paediatric specialist (see NICE guideline2)• When specialist paediatric referral is not required:- arrange urgent microscopy and culture- start antibiotic treatment if microscopy is positive- consider dipstick testing if urgent microscopy is not available- start antibiotic treatment if nitrites are present (these suggest the possibility of infection)• In all cases, a urine sample should be sent for microscopy and cultureLow risk of serious illness: • Send urine sample for microscopy and culture• Start antibiotic treatment if microscopy or culture is positiveIf leucocyte esterase and nitrite are positive• Start antibiotic treatment for urinary tract infection• If child has high or intermediate risk of serious illness or a history of infection, send urine sample for cultureIf leucocyte esterase is negative and nitrite is positive• Start antibiotic treatment if fresh sample was tested• Send urine sample for cultureIf leucocyte esterase is positive and nitrite is negative• Send urine sample for microscopy and culture• Only start antibiotic treatment for urinary tract infection if there is good clinical evidence of such infection• Result may indicate infection elsewhere• Treat depending on results of cultureIf leucocyte esterase and nitrite are negative• Do not start treatment for urinary tract infection• Explore other causes of illness• Do not send urine sample for culture unless recommended (see recommendations on urine culture) Atypical (any of the following)• Septicaemia or patient who looks seriously ill (see NICE guideline2)• Abdominal or bladder mass• Raised creatinine concentration• Failure to respond to treatment with suitable antibiotics within 48 hours • Infection with non-Escherichia coli organismsRecurrent (any of the following)• Two or more episodes of urinary tract infection with acute pyelonephritis or upper urinary tract infection• One episode of urinary tract infection with acute pyelonephritis or upper urinary tract infection plus one or more episode of urinary tract infection with cystitis or lower urinary tract infection • Three or more episodes of urinary tract infection with cystitis or lower urinary tract infectionDespite strongly held views by some clinicians about the role of intensive imaging strategies and prophylactic antibiotic treatment in preventing renal failure after urinary tract infection, current evidence shows no such benefit. The most useful strategy for reducing morbidity from urinary tract infection and preventing subsequent renal parenchymal defects is the prompt diagnosis and treatment of the infection. This is particularly important in infants and young children, in whom the diagnosis can easily be missed.NICE has developed tools to help organisations implement the guidance (see www.nice.org.uk/page.aspx?o=tools).Useful reading • Whiting P, Westwood M, Bojke L, Palmer S, Richardson G, Cooper J, et al. Clinical effectiveness and cost-effectiveness of tests for the diagnosis and investigation of urinary tract infection in children: a systematic review and economic model. Health Technology Assessment 2006;10 (No 36).• Jepson RG, Mihaljevic L, Craig JC. Cranberries for treating urinary tract infections. Cochrane Database Syst Rev 1998;(4):CD001322.• Michael M, Hodson EM, Craig JC, Martin S, Moyer VA. Short versus standard duration oral antibiotic therapy for acute urinary tract infection in children. Cochrane Database Syst Rev 2003;(1):CD003966.• Williams GJ, Wei L, Lee A, Craig JC. Long-term antibiotics for preventing recurrent urinary tract infection in children. Cochrane Database Syst Rev 2006;(3):CD001534.• Bloomfield P, Hodson EM, Craig JC. Antibiotics for acute pyelonephritis in children. Cochrane Database Syst Rev 2005;(1):CD003772.• Wheeler DM, Vimalachandra D, Hodson EM, Smith GH, Craig JC. Interventions for primary vesicoureteric reflux. Cochrane Database Syst Rev 2007;(3):CD001532. The most recent previous guidance on imaging after urinary tract infection in childhood was published by the Royal College of Physicians in 1991.3 In a national audit of the guideline reported in 20014 5 (which included 746 children under 2 years old with a fever in 31 hospitals) testing for possible urinary tract infection was highly variable. Altogether, 38/74 infants with a positive result on urine culture were not given a diagnosis of urinary tract infection and did not receive any treatment, prophylaxis, imaging, or follow-up. There was also no communication with the general practitioner or the patient's carers about the positive culture result. Thus half of the infants and children seen in secondary care with evidence for urinary tract infection did not receive the correct diagnosis or recommended management.Imaging and follow-up of correctly diagnosed cases were assessed in a second study and showed that 93% of children had at least an ultrasound scan, and only 5% had no imaging test, indicating a high degree of compliance with the imaging strategy.The new NICE guidance1 proposes that:• Dipstick urine testing is the first line investigation for children aged 3 years or older• Urgent microscopy and culture is the first line investigation for children younger than 3 years (dipsticks are recommended for use only as a substitute when transport of a sample to the laboratory is impossible and the child has a low to intermediate risk of serious illness)• Antibiotic treatment duration is influenced by clinical evidence of acute pyelonephritis or upper urinary tract infection• Routine prophylactic antibiotics are not recommended• Imaging tests are only for those with an increased risk of developing serious renal consequences, including infants under 6 months, and all children with atypical or recurrent urinary tract infection.The guideline was developed by the National Collaborating Centre for Women and Children's Health. The collaborating centre convened a Guideline Development Group consisting of two paediatric nephrologists, one general paediatrician, one general practitioner, one paediatric urologist, one paediatric radiologist, one paediatric microbiologist, two paediatric nurses, and one patient/carer representative. Technical support was provided by the collaborating centre.The guideline was developed according to the standard NICE methods (www.nice.org.uk/page.aspx?o=howwework) and checked against a wider stakeholder community of clinicians, methodologists, researchers, patient/carers, and policy makers. NICE has produced four different versions of the guideline: a full version; a quick reference guide; a version known as the “NICE guideline” that summarises the recommendations; and a version for patients and the public. All these versions are available from the NICE website (www.nice.org.uk/CG054).Future updates of the guideline will be produced as part of the NICE guideline development programme.6Future research• The diagnostic accuracy of dipstick tests for nitrites and leucocyte esterase (separately and in combination) needs further evaluation in studies stratified by age and method of urine collection.• Well designed randomised, double blind, placebo controlled trials are required to determine the effectiveness of prophylactic antibiotics for preventing subsequent symptomatic urinary tract infections and renal parenchymal defects in children.• Well designed randomised, placebo controlled trials are required to determine the effectiveness of various surgical procedures for vesicoureteral reflux in preventing recurrent urinary tract infection or renal parenchymal defects.• A well designed cohort study investigating long term outcomes (including renal scarring and renal function) of children who have had urinary tract infection should be conducted in the United Kingdom.The members of the Guideline Development Group were Kate Verrier Jones, Jay Banerjee, Su-Anna Boddy, David Grier, Lyda Jadresic, James Larcombe, Julie Marriott, Jeni Senior, Kjell Tullus, Sue Vernon, and Craig Williams, with Monica Lakhanpaul, Rintaro Mori, Anita Fitzgerald, Jeff Round, Michael Corkett, Samantha Vahidi, and Rosie Crossley from the National Collaborating Centre for Women's and Children's Health.Contributors: RM was the project manager and systematic reviewer; he drafted the paper, and all authors contributed to its revision and the final draft. ML is the clinical co-director for the guidelines, was the project director, and convened the Guideline Development Group. KV-J chaired the Guideline Development Group. Competing interest: None declared. Funding: The National Collaborating Centre for Women's and Children's Health was commissioned and funded by the National Institute for Health and Clinical Excellence to write this summary.Provenance and peer review: Commissioned; not externally peer reviewed.1. National Institute for Health and Clinical Excellence. U rinary tract infection in children London: NICE, 2007. (. National Institute for Health and Clinical Excellence. Feverish illness in children London: NICE, 2007. (. Guidelines for the management of acute urinary tract infection in childhood. Report of a Working Group of the Research Unit, Royal College of Physicians. J R Coll Physicians Lond 1991;25(1):36-42. [PMC free article] [PubMed] [Google Scholar]4. Deshpande PV, Verrier Jones K. An audit of RCP guidelines on DMSA scanning after urinary tract infection. Arch Dis Child 2001;84:324-7. [PMC free article] [PubMed] [Google Scholar]5. Verrier-Jones K, Hockley B, Scrivener R, Pollock JI. Diagnosis and management of urinary tract infections in children under two years: assessment of practice against published guidelines London: Royal College of Paediatrics and Child Health, 20016. National Institute for Health and Clinical Excellence. Updating guidelines and correcting errors. In: The guidelines manual (Ch 15.) (www.nice.org.uk/page.aspx?o=423088Articles from The BMJ are provided here courtesy of BMJ Publishing Group

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