Acute Cystitis and Pyelonephritis Pathway

Patient has symptoms suggestive of a lower urinary tract infection (cystitis) or ascending infection (pyelonephritis)

Assessment should include:

-History
-Physical examination and vital signs recording
- Blood tests including FBC, UEs, CRP
- Urine dipstick, Urine microscopy*
*Mandatory

- Blood and urine cultures if febrile*
- Change of catheter*
- Nephrostomy urine cultures*

- Imaging – US or CT scan imaging should be performed in ED if suspecting obstructed pyelonephritis (history of renal stones, or clinical presentation suggest renal colic), Patient has sings of acute abdomen, emphysematous pyelonephritis or abscess

No admission needed

-Oral antibiotics prescribed as per Trust guidelines.
-If A+E review a patient and want them to return the following day for imaging then they are to be reviewed by A+E team and discussed with Urology if the scan shows urological pathology

Yes admission needed

Use the following criteria to determine if the patient admission is to medicine or to surgery.

Contact Medical Team if the following applies:

- Female patients with cystitis/ ascending pyelonephritis.

-Elderly patients of both genders who have urosepsis with or without a LTC

(Consider imaging US or CT within 24hrs from admission if patient did not have recent renal tract imaging within last 3 months)

-Pregnancy associated cystitis/ pyelonephritis – consider Obs+Gynae review.
(note that physiological hydronephrosis accompanying pregnancy is not a urological condition)

Contact the Surgical SHO if the following applies:

-Patients with CT proven obstructing stone with signs of sepsis

-Any recent Urological procedure or operation in the past 14 days

-Patients who are known to Urology with an underlying anatomoical abnormalities of urinary tract eg Spina Bifida or previous reconstruction of urinary system eg ileal conduit

- Male patients with first presentation for UTI/prostatitis

- Patients who are awaiting a Urology procedure in the future and have a LTC in situ (TURP)

-Patients with double JJ stents in situ