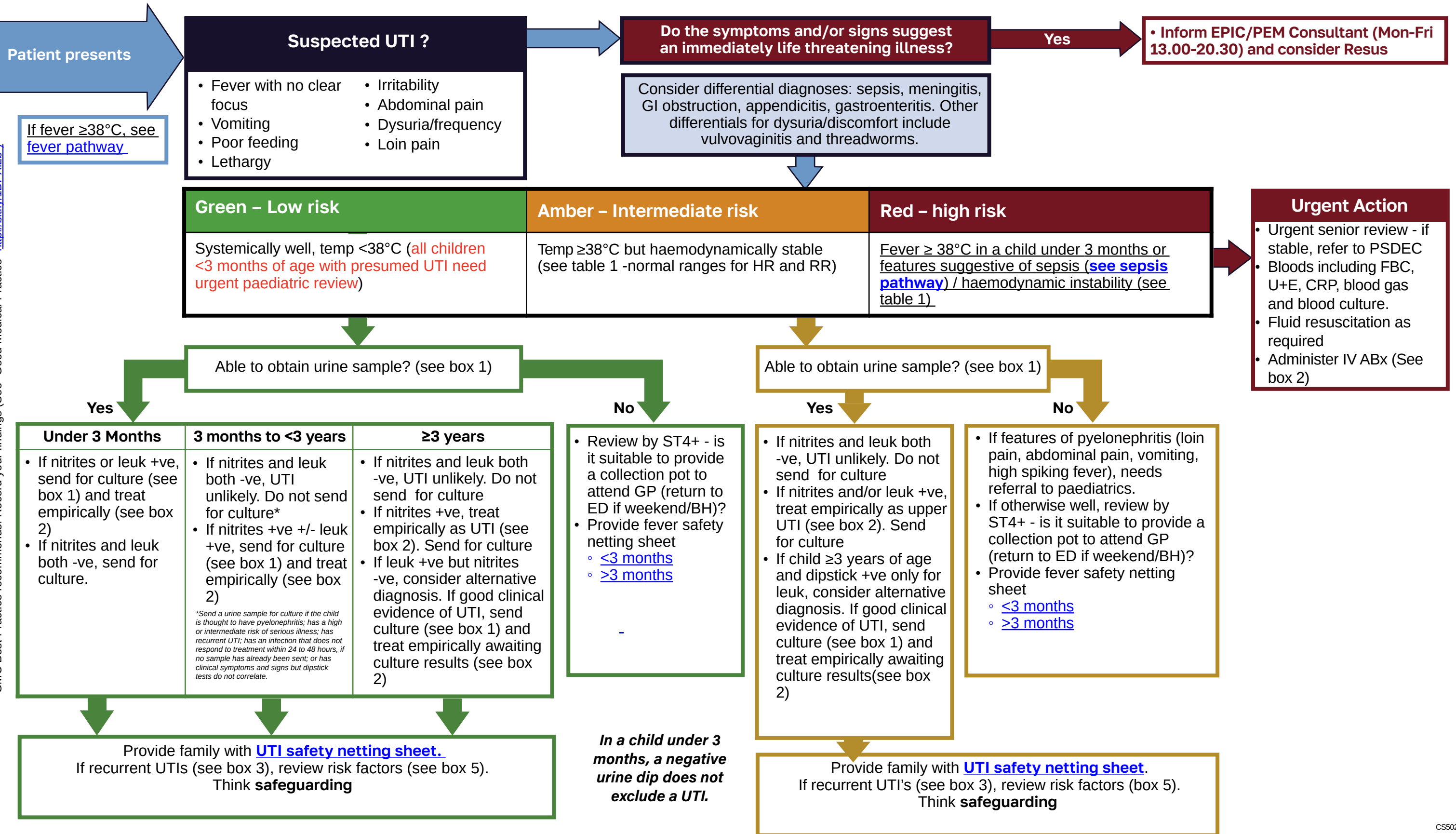


Suspected Urinary Tract Infection

Clinical Assessment/ Management tool for Children



Management - Acute Setting



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Table 1: Normal Paediatric Values:

(APLS*)	Respiratory Rate at rest (b/min)	Heart Rate (b/min)
< 1 year	30 -40	110 -160
1 -2 years	25 -35	100 -150
> 2 -5 years	25 -30	95 -140
5 -12 years	20 -25	80 -120
Over 12	15 -20	60 -100

* Advanced Paediatric Life Support The Practical Approach Fifth Edition Advanced Life Support Group Edited by Martin Samuels; Susan Wieteska Wiley-Blackwell / 2011 BMJ Books.

Box 1

Urine collection and preservation

- Clean catch is recommended method. Gentle suprapubic cutaneous stimulation using gauze soaked in cold fluid helps trigger voiding*
- Unless urine can get straight to lab preservation in a boric acid (red top) container will allow 48 hours delay



*Quick-Wee Method

Box 2

Treatment (Prescribing Information)

≤3 month: treat as pyelonephritis (refer to paediatrics)

>3 months of age:

If unable to tolerate oral Abs or systemically unwell (suggestive of bacteraemia), requires consideration of IV antibiotics– refer to paediatrics.

- Lower UTI: Trimethoprim (first line and if no sensitivities available). Infants and children who are already receiving prophylactic antibiotics, should be treated with an alternative antibiotic. Second-line options (if there is no improvement in UTI symptoms 48 hours after starting first-line treatment, or first choice is not suitable) include cefalexin, amoxicillin (only if culture results available and susceptible) and nitrofurantoin (if eGFR is 45ml/minute or more).
- Upper UTI/pyelonephritis: Cefalexin or, only if culture results are available and susceptible, co-amoxiclav.
- For more information about treatment, see [CHT's Antibiotic Guidance](#)

Box 3

Who needs imaging?

Ultrasound:

- Acutely - Atypical infection (regardless of age) or recurrent infection in <6 months old
- Within 6 weeks - Recurrent infection in >6 months, typical infection in <6 months oldt*** infection.

Atypical UTI = seriously ill/ sepsis, poor urine flow, non E-Coli, abdominal or bladder mass, raised creatinine, failure to respond in 48 hours * Recurrent UTIs = ≥3 lower UTIs, ≥2 upper UTIs or 1 upper and 1 lower UTI

How to organise in ED?

- Phone call to parents to explain results, follow-up plan
- If required acutely, request US and contact Paeds On-call to arrange PSDEC review. They will contact parents with a time slot. If within 6 weeks, Letter to GP to arrange US as per NICE guidance

Box 4

Who needs paediatric follow-up?

- Children with recurrent UTIs not responding to simple advice (see risk factors)
- Children with abnormal imaging or if appropriate imaging cannot be arranged in primary care

Box 5

Risk factors for recurrent UTIs

- Constipation
- Poor fluid intake
- Infrequent voiding esp at school (holding on)
- Irritable bladder (can happen following UTI)
- Neuropathic bladder
- Examine spine
- Genitourinary abnormalities
- Examine genitalia

Box 6

Paediatric Urine Microscopy Interpretation & Action

Microscopy results	Interpretation
Pyuria and bacteriuria are both positive	Assume the baby or child has a urinary tract infection (UTI)
Pyuria is positive and bacteriuria is negative	Start antibiotic treatment if the baby or child has symptoms or signs of a UTI
Pyuria is negative and bacteriuria is positive	Assume the baby or child has a UTI
Pyuria and bacteriuria are both negative	Assume the baby or child does not have a UTI

For further information, see NICE guidelines: <https://cks.nice.org.uk/topics/urinary-tract-infection-children/>