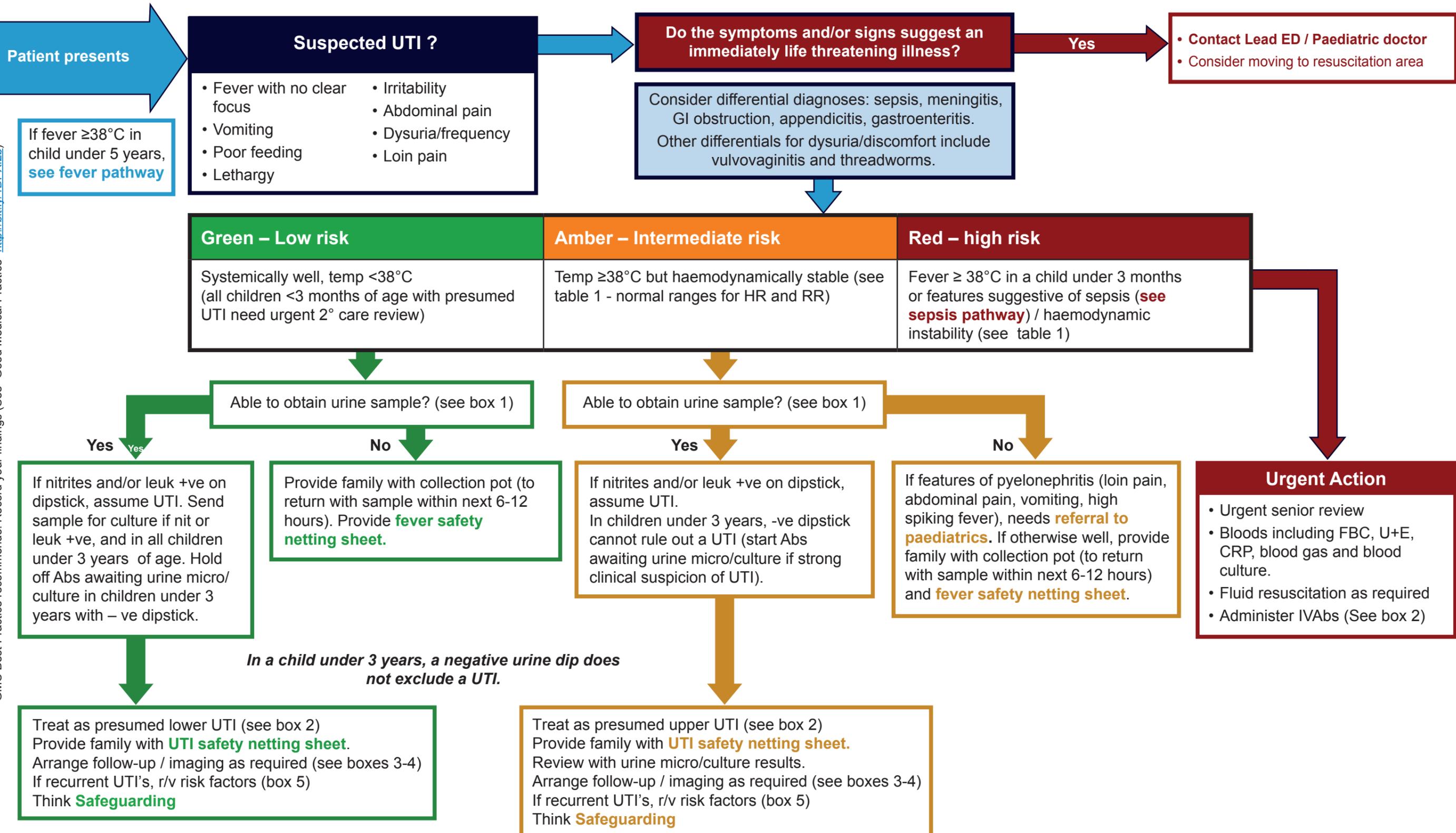


Suspected Urinary Tract Infection

Clinical Assessment/ Management tool for Children



Management - Acute Setting



GMC Best Practice recommends: Record your findings (See "Good Medical Practice" <http://bit.ly/1DPX12b>)

First Draft Version: November 2017 Review Date: November 2019.

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Management - Acute Setting

Table 1: Normal Paediatric Values:

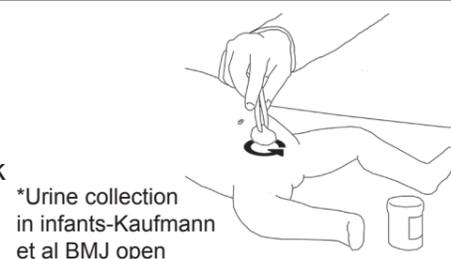
(APLS*)	Respiratory Rate at rest (b/min)	Heart Rate (b/min)
< 1 year	30 - 40	110 - 160
1 - 2 years	25 - 35	100 - 150
> 2 -5 years	25 - 30	95 - 140
5 - 12 years	20 - 25	80 - 120
Over 12	15 - 20	60 - 100

* 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*
- If absolutely unavoidable pads / bags must be put on clean skin and checked very regularly to minimise contamination risk
- Unless urine can get straight to lab preservation in a boric acid (red top) container will allow 48 hours delay



Box 2

Treatment

≤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 (4mg/kg (max 200mg/dose) 12 hourly for 3 days). If previous treatment with trimethoprim in preceding 3 months, use nitrofurantoin if able to swallow tablets (age 12-18 years 50mg 6 hourly) for 3 days or cefalexin 25mg/kg 8 hourly for 3 days (max 1g/dose). If confirmed severe penicillin allergy and unable to swallow nitrofurantoin tablets, prescribe ciprofloxacin 20mg/kg 12 hourly for 3 days (max 750mg/dose).
- Upper UTI/pyelonephritis: cefalexin (25mg/kg 8 hourly (max 1g/dose) for 7 days). If severe penicillin allergy, use ciprofloxacin 20mg/kg 12 hourly for 7 days (max 750mg/dose).
- For more information about treatment, see [Wessex empirical antibiotic guide](#) / microguide.

Box 3

Who needs imaging?

Ultrasound:

- Under 6 months- within 6 weeks, acutely if atypical** or recurrent*** infection
- Over 6 months- not routinely, acutely if atypical infection, within 6 weeks if recurrent infection.

DMSA:

- Atypical infections under 3 years
- Recurrent infections at all ages

MCUG:

- Under 6 months with atypical or recurrent infections
- Consider in all under 6 months with abnormal ultrasound.
- Consider 6-18 months if non E-Coli UTI, poor flow, dilatation on USS or family history VUR

**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

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

For further information, see NICE guidelines: <https://pathways.nice.org.uk/pathways/urinary-tract-infection-in-under-16s#path=view%3A/pathways/urinary-tract-infection-in-under-16s/diagnosing-urinary-tract-infection-in-under-16s.xml&content=view-index>