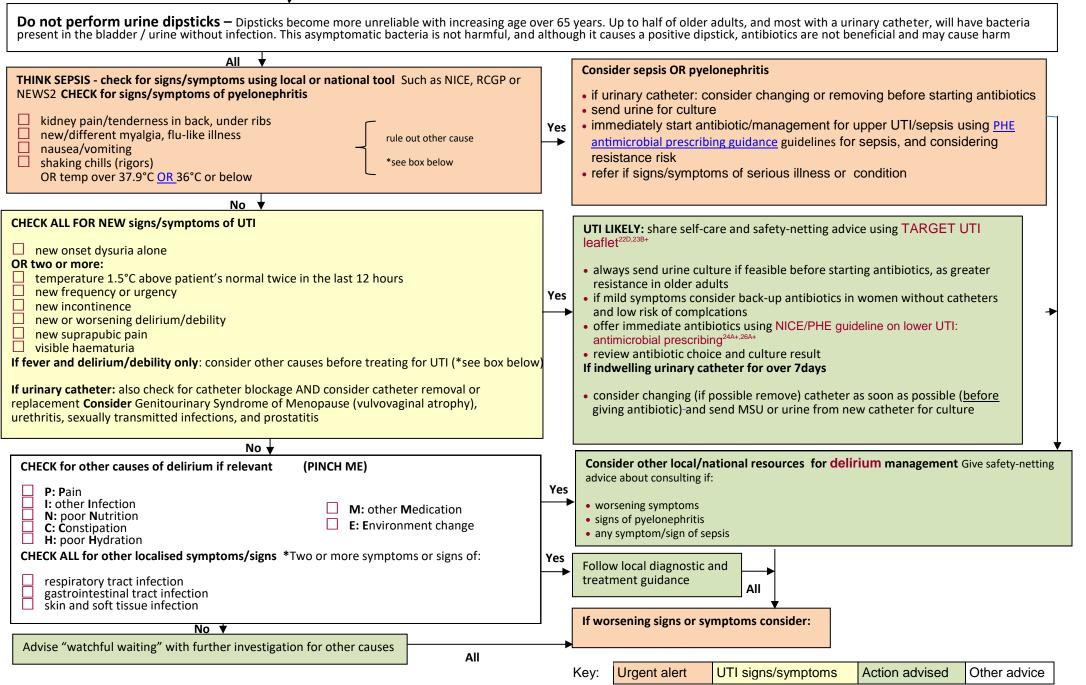


NW UTI Pathway January 2019 for review January 2021 or earlier if guidance changes

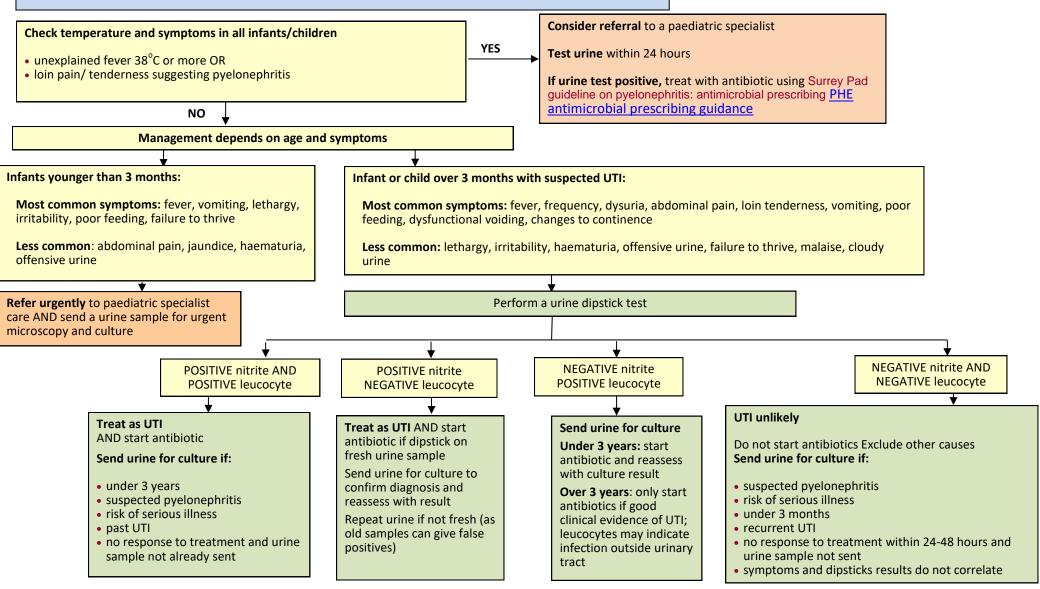
UTI –Flowchart for men and women (over 65 years) with suspected UTI - Urinary signs/symptoms, abnormal temperature, non-specific signs of infection



NW UTI Pathway January 2019 for review January 2021 or earlier if guidance changes

Flowchart for Infants/children with suspected UTI

Consider UTI in any sick child and every young child with unexplained fever



In ALL follow NICE/PHE guideline on lower UTI: antimicrobial prescribing, safety-net and give self-care advice: advise carer to bring the infant or child for reassessment if the infant or child is not improved or worse after 24–48 hours

Refer to NICE CG54 for other things to consider in suspected UTI in children. For treatment refer to joint NICE/PHE guidance: NICE guidelines on UTI (lower): antimicrobial prescribing or NICE guidelines on pyelonephritis (acute): antimicrobial prescribing

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Diagnostic points for men under 65 years - Asymptomatic bacteriuria is rare in men <65yrs^{4C}

Consider other genitourinary causes of urinary symptoms

- in sexually active, check sexual history for STIs for example chlamydia and gonorrhoea
- urethritis due to urethral inflammation post sexual intercourse, irritants, or STIs

Check for pyelonephritis, prostatitis, systemic infection, or suspected sepsis using local policy

- urinary symptoms with fever or systemic symptoms in men are strongly suggestive of prostatic involvement or pyelonephritis
- acute prostatitis may present with feverish illness of sudden onset, symptoms of prostatitis (low back, suprapubic, perineal, or sometimes rectal pain), symptoms of UTI (dysuria, frequency, urgency or retention), or exquisitely tender prostate on rectal examination
- recurrent or relapsing UTI in men should prompt referral to urology for investigation

Diagnostic points in men

- always send a mid-stream urine sample for culture, collected before antibiotics are given
- dipsticks are poor at ruling out infection. Positive nitrite makes UTI more likely (PPV 96%). Negative for both nitrite and leucocyte makes UTI less likely, especially if symptoms are mild
- if suspected UTI, offer immediate treatment according to NICE/PHE guideline on lower UTI: Surrey Pad: http://pad.res360.net/ antimicrobial prescribing and review choice of antibiotic with pre-treatment culture results

Sampling in children:

- if sending a urine culture, obtain sample before starting antibiotics
- if child has alternative site of infection do not test urine unless remain unwell then test within 24 hour
- in infants/toddlers, clean catch urine advised; gentle suprapubic cutaneous stimulation using gauze soaked in cold fluid helps trigger voiding; clean catch urine using potties cleaned in hot water with washing up liquid; nappy pads cause more contamination, and parents find bags more distressing
 if non-invasive not possible consider: catheter sample, or suprapubic aspirate (with ultrasound guidance)
 culture urine within 4 hours of collection, if this is not possible refrigerate, or use boric acid preservative. Boric acid can cause false negative culture if urine not filled to correct mark on
- specimen bottle

Interpretation of culture results in children:

- single organism >106 cfu/L (103 cfu/mL) may indicate UTI in voided urine
- any growth from a suprapubic aspirate is significant
- pyuria >107 WBC/L (104 WBC/mL) usually indicate UTI, especially with clinical symptoms but may be absent

Other diagnostic tests: do not use CRP to differentiate upper UTI from lower UTI -Ultrasound: if proven UTI is atypical (seriously ill, poor urine flow, abdominal or bladder mass, raised creatinine, septicaemia, failure to respond to antibiotic within 48 hours, non-E.coli infection): ultrasound all children in acute phase and undertake renal imaging within 4-6 months if under 3 years. ALL ages with recurrent UTI for children under 6 months OR those with non-E.coli UTI: ultrasound within 6 weeks if UTI not atypical AND responding to antibiotics