Suspected Urinary Tract Infection

Clinical Assessment/ Management tool for Children

Management - Primary Care and Community Settings





This guidance has been reviewed and adapted by healthcare professionals across HWE with consent from the Healthier Together Steering group

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.





Suspected Urinary Tract Infection

Clinical Assessment/ Management tool for Children

Management - Primary Care and Community Settings

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*
- 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

*Urine collection in infants Kaufmann et al BMJ open

Box 2

Treatment

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

>3 months of age:

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

Refer NICE guidance for more information on treatment of both lower UTI and upper UTI (pyelonephritis).

Scenario: UTI in children | Management | Urinary tract infection - children | CKS | NICE Refer to BNFC for antibiotic dosing.

Urinary-tract infections | Treatment summaries | BNFC | NICE

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: UTI Management guidance for Under 16s

This guidance has been reviewed and adapted by care professionals across HWE with consen from the Hampshire development groups

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.





