

## **BAPN Response to NICE Guidance CG 54 : Urinary Tract Infection in Childhood**

### **Purpose of Questionnaire:**

The questionnaire was devised to assess the response of the BAPN membership to CG 54.

### **Outline of Questionnaire**

66 statements were extracted from CG 54.

The BAPN membership was asked to respond to each statement as:-

Yes	(agree)
No	(Disagree)
Not Appropriate	(N/A)
Insufficient Evidence	(I/E)

A single response was requested from each unit. However, where there was diversity within units, more than one response was accepted.

### **BAPN Responses**

- There were 20 responses from 19 units.
  - 14 responses were received from 13 paediatric nephrology "dialysis" units.
  - 6 responses were received from 6 paediatric units with interest in nephrology "non-dialysis units".

### **Summary of BAPN Responses**

100% of units responded yes to 21 out of 66 (27%) statements. 45 statements yielded a slow/not applicable/insufficient evidence ("non yes") response from one or more units

The highest level of 'non yes' answers was seen in the following categories :-

- i. Imaging Tests (7/9 statements).
- ii. Follow up (7/9 statements)
- iii. Management (12 out of 18 statements)
- iv. Diagnosis (19 out of 29 statements)

### **Statements receiving non-yes responses from > 30% of units**

**1.1.5.1** Urine testing strategies for children three years or older - dipstick testing for leucocyte esterase and nitrite is diagnostically as useful as microscopy and culture and can safely be used.

Yes	-	10
No	-	9
Insufficient Evidence	-	1

1.1.5.1 Urine testing strategies for children three years or older - leucocyte esterase and nitrite are negative. The child should not be regarded as having UTI. Antibiotic treatment for UTI should not be started and a urine sample should not be sent for culture. Other causes of illness should be explored.

Yes	-	12
No	-	4
Not Applicable	-	1
Insufficient Evidence	-	3

1.1.8.1. Infants and children who have bacteriuria and fever of 38°C or higher should be considered to have acute pyelonephritis/upper urinary tract infection. Infants and children presenting with fever lower than 38°C with loin pain/tenderness and bacteriuria should also be considered to have acute pyelonephritis/upper urinary tract infection. All other infants and children who have bacteriuria but no systemic symptoms or signs should be considered to have lower urinary tract infection.

Yes	-	11
No	-	1
Not Applicable	-	1
Insufficient Evidence	-	7

**1.2.1.4** For infants and Children 3 months or older with cystitis/lower urinary tract infection:

- treat with oral antibiotics for three days. The choice of antibiotics should be directed by locally developed multi-disciplinary guidance. Trimethoprim, Nitrofurantoin, cephalosporin or Amoxicillin may be suitable.

Yes	-	10
No	-	4
Insufficient Evidence	-	6

1.2.1.8 Asymptomatic bacteriuria in infants and children should not be treated with antibiotics.

Yes	-	12
No	-	3
Not Applicable	-	3
Insufficient Evidence	-	2

1.2.3.1. Antibiotic prophylaxis should not be routinely recommended in infants and children following first time UTI.

Yes	-	11
No	-	4
Insufficient Evidence	-	5

**1.3.1.3** Infants and Children aged six months and older with first time UTI's that respond to treatment, routine ultrasound is not recommended unless the infant or children has atypical UTI, as outlined in Tables 7 and 8.

Yes	-	6
No	-	10
Not Applicable	-	1
Insufficient Evidence	-	3

**1.3.1.4.** Infants and Children who have had a lower urinary tract infection should undergo ultrasound (within six weeks) only if they are younger than six months or have had recurrent infections.

Yes	-	9
No	-	8
Insufficient Evidence	-	3

1.3.1.5 A DMSA scan four to six months following the acute infection should be used to detect renal parenchymal defect as outlined in Tables 6, 7 & 8.

Yes	-	13
No	-	5
Insufficient Evidence	-	2

1.3.1.6. If the infant or child has subsequent UTI while awaiting a DMSA, the timing of the DMSA should be reviewed and consideration given to doing it sooner.

Yes	-	12
No	-	8

1.3.1.7. Routine imaging to identify VUR is not recommended for infants and children who have had a UTI, except in for specific circumstances, which are outlined in tables 6, 7 & 8.

Yes	-	14
No	-	4
Insufficient Evidence	-	2

**1.3.1.9** Infants and Children who have had a UTI should be imaged as outlined in Table 6, 7 & 8.

Yes	-	10
No	-	7
Insufficient Evidence	-	3

**1.5.1.6.** Infants and Children with a minor, unilateral renal parenchymal defect do not need long term follow up unless they have recurrent UTI or family history or life style risk factors for hypertension.

Yes	-	8
No	-	6
Insufficient Evidence	-	5

## **Overall Summary**

13 out of 66 statements generated non-yes responses from 30% of units or more. Six statements elicited a non-yes response in 50% of units or more (highlighted).

## **Supplementary Point**

In addition to the responses detailed above, there was a consistent view that urine should be sent for culture in all children where there is a suspicion of urinary tract infection. This is contrary to the recommendations outlined in Section 1.1.6.1

## **Appendix One**

Results of BAPN Questionnaire – Assessment of NICE Guidance CG 54

## **Appendix Two**

Participating centres:-

Dialysis Centres – Leeds, Liverpool, Great Ormond Street (2 responses), Evalina, Bristol, Southampton, Birmingham, Cardiff, Nottingham, Newcastle, Belfast, Manchester, Glasgow

Non-Dialysis Centres – Leicester, Plymouth, St Marys, Paddington, Oldham, Manchester General Hospital and Gloucester.

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