Urinary Tract Infections - refer to PHE UTI guidance for diagnosis information

Illness	Comments	Drug	Dose	Duration of Tx
Note: doses are oral and for adults unless otherwise stated. Please refer to BNF for further information.				
UTI in adults (no fever or flank pain)	**Treat women** with severe/or ≥ 3 symptoms. Women with mild/or ≤ 2 symptoms AND a) Urine NOT cloudy 97% negative predictive value (NPV), do not treat unless other risk factors for infection. b) If cloudy urine use dipstick to guide treatment. Nitrite plus blood or leucocytes has 92% positive predictive value; nitrite, leucocytes, blood all negative 76% NPV c) Consider a back-up / delayed antibiotic option **Men**: Consider prostatitis and send pre-treatment MSU OR if symptoms mild/non-specific, use negative dipstick to exclude UTI. Men with symptoms of an upper urinary tract infection should be referred for urological investigation. **Always safety net.** ***First line**: nitrofurantoin if eGFR over 45ml/min eGFR 30-45:only use if resistance & no alternative	Nitrofurantoin (see comments)* OR Trimethoprim OR (Pivmecillinam - only if reported as sensitive and other agents not clinically appropriate) *If organism susceptible* Amoxicillin	100mg mr BD 200mg BD 400mg STAT then 200mg TDS 500mg TDS	Women all ages, 3 days Men 7 days
		In treatment failure: ALWAYS perform culture		

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UTI in pregnancy	Send MSU for culture and start antibiotics. Although short term use of nitrofurantoin in pregnancy is unlikely to cause problems to the foetus, avoid at term as may produce neonatal haemolysis. Avoid trimethoprim if low folate status or on folate antagonist (e.g. antiepileptic or proguanil). Avoid Nitrofurantoin in renal impairment if eGFR less than 45ml per minute per 1.73 m^2	**First line:** Nitrofurantoin If susceptible: Amoxicillin **Second line:** Trimethoprim **Give folate if 1st trimester**	100 mg m/r BD 500 mg TDS 200mg BD (off-label)	7 days
UTI in Children	Infants, children and young people with a urinary tract infection should have risk factors for urinary tract infection and serious underlying pathology recorded as part of their history and examination, in order to identify whether onward referral and further investigations will be needed Child <3 months: refer urgently for assessment. Child ≥ 3 months: use positive nitrite to guide. Start antibiotics, ALSO send pre-treatment MSU. Imaging: only refer if child <6 months, or recurrent or atypical UTI	**Lower UTI:** Trimethoprim OR nitrofurantoin. *If susceptible*, amoxicillin Second line: Co-amoxiclav **Upper UTI:** Co-amoxiclav	Refer to BNFC	3 days 7-10 days

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Catheter associated UTI	**Catheter in situ: antibiotics will not eradicate asymptomatic bacteriuria;** only treat if systemically unwell or pyelonephritis likely [2B+]. Do not use prophylactic antibiotics for catheter changes unless history of catheter-change-associated UTI or trauma (NICE & SIGN guidelines). 1. Routine CSU for cultures and sensitivities are not indicated. 2. A clearly marked CSU with relevant clinical details should be sent for C&S prior to starting antibiotic treatment, if infection suspected. 3. Laboratory microscopy and dipstick testing should not be used to diagnose UTI in catheterised patients as they often have while cells or bacteraemia because of the catheter. A strong smelling urine is not indicative of a UTI. 4. Symptoms that may suggest UTI include fever, flank pain, or supra-pubic discomfort, change in voiding patterns, nausea, vomiting, malaise or confusion. Patients should be referred to hospital if systemic symptoms such as fever, chills, rigors or confusion appear. 5. In patients with a long term indwelling catheter, it should be changed 12 to 24 hours after treatment for symptomatic UTI has been started. 6. Take into account previous treatments and culture results when choosing an antibiotic for empirical treatment. 7. If no previous sensitivities are available and if immediate treatment for lower UTI is required treat empirically with **trimethoprim 200mg BD for 7 days or contact Microbiology for advice.**			

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Acute pyelonephritis	If admission not needed, send MSU for culture & sensitivities and start antibiotics. If no response within 24 hours, admit.	Co-amoxiclav **or** Ciprofloxacin	625mg TDS 500 mg BD	14 days 7 days
Acute prostatitis	Send MSU for culture and start antibiotics. 4-wk course may prevent chronic prostatitis. Quinolones achieve higher concentrations in the prostate tissue than trimethoprim .	**Ciprofloxacin** **2nd line:** Trimethoprim	500 mg BD 200 mg BD	28 days 28 days

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