Definition: The presence of a pure growth of more than 100,000 colony-forming units (cfu) of bacteria per milliliter of urine in a patient with clinical signs and laboratory values suggestive of UTI (positive urinalysis required). Lower counts of bacteria may be clinically significant, especially in boys and specimens obtained by catheterization or suprapubic aspiration. (1,2)

Pathophysiology: The disease is usually caused by a bacterial infection. *Escherichia coli* is the most common bacterial species identified. Other common gram negative species include *Klebsiella*, *Proteus*, *Enterobacter*, and *Citrobacter*. Gram positive species include *Staphylococcus saprophyticus* and *Enterococcus*. Pyelonephritis results from bacterial infection of the kidney.

Inclusion Criteria (1-3)
- 1 month - 12 years
- Prepubertal children
- First episode of UTI
- Febrile

Exclusion Criteria (1-3)
- Afebrile
- Conditions in which immunity may be compromised (e.g., transplant recipient [solid organ or hematopoietic], chronic renal insufficiency/kidney disease)
- Known major genitourinary anomalies
- Toxic-appearing
- Sepsis with shock or meningitis
- PICU or NICU 3/4 admission
- Extended-spectrum beta-lactamase (ESBL) producing bacteria
- Other severe comorbid conditions

Differential Diagnosis
Renal abscess Discitis
Kidney stones Trauma
Sacroilitis Fever
Vertebral osteomyelitis Gastroenteritis
Appendicitis Vaginitis/Urethritis

Diagnostic Evaluation: Children with urinary tract infections have a risk of progressing to septic shock. Clinicians should immediately refer to the Septic Shock guideline and intervene rapidly if patient has toxic appearance, ill appearance, altered mental status, and/or compromised perfusion with abnormal vital signs.

Vital Sign Changes of Sepsis (4)

<table>
<thead>
<tr>
<th>Age</th>
<th>Heart Rate</th>
<th>Resp Rate</th>
<th>Systolic BP</th>
<th>Temp (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0d - 1m</td>
<td>&gt;205</td>
<td>&gt;60</td>
<td>&lt;60</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;1m - 3m</td>
<td>&gt;205</td>
<td>&gt;60</td>
<td>&lt;70</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;3m - 1y</td>
<td>&gt;190</td>
<td>&gt;80</td>
<td>&lt;70</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;1y - 2y</td>
<td>&gt;190</td>
<td>&gt;40</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;2y - 4y</td>
<td>&gt;140</td>
<td>&gt;40</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;4y - 6y</td>
<td>&gt;140</td>
<td>&gt;34</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;6y - 10y</td>
<td>&gt;140</td>
<td>&gt;30</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;10y - 13y</td>
<td>&gt;100</td>
<td>&gt;30</td>
<td>&lt;90</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;13y</td>
<td>&gt;100</td>
<td>&gt;16</td>
<td>&lt;90</td>
<td>&lt;36 or &gt;38</td>
</tr>
</tbody>
</table>

Clinical history, physical examination, and labs are used to diagnose UTI.

History: Assess for
- Urinary symptoms (incontinence, lack of proper stream, withholding maneuvers, frequency, urgency, dysuria)
- Previous UTIs
- Vesicoureteral reflux (VUR)
- Previous undiagnosed febrile illnesses
- Family history of frequent UTIs, VUR, and other genitourinary abnormalities
- Constipation
- Sexual history

Physical Examination
Complete routine vital signs including blood pressure
Assess for
- Toxic appearance, irritable
- Fever
- Disinterested in feeding
- Lethargic
- Poor tone (floppy)
- Poor perfusion
- Sluggish capillary refill
- Tachycardia or bradycardia
- Tachypnea or apnea
- Sunken fontanelle
- Dry mucous membranes
- Jaundice
- Vomiting
- Suprapubic tenderness
- Abdominal/Flank tenderness
- Abdominal mass
- Failure to thrive

Laboratory Tests (5)
Urinalysis is positive if the sample is positive for leukocyte esterase (LE) or nitrates or microscopy is positive for WBC (≥5 WBCs per high-power field) or bacteria. UTI is unlikely (<0.3%) if the urinalysis is negative.
**Sensitivity and Specificity of Urinalysis Components** *(1,8-9)*

Consider empiric treatment until culture results are available.

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>LR+</th>
<th>LR-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dipstick</td>
<td>70%</td>
<td>98%</td>
<td>35</td>
<td>0.3</td>
</tr>
<tr>
<td>Dipstick &amp; Micro</td>
<td>80%</td>
<td>64%</td>
<td>2.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Dipstick &amp; Micro 0-1 mos</td>
<td>82%</td>
<td>92%</td>
<td>10</td>
<td>0.2</td>
</tr>
<tr>
<td>Dipstick &amp; Micro &gt;1-3 mos</td>
<td>82%</td>
<td>94%</td>
<td>13</td>
<td>0.07</td>
</tr>
<tr>
<td>Bag LE</td>
<td>76%</td>
<td>84%</td>
<td>4.75</td>
<td>0.29</td>
</tr>
</tbody>
</table>

If nitrites are positive, diagnosis of UTI is very likely.

*LR+: a positive test increases the odds that a patient has the disease by this factor

*LR-: a negative test decreases the odds that a patient has the disease by this factor

---

**Positive Urine Culture** *(1,3)*

<table>
<thead>
<tr>
<th>Test</th>
<th>Minimum CFU/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheterization/Suprapubic Aspiration</td>
<td>&gt;50,000 cfu/mL</td>
</tr>
<tr>
<td>Midstream Clean Catch</td>
<td>≥100,000 cfu/mL</td>
</tr>
</tbody>
</table>

Urine specimens should be processed as expeditiously as possible. If the specimen is not processed promptly, then it should be refrigerated to prevent the growth of organisms. Urine specimens with ≥3 different colony types above the threshold will not be evaluated.

---

**Critical Points of Evidence**

**Evidence Supports**

- Obtain a urine specimen via transurethral catheterization in non-toilet trained children and via midstream clean catch for toilet trained children. *(8-14)* – Strong recommendation, moderate quality evidence
- For rapid diagnosis of UTI, utilize LE and nitrite testing. *(13,15-22)* – Strong recommendation, moderate quality evidence
- Obtain a renal ultrasound (RUS) in children 1-24 months with their first febrile UTI. If RUS is normal, a voiding cystourethrogram (VCUG) is not needed. Consider a RUS based on clinical findings in children >24 months. *(23-44)* – Strong recommendation, moderate quality evidence
- Administer oral antibiotics (7-14 days total of effective antimicrobial therapy) to toilet trained children and/or children >60 days who are tolerating PO. *(45-49)* – Strong recommendation, moderate quality evidence
- Administer oral antibiotics (10-14 days total of effective antimicrobial therapy) and consider outpatient management for non-toilet trained children and/or children 31-60 days who meet the following criteria: no elevated inflammatory markers, tolerating PO, well-hydrated, not tachycardic, adequate transportation, ability to follow up with PCP within 24-48 hours. *(46-51)* – Weak recommendation, low quality evidence
- Utilize short-course IV antibiotics (3-4 days) followed by oral antibiotics (once afebrile and feeding adequately) in children who require admission. Total duration of effective antimicrobial therapy should be 10-14 days for non-toilet trained children and/or children 31-60 days and 7-14 days for toilet trained children or children >60 days. *(46-49)* – Strong recommendation, low quality evidence
- The health benefits of newborn male circumcision outweigh the risks and that the procedure’s benefits justify access to this procedure for families who choose it (per the AAP’s Circumcision Policy Statement). *(52-55)* – Strong recommendation, moderate quality evidence

**Evidence Against**

- Do not routinely administer prophylactic antibiotics to infants/children with their first febrile UTI with a normal renal ultrasound. *(56-62)* – Strong recommendation, moderate quality evidence
- Do not administer prophylactic antibiotics to infants/children with Grades I-III vesicoureteral reflux. *(56-62)* – Weak recommendation, moderate quality evidence

**Evidence Lacking/Inconclusive**

- A positive culture is indicated by >50,000 cfu/mL of a single urinary pathogen from a urine specimen obtained by catheterization or SPA. The cutoff for a clean-catch specimen from a child beyond toilet-training is >100,000 cfu/mL. The diagnosis of UTI requires both a positive culture and a urinalysis suggesting infection. *(63-64)* – Weak recommendation, very low quality evidence
- No evidence addressing whether the diagnostic accuracy of RUS is affected if taken within two days after UTI diagnosis versus several days after diagnosis.

*NOTE: The references cited represent the entire body of evidence reviewed to make each recommendation.*
**Condition-Specific Elements of Clinical Management**

**Urine Specimen for Urinalysis and Culture*** (1-14)
- Non-toilet trained children: transurethral catheterization
- Toilet trained children: midstream clean catch

**Hydration**
- IV fluids if not taking oral fluids adequately.

**Imaging Studies** (1,23-44)

<table>
<thead>
<tr>
<th>Age</th>
<th>Imaging Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-24 months</td>
<td>Renal ultrasound (RUS)</td>
</tr>
<tr>
<td></td>
<td>If RUS is normal, a VCUG is not needed.</td>
</tr>
<tr>
<td>&gt;24 months</td>
<td>RUS at discretion of physician based on clinical findings</td>
</tr>
</tbody>
</table>

*VCUG may be performed as soon as fever is decreasing and culture-specific antibiotics are in use. There is no need to perform an additional urinalysis if the patient is on appropriate antibiotics.

**Admission Criteria**
- Unable to tolerate oral fluids (requires IV fluids for hydration)
- Failed outpatient therapy (requires IV antibiotics)

**Inpatient Discharge Criteria**
- A decreasing trend in daily maximal temperatures combined with physician discretion
- On culture-specific antibiotics
- Tolerating oral intake
- Patient/Caregiver discharge teaching completed on:
  - Discharge care
  - Signs and symptoms of concern
  - Risk of recurrence
  - Proper perineal care
  - Documentation of scheduled PCP follow-up

**Parent Teaching**
- Teach parents to recognize symptoms of UTI
- Clearly explain the course of necessary testing and treatment
- Explain strategies to prevent future recurrence (e.g., adequate hydration, frequent voiding, perineal hygiene, completion of antibiotic course)
- Pediatrician follow-up

**Consults/Referrals**
- Refer to urology if surgical intervention is being considered and/or if child has VUR.
- Refer to nephrology if child has VUR and associated renal insufficiency, hypertension, abnormal serum chemistries, or renal scarring.

**Measures**

**Structure**
- Location of radiologic studies (inpatient or outpatient setting)

**Process**
- Utilization of the order set(s)
- Frequency of completed radiologic studies
- Time frame to complete radiologic studies

**Outcome**
- Use of prophylactic antibiotics with documented reflux
- EC visit within 14 days and reason for visit
- Documented use of prophylactic antibiotics
- Length of stay
- Organisms and their resistance patterns
- Rate of positive/negative RUS, radionuclide cystogram, and VCUG

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### Antibiotic Therapy

Consider insurance/Medicaid formulary restrictions.

#### Empirical Oral Therapy - Outpatient

<table>
<thead>
<tr>
<th>Age &amp; Weight Parameters</th>
<th>Dose and Frequency</th>
<th>TCH Formulary</th>
<th>Cost $-$$$$$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cefixime</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants and children ≤45 kg</td>
<td>8 mg/kg/dose PO every 24 h (MAX: 400 mg/DAY)</td>
<td>No</td>
<td>$$$$</td>
</tr>
<tr>
<td>Children &gt;45 kg and adolescents</td>
<td>400 mg PO every 24 h</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cefdinir</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children ≥6 months to 12 years</td>
<td>14 mg/kg/dose PO every 24 h (MAX: 600 mg/DAY)</td>
<td>Yes</td>
<td>$$</td>
</tr>
<tr>
<td>Adolescents</td>
<td>600 mg PO every 24 h</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Empirical Parenteral Therapy (IV/IM) - Emergency Center or Inpatient

<table>
<thead>
<tr>
<th>Age &amp; Weight Parameters</th>
<th>Dose and Frequency</th>
<th>TCH Formulary</th>
<th>Cost $-$$$$$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CefTRIAXone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants and children 2-24 months</td>
<td>50-75 mg/kg/dose IV every 24 h (MAX: 2 grams/DAY)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Children &gt;24 months and adolescents</td>
<td>50 mg/kg/dose IV every 24 h (MAX: 2 grams/DAY)</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>CefOTAXime</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children ≥2 months to 12 years (&lt;50 kg)</td>
<td>33-75 mg/kg/dose IV every 8 h (MAX: 2 grams/dose)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Adolescents (≥50 kg)</td>
<td>1-2 grams/dose IV every 8 h (MAX: 2 grams/dose)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Gentamicin</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants, children and adolescents</td>
<td>2.5 mg/kg/dose IV every 8 h (MAX: 3 mg/kg/dose not to exceed 120 mg/dose)</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

*Not for use in patients receiving Y-site administration of calcium-containing IV fluids with a single lumen or single IV site
*Use cefOTAXime as an alternative

#### Directed Oral Therapy (Based on Lab Results)

<table>
<thead>
<tr>
<th>Age &amp; Weight Parameters</th>
<th>Dose and Frequency</th>
<th>TCH Formulary</th>
<th>Cost $-$$$$$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cefixime</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants and children ≤45 kg</td>
<td>8 mg/kg/dose PO every 24 h (MAX: 400 mg/DAY)</td>
<td>No</td>
<td>$$</td>
</tr>
<tr>
<td>Children &gt;45 kg and adolescents</td>
<td>400 mg PO every 24 h</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cefdinir</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children ≥6 months to 12 years</td>
<td>14 mg/kg/dose PO every 24 h (MAX: 600 mg/DAY)</td>
<td>Yes</td>
<td>$$</td>
</tr>
<tr>
<td>Adolescents</td>
<td>600 mg PO every 24 h</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Amoxicillin</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants and children &lt;40 kg</td>
<td>13 mg/kg/dose PO every 8 h (MAX: 500 mg/dose)</td>
<td>Yes</td>
<td>$</td>
</tr>
<tr>
<td>Children and adolescents ≥40 kg</td>
<td>500 mg PO every 8 h</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Trimethoprim and Sulfamethoxazole (TMP/SMX)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children 2-24 months</td>
<td>3-6 mg TMP/kg/dose PO every 12 h (MAX: 160 mg TMP/dose)</td>
<td>Yes</td>
<td>$</td>
</tr>
<tr>
<td>Children &gt;24 months and adolescents</td>
<td>4 mg TMP/kg/dose PO every 12 h (MAX: 160 mg TMP/dose)</td>
<td>Yes</td>
<td>$</td>
</tr>
</tbody>
</table>

#### Directed Parenteral Therapy (IV) - Inpatient (Based on Micro Results)

<table>
<thead>
<tr>
<th>Age &amp; Weight Parameters</th>
<th>Dose and Frequency</th>
<th>TCH Formulary</th>
<th>Cost $-$$$$$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CefTRIAXone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infants and children 2-24 months</td>
<td>50-75 mg/kg/dose IV every 24 h (MAX: 2 grams/DAY)</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Children &gt;24 months and adolescents</td>
<td>50 mg/kg/dose IV every 24 h (MAX: 2 grams/DAY)</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

*Not for use in patients receiving Y-site administration of calcium-containing IV fluids with a single lumen or single IV site
*Use cefOTAXime as an alternative

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### CefOTAXime
**NOTE:** Restricted usage to:
- Neonatal patients (defined as ≤44 weeks postmenstrual age OR neonates <1 month of age)
- Patients receiving calcium-containing IV fluids with a single lumen or single IV site
*Use cefTRIAXone as an alternative

<table>
<thead>
<tr>
<th>Group</th>
<th>Dose Details</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children ≥2 months to 12 years (&lt;50 kg)</td>
<td>33-75 mg/kg/dose IV every 8 h (MAX: 2 grams/dose)</td>
<td></td>
</tr>
<tr>
<td>Adolescents (≥50 kg)</td>
<td>1-2 grams/dose IV every 8 h (MAX: 2 grams/dose)</td>
<td>Yes</td>
</tr>
<tr>
<td>Infants and children</td>
<td>25-50 mg/kg/dose IV every 6 h (MAX: 100 mg/kg/dose not to exceed 2 grams/dose or 12 grams/DAY)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Ampicillin

- Infants and children

<table>
<thead>
<tr>
<th>Dose Details</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-50 mg/kg/dose IV every 6 h (MAX: 100 mg/kg/dose not to exceed 2 grams/dose or 12 grams/DAY)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Gentamicin

- Infants and children

<table>
<thead>
<tr>
<th>Dose Details</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5 mg/kg/dose IV every 8 h (MAX: 3 mg/kg/dose not to exceed 120 mg/dose)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Clinical Algorithm for Children with First Febrile Urinary Tract Infection (UTI)

**Abbreviations:**
- UA - urinalysis
- LE - leukocyte esterase
- IV - intravenous
- RUS - renal ultrasound
- VCU - voiding cystourethrogram

**Inclusion Criteria**
- 1 month - 12 years
- Prepubertal
- First episode of UTI
- Febrile

**Exclusion Criteria**
- Afebrile
- Conditions in which immunity may be compromised (transplant recipient or chronic renal insufficiency/kidney disease)
- Known major genitourinary anomalies
- Toxic-appearing
- Sepsis with shock or meningitis
- PICU or NICU 3/4 admission
- Extended-spectrum beta-lactamase (ESBL) producing bacteria
- Other severe comorbid conditions

**Admission Criteria**
- Unable to tolerate oral fluids (requires IV fluids for hydration)
- Failed outpatient therapy (requires IV antibiotics)

**OFF algorithm**
Search for alternate source of infection and follow up appropriately
NOTE: Antibiotics should be discontinued if the culture is negative and the child has NOT been treated with antibiotics prior to obtaining the urine culture.

- Obtain specimen for analysis (dipstick or urinalysis) and urine culture via transurethral catheterization (non-toilet trained) or midstream clean catch (toilet trained)
- If 29-60 days, refer to the FWLS 0-60 Days guideline for additional studies (e.g., blood culture)

- UA + for LE or nitrates
- OR microscopy + for WBC or bacteria

**Initiate empiric antimicrobial therapy (See antibiotic table, pp. 4-5)**

- Well-appearing and tolerating oral fluids

**OFF algorithm**
Search for alternate source of infection and follow up appropriately

- Admit; consider observation status
- Continue antimicrobial therapy
- Follow culture and adjust therapy based on antimicrobial susceptibility results to choose the most appropriate, narrow spectrum agent

NOTE: Antibiotics should be discontinued if the culture is negative and the child has NOT been treated with antibiotics prior to obtaining the urine culture.

**OFF algorithm**
Search for alternate source of infection and follow up appropriately

**Discharge Criteria**
- Tolerating oral intake
- Patient/Caregiver discharge teaching complete on:
  - Discharge care
  - Signs and symptoms of concern
  - Risk of recurrence
  - Proper perineal care
  - Documentation of scheduled PCP follow-up
- If admitted, decreasing trend in daily maximal temperatures combined with physician discretion

**RUS abnormal**

- PCP to follow up VCUG results for VUR
- Refer to urology if child has VUR and/or surgical intervention is being considered
- Refer to nephrology if child has VUR and associated renal insufficiency, hypertension, abnormal serum chemistries, or renal scarring

**Schedule VCUG**
(may be done outpatient)

**Meets discharge criteria**

**OFF algorithm**
Consider additional antibiotics and search for alternate source of infection; follow up appropriately

**Discharge home on appropriate antibiotics**


3. Cincinnati Children's Hospital Medical Center, Health Policy and Clinical Effectiveness Program. (2006). Evidence-based care guideline for children 12 years of age or less with first urinary tract infection.


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Clinical Standards Preparation
This clinical standard was prepared by the Evidence-Based Outcomes Center (EBOC) team in collaboration with content experts at Texas Children’s Hospital. Development of this clinical standard supports the TCH Quality and Patient Safety Program initiative to promote clinical standards and outcomes that build a culture of quality and safety within the organization.

First Febrile UTI Content Expert Team
Carmen Broussard, Patient and Family Advocate
Andrea Cruz, MD, MPH, Emergency Medicine Infectious Diseases
Ewa Ellenberg, MD, Nephrology
Helen Haney, MD, Texas Children’s Pediatrics
Nicolette Janzen, MD, Urology
Eric Jones, MD, Urology
Shelly Kim, PharmD, Pharmacy
Rajesh Krishnamurthy, MD, Radiology
Robert Orth, MD, Radiology
Debra Palazzi, MD, Infectious Diseases
Geeta Singhal, MD, Pediatric Hospital Medicine
Sowdhamini Wallace, DO, Pediatric Hospital Medicine
Andy Wei, MD, Texas Children’s Pediatrics
Elizabeth Wuestner, RN, Emergency Center

EBOC Team
Jennifer Loveless, MPH, Research Specialist
Karen Gibbs, MSN/MPH, RN, Research Specialist
Charles Macias, MD, MPH, Medical Director

Additional EBOC Support
Tom Burke, Research Assistant
Sherin Titus, Research Assistant
Andrea Jackson, MBA, RN, Research Specialist
Christine Procido, MPH, Research Specialist
Anne Dykes, MSN, RN, Assistant Director
Kathy Carberry, MPH, RN, Director

Development Process
This clinical standard was developed using the process outlined in the EBOC Manual. The literature appraisal documents the following steps:
1. Review Preparation
   - PICO questions established
   - Evidence search confirmed with content experts
2. Review of Existing Internal and External Guidelines
   - Cincinnati Children’s First Urinary Tract Infection in Children ≤12 Years; American Academy of Pediatrics’ Urinary Tract Infection: The Diagnosis and Management of Initial UTI in Febrile Infants and Children 2 to 24 Months; National Institute of Health and Clinical Excellence Urinary Tract Infection in Children
3. Literature Review of Relevant Evidence
   - Searched: PubMed, Cochrane Collaboration, CINAHL, Google
4. Critically Analyze the Evidence
   - 13 systematic reviews/meta-analyses, 3 randomized controlled trials, 39 nonrandomized studies
5. Summarize the Evidence
   - Materials used in the development of the guideline, evidence summary, and order sets are maintained in a UTI evidence-based review manual within EBOC.

Evaluating the Quality of the Evidence
Published clinical guidelines were evaluated for this review using the AGREE II criteria. The summary of these guidelines are included in the literature appraisal. AGREE II criteria evaluate Guideline Scope and Purpose, Stakeholder Involvement, Rigor of Development, Clarity and Presentation, Applicability, and Editorial Independence using a 4-point Likert scale. The higher the score, the more comprehensive the guideline.

This clinical standard specifically summarizes the evidence in support of or against specific interventions and identifies where evidence is lacking/inconclusive. The following categories describe how research findings provide support for treatment interventions.
- “Evidence Supports” provides evidence to support an intervention.
- “Evidence Against” provides evidence against an intervention. “Evidence Lacking/Inconclusive” indicates there is insufficient evidence to support or refute an intervention and no conclusion can be drawn from the evidence.

The GRADE criteria were utilized to evaluate the body of evidence used to make practice recommendations. The table below defines how the quality of the evidence is rated and how a strong versus weak recommendation is established. The literature appraisal reflects the critical points of evidence.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRONG</td>
<td>Desirable effects clearly outweigh undesirable effects or vice versa</td>
</tr>
<tr>
<td>WEAK</td>
<td>Desirable effects closely balanced with undesirable effects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies</td>
</tr>
<tr>
<td>MODERATE</td>
<td>Evidence from RCTs with important limitations (e.g., inconsistent results, methodological flaws, indirect evidence, or imprecise results) or unusually strong evidence from unbiased observational studies</td>
</tr>
<tr>
<td>LOW</td>
<td>Evidence for at least 1 critical outcome from observational studies, RCTs with serious flaws or indirect evidence</td>
</tr>
<tr>
<td>VERY LOW</td>
<td>Evidence for at least 1 critical outcome from unsystematic clinical observations or very indirect evidence</td>
</tr>
</tbody>
</table>

Recommendations
Practice recommendations were directed by the existing evidence and consensus amongst the content experts. Patient and family preferences were included when possible. The Content Expert Team and EBOC team remain aware of the controversies in the diagnosis/management of first febrile UTI in children. When evidence is lacking, options in care are provided in the clinical standard and the accompanying order sets (if applicable).

Approval Process
Clinical standards are reviewed and approved by hospital committees as deemed appropriate for its intended use. Clinical standards are reviewed as necessary within EBOC at Texas Children’s Hospital. Content Expert Teams are involved with every review and update.

Disclaimer
Practice recommendations are based upon the evidence available at the time the clinical standard was developed. Clinical standards (guidelines, summaries, or pathways) do not set out the standard of care and are not intended to be used to dictate a course of care. Each physician/practitioner must use his or her independent judgment in the management of any specific patient and is responsible, in consultation with the patient and/or the patient’s family, to make the ultimate judgment regarding care.

Version History

<table>
<thead>
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<th>Action</th>
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<td>Originally completed</td>
<td>May 2008</td>
</tr>
<tr>
<td>Updated</td>
<td>January 2012</td>
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<td>Updated</td>
<td>December 2015</td>
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