Table 2: PHE management for infection guidance in Primary Care – March 2017

https://www.gov.uk/government/publications/managing-common-infections-guidance-for-primary-care

Please use this link for most recent updates, hyperlinks and references.

URINARY TRACT INFECTIONS

Note: As antibiotic resistance and Escherichia coli bacteraemia in the community is increasing, use nitrofurantoin first line,[1D] always give safety net and self-care advice, and consider risks for resistance.[2D] Give TARGET UTI leaflet,[3D] and refer to the PHE UTI guidance for diagnostic information.[1D]

UTI in adults (lower) PHE UTI TARGET UTI RCGP UTI SIGN UTI NHS Scotland UTI	**Treat women** with severe/≥3 symptoms.[1D,2D] **All patients first line antibiotic:** nitrofurantoin if GFR >45mls/min;[3A+] if GFR 30-45, only use if resistance and no alternative.[4B-] **Women <65 years (mild/≤2 symptoms):**[1D] pain relief,[5A-,6A-] and consider delayed antibiotic.[7D] If urine not cloudy, 97% NPV of no UTI.[8A-] If urine cloudy, use dipstick to guide treatment:[9D] nitrite, leukocytes, blood all negative 76% NPV;[8A-] nitrite plus blood or leukocytes 92% PPV of UTI.[8A-] **Men <65 years:** consider prostatitis and send MSU,[1D,10D] or if symptoms mild or non-specific, use negative dipstick to exclude UTI.[10D] **>65 years:**[11A-] treat if fever >38°C, or 1.5°C above base twice in 12 hours, and >1 other symptoms.[12B-] **If treatment failure:** always perform culture.[1D]	***First line:*** nitrofurantoin[13A-] *If low risk of resistance:* trimethoprim[14D,15A+] ***If first line unsuitable and GFR<45mls/min:***[16A+] pivmecillinam[17B+,18D,19B-,20A+] *If organism susceptible:* amoxicillin[21A+] *If very high resistance risk:* fosfomycin[22A+,23B-,24B+]	100mg m/r BD, *OR* 50mg i/r QDS[25A-] (BD dose increases compliance)[26D] 200mg BD[27D] 400mg stat then 200mg TDS[28B+,29B+] 500mg TDS[27D] Women: 3g stat[27D] Men: 3g dose 3 days later (unlicensed)[38D]	Women: 3 days[30A+,31B-,32B-,33B+] Men: 7 days[34B+,35A+,36A-,37A-]
	Low risk of resistance: younger women with acute UTI and no risk.[31B-,39C] **Risk factors for increased resistance include:** care-home resident;[11A-,12B-] recurrent UTI; hospitalisation for >7 days in the last 6 months; unresolving urinary symptoms; recent travel to a country with increased resistance; previous UTI resistant to trimethoprim, cephalosporins, or quinolones.[31B-,39C,40D] **If risk of resistance:** send urine for culture and susceptibilities; safety net.[31B-]			
UTI in patients with catheters: antibiotics will not eradicate asymptomatic bacteriuria;[1D,2D] only treat if systemically unwell or pyelonephritis likely.[2D] Do not use prophylactic antibiotics for catheter change unless there is a history of catheter-change-associated UTI or trauma.[3D,4A+] Take sample if new onset of delirium, or one or more symptoms of UTI.[5A-,6B-,7D]				
UTI in pregnancy SIGN UTI	Send MSU for culture;[1D] start antibiotics in all with significant bacteriuria, even if asymptomatic.[1D] Avoid trimethoprim if first trimester or low folate status,[2D,3D,4D] or on folate antagonist.[2D,3D] Short-term use of nitrofurantoin is appropriate.[4D,5D] Avoid cephalosporins as high risk of *C. difficile*.[6C]	Nitrofurantoin[4D,5D] (avoid at term)[4D,5D] Trimethoprim[3D,4D] *Give folate if first trimester*[2D] Cefalexin[3D,4D,7D]	100mg m/r BD[4D] *OR* 50mg i/r QDS[4D] 200mg BD (off-label)[4D] 500mg BD[4D]	7 days[8D]
Acute prostatitis	Send MSU for culture and start antibiotics.[1D] 4 week course may prevent chronic prostatitis.[1D,2D] Quinolones achieve high prostate levels.[1D,2D]	Ciprofloxacin[1D,3D] *OR* ofloxacin[1D,3D] *Second line:* trimethoprim[1D]	500mg BD[1D] 200mg BD[1D] 200mg BD[1D]	28 days[1D,2D]
UTI in children NICE UTI in under 16s	**Child <3 months:** refer urgently for assessment.[1D] **Child >3 months:** use positive nitrite to guide antibiotic use;[1A-] send pre-treatment MSU.[1D] **Imaging:** refer if child <6 months, or recurrent or atypical UTI.[1D]	**Lower UTI:** nitrofurantoin[1A-] *OR* trimethoprim[1A-] *Second line:* cefalexin[1D] *If organism susceptible:* amoxicillin[1A-] **Upper UTI:** co-amoxiclav[1A+] *Second line:* cefixime[2A+]		3 days[1A+,3A+] 7-10 days[1A+]
Acute pyelonephritis	If admission not needed, send MSU for culture and susceptibility testing,[1D] and start antibiotics.[1D] If no response within 24 hours, seek advice.[2D] **If ESBL risk**,[3D] and on advice from a microbiologist, consider IV antibiotic via OPAT.[4D]	Ciprofloxacin[5A-,6D] *OR* co-amoxiclav[5A-] *If organism sensitive:* trimethoprim[5A-,7A+]	500mg BD[5A-,6D,8D] 500/125mg TDS[8D] 200mg BD[8D]	7 days[5A-,7A+] 7 days[5A-,7A+] 14 days[7A+]
Recurrent UTI in non-pregnant women *(2 in 6 months or ≥3 in a year)* TARGET UTI	**First line:** advise simple measures,[1D] including hydration[2D,3D] and analgesia.[4A-,5A-] Cranberry products work for some women.[6A+,7A+] **Second line:** standby[1D] or post-coital antibiotics.[8A+] **Third line:** antibiotic prophylaxis.[1D,8A+,9D] Consider methenamine if no renal/hepatic impairment.[10A+,11D]	*First line:* nitrofurantoin[11D] Ciprofloxacin[8A+,11D] *If recent culture sensitive:* trimethoprim[11D] Methenamine hippurate[10A+]	100mg m/r[11D] 500mg[11D] 100mg[11D] 1g BD[11D]	At night or post-coital stat (off-label)[1D,8A+,9D,11D] 3-6 months,[1D,11D] then review recurrence rate and need[1D,8A+] 6 months[11D]