RCGP College Response - Urinary tract infection: diagnostic tools for primary care

General feedback for the resource including the background section

1. Overall, It is clear and useful, and we are pleased to see that pregnancy has been highlighted. The changes to previous well-constructed pathways are limited. Additionally, the inclusion of the text and algorithms are useful. However, in practice, most clinicians are using NICE CKS as a guide. This is useful for many Additional role staff in General Practice but could also be used within the context of Pharmacy First and would include Community Pharmacy too.
2. It is important to provide some acknowledgment of the fact that it is not always possible to send a urinary sample off e.g. if a person cannot provide one, or if its too late for primary care transport of specimens to the hospital lab as at present you will be sent several fridged overnight specimens.
3. RBCs: it is lamentable that these were removed from lab results as they were an excellent past sign for secondary pathology. The microhematuria picked up on stick testing or macrohematuria in conjunction with positive UTI diagnosis therefore needs a statement to ensure it is cleared in x days post treatment to rule out hematuria and therefore a referral. The guidance must include other eventualities and not be exclusive to UTI.
4. Put sending sample at the start and interpretation at the end (as is)
5. SaIt would be useful to cover: the rationale for antibiotic choice (as NICE publishes only 'quick guidance'); the differences between use for Lower and Upper UTI; the significance of some antibiotics concentrating in the bladder (especially nitrofurantoin, trimethoprim) and thus 'overperforming' as treatment choices for cystitis (Gupta, Hooton, Stamm 2001 Ann Intern Med); and the importance of preserving wider spectrum antibiotics for more severe infections.

Diagnostic decision tool for women (under 65 years) with suspected urinary tract infection - algorithm, web text, and rationale

1. Evidence appears almost unchanged, and pathway is sensible and pragmatic.
2. The use of ciprofloxacin as first line and NICE advice re antimicrobial stewardship and C Diff
3. For the layout, particularly for the algorithm, we appreciate the need to try and put all the information in one page however it makes it very congested and less accessible to follow. The text is stepwise and helpful but again compared to other resources (namely CKS) it is harder to follow. To enhance accessibility, we recommend trying to use single colour gradients and accounting for those who have colour differentiation challenges. Similarly, the text size is small and for those with dyslexia or challenges with text-based information, the flow and content are not succinct.
4. Overall, the information is clinically sound and follows known principles. We believe it lends itself well for teaching purposes and is likely to be used.

Diagnostic points for men under 65 years - web text and rationale

1. Overall, it is easy to follow. We are pleased to see that it emphasises that most urinary symptoms are not UTIs. However, we recommend considering if this is a symptom due to BPH, prostate cancer or bladder cancer if the patient is a smoker. Simple UTIs is rare in adult men.
2. The section stating: It is important not to use dipsticks to rule out infection as they are unreliable for this (see rationale), is simple and understandable. However, we believe that the next sentence should start with - Use dipsticks to rule in infection, A urine dipstick test with positive nitrates makes UTI more likely in men (PPV 96%). This will make the impact of the two statements clear.
3. A negative for both nitrite and leucocyte makes UTI less likely, especially if symptoms are mild. We believe this is confusing as this is using a dipstick to rule out infection (contradicts the above statement suggesting not using a dipstick to rule out infection).

Diagnostic decision tool for adults over 65 years with suspected uncomplicated UTI - algorithm, web text and rationale

1. We are pleased to see STIs considered in older people.
2. Temperature above 1.5C of a person's normal temperature is unhelpful. We recommend providing a number as no one knows their usual temperature, as this may be an unnecessary complication. Pyrexia is pyrexia in primary care, they are not being monitored in bed.
3. We believe, retention for older men should be in symptoms as it can often aggravate prostatic issues
4. We are concerned that age cut-offs seem to vary in the guidance and we wonder whether your pathways should also consider this approach. Frailty is a better indication of how UTI should be approached than age and adults with frailty are more likely to deteriorate more quickly and this is relevant in terms of risk of Delerium.
5. We would also recommend the use of 4AT in diagnosing Delerium.
6. We are concerned that dysuria is promoted as a single sign. The referenced study concludes that painful voiding is a symptom more associated with UTI in older people but burning pain is not. As both of them are symptoms of dysuria, this appears confusing. We question with the small numbers in the cohort study and this contradiction whether this is sufficient evidence to back up the decision to base the initial diagnosis on dysuria alone

Diagnostic decision tool for adults who have a suspected catheter-associated UTI (CAUTI) - algorithm, web text and rationale

1. We agree with the pathway, but recommend providing stronger emphasis on the fact that fever + delirium + positive MSU does not necessarily = UTI as the cause. This may help to reduce the number of hospital discharge letters that attribute these symptoms to UTI, when other relevant conditions are not investigated. As with the elderly, it is important to distinguish that Lower and Upper UTIs Nitrofurantoin are sometimes used inappropriately because of diagnostic confusion, and lower UTIs are overdiagnosed in catheterized patients (and sometimes Upper UTI underdiagnosed). The rationale is correct but one has to read the passage a couple of times to reassure yourself that it is in line with visual pathway i.e. don't send samples for uncomplicated UTI in adult women under 65 – This needs to be made clearer.
2. For paragraph 3, we would like to make the same comment as above regarding the temp of 1.5C above normal, twice in the last 12 hours. This is not a practical situation for general practice and would suggest rewording it.
3. We recommend including something about the person or carer checking catheter outflow after the initial assessment

Rationale for sending urine for culture and interpreting results in all adults - web text and rationale

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Any other comments

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