National Institute for Health and Clinical Excellence

CG54: Urinary Tract Infections in children
Guideline Review Consultation Comments Table
18 November – 1 December 2010

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
GDG member	NO	The algorithm is too complex and some of the evidence/ consensus contested. If CG54 does not increase diagnostic accuracy (there is some evidence that this may be true) then it would be better to reconfigure/ simplify the algorithm to improve implementation and pick-up rates. The T38 degree cut off, age ranges for consideration of risk and management, and imaging choices are reported areas of disagreement. The concept of selecting children for investigation rather than mass screening (on presentation of a +ve MSU) appears accepted but the evidence for individual criteria on which we can base a selective strategy isn't strong. The message emphasising diagnosis does appear to have been successfully communicated, but the problem of over-diagnosis appears as common as the lack of consideration of a possible UTI – however, this may be difficult to address until 'DUTY' reports. I personally feel the evidence for the dipstick strategy is robust, but the significance of its negative predictive value is contested, and its relative importance compared to symptoms is not as clear as it could be.	1) The original scope excluded children with 'abnormalities' but it soon became clear that children with VUR couldn't easily be separated out for certain sections of the guidance. CG54 could not redefine its position, constrained by the scoping document. Confusion has arisen, where it is unclear to readers if the management of children with VUR is included- eg prophylaxis. 2) Since CG54, clearer evidence has become available on the differential risk for renal scarring for recurrent and first-time UTI in older children. As CG54 strayed into this territory, it would be helpful to explicitly clarify the issues and strategies. 3) Age defined management strategies has in some places been co-ordinated with other guidance that has a different focus – eg Fever.	

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
			I'd suggest independently reviewing these cut-offs and once consensus has been reached, looking at how co-ordination can be re-established.	
Royal Devon & Exeter NHS Foundation Trust	Yes		It is not clear from the descriptors on this form whether the following comments constitute valid feedback. Nevertheless I would like to comment on the role of DMSA scanning following UTI in children. In my experience (evidenced by local audit) the acuity of modern ultrasound in experienced hands is such that infants and children with normal renal ultrasound findings never have abnormal DMSA scans. I would therefore like to see the guideline giving clinicians more freedom to decide which children warrant an interval DMSA scan. I am conscious that the available evidence does not support this approach but it must be born in mind that the quality of contempoaray USS is far better than it was when the original studies were performed.	
DEPARTMENT OF HEALTH	No	There was much discussion at clinical meetings and in the literature about this guideline. There was a vocal body of opinion that some aspects of the guideline were not correct, and that following the guideline may risk harm to some children with		

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
		urinary infections. In our view therefore, it is extremely important that there is a timely review of this guideline, taking into account those arguments, and evidence published since the last search, so that we can be sure that the pathway is right		
North East Strategic Health Authority	No	Most paediatricians in the North East Region have had serious concerns about several aspects of CG54 since it was issued in 2007. These relate to various issues concerning diagnosis, management and investigation of childhood UTI, the most prominent being imaging strategy. In view of this, the Child Health Clinical Innovation Team (CIT) of the North East SHA set up a subgroup to discuss the issues and produce consensus recommendations for the region. This subgroup has met periodically over the past year. It has produced a report which is currently at the stage of 2nd draft, and is almost ready for ratification by the CIT. The subgroup includes representation from each NHS Trust within the region. It comprises several general paediatricians who see many cases of UTI in their practice, together with representatives of paediatric nephrology, general practice, radiology and medical physics. Ideally the SHA would have submitted this report to NICE after formal ratification within the region, but in view of the deadline set by NICE for this consultation, the report is being submitted along with this form in its current 2nd draft form with the support of the chairman of the CIT, Prof Andrew Cant. The subgroup requests that NICE considers this report and, in view of the arguments presented, reconsiders its proposed decision not to update its guidance. The definitive version of the report can be forwarded as soon as it is available. (The North East SHA applied to NICE on 23/11/2010 for registration as a stakeholder and received an automated acknowledgement with reference number NF-2311-0017922.)		

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
NHS Pathways	Yes			
GDG member	Yes mostly but not totally	I think that there is quite much new relatively good information under clinical area 3 regarding when and how to use prophylactic antibiotics. This would of course only lead to a small change in the big guidelines and I can understand if you need more to start the whole process.	No	No
United Kingdom Clinical Pharmacy Association (UKCPA)		We have currently have no comments to make on this consultation.		
The Newcastle Hospitals NHS Foundation Trust	No	There was considerable disagreement with the guideline by paediatric nephrologists around the UK – see results of questionnaire on BAPN website. Most disagreement was in areas where the guideline was not evidence based, but based on opinion of GDG. The guideline has been audited in this Trust & results presented to the clinical governance committee, showing many serious abnormalities would be likely to be missed if the guideline was fully implemented. The guideline has therefore not been fully implemented in this Trust, though many important improvements have been noted & implemented. It continues to be audited. The SHA has recently reviewed local practice as there has not been widespread implementation in many local areas and will shortly report (next few weeks). There is new evidence published since 2007 in a number of areas which should influence this guideline. This Guideline should be reviewed.		

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
British Association for Paediatric Nephrology	Yes		There was a range of views held by members of the BAPN regarding the original guidelines with some members feeling that there had been misinterpretation of some of the literature reviewed and omission of other important studies. A survey was conducted of members which is on the BAPN website, and which is enclosed for information, on the views on the original guideline. Our overall view is that this guideline does need re-visiting but that this is not yet the time to do it We are aware that 2 large studies are currently being conducted which will give useful information in future. The first is the RIVUR study a randomised intervention for children with vesico-ureteric reflux. This is a large North American study which will be suffiently powered to provide answers to which previous studies have been unable to do. The second is the DUTY study, a UK community based study on the diagnosis of urinary tract infection in young children. There may be other studies of which we are unaware. We recommend that a review of these guidelines should be deferred until the results of these 2 studies are available	

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
Royal College of Nursing	Yes	1. It is crucial that this guideline is reviewed in view of the continued and wide disparity in opinion that a new robust and evidence based consensus guideline is produced. Currently there is a lot of difference of opinion regarding the statements for which there is either limited or no evidence and this has caused the most problems for healthcare professionals caring for these patients. 2. It is not clear as to who recommends whether the guideline is reviewed or not. To be credible, it is crucial that this review is done by experienced clinicians working in the field. A major concern is that the evaluation of the guideline is neither done by people with clinical expertise nor have an awareness of the complexity and paucity of the available evidence. It is important to note that the British Association for Paediatric Nephrology is split down the middle over this guideline (this information is on their web site). 3. The current guideline has resulted in increased confusion amongst GPs and the public rather than clarification.	We consider that the guideline was formulated from a narrow perspective with a misunderstanding and limiting the effect of UTI in Childhood and without any understanding or acceptance of the fact that significant renal damage may result from Childhood UTI which can persist into adulthood. We would once again, reiterate the importance for this guideline to be reviewed.	
Royal College of Paediatrics and Child Health	Yes	The College is broadly in agreement with the NICE proposal. We are aware that there is particular concern about the imaging strategy. We suggest that any review also takes a pragmatic approach of cost vs test value. For example, the cost of urine dipstix for nitrites and leucocytes less than getting out of hours urgent microscopy – is the dipstix test good enough from age 6 months	Regarding drug dosage advice/use of rotating antibiotics in UTI prophylaxis, this is important because despite lack of evidence for long-term benefit from prophylaxis, this is still widely used in clinical practice. Imaging investigations: What happens if the child had first proven	

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
		or from age 1 year to warrant it as first line use?	UTI above 3 years (improved within 48hrs) but was treated with antibiotics for possible UTIs (No cultures done) based on symptoms and dipstick before by GP? In practice, members have reported that they have faced this situation several times. If you don't investigate based on NICE guidelines, there is a potential possibility that we would be missing complications. Regarding UTI guidelines in the presence of uropathy, we understand why this was excluded, but it remains an important topic, and wonder if it could it be included in a future review.	