

North Carolina Clinical Antibiotic Stewardship Partners

INFECTION MANAGEMENT AND antibiotic stewardship
 Urinary Tract Infections: Appropriate Prevention, Diagnosis, Treatment and Care


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Conflict of interest Disclosures


- ▶ The views and opinions expressed in this course are my own and do not reflect the official policy or position of any agency of the U.S. or NC government or UNC.
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- ▶ These slides contain materials from a variety of colleagues including CDC, WHO, AHRQ, etc.




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Outline of today's session

1. Define UTIs
2. Discuss prevention of UTIs
3. Review purpose of UA and components of UA
4. Review the McGeer Criteria
5. Discuss treatment for UTIs






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A Common Case


- ▶ 84 yo F living in your facility is “more fatigued” today per son’s report. Staff note she has eaten less than usual and does seem more fatigued but has no other symptoms of note. Son insists that this is what happens “every time Mom has a uti” and requests that antibiotic treatment be initiated now. How do you respond?



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CDC NHSN UTI Definitions

- ▶ Urinary Tract Infection (UTI)/Cystitis
 - ▶ infection of the bladder (lower urinary tract).
- ▶ Pyelonephritis –
 - ▶ infection of the upper urinary tract (ureters / renal collecting system / kidneys).
- ▶ “Mixed flora” is not considered an organism and cannot be reported.
- ▶ Yeast **cannot** be reported as an organism for a UTI.




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UTIs: Why do we worry?

Primary cause of bacteremia in LTC residents is due to UTIs!

Incidence of **symptomatic UTIs** in elderly in LTC around 10%

Asymptomatic bacteriuria prevalence: 30% F/ 10% M



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Prevention of UTI

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Physiologic Risk Factors for UTIs in the Elderly

- ▶ Physiologic changes of the bladder with aging:
 - ▶ Women
 - ▶ Men



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Physiologic Risk Factors for UTIs in the Elderly

PHYSIOLOGIC CHANGES OF BLADDER WITH AGING:

Women:

- ▶ Elevation of vaginal pH due to estrogen deficiency
- ▶ Results in increased ability of bacteria to adhere to the mucosal cells of the bladder.

Men:

- ▶ Decreased bactericidal activity of prostatic secretions
- ▶ Increased post-void residual volume of urine
 - Cystocele/rectocele
 - Prostate hypertrophy
 - Neurogenic bladder from comorbidity



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Environmental Risk Factors for UTI in the Elderly

Environmental Risk Factors

- ▶ Indwelling urinary catheters
- ▶ Congregate living
- Mechanical/chemical restraints
- Increased exposure to antibiotics
- Poor infection control techniques



The more impaired or frail the greater the risk of UTI!

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Physiologic Risk Factors for UTIs in the Elderly (2)

Functional / Cognitive Impairment

- ▶ Decrease self care
- ▶ Decrease cues to void
- ▶ Increased incontinence and perineal soiling
- ▶ Difficulty finding bathroom / suitable location to void



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Risk Factors for CAUTI

Urinary stasis- no below the bladder drainage

Over-distention and pyelonephritis- kinks with backflow

Urethral trauma – catheter tugging

Improper handling of urine collection bag

Duration of catheter use – biofilm buildup

- 5% risk per day of catheterization, >30 days universal asymptomatic bacteriuria

SPICE

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From this information, what are targeted ways to prevent UTI?

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Prevention of UTIs

Hand Hygiene – both residents and staff

Adequate hydration – 30cc/kg of body weight/day

Perineal hygiene after toileting

Routine toileting

Removing urinary catheter as early as possible.

SPICE

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WHO NEEDS A UA?

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Who Needs a UA?

Burning

Frequency

Irritation

Urgency

New Blood in the Urine

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Dipstick Urinalysis

- ▶ Leukocyte esterase
- ▶ Nitrites
- ▶ Protein
- ▶ Blood



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Dipstick Urinalysis

- ▶ Leukocyte esterase positive (pyuria)
 - ▶ Nitrites: positive (bacteriuria)
 - ▶ Protein: small amount may be present
 - ▶ Blood: small amount may be present
- Leukocyte positive: 50–75% specific; 80–90% sensitive

Pyuria alone not an indication for treatment.



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UA: Hematuria

- ▶ Blood is not common with UTIs in older adults.
- ▶ Frank hematuria should be evaluated promptly!
- ▶ Causes:
 - ▶ Stones
 - ▶ Cancer
 - ▶ Trauma
 - ▶ **infection**
 - ▶ hemorrhage.



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Diagnostic Dilemmas for Older Adults with UTI

Common symptoms

Atypical symptoms

Fever?

Getting the history

SPICE

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Evaluation of Possible UTI

- ▶ Vital signs
- ▶ Fever!?
- ▶ History and examination
- ▶ U/A and C&S BEFORE starting antibiotics
- ▶ Clean catch vs I&O catheterization.



"Pyuria2011" by James Hellman, MD - Own work. Licensed under CC BY-SA 3.0 via Wikimedia Commons - <http://commons.wikimedia.org/wiki/File:Pyuria2011.JPG#mediaviewer/File:Pyuria2011.JPG>

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Microbiology of UTI

- ▶ 80% are caused by **gram negative bacilli**
 - E.coli, Klebsiella, Enterobacter, Proteus, and Serratia
- Gram positive bacilli - Staphylococcus



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Urine Culture



- ▶ Gold STANDARD to guide appropriate treatment
- ▶ Results : **>100,000 colonies** of one species
- ▶ Treatment can be delayed until culture results available.
- ▶ Positive culture (bacteriuria) alone **not** a reason to treat.

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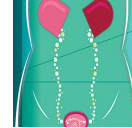
McGeer Criteria

- ▶ Must fulfill both 1 AND 2
 - ▶ 1. At least 1 of the following signs/symptoms
 - ▶ Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate
 - ▶ Fever or leukocytosis and ≥1 of the following:
 - ▶ Acute costovertebral angle pain or tenderness
 - ▶ Suprapubic pain
 - ▶ Gross hematuria
 - ▶ New or marked increase in incontinence
 - ▶ New or marked increase in urgency
 - ▶ New or marked increase in frequency
 - ▶ If no fever or leukocytosis, then ≥2 of the following:
 - ▶ Suprapubic pain • Gross hematuria • New or marked increase in incontinence • New or marked increase in urgency • New or marked increase in frequency
 - ▶ 2. At least 1 of the following microbiological criteria:
 - ▶ ≥105 cfu/mL of no more than 2 species of organisms in a voided urine sample
 - ▶ ≥102 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter

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Treatment /NO Treatment

- ▶ Asymptomatic bacteriuria should **NOT** be treated.
- ▶ Routine or post-treatment screening for bacteriuria is not recommended. (Infectious Diseases Society of America)
- ▶ No benefits in decreasing rates of subsequent UTIs
- ▶ Increased risk of resistance and uropathogens



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Indwelling Catheter-Associated UTI (CAUTI)

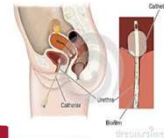
- ▶ Catheter colonization and infection is inevitable and expected!
- ▶ Once bacteria colonizes urine, concentration is 100,000 colonies within 72 hours!!



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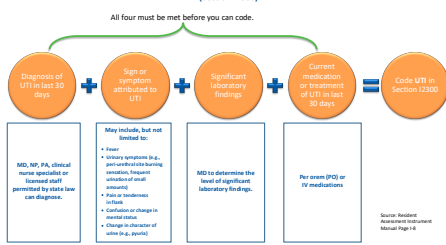
Mechanisms of Colonization

- ▶ Colonic and perineal flora primary source
- ▶ Extra-luminal-- women – shorter urethra
- ▶ Manipulation of the collection system
- ▶ From hands of personnel during insertion
- ▶ Ascending from drainage bag/junction



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Minimum Data Set (MDS) Coding Guidelines for Urinary Tract Infection (UTI) (Section 12300)



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CMS UTI Antibiotic Treatment

Minimum criteria for initiating antibiotics for UTI

NO indwelling catheter, include:

1. acute dysuria alone or fever ($>37.9^{\circ}\text{C}$ [100°F] or 1.5°C [2.4°F] increase above baseline temperature) and at least one of the following:
 - ▶ new or worsening urgency, frequency, suprapubic pain, gross hematuria, costovertebral angle tenderness, or urinary incontinence.

Reference: "Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term-Care Facilities: Results of a Consensus Conference". *Infect Control Hosp Epidemiol* 2001;22:120-124.

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CMS UTI Antibiotic Treatment

Minimum criteria for initiating antibiotics for UTI

2. **Chronic indwelling catheter** (indwelling Foley catheter or a suprapubic catheter), includes the presence of at least one of the following:
- ▶ fever ($>37.9^{\circ}\text{C}$ [100°F] or 1.5°C [2.4°F] increase above baseline temperature),
 - ▶ new costovertebral tenderness, rigors (shaking chills) with or without identified cause, or new onset of delirium."

▶ Reference - "Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term-Care Facilities: Results of a Consensus Conference" - Infect Control Hosp Epidemiol 2001;22:120-124.

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Intermittent Catheterization

- ▶ Intermittent catheterization can often manage overflow incontinence effectively.
- ▶ New onset incontinence from a transient, hypotonic/atonic bladder (usually seen following indwelling catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns (e.g., up to approximately 7 days).
- ▶ A voiding trial and post void residual can help identify when bladder tone has returned.

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USE of Urinary Catheters

APPROPRIATE

- ▶ Clinical criteria for long/short for indwelling catheter:
 - ▶ Obstruction
 - ▶ Neurogenic bladder
 - ▶ Hematuria (short term)
 - ▶ Wounds stage 3 or >
 - ▶ Aggressive diuresis / monitoring of strict I/O (short term)
 - ▶ Terminally ill for comfort measures

INAPPROPRIATE

- ▶ Used for the convenience of nursing staff.
- ▶ Used in lieu of other bladder management strategies.
- ▶ Used for specimen collection when the resident can voluntarily void

(Indwelling catheters are associated with a 5% risk/day of new UTI)

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Prevention of UTIs

Hand Hygiene – both residents and staff

Adequate hydration – 30cc/kg of body weight/day

Perineal hygiene after toileting

Routine toileting

Removing urinary catheter as early as possible.

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Prophylaxis For UTI Prevention

- ▶ **Cranberry juice/extract** – Cochrane guidelines from 2022 with some evidence to support use



- ▶ **Oral Estrogens** not shown to be beneficial.
- ▶ Topical, **vaginally applied estrogens** have been shown to be effective – 6 studies applying estrogen by ring, cream, or intravaginal tablet

Antoniou & Somani. Eur Urol Focus. 2022 Nov;8(6):1768-1774
Perrotta et al. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD005131

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Prophylaxis for UTI prevention

- ▶ Methenamine vs Antibiotics in NH Patients (ALTAR Trial)
- ▶ 102 with daily antibiotics vs 103 with methenamine Hippurate over 12 months
 - ▶ Abx Rx: 0.89 episodes/person/year (95% CI, 0.65-1.12); Methenamine RX: 1.38 episodes/person/year (95% CI, 1.05-1.72)
 - ▶ Development of resistance among E Coli: 72% of participants in daily antibiotics group vs 56% in the methenamine arm ($p = 0.05$)
 - ▶ 52% of cultures during "symptomatic UTIs" grew bacteria.

Saul H, et al. C. Methenamine is as effective as antibiotics at preventing urinary tract infections. BMJ. 2023 Jan 17;380:72.
Handing C, et al. Alternative to prophylactic antibiotics for the treatment of recurrent urinary tract infections in women: multicentre, open label, randomised, non-inferiority trial. BMJ 2022;376:e068229.

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Prevention of UTI or Overtreatment

- ▶ Risk factor: Colonization
- ▶ Risk factor: Yeast
- ▶ Risk factor: Vaginal atrophy
- ▶ Risk factor: Indwelling Catheter
- ▶ Risk factor: Poor hygiene
- ▶ Prevention: Documentation
- ▶ Prevention: Await cultures
- ▶ Treatment: Vaginal estrogen, Vaseline
- ▶ Prevention: Remove catheter
- ▶ Prevention: Peri care and staff hand hygiene



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De-escalation in Urinary Tract Infection

1. Shorter length of therapy
 - Standard of care depends on the antibiotic choice, but is now typically 3 or 5 days.
 - Minimum necessary is best
2. Narrowing of spectrum
 - Utilize the culture results.
 - Consider awaiting treatment until these culture results return to ensure the appropriate antibiotic is being utilized.
3. Is this truly a UTI?



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Prevention Catheter-Associated UTI (1)

- ▶ Catheter used for appropriate indications.
- ▶ Urinary catheter duration of use minimized.
Increase of 5% risk per day!
- ▶ Hand hygiene before and after insertion of catheter and during any manipulation.
- ▶ Only properly trained persons for insertion using aseptic technique.



CDC HICPAC Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009



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Prevention of Catheter-Associated UTI(2)

CDC HICPAC Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009

- ▶ Clean technique for intermittent catheterization.
- ▶ Standard Precautions during catheter manipulation.
- ▶ Periurethral cleaning with antiseptics not recommended. Routine hygiene recommended.
- ▶ Routine use of antimicrobial/antiseptic-impregnated catheters not recommended.
- ▶ No routine schedule for catheter replacement (e.g. monthly)
- ▶ Urine samples obtained aseptically.



Note: Before urine samples for culture are obtained from resident in place > 14 days, catheter should be replaced and specimen obtained aseptically.
If obstruction or infection occurs - change the catheter.



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CDC Guidelines on Flushing and irrigation

- ▶ If obstruction or infection occurs - change the catheter.

"Unless obstruction is anticipated (e.g., as might occur with bleeding after prostatic or bladder surgery) bladder irrigation is not recommended...If obstruction is anticipated, closed continuous irrigation is suggested to prevent obstruction."

- ▶ "Q2C.3. Bladder irrigation
Low-quality evidence suggested no benefit of bladder irrigation in patients with indwelling or intermittent catheters.

www.cdc.gov/infectioncontrol/pdf/guidelines/...



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In Summary



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A Common Case

- ▶ 84 yo F living in your facility is “more fatigued” today per son’s report. Staff note she has eaten less than usual and does seem more fatigued but has no other symptoms of note. Son insists that this is what happens “every time Mom has a uti” and requests that antibiotic treatment be initiated now. How do you respond?

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Questions and Discussion



- ▶ Find session slides at <https://spice.unc.edu> → ncclasp → nursing homes

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