Risk Management Pitfalls For Pediatric Urinary Tract Infections

1. “The patient never made urine, so I just empirically treated for UTI.”
   It is vital to obtain an appropriate urine specimen, both for diagnosis and for later antibiotic-sensitivity assessment. If the patient has no urine, even on bladder catheterization, then significant dehydration and possibly a more serious infection should be considered.

2. “I prescribed an antibiotic, so I’m not sure why the patient returned with sepsis.”
   Not only is it vital to make sure that the patient’s bacterial agent is sensitive to your antibiotic, you must make sure that he or she can actually tolerate oral intake before discharge and has not had difficulty with oral medications in the past.

3. “The patient’s mom didn’t want her child to have an intravenous line, so I thought oral antibiotics were the right choice.”
   While it is prudent to minimize trauma and harm to the child, there are certain indications that warrant intravenous antibiotics, including sepsis, inability to tolerate oral intake, evidence of pyelonephritis, and significant dehydration.

4. “I treated the patient with locally-susceptible antibiotics. I don’t know why her condition did not improve.”
   While verifying local susceptibilities is important, assessing the patient for risk factors (such as pediatric intensive care unit stay, immunosuppression, renal transplant, recurrent UTIs, or genitourinary deformities) is also necessary in determining the proper pharmacologic agent.

5. “The adolescent girl complained of dysuria and was certain it was a UTI because her mom had recurrent cystitis. I treated it, even though the urinalysis was unremarkable.”
   In adolescent females, sexually transmitted diseases must be on the differential for complaints of dysuria, and, in the presence of any uncertainty, a pelvic examination is necessary. Asking the parent to leave the room in order to obtain a more detailed history is always warranted, especially in this age population. It is also not uncommon for urine WBCs or LE to be elevated in a patient with sexually transmitted urethritis or cervicitis.

6. “The patient was afebrile in the ED, so I didn’t consider UTI.”
   It is important in pediatric populations to note in the history the patient’s objective or even subjective febrile temperatures before presentation to the ED, especially as the child may have received anti-inflammatory medications prior to arrival. Additionally, it is important to remember that not all UTIs present with fever.

7. “I didn’t check for a UTI because the patient is a boy.”
   In male patients aged < 2 years and, especially male patients aged < 6 months, UTI is not uncommon and approaches the prevalence of this condition in females. For male patients aged > 2 years, circumcision status should be sought, as uncircumcised males still have a higher prevalence of UTIs.

8. “The patient’s father didn’t want us to catheterize his newborn baby, so we placed an adhesive bag. When the UA showed bacteria, I treated it.”
   In all infants and toddlers who are not toilet-trained, an adhesive bag, regardless of perineal cleansing, is not as specific as a straight catheterization. Contaminated specimens from a bag may result in unnecessary treatment or a missed diagnosis.

9. “The 3-month-old looked great. I can’t believe his dad is threatening to sue because I didn’t admit him.”
   New guidelines suggest that infants aged > 2 months who appear well can be sent home on oral antibiotics. Additionally, new studies have shown that patients “on the cusp” can obtain effective treatment in facilities that provide daily ambulatory intravenous antibiotics.

10. “I treated the otherwise healthy girl who had positive nitrites and LE on dipstick with an antibiotic. How would I have known that it was not a sensitive antibiotic?”
    While it is acceptable to treat a patient with a strongly positive urine dipstick, sending the urine for a formal culture is recommended to ensure a correct diagnosis and to confirm that the antibiotic choice was appropriate.
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