Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
ADVANZ Pharma	Guideline	004	016	1.1.3 We recommend updating table 1 referred to in section 1.1.3 to include: **Symptoms and signs that suggest a UTI is more likely**: following surgical procedures. There is evidence to suggest that following cardiovascular surgery UTIs are developed [1,2] 1.Mohamed S. Kabbani, Sameh R. Ismail, Anis Fatima, Rehana Shafi, Julinar A. Idris, Akhter Mehmood, Reetam K. Singh, Mahmoud Elbarabry, Omar Hijazi, Mohamed A. Hussein,Urinary tract infection in children after cardiac surgery: Incidence, causes, risk factors and outcomes in a single-center study,Journal of Infection and Public Health,Volume 9, Issue 5,2016,Pages 600-610,ISSN 1876-0341, https://doi.org/10.1016/j.jiph.2015.12.017.(https://www.sciencedirect.com/science/article/pii/S1876034116000083) 2.Matlow AG, Wray RD, Cox PN. Nosocomial urinary tract infections in children in a pediatric intensive care unit: a follow-up after 10 years. Pediatr Crit Care Med. 2003 Jan;4(1):74-7. doi: 10.1097/00130478-200301000-00015. PMID: 12656548. https://pubmed.ncbi.nlm.nih.gov/12656548/	Thank you for your comment. Predisposing factors for a UTI, such as surgery, are not within the scope of this guideline update which focused on symptoms and signs. As a result, the committee did not review any evidence on the development of UTIs following cardiac surgery and are therefore unable to make the requested changes. They did, however, include a history of previous UTI in their table of symptoms and signs because, although this is part of the medical history rather than a symptom or sign, it was prespecified at the protocol stage and was reported in the studies we included in the review that focused on symptoms and signs of a UTI.
BAME Health Collaborative	Guideline	004	019	1.1.4 "Do not routinely test the urine of babies, children and young people 20 3 months and over who have symptoms". We are concerned that this recommendation does not reflect standard operating procedure at most general practices, and it is one of the	Thank you for your comment. The committee discussed your comment but agreed that the recommendation is reflective of UK clinical practice and both previous NICE guidance (recommendation 1.1.1.2 in the 2007 version of the UTI in under 16s guideline recommends that infants and children with an

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				ways that clinicians can quickly identify cause of the clinical presentation. Consideration should be given to the possibility of sexual activities of the child or young person which may be contributing to their symptoms of UTI.	alternative site of infection should not have a urine sample tested) and other UK guidelines such as Public Health England (now UKHSA) 2018 guidance on Diagnosis of urinary tract infections: quick reference tool for primary care. The committee also noted that health economic evidence reviewed for increased testing was not cost-effective (please see the evidence review for more detail). Predisposing factors/ causes of UTI such as sexual activity are not within scope of this guideline update, which focused on symptoms and signs. As a result, the committee did not review any evidence on this topic and were therefore unable to make the requested changes. In response to your comment the committee discussed the issue of sexual activity in the context of diagnosing a UTI. They were aware that sexual activity may increase the possibility of a urinary tract infection but noted that the scope of the guideline excludes sexually active girls with recurrent urinary tract infections. The committee discussed the implications for safeguarding in babies, children, and young people under 16 years. They expect that clinicians who have concerns should refer to the NICE guideline on child maltreatment: when to suspect maltreatment in under 18s for details.
BAME Health Collaborative	Guideline	005	013	1.1.5 Avoid delay when collecting and testing the urine sample, this is a very ambiguous statement, and we	Thank you for your comment. The committee discussed your comment and agreed that it is not

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				recommend a timeframe to describe to specify a delay. Example more than 5 hours etc.	possible to set a definitive timeframe for the delay as there are several factors that will affect how long is judged to be a delay and they do not lend themselves to the setting of a single time frame. Firstly, not all samples can be obtained at the time of consultation, particularly in primary care settings, and collection may occur later at home and then be delivered back to the practice. The committee have specified a target time frame of 24hrs for parents to return urine samples if they cannot be taken at the consultation. Secondly, the tests carried out on the urine after collection vary by age of the child. Babies under 3 months require urgent microscopy and culture, whilst older babies, children and young people may have dipstick testing first. The time to testing depends on what test is required as dipstick testing can occur rapidly but samples requiring laboratory testing may require storage and/or transportation before they can be tested (please see the sections on Urine testing and Urine preservation in the guideline).
BAME Health Collaborative	Guideline	006	001	1 1.1.6 If a baby, child or young person has suspected sepsis, assess and 2 manage their condition in line with NICE's guideline on sepsis: 3 recognition, diagnosis and early management. [2022], We agree with the recommendation however we propose that a more robust approach would be to linked the sepsis assessments e.g. Modified Early Warning Score (***MEWS***	Thank you for your comment. This update focuses on the symptoms and signs of UTI in under 16s and we are therefore unable to amend recommendations contained within NICE's guideline on sepsis: recognition, diagnosis and early management. We are only able to hyperlink to the existing NICE guideline. Please note that there are 8 algorithms for sepsis

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				NICE guidelines should be driving local policy around the management of Sepsis. Each Trust should have its approved Sepsis Bundle which staff should be referring to when sepsis is suspected or confirmed. Frontline staff do not routinely refer to NICE guidelines as their reference point when dealing with a clinical situation. This tends to feature in Action Plans as part of an incident investigation report.	assessment (depending on age and location) and 3 risk stratification tools (based on age) in the NICE guideline on sepsis. For purposes of accessibility and readability we have used only a single link to the main NICE sepsis guideline page, from which each of the assessment and risk stratification tools can be accessed. NICE guidelines set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. Local organisations are required to have due regard to the guidance, but it is beyond NICEs remit to set out where and how they are used locally in practice.
Bladder Health UK	Guideline	023	006	We welcome the committee's decision to recommend that further research be carried out into the symptoms and signs of persistent UTI in children. Bladder Health UK regularly hears from members of the public with children who are affected by persistent symptoms.	Thank you for your comment and support of this research recommendation. After discussion, the committee have reworded this recommendation to make it more specific and relevant as at the time of publication long-term (chronic or persistent) UTI is still poorly characterised and lacks a clear diagnostic definition. The reworded research recommendation is intended to help provide information to facilitate future research on this topic.
British Paediatric Allergy Infection and Immunity Group	Guideline	009	006	Comment from BPAIIG member: It would be helpful to clarify the meaning of the term "has a high to intermediate risk of serious illness" - this impacts on decision making about whether to send dipstick positive urine for culture.	Thank you for your comment. The recommendation you refer to in the indication for culture section recommendations, wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					did not review any evidence on this topic and were therefore unable to provide the detailed clarification you requested. However, in the section on assessment of serious risk there is a recommendation that direct readers to the NICE guideline on fever in under 5s: assessment and initial management to assess the level of illness. In this guideline the section on the clinical assessment of children with fever refers to using the NICE traffic light system to assess the level of risk as well as listing symptoms and signs of different levels of severity of illness. The committee have added a cross reference to the assessment of risk of serious illness section of the UTI guideline from the consultation recommendation you refer to (1.1.22) to make this clearer. They have also added fever in under 5s section specific cross reference to the UTI assessment of risk of serious illness recommendation (consultation recommendation 1.1.9).
British Society for Antimicrobial Chemotherapy	General	General	General	Members of The British Society for Antimicrobial Chemotherapy (BSAC) have no comments at this time.	Thank you for your comment.
Cardiff University	Guideline	005	003	Table 1: Symptoms and signs that suggest a UTI is more or less likely. Could the Guideline Committee review the inclusion of 'Fever with known alternative cause' in the symptoms that suggest a UTI is less likely. This will likely result in no urine sample being taken if the clinician thinks the cause of fever is something else e.g. URTI. However, there is evidence to suggest that UTI is	Thank you for your comment. The inclusion of fever with known alternative cause in the table is consistent with the findings of the current evidence review which included the Boon et al (2021) systematic review and the studies by Shaw et al (1998), Hay et al (2016, DUTY), and O'Brien et al (2013, EURICA) in addition to a number of studies caried out in hospital or ED

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				still frequent among children with a known alternative cause of fever. For example, Shaw et al found that infants without a potential source of fever were more likely to have a UTI (5.9% of 474 with no potential source of fever had UTI vs 2.7% of 1858 with a potential source of fever; p<0.001). However, given the large number of presenting infants with a potential alternative source of fever, this feature is less helpful when trying to rule out UTI. Using the numbers provided by the authors, this equates to 64% of children found to have UTI actually presenting with an alternative source of infection. The Boon et al Systematic Review found that finding an apparent source of infection reduced the probability of UTI but not sufficiently to rule out UTI and they conclude that urine sampling should not be restricted to children with unexplained fever. Also of note, the 4 studies in which the slight reduction in probability of UTI was found were all conducted in ED or hospital settings with higher levels of severe illness and prevalence of UTI than in GP settings. GPs see many acutely ill children and it is primarily here that guidance is needed as there is evidence of many missed UTI diagnoses. The presenting symptoms and signs suggestive of UTI are particularly useful in young children who are more likely to have non-specific symptoms and signs, and more at risk of renal scarring. The large DUTY study, and the EURICA study, both conducted in children <5, predominantly in general practices, did not find that an alternative source of	settings. The committee agreed with your comment that the presence of a fever with known alternative cause does not exclude the possibility of UTI. However, as noted in table 1 and the explanatory text below, the symptoms and signs listed only suggest that a UTI is more, or less, likely; and the presence or absence of a single symptom or sign in isolation should not necessarily be used to decide whether or not to test for UTI. Therefore, in isolation, fever with known alternative cause should not exclude the possibility of UTI, but rather clinician judgement is required taking into account all of the symptoms and signs listed in the table. The committee do not expect that urine sampling will be restricted to children with unexplained fever if the points made above are taken into account as part of the decision-making process. The committee agreed that it may be useful to consider alternative diagnoses where the symptoms and signs make it less probable that a UTI is present. They have carefully worded a recommendation about not routinely testing babies, children and young people 3 months and over who have symptoms and signs that suggest an infection other than a UTI. But clarified this by adding that if the baby, child or young person remain unwell and there is diagnostic uncertainty, then urine testing should be considered.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				infection reduced the probability of UTI (fever of unknown origin was not associated with UTI).	
Cardiff University	Guideline	007	026	This states that if both leukocyte esterase & nitrite are negative on dipstick, do not send a urine sample for microscopy and culture unless at least 1 of the criteria in recommendation 1.1.22 apply. This table of criteria includes 'has a high to intermediate risk of serious illness' – presumably from the NICE Traffic Light System. Could the Guideline committee review this in view of a recent paper (Br J Gen Pract 2022; DOI: https://doi.org/10.3399/BJGP.2021.0633) which validated the NICE Traffic Light system in general practice and found that 94% children <5 years old fulfil the criteria for high or intermediate risk of serious illness (red and amber categories). Therefore, in children <5 seen in General Practice, if a sample should be sent for microscopy and culture in all children at high or intermediate risk of serious illness according to these criteria, (i.e. 94% children) even if the dipstick is negative for both leukocyte esterase and nitrite it may be clearer to advise urine culture in all children <5 in general practice irrespective of the dipstick result.	Thank you for your comment. The NICE Traffic light system was included in the current update as a combination of symptoms and signs that could be used to predict a UTI, but it was not sufficiently diagnostically accurate to be of use and was therefore not recommended by the committee. However, the recommendation you refer to is in the urine testing section which wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest the existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make any changes to the recommendations you refer to. In the section on assessment of serious risk in the UTI guideline there is a recommendation that directs readers to the NICE guideline on fever in under 5s: assessment and initial management to assess the level of illness. In this guideline the section on the clinical assessment of children with fever refers to using the NICE traffic light system to assess the level of illness as well as listing symptoms and signs of different levels of severity of illness. We have included a cross reference to this section directly from the UTI guideline section on the assessment of risk of serious illness to improve navigation for readers. The

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					information you have provided is of more relevance to this section of the fever in under 5s guideline and we will pass your comment and the paper by Clark et al (2022) to the NICE surveillance team which monitors guidelines to ensure that they are up to date to review in relation to that guideline instead.
NHS England and Improvement	Guideline	004	004	Suggest also link to 1.1.10 Urine collection. Important info to minimise risk of contaminated sample.	Thank you for your comment. The committee discussed your comment but decided against adding the suggested hyperlink as the recommendations contained within the section on urine collection are already hyperlinked from another recommendation in the symptoms and signs section. This recommendation covers avoiding delay when collecting and testing urine and the committee thought the cross reference to how to collect urine was more appropriate here.
NHS England and Improvement	Guideline	004	009	Some overlap and duplication in information for babies under 3 months (appears included in 1.1.1 + specifics in 1.1.17 _+ specific guideline for fever under 5s). This makes it harder for user to know what to do for this patient group. Suggest combine text e.g."Test the urine of babies under 3 months who have symptoms and signs that suggest a UTI is more likely (see table 1) or who have a fever (see NICE guideline on fever in under 5s: assessment and initial management. Send urine sample for urgent microscopy and culture. Refer babies under 3 months with a suspected UTI to paediatric specialist care (see section 1.1.17).	Thank you for your comment. We have not combined the recommendations in the way suggested, because the 2 recommendations have separate populations (one refers to babies, children, and young people the other is specific to those under 3 months) and have different actions (the first is to test the urine the latter to refer and send an urgent urine sample). The committee however, agreed that it would be easier to follow the flow of recommendations if the recommendation for referring babies under 3 months to paediatric care (formerly consultation recommendation 1.1.17) was moved up into the same section (symptoms and signs) as the other recommendations.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					In addition, the committee took note of stakeholder comments and have edited the wording of the consultation recommendation 1.1.2 that referred to testing the urine of babies under 3 months with fever. It was not their intention to suggest that every child under three months with a fever needs testing for UTI by a paediatrician, but rather to raise the awareness of paediatricians that there are recommendations covering testing the urine for UTI of babies under 3 months who are already under their care. The amended recommendation makes this clearer and has been expanded to cover all under 5s with fever because there are additional recommendations for urine testing for a UTI for babies and children over 3 months but under 5 in the section on management by the paediatric specialist in NICE's guideline on fever in under 5s: assessment and initial management. The amended recommendation has been moved further down the list of recommendations to try to reduce confusion.
NHS England and Improvement	Guideline	005	003	Table is useful	Thank you for your comment.
NHS England and Improvement	Guideline	005	013	Clarification on what to do if urine sample cannot be collected is useful	Thank you for your comment and support of this recommendation.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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NHS England and Improvement	Guideline	006	004	Why refer to 'corrected gestational age' here but not when referring to babies under 3 months? If it matters, then suggest adding this for references to babies under 3 months throughout document	Thank you for your comment. The purpose of adding the information about corrected gestational age is that it defines the population covered in the NICE guideline on neonatal infection: antibiotics for prevention and treatment which is linked to in the recommendation. This is different to the population covered in NICE guideline on Urinary tract infection in under 16s and therefore the committee decided against adding the suggested information when referring to babies under 3 months.
NHS England and Improvement	Guideline	006	004	Should this specify non-UTI bacterial infection?	Thank you for your comment. There are recommendations on both urinary tract and non-urinary tract related investigations in the NICE guideline on neonatal infection: antibiotics for prevention and treatment and therefore it would be inappropriate to specify non-UTI bacterial infection here.
NHS England and Improvement	Guideline	006	014	Ref relates to those with fever, which implies that risk of serious illness is only when fever is present. Is it possible to have serious illness without fever? I know this section is grey but perhaps a new point can be added about how to manage those assessed as potential serious illness?	Thank you for your comment. The recommendation you refer to (Assessment of risk of serious injury section recommendation 1.1.9) wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make the requested addition to this content. Please note that the recommendation does not state that fever needs to be present, only that the level of illness should be assessed in the same way as recommended in NICE's guideline on fever in under

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					5s: assessment and initial management under the section on the clinical assessment of children with fever.
NHS England and Improvement	Guideline	016	Box 1	Septicaemia included as a sign of atypical UTI, should this be bacteraemia?	Thank you for your comment. The box you refer to (Box 1 Definitions) is within the imaging tests section which wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make any changes to this definition.
NHS England and Improvement	Guideline	018	014	Do we also need research to determine appropriateness of no treatment for this patient cohort (esp for older children?) and typical duration of symptoms with and without treatment?	Thank you for your comment. The research recommendations made by the current committee must fall within the scope of the update, which covered symptoms and signs of UTI. The committee did not review any evidence on treating UTIs and were therefore unable to make the requested research recommendation.
NHS England and Improvement	Guideline	020	016	Do we also need research to develop a clinical scoring system for predicting when treatment is needed?	Thank you for your comment. The research recommendations made by the current committee must fall within the scope of the update, which covered symptoms and signs of UTI. The committee did not review any evidence on treating UTIs and were therefore unable to make the requested research recommendation.
NHS England and Improvement	Guideline	021	001	As above – another reason to highlight research needed to develop a clinical scoring system?	Thank you for your comment. The text you refer to in the rationale refers to the poor diagnostic accuracy of the diagnostic prediction models that were identified as part of this review work. This included the model

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					derived from the DUTY study which was carried out in response to a research recommendation in the 2007 version of this guideline. This was a very large UK NIHR study that looked at over 100 symptoms and signs in over 7,000 children and babies under 5 years old, but despite this the model developed demonstrated poor diagnostic accuracy and could not be recommended. The committee did not prioritise making another research recommendation on this topic because the DUTY study had already investigated this issue.
NHS England and Improvement	Guideline	022	004	Frank haematuria will likely be detected by parent/carer (e.g. in nappy) or by patient prior to consultation if present so can be included in table 1.	Thank you for your comment. The committee discussed stakeholder comments on haematuria and have responded by amending table 1 to include this sign as well as adding an additional statement to the notes under the table. This highlights that the symptoms and signs are expected to be assessed before a decision is made about whether urine collection and testing is necessary. Frank haematuria would therefore be assessed based on feedback from the patient or parents/ carers rather than by the clinician taking a urine sample at this stage in the diagnostic pathway.
NHS England and Improvement	Guideline	022	025	Double negative: please reword this sentence 'However, the committee were aware that not everyone with a UTI will not necessarily be detected by a urine culture.'	Thank you for your comment. We have corrected this sentence to remove the double negative.
NHS England and Improvement	Guideline	General	General	Good to see diagnostic section such as symptoms and signs included. However, unclear when treatment should be considered (for all patients with positive dipstick or	Thank you for your comment. The section you refer to on acute management wasn't prioritised for update at the scoping stage as no evidence was identified in the

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				culture? Presence of bacteria in urine sample may sometimes be due to contamination so how to mitigate this to avoid unnecessary treatment, hospitalisation, adverse drug effects, burden on patient/carer/healthcare etc.) Perhaps add decision flowchart?	surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to design a decision flow chart as requested. Please note that the guideline contains sections on when to progress to urine sample collection and urine testing (including dipstick interpretation) and indications for culture and when to treat. Additionally, the guideline section on acute management links to the NICE antimicrobial prescribing guidelines on urinary tract infection (lower) and pyelonephritis (acute) for the recommended antimicrobial drug, dose, duration, and route of administration. The UTI in under 16s guideline has a recommendation on not treating those in whom asymptomatic bacteriuria is the presentation (for example due to contamination of the sample).
NICE GP Reference Panel	Guideline	004	009	Rec 1.1.2 Please clarify within these recommendations that this statement is for children under the care of paediatric specialists. Please also clarify what recommendations should be used for children with a low grade fever (i.e. < 38degC)	Thank you for your comment. In consultation recommendation 1.1.2 it was not the intention of the committee to suggest that every child under three months with a fever needs testing for UTI by a paediatrician, but rather as you note, to raise the awareness of paediatricians that there are recommendations covering testing the urine for UTI of babies under 3 months who are already under their care. The amended recommendation makes this clearer and has been expanded to cover all under 5s with fever because there are additional

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					recommendations for urine testing for a UTI for babies and children over 3 months but under 5 in the section on management by the paediatric specialist in NICE's guideline on fever in under 5s: assessment and initial management. Children with a low-grade fever (i.e. < 38°C) are covered by the first recommendation in this section and if based on this recommendation (and table 1) they are suspected of having a UTI then they should have a urine test. Alternatively, if there is clinical suspicion of a UTI in the absence of the symptoms and signs in table 1 a urine test may also be considered. If they are not suspected of having a UTI then they should not have a urine test at that time and the clinician should refer to recommendations in the NICE guideline on fever in under 5s: assessment and initial management which provides guidance on reaching alternative diagnoses. The NICE guideline on fever in under 5s: assessment and initial management defines fever as an elevation of body temperature above the normal daily variation and this definition has been adopted by the UTI in under 16s committee for consistency with the exception being if a particular recommendation mentions a specific temperature. The definition is now provided in the terms used in this guideline section and is hyperlinked from Table 1.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
NICE GP Reference Panel	Guideline	004	019	Rec 1.1.4 In concept this is a very important point which can reduce inappropriate testing, but there is potential for confusion as it doesn't perfectly match NG143	Thank you for your comment. NICE have looked at ways of harmonising the recommendations between the 2 guidelines. We plan to stand down recommendations in NICE's guideline on fever in under 5s: assessment and initial management that have been superseded by the current work on UTI diagnosis where appropriate which should help ensure consistency. However, it should also be recognised that the guidelines have different populations as the UTI guideline is for under 16s and includes those with and without fever compared to NG143 which is for those aged under 5 years with a fever.
NICE GP Reference Panel	Guideline	005	003	Table 1: Capillary refill: a capillary refill time of > 3 secs is more a symptom of being systemically unwell/dehydrated/peripherally shut down rather than specifically a UTI.	Thank you for your comment. The committee noted that some of the signs and symptoms were systemic/ non-localising but still increased the likelihood of UTI. The non-specific nature of some of the symptoms and signs is addressed in the rationale section that accompanies the recommendations and as noted in the text under Table 1 that individual symptoms should not be taken in isolation but rather be used in combination with the presence/ absence of other symptoms or signs during the decision-making process.
NICE GP Reference Panel	Guideline	005	003	Table1: Dysuria symptom. Some children present 'not wanting to pass urine' or 'passing small amounts' as an expression of dysuria	Thank you for your comment. The committee expects that clinicians will be aware that dysuria can present in different ways and will be able to elicit this information during consultation. The committee agreed that

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					specifying all the possible presentations of dysuria would be too much detail for inclusion in Table 1. However, several different expressions of dysuria were included by the committee in the research recommendations (please see the Evidence review for details).
NICE GP Reference Panel	Guideline	005	003	Table 1: Dark urine is a very subjective/ non-specific finding and is associated with dehydration	Thank you for your comment. The committee have included the limitations of darker urine in the rationale section which notes that 'darker urine is not specific to urinary tract infection and is common in those who are unwell and dehydrated. However, as noted in the rationale and text under Table 1, individual non-specific symptoms and signs should not be taken in isolation but rather be used in combination with the presence/ absence of other symptoms or signs during the decision-making process.
NICE GP Reference Panel	Guideline	005	003	Table 1: Symptoms and signs that suggest a UTI is less likely could currently include a positive COVID-19 lateral flow test	Thank you for your comment. The committee did not look for evidence for COVID-19 testing as a sign that would make a UTI less probable. This was not raised by the committee during protocol development or at the scoping stage. In addition, none of the included studies were recent enough to look at whether a positive COVID-19 lateral flow test made a UTI more or less likely. The committee were therefore unable to make the requested changes at this time, although this may be something that could be considered if the symptoms and signs are updated again in the future.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
NICE GP Reference Panel	Guideline	005	017	Whilst sampling isn't under review, it is hyperlinked on this line. Half of those responding commented on this section: the use of urine bags is not mentioned; age-specific advice would help; the use of boric acid is important for most GPs who cannot get samples quickly to labs.	Thank you for your comment. As you note in your comment the sections you refer to (urine collection and urine preservation) weren't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make the requested changes. However, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NICE GP Reference Panel	Guideline	006	004	Rec 1.1.7 This needs to be clear without reference to another guideline. Sounds like there may be an important management difference in this age group which primary care practitioners need to know.	Thank you for your comment. The intent was to flag when it may be appropriate to switch to another guideline (NICE guideline on neonatal infection: antibiotics for prevention and treatment.). Large parts of this guideline are potentially relevant for babies up to and including 28 days corrected gestational age who have a suspected or confirmed bacterial infection, with the specific sections depending on the age of the child. Therefore, the committee were unable to avoid referring to this guideline. However, they have reworded draft recommendation 1.1.7 to include hyperlinks to the relevant sections for the assessment and management of early and late onset neonatal infection. They hope this will make the cross reference more useful in practice.
NICE GP Reference Panel	Guideline	018	014	We agree with the key recommendations for research	Thank you for your comment and support for these research recommendations.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
NICE GP Reference Panel	Guideline	General	General	We are in general agreement with the recommendations	Thank you for your comment and support of the recommendations.
NICE GP Reference Panel	Guideline	General	General	Please clarify advice within the guideline rather than hyperlinking, unless this can take the reader to a specific target recommendation (this was a particular problem when referencing the fever under 5s guideline). Around half the comments we received related to issues of uncertainty arising from hyperlinked recommendations.	Thank you for your comment. NICE have discussed the issue of cross-referencing and hyperlinking between multiple guidelines. We are working to resolve these issues, which result from overlapping guideline populations, but currently we cannot import recommendations directly from other guidelines as this causes issues when the original recommendations are amended or stood down. There are workstreams in progress looking at how better to present our content digitally and these include consideration of bringing relevant content from multiple guidelines into one place to improve the user experience. With regard to the specific problems with overlap between the NICE guideline on fever in under 5s: assessment and initial management and Urinary tract infection in under 16s: diagnosis and management guideline we have looked at ways of harmonising the recommendations between the 2 guidelines. To help improve consistency and reduce unnecessary switching between these 2 guidelines, we plan to stand down recommendations in the fever in under 5 guideline concerning the diagnosis of a UTI that have been superseded by the recommendations in the current update. We have also improved the cross reference to the fever in under 5s guideline to make it

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					clearer when a clinician would need to consult it instead of or in addition to the UTI guideline (ie. if the babies or children under 5 have fever with no obvious cause who do not have a suspected UTI or if they are paediatricians). We have also hyperlinked to specific sections of the other guidelines, were relevant, to improve navigation.
Royal College of General Practitioners	Guideline	004	004	The sentence appeared difficult to understand. Some members asked to clarify whether the UTI was more likely than what? Would the sentence be better broken down (with second sentence highlighting table 1)	Thank you for your comment. The committee discussed your comment and have amended the wording to increase or decrease the likelihood from 'more likely'. They felt that the use of term likelihood was consistent with the analysis conducted by NICE in the evidence review (please see the Evidence review A document) and is readily understood by clinicians.
Royal College of General Practitioners	Guideline	004	009	The link here was to a full NICE guideline, and it was not easy to find the area pertaining to babies under three months with a fever. The sentence might need rephrasing. It appears to suggest that every child under three months with a fever needs testing for UTI by a paediatrician. In primary care many children in this age are seen with URTI and many with a fever without recourse to admission to paediatrician. Please consider the implications if all are to be referred or clarify if not. The guidance is clear … Test… as opposed to line 16 which is consider. Can this be considered please?	Thank you for your comment. The committee took note of stakeholder comments and have edited the wording of the consultation recommendation 1.1.2 that referred to testing the urine of babies under 3 months. It was not their intention to suggest that every child under three months with a fever needs testing for UTI by a paediatrician, but rather to raise the awareness of paediatricians that there are recommendations covering testing the urine for UTI of babies under 3 months who are already under their care. The amended recommendation makes this clearer. It has also been expanded to cover all under 5s with fever because there are additional

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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					recommendations for urine testing for a UTI for babies and children over 3 months but under 5 in the section on management by the paediatric specialist in NICE's guideline on fever in under 5s: assessment and initial management (The hyperlinks in the recommendation open to the correct section required.) However, according to an existing recommendation in the section on urine testing in the UTI guideline, babies under 3 months **with a suspected UTI** should be referred to paediatric specialist care and have their urine tested urgently. This recommendation has been moved into the symptoms and signs section of the guideline to increase clarity rather than cross referring to it as was the case in the consultation draft. .
Royal College of General Practitioners	Guideline	004	016	The sentence is not clear. On page 4 / line 5 the suggestion is test for UTI if symptoms / signs suggesting but this sentence perhaps contradicts suggesting test even if there are none of the symptoms / signs in table 1). We note is says consider which perhaps could be in bold?	Thank you for your comment. Consultation recommendation 1.1.3 was intended to address the issue that the symptoms and signs listed in the table are not exhaustive and should be used as a guide alongside clinical judgement. In addition, the presence or absence of these symptoms or signs only increase or decreases the probability of a UTI being present. These points are covered in the information below table 1 and in the rationale. Therefore, it may still be

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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					necessary to test urine if healthcare professionals suspect a UTI despite the absence of any symptoms or signs in the table. Taking this into account, the committee decided against making any amendments to the recommendations because they believe that it is sufficiently clear when the explanatory text is consulted. As you note, this recommendation is a consider recommendation as it was based on committee consensus, but we are unable to make this bold as it is in not within NICE's editorial policy to emphasise 'consider' in this manner. However, the committee have re-ordered the recommendations so that this recommendation now follows on directly from the initial recommendation to test the urine where symptoms and signs are present. We hope that this will make the committee's logic clearer when read alongside the notes under the table and the rationale that accompanies the recommendations.
Royal College of General Practitioners	Guideline	005	019	Many in primary care are not familiar with non-invasive methods such as urine collection pads, though we recognise more commonly undertaken in hospital. It would be useful to clarify if this testing has been found to be beneficial in a primary care setting and if so, liaison would be needed to ensure that primary care is familiar with local methods, in liaison with laboratories and that parents and carers have resources readily available to	Thank you for your comment. The recommendation you refer to (the urine collection section recommendation on obtaining a sample if a clean catch is not possible) wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make the requested changes.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				provide them with supportive information on how to use the pads. A clear NICE steer on this would be useful.	However, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of General Practitioners	Guideline	008	010	The guidance appears clear however many clinicians are taught if in a male child to send an MSU test if the urinalysis is positive on the first occasion. Colleagues report paediatricians suggesting that young boys with a confirmed urine infection require further investigation. This guidance appears to suggest send MSU on the second episode. Is NICE comfortable with this guidance compared to much current practice?	Thank you for your comment. The recommendation you refer to (urine testing section table 2) wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee have reviewed your comment and believe that Table 2 is clear about when a urine sample should be sent (when positive for leukocyte esterase and/or nitrite, i.e., when either test is positive). Only when both are negative is no further testing recommended. The committee did not think that there was a difference in approach to the diagnosis of UTI between boys and girls using this table and they agreed that the urine was being tested on the first presentation of symptoms or signs that suggest a UTI rather than a second episode as you suggest. However, we have passed your comment to the surveillance team as a point for consideration when this section of the guideline is updated in future.
Royal College of General Practitioners	Guideline	009	001	Where pyuria is negative and bacteriuria are found some laboratories report mixed bacterial growth (still bacteria in the urine) and some report growth of low numbers ($>10^4$ / ml) – the guidance would suggest here that treatment is necessary whatever is grown but we wondered if some of these would be contamination or specimens that had delayed delivery before culture.	Thank you for your comment. The section you refer to on urine testing (including table 3) wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest existing recommendations needed amending. The committee did not review any evidence on this topic and were

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				Though many clinicians would interpret this clinically there are many clinicians with a variety of experience managing clinical cases both in primary and secondary care. We feel the guidance may need to be more specific.	therefore unable to make the requested changes to make this particular guidance more specific.
Royal College of General Practitioners	Guideline	011	017	This seems to contradict the advice provided about treating microscopy results when no pyuria but bacteriuria? (page 9/ line 1) the guidance needs to be consistent.	Thank you for your comment. Please note that according to the diagnostic pathway presented in this guideline to progress to urine testing for pyuria and bacteriuria (Table 3) the baby or child should have been unwell or had symptoms of UTI (please see the section on symptoms and signs). Therefore, the instructions in table 3 are not inconsistent with the recommendation you refer to, which relates instead to asymptomatic bacteriuria. The comittee have re-ordered some of the recommendations and the position of the tables in this section to try to make things clearer.
Royal College of General Practitioners	Guideline	General	General	Overall this is a useful clinical guideline for clinicians in primary care.	Thank you for your comment and support of the guideline.
Royal College of Nursing	General	General	General	We do not have any comments to add on this. Many thanks for the opportunity to contribute.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	004	004	We believe this recommendation is not appropriate for infants and children with congenital anomalies of the kidneys and urinary tract. We suggest adding this situation (a child with congenital anomalies of the kidneys and urinary tract) to the recommendation to	Thank you for your comment. Children with known congenital anomalies of the kidneys and urinary tract are not within the scope of this guideline. The committee are therefore unable to make the requested changes. Please see the published final scope for this

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				consider urine testing even in the face of a different source of infection. Children with congenital anomalies of the kidneys and urinary tract can have a urinary tract infection as well as another infection, particularly during younger years when viral illnesses are very common	guideline for full details of the populations that are excluded. To make this clearer to readers of the guideline we have added this information to the text at the beginning of the Urinary tract infection in under 16s: diagnosis and management website.
Royal College of Paediatrics and Child Health	Guideline	General	General	Urinary tract symptoms are one of the most common reasons why children present to their GP or paediatric emergency department. If they have a proven urinary tract infection, imaging studies and follow-up are arranged for them. It would be helpful for all UK paediatricians if NICE could develop an easy-to-follow pathway/algorithm similar to the paediatric head injury pathway which could be displayed in surgeries and emergency rooms.	Thank you for your comment. The committee discussed your comment, but NICE does not have the resource to develop an implementation tool for the full diagnostic pathway at this current time. However, we will flag your suggestion to our surveillance team to consider during the work on any future updates of the guideline.
Royal College of Paediatrics and Child Health	Guideline	General	General	The criteria and prerequisites for developing a guideline are a highly prevalent disease, or frequently used medical procedures, high associated costs, and current variations of practice. They are particularly important for diseases leading to premature mortality, avoidable morbidity, or negative effects on health related quality of life. The evidence should indicate that medical care can make a difference to outcome. The above criteria have been justified in the guideline – urinary tract infection in under 16s - diagnosis and management. The guideline has specifically emphasised that • it is important to diagnose urinary tract infection quickly and accurately to prevent unnecessary	Thank you for your comment and support of this guideline update.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				suffering and serious complications like renal scarring • has highlighted the many symptoms and signs, as tables, to be used as a guide with clinical judgement • has emphasized the accurate diagnosis of urinary tract infection in unwell babies especially under the age of 3 months And that it may still be necessary to test for urinary tract infection if health care professionals suspect urinary tract infection, despite the absence of any symptoms or signs.	
Royal College of Paediatrics and Child Health	Guideline	General	General	Areas that will have the biggest impact on practice and be challenging to implement: • Gaps between guideline development and implementation are well documented with implications for health care quality, safety, and effectiveness. • the development phase of a guideline has been shown to be important both for the quality of the guideline content and for the success of implementation. • Practice environment, evidence-based health care system, individual context and political macro support are all important for implementation. • Areas related to practice environment also include sub themes such as regulations and rules, economic factors	Thank you for your comment. NICE recognise the validity of your comments although in the context of update to this guideline the recommendation to conduct research on promoting the systematic translation of current research evidence into routine practices is out of scope.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				• Guidelines are not often applied and non-adherence to guidelines may lead to unnecessary diagnostics and suboptimal treatment and hence the focus should be on implementation. • A successful introduction of guidelines involves the three steps of development, dissemination, and implementation. • Summaries and patient versions should be developed to support implementation. More research is needed to promote the systematic translation of current research evidence into routine practices.	
Royal College of Paediatrics and Child Health	Guideline	General	General	How to help users overcome challenges: • The development and implementation of a guideline is intended to provide the best available evidence to support clinical decision making to improve quality of care, patient outcomes and cost effectiveness • The challenges that should be overcome are personal barriers and external barriers. • Personal factors are that related to Physicians' knowledge (lack of awareness, lack of familiarity), barriers that affect Physicians' attitudes (lack of agreement, lack of motivation) • Lack of awareness can be addressed by increased dissemination of guidelines, use of mass media to increase awareness, continuing medical education, making guidelines available	Thank you for your comment and this information. The committee have tried to improve the improve the layout and clarity of the current section on symptoms and signs by moving a related recommendation to this section rather than cross referring to it and by improving the hyperlinks to other guidelines to ensure that they link to the appropriate sections. They hope that this will improve the usability of the guideline and thus make it easier to implement.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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				with practical instruments, educational posters in examination room etc • Lack of attitude can be overcome by addressing lack of agreement, self-efficacy, skills, outcome, expectancy, and motivation • The external barriers include that related to the patients, guideline, and environment. • Guideline related challenges can be overcome by addressing the evidence and plausibility of recommendations in addition to the complexity, layout, accessibility, and applicability of the said guideline • Guidelines should be as short and user friendly as possible. Therefore, the central elements of successful strategies for guideline implementation are - dissemination, education and training, social interaction, and decision support systems.	
UK Health Security Agency	Guideline	005	013	To align with prescribing guidance, it would be useful to prompt that you need to obtain a urine sample before starting antibiotics (but not withhold if sampling isn't possible).	Thank you for your comment. The committee agreed with your comment that it would be useful to align this guideline with the antimicrobial prescribing guidelines on Urinary tract infection (lower) and Pyelonephritis (acute). The committee have therefore added a recommendation to the urine collection section that highlights the need to obtain a urine sample before antibiotics are started, which is in line with recommendations in both UTI antimicrobial prescribing guidelines.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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UK Health Security Agency	Guideline	005	018	One of your recommendations is to send a sample if a child "has clinical symptoms and signs but dipstick tests do not correlate." Users may find it useful if you specify the colony counts that would indicate a UTI in children or refer to the updated SMI recommendations (page 13). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770688/B_41i8.7.pdf	Thank you for your comment. The recommendation you refer to (indications for culture section) wasn't prioritised for update at the scoping stage as no evidence was identified in the surveillance review to suggest the existing recommendations needed amending. The committee did not review any evidence on this topic and were therefore unable to make the requested changes. However, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
UK Health Security Agency	Why the committee made the recommendation	022	004	Concerned that you have removed "haematuria and cloudy urine" as a diagnostic sign/symptom because parents/carers and children might be less likely to report, and it is not picked up until after a sample is obtained. This is something that older children, especially teenage girls, would be likely to notice, and "dark urine" could be interpreted quite differently.	Thank you for your comment. The committee discussed stakeholder comments about the exclusion of haematuria and cloudy urine and have responded by amending table 1 to include these signs as well as adding an additional statement to the notes under the table. This highlights that the symptoms and signs are expected to be assessed before a decision is made about whether urine collection and testing is necessary. Frank haematuria and cloudy urine would therefore be assessed based on feedback from the patient or parents/ carers rather than by the clinician taking a urine sample at this stage in the diagnostic pathway.

Urinary tract infection in under 16s: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
11/05/22 – 25/05/22

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