Microbiology of Urogenital system

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Lecture 3
The term urinary tract infection (UTI) encompasses a variety of clinical entities, including:

- Asymptomatic bacteriuria (ASB)
- Cystitis
- Pyelonephritis.
- Prostatitis
Asymptomatic bacteriuria (ASB)

- The diagnosis of ASB involves criteria that is both *microbiologic* (cut off count of CFU in urine) and *clinical* (no referable symptoms to UTI).

- For asymptomatic women, bacteriuria is defined as 2 consecutive voided urine specimens with isolation of the same bacterial strain in quantitative counts $\geq 10^5$ cfu/mL.

- A single, clean-catch voided urine specimen with 1 bacterial species isolated in a quantitative count $\geq 10^5$ cfu/mL identifies bacteriuria in men.

- *Escherichia coli* remains the single most common organism isolated from bacteriuric women, characterized by fewer virulence characteristics than are those isolated from women with symptomatic infection.

- The diagnosis of asymptomatic bacteriuria should be based on culture of a urine specimen collected in a manner that minimizes contamination.
Asymptomatic bacteriuria (ASB)

- Screening of asymptomatic subjects for bacteriuria is appropriate if bacteriuria has adverse outcomes that can be prevented by antimicrobial therapy.

- Women identified with ASB in early pregnancy have a 20–30-fold increased risk of developing pyelonephritis during pregnancy. As well as experience premature delivery and to have infants of low birth weight.

- Pregnant women should be screened for bacteriuria by urine culture at least once in early pregnancy, and they should be treated if the results are positive.

- ASB or funguria should not screened for or treated in patients with an indwelling urethral catheter.

- Patients with asymptomatic bacteriuria who undergo traumatic genitourinary procedures associated with mucosal bleeding have a high rate of postprocedure bacteremia and sepsis.

- Screening for and treatment of ASB before transurethral resection of the prostate is recommended.
Urinary tract infections are the most common type of healthcare-associated infection, accounting for more than 30% of infections reported by acute care hospitals.

Virtually all healthcare-associated UTIs are caused by instrumentation (CAUTI).

The source of microorganisms causing CAUTI can be endogenous, typically via meatal, rectal, or vaginal colonization, or exogenous, such as via contaminated hands of healthcare personnel or equipment.

Patients should be catheterized for clear indications only. Consider alternatives to chronic indwelling catheters, such as intermittent catheterization.

Bacteria may persist in the catheter biofilm, and it is sensible to remove or replace the catheter, if possible. Patients are treated with empirical IV antibiotics, based on local antibiotic susceptibility patterns and previous infections.
Acute onset of urinary symptoms
- Dysuria
- Frequency
- Urgency

Clinical Presentation

Patient Characteristics
- Otherwise healthy woman who is not pregnant, clear history
- Woman with unclear history or risk factors for STD
- Male with perineal, pelvic, or prostatic pain
- All other patients

Diagnostic and Management Considerations
- Consider uncomplicated cystitis
  - No urine culture needed
  - Consider telephone management
- Consider uncomplicated cystitis or STD
  - Dipstick, urinalysis, and culture
  - STD evaluation, pelvic exam
- Consider acute prostatitis
  - Urinalysis and culture
  - Consider urology evaluation
- Consider complicated UTI
  - Urinalysis and culture
  - Address any modifiable anatomic or functional abnormalities
Acute onset of
- Back pain
- Nausea/vomiting
- Fever
- Cystitis symptoms

Otherwise healthy woman who is not pregnant
- Urine culture
- Consider outpatient management

All other patients
- Urine culture
- Blood cultures

Consider uncomplicated pyelonephritis

No obvious non-urinary cause
- Urine culture
- Blood cultures

Consider complicated UTI, CAUTI, or pyelonephritis
- Exchange or remove catheter if present
Positive urine culture in the absence of:

- Urinary symptoms
- Systemic symptoms related to the urinary tract

Patient who is pregnant, is a renal transplant recipient, or will undergo an invasive urologic procedure:
- Consider ASB
  - Screening and treatment warranted

Patient with urinary catheter:
- Consider CA-ASB
  - No additional workup or treatment needed
  - Remove unnecessary catheters

All other patients:
- Consider ASB
  - No additional workup or treatment needed
A 23-year-old woman at 8 weeks gestation, comes to the clinic for her first antenatal visit. She reports no symptoms apart from some mild nausea which she is managing with small, frequent meals. A urine sample is sent as part of the routine pregnancy panel. Culture shows greater than 100,000 CFU/mL of gram-negative rods. Failure to appropriately treat this condition will place this patient at an increased risk for?

An untreated urinary tract infection in pregnant patients is associated with an increased risk of several complications including: pyelonephritis, preterm labor, second-trimester abortion, preeclampsia, maternal anemia, and chorioamnionitis. Nitrofurantoin or trimethoprim tend to be used first line for empiric treatment and are both safe in pregnancy.
A 25-year-old woman comes to the clinic because of urinary frequency and dysuria for the past 3 days. She is otherwise healthy and states that she is sexually active. Physical examination shows suprapubic tenderness. Urinalysis shows the presence of leukocyte esterase and nitrites. Which of the following is the most likely causative organism for her condition?

*Escherichia coli* is a gram-negative bacteria that is the most common pathogen found in community-acquired urinary tract infections.
A 82-year-old woman is sent from her nursing home to the emergency department because of concerns for sepsis. The patient has late-stage Alzheimer's, no known drug allergies, and an indwelling Foley catheter. The referral letter states that she has had back pain, fevers, and tachycardia for the past two days. Physical examination shows costovertebral tenderness on the right. Urinalysis is positive for protein, leukocyte esterase, and nitrates and shows greater than 50 WBC per high powered field. Laboratory studies show a leukocytosis. Which of the following is the next best step in the management of this patient?

This patient has classic signs of urosepsis, most likely caused by a catheter-associated urinary tract infection (CAUTI). While the culture is pending, the next best step is to remove the indwelling Foley catheter and then commence empiric antibiotic therapy according to local guidelines.
A 48-year-old woman comes to the emergency department because of 'burning, bloody urine'. She has been urinating more frequently for the past 2 days, but she denies polydipsia, vaginal discharge, back pain, abdominal pain, nausea, vomiting, or fevers. Physical examination shows that she is afebrile and her other vital signs are stable. Her abdomen is soft, non-tender and there is no flank tenderness. Urine dipstick is positive for leukocyte esterase and nitrites. What is the most appropriate initial treatment option?

Uncomplicated UTI is most commonly caused by Escherichia coli and trimethoprim-sulfamethoxazole (TMP-SMX) is the most common first line empiric antibiotic used for treatment whilst awaiting culture results.

Individualized treatment choice between nitrofurantoin, TMP-SMX, and ciprofloxacin depends largely on clinical picture, allergy, tolerability, compliance and local community resistance patterns.
A 38-year-old woman comes to the office because of ongoing urinary frequency, urgency, and dysuria. Patient’s medical history includes recurrent urinary tract infections, with about four to six each year for the last three years. She says that her symptoms typically resolve with antibiotic use, but will return once she stops using the antibiotics. Urinalysis is performed and shows the following:

<table>
<thead>
<tr>
<th>Urine Studies</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>8</td>
</tr>
<tr>
<td>Protein</td>
<td>0 mg/dL</td>
</tr>
<tr>
<td>Glucose</td>
<td>Negative</td>
</tr>
<tr>
<td>Blood</td>
<td>Negative</td>
</tr>
<tr>
<td>White blood cells</td>
<td>15-20 cells HPF</td>
</tr>
<tr>
<td>Leukocyte esterase</td>
<td>Positive</td>
</tr>
<tr>
<td>Epithelial cells</td>
<td>&lt;5 cells HPF</td>
</tr>
<tr>
<td>Bacteria</td>
<td>Absent</td>
</tr>
</tbody>
</table>

What is the most likely underlying cause of this patient’s recurrent urinary tract infections?

Recurrent urinary tract infections despite appropriate antibiotic use, and a urinary pH $>8$ should clue you into a urease producing organism or a struvite kidney stone. Struvite kidney stones or triple phosphate stones are composed of magnesium, ammonium and phosphate.
Further reading:

• Oxford handbook of infectious diseases and microbiology-
  Part4: Clinical syndroms
  Chapter 17 Urinary tract infections

• Harrison's Infectious Diseases 3rd Edition
  SECTION III Infections in organ systems
  Chapter 33