

**American College of Radiology
ACR Appropriateness Criteria®**

Clinical Condition: Urinary Tract Infection — Child

Variant 1: Age 0-2 years; maximum temperature <38.5°C.

Radiologic Procedure	Rating	Comments	<u>RRL*</u>
US kidneys and bladder	9	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	8	Accurate in evaluation of reflux. Better anatomic differentiation. Should be cycled.	Low
Radionuclide cystography (girls)	8	Accurate in evaluation of reflux. Lower radiation dose. Use in girls when no anatomic abnormality is suspected.	Min
X-ray voiding cystourethrography (girls)	7	Useful in girls when significant anatomic abnormality is suspected in addition to reflux. Should be cycled.	Low
Renal cortical scintigraphy	6	Small infants may present with pyelonephritis without fever. Consider pinhole and/or SPECT.	Med
CT abdomen with contrast	4	Also an acceptable method of cortical imaging. Higher radiation dose.	High
MRI abdomen and pelvis with contrast	4	Also an acceptable method of cortical imaging. No ionizing radiation. Sedation required. See statement regarding contrast in text under “Anticipated Exceptions.”	None
Radionuclide cystography (boys)	2	Accurate in evaluation of reflux. Lower radiation dose. Poor anatomic differentiation.	Min
X-ray intravenous urography	1		Med
<u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

Clinical Condition:**Urinary Tract Infection — Child****Variant 2:****Age 0-2 years; maximum temperature $\geq 38.5^{\circ}\text{C}$.**

Radiologic Procedure	Rating	Comments	<u>RRL*</u>
US kidneys and bladder	9	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	8	Accurate in evaluation of reflux. Better anatomic differentiation. Should be cycled.	Low
Radionuclide cystography (girls)	8	Accurate in evaluation of reflux. Lower radiation dose. Use in girls when no anatomic abnormality is suspected.	Min
X-ray voiding cystourethrography (girls)	7	Useful in girls when significant anatomic abnormality is suspected in addition to reflux. Should be cycled.	Low
Renal cortical scintigraphy	7	Use pinhole and/or SPECT.	Med
MRI abdomen and pelvis with contrast	5	Also an acceptable method of cortical imaging. No ionizing radiation. Sedation required. See statement regarding contrast in text under “Anticipated Exceptions.”	None
CT abdomen with contrast	4	Also an acceptable method of cortical imaging, or if concerned for abscess. Higher radiation dose.	High
Radionuclide cystography (boys)	2	Accurate in evaluation of reflux. Lower radiation dose. Poor anatomic differentiation.	Min
X-ray intravenous urography	1		Med
Rating Scale: 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

Variant 3:**Age 2-7 years; maximum temperature $< 38.5^{\circ}\text{C}$.**

Radiologic Procedure	Rating	Comments	<u>RRL*</u>
US kidneys and bladder	9	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	8	Accurate in evaluation of reflux. Better anatomic differentiation. Consider cycling.	Low
Radionuclide cystography (girls)	8	Accurate in evaluation of reflux. Lower radiation dose. Use in girls when no anatomic abnormality is suspected.	Min
X-ray voiding cystourethrography (girls)	7	Useful in girls when significant anatomic abnormality is suspected in addition to reflux. Consider cycling.	Low
MRI abdomen and pelvis with contrast	4	Also an acceptable method of cortical imaging. No ionizing radiation. Sedation required. See statement regarding contrast in text under “Anticipated Exceptions.”	None
Renal cortical scintigraphy	4	Use pinhole and/or SPECT.	Med
CT abdomen with contrast	3		High
Radionuclide cystography (boys)	2	Accurate in evaluation of reflux. Lower radiation dose. Poor anatomic differentiation.	Min
X-ray intravenous urography	1		Med
Rating Scale: 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

Clinical Condition:**Urinary Tract Infection — Child****Variant 4:****Age 2-7 years; maximum temperature $\geq 38.5^{\circ}\text{C}$.**

Radiologic Procedure	Rating	Comments	RRL*
US kidneys and bladder	9	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	8	Accurate in evaluation of reflux. Better anatomic differentiation. Consider cycling.	Low
Radionuclide cystography (girls)	8	Accurate in evaluation of reflux. Lower radiation dose. Use in girls when no anatomic abnormality is suspected.	Min
X-ray voiding cystourethrography (girls)	7	Useful in girls when significant anatomic abnormality is suspected in addition to reflux. Consider cycling.	Low
Renal cortical scintigraphy	7	Consider pinhole and/or SPECT.	Med
CT abdomen with contrast	5	Also an acceptable method of cortical imaging. Higher radiation dose.	High
MRI abdomen and pelvis with contrast	5	Also an acceptable method of cortical imaging. No ionizing radiation. Sedation required. See statement regarding contrast in text under “Anticipated Exceptions.”	None
Radionuclide cystography (boys)	2	Accurate in evaluation of reflux. Lower radiation dose. Poor anatomic differentiation.	Min
X-ray intravenous urography	1		Med
Rating Scale: 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

Variant 5:**Age 8+ years; maximum temperature $< 38.5^{\circ}\text{C}$.**

Radiologic Procedure	Rating	Comments	RRL*
US kidneys and bladder	8	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	5		Low
X-ray voiding cystourethrography (girls)	5		Low
Radionuclide cystography (boys)	5		Min
Radionuclide cystography (girls)	5		Min
CT abdomen with contrast	4		High
MRI abdomen and pelvis with contrast	4	No ionizing radiation, and sedation likely not required in this age group. See statement regarding contrast in text under “Anticipated Exceptions.”	None
Renal cortical scintigraphy	2		Med
X-ray intravenous urography	1		Med
Rating Scale: 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

Clinical Condition:

Urinary Tract Infection — Child

Variant 6:Age 8+ years; maximum temperature $\geq 38.5^{\circ}\text{C}$.

Radiologic Procedure	Rating	Comments	RRL*
US kidneys and bladder	8	Power Doppler should be considered.	None
X-ray voiding cystourethrography (boys)	5		Low
X-ray voiding cystourethrography (girls)	5		Low
Radionuclide cystography (boys)	5		Min
Radionuclide cystography (girls)	5		Min
Renal cortical scintigraphy	5	Most appropriate if localizing symptoms not apparent. Use pinhole and/or SPECT.	Med
MRI abdomen and pelvis with contrast	5	No ionizing radiation, and sedation likely not required in this age group. See statement regarding contrast in text under “Anticipated Exceptions.”	None
CT abdomen with contrast	4		High
X-ray intravenous urography	1		Med
Rating Scale: 1=Least appropriate, 9=Most appropriate			*Relative Radiation Level

URINARY TRACT INFECTION — CHILD

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Summary of Literature Review

Definition of Urinary Tract Infection

The main goal of imaging in childhood urinary tract infection (UTI) is to identify children at risk for developing recurrent infections, renal scarring, and long-term sequelae. The UTI should be well documented. Specimens from infants and young children collected in plastic bags are not acceptable because they are frequently contaminated; the use of bagged specimens leads to a child undergoing unnecessary imaging procedures [1-3].

Sequelae of Urinary Tract Infection

Cystitis in the absence of pyelonephritis is not associated with long-term sequelae. The incidence of scarring in children following infection of the renal parenchyma varies widely in the literature, with a mean of about 40%-45% of cases across a wide age range [4-25]. Renal insufficiency is an uncommon sequela of pyelonephritis in childhood, except in cases where there has been substantial prenatal injury due to obstruction or vesicoureteral reflux, and in cases with bilateral renal scarring [15,16,26]. Hypertension appears to be a more common sequelum of moderately severe or severe scarring, affecting 10%-20% of young adults who have significant renal scarring, with the frequency of hypertension increasing through their second, third and fourth decades [15,16,27,28]. At this time, there is no evidence that a few scattered small parenchymal scars predispose adolescents or young adults to hypertension, but there may be some risk of hypertension associated with medium-sized scars [27-29].

Risk of Pyelonephritis

The relationship between childhood UTI, vesicoureteral reflux (VUR), and renal damage is complex and

incompletely understood. Children with VUR are at increased risk for pyelonephritis and parenchymal scarring, but VUR is not a prerequisite for renal damage, and neither are all patients with VUR at risk of renal scarring [7,13,14,17,20,21,24,30-32]. Long-term low-dose antibiotic suppression is widely used after the acute infection in children with VUR. Until 1986, it was thought that pyelonephritis in children occurred only when VUR was present, but it has become clear that more than half the cases of acute pyelonephritis occur in the absence of VUR [1,14,18,20,21,32-35]. The incidence of acute pyelonephritis in the absence of documented VUR is much too high to be explained by intermittent VUR [36,37]. Pyelonephritis in these children appears to be due to the same pathogens as those in children with documented VUR. Previous episodes of pyelonephritis or VUR place the child at increased risk for future episodes of pyelonephritis [4,20,32]. Accurate diagnosis of acute pyelonephritis may affect the length of stay in hospitalized patients and may also affect treatment after the acute infection—for example, the decision whether to place the child on antibiotic suppression.

Imaging Evaluation

Clinical Diagnosis of Acute Pyelonephritis

Approximately 50%-90% of children hospitalized for acute pyelonephritis have evidence of acute pyelonephritis by the most accurate imaging examinations, and clinical signs and laboratory examinations are only moderately useful [6,18,38-46]. The usual clinical definition of acute pyelonephritis (particularly in Europe) is fever of >38.5° C, UTI adequately proven by culture, and elevated acute phase reactants (usually C-reactive protein (CRP) levels >10 mg/L). In most series, approximately 50%-80% of children who meet these criteria have evidence of acute pyelonephritis on cortical scintigraphy [6,18,40,41,44,47].

Voiding Cystography and Vesicoureteral Reflux

Imaging evaluation for VUR in the presence of a normal renal scan performed during an acute UTI is a controversial subject with mixed data in the recent literature. While some recent studies have suggested that a negative acute-phase renal cortical scan can obviate the need for cystography evaluation for VUR in children with UTI, others have suggested that VUR should be considered in all children with UTI even in the presence of a normal renal scan and ultrasound (US), as approximately 13% of these patients may have grade III VUR or higher [8,30,43,48-52]. This remains an area requiring further prospective long-term studies prior to significantly altering currently accepted imaging guidelines, although the evidence-based literature support for not evaluating every child with a UTI for possible VUR is strengthening.

VUR is detected with equal sensitivity by fluoroscopic contrast voiding cystourethrography (VCUG) and direct radionuclide cystography (RNC) [53-55]. Failure to detect

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reflux by either method is usually due to intermittent low-grade VUR; in other words, the patient has intermittent VUR but simply did not reflux at the time the bladder was filled and imaged [36,37]. A second filling of the bladder (cyclic cystography) is appropriate in children <2 years of age who cannot inhibit voiding and when there is a high suspicion that VUR is present, as children in both of these groups are at higher risk of developing renal damage from urinary infection [36,37]. Cyclic cystography may be appropriate in children >2 years of age as well [36].

RNC has a lower absorbed radiation dose than VCUG, but it does not have the spatial resolution needed to identify anatomic abnormalities of the urethra, bladder, and ureters. RNC is appropriate for follow-up of VUR and for screening asymptomatic siblings of children with VUR. Initial evaluation of VUR in girls may be done by RNC, unless there is reason to believe that a significant anatomic abnormality of the upper urinary tract is present (for example, from a prior US). The frequency of lower urinary tract findings other than VUR in girls with UTI is extremely low [10,56]. Initial evaluation of VUR in boys should not be done exclusively by RNC, as adequate anatomic imaging of the urethra and bladder can only be done with VCUG.

Detection of Acute Pyelonephritis and Renal Parenchymal Scarring

Renal Cortical Scintigraphy

Renal cortical scintigraphy (RCS) using technetium-99m DMSA or technetium-99m glucoheptonate is sensitive and specific for detecting acute pyelonephritis in animal studies, with sensitivity of about 90% and specificity of 95% [22,38,45]. Evidence of acute pyelonephritis is detected by RCS in children with UTI in about 50%-80% of cases [6,18,40,41,43,44,47,51,52]. RCS is more sensitive than US and intravenous pyelography (IVP) in detecting renal parenchymal scars [5,12,19,23,57,58]. In the typical clinical setting, however, acute pyelonephritis and renal parenchymal scarring are usually but not always distinguishable from each other by RCS. RCS may also be helpful in predicting the risk of breakthrough infection and renal damage in children with VUR [30,59].

Although RCS images are of somewhat higher quality when technetium-99m DMSA is used, technetium-99m glucoheptonate has equal sensitivity for detecting acute and chronic pyelonephritis, and it allows identification of most dilated uropathies (which is somewhat more difficult with DMSA) due to its approximately 40%-65% renal excretion [35,57,60]. However, in the presence of significant hydronephrosis or dilative VUR, it may be difficult to differentiate cortical activity from collecting system activity with technetium-99m-glucoheptonate, which makes DMSA a more desirable agent for renal cortical imaging in most cases [57]. Technetium-99m DMSA is preferred in small infants, in poorly functioning kidneys, and when other studies have identified dilated uropathy or high-grade VUR. Pinhole imaging or single photon emission computed tomography (SPECT) should be considered to maximize the sensitivity of RCS without

loss of specificity [22,38,40]. RCS may require sedation in young children.

Ultrasonography

Gray-scale US identifies about 25% of acute pyelonephritis and about 40% of chronic parenchymal scarring [9,12,19,23,39,44,46,47,58,61-64]. Acute pyelonephritic changes, particularly renal enlargement, cannot be identified on US 1-2 weeks after presentation, when the acute infection has cleared. US reliably identifies severe parenchymal scarring, but not moderate or minimal scarring [58]. Interobserver and intraobserver error makes assessment of renal growth unreliable after the first year of life unless the period of observation is at least 12-18 months [65,66]. US cannot reliably identify VUR [1,34,67-70], but it is extremely effective in identifying urinary tract malformations such as hydronephrosis, hydroureter, and ureterocele. It is noninvasive and does not involve ionizing radiation. While animal studies have shown power Doppler US imaging to be significantly less accurate in detecting acute pyelonephritis compared with other imaging modalities, recent clinical studies in children have shown good results [42,43,45,47,71,72]. A positive power Doppler US may be able to obviate the need for a renal cortical scan in the detection of acute pyelonephritis in children [71,72].

Contrast-Enhanced Computed Tomography and Magnetic Resonance Imaging

Helical contrast-enhanced computed tomography (CT) and magnetic resonance imaging (MRI) after contrast administration are probably as sensitive as RCS in detecting acute pyelonephritis [45,73-75]. Both CT and MRI provide more anatomic information about the collecting systems and ureters than is available from RCS, and both can provide information about renal scarring [11,75-78]. CT has a considerably higher effective absorbed radiation dose than RCS. MRI is more expensive than CT, typically requires sedation in young children, and uses no ionizing radiation. MRI may be used to identify ectopic ureters and can provide renal functional data. Early studies indicate that post-gadolinium imaging may be most effective in identifying acute pyelonephritis, while T1-weighted sequences may be all that is necessary for identifying renal scarring [11,73,74,76,77].

Intravenous Urography

Intravenous urography (IVU) is insensitive when compared with other imaging modalities in diagnosing acute pyelonephritis or postinfectious scar [5,35]. It is valuable in identifying detailed ureteral and calyceal anatomy, permitting characterization of duplication anomalies when this information is needed. Routine anatomic diagnosis is usually done by US. IVU examinations in infants are often of poor quality. IVU is generally not indicated in the routine evaluation of pediatric UTI.

Choice of Upper Urinary Tract Examination in Children

Acute pyelonephritis may occur in the absence of fever in an infant [41,79]. If only a single upper urinary tract examination can be performed, the physician must compare the relative risk of failing to detect acute pyelonephritis when only power Doppler US is used to the risk of failing to detect dilated uropathy when only RCS is used. Appropriate sequencing of RCS and US also may be used to improve diagnostic yield and control imaging costs. Whenever it is important to identify both pyelonephritis and urinary tract dilatation (in an individual or a subpopulation), both RCS and US should be used, or alternatively, a single contrast-enhanced CT or MRI examination may be performed.

Age and the Choice of Examination

Findings on imaging studies vary considerably according to the age at which the child is imaged. It is well known that the incidence of VUR decreases with age [1,18,33]. The prevalence of VUR in children with UTI drops from approximately 50% to 30% from 0 to about 2 years of age, plateaus at approximately 30% from about 2 to about 7 years of age, and then drops precipitously at about 7 years of age [1]. Another factor that may support the use of age-specific algorithms is the higher incidence of acute pyelonephritis in young children with UTI when compared to infants with UTI [18]. Infants and toddlers appear to be at greater risk for extensive renal injury from acute pyelonephritis than older children, and afebrile pyelonephritis is probably rare after the first year of life [37]. In the school-age period, children between 5 and 8 years of age acquire the ability to identify acute pyelonephritis as flank pain. At the same time, the incidence of acute pyelonephritis is relatively low, and the incidence of VUR continues to decrease [33].

Summary

- US of the kidneys and bladder is the most appropriate initial imaging examination in a child with a UTI, though some cases of acute pyelonephritis will be missed using US alone.
- The relationship between childhood UTI, VUR, and renal damage is complex and incompletely understood. Children with VUR are at increased risk for pyelonephritis and parenchymal scarring, but reflux is not a prerequisite for renal damage, and neither are all patients with reflux at risk of renal scarring.
- Initial imaging evaluation for VUR in boys should be performed with x-ray VCUG. Initial imaging evaluation of reflux in girls may be done by radionuclide cystography, unless there is reason to believe that a significant anatomic abnormality of the upper urinary tract is present. Cyclic cystography is appropriate in children <2 year of age and may be appropriate in children >2 years of age as well.
- RCS is considered the gold standard imaging modality for evaluating acute pyelonephritis and renal parenchymal scarring. CT, MRI, and power

Doppler US are reasonable alternatives in the appropriate clinical setting.

- Imaging choices for childhood UTI may vary depending on the child's age and clinical presentation.

Anticipated Exceptions

Nephrogenic systemic fibrosis (NSF) is a disorder with a scleroderma-like presentation and a spectrum of manifestations that can range from limited clinical sequelae to fatality. It appears to be related to both underlying severe renal dysfunction and the administration of gadolinium-based contrast agents. It has occurred primarily in patients on dialysis, rarely in patients with very limited glomerular filtration rate (GFR) (ie, <30 mL/min/1.73m²), and almost never in other patients. There is growing literature regarding NSF. Although some controversy and lack of clarity remain, there is a consensus that it is advisable to avoid all gadolinium-based contrast agents in dialysis-dependent patients unless the possible benefits clearly outweigh the risk, and to limit the type and amount in patients with estimated GFR rates <30 mL/min/1.73m². For more information, please see the [ACR Manual on Contrast Media](#) [80].

Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

Relative Radiation Level Designations	
Relative Radiation Level	Effective Dose Estimate Range
None	0
Minimal	< 0.1 mSv
Low	0.1-1 mSv
Medium	1-10 mSv
High	10-100 mSv

Supporting Document(s)

- [ACR Appropriateness Criteria® Overview](#)
- Evidence table under review

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The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.