

# kidney news

Volume 1, Issue 2

September 1999

## Introduction

Thank you to those who sent comments on the inaugural *kidney news* in June. Here is issue number 2! I need to meet you as my referrer's. I hope to be able to meet some of you over the next few months. I plan to ask my nurse to contact your practice, and make a time for us to meet.

Last issue was sent to all Botany Clinic GPs. This time I have attempted to reach more of you. Hopefully I have not double mailed! And if you know someone I have missed, who would like a copy, please let me know/get them to contact me. Thank you.

Space in this issue is restricted, so the discussion of some topics (eg. prostatitis and urethral syndrome) is limited.

## Case Study

Having recently moved to Auckland, Julia, aged 27 years, presents to you with frequency and dysuria.

Frequently she has had similar urinary symptoms, but these have settled with high fluid intake and cranberry juice. Julia has not consulted a doctor for this problem before. She is a naturopath. Now, however, she is concerned as she thinks she is pregnant, and understands urinary infections and pregnancy are a potential problem. No history of loin pain.

She has not ever had any urinary tract investigations.

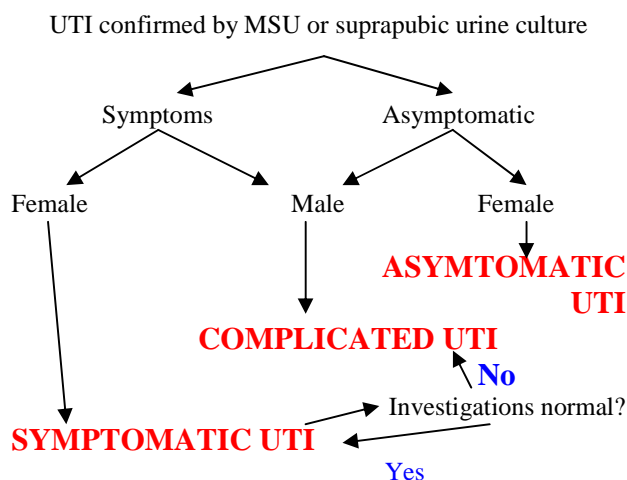
No previous obstetric history. For seven years, has lived, and continues to do so, in a stable relationship, with her partner. Never smoked. Occasionally drinks alcohol. No other medical or surgical history.

1. What other information is useful/should be asked about?
2. What investigations are appropriate?
3. What management plan is appropriate now?
4. What if this fails?

1. Childhood enuresis. Unexplained fevers as a child or early adolescence. Checking with Mother or Plunket book maybe necessary.
2. MSU (for WBC > 100/ml; RBC may or may not be present; exclusion of epithelial cells (represent contaminated specimen). Pregnancy test. Serum electrolytes, urea, creatinine.
3. PREG test POSITIVE: high fluid intake (so > 2litres of urine produced per day) – especially lots of fluid at night – this will result in nocturia, but reduce stagnant bladder urine at night. She should continue/reintroduce cranberry juice. If failed (or does fail), a single dose of trimethoprim 600mg; or a 3-day course of a safe-in-pregnancy antibiotic (see over) should be adequate. If this three-day course fails, prophylactic antibiotic course (if Julia agrees) is indicated. Julia should have an ultrasound scan (looking for renal scars) or DMSA scan (more sensitive than IVU or USS) after delivery. If abnormal refer to renal physician.
4. PREG test NEGATIVE: USS for renal scars as initial screen test although DMSA scan is more sensitive. Consider referral if symptoms do not settle, or if trying to get pregnant, refer for both further genetic advise (50% chance of Julia's offspring developing reflux nephropathy).
5. Referral to a renal physician. Radiographic investigations usually can wait until pregnancy is over. If renal scars found, referral needed. If no renal scars, and a persistent problem, and general advise (see over) unsuccessful; a prolonged course (6 or more months) of prophylactic antibiotics maybe needed.

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#### **THERAPY - ASYMPTOMATIC UTI (bacterial cystitis)**

One-day course of any one of: Augmentin 3G; trimethoprim 600mg; norfloxacin 800mg. OR 3 day antibiotic course (see symptomatic UTI therapy, below)

#### **THERAPY - SYMPTOMATIC UTI**

3 day course of Augmentin 500mg tds; or trimethoprim 300mg daily with food; or norfloxacin 400mg bd; or cephalexin 500mg bd (especially if low GFR).

#### **THERAPY - COMPLICATED UTI**

Referral may be appropriate. 3-day antibiotic course usually not adequate (except perhaps males with their first UTI, and normal renal tract investigations. Ten to 14 days therapy often needed, or until complicating factor reversed/removed – if possible (e.g. urinary catheter removed, obstruction (stones, tumour) removed. Sometimes long-term prophylaxis needed (six months often adequate). May need urologist for stone removal (and analysis), and renal physician for metabolic workup (for stone aetiology).

#### **THERAPY – PYELONEPHRITIS**

5 day course of oral (or IV and oral) antibiotics usually adequate. May involve hospital admission if unwell. Often one IV dose of gentamicin (2-3mg/kg body weight – if normal renal function (any doubt? –use ceftriaxone IV 2G)). Followed by oral therapy (norfloxacin 400mg bd) adequate.

**PLEASE NOTE.** Not all antibiotic choices are listed, merely some common effective ones.

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**Interests**

Investigation of renovascular disease and hypertension

Management of urinary tract infections

Investigation of urinary calculi

Investigation of proteinuria and haematuria

Investigation and management of impaired renal

function.

#### **Antibiotics “safe to use” in pregnancy**

Most cephalosporins – in usual doses.

Single dose: trimethoprim 600mg, single dose.

Prophylaxis: Nitrofurantoin 50mg nocte

Amoxicillin 250mg nocte

***Often alternate day, or three days per week, prophylaxis is adequate.***

#### **General advise for urinary infections**

High fluid intake – at least 2l of urine output/day (especially evening/ night to minimise time urine is stagnant in bladder – nocturia will be a consequence).

Wearing of loose perineal region clothing.

Double voiding of bladder (consciously attempt to empty bladder each visit, after initial emptying).

Post-coital micturition (and drink of water).

0.5% cetrimide w/w antiseptic cream topically immediately prior to sexual intercourse may be tried.

Cranberry juice is effective at preventing UTIs.