Association of Ontario Midwives
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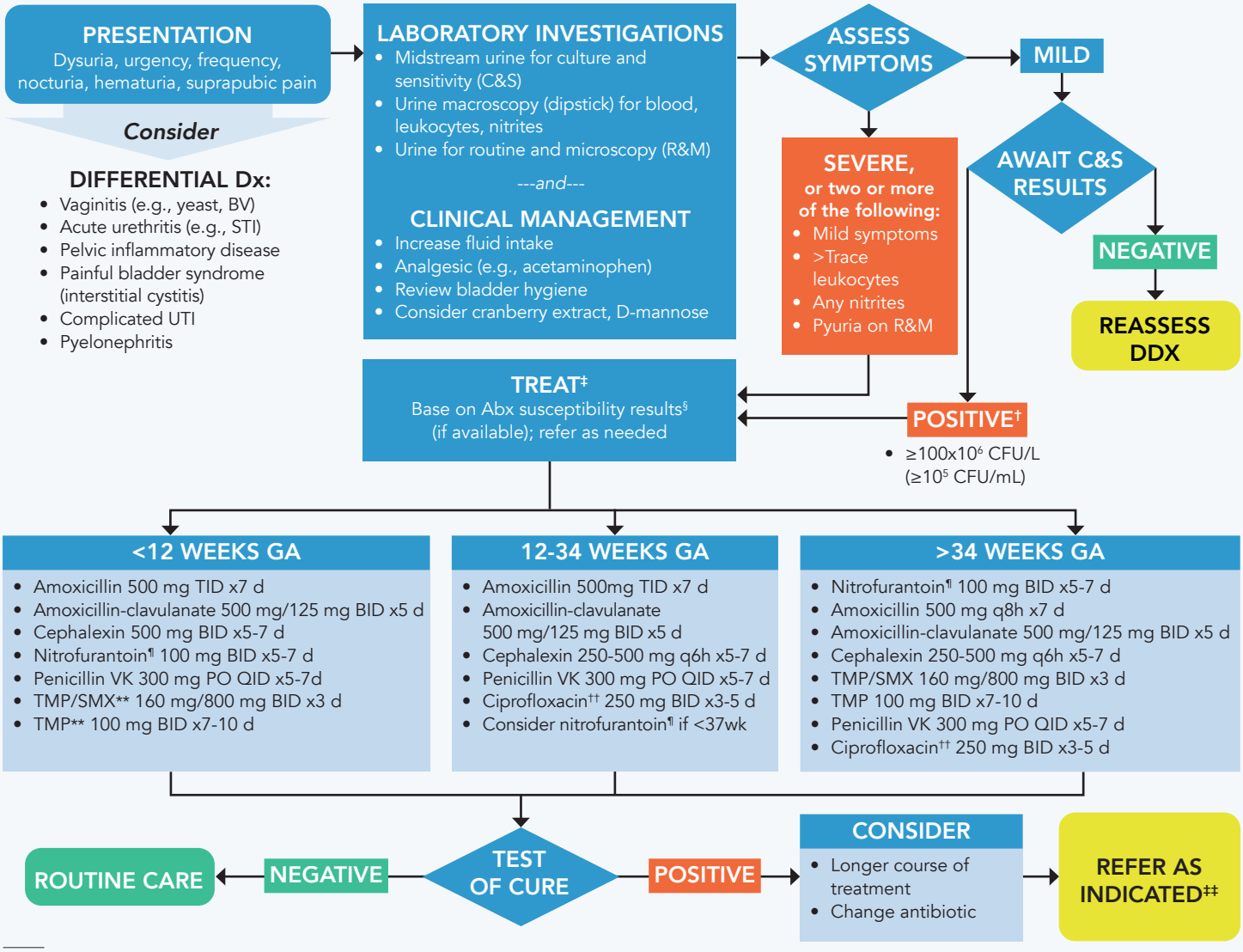
CLINICAL TREATMENT ALGORITHM

Acute urinary tract infection (UTI) in pregnancy

RISK FACTORS: Pregnancy, frequent sexual activity (≥3x/wk), poor bladder hygiene, **recurrent UTI, pre-gestational diabetes, polycystic kidneys, congenital kidney anomalies, sickle cell disease***



* If bolded risk factor(s) present, review guidelines for higher-risk populations and manage or refer accordingly.

† For results indicating GBS is present, consult the GBS bacteriuria algorithm.

‡ Recommended treatment regimens may vary by community and local antimicrobial resistance rates, **this is not an exhaustive list** of antibiotic options for treatment. Further, this algorithm only includes drugs within prescribing scope for Ontario midwives at the time of publication. Additional drugs may be appropriate (e.g., fosfomycin); midwives may refer as indicated or order/administer under directive as per Ontario Regulation.

§ *E. coli* (most common uropathogen in UTI) has high antimicrobial resistance to amoxicillin (up to ~85%), penicillin VK (≥90% in some areas) and TMP (up to ~40%); consider alternate drug for empiric therapy if susceptibility results not available.

¶ Consider alternate drug in T1 if available, but may be most suitable for empiric treatment. Contraindicated in T3 or if labour/birth imminent.

** TMP(/SMX) is reasonable in first trimester if no appropriate alternatives available. TMP is a folate antagonist; consider concurrent folate supplementation. Avoid in last 6 weeks of pregnancy due to risk of kernicterus in infants (especially if preterm).

†† Generally recommended to avoid fluoroquinolones in pregnancy, especially T1, can consider if no appropriate alternatives available.

‡‡ Assess for urgency & complications (e.g., suspected pyelonephritis) and refer accordingly (community vs. urgent care).

REFERENCES

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