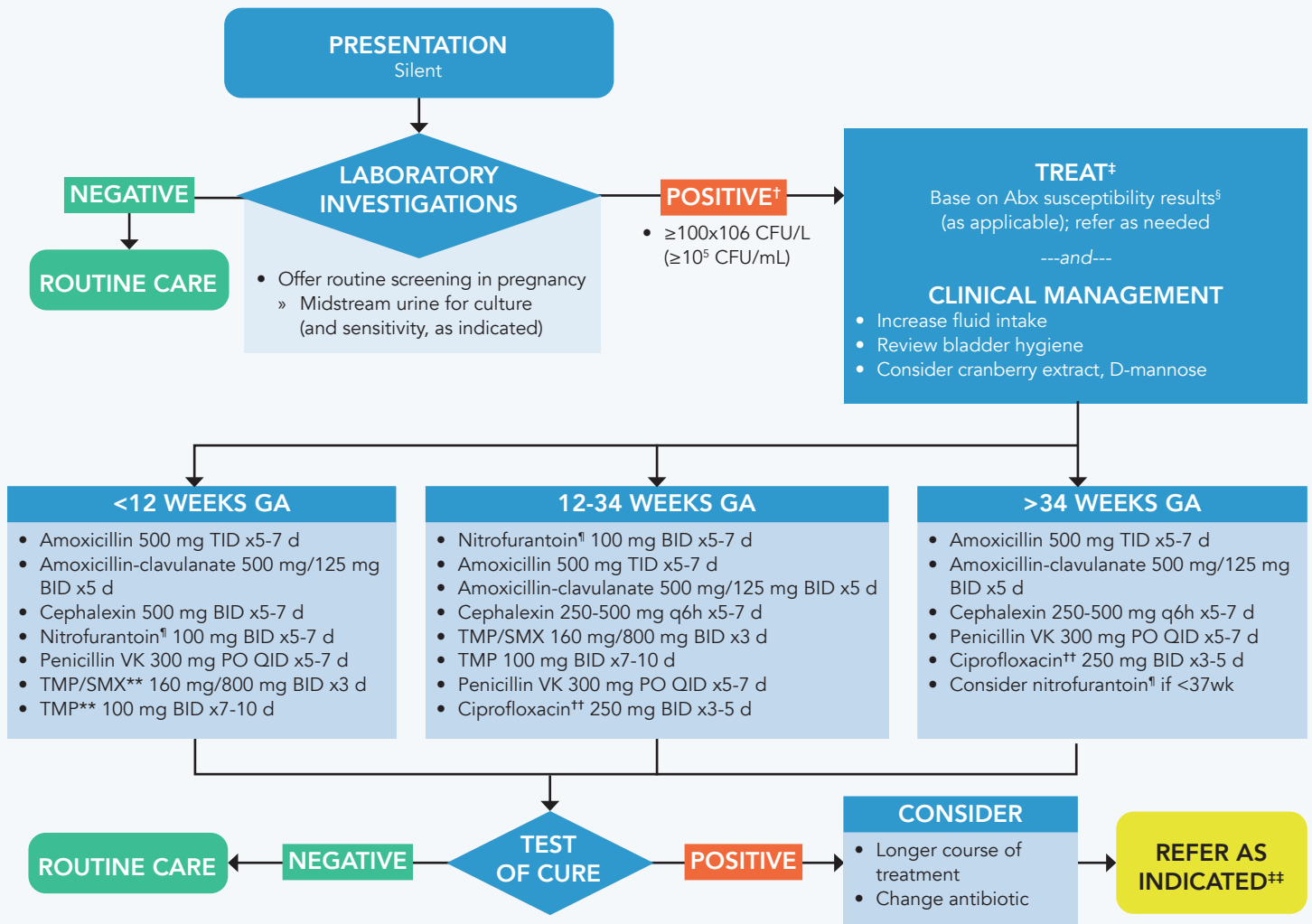




## Asymptomatic bacteriuria in pregnancy (ASB)

**RISK FACTORS:** Pregnancy, frequent sexual activity ( $\geq 3$ x/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. For results with  $\geq 2$  organisms, consider contamination vs. bacteriuria.

‡ Recommended treatment regimens 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 per [Ontario Regulation](#).

§ E. coli (most common uropathogen in ASB) has high antimicrobial resistance to amoxicillin (up to ~85%), penicillin VK ( $\geq 90\%$  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 and refer accordingly (community vs. urgent care).

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