



# RAMA UNIVERSITY

---

[www.ramauniversity.ac.in](http://www.ramauniversity.ac.in)  
FACULTY OF NURSING

# Pyelonephritis



BY:-

Arpit Kamal

Nursing Tutor

MSN Department

Rama College Of Nursing

## Definition:

Inflammation of the parenchyma and lining of renal pelvis of kidney

# Epidemiology and Risk Factors:

## Host factor:

Female :Shorter urethra

Male : uncircumcised infant → bacterial colonization  
inside prepuce and urethra

## Catherization

DIRECT: Bacteria carried directly into bladder during  
insertion

INDIRECT:Facilitation of bacterial access via  
lumen of catheter

Tracking up between outside catheter and urethral  
wall

# Host factor:

- Normal urine flow disruption ( obstruction )→ Incomplete bladder emptying → > 2-3ml residual urine → infection → ascent of infection → pyelonephritis
  - Pregnancy
  - Prostatic hypertrophy
  - Renal calculi
  - Tumor
  - Stricture
- Loss of neurological control of bladder and sphincter( spina bifida , paraplegia, multiple sclerosis)
- Vesicourethral reflux ( urine reflux from bladder to ureter, renal pelvis and parenchyma)
- Diabetes Mellitus → diabetic neuropathy → interfere with bladder function
- Diabetes Mellitus → Impaired cytokine secretion

# Host factor:

- genetic background of the host
- familial disposition to pyelonephritis
- women with recurrent UTI
- Have had their first UTI before the age of 15 years
- persistent vaginal colonization
- Mutations in host response genes(those coding for Toll-like receptors and the interleukin 8 receptor)

# Host factor:

- Factors independently associated with pyelonephritis in young healthy women include:
- Frequent sexual intercourse
- New sexual partner,
- UTI in the previous 1 2 months,
- Maternal history of UTI,
- Diabetes
- Incontinence.
- spermicide use
- And cystoceles ,incontinence and residual urine in postmenopausal women,

# Etiology:

- The uropathogens causing Pyelonephritis vary by clinical syndrome but are usually enteric gram-negative rods that have migrated to the urinary tract. The susceptibility patterns of these organisms vary by clinical syndrome and by geography.
- Gram negative organism
- E.coli (common)
- Proteus mirabilis, Citrobacter, klebsiella, enterobacter, proteus pseudomonas aeruginosa
- Gram positive organism
- Staph.saprophyticus, Staph. Epidermidis enterococcus, Corynebacteria and lactobacilli



# Virus

- Rare
- Virus Human  
polyomaviruses , JC and BK
- Cytomegalovirus and rubella
- Korean hemorrhagic fever virus
- Mumps and HIV
- Recovered in urine in absence of UTI

# Parasite

- Fungi : candida spp  
and histoplasma  
capsulatum
- Protozoa :  
trichomonas vaginalis
- Helminth:  
schistosoma  
haematobium

# Pathogenesis:

- The urinary tract can be viewed as an anatomic unit united by a continuous column of urine extending from the urethra to the kidneys. In the majority of UTIs bacteria establish infection by ascending from the urethra to the bladder. Continuing ascent up the ureter to the kidney is the pathway for most renal parenchymal infections.

# Vaginal Ecology:

- Colonization of the vaginal introitus and periurethral area with organisms from the intestinal flora (usually *E. coli*)
- Sexual intercourse is associated with an increased risk of vaginal colonization with *E. coli*
- Nonoxynol-9 in spermicide is toxic to the normal vaginal microflora and thus is likewise associated with an increased risk of *E. coli* vaginal colonization and bacteriuria

# Anatomical And Functional Abnormalities

- urinary stasis or obstruction
- Foreign bodies:stones or urinary catheters
- vesicoureteral reflux
- ureteral obstruction secondary to prostatic hypertrophy
- neurogenic bladder
- urinary diversion surgery

# Microbial Factors:

- Uropathogenic E. Coli (UPEC)
  - Pyelonephritis associated pili (PAP) adhesion to urethral and bladder epithellium in
  - K antigen that help E coli to be phagocytosis-resistant
  - Hemolysin ( membrane damaging toxin)

# Clinical Feature

- Mild pyelonephritis:
  - low-grade fever
  - with or without lower-back or costovertebral-angle pain
- severe pyelonephritis:
  - High fever “picket-fence” 72hr
  - Nausea
  - vomiting
  - flank and/or loin pain

- **Emphysematous pyelonephritis:**
  - exclusively in diabetic patients
  - production of gas in renal and perinephric tissues
  - bilateral papillary necrosis
  - rise in the serum creatinine level
  
- **Xanthogranulomatous pyelonephritis**
  - chronic urinary obstruction (often by staghorn calculi)
  - chronic infection
  - Suppurative destruction of renal tissue
  
- **Pyelonephritis** can also be complicated by intraparenchymal abscess formation; this situation should be suspected when a patient has continued fever and/or bacteremia despite antibacterial therapy.

# Laboratory Diagnosis:

- The Urine Dipstick Test:
- Rapid diagnostic test
- Appearance of WBC in urine
- test for nitrite & leukocyte esterase
- ( family Enterobacteriaceae, in detected in urine PMN )
- Negative outcome ,it s not sufficient for pregnancy women
- Urinalysis:
- WBC in Cast shape due to of pyelonephritis
- No WBC ,No Infection



- **Urine Culture:**
- Method of Sampling:
- Clean Catch:
- Straight Catheterization:
- foley cathatere:
- Suprapubic Aspiration:
- **Urine culture interpretation:**
- It is positive with colony count equal or more than  $10^2$  In women with dysuria & pyuria
- It is positive with colony count  $> 10^3$  In Men

# Treatment:

- Fluoroquinolones the first- line therapy for acute uncomplicated pyelonephritis
- A randomized clinical trial demonstrated that a 7-day course of therapy with oral ciprofloxacin (500 mg twice daily with or without an initial IV 400-mg dose) Was highly effective for the initial management of pyelonephritis in the outpatient setting
- Oral TMP-SMX (one double-strength tablet twice daily for 14 days) also is effective for treatment of acute uncomplicated pyelonephritis if the uropathogen is known to be susceptible.
- If the pathogen's susceptibility is not known and TMP SMX is used an initial IV 1-g dose of ceftriaxone is recommended

- Options for parenteral therapy for uncomplicated pyelonephritis include fluoroquinolones an extended-spectrum cephalosporin with or without an aminoglycoside
- or a carbapenem. Combinations of a  $\beta$ -lactam and a  $\beta$ -lactamase inhibitor (e.g. ampicillin-sulbactam, ticarcillin-clavulanate, piperacillin-tazobactam) or imipenem-cilastatin can be used in patients with more complicated histories previous episodes of pyelonephritis or recent urinary tract manipulations

THANK YOU