

## Full Length Research Paper

# A study of the incidence of urinary tract infections (UTI) among children and adolescents

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This study was carried out in order to determine the incidence of urinary tract infection in children and adolescents, identify the uro-pathogens responsible for the infection and study the antibiotic sensitivity patterns of the uro-pathogens. Clean voided mid-stream urine samples were collected in sterile universal bottles from 301 children and adolescents between the ages of 5 and 18 years at the Obafemi Awolowo University Teaching Hospital complex (OAUTHC) Ile-Ife, Nigeria from December 2005 - July 2006. Culture plates with bacteria counts greater than or equal to  $1 \times 10^5$  cfu-ml<sup>-1</sup> were taken as positive, thus indicative of Urinary Tract Infection (UTI). The bacteria isolates were identified based on colony morphology characteristics, Gram stain reaction and biochemical tests using API 20E kits. The identified bacteria were then tested *in vitro* with standard antibiotics disc to determine their antibiotics sensitivity patterns. The result of this study shows that 36 (11.96%) of the 301 patients studied had UTI. Of the 124 females examined, 28 (22.4%) had positive urine culture while 8 (4.56%) of the 177 males had significant bacteriuria. A total of 36 bacterial isolates were obtained. *Escherichia coli* constituted the predominant organism and was responsible for (52.77%) of the cases of UTI. This was followed by *Klebsiella* sp. (25%), *Proteus mirabilis* (13.89%), *Streptococcus faecalis* (5.56%) and *Pseudomonas aeruginosa* (2.78%). The antibiotics sensitivity test revealed a high level of resistant to cotrimoxazole, amoxicillin and colistin as more than 60% of the isolates were resistance to these. This study highlights the presence of multi-resistance *P. aeruginosa* and poor compliance of the pathogens *in vitro* to antibiotics commonly used in treating UTI. It is therefore suggested that appropriate antimicrobials be administered to reduce the risk of multiply resistance organisms developing and avert ineffectiveness of antibiotics. Prompt therapeutic intervention is also essential to prevent cases of asymptomatic UTI from becoming symptomatic with resultant damage.

**Key words:** UTI, uro-pathogens, antibiotic sensitivity.

## INTRODUCTION

Urinary tract infections (UTI) are among the most common conditions causing individuals to seek medicare. They are also among the most common bacterial infections in humans, both in the community and hospital settings (Hooton et al., 1997), and have been reported in all age groups in both sexes. UTI may be asymptomatic in many cases, while it may be accompanied by dysuria, cystitis and pyelonephritis in other patients (Karaou and Hanna, 1981).

UTI are responsible for considerable morbidity and when associated with urinary obstruction or renal papillary damage, can lead to serious kidney damage.

UTI are a serious health problem affecting millions of people each year. In the USA, it is estimated from surveys of office practices, hospital-based clinics and emergency departments that there are over eight million cases of UTI annually (National Institutes of Health, 1999). The prevalence of asymptomatic bacteriuria in Sweden was reported as being between one and three percent from neonatal period to school age (Rudolph, 1996), while in Saudi Arabia at prevalence rate of 5.3% was reported

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(Omar et al., 1992). In Nigeria, Okafor et al. (1993) found at prevalence rate of 2.1% in Enugu, Akinkugbe et al. (1973) reported prevalence rates of 24 and 6% among rural and urban children, respectively, while Bello et al. (1988) reported that the annual incidence of symptomatic bacteriuria was 6.5 per 1000 admissions.

UTI in children are a significant source of morbidity, particularly when associated with abnormalities (Ross, 1994). Vesico-ureteral reflux is the most commonly associated abnormality and reflux nephropathy is an important cause of end stage renal disease in children and adolescents (Bailey, 1992). However, when reflux is recognized early and managed appropriately, renal insufficiency is rare. Some adolescents who present with an apparently uncomplicated first urinary tract infection turn out to have considerable reflux. Subclinical infections can sometimes lead to severe bilateral renal scarring. Therefore, even a single documented urinary tract infection in an adolescent must be taken seriously. In this study, we determined the incidence of urinary tract infections in adolescents in Ile-Ife, Nigeria; identified the uropathogens responsible for the infection; and studied the patterns of antibiotic sensitivity of the uropathogens and correlated these with patient symptom profile. This was all done in order to ascertain appropriate antibiotic treatment therapy.

## MATERIAL AND METHODS

### Study population

Urine samples were collected from a total of 301 children and adolescents between the ages of 5 to 18 years - during the period of December 2005 - July 2006. All these persons were outpatients visiting the Obafemi Awolowo Teaching Hospital Complex (OAU-THC) Ile-Ife, Nigeria. In the collection of urine from patients the following exclusion criteria were used: - Patients who have been on antibiotics for at least three days were excluded; - patients who have not attained the age of 5 years and patients who took large quantities of fluids less than an hour before coming to clinic.

### Sterilization of media and materials

The media used were Nutrient Agar (NA) from Biotec Limited, while Nutrient Broth (NB), MacConkey agar (MCA), Blood Agar (BA) and Muller Hinton Agar were supplied by Oxoid Limited. All glassware were washed with detergent and rinsed with water, then allowed to dry. The glassware were later wrapped in aluminum foil and sterilized in a hot air oven at  $160^{\circ}\text{C}$  for 3 h. Media were sterilized by autoclaving at  $121\text{ lb g}^{-1}$  for 15 min.

### Urine collection

Clean voided mid-stream urine specimens were obtained from patients in sterile universal bottles which were given to their parents for collections and transported to the laboratory immediately in ice pack bags for urinalysis.

### Culturing of urine sample

Ten-fold serial dilutions were made by transferring 1.0 ml of the sample in 9.0 ml of sterile physiological saline. One ml was then poured into molten nutrient agar in Petri dishes and rotated gently

**Table 1.** Age and sex distributions.

Age (years)	Males	Female	Total	Percent (%) of Total
5-11	08	18	26	72.2%
12-18	-	10	10	27.8%
Total	08 (22.2%)	28 (77.8%)	36	100%

to mix. The contents were allowed to set and the plates were then incubated at  $37^{\circ}\text{C}$  for 24 h. Bacterial colonies appearing on the plates after the incubation period were enumerated to determine urine samples with significant bacteriuria. A loopful of each urine sample was also streaked on MacConkey agar and Blood agar plate for the isolation of the bacteria present in the urine. After incubation, plates with growth were selected, the colonies were isolated using inoculating loop and subsequently subcultured on agar slants for use in further tests.

### Bacterial identification

The methods used in the identification and characterization of isolated bacteria include Gram stain followed by microscopic examination, motility test and biochemical tests using API 20E kit (BioMerieux).

### Antibiotic sensitivity test

Bacterial isolates were tested for anti-microbial sensitivity, using the agar-disc diffusion method as described by Bauer et al. (1996). The turbidity of the bacterial suspension was then compared with MacFarland's barium sulfate standard

$1.5 = 10\text{ cfu ml}^{-1}$ . The standardized bacterial suspension was then swab-inoculated onto Muller Hinton Agar (Oxoid) using sterile cotton swabs, which were then left to dry for 10 min before placing the antimicrobial sensitivity discs. Antibiotics impregnated on discs of 8 mm in diameter were used for the test. Disks containing the following antibacterial agents were placed onto the agar surface and incubated overnight: Erythromycin ( $5\text{ }\mu\text{g ml}^{-1}$ ); Ciprofloxacin, Cloxacilin and Gentamycin ( $10\text{ }\mu\text{g ml}^{-1}$ ); Amoxicillin ( $24\text{ }\mu\text{g ml}^{-1}$ ); Colistin and Cotrimoxazole ( $25\text{ }\mu\text{g ml}^{-1}$ ); Ofloxacin, Tetracyclin, Augmentin and Nalidixic Acid ( $30\text{ }\mu\text{g ml}^{-1}$ ); Chloramphenicol ( $32\text{ }\mu\text{g ml}^{-1}$ ); Nitrofurantoin ( $200\text{ }\mu\text{g ml}^{-1}$ ). The antibiotics were supplied by Fondon (Nigeria) and Abtek laboratories (United Kingdom). After incubation, the diameter of the zone of inhibition was measured and compared with a zone diameter interpretative chart to determine the sensitivity of the isolates to the antibiotics. The procedure is intended for *in vitro* susceptibility testing of common rapidly growing and certain fastidious bacterial pathogens.

## RESULTS

There were 301 patients (177 males and 124 females) aged between 5 years to 18 years who visited Obafemi Awolowo University Teaching Hospital Complex (OAU-THC) Ile-Ife, Nigeria, during the study period December 2005 - July 2006 and from whom urine sample were collected. Of these patients, 36 (11.96%) had significant bacteriuria, that is, they had at least  $10^5\text{ cfu}$  of bacteria per ml of urine. Table 1 show the sex and age of patients with significant bacteriuria. Of the 124 females, 28

**Table 2.** Distribution of bacterial isolates from sexes.

Bacterial isolate	Female	Male	Total
<i>Escherichia coli</i>	15 (78.9%)	4 (21.1%)	19(52.77%)
<i>Pseudomonas aeruginosa</i>	1 (100%)	-	1(2.78%)
<i>Streptococcus faecalis</i>	2 (100%)	-	2(5.56%)
<i>Proteus mirabilis</i>	4 (80%)	1(20%)	5(13.89%)
<i>Klebsiella</i> spp.	6 (66.7%)	3(33.3%)	9(25.0%)
Total	28 (77.8%)	9(22.2%)	36(100%)

(22.4%) came up with positive cultures while 8 (4.6%) of the 177 males had significant bacteriuria. Fifty five percent of patients with positive cultures presented with symptoms that are not indicative of urinary tract infection such as catarrh, cold ear ache, cough, septic rash, tinea etc., 2.78% had haematuria, 27.8% presented with abdominal pain and vomiting, 2.78% had vaginal discharge, while 11.1% presented with fever (body

temperature 38 °C). Five different microorganisms were isolated and identified from 36 positive cultures and included *Escherichia coli*, *Klebsiella* spp., *Proteus mirabilis*, *Streptococcus faecalis* and *Pseudomonas aeruginosa*. *E. coli* was isolated in 19 cases (52.77%), followed by *Klebsiella* spp. in 9 cases (25%), *P. mirabilis* in 5 patients (13.89%), *S. faecalis* was isolated in 2 cases (5.56%) and *P. aeruginosa* in one patient (2.78%), as shown in Table 2.

### Antibiotic sensitivity testing

The Gram-negative bacterial isolates were tested against 10 different antibiotics, while eight antibiotics were used to determine the sensitivity pattern of the Gram-positive isolates. From the results shown in Tables 3 and 4, the following was observed: 47% of the isolates were sensitive to amoxicillin, 33.3% to cotrimoxazole, 50% to nitrofurantoin, 77.8% to ofloxacin, 73.5% to nalidixic acid, 63.9% to gentamycin, 97.1% to ofloxacin, 27.8% to augmentin, 30.6% to colistin 61.1% to tetracycline and 100% of *S. faecalis* were sensitive to erythromycin and chloramphenicol while 50% were sensitive cloxacilin (Tables 3 and 4).

### DISCUSSION

The study was undertaken to determine the incidence of urinary tract infection in children and adolescents as well as to evaluate the bacterial agents involved in this UTI. Out of the 301 patients (124 female and 177 males between the ages of 5 and 18 years) that participated in this study only 36 (11.96%) had urine samples with significant bacteriuria, and 28 (77.8%) of these patients were female between the ages of 5 - 18 years. The find-

ings in this study is similar to that reported by Okafor et al. (1993) where a prevalence rate of 16.5% was reported in patients between ages 0 and 20 years. However, the result obtained in this study (11.96%) appears low when compared with those obtained elsewhere. For instance Olowu (1996) reported an incidence of 28.1% in a population of 2780 out-patients at the Lagos University Teaching Hospital and Anochie et al. (2001) reported a prevalence of 30% among a population of 100 school children, between ages 4 - 18 years in a rural community in Enugu. The low incidence of urinary tract infection reported here in Ile-Ife may be attributed to the extensive health care talk given regularly by the staff of the school's health service department locality.

A large number of microorganisms were isolated from female patients with the high bacterial count being  $1.2 \times 10^7$  cfu ml<sup>-1</sup> and the lowest bacterial count being  $1.5 \times 10^6$  cfu ml<sup>-1</sup>, while the bacterial counts in males ranged between  $8 \times 10^5$  cfu ml<sup>-1</sup> to  $6.3 \times 10^6$  cfu ml<sup>-1</sup>. This study shows a higher incidence of urinary tract infection in females than males. In this study, 77.8% of females had positive urine cultures and this is similar to those obtained by other authors. Anochie et al. (2001) reported a predominance of female patients in a study carried out to determine the influence of instruction about the method of urine collection and storage on the prevalence of urinary tract infection. Similar findings were reported by Olowu (1996). The higher incidence of urinary tract infections in females might be as a result of a variety of factors, such as the close proximity of the female urethral meatus to the anus (Lipsky, 1990) and incomplete and in coordinate voiding of urine in school girls which is often associated with constipation and encourages infection of the urinary tract (Mond et al., 1970). Alterations in vaginal microflora also play a critical role in encouraging vaginal colonization with coliforms and this can lead to urinary tract infection (Hooton et al., 1997).

The symptoms noted in the majority of the patient were not indicative of urinary tract infection referable to the renal system. Fifty five percent of patient with positive culture showed symptoms such as catarrh, cold, ear ache, cough and septic rash, 2.78% had haematuria, 27.8% had abdominal pain with vomiting, 2.78% had vaginal discharge, while 11.1% had fever (body temperature 38 °C). The findings are similar to those of Morton and Lawande (1982) in Zaria. They found urinary tract infection in 10% of children with fever and 22% with diarrhea while Anochie et al. (2001) reported 65 cases of fever in children with positive urine cultures. It is therefore suggested that urinary tract infection should be investigated in any child that presents with a history of non-specific fever, even in the absence of symptoms referable to the renal system.

A total number of 36 isolates were obtained from the 36 patients with positive cultures, that is only one bacterial species was isolated from each patient, suggesting a

**Table 3.** Antibiotics sensitivity pattern of Isolates

ISOLATES	AMX	COT	NIT	CPX	NAL	GEN	OFL	AUG	COL	TET	ERY	CXC	CHL
<i>Escherichia coli</i>	S	S	S	R	S	S	S	S	S	S	ND	ND	ND
<i>Escherichia coli</i>	R	R	S	S	S	R	S	R	R	S	ND	ND	ND
<i>Streptococcus faecalis</i>	S	R	ND	ND	ND	S	ND	S	ND	S	S	R	S
<i>Pseudomonas aeruginosa</i>	R	R	R	S	R	R	S	R	R	R	ND	ND	ND
<i>Escherichia coli</i>	S	S	R	S	R	S	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	R	R	R	S	S	S	S	R	R	S	ND	ND	ND
<i>Streptococcus faecalis</i>	S	S	ND	ND	ND	S	ND	S	ND	ND	S	S	S
<i>Klebsiella spp.</i>	R	R	R	S	R	R	S	R	R	D	ND	ND	ND
<i>Proteus mirabilis</i>	S	S	R	R	R	R	R	R	S	R	ND	ND	ND
<i>Escherichia coli</i>	R	R	R	S	S	S	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	R	S	S	S	S	S	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	R	R	S	S	S	R	S	R	R	S	ND	ND	ND
<i>Klebsiella spp.</i>	R	S	S	S	R	R	S	R	R	R	ND	ND	ND
<i>Escherichia coli</i>	S	S	R	S	R	S	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	S	S	R	S	S	S	R	S	S	S	ND	ND	ND
<i>Escherichia coli</i>	R	R	S	S	R	R	S	S	R	S	ND	ND	ND
<i>Klebsiella spp.</i>	R	S	S	S	S	R	S	S	R	R	ND	ND	ND
<i>Proteus mirabilis</i>	R	R	R	S	R	S	S	R	R	S	ND	ND	ND
<i>Klebsiella spp.</i>	S	R	S	S	S	S	S	S	S	S	ND	ND	ND
<i>Klebsiella spp.</i>	S	R	S	R	S	S	S	R	R	R	ND	ND	ND
<i>Escherichia coli</i>	S	R	S	R	R	R	S	S	S	R	ND	ND	ND
<i>Klebsiella spp.</i>	R	R	R	S	R	R	S	S	R	R	ND	ND	ND
<i>Escherichia coli</i>	S	R	S	R	R	S	S	R	R	R	ND	ND	ND
<i>Klebsiella spp.</i>	R	R	R	S	S	S	S	R	R	R	ND	ND	ND
<i>Proteus mirabilis</i>	R	R	R	S	S	R	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	S	R	S	S	S	R	S	R	S	S	ND	ND	ND
<i>Proteus mirabilis</i>	R	R	S	S	S	S	S	R	S	S	ND	ND	ND
<i>Escherichia coli</i>	R	R	R	S	S	S	S	S	S	S	ND	ND	ND
<i>Escherichia coli</i>	R	S	R	S	S	S	S	R	S	R	ND	ND	ND
<i>Escherichia coli</i>	S	S	R	S	S	R	S	R	S	R	ND	ND	ND
<i>Klebsiella spp.</i>	R	R	R	S	R	S	S	R	R	S	ND	ND	ND
<i>Escherichia coli</i>	S	R	S	S	S	S	R	S	S	S	ND	ND	ND
<i>Klebsiella spp.</i>	S	S	R	S	R	S	S	R	R	S	ND	ND	ND
<i>Proteus mirabilis</i>	R	R	R	S	R	S	S	R	R	R	ND	ND	ND
<i>Escherichia coli</i>	S	R	S	S	S	R	S	S	S	S	ND	ND	ND
<i>Escherichia coli</i>	S	S	S	R	S	S	S	R	S	S	ND	ND	ND

AMX = Amoxicillin 24 µg ml<sup>-1</sup>  
 CPX = Ciprofloxacin 10 µg ml<sup>-1</sup>  
 OFL = Ofloxacin 30 µg ml<sup>-1</sup>  
 CXC = Cloxacilin 10 µg ml<sup>-1</sup>

COT = Cotrimoxazole 25 µg ml<sup>-1</sup>  
 NAL = Nalidixic Acid 30 µg ml<sup>-1</sup>  
 AUG = Augmentin 30 µg ml<sup>-1</sup>  
 TET = Tetracyclin 30 µg ml<sup>-1</sup>

NIT = Nitrofurantoin 200 µg ml<sup>-1</sup>  
 GEN = Gentamycin 10 µg ml<sup>-1</sup>  
 COL = Colistin 25 µg ml<sup>-1</sup>  
 ERY = Erythromycin 5 µg ml<sup>-1</sup>

CHL = Chloramphenicol 32 µg ml<sup>-1</sup>

ND = Not Determined

**Table 4.** Number and percent (%) susceptibility of isolates.

ISOLATES	No. of ISOLATES	AMX	COT	NIT	CPX	NAL	GEN	OFL	AUG	COL	TET	ERY	CXC	CHL
<i>Escherichia coli</i>	19	11 (57.9)	8 (42.1)	12 (63.1)	15 (78.9)	13 (68.4)	11 (57.9)	19 (100)	6 (31.57)	8 (42.1)	14 (73.7)	ND	ND	ND
<i>Pseudomonas aeruginosa</i>	1	0	0	0	1 (100)	0	1 (100)	1 (100)	0	0	0	ND	ND	ND
<i>Streptococcus faecalis</i>	2	2 (100)	1 (50)	ND	ND	2 (100)	ND	2 (100)	ND	2 (100)	2 (100)	1 (50)	2 (100)	
<i>Proteus mirabilis</i>	5	1 (20)	1 (20)	1 (20)	4 (80)	4 (80)	3 (60)	4 (80)	0	2 (50)	2 (50)	ND	ND	ND
<i>Klebsiella spp.</i>	9	3 (33.3)	3 (33.3)	4 (44.4)	8 (88.8)	8 (88.8)	5 (55.6)	9 (100)	2 (22.2)	1 (11.1)	4 (44.4)	ND	ND	ND
Total (%)	36	17 (47.2)	12 (33.3)	17 (50)	28 (77.8)	25 (73.5)	23 (63.9)	33 (97.1)	10 (27.8)	11 (30.6)	22 (61.1)	2 (100)	1 (50)	2 (100)

AMX = Amoxicillin 24 µg ml<sup>-1</sup> CPX = Ciprofloxacin 10 µg ml<sup>-1</sup> OFL = Ofloxacin 30 µg ml<sup>-1</sup> CXC = Cloxacilin 10 µg ml<sup>-1</sup>  
 CHL = Chloramphenicol 32 µg ml<sup>-1</sup>  
 COT = Cotrimoxazole 25 µg ml<sup>-1</sup> NAL = Nalidixic Acid 30 µg ml<sup>-1</sup> AUG = Augmentin 30 µg ml<sup>-1</sup> TET = Tetracyclin 30 µg ml<sup>-1</sup>  
 NIT = Nitrofurantoin 200 µg ml<sup>-1</sup> GEN = Gentamycin 10 µg ml<sup>-1</sup> COL = Colistin 25 µg ml<sup>-1</sup> ERY = Erythromycin 5 µg ml<sup>-1</sup> ND = Not Determined

The antibiotic sensitivity test of this study shows that ofloxacin was the most effective antibiotic in *in vitro* testing followed by ciprofloxacin which was effective against 77.8% of the pathogens. Similar results with quinolones have been reported by other authors. Gupta et al. (1999) reported in their study that resistance to fluoroquinolones was absent among Gram-negative pathogens and Christiaen et al. (1998) reported that 1% of the pathogens were resistant to fluoroquinolones. This low resistance of pathogens might be attributed to the fact that quinolones are relatively new antibiotics and have not been extensively used to warrant resistance developing against them by pathogens. More so, quinolones have been indicated to be effective in the treatment of urinary tract infection caused by Gram-negative bacteria such as *E. coli*, *Serratia spp.*, *P. aeruginosa*, and *Proteus spp.* (Prescott et al., 2002). A reduced sensitivity of *E. coli* to nitrofurantoin was observed in this study as only 63.6% of the *E. coli* was sensitive to the antibiotics as opposed to the findings of Goldraichi and Manfrori (2002), who reported a higher efficacy of the drug against *E. coli in vitro*. They reported a sensitivity of *E. coli* to nitrofurantoin of 92, 95 and 94%, respectively over a three-year period. Olowu and Oyetunji, (2003) reported a 57.9% sensitivity of pathogens towards nitrofurantoin; this is similar to that found in this study, in which 50% of the pathogens were sensitive to nitrofurantoin. The sensitivity of *E. coli* to tetracycline in this study was 73.7% and was similar to that reported by Gupta et al. (1999) who reported a 76% sensitivity of *E. coli* to tetracycline.

In this study, colistin was the most ineffective antibiotic in *in vitro* testing, since 70% of the pathogens were

resistant to it. Olowu and Oyetunji (2003) also reported a resistance rate of 63.16% to colistin in their study. Resistance of cotrimoxazole in this study was quite high compared to those commonly reported. In this study, 66.7% of the pathogens were resistance to cotrimoxazole. Resistance of *E. coli* to cotrimoxazole was 57.9% and is in contrast to results obtained elsewhere. Christiaen et al. (1998) reported a resistance of 17% to cotrimoxazole and a similar result was reported for resistance to quinolones. *Klebsiella spp.* showed a high level of resistance to most of the antibiotics used. A resistance of 66.7% was seen against amoxicillin and cotrimoxazole, 88.9% were resistant to colistin, 55.6% to tetracycline and nitrofurantoin but all were sensitive to ofloxacin. This result is similar to that reported by Reish et al. (1993).

The study on the outbreak of multi-resistance *Klebsiella* in a neonatal intensive care unit in a hospital in Israel in which the *Klebsiella* isolates were resistant to chloramphenicol, gentamycin, cefuroxin but sensitive to quinolones. *P. aeruginosa* isolated in this study was resistant to seven out of the ten antibiotics *in vitro* (Amoxicillin, colistin, nitrofurantoin, nalidixic acid augmentin, tetracycline and cotrimoxazole), but sensitive to gentamycin, ofloxacin and ciprofloxacin. Multi-resistance *P. aeruginosa* was also isolated by Olowu and Oyetunji (2003) in their study of nosocomial urinary tract infection. A high level of resistance of *P. mirabilis* was seen *in vitro* against the antibiotic used, 80% of the pathogen were resistant to amoxicillin, cotrimoxazole and nitrofurantoin.

In conclusion, this study determined the incidence of urinary tract infection in children and adolescents in Ile-Ife and highlighted the major bacterial agent involved in this

condition. The pattern of isolates reported in this study is consistent with the usually reported pattern, with *E. coli* being the most common organism isolated in cases of urinary tract infection. This was followed by *Klebsiella* spp., *P. mirabilis*, *S. faecalis* and *P. aeruginosa*.

The study reveals the prevalence of multi-resistance *P. aeruginosa* and *Klebsiella* spp. in the environment; hence caution must be exercised whenever antibiotics therapy is to be administered. This study shows a high level of resistance to cotrimoxazole, amoxicillin and colistin as more than 60% of the isolates were resistant to them *in vitro* and, as such, these antimicrobials may not be suitable for treating case of UTI in this locality.

However, a large proportion of the isolates were sensitive to ofloxacin, ciprofloxacin, nalidixic acid and gentamycin, and should be considered as first line drugs for treating cases of urinary tract infection in this environment. Ciproflaxin and ofloxacin are however best avoided in children as they have been shown to cause arthropathy in animal's studies.

Since urinary tract infection may be asymptomatic in most cases (as this study has shown), it is therefore suggested that routine screening of patie unexplained sources of fever be done for urinary tract infection and the appropriate antimicrobials administered after sensitivity tests have been carried out in order to prevent the cases becoming symptomatic later with resultant renal damage.

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