Tablet Press EXTRA
The prescribing newsletter for GPs, nurses and pharmacists
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Recurrent UTI in Adults

Recurrent UTI is defined as 2 uncomplicated UTIs in 6 months or 3 or more UTIs in a year.

General Key Points for patients who do NOT respond to first choice antibiotics

- If loin pain or fever develops in a patient with a UTI consider pyelonephritis.
- Always send urine for culture and sensitivity.
- Treat according to sensitivities if known or pivmecillinam 400mg stat followed by 200mg tds (10 tablets) for women with uncomplicated UTI, increased to 400mg tds if there is an increased risk of resistance, 7 days in men and those with an abnormal urinary tract or immunosuppression.
- Adjust treatment as necessary once sensitivity results become available.
- Seek specialist advice if a multi- resistant organism is cultured. E.g. ESBL
- Refer urgently (2-week wait) if a urological cancer is suspected e.g. haematuria persists after successful treatment of a previous acute UTI.

Key points for the following patient groups:

- **Recurrent UTI in Men –** no visible haematuria, not catheterised
  - Refer all men with problematic recurrent UTI to a urologist to identify and manage possible underlying causes.
  - Treat acute episode and send urine for culture while awaiting referral
  - There is no evidence to support antibiotic prophylaxis for recurrent UTI in men

- **Recurrent UTI in Women (2 UTIs in 6 months or 3 or more UTIs in a year) -** no visible haematuria, not pregnant or catheterised
  - Review diagnosis
  - Send urine for culture to confirm infection and exclude other causes
  - Assess risk factors for recurrent cystitis e.g. stones, papillary necrosis or vesicoureteric reflux as this may require imaging and urological referral
  - If symptoms are mild suggest delaying prescribing an antibiotic until UTI is confirmed and culture results are available to guide antibiotic choice, provided the woman has normal immunity, normal renal function, and a normal renal tract, especially if the probability of a UTI is low (indicated by a negative urine dipstick test for nitrites, and leucocyte esterase).
  - Advise symptomatic relief with OTC paracetamol. If this is insufficient an OTC NSAID may be added provided there are no contraindications.
  - If antibiotics are indicated, first line is **nitrofurantoin MR 100mg bd for 3 days** if GFR >45mls/min unless previous culture indicates resistance. Nitrofurantoin may be used with caution if GFR 30-44 mls/min.
  - In women who have an abnormal urinary tract or immunosuppression a longer course of 5-10 days may be indicated.

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- Advise all women to seek medical attention if they develop fever, loin pain, or do not respond to treatment.
- **Advise simple measures including hydration** (preferably with non-caffeine containing drinks) **and analgesia.** Some women may benefit from OTC cranberry products, but there is a lack of robust evidence to support their use.
- **Consider offering a prescription for 'stand-by' antibiotics based on previous sensitivities -** to be used for future episodes of suspected UTI if episodes are frequent and renal tract abnormalities such as renal calculi have been excluded, following investigations by a specialist. Advise the woman to collect and submit a mid-stream sample of urine before starting the treatment, and to seek medical advice if symptoms have not resolved within 48 hours.
- Adjust treatment as necessary once sensitivity results become available.
- Seek specialist advice if a multi-resistant organism is cultured.
- If there is no bacterial growth after culturing the urine consider an alternative cause for symptoms
- Refer urgently (2-week wait) if a urological cancer is suspected e.g. haematuria persists after successful treatment of a previous acute UTI.
- Consider non-urgent referral in women aged 60 and over with recurrent or persistent unexplained urinary tract infection to rule out bladder cancer.
- Consider routine referral for women with recurrent UTI who have a known abnormality of their renal tract who might benefit from surgical correction such as cystocele, vesicoureteric reflux or bladder outlet obstruction, who have not responded to preventative treatments or who have a risk factor for abnormality of the renal tract including women with:
  - A past history of urinary tract surgery or trauma
  - A past history of bladder or renal calculi.
  - Obstructive symptoms such as straining, hesitancy, poor stream.
  - Urea splitting bacteria on culture of the urine such as Proteus or Yersinia.
  - Persistent bacteriuria despite appropriate antibiotic treatment.
  - A past history of abdominal or pelvic malignancy.
  - Symptoms of a fistula such as pneumaturia.
- **Consider** longer term prophylactic drug treatment when there is unacceptable discomfort or disruption to their lives.
- Choice should be based on recent sensitivities, first line nitrofurantoin 100mg N for 3-6 months or trimethoprim 200mg N for 3-6 months if recent culture sensitive. Second line ciprofloxacin 500mg N for 3-6 months (but be aware of risk of C. Diff). After 3-6 months review recurrence rate and need.
- Consider methenamine 1g bd for 6 months if there is no renal or hepatic impairment. Tablets may be halved, or they can be crushed and taken with a drink of milk or fruit juice if the patient prefers.
- If UTI develops in spite of prophylactic antibiotic treatment, stop prophylactic antibiotic, send urine for culture and review choice of antibiotic.

Recurrent cystitis associated with sexual intercourse

- Consider using a different contraceptive method if a diaphragm is being used.
- Offer Trimethoprim 100 mg to be taken within 2 hours of intercourse (off-label use).

References:
Urinary tract infection (lower) women - NICE CKS
Urinary tract infection (lower) men - NICE CKS
Management of Common Infections: Guidance for Primary Care Feb 2017 PHE.
Recurrent UTI in men NICE CKS
Recurrent UTI in women NICE CKS

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