Patient Presents with Recurrent UTI

NHS Hampshire and Isle of Wight

This document is designed to aid the clinical decision making for GPs seeing patients presenting with recurrent UTIs in the Primary Care Setting. Clinical examination will aid the decision as to the appropriate health care support.

The decision-making pathway is not a substitute for the exercise of professional/clinical judgement.

Supporting Notes/References For treatment of acute lower tract UTI and pyelonephritis please see NICE Guidance NG 112, Oct 2018

Pre-Requisites for entry to recurrent UTI pathway
Patients that can be considered for the recurrent UTI pathway include (but not exhaustive):

- 3 or more UTI in 6 months (females)
- 4 or more UTI in 12 months

(UTI to be confirmed on MSU)

Symptoms of recurrent UTI not confirmed on MSU

see page 2

Exclude patients with

Advice and Guidance is readily accessible if GPs are uncertain that a referral to secondary care is required.

Exclude patients with Asymptomatic bacteriuria (ABU)

Do not screen or treat in:

- Well controlled diabetes mellitus
- Post-menopausal women
- Elderly institutionalised or catheterised patients.
- Renal transplant patient

Screen for and treat:
ABU in pregnant women with short course antibiotics, MSU after treatment (as per microbiology results and inform obstetric/midwife team).

Initial Assessment

- History (including risk factors)
- Abdominal/vaginal examination
- Renal Tract Ultrasound (specifying post-void bladder scan and that pre-void hydronephrosis should be re-evaluated post-void. Hydronephrosis that resolves with voiding is not significant.)

Medical Management /Pre-Referral Management
see page 2

Contact urology via A&G for the following groups if failure of pre-referral management (see page 2)

- Diabetics (whilst optimising diabetic control)
- Immunosuppressed.
- Incomplete voiding (residual volume >150ml).
- History of vesico-ureteric reflux

Urology A&G

Urology Consultant Triage

Urology convert A&G to outpatient appointment.

Medical treatment/ follow-up care by Urology Dept

Advice given to GP, with no further referral felt needed under Urology

Problem unclear, GP advised to provide further supporting information

Advice

Process

Start/End

Decision

Patient Presents with Recurrent UTI - continued

Medical Management

- Consider under-treated pyelonephritis or cystitis.
- Recent history of multiple infections, close together, without previous recurrent UTI.
- History of fevers, rigors, or loin pain.
- Antibiotics improve but do not resolve symptoms.
- Symptoms recur quickly after completing antibiotics.
- MSU show identical organisms with identical or evolving sensitivities.

Treat for 7-10 days with:

- Cefalexin 500mg BD/TDS.
- Consider Co-amoxiclav 500/125mg TDS or Trimethoprim 200mg BD (for 14 days) only in line with sensitivity results.

NICE NG111, Oct 2018.

Risk Factors

- Sexual intercourse
- New sexual partner
- Pregnancy
- History of childhood UTI`s
- UTI post-menopausal women
- History of UTI before menopause
- Urinary Incontinence
- Atrophic vaginitis
- Cystocoele
- Deterioration in functional status in elderly Institutionalised women
- Neurogenic bladder +/- self catheterisation

Pre-Referral Management

(in order, where applicable to the individual patient)

- Behavioural/lifestyle: increase fluid intake, voiding after sexual activity, avoid barrier contraceptives/spermicides.
- Vaginal oestrogen replacement in post-menopausal women
- Post-coital ABs (if appropriate history): Nitrofurantoin 100mg or Trimethoprim 200mg
- Self-start ABs (short course) in patients with good compliance and no more than 4 UTIs in 12 months.
- Continuous rotating ABs for no more than 6 months, once daily as prophylaxis (Trimethoprim 100mg, Nitrofurantoin 50-100mg, Amoxicillin 250mg, Cefalexin 125mg)
- Consider OTC D-Mannose (2g daily) in patients with E. coli cystitis (not pyelonephritis).
- Methenamine Hippurate (1g BD) and consider adding OTC Vitamin C 500mg BD for six months (check/monitor eGFR as per BNF). Only to be used on specialist recommendation.
- Cranberry can be considered in women with recurrent UTI as per Cranberries for preventing urinary tract infections | Cochrane

Symptoms of recurrent UTI not confirmed on MSU

Consider:

- Decaffeinate and decarbonise fluids, include water in daily fluids
- Frequency Volume chart to asses 24-hour urine output (aim for 1800ml)
- Request laboratory culture specimen if pyuria 1-50 (x 10 ^3/ml). If significant growth treat as UTI
- If sterile pyuria, consider urology referral

Features of:

STI / Urethritis - refer GUM

Advice

Process

Start/End

Decision

Pathway co-design: - HIOW provider Urologist/HIOW ICB GP Clinical Leads. Published: March'24 Review Due March 25
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