RECURRENT URINARY TRACT INFECTION (UTI) IN **NON-PREGNANT ADULT FEMALES**

Cheshire & Merseyside Benign Urology Area Network Advice & Guidance 2025.

These recommendations aim to complement NICE guideline NG112 by providing guidance for primary care clinicians on when to refer women with rUTIs to specialist urology services and the investigations that should be performed prior to referral.

Definition:

Recurrent UTI is defined as having 2 or more symptomatic and microbiologically and/or clinically confirmed UTIs within 6 months, or more than 3 in 12 months.

When to refer for specialist urology input:

- The ultrasound of kidney, ureters and bladder is abnormal (see box below)
- First line recurrent UTI treatment (see below) fails and there is a proven breakthrough UTI.
- There are any red flag symptoms, as listed in the Evidence Based Interventions programme: https://ebi.aomrc.org.uk/interventions/investigation-and-onward-referral-of-women-with-recurrent-uti
- If there is persistent haematuria after UTI treatment this should be referred to the haematuria clinic as a **2 week wait referral**.
- ❖ AOMRC acknowledge that cystoscopy is currently considered part of the standard work-up of rUTI in secondary care. Based on the available evidence AOMRC consider that most women **are unlikely** to derive benefit from cystoscopy and specialist referral **should not** be routinely justified so this test can be performed.

1. Hydroureter or hydronephrosis.
2. Bladder OR ureteric OR obstructive renal stones (for non-obstructive renal stones please use advice and guidance).
3. Post-micturition residual volume greater than 150ml.

Primary care Management:

- Perform a urinary ultrasound which should include post void residual (see above).
- Advice on self-help is available here: https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Recurrent cystitis.pdf
- Topical oestrogen for peri and post-menopausal patients.
- Methenamine Hippurate 1g bd – noninferior to antibiotics (ALTAR) particularly if resistance in cultures. This is the preferred option. The addition of ascorbic acid 0.5g tds can be considered.
- Alternatively low dose antibiotic prophylaxis (see regional formulary), single agent, if well on prescription for 6/12 then stop and reassess.
- Note that asymptomatic bacteriuria should not be treated with antibiotics as there is no good evidence of its efficacy.

Information provided is based upon NICE NG112, AOMRC 2024 guidelines & GIRFT 2024 A&G recommendations.