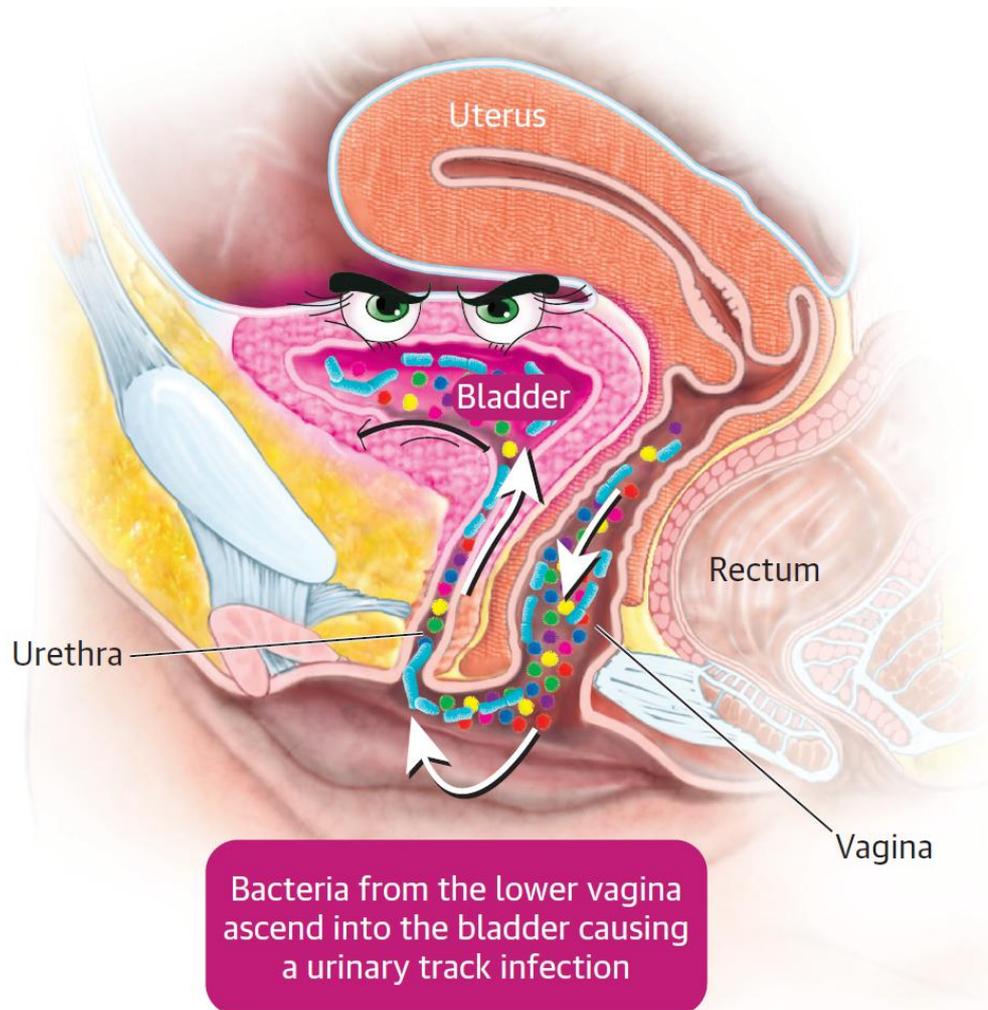




Urinary Tract Infections in Women

Urinary tract infections (UTI) can affect any part of the urinary tract – bladder (cystitis), urethra (urethritis) and/or the kidneys (pyelonephritis). They are usually caused by bacteria that live in the lower gut that travel into the urinary tract. The commonest bacteria is *E. coli*.

Women are more prone to developing UTI due to the short length of the urethra compared to men, which allows normal vaginal bacteria to travel up the urethra into the bladder as shown in the diagram. Up to 50% of women will have a UTI during their life. Other factors that increase the risk of UTI are sexual activity, pregnancy and breast feeding, menopause and any instrumentation of the bladder (such as having a catheter).



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What are the symptoms of UTI?

The classic symptoms of UTI include increased urinary frequency, but often with only small amounts of urine passed, bladder discomfort, pain with passing urine (often described as “like passing razorblades”) and sometimes blood in the urine. Older women may have more subtle symptoms, such as increased urinary frequency, new onset or worsening urine leakage and confusion. If the infection reaches the kidneys, fever, chills and kidney pain may occur.

What should I do if I have these symptoms?

It is important to confirm that the symptoms you are having are due to a bacterial infection, as there are other conditions that can mimic UTI. You should see your GP so that a specimen of urine can be collected and sent to the laboratory for analysis. This should be a “mid-stream urine” sample to minimise contamination of the specimen. First pass a small amount of urine into the toilet and then collect urine in the collection jar; you can then pass the rest of the urine into the toilet.

It will often take a few days for the results to come back, so your GP may give you a course of antibiotics to start with. You should start to feel better after 24 hours of taking the antibiotics. Other things that can help reduce the symptoms of UTI are increasing your water intake and taking Ural to reduce the acidity of the urine. It is important to prove that the infection has been completely treated after finishing the course of antibiotics. Collecting another mid-stream urine sample for testing will identify if the infection has been treated, or if another course of antibiotics is required.

Recurrent UTI

Up to 40% of women will have recurrent UTI – defined as 2 UTI in 6 months or 3 or more UTI per year. Recurrent UTI may be due to incomplete bladder emptying, an abnormal renal tract or bladder pathology (bladder tumour, polyp, stones), but frequently no cause is found. Often women with recurrent UTI require further investigations to rule out any obvious cause – a kidney/bladder ultrasound will check for any anatomical abnormality and assess bladder emptying; a cystoscopy may be needed to look inside the bladder to ensure there are no abnormalities. A diabetes test may be appropriate to rule out diabetes as a cause.

Preventing recurrent UTI

The following measures can help reduce the incidence of UTI.

- Passing urine immediately after intercourse to flush any bacteria out of the lower urethra
- Menopausal women can use vaginal oestrogen cream or pessaries to help prevent recurrent UTI
- Taking high-dose cranberry tablets may be effective, but there is little data supporting the effectiveness of drinking cranberry juice to prevent recurrent UTI.

While taking treatment courses of antibiotics for each episode of UTI may be appropriate, for those women having frequent UTI this may not be acceptable. Other strategies include the following.

- Taking a low dose antibiotic every day for 4–6 months
- Taking a single dose of antibiotic after intercourse if sexual activity appears to be a trigger for recurrent UTI
 - Taking Hiprex tablets (1g twice daily). Hiprex works best in acidic urine so don't take Ural at the same time. One gram of vitamin C daily improves the efficacy of Hiprex

This statement has been developed by the Urogynaecological Society of Australasia (UGSA).

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.