This guideline was peer-reviewed by the SOGC's Uroynaecology Committee and/or principal author(s) in January 2015, and has been reaffirmed for continued use until further notice.

No. 250 (Reaffirmed October 2017)

No. 250-Recurrent Urinary Tract Infection

This Clinical Practice Guideline has been prepared by the Urogynaecology Committee, reviewed by the Family Physicians Advisory Committee, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To provide an update of the definition, epidemiology, clinical presentation, investigation, treatment, and prevention of recurrent urinary tract infections in women.

Options: Continuous antibiotic prophylaxis, post-coital antibiotic prophylaxis, and acute self-treatment are all efficient alternatives to prevent recurrent urinary tract infection. Vaginal estrogen and cranberry juice can also be effective prophylaxis alternatives.

Evidence: A search of PubMed and The Cochrane Library for articles published in English identified the most relevant literature. Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no date restrictions.

Values: This update is the consensus of the Sub-Committee on Urogynaecology of the Society of Obstetricians and Gynaecologists of Canada. Recommendations were made according to the guidelines developed by the Canadian Task Force on Preventive Health Care (Table 1).

Options: Recurrent urinary tract infections need careful investigation and can be efficiently treated and prevented. Different prophylaxis options can be selected according to each patient's characteristics.

Recommendations:

1. Urinalysis and midstream urine culture and sensitivity should be performed with the first presentation of symptoms in order to establish a correct diagnosis of recurrent urinary tract infection (III-L).
2. Patients with persistent hematuria or persistent growth of bacteria aside from Escherichia coli should undergo cystoscopy and imaging of the upper urinary tract (III-L).
3. Sexually active women suffering from recurrent urinary tract infections and using spermicide should be encouraged to consider an alternative form of contraception (II-2B).
4. Prophylaxis for recurrent urinary tract infection should not be undertaken until a negative culture 1 to 2 weeks after treatment has confirmed eradication of the urinary tract infection (III-L).

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Women have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice women should be provided with information and support that is evidence based, culturally appropriate and tailored to their needs. The values, beliefs and individual needs of each woman and her family should be sought and the final decision about the care and treatment options chosen by the woman should be respected.

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment[a]	Classification of recommendations[b]
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well–designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

[a]The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.[82]

[b]Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the The Canadian Task Force on Preventive Health Care.[82]

5. Continuous daily antibiotic prophylaxis using cotrimoxazole, nitrofurantoin, cephalexin, trimethoprim, trimethoprim- sulfamethoxazole, or a quinolone during a 6- to 12-month period should be offered to women with 2: 2 urinary tract infections in 6 months or 2: 3 urinary tract infections in 12 months (I-A).
6. Women with recurrent urinary tract infection associated with sexual intercourse should be offered post-coital prophylaxis as an alternative to continuous therapy in order to minimize cost and side effects (I-A).
7. Acute self-treatment should be restricted to compliant and motivated patients in whom recurrent urinary tract infections have been clearly documented (I-B).
8. Vaginal estrogen should be offered to postmenopausal women who experience recurrent urinary tract infections (I-A).
9. Patients should be informed that cranberry products are effective in reducing recurrent urinary tract infections (I-A).
10. Acupuncture may be considered as an alternative in the prevention of recurrent urinary tract infections in women who are unresponsive to or intolerant of antibiotic prophylaxis (I-B).
11. Probiotics and vaccines cannot be offered as proven therapy for recurrent urinary tract infection (II-2C).
12. Pregnant women at risk of recurrent urinary tract infection should be offered continuous or post-coital prophylaxis with nitrofurantoin or cephalexin, except during the last 4 weeks of pregnancy (II-1B).

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