

RECURRENT URINARY TRACT INFECTIONS: MANAGEMENT CHALLENGES

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Recurrent urinary tract infections (rUTIs) represent a significant clinical burden, accounting for 25–40% of all UTIs in adults. Effective management requires a systematic, evidence-based approach that addresses diagnostic accuracy, host factors, structural evaluation, antimicrobial therapy, and preventive strategies. Key principles include obtaining urine culture prior to antibiotic initiation, distinguishing reinfection from relapse, and avoiding overdiagnosis of asymptomatic bacteriuria. In men, rUTI should be considered “complicated until proven otherwise,” warranting prostate evaluation and imaging. Patients with hematuria, sterile pyuria, relapse with the same organism, or upper tract symptoms require upper tract imaging (ultrasound or CT urogram) and possible cystoscopy. Antimicrobial therapy should be culture-guided whenever possible, with short courses (3–5 days) preferred for uncomplicated rUTI and extended therapy (7–14 days) for complicated infections. Emerging agents such as gepotidacin and cefepime-enmetazobactam offer options for multidrug-resistant strains. Non-antibiotic preventive strategies include hydration, voiding hygiene, and cranberry products. Antibiotic prophylaxis is reserved for patients with three or more UTIs annually despite non-antibiotic measures, with reassessment every 6–12 months. Antimicrobial stewardship remains foundational: avoid treating asymptomatic bacteriuria, use narrowest-spectrum agents, de-escalate based on culture results, and limit fluoroquinolone use. Multidisciplinary collaboration among internal medicine, urology, and infectious diseases optimizes patient outcomes. A systematic, vigilant approach is essential to identify underlying structural or malignant pathology that may masquerade as benign recurrent infection.

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