

Urinary Tract Infections in Pregnant Women

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Description

Urinary tract infections are prevalent during pregnancy, with *Escherichia coli* being the most common causing bacteria. Cystitis or pyelonephritis can occur as a result of asymptomatic bacteriuria [1]. Antibiotics such as nitrofurantoin, sulfisoxazole, or cephalexin should be given to all pregnant women who test positive for bacteriuria. Due to high rates of resistance, ampicillin should no longer be used to treat asymptomatic bacteriuria. Pyelonephritis is a potentially fatal condition that increases the risk of prenatal and neonatal morbidity. Infections recur often during pregnancy, necessitating preventative therapy [2,3]. Pregnant women who have a urinary group B streptococcal infection should be treated and should not be exposed to the bacteria. In the office of a family physician, urinary tract infections (urinary tract infections) are common. Urinary tract infections account for about 10% of women's doctor visits and 15% of women will experience urinary tract infections at some point in their lives. In pregnant women, the incidence of urinary tract infections can be as high as 8 percent.

The pathophysiology and bacteriology of urinary tract infections during pregnancy, as well as patient-oriented outcomes, are briefly discussed in this article. Asymptomatic bacteriuria, acute cystitis, and pyelonephritis are discussed, as well as the particular difficulties of group B streptococcus and recurrent infections [4]. Urinary tract infections are more likely to occur in pregnant women. Approximately 90% of pregnant women have ureteral dilatation beginning in week 6 and peaks in weeks 22 to 24, which last until birth (hydronephrosis of pregnancy). Increased urine stasis and ureterovesical reflux are caused by increased bladder capacity and decreased bladder tone, as well as decreased ureteral tone. Furthermore, during pregnancy, the natural increase in plasma volume lowers urine concentration [5]. Glycosuria, which stimulates bacterial development in the urine, affects up to 70% of pregnant women. Increases in urine progesterins and oestrogens may impair the lower urinary tract's ability to function. Reduced ureteral tone or allowing some bacteria strains to proliferate selectively may be the reason of this reduced capacity. All of these factors could play a role in the development of urinary tract infections during pregnancy.

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urine stasis and ureterovesical reflux are caused by increased bladder capacity and decreased bladder tone, as well as decreased ureteral tone. Furthermore, during pregnancy, the natural increase in plasma volume lowers urine concentration. Glycosuria, which stimulates bacterial development in the urine, affects up to 70% of pregnant women [6]. Increases in urine progesterins and oestrogens may impair the lower urinary tract's ability to function.

Asymptomatic patients may have significant bacteriuria. Kass discovered a higher incidence of pyelonephritis in patients with asymptomatic bacteriuria in the 1960s. Historically, significant bacteriuria was defined as more than 105 colony-forming units per mL of urine. In recent studies of women with acute dysuria, considerable bacteriuria was seen along with reduced colony counts. This has not been examined in pregnant women, and the usually accepted standard is more than 105 colony-forming units per mL of urine. Asymptomatic bacteriuria is frequent during pregnancy, with a prevalence of 10%. As a result, for urinary tract infections, bacteriuria screening is recommended. Asymptomatic bacteriuria that goes untreated causes symptomatic cystitis in about 30% of patients and can proceed to pyelonephritis in up to 50%. Asymptomatic bacteriuria has been linked to a higher risk of intrauterine growth retardation and low birth weight babies. Screening pregnant women for bacteriuria is justified due to the relatively high frequency of asymptomatic bacteriuria during pregnancy, the serious repercussions for women.

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