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# Is It Menopause or Is It Me?: Recurring UTIs

Urinary tract infections do become more common in midlife, but you can break the cycle with these expert tips.

By Lisa Arbetter Published: Sep 16, 2026 10:09 AM EDT

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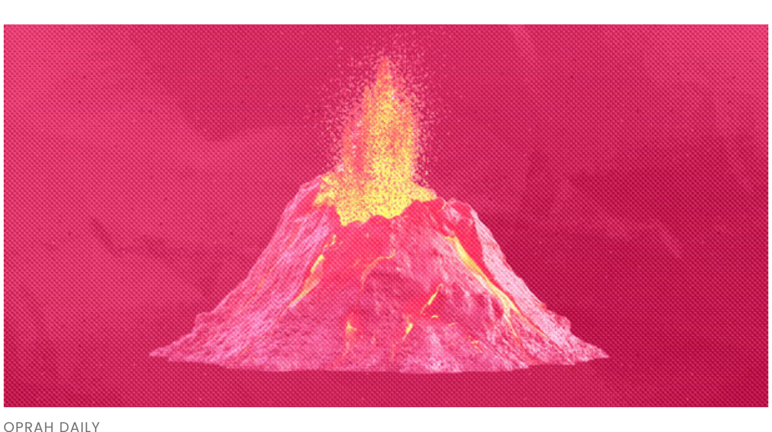

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Few things hijack a day quite like a urinary tract infection (UTI). Everything's fine at breakfast, but by lunch, you're peeing lava and mentally mapping every bathroom in a five-block radius.

Thanks to our unique anatomical quirks, women are far more prone to UTIs than men. But the menopause transition makes us even more susceptible. In a national survey of adults over 50, nearly one in five women said they'd been diagnosed and treated for a UTI in the previous year—roughly three times the rate among men the same age.

The biological shifts that raise UTI risk can begin surprisingly early. "We see changes in the microbiome and changes in lubrication in perimenopause—way before women even stop having their periods," says A. Lenore Ackerman, MD, PhD, a UCLA urologist and urogynecologist who served on the panel behind the American Urological Association's (AUA) 2025 update to its recurrent UTI guidelines. Here's more on what happens below the belt at this life stage, and how to deal.

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## How Menopause Sets the Stage

When estrogen is plentiful (a.k.a. the glory days), the vagina is typically dominated by bacteria called lactobacilli, which keep the environment acidic. That acidity, along with other substances produced by lactobacilli, is thought to make it harder for troublemakers like *E. coli*—the most common cause of UTIs—to get established.

As estrogen fluctuates and falls, those defenses start to weaken. Vaginal and urinary tissues become thinner, vaginal pH rises (making the environment less acidic), and lactobacilli lose their grip. There's evidence that the bladder lining changes, too, though that part is less well understood, according to Dr. Ackerman. These changes make you more vulnerable to UTIs, and are part of a larger issue called genitourinary syndrome of menopause (GSM): the vaginal, vulvar, sexual, and urinary changes linked to declining estrogen.

## But Is It Actually a UTI?

Here's the tricky part: There are some highly convincing UTI impostors. GSM itself can cause burning, urgency, and frequency with no infection behind it. Same for interstitial cystitis/bladder pain syndrome. Lichen sclerosus, an inflammatory skin condition that often affects the vulva and becomes more common after menopause, can cause burning when urine hits irritated skin. Tight, tender pelvic floor muscles can also produce UTI-like symptoms.

None of the above-mentioned impostors can be effectively treated with antibiotics (the standard of care for a UTI). Unfortunately, there's a tendency to label other problems below deck as a UTI and treat them as one, says Dr. Ackerman. A 2026 review published in ***The Journal of Sexual Medicine*** found that in a sample of 253 women diagnosed with recurrent UTIs, just 15 percent had problems specific to the bladder or urinary tract. Instead, the vast majority had pelvic floor dysfunction and/or hormonally driven inflammation—issues that can cause symptoms that are very similar to UTIs. In other words, many of those women might have been misdiagnosed.

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To make things even more frustrating, urine testing—standard for diagnosing UTIs—isn't always effective at ruling out other potential causes of your symptoms. The first test many patients get is a urinalysis, which just looks for inflammation rather than bacterial infection. And urine cultures (which check what bacteria and yeast are present in a sample) aren't a perfect diagnostic tool, either. A recent study coauthored by Dr. Ackerman found that the bacteria levels in urine samples of women with UTIs, women with noninfectious urinary tract symptoms, and controls were similar enough that it was hard to distinguish them from each other, even with super-sophisticated molecular testing.

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That's why, if you have what seems like recurring UTIs, or your symptoms aren't improving with treatment, you need to see a gynecologist for a pelvic exam. It can reveal things a conversation or urine test can't—like a vulvar skin condition or painful pelvic floor muscles.

Timing is a useful clue, too. A typical UTI tends to make a dramatic entrance. "You felt fine at 10 o'clock this morning," Dr. Ackerman says, "and by three o'clock you're like, 'This is not right.'" Symptoms that smolder for weeks, flare and fade, or don't respond as expected to antibiotics suggest something else may be going on. And if symptoms are accompanied by fever, chills, nausea or vomiting, or pain in your back or side, get medical care ASAP—those can be signs the infection has reached the kidneys.

In other words, to properly diagnose a UTI, the symptoms, exam, and lab results have to make sense together.

## How to Stop the Cycle

An active bacterial UTI is best treated with antibiotics. But if you're having recurrent infections—generally two within six months or three within a year—the conversation should go beyond *Which antibiotic do I take this time?*

"Prevention is worth so much more than intermittent treatment of infections," Dr. Ackerman says. For women in perimenopause or postmenopause, vaginal estrogen is one of the most effective preventive tools we have. It works locally to help restore vaginal tissue, lower pH, and create a more hospitable environment for protective lactobacilli. A clinical trial found that vaginal estrogen reduced UTI recurrences, and the AUA recommends it for perimenopausal and postmenopausal women with recurrent UTIs when appropriate. "It is safe, effective, and has so many other benefits with really not a lot of side effects," Dr. Ackerman says. "We can't say that about much else."

Vaginal estrogen takes one to two months to work its magic (and reader, it really is magic). Dr. Ackerman's approach is often to start vaginal estrogen, add another preventive measure while it takes effect, then see whether that extra layer can eventually be dropped. Those additional helpers include:

- **Cranberry**. Yes, really: A 2023 review of 50 trials found that cranberry products reduced symptomatic, culture-confirmed UTIs, and among women prone to recurrent infections, risk was about 26 percent lower. But note: Products vary widely in how much of an active compound—like proanthocyanidins (PACs)—they contain, and getting enough through juice can mean drinking a *lot* of sugar. Dr. Ackerman recommends taking a cranberry extract supplement with at least 36 milligrams of PACs.
- **Water, particularly if you're underhydrated.** In one randomized trial, women who had been drinking less than 1.5 liters of fluid a day who added 1.5 liters of water daily had roughly half as many episodes of bladder infections (a specific type of UTI). The participants were premenopausal, so we can't assume the effect is identical after menopause, but staying adequately hydrated is an easy, low-risk habit to adopt.
- **Methenamine hippurate**. This prescription, nonantibiotic urinary antiseptic was just as effective as daily low-dose antibiotics in preventing infections over 12 months, per a randomized trial.
- **Preventive antibiotics**. Depending on the pattern, low doses of antibiotics may be taken daily or around a predictable trigger such as sex. But long-term use comes with trade-offs, including antibiotic resistance and disruption of the gut and vaginal microbiomes, says Dr. Ackerman.

The AUA guidelines bust a few long-standing UTI myths, too: wiping front-to-back, peeing before or after sex, or avoiding tampons and hot tubs haven't been shown to prevent UTIs. Spermicides are different: They're associated with increased UTI risk, in part because they can disrupt protective lactobacilli. Ordinary lubricants and vaginal moisturizers are fine, but in general, says Dr. Ackerman, "Leave your vagina alone—except for vaginal estrogen."

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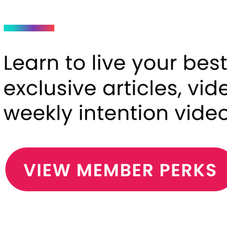

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