

## GUIDELINES FROM THE INFECTIOUS DISEASES SOCIETY OF AMERICA

**Guidelines for Antimicrobial Treatment of Uncomplicated Acute Bacterial Cystitis and Acute Pyelonephritis in Women**

**John W. Warren, Elias Abrutyn, J. Richard Hebel,  
James R. Johnson, Anthony J. Schaeffer,  
and Walter E. Stamm**

*From the Division of Infectious Diseases and Department of Epidemiology, University of Maryland, Baltimore, Maryland; Department of Medicine, MCP Hahnemann School of Medicine, Philadelphia, Pennsylvania; Division of Infectious Diseases, Department of Veterans Affairs Medical Center, Minneapolis, Minnesota; Department of Urology, Northwestern University, Chicago, Illinois; and the Division of Allergy and Infectious Diseases, University of Washington Medical Center, Seattle, Washington*

This is part of the series of practice guidelines commissioned by the Infectious Diseases Society of America (IDSA) through its Practice Guidelines Committee. The purpose of this guideline is to provide assistance to clinicians in the diagnosis and treatment of two specific types of urinary tract infections (UTIs): uncomplicated, acute, symptomatic bacterial cystitis and acute pyelonephritis in women. The guideline does not contain recommendations for asymptomatic bacteriuria, complicated UTIs, Foley catheter-associated infections, UTIs in men or children, or prostatitis. The targeted providers are internists and family practitioners. The targeted groups are immunocompetent women. Criteria are specified for determining whether the inpatient or outpatient setting is appropriate for treatment. Differences from other guidelines written on this topic include use of laboratory criteria for diagnosis and approach to antimicrobial therapy. Panel members represented experts in adult infectious diseases and urology. The guidelines are evidence-based. A standard ranking system is used for the strength of the recommendation and the quality of the evidence cited in the literature reviewed. The document has been subjected to external review by peer reviewers as well as by the Practice Guidelines Committee and was approved by the IDSA Council, the sponsor and supporter of the guideline. The American Urologic Association and the European Society of Clinical Microbiology and Infectious Diseases have endorsed it. An executive summary and tables highlight the major recommendations. Performance measures are described to aid in monitoring compliance with the guideline. The guideline will be listed on the IDSA home page at <http://www.idsociety.org> It will be evaluated for updating in 2 years.

—Peter A. Gross, MD for the  
IDSA Practice Guidelines Committee

**Executive Summary**

*Objective:* To develop evidence-based guidelines for antimicrobial treatment of uncomplicated acute bacterial cystitis and acute pyelonephritis in women.

*Options:* Many antimicrobial regimens comprising different drugs, doses, schedules, and durations have been used to treat these common bacterial infections. Only a few of these regi-

mens have been directly compared in adequately designed studies.

*Outcomes:* We evaluated three end points for each regimen: frequency of eradication of initial bacteriuria, recurrent bacteriuria, and adverse effects.

*Evidence:* We identified articles by Medline searches and supplemented them with papers referenced in their bibliographies and those of reviews, monographs, and textbooks. Two authors read each article in English that appeared to meet a priori inclusion and exclusion criteria and completed a data form for each article. All authors reviewed articles meeting inclusion and exclusion criteria, and pertinent data were sorted into tables. Prospective, randomized, controlled trials were accepted for analysis and assessed individually, if of sufficient size. Trials of comparable agents were consolidated by use of meta-analytic techniques. Searches, reviews, and tables were completed in 1997; analyses and writing were done in 1998.

---

Received 17 March 1999; revised 17 May 1999.

This guideline is part of a series of updated or new guidelines from the IDSA that will appear in *CID*.

Reprints or correspondence: Dr. John W. Warren, Division of Infectious Diseases, University of Maryland School of Medicine, 10 South Pine Street, Room 9-00, Baltimore, Maryland 21201.

**Clinical Infectious Diseases** 1999;29:745-58

© 1999 by the Infectious Diseases Society of America. All rights reserved.  
1058-4838/99/2904-0002\$03.00

### Recommendations:

*Acute uncomplicated bacterial cystitis.* In otherwise healthy adult nonpregnant women with acute uncomplicated bacterial cystitis, single-dose therapy is generally less effective than the same antimicrobial used for longer durations (A,I). However, most antimicrobials given for 3 days are as effective as the same antimicrobial given for a longer duration (A,I).

Trimethoprim-sulfamethoxazole for 3 days should be considered the current standard therapy (A,I). Trimethoprim alone (A,II) and ofloxacin (A,I) are equivalent to trimethoprim-sulfamethoxazole; other fluoroquinolones, such as norfloxacin, ciprofloxacin, and fleroxacin, are probably of similar effectiveness (A,II). Fluoroquinolones are more expensive than trimethoprim-sulfamethoxazole and trimethoprim, and, to postpone emergence of resistance to these drugs, we do not recommend them as initial empirical therapy except in communities with high rates of resistance (i.e., >10%–20%) to trimethoprim-sulfamethoxazole or trimethoprim among uropathogens. When given for 3 days,  $\beta$ -lactams as a group are less effective than the foregoing drugs (E,I). Nitrofurantoin and fosfomycin may become more useful as resistance to trimethoprim-sulfamethoxazole and trimethoprim increase (B,I).

*Acute pyelonephritis.* The few properly designed trials for management of acute pyelonephritis are several years old, precluding recommendations firmly based on recent evidence. For young nonpregnant women with normal urinary tracts presenting with an episode of acute pyelonephritis, 14 days of antimicrobial therapy is appropriate (A,I); courses of highly active agents as short as 7 days may be sufficient for mild or moderate cases (B,I). Mild cases can be managed with oral medications (A,II), and we recommend an oral fluoroquinolone (A,II) or, if the organism is known to be susceptible, trimethoprim-sulfamethoxazole (B,II). If a gram-positive bacterium is the likely causative organism, amoxicillin or amoxicillin/clavulanic acid may be used alone (B,III). Patients with more severe cases of acute pyelonephritis should be hospitalized (A,II) and treated with a parenteral fluoroquinolone, an aminoglycoside with or without ampicillin, or an extended-spectrum cephalosporin with or without an aminoglycoside (B,III); if gram-positive cocci are causative, we recommend ampicillin/sulbactam with or without an aminoglycoside as therapy (B,III). With improvement, the patient's regimen can be changed to an oral antimicrobial to which the organism is susceptible to complete the course of therapy (B,III).

These guidelines are based on antimicrobial susceptibilities reported in the late 1990s, which are changing over time and vary geographically; thus, we recommend that communities periodically reassess susceptibility of uropathogens to commonly used antibiotics. *Validation:* This manuscript was reviewed by infectious disease specialists and urologists interested in urinary tract infections (see Acknowledgments), and

many of their comments have been incorporated. The conclusions were presented at the 1998 meeting of the Infectious Diseases Society of America. *Sponsors:* This process was sponsored by the Infectious Diseases Society of America and endorsed by the American Urological Association.

### Introduction

Symptomatic urinary tract infections (UTIs) are among the most common of bacterial infections. Their magnitude can be judged either by visits to physicians, estimated as high as 8,000,000 per year in the United States (mostly for cystitis) [1], or by admission to hospitals, estimated at >100,000 per year (mostly for acute pyelonephritis) [2, 3]. A variety of antimicrobial regimens comprising different drugs, doses, schedules, and durations have been used to treat UTIs. Thus, the Infectious Diseases Society of America (IDSA) convened a committee to systematically review this topic and develop guidelines for the antimicrobial treatment of acute uncomplicated bacterial cystitis and acute pyelonephritis in women.

### Methods

Two separate reviews and analyses were done, one for cystitis and one for pyelonephritis. For each, the review began with a Medline search making use of key words such as "cystitis," "urinary tract infection," "UTI," "acute pyelonephritis," and "kidney infection." These articles were supplemented with others obtained from their bibliographies and from reviews, monographs, and textbooks. Only articles in English could be reliably reviewed. The abstracts of all articles were read, and articles that appeared to meet a priori inclusion and exclusion criteria were obtained and read by two committee members who each completed a data form for each article. Discrepancies were discussed by the two reviewers until resolved. All articles meeting inclusion and exclusion criteria were distributed to all reviewers, and pertinent data were sorted into tables for analyses.

*Acute uncomplicated bacterial cystitis.* We reviewed studies of women with acute bacterial cystitis, which was characterized as dysuria, frequency, and/or urgency confirmed by the presence of bacteriuria in adult nonpregnant women with apparently normal urinary tracts. We excluded articles if they did not include a clinical description of the UTI or the patient population and if we could not remove from analysis pregnant patients, those who were <12 years of age, or those with complicated UTIs (urinary catheterization, renal transplantation, or urologic abnormalities). Articles were also excluded if >2% of patients had fever and/or flank pain or asymptomatic bacteriuria or were men. Also excluded were studies of UTIs in selected patient groups with a specific medical illness, such as diabetes mellitus. Inclusion criteria required the article to state that all patients had "cystitis," "uncomplicated UTI," or one or

**Table 1.** Categories reflecting the strength of each recommendation and grades reflecting the quality of evidence on which recommendations are based.

Category or grade	Definition
Strength of recommendation	
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation for or against use
D	Moderate evidence to support a recommendation against use
E	Good evidence to support a recommendation against use
Quality of evidence	
I	Evidence from at least one properly randomized, controlled trial
II	Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), from multiple time-series studies, or from dramatic results in uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

NOTE. Adapted from [6].

more of dysuria, frequency, and urgency; were “women,” “adult females,” or females  $\geq 12$  years of age; had a quantitative urine culture yielding  $\geq 10^2$  cfu of a uropathogen/mL; were assigned to oral antimicrobial regimens by prospective randomization; and had at least one follow-up visit for microbiological assessment after antimicrobial therapy.

Data collection included antimicrobial type, dose, and duration; type of patient population; definition of bacteriuria; whether the study was blinded or not; and whether patients were excluded because of resistant organisms. We collected data for one primary and two secondary end points. The primary end point was eradication of initial bacteriuria, which we assessed at the follow-up visit closest to 7 days after the end of therapy. A secondary end point was recurrent bacteriuria. Because of different definitions of relapse (with the initial infecting organism) and reinfection (with a different organism) among the articles, we consolidated these into one category: recurrent bacteriuria, that is, documentation of eradication of the initial infecting bacteria followed by a new episode of bacteriuria within 6 weeks after the end of therapy. Another secondary end point was adverse effects, usually assessed on or before the 7-day follow-up visit, which, when possible, we defined as all new symptoms or signs, not just those thought by the investigators to be “probably related” to the antimicrobials.

*Acute uncomplicated pyelonephritis.* Except for flank pain and/or fever, exclusion criteria were similar to those used for acute cystitis. Inclusion criteria required statements that each patient had “acute pyelonephritis,” “kidney infection,” “febrile UTI,” or flank pain (and/or tenderness) and/or fever. Patients had to be “women,” “adult females,” or females  $\geq 15$  years of age and had to have at least one follow-up visit after antimicrobial therapy for microbiological assessment. Because of the dearth of papers anticipated in this category, two differences from the cystitis inclusion criteria were that bacteriologic documentation, although required, was not required to be quanti-

tative, and randomized antimicrobial assignment was not required for initial review. Data collection and assessment were similar to those for cystitis.

*Statistics.* The relative effect of one antimicrobial compared with that of another was estimated by the risk difference: the difference in the observed probabilities of end point events. For meta-analyses of multiple studies of the same comparison, the risk differences were pooled by use of a random effects model [4]. A two-tailed *P* value, pertaining to the pooled risk difference, was derived from this procedure. The *Q* statistic was used to test for homogeneity of effect sizes [4]. If the *Q* statistic for the primary objective of the meta-analysis, that is, comparison of initial eradication rates, revealed significant heterogeneity ( $P < .05$ ), meta-analysis was not used. A normal approximation (*Z*) test (two-tailed) was used to evaluate the statistical significance of risk differences for individual studies.

As with other IDSA guidelines [5], our recommendations were classified by strength and by quality of evidence (table 1) [6]. A prepublication draft was circulated to 27 selected experts

**Table 2.** Meta-analyses of studies examining the duration of treatment with trimethoprim-sulfamethoxazole for acute uncomplicated cystitis.

Comparison, parameter [reference]	Short-term therapy	Longer-term therapy	<i>P</i> value
Single-dose vs. $\geq 7$ d [7–13]			
Eradication	416/480 (87)	438/466 (94)	.014
Recurrence	61/353 (17)	47/360 (13)	NS
Adverse effects	46/430 (11)	121/432 (28)	<.001
3 d vs. $\geq 7$ d [9, 14]			
Eradication	161/174 (93)	166/176 (94)	NS
Recurrence	34/176 (19)	21/175 (12)	.053
Adverse effects	52/297 (18)	88/298 (30)	.057

NOTE. Data are no. with parameter/total (%). NS = not significant, i.e.,  $>.05$ .

in the UTI field, and 26 returned comments, some of which were incorporated in subsequent manuscript revisions.

## Results

### Acute Uncomplicated Bacterial Cystitis

Of the several thousand titles and abstracts screened, 337 articles were identified that possibly met our criteria and were copied and reviewed by two reviewers. Of these, 76 indeed did meet exclusion and inclusion criteria for the analysis. Of the 76, 53 used  $\geq 10^5$  cfu/mL as the quantitative break point for diagnosis of bacteriuria, 11 used  $\geq 10^4$ , 3 used  $\geq 10^3$ , 8 used  $\geq 10^2$ , and 1 accepted any organisms found by suprapubic aspiration of bladder urine. Some used lower concentrations for diagnosis of UTI caused by *Staphylococcus saprophyticus* than for that caused by *Escherichia coli*. All were randomized, as required by inclusion criteria, and 32 were double-blinded. Fifty-five trials did not exclude from analysis patients infected with organisms resistant to one or more of the trial antimicrobials.

**Trimethoprim-sulfamethoxazole.** This was the most common antimicrobial studied. Of the 76 reports, 30 included trimethoprim-sulfamethoxazole and another examined trimethoprim/sulfadiazine. Seven trials compared trimethoprim-sulfamethoxazole as single-dose therapy vs. longer durations of therapy [7–13]. Table 2 demonstrates that trimethoprim-sulfamethoxazole was significantly less effective as single-dose therapy than as multiday therapy in eradicating initial bacteriuria (87% vs. 94%;  $P = .014$ ); there were no significant differences in rates of recurrence. Five of the seven studies investigated adverse effects; these reports, each independently and by meta-analysis as a group, revealed significantly lower incidences of adverse effects with single-dose therapy than with multiday therapy (meta-analysis, 11% vs. 28%;  $P < .001$ ).

Two studies compared 3 days of trimethoprim-sulfamethoxazole with longer durations [9, 14]. Meta-analysis revealed that 3-day therapy with trimethoprim-sulfamethoxazole yielded eradication rates equivalent to those seen with therapy given for 7 or 10 days (table 2). However, there tended to be an increased recurrence rate with the 3-day trimethoprim-sulfamethoxazole therapy (19% vs. 12%;  $P = .053$ ). This was counterbalanced by a trend toward a higher incidence of adverse effects with the longer durations (18% vs. 30%;  $P = .057$ ).

On the basis of the high frequency of trimethoprim-sulfamethoxazole use among the studies meeting our criteria, its choice by many experts as standard therapy for uncomplicated cystitis in women [15–17], and its success in eradicating initial bacteriuria (average of 93% in the studies included herein), we used trimethoprim-sulfamethoxazole treatment for  $\geq 3$  days as the standard against which other antimicrobials were compared. The use of trimethoprim-sulfamethoxazole as a standard also allowed us to conduct a power analysis that defined the sample size needed to permit individual assessment

**Table 3.** Meta-analyses of studies examining the duration of treatment with trimethoprim and comparison of trimethoprim (TMP) with trimethoprim-sulfamethoxazole (TMP-SMZ) for acute uncomplicated cystitis.

Comparison, parameter [reference]	Single-dose therapy	$\geq 5$ d	<i>P</i> value
Single-dose vs. $\geq 5$ d [18–20]			
Eradication	201/243 (83)	230/247 (93)	<.001
Recurrence	18/178 (10)	13/169 (8)	NS
Adverse effects	35/270 (13)	53/283 (19)	NS
	TMP, 7 d	TMP-SMZ, 7 d	
TMP vs. TMP-SMZ [21, 22]			
Eradication	185/210 (88)	112/128 (88)	NS
Recurrence	ND	ND	—
Adverse effects	28/179 (16)	28/181 (15)	NS

NOTE. Data are no. with parameter/total (%). ND = not determined; NS = not significant, i.e.,  $>.05$ .

of single trials, as well as to judge the power of meta-analyses. To detect a difference of  $\geq 7\%$  compared with the 93% eradication rate for trimethoprim-sulfamethoxazole, 135 women were needed in each study group (80% power). In studies of  $\geq 135$  patients per group, if the rate of an end point in one group was not significantly different from that in the other group, we defined the groups as being equivalent in rates of that end point.

Below, we first discuss trials that sought optimal durations of an antimicrobial for treatment of acute bacterial cystitis; next, trials that compared the antimicrobial with trimethoprim-sulfamethoxazole as a standard; and, finally, trials that examined the antimicrobial against drugs that in other studies were proven comparable to trimethoprim-sulfamethoxazole.

**Trimethoprim.** Nine of the trials that met our criteria included trimethoprim in at least one arm. Three studies compared trimethoprim as single-dose therapy with longer durations [18–20]. A meta-analysis of these revealed that single-dose therapy was less effective in eradicating bacteriuria than was therapy lasting for  $\geq 5$  days (83% vs. 93%;  $P < .001$ ) (table 3). One study showed significantly fewer side effects with the single dose of trimethoprim [18], but the meta-analysis that included this trial did not show a significant difference ( $P = .53$  with a *Q* statistic of 5.84, indicating a trend toward heterogeneity of the rate of side effects;  $P = .054$ ).

Only one small study compared trimethoprim for 3 days vs. a longer duration (10 days) [23]. The eradication rates were similar, but the size of the trial was insufficient to demonstrate a significant difference; nevertheless, the trial did reveal that the longer duration of therapy was associated with a significantly higher incidence of adverse effects (3 [6%] of 50 vs. 12 [19%] of 64;  $P = .032$ ).

Trimethoprim alone has been compared with trimethoprim-sulfamethoxazole, each given for 7 days, in two trials [21, 22];



**Table 4.** Studies examining the duration of therapy with fluoroquinolones for acute uncomplicated cystitis.

Drug and comparison, parameter [reference]	Shorter-term	Longer-term	P value
Norfloxacin, SDT vs. 3 or 7 d [24, 25]*			
Eradication	107/130 (82)	127/133 (95)	<.001
Recurrence	36/127 (28)	18/130 (14)	.007
Adverse effects	29/169 (17)	45/157 (29)	NS
Ciprofloxacin, SDT vs. 7 d [26]			
Eradication	95/107 (89)	102/103 (99)	.001
Recurrence	7/87 (8)	6/95 (6)	NS
Adverse effects	24/145 (17)	16/146 (11)	NS
Fleroxacin, SDT vs. 7 d [27]			
Eradication	151/172 (88)	173/180 (96)	.004
Recurrence	9/48 (19)	11/66 (17)	NS
Adverse effects	94/316 (30)	97/321 (30)	NS
Norfloxacin, 3 vs. 7 d [28, 29]*			
Eradication	346/356 (97)	331/337 (98)	NS
Recurrence	57/357 (16)	29/343 (8)	.018
Adverse effects	74/436 (17)	80/437 (18)	NS
Ciprofloxacin, 3 vs. 5 or 7 d [26]			
Eradication	340/359 (95)	241/255 (95)	NS
Recurrence	40/289 (14)	38/206 (18)	NS
Adverse effects	119/515 (23)	62/362 (17)	NS
Lomefloxacin, 3 vs. 7 d [30]			
Eradication	180/196 (92)	190/194 (98)	.006
Recurrence	22/194 (11)	30/194 (15)	NS
Adverse effects	57/228 (25)	73/235 (31)	NS

NOTE. Data are no. with parameter/total (%). NS = not significant, i.e., >.05; SDT = single-dose therapy.  
\* Meta-analysis.

the meta-analysis was of sufficient power to demonstrate an equivalent rate of eradication of initial bacteriuria and of adverse effects (table 3). In neither study was the incidence of recurrent bacteriuria investigated.

**Fluoroquinolones.** Thirty-eight reports provided data on 40 trials with a fluoroquinolone in at least one arm. Among these, six studies compared single-dose therapy with longer durations. Four of these, of norfloxacin, ciprofloxacin, and fleroxacin\* [24–27], individually revealed significantly lower eradications with single-dose therapy than with longer durations (table 4). However, when all six studies were combined into a meta-analysis, significant heterogeneity was revealed. This heterogeneity was contributed primarily by two small studies [31, 32] that had high rates of eradication attained by use of single-dose therapy with ofloxacin (42/45, 93%) and pefloxacin\* (32/32, 100%).

Four studies compared therapy with a fluoroquinolone for 3 days vs. a longer duration (table 4). For norfloxacin [28, 29], 3-day therapy was equivalent to 7-day therapy in eradication of initial

bacteriuria and in adverse effects. Although recurrence rates with norfloxacin given for 3 days were significantly higher than 7-day therapy ( $P = .018$ ), both were relatively low (16% vs. 8%). Ciprofloxacin given for 3 days yielded rates of eradication, recurrence, and adverse effects equivalent to those found for 5- or 7-day therapies [26]. Lomefloxacin given for 3 days yielded a high eradication rate (92%); however, it was lower than the eradication rate for 7-day therapy (98%;  $P = .006$ ) [30].

Among the fluoroquinolone trials that met our criteria and were individually of sufficient size or could be combined into meta-analyses, only ofloxacin has been compared with trimethoprim-sulfamethoxazole at the same durations of use. These two antimicrobials had equivalent rates both of eradication and of adverse effects (table 5) [31, 33, 34]. One of the three studies [34] demonstrated a significantly lower rate of recurrent bacteriuria with ofloxacin than with trimethoprim-sulfamethoxazole. However, this was not found in the two other studies, and meta-analysis of the three yielded no difference in the rate of recurrent infections but did in heterogeneity of these rates ( $Q$  statistic of 8.29;  $P = .015$ ).

Studies comparing fluoroquinolones are also outlined in table 5. Ciprofloxacin given for 3 days appeared to be equivalent to norfloxacin given for 7 days [26]. Two other fluoro-

**Table 5.** Comparative studies of fluoroquinolones for treatment of acute uncomplicated cystitis.

Reference, parameter	Ofloxacin, ≥3 d	TMP-SMZ, ≥3 d	P value
[28, 33, 34]*			
Eradication	241/253 (95)	183/191 (96)	NS
Recurrence	18/240 (8)	16/184 (9)	NS
Adverse effects	65/277 (23)	55/221 (25)	NS
	Ciprofloxacin, 3 d	Norfloxacin, 7 d	
[26]			
Eradication	142/149 (95)	135/141 (96)	NS
Recurrence	19/126 (15)	13/112 (12)	NS
Adverse effects	45/211 (21)	37/213 (17)	NS
	Fleroxacin, 7 d	Ciprofloxacin, 7 d	
[27]			
Eradication	173/180 (96)	196/204 (96)	NS
Recurrence	11/66 (17)	8/63 (13)	NS
Adverse effects	97/321 (30)	84/324 (26)	NS
	Lomefloxacin, 3 and 7 d	Norfloxacin, 3 and 7 d	
[32, 35]*			
Eradication	251/256 (98)	241/248 (97)	NS
Recurrence	36/254 (14)	32/251 (13)	NS
Adverse effects	113/319 (35)	72/303 (24)	<.001

NOTE. Data are no. with parameter/total (%). NS = not significant, i.e., >.05; TMP-SMZ = trimethoprim-sulfamethoxazole.  
\* Meta-analysis.

\* Not available in the United States as of this writing.

**Table 6.** Comparative studies of single-dose therapy (SDT) with pefloxacin and with rifloxacin for acute uncomplicated cystitis.

Reference, parameter	Pefloxacin SDT	TMP-SMZ, $\geq 5$ d	P value
[36, 37]*			
Eradication	199/206 (97)	202/211 (96)	NS
Recurrence	11/203 (5)	15/209 (7)	NS
Adverse effects	33/206 (16)	33/211 (16)	NS
	Rifloxacin SDT	Pefloxacin SDT	
[38]			
Eradication	158/165 (96)	171/178 (96)	NS
Recurrence	31/165 (19)	35/178 (20)	NS
Adverse effects	42/218 (19)	40/228 (18)	NS
	Pefloxacin SDT	Norfloracin, 5 d	
[39]			
Eradication	69/75 (92)	72/75 (96)	NS
Recurrence	14/67 (21)	18/73 (25)	NS
Adverse effects	39/98 (40)	23/101 (23)	.008
	Rifloxacin SDT	Norfloracin, 3 d	
[40]			
Eradication	77/82 (94)	73/74 (99)	NS
Recurrence	3/64 (5)	2/54 (4)	NS
Adverse effects	21/103 (20)	12/100 (12)	NS

NOTE. Data are no. with parameter/total (%). TMP-SMZ = trimethoprim-sulfamethoxazole.

\* Meta-analysis.

quinolones were compared with either ciprofloxacin or norfloxacin. Fleroxacin was equivalent to ciprofloxacin for 7-day therapy [27]. Lomefloxacin, while equivalent to norfloxacin in eradication and recurrences, was associated with a significantly higher incidence of adverse effects (35% vs. 24%;  $P < .001$ ) [30, 35].

Two more recently released fluoroquinolones with longer half-lives, pefloxacin and rifloxacin,\* have been studied predominantly as single-dose therapy. A small underpowered study compared single-dose therapy and 3-day therapy with pefloxacin and did not demonstrate a difference between the regimens [32]. In two studies, single-dose therapy with pefloxacin was compared with 5- or 7-day treatment with trimethoprim-sulfamethoxazole and demonstrated equivalent rates of eradication, recurrent bacteriuria, and side effects [36, 37] (table 6). Subsequently, in a single large study, rifloxacin and pefloxacin each as single-dose therapy were compared and found to be equivalent [38]. These studies of single-dose pefloxacin yielded rates of adverse effects of 15%–18%. However, a moderate-sized study of single-dose therapy with pefloxacin vs. 5-day therapy with norfloxacin yielded an adverse effect rate for pefloxacin of 40%, which was significantly higher than that for norfloxacin (23%) [39]. Additionally, ru-

floxacin had significantly more adverse effects on the CNS than did pefloxacin [38] or norfloxacin [40].

**Nitrofurantoin.** Only three studies of nitrofurantoin met our criteria. One compared nitrofurantoin single-dose therapy with a 10-day regimen; this was of insufficient power to show a difference in eradication rates but did show a significantly higher rate of adverse effects with the longer-term therapy (4 [4%] of 104 vs. 15 [13%] of 114;  $P = .011$ ) [41]. Two studies compared nitrofurantoin preparations with trimethoprim-sulfamethoxazole. In a small study, nitrofurantoin in macrocrystal form given q.i.d. was compared with trimethoprim-sulfamethoxazole given b.i.d., each for 3 days. The nitrofurantoin preparation had a significantly lower eradication rate: 32 of 38 vs. 39 of 40 ( $P = .038$ ) [42]. A larger, but still underpowered, study of 7 days of therapy with nitrofurantoin monohydrate macrocrystals, trimethoprim-sulfamethoxazole, or trimethoprim, all at b.i.d. dosage, revealed similar rates of eradication and adverse effects among the three antimicrobials, but eradication rates for all three were low (77%–83%) [21].

**$\beta$ -lactams.**  $\beta$ -lactams were studied in 26 reports that met our criteria. Six studies compared  $\beta$ -lactams as single-dose therapy with longer durations of therapy and showed that single-dose therapy was significantly less effective at eradication than was multiday therapy (four studies were of treatment for  $\geq 10$  days), although significantly fewer patients had side effects with single-dose therapy (table 7) [43–48]. The only study of adequate size that compared a  $\beta$ -lactam antimicrobial given for 3 days vs. longer durations was for pivmecillinam\* [49]; 3 days was equivalent to 7 days of therapy in eradication of initial bacteriuria, although the shorter treatment was associated with an increased incidence of recurrence ( $P = .04$ ).

Only three trials of various  $\beta$ -lactams vs. adequate comparators were useful (table 7). One moderate-sized trial compared 3-day therapy with each of two  $\beta$ -lactam antimicrobials, cefadroxil and amoxicillin, vs. trimethoprim-sulfamethoxazole [42]. Although only of low power, the study revealed that trimethoprim-sulfamethoxazole was more effective in eradication of bacteriuria than was amoxicillin ( $P = .05$ ). The study was insufficiently powerful to demonstrate that the similarity between trimethoprim-sulfamethoxazole and cefadroxil eradication rates was meaningful, but the rate of recurrence with cefadroxil was higher, although not quite significantly so ( $P = .063$ ). Another small study examined 3-day therapy with amoxicillin vs. trimethoprim/sulfadiazine\* [50]. This trial demonstrated a significantly lower eradication rate with amoxicillin ( $P = .004$ ) and a higher rate of recurrent bacteriuria that was not quite significant ( $P = .085$ ). Finally, a Swedish study compared 5-day therapy with the  $\beta$ -lactam ritipenem acoxil\* vs. norfloxacin [51]. The  $\beta$ -lactam yielded a significantly lower eradication rate ( $P < .001$ ) and a higher rate of adverse effects ( $P = .001$ ).

**Fosfomycin.** Fosfomycin trometamol has been approved for use as single-dose therapy for treatment of acute uncom-

**Table 7.** Duration-of-therapy and comparative studies of  $\beta$ -lactams for treatment of acute uncomplicated cystitis.

Reference, parameter	Various, SDT	Various, $\geq 3$ d	<i>P</i> value
[43–48]*			
Eradication	225/293 (77)	227/264 (86)	.004
Recurrence	28/147 (19)	14/119 (12)	NS
Adverse effects	25/271 (9)	44/253 (17)	.024
Pivmecillinam, 3 d vs Pivmecillinam, 7 d			
[49]			
Eradication	138/151 (91)	139/148 (94)	NS
Recurrence	15/121 (12)	6/119 (5)	.04
Adverse effects	17/174 (10)	18/171 (11)	NS
Amoxicillin, 3 d vs Cefadroxil, 3 d vs TMP-SMZ, 3 d			
[42]			
Eradication	37/43 <sup>†</sup> (86)	37/37 (100)	39/40 <sup>†</sup> (98)
Recurrence	8/42 (19)	11/32 <sup>‡</sup> (34)	6/39 <sup>‡</sup> (15)
Adverse effects	13/52 (25)	12/40 (30)	16/46 (35)
Amoxicillin, 3 d vs TMP/sulfadiazine, 3 d			
[50]			
Eradication	59/67 (88)	76/76 (100)	.004
Recurrence	19/64 (30)	13/75 (17)	.085
Adverse effects	16/107 (15)	9/107 (8)	NS
Ritipenem acoxil, 5 d vs Norfloxacin, 5 d			
[51]			
Eradication	73/114 (64)	97/109 (89)	<.001
Recurrence	ND	ND	—
Adverse effects	42/140 (30)	19/138 (14)	.001

NOTE. Data are no. with parameter/total (%). ND = not determined; SDT = single-dose therapy; SMZ = sulfamethoxazole; TMP = trimethoprim.

\* Meta-analysis.

<sup>†</sup> *P* = .05.

<sup>‡</sup> *P* = .063.

plicated cystitis. Although eight trials examining fosfomycin met our criteria, none compared single-dose therapy vs. longer durations of the same drug, and six were not useful because either they were too small or compared fosfomycin against inappropriate comparator regimens, such as other antimicrobials as single-dose therapy [52–57]. In the two useful trials, fosfomycin single-dose therapy was compared with norfloxacin for 5 or 7 days [58, 59]. Although a meta-analysis of these two trials yielded inadequate power to distinguish differences in eradication rates, it showed a significantly higher rate of adverse effects with single-dose fosfomycin (table 8).

Examination of two of the six trials initially excluded for the reasons noted above is instructive. In one of these studies [54], fosfomycin as single-dose therapy was compared with ofloxacin and trimethoprim-sulfamethoxazole, each also given as single-dose therapy; fosfomycin was significantly less effective in eradicating initial bacteriuria than was ofloxacin (135 [70%

of 194 vs. 92 [86%] of 107; *P* < .001). In the other [57], fosfomycin as single-dose therapy was significantly less effective than was the quinolone pipemidic acid\* for 5 days (84% vs. 93%; *P* = .018) (table 8). Finally, although not meeting our criteria because they are unpublished, data presented to the U.S. Food and Drug Administration Anti-Infective Drugs Advisory Committee [60] indicated that among a total of >1,000 patients, single-dose therapy with fosfomycin was significantly less effective in eradicating bacteriuria (77%–82%) than was trimethoprim-sulfamethoxazole for 10 days or ciprofloxacin for 7 days (98% each).

*Additional comments.* Although not among the primary objectives of this study, two observations are of note. First, several studies suggested that older women tended to have lower bacteriuria eradication rates [24, 29, 61]. Second, infections with *S. saprophyticus*, commonly a distant second to *E. coli* in incidence among UTIs in women of childbearing age,

**Table 8.** Comparative studies of fosfomycin treatment for acute uncomplicated cystitis.

Trial [reference], parameter	Fosfomycin SDT	Comparator	P value
Fosfomycin SDT vs. norfloxacin, $\geq 5$ d [58, 59]*			
Eradication	91/94 (97)	74/80 (93)	NS
Recurrence	26/85 (31)	22/76 (29)	NS
Adverse effects	29/112 (26)	12/109 (11)	.004
Fosfomycin SDT vs. piperimic acid, 5 d [57]			
Eradication	123/146 (84)	133/143 (93)	.018
Recurrence	9/122 (7)	8/122 (7)	NS
Adverse effects	25/144 (17)	21/144 (15)	NS

NOTE. Data are no. with parameter/total (%). NS = not significant, i.e.,  $>.05$ ; SDT = single-dose therapy.

\* Meta-analysis.

tended to be eradicated less frequently with 3-day than with longer therapy in some studies, particularly of fluoroquinolones [28–30]. Consequently, prudence might suggest that cystitis in older women or caused by *S. saprophyticus* might be better managed by longer courses of antimicrobials, for example, 7 days.

Not all of the 76 articles meeting our criteria have been discussed herein. Those that do not appear in the text or tables were not useful in our assessment because of inappropriate comparators or insufficient power and/or because they were not amenable to meta-analysis.

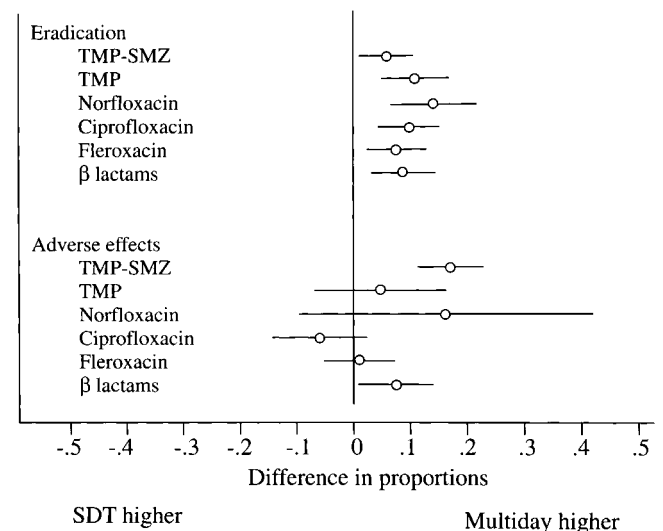
### Acute Pyelonephritis

Studies of antimicrobial treatment of acute uncomplicated pyelonephritis that met our criteria were uncommon. Of several hundred articles screened by title and abstract, only 42 appeared relevant, and of these, only nine met our inclusion and exclusion criteria.

Of these nine, five were prospective, randomized, controlled trials [62–66]. However, one randomized patients to two durations of therapy and used a variety of antimicrobial regimens [62]. Thus, only four randomized, controlled trials of antimicrobial agents could be adequately reviewed. We derived two conclusions from these studies. The first is that trimethoprim-sulfamethoxazole is preferred over ampicillin. There are at least two reasons for this. The first is a relatively high prevalence of organisms causing acute pyelonephritis that are resistant to ampicillin [63, 64]. The second is that even for susceptible organisms, there is a significantly increased recurrence rate in patients given ampicillin compared with those given trimethoprim-sulfamethoxazole [64]; Ode et al. [65] and Jernelius et al. [66], in their studies of duration of treatment with ampicillin or ampicillin-like compounds, also found high recurrence rates with these  $\beta$ -lactams.

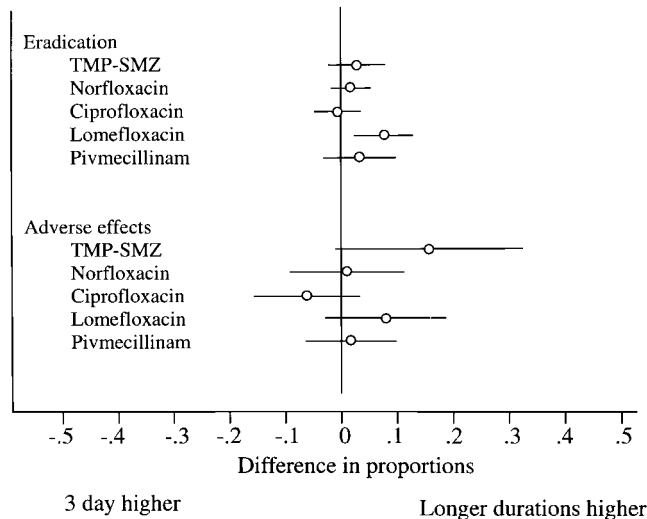
The second conclusion is that 2 weeks of therapy for acute uncomplicated pyelonephritis appears to be adequate for the majority of women. Stamm et al. [64] demonstrated that treatment of mild acute uncomplicated pyelonephritis with

trimethoprim-sulfamethoxazole or ampicillin for 2 weeks was similar to 6 weeks of therapy with these agents. Jernelius et al. [66] studied pivampicillin\* plus pivmecillinam\* as a combination given for 1 week or 3 weeks. At follow-up after 3–4 weeks, only 6 of the 14 patients receiving 1-week therapy remained free of bacteriuria, compared with 14 of the 16 who had received 3 weeks of therapy ( $P = .014$ ). These data suggest that 2 weeks of treatment yields results similar to those of 6 weeks of treatment and, at least with this  $\beta$ -lactam combination, 1 week of therapy is less effective than 3 weeks. Additionally, although not in controlled trials of duration, Johnson et al. [63] and Ward et al. [67] demonstrated high cure rates with 2 weeks and a mean of 11 days, respectively, of therapy.



**Figure 1.** Single-dose therapy (SDT) vs. multiday therapy for uncomplicated cystitis: differences in proportions of patients experiencing eradication and adverse effects, with 95% confidence intervals. SMZ = sulfamethoxazole; TMP = trimethoprim. These plots represent data from respective tables. Note that meta-analyses of separate studies pool differences by a weighting procedure (see Methods); therefore, the plotted risk differences may not agree exactly with those derived from the proportions in the tables.





**Figure 2.** Three-day vs. longer-duration therapy for uncomplicated cystitis: differences in proportions of patients experiencing eradication and adverse effects, with 95% confidence intervals. SMZ = sulfamethoxazole; TMP = trimethoprim. These plots represent data from respective tables. Note that meta-analyses of separate studies pool differences by a weighting procedure (see Methods); therefore, the plotted risk differences may not agree exactly with those derived from the proportions in the tables.

Taken together, these data suggest that 10–14 days is a sufficient duration of therapy for acute pyelonephritis.

It should be noted, however, that some experienced clinicians have successfully treated cases of acute pyelonephritis with 5- to 7-day therapy with aminoglycosides,  $\beta$ -lactams, or fluoroquinolones [68, 69]. These latter findings must be reconciled with those of Jernelius et al. [66], however, and controlled trials examining shorter durations of therapy with highly active agents for acute uncomplicated pyelonephritis are thus needed [69].

**Discussion**

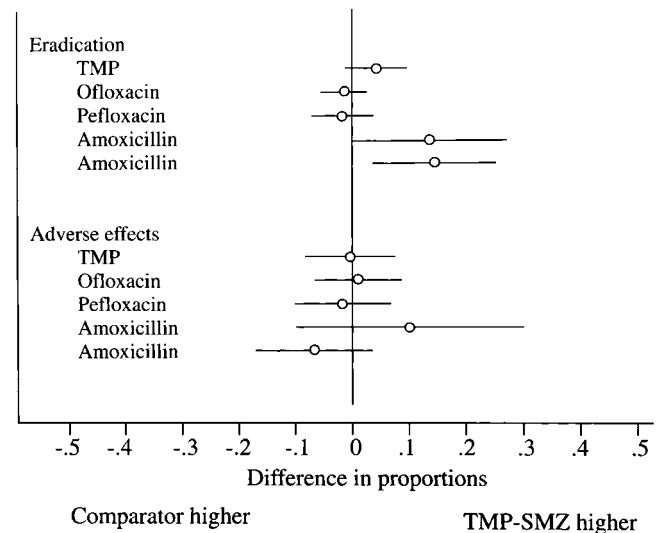
**Acute Uncomplicated Cystitis**

*Single-dose therapy.* Interest in single-dose therapy for treatment of acute cystitis [70] is evident from the fact that 50 of the 76 reports assessed herein included single-dose therapy as at least one arm. However, this systematic review revealed that single-dose therapy was significantly less effective in eradicating initial bacteriuria than were longer durations of treatment with trimethoprim-sulfamethoxazole, trimethoprim, norfloxacin, ciprofloxacin, fleroxacin, and, as a group,  $\beta$ -lactam antimicrobials (figure 1). In no reviewed study was single-dose therapy found to be significantly better in eradicating initial bacteriuria than was a longer duration with the same antimicrobial. Indeed, in no trial nor meta-analysis of sufficient power was single-dose therapy found to be even equivalent to

longer durations of the same antimicrobial. This finding is consistent with two previous systematic reviews [71, 72].

Nevertheless, although not adequately tested against longer durations, three antimicrobials have recently emerged as possible candidates for single-dose therapy. Two are fluoroquinolones, pefloxacin and rufloxacin. Single-dose therapy with pefloxacin was tested against multiday trimethoprim-sulfamethoxazole and appeared promising; single-dose therapy with rufloxacin in a single large study was shown to be equivalent to single-dose therapy with pefloxacin. However, rates of adverse effects of these agents require definition by further studies.

The third antimicrobial of interest for single-dose therapy was fosfomycin trometamol. However, no trial meeting our criteria compared single-dose vs. longer durations of therapy with fosfomycin, and only two trials included an appropriate control. A meta-analysis of these two trials, while still of insufficient power to distinguish differences in eradication rates, demonstrated a significantly higher incidence of adverse effects with fosfomycin than with norfloxacin. Furthermore, two other studies demonstrated significantly lower rates of eradication of initial bacteriuria by fosfomycin single-dose therapy than by ofloxacin single-dose therapy and than by multiday pipemidic acid.\* Finally, large but unpublished studies suggest that single-dose therapy with fosfomycin is less effective than multiday therapy with either trimethoprim-sulfamethoxazole or ciprofloxacin.



**Figure 3.** Comparison of various antibiotics with trimethoprim-sulfamethoxazole (TMP-SMZ) at the same durations of therapy for uncomplicated cystitis: differences in proportions of patients experiencing eradication and adverse effects, with 95% confidence intervals. These plots represent data from respective tables. Note that meta-analyses of separate studies pool differences by a weighting procedure (see Methods); therefore, the plotted risk differences may not agree exactly with those derived from the proportions in the tables.

*Three-day therapy.* Unlike single-dose therapy, 3 days of therapy is equivalent in efficacy to longer durations in studies of sufficient power for trimethoprim-sulfamethoxazole, norfloxacin (although an increased incidence of recurrences was noted), and ciprofloxacin (figure 2). Although lomefloxacin when given for 3 days had a 92% eradication rate, this was significantly lower than the 98% eradication rate for 7 days of therapy (however, lomefloxacin may be less appealing than other fluoroquinolones because of a significantly higher rate of adverse effects than seen with norfloxacin at equivalent durations). Among our assessed trials, the only  $\beta$ -lactam studied in this way was pivmecillinam, for which 3-day therapy was equivalent to 7 days of therapy in rates of eradication and adverse effects but yielded significantly higher recurrence rates.

If trimethoprim-sulfamethoxazole at  $\geq 3$  days is the standard of therapy, other antimicrobials shown to be equivalent to trimethoprim-sulfamethoxazole include trimethoprim and ofloxacin when used in the same durations and pefloxacin when used as single-dose therapy (figure 3).

*Fluoroquinolones.* It is unfortunate that of fluoroquinolones, only ofloxacin and pefloxacin were tested against trimethoprim-sulfamethoxazole in studies of acceptable design and/or size. However, perhaps one can extrapolate useful information by analyzing a series of comparative studies. Pefloxacin single-dose therapy appears to be equivalent to trimethoprim-sulfamethoxazole therapy of  $\geq 5$  days. Rufloxacin is equivalent to pefloxacin and both pefloxacin and rufloxacin as single-dose therapy appear to be similar to norfloxacin as multiday therapy in eradication of initial bacteriuria (although norfloxacin has fewer adverse effects). Therefore, norfloxacin for 3 or 5 days may be similar to trimethoprim-sulfamethoxazole for 5 days. Norfloxacin for 7 days is equivalent to ciprofloxacin for 3 days, and 7 days of ciprofloxacin is equivalent to ofloxacin. Lomefloxacin is equivalent to norfloxacin in eradication and recurrence but has more adverse effects.

Therefore, of the fluoroquinolones, the following may be equivalent or similar to  $\geq 3$  days of trimethoprim-sulfamethoxazole in eradication of initial bacteriuria, recurrence, and adverse effects: ofloxacin, norfloxacin, ciprofloxacin, and ofloxacin. Pefloxacin single-dose therapy, rufloxacin single-dose therapy, and lomefloxacin at  $\geq 3$  days may have higher rates of adverse effects than does norfloxacin.

*$\beta$ -lactams.* Most of the  $\beta$ -lactams appear to be less effective than trimethoprim-sulfamethoxazole, trimethoprim, and the fluoroquinolones in eradication of initial bacteriuria and may yield increased incidences of recurrences and of adverse effects. Among the 26 trials in which a  $\beta$ -lactam was included in at least one arm, in only one did the  $\beta$ -lactam yield significantly greater rates of eradication of initial bacteriuria than did the non- $\beta$ -lactam comparator: 3-day cefadroxil vs. 3-day macrodantin [42]. In the other trials, the  $\beta$ -lactams tended to be less effective in eradication of

initial bacteriuria or in prevention of recurrence than were the non- $\beta$ -lactam comparators. This is similar to the conclusions reached in other reviews [71]. The reasons for the relatively poor performance of  $\beta$ -lactams in treating symptomatic cystitis, particularly compared to their usefulness in other situations, is not completely clear. One reason may be that many  $\beta$ -lactams are rapidly excreted and the time during which significant drug concentrations are present in urine is short. Another is that  $\beta$ -lactams are relatively ineffective in clearing gram-negative rods from the vaginal and colonic flora, thus possibly predisposing to recurrence [73].

*Nitrofurantoin.* Unfortunately, nitrofurantoin as therapy for UTI has been studied infrequently in well-designed trials; assessment is further confounded by the use of different preparations. A small study found that 3-day treatment with nitrofurantoin macrocrystals was significantly less effective than 3-day treatment with trimethoprim-sulfamethoxazole in eradicating initial bacteriuria. A larger study, but of insufficient power, suggested that 7-day nitrofurantoin monohydrate macrocrystals was similar to 7-day trimethoprim and trimethoprim-sulfamethoxazole in eradication of initial bacteriuria, although rates were low for all three antimicrobials. We conclude that 3 days is too short a duration for nitrofurantoin treatment, that nitrofurantoin for 7 days may or may not be similar in effectiveness to trimethoprim and trimethoprim-sulfamethoxazole, and that this venerable urinary tract antimicrobial needs to be studied against current standard therapies in larger trials.

*Recommendations.* For susceptible organisms, trimethoprim-sulfamethoxazole double-strength given for 3 days is highly effective therapy for uncomplicated bacterial cystitis in adult non-pregnant women (A,I). Trimethoprim alone is equivalent to trimethoprim-sulfamethoxazole, at least for 7 days of therapy (A,I); thus, although not clearly documented in clinical trials, we conclude that with 3 days of therapy, trimethoprim is similar to trimethoprim-sulfamethoxazole (A,II). Intuitively, we recognize the likelihood that trimethoprim alone when compared in large populations against trimethoprim-sulfamethoxazole would have a lower incidence of side effects. Among the fluoroquinolones used for multiday therapies, ofloxacin is equivalent to trimethoprim-sulfamethoxazole (A,I), and norfloxacin (A,II), ciprofloxacin (A,II), and ofloxacin (A,II) are similar to trimethoprim-sulfamethoxazole. Other recently introduced fluoroquinolones are probably as effective (B,II), but some may have different incidences of side effects; furthermore, for those with broader antimicrobial spectra, widespread use for UTI and resulting emergence of resistance may limit their usefulness for respiratory, polymicrobial, and other non-urinary infections.

For uncomplicated cystitis, one should expect that  $\geq 90\%$  of patients will experience eradication of bacteriuria and a low risk of recurrence and that treated patients will have an acceptably low risk of adverse effects if given treatment for 3 days with trimethoprim-sulfamethoxazole; with trimethoprim; or with the fluoroquinolones, ofloxacin, norfloxacin, ciprofloxacin,

cin, or fleroxacin. For empirical treatment of acute uncomplicated cystitis, we recommend trimethoprim-sulfamethoxazole or trimethoprim in areas where the prevalence of resistance to these drugs among *E. coli* strains causing cystitis is <20%; other studies of UTI suggest a threshold as low as 10%. Increasing resistance to these drugs among strains causing cystitis may soon limit their usefulness. The fluoroquinolones as a group are highly effective in treating cystitis, but because of their utility in treating complicated UTIs and prostatitis, which would be compromised if widespread use led to increased resistance, and because of their expense, we do not recommend these universally as first-line empirical therapy for uncomplicated cystitis. The fluoroquinolones could be used, however, in areas where the prevalence of resistance to trimethoprim and trimethoprim-sulfamethoxazole among uropathogens is high. Other options include nitrofurantoin, perhaps as 7-day therapy, and fosfomycin single-dose therapy (B,I); each of these requires further study. Although useful in other types of infections,  $\beta$ -lactams as a group are less effective in treatment of cystitis than are trimethoprim-sulfamethoxazole, trimethoprim, and the fluoroquinolones (E,I).

#### Acute Pyelonephritis

For decades, the traditional therapy for patients with acute uncomplicated pyelonephritis was hospitalization and treatment with intravenous antimicrobials for up to 6 weeks. More recent studies suggest that most young healthy women with acute pyelonephritis and uncomplicated urinary tracts will have a satisfactory outcome with 2 weeks of antimicrobial therapy [74, 75] (A,I). Some have advocated therapy lasting for 5–7 days [68, 69, 76], especially for mild to moderate pyelonephritis (B,I). Furthermore, accumulating data support the notion that not all and perhaps none of the therapy must be delivered iv [74, 75, 77, 78] (A,II). A woman who has a mild case of acute pyelonephritis (i.e., low-grade fever and a normal or slightly elevated peripheral leukocyte count without nausea or vomiting) and is compliant with therapy can be treated with oral antimicrobials on an outpatient basis. For empirical therapy, we recommend an oral fluoroquinolone (A,II). If the organism is known to be susceptible, oral trimethoprim-sulfamethoxazole provides an alternative (B,II). Many physicians administer a single parenteral dose of antimicrobial (ceftriaxone, gentamicin, or a fluoroquinolone) before initiating oral therapy [75, 79] (B,III). If a gram-positive organism is causative, we recommend the use of amoxicillin or amoxicillin/clavulanic acid (B,III). A useful option for some patients may be admission to a 12- to 24-hour observation unit of an emergency department where the response to initial therapy with a parenteral agent can be monitored [79] (B,II).

If a patient at the time of presentation is sufficiently ill to require hospitalization (high fever, high white blood cell count, vomiting, dehydration, or evidence of sepsis) or fails to improve during an initial outpatient treatment period, she should

be admitted to a hospital and treated with iv antimicrobials (A,II). We recommend use of a parenteral fluoroquinolone, an aminoglycoside with or without ampicillin, or an extended-spectrum cephalosporin with or without an aminoglycoside (B,III). If gram-positive cocci are causative, we would use instead ampicillin/sulbactam with or without an aminoglycoside (B,III). After clinical improvement, as measured by resolution of fever (usually at 48–72 hours), we suggest changing to an oral regimen with agents active against the infecting organism and recommend fluoroquinolone compounds or trimethoprim-sulfamethoxazole (and for gram-positive organisms, amoxicillin or amoxicillin/clavulanic acid) (B,III).

#### Antimicrobial Susceptibility Profiles

We believe that these recommendations are appropriate for infections in the late 1990s in most communities in the United States. However, the clinician should be aware of current antimicrobial susceptibility patterns for *E. coli* and other uropathogens in the local community. Unfortunately, this information may become increasingly difficult to obtain because of the trend toward treating episodes of acute cystitis without obtaining cultures of urine [15, 16]. For cases of acute pyelonephritis, because of the potential severity of the infection, we strongly advocate culture of urine and susceptibility testing of isolated organisms [15, 16].

Data from bacteria isolated from the urine of patients with cystitis and pyelonephritis in Seattle are instructive [80]. In >4,000 isolates from women with acute uncomplicated cystitis seen at a health maintenance organization, the prevalence of resistance to trimethoprim-sulfamethoxazole, trimethoprim, and amoxicillin significantly increased over the period 1992–1996. Of greatest concern, the prevalence of resistance to trimethoprim-sulfamethoxazole was  $\geq 18\%$  in 1996 [80]. Resistance to fluoroquinolones and nitrofurantoin among *E. coli* strains causing cystitis was <1% throughout the study period. Among 50 strains causing acute uncomplicated pyelonephritis in college women, resistance to trimethoprim-sulfamethoxazole was 30% [81]. These data indicate that routine mechanisms must be established in communities to assess antimicrobial susceptibility of uropathogens and that standard regimens for empirical therapy must be reassessed periodically in light of changing susceptibility patterns.

#### Indications and Performance Measures

*Uncomplicated acute bacterial cystitis in women.* The indicator, in areas where the prevalence of resistance to trimethoprim-sulfamethoxazole and to trimethoprim is <20%, is that uncomplicated acute bacterial cystitis should be treated for 3 days with trimethoprim-sulfamethoxazole or trimethoprim. The performance measure would be the rate of

compliance with this A,I recommendation. The denominator would be all otherwise healthy adult nonpregnant women with symptoms of frequency, urgency, and/or dysuria and with  $\geq 10^2$  cfu of bacteria/mL of urine. The numerator would be the number of such women treated with oral trimethoprim-sulfamethoxazole or trimethoprim for 3 days.

*Uncomplicated acute pyelonephritis in women.* The indicator is that otherwise healthy young women with acute pyelonephritis should be treated for 7–14 days, mostly with oral antibiotics. The performance measure would be degree of compliance with this B,I recommendation. The denominator would be all young otherwise healthy nonpregnant women with normal urinary tracts presenting with flank pain and/or fever and with  $\geq 10^2$  cfu of bacteria/mL of urine. The numerator would be the number of such women treated for 7–14 days, either totally with oral antibiotics or with oral antibiotics following improvement with initial parenteral antibiotics.

### Suggestions for Future Studies

We reviewed treatment studies of one of the most common bacterial infections in humans, acute bacterial cystitis in otherwise healthy women. However, our criteria to insure study rigor, developed a priori, excluded the great majority of reports. The usual reason for rejection was that the study populations included not only women with uncomplicated cystitis but also men as well as persons with asymptomatic bacteriuria, fever, or flank pain or complicated urinary tract infections. Although we recognize that many of these studies were designed by pharmaceutical firms seeking regulatory approval for their drugs, we suggest that future investigations be reported to allow separate analyses of adult, nonpregnant women with normal urinary tracts who are experiencing dysuria, frequency, and/or urgency in the absence of fever or flank pain. The design should be that of a prospective, double-blind, randomized trial using as the control agent one of the antimicrobials recommended here; numerators and denominators for recurrences should be easily discernible. Analyses should include an intent-to-treat approach that includes not only patients with uropathogens subsequently found to be susceptible but also those with organisms resistant to the study drug(s). Outcome measures should be not only bacteriologic but also clinical symptoms; at least a 4-week evaluation should be conducted. These suggestions are consistent with the guidelines developed by the IDSA and the U.S. Food and Drug Administration [82].

Our recommendations regarding the treatment of acute pyelonephritis are limited by the relative paucity of appropriate studies. Controlled trials examining management of acute pyelonephritis are few, and many of the available studies are weakened by participation of heterogeneous populations, including men and patients with complicated urinary tracts. We suggest that more attention be devoted not only to trials of therapy for acute pyelonephritis but also to presentation of data

in a manner allowing analyses of relatively homogeneous populations, such as women with uncomplicated urinary tracts.

Additional types of studies would enhance our understanding of optimal management of uncomplicated UTIs. Antimicrobial resistance patterns will continue to change, implying that properly designed studies performed in a timely fashion will be necessary to maintain currency. These trials should include not only newly introduced agents but also extant antimicrobials, to gauge their relative importance; examples of the latter may be nitrofurantoin and fosfomycin. Studies also would be helpful that focus on specific subsegments, such as the elderly and those with UTIs due to enterococci or *S. saprophyticus*.

### Acknowledgments

We would like to acknowledge the superb administrative and typing skills of Linda Horne and the library research performed by Theresa Jackson and Deborah Bills. The following persons reviewed the manuscript and did not have substantive disagreements with its conclusions or recommendations: Vincent T. Andriole, Michel G. Bergeron, Stacy J. Childs, Clair E. Cox, Stephan D. Fihn, Ellie J. C. Goldstein, J.M.T. Hamilton-Miller, Godfrey K. Harding, Donald Kaye, Calvin M. Kunin, Leonard Leibovici, Benjamin A. Lipsky, William M. McCormack, Kurt G. Naber, J. Curtis Nickel, Lindsay E. Nicolle, S. Ragnar Norrby, Lawrence L. Pelletier, Jr., Raul Raz, Allan R. Ronald, Robert H. Rubin, Thomas A. Russo, Charles V. Sanders, Jack D. Sobel, Russell W. Steele, and Gary E. Stein.

### References

1. National Institutes of Health. The National Kidney and Urologic Diseases Advisory Board 1990 long-range plan—window on the 21st century. Bethesda, MD: National Institutes of Health, 1990; NIH publication no. 90-583.
2. Johnson JR, Stamm WE. Urinary tract infections in women: diagnosis and treatment. *Ann Intern Med* 1989;111:906–17.
3. Patton JP, Nash DB, Abrutyn E. Urinary tract infection: economic considerations. *Med Clin North Am* 1991;75:495–513.
4. Hedges LV, Ingram O. Statistical methods for meta-analysis. Boston: Academic Press, 1985.
5. Gross PA, Barrett TL, Dellinger EP, et al. Infectious Diseases Society of America quality standards for infectious diseases. Purpose of quality standards for infectious diseases. *Clin Infect Dis* 1994;18:421.
6. McGowan JE Jr, Chesney PJ, Crossley KB, LaForce FM. Guidelines for the use of systemic glucocorticosteroids in the management of selected infections. *J Infect Dis* 1992;165:1–13.
7. Counts GW, Stamm WE, McKeivitt M, Running K, Holmes KK, Turck M. Treatment of cystitis in women with a single dose of trimethoprim-sulfamethoxazole. *Rev Infect Dis* 1982;4:484–90.
8. Tolkoff-Rubin NE, Weber D, Fang LS, Kelly M, Wilkinson R, Rubin RH. Single-dose therapy with trimethoprim-sulfamethoxazole for urinary tract infection in women. *Rev Infect Dis* 1982;4:444–8.
9. Gossius G, Vorland L. A randomised comparison of single-dose vs. three-day and ten-day therapy with trimethoprim-sulfamethoxazole for acute cystitis in women. *Scand J Infect Dis* 1984;16:373–9.
10. Schultz HJ, McCaffrey LA, Keys TF, Nobrega FT. Acute cystitis: a prospective study of laboratory tests and duration of therapy. *Mayo Clin Proc* 1984;59:391–7.



11. Leibovici L, Laor A, Alpert G, Kalter-Leibovici O. Single-dose treatment of urinary tract infection in young women: data indicating a high rate of recurrent infection during a short follow-up. *Isr J Med Sci* **1984**;20:257-9.
12. Prentice RD, Wu LR, Gehlbach SH, Hanlon JT, Clapp-Channing NE, Finn AL. Treatment of lower urinary tract infections with single-dose trimethoprim-sulfamethoxazole. *J Fam Pract* **1985**;20:551-7.
13. Fihn SD, Johnson C, Roberts PL, Running K, Stamm WE. Trimethoprim-sulfamethoxazole for acute dysuria in women: a single-dose or 10-day course. A double-blind, randomized trial. *Ann Intern Med* **1988**;108:350-7.
14. Trienekens TA, Stobberingh EE, Winkens RA, Houben AW. Different lengths of treatment with co-trimoxazole for acute uncomplicated urinary tract infections in women. *Br Med J* **1989**;299:1319-22.
15. Johnson JR. Treatment and prevention of urinary tract infections. In: Mobley HLT, Warren JW, eds. *Urinary tract infections: molecular pathogenesis and clinical management*. Washington, DC: American Society for Microbiology Press, **1996**:95-118.
16. Hooton TM, Stamm WE. Diagnosis and treatment of uncomplicated urinary tract infection. In: Moellering RC Jr, Andriole VT, eds. *Infect Dis Clin North Am* **1997**;11:551-81.
17. Norrby SR. Useful agents in the management of urinary tract infections. *Int J Antimicrob Agents* **1994**;4:129-34.
18. Baerheim A. Single-dose versus five-day treatment with trimethoprim for the acute dysuria/pyuria syndrome in women. *Scand J Prim Health Care* **1987**;5:87-90.
19. Bailey RR, Keenan TD, Elliott JC, Peddie BA, Bishop V. Treatment of bacterial cystitis with a single dose of trimethoprim, co-trimoxazole, or amoxicillin compared with a course of trimethoprim. *N Z Med J* **1985**;98:387-9.
20. Österberg E, Åberg H, Hallander HO, Kallner A, Lundin A. Efficacy of single-dose versus seven-day trimethoprim treatment of cystitis in women: a randomized double-blind study. *J Infect Dis* **1990**;161:942-7.
21. Spencer RC, Moseley DJ, Greensmith MJ. Nitrofurantoin modified release versus trimethoprim or co-trimoxazole in the treatment of uncomplicated urinary tract infection in general practice. *J Antimicrob Chemother* **1994**;33(suppl A):121-9.
22. Trimethoprim Study Group. Comparison of trimethoprim at three dosage levels with co-trimoxazole in the treatment of acute symptomatic urinary tract infection in general practice. *J Antimicrob Chemother* **1981**;7:179-83.
23. Gossius G, Vorland L. The treatment of acute dysuria-frequency syndrome in adult women: double-blind, randomized comparison of three day vs ten day trimethoprim therapy. *Curr Ther Res* **1985**;7:34-42.
24. Saginur R, Nicolle LE, Canadian Infectious Diseases Society Clinical Trials Study Group. Single-dose compared with 3-day norfloxacin treatment of uncomplicated urinary tract infection in women. *Arch Intern Med* **1992**;152:1233-7.
25. Arav-Boger R, Leibovici L, Danon YL. Urinary tract infections with low and high colony counts in young women. *Arch Intern Med* **1994**;154:300-4.
26. Iravani A, Tice AD, McCarty J, et al. Short-course ciprofloxacin treatment of acute uncomplicated urinary tract infection in women. The minimum effective dose. *Arch Intern Med* **1995**;155:485-94.
27. Iravani A. Multicenter study of single-dose and multiple-dose feroxacin versus ciprofloxacin in the treatment of uncomplicated urinary tract infections. *Am J Med* **1993**;94(suppl 3A):89S-96S.
28. Inter-Nordic Urinary Tract Infection Study Group. Double-blind comparison of 3-day versus 7-day treatment with norfloxacin in symptomatic urinary tract infections. *Scand J Infect Dis* **1988**;20:619-24.
29. Piippo T, Pitkääjärvi T, Salo SA. Three-day versus seven-day treatment with norfloxacin in acute cystitis. *Curr Ther Res* **1990**;47:644-53.
30. Neringer R, Forsgren A, Hansson C, Ode B, South Swedish Lolex Study Group. Lomefloxacin versus norfloxacin in the treatment of uncomplicated urinary tract infections: three-day versus seven-day treatment. *Scand J Infect Dis* **1992**;24:773-80.
31. Hooton TM, Johnson C, Winter C, et al. Single-dose and three-day regimens of ofloxacin versus trimethoprim-sulfamethoxazole for acute cystitis in women. *Antimicrob Agents Chemother* **1991**;35:1479-83.
32. Leelarasamee A, Leelarasamee I. Comparative efficacies of oral pefloxacin in uncomplicated cystitis. *Drugs* **1995**;49(suppl 2):365-7.
33. Hooton TM, Latham RH, Wong ES, Johnson C, Roberts PL, Stamm WE. Ofloxacin versus trimethoprim-sulfamethoxazole for treatment of acute cystitis. *Antimicrob Agents Chemother* **1989**;33:1308-12.
34. Block JM, Walstad RA, Bjertnaes A, et al. Ofloxacin versus trimethoprim-sulphamethoxazole in acute cystitis. *Drugs* **1987**;34(suppl 1):100-6.
35. Nicolle LE, Dubois J, Martel AY, Harding GKM, Shafran SD, Conly JM. Treatment of acute uncomplicated urinary tract infections with 3 days of lomefloxacin compared with treatment with 3 days of norfloxacin. *Antimicrob Agents Chemother* **1993**;37:574-9.
36. Petersen EE, Wingen F, Fairchild KL, et al. Single dose pefloxacin compared with multiple dose co-trimoxazole in cystitis. *J Antimicrob Chemother* **1990**;26(suppl B):147-52.
37. Dubois J, St-Pierre C, Auger P, Phillips R, Perrier A. Single-dose pefloxacin vs. seven days of trimethoprim-sulfamethoxazole in uncomplicated infection of the lower urinary tract in women. *Rev Infect Dis* **1989**;11(suppl 5):S1343-4.
38. Jardin A, Cesana M, French Multicenter Urinary Tract Infection-Rufloxacin Group. Randomized, double-blind comparison of single-dose regimens of rufloxacin and pefloxacin for acute uncomplicated cystitis in women. *Antimicrob Agents Chemother* **1995**;39:215-20.
39. van Balen FA, Touw-Otten FW, de Melker RA. Single-dose pefloxacin versus five-days treatment with norfloxacin in uncomplicated cystitis in women. *J Antimicrob Chemother* **1990**;26:153-60.
40. Del Rio G, Dalet F, Aguilar L, Caffaratti J, Dal-re R. Single-dose rufloxacin versus three day norfloxacin treatment of uncomplicated cystitis: clinical evaluation and pharmacodynamic considerations. *Antimicrob Agents Chemother* **1996**;40:408-12.
41. Gossius G. Single-dose nitrofurantoin therapy for urinary tract infections in women. *Curr Ther Res* **1984**;35:925-31.
42. Hooton TM, Winter C, Tiu F, Stamm WE. Randomized comparative trial and cost analysis of 3-day antimicrobial regimens for treatment of acute cystitis in women. *JAMA* **1995**;273:41-5.
43. Fang LST, Tolkoff-Rubin NE, Rubin RH. Efficacy of single-dose and conventional amoxicillin therapy in urinary tract infection localized by the antibody-coated bacteria technic. *N Engl J Med* **1978**;298:413-6.
44. Savard-Fenton M, Fenton BW, Reller LB, Lauer BA, Byyny RL. Single-dose amoxicillin therapy with follow-up urine culture. Effective initial management for acute uncomplicated urinary tract infections. *Am J Med* **1982**;73:808-13.
45. Rubin RH, Fang LS, Jones SR, et al. Single-dose amoxicillin therapy for urinary tract infection. Multicenter trial using antibody-coated bacteria localization technique. *JAMA* **1980**;244:561-4.
46. Raz R, Rottensterich E, Boger S, Potasman I. Comparison of single-dose administration and three-day course of amoxicillin with those of clavulanic acid for treatment of uncomplicated urinary tract infection in women. *Antimicrob Agents Chemother* **1991**;35:1688-90.
47. Greenberg RN, Sanders CV, Lewis AC, Marier RL. Single-dose cefaclor therapy of urinary tract infection. Evaluation of antibody-coated bacteria test and C-reactive protein assay as predictors of cure. *Am J Med* **1981**;71:841-5.
48. Iravani A, Richard GA. Single-dose cefuroxime axetil versus multiple-dose cefaclor in the treatment of acute urinary tract infections. *Antimicrob Agents Chemother* **1989**;33:1212-6.
49. Pitkääjärvi T, Pyykonen ML, Kannisto K, Piippo T, Viita P. Pivmecillinam treatment in acute cystitis. Three versus seven days study. *Arzneimittelforschung* **1990**;40:1156-8.



50. Sigurdsson JA, Ahlmen J, Berglund L, et al. Three-day treatment of acute lower urinary tract infections in women. A double-blind study with amoxicillin and co-trimazine. *Acta Med Scand* **1983**;213:55–60.
51. Swedish Urinary Tract Infection Study Group. Interpretation of the bacteriologic outcome of antibiotic treatment for uncomplicated cystitis: impact of the definition of significant bacteriuria in a comparison of ritipenem acoxil with norfloxacin. *Clin Infect Dis* **1995**;20:507–13.
52. Crocchiolo P. Single-dose fosfomycin trometamol versus multiple-dose cotrimoxazole in the treatment of lower urinary tract infections in general practice. *Chemotherapy* **1990**;36(suppl 1):37–40.
53. Harvard Davis R, Dowd TCO, Holmes W, Smail J, Slack RCB. A comparative double-blind randomised study of single dose fosfomycin trometamol with trimethoprim in the treatment of urinary tract infections in general practice. *Chemotherapy* **1990**;36(suppl 1):34–6.
54. Naber KG, Thyroff-Friesinger U. Fosfomycin trometamol versus ofloxacin/co-trimoxazole as single dose therapy of acute uncomplicated urinary tract infection in females: a multicentre study. *Infection* **1990**;18:S70–6.
55. Neu HC. Fosfomycin trometamol versus amoxicillin—single-dose multicenter study of urinary tract infections. *Chemotherapy* **1990**;36:19–23.
56. Elhanan G, Tabenkin H, Yahalom R, Raz R. Single-dose fosfomycin trometamol versus 5-day cephalexin regimen for treatment of uncomplicated lower urinary tract infections in women. *Antimicrob Agents Chemother* **1994**;38:2612–4.
57. Jardin A. A general practitioner multicenter study: fosfomycin trometamol single dose versus piperidic acid multiple dose. *Infection* **1990**;18(suppl 2):S89–93.
58. Boerema JBJ, Willems FTC. Fosfomycin trometamol in a single dose versus norfloxacin for seven days in the treatment of uncomplicated urinary infections in general practice. *Infection* **1990**;18(suppl 2):S80–8.
59. De Jong Z, Pontonnier F, Plante P. Single-dose fosfomycin trometamol (Monuril) versus multiple-dose norfloxacin: results of a multicenter study in females with uncomplicated lower urinary tract infections. *Urol Int* **1991**;46:344–8.
60. Fosfomycin for urinary tract infections. *Med Lett* **1997**;39:66–8.
61. Nicolle LE, Hoepelman AIM, Floor M, Verhoef J, Norgard K. Comparison of three days' therapy with cefcanol or amoxicillin for the treatment of acute uncomplicated urinary tract infection. *Scand J Infect Dis* **1993**;25:631–7.
62. Gleckman R, Bradley P, Roth R, Hibert D, Pelletier C. Therapy of symptomatic pyelonephritis in women. *J Urol* **1985**;133:176–8.
63. Johnson JR, Lyons MF II, Pearce W, et al. Therapy for women hospitalized with acute pyelonephritis: a randomized trial of ampicillin versus trimethoprim-sulfamethoxazole for 14 days. *J Infect Dis* **1991**;163:325–30.
64. Stamm WE, McKeivitt M, Counts GW. Acute renal infection in women: treatment with trimethoprim-sulfamethoxazole or ampicillin for two or six weeks. *Ann Intern Med* **1987**;106:341–5.
65. Ode B, Bröms M, Walder M, Cronberg S. Failure of excessive doses of ampicillin to prevent bacterial relapse in the treatment of acute pyelonephritis. *Acta Med Scand* **1980**;207:305–7.
66. Jemelius H, Zbornik J, Bauer CA. One or three weeks' treatment of acute pyelonephritis? A double-blind comparison, using a fixed combination of pivampicillin plus pivmecillinam. *Acta Med Scand* **1988**;223:469–77.
67. Ward G, Jordan RC, Severance HW. Treatment of pyelonephritis in an observation unit. *Ann Emerg Med* **1991**;20:258–61.
68. Bailey RR, Peddie BA. Treatment of acute urinary tract infection in women. *Ann Intern Med* **1987**;107:430.
69. Talen D, Stamm WE, Reuning-Scherer J, Church D. Ciprofloxacin (CIP) 7-day vs. TMP/SMX 14-day +/- ceftriaxone (CRO) for acute uncomplicated pyelonephritis: a randomized, double-blind trial. Boston: International Congress of Infectious Diseases, **1998**.
70. Bailey RR. Single dose therapy of urinary tract infection. Sydney, Australia: ADIS Health Science Press, **1983**:1–125.
71. Norrby SR. Short-term treatment of uncomplicated lower urinary tract infections in women. *Rev Infect Dis* **1990**;12:458–67.
72. Leibovici L, Wysenbeek AJ. Single-dose antibiotic treatment for symptomatic urinary tract infections in women: a meta-analysis of randomized trials. *Q J Med* **1991**;78:43–57.
73. Hooton TM, Stamm WE. The vaginal flora and urinary tract infections. In: Mobley HLT, Warren JW, eds. *Urinary tract infections: molecular pathogenesis and clinical management*. Washington, DC: American Society for Microbiology Press, **1996**:67–94.
74. Safran S, Siegel D, Black D. Pyelonephritis in adult women: inpatient versus outpatient therapy. *Am J Med* **1988**;85:793–8.
75. Pinson AG, Philbrick JT, Lindbeck GH, Schorling JB. ED management of acute pyelonephritis in women: a cohort study. *Am J Emerg Med* **1994**;12:271–8.
76. Bailey RR. Duration of antimicrobial treatment and the use of drug combinations for the treatment of uncomplicated acute pyelonephritis. *Infection* **1994**;22(suppl 1):S50–2.
77. Bach D, van den Berg-Segers A, Hübner A, van Breukelen G, Cesana M, Plétan Y. Rufloxacin once daily versus ciprofloxacin twice daily in the treatment of patients with acute uncomplicated pyelonephritis. *J Urol* **1995**;154:19–24.
78. Bergeron MG. Treatment of pyelonephritis in adults. *Med Clin North Am* **1995**;79:619–49.
79. Israel RS, Lowenstein SR, Marx JA, Koziol-McLain J, Svoboda L, Ranniger S. Management of acute pyelonephritis in an emergency department observation unit. *Ann Emerg Med* **1991**;20:253–7.
80. Gupta K, Scholes D, Stamm WE. Increasing prevalence of antimicrobial resistance among uropathogens causing acute uncomplicated cystitis. *JAMA* **1999**;281:736–8.
81. Hooton TM, Stamm WE. Diagnosis and treatment of uncomplicated urinary tract infection. *Infect Dis Clin North Am* **1997**;11:551–82.
82. Rubin RH, Shapiro ED, Andriole VT, Davis RJ, Stamm WE. Evaluation of new anti-infective drugs for the treatment of urinary tract infection. *Clin Infect Dis* **1992**;15(suppl 1):S216–27.