### Expert Committee recommendation

The Expert Committee endorsed the inclusion of the following medicines as first-choice therapies on the EML and EMLc list: • lower UTI: amoxicillin or amoxicillin + clavulanic acid or sulfamethoxazole + trimethoprim or nitrofurantoin • pyelonephritis or prostatitis, mild to moderate: ciprofloxacin • pyelonephritis or prostatitis, severe: ceftriaxone or cefotaxime. The Expert Committee endorsed the inclusion of the following medicines as second-choice therapies on the EML and EMLc list: • pyelonephritis or prostatitis, mild to moderate: ceftriaxone or cefotaxime. The Committee recommended the addition of amikacin (in combination with ceftriaxone or cefotaxime) for severe pyelonephritis or prostatitis to the EML and EMLc for UTI therapy.

### Background

Urinary tract infections (UTI) in the outpatient setting are a common reason for young women in particular to seek medical attention. Randomized controlled trials (RCTs) have addressed the type and duration of antibiotic treatments in this and other populations. Use of antibiotics for asymptomatic bacteriuria can drive antibiotic resistance and may also increase the risk for subsequent symptomatic UTI. While it is accepted practice that asymptomatic bacteriuria should be treated in pregnant women and in men about to undergo urological procedures, the benefits of therapy in other groups have been questioned and addressed in RCTs.

### Summary of evidence

A 2010 Cochrane systematic review (21 RCTs; 6016 participants) of acute uncomplicated UTI, found that sulfamethoxazole +
Guidelines

Rationale for antibiotic selection

Committee considerations

The Infectious Diseases Society of America (IDSA) and European Society of Clinical Microbiology and Infectious Diseases (ESCMID) guidelines recommend nitrofurantoin and SMX–TMP for acute uncomplicated cystitis in women (4). Amoxicillin + clavulanic acid is an alternative choice. Oral fosfomycin is recommended where available because of its minimal propensity for resistance. Ceftriaxone is recommended for acute pyelonephritis in women, as is ciprofloxacin. However, the guideline recommends that resistance rates for empirically selected antibiotics should be below 10% for pyelonephritis and below 20% for treatment of lower UTI, a threshold no longer met for fluoroquinolones in many countries. Amoxicillin + clavulanic acid and SMX–TMP are also recommended for empirical treatment in children aged 2–24 months by the American Academy of Pediatrics (5). The European Association of Urology and European Society for Paediatric Urology state that antimicrobial choice is dictated by local resistance patterns (6). For young children, newborns and infants, parenteral therapy is advised, such as combination treatment with ampicillin and an aminoglycoside (e.g. tobramycin or gentamicin) or a third-generation cephalosporin. For pyelonephritis during the first 6 months of life, ceftazidime plus ampicillin or an aminoglycoside plus ampicillin is recommended. A third-generation cephalosporin is recommended for children over 6 months of age for uncomplicated pyelonephritis while ceftazidime plus ampicillin or aminoglycoside plus ampicillin are suggested for complicated pyelonephritis. Although the guidelines list parenteral as well as oral cephalosporins, in addition to beta-lactams (including piperacillin, amoxicillin, amoxicillin + clavulanic acid, nitrofurantoin and aminoglycosides), fluoroquinolones are considered second- or third-line antibiotics for complicated urinary tract infection. The recommendations of the Italian Society for Pediatric Nephrology are similar (7).

The systematic review evidence showed that SMX–TMP was equivalent to fluoroquinolones for uncomplicated UTI and that nitrofurantoin was equivalent to SMX–TMP. SMX–TMP and nitrofurantoin are therefore proposed as core antibiotics. Fluoroquinolones were not included because of the need to preserve this class of antibiotics. Oral fosfomycin is proposed because of minimal resistance and good safety profile. Amoxicillin + clavulanic acid is proposed for young children while ampicillin and gentamicin are for children with severe illness. Fosfomycin is included as a core antibiotic.

For common community-acquired infections, the main focus has been on empirical treatment choices that are broadly applicable in most countries. Generally, alternatives for use in case of allergy were not considered. The Expert Committee considered the various antibiotics proposed in the application under the guiding principle of parsimony and selected first- and second-choice antibiotics for this indication for inclusion on the EML and/or EMLc. Ampicillin, fosfomycin and gentamicin were excluded. Amikacin was preferred to gentamicin because it is generally more active on Enterobacteriaceae; ciprofloxacin was added as a recommended first-line option for empirical treatment in mild-to-moderate pyelonephritis and prostatitis because of its good bioavailability and
EML recommendations: Infectious cystitis

First choice
- nitrofurantoin
- amoxicillin + clavulanic acid
- sulfamethoxazole + trimethoprim
- trimethoprim

Second choice