

Save Newer Antibiotics as Alternatives for Complicated UTIs

New guidelines from the Infect Dis Soc of America **stress stewardship around antibiotics for complicated urinary tract infections (cUTIs).**

Be aware of IDSA's new UTI definitions. Before, a cUTI was anything other than acute cystitis or pyelonephritis in nonpregnant women.

Now, simple cystitis in men is considered UNcomplicated.

And UTIs in any sex are cUTIs if they are outside the bladder (pyelonephritis, prostatitis, etc), are catheter-associated, or fever or bacteremia are present.

In general, continue recommending typical antibiotics for empiric therapy while considering sepsis status, resistance, po tolerance, etc.

For example, stick with IV options...ceftriaxone, cefepime, piperacillin/tazobactam, carbapenems (meropenem, etc), or quinolones (levofloxacin, etc)...if patients have sepsis or cannot take po meds.

Tailor these IV options based on your local antibiogram. For instance, pick options with 90% susceptibility or more for septic shock cases...or at least 80% for sepsis patients withOUT shock.

If patients don't have sepsis AND can take pills, still prefer po trimethoprim/sulfamethoxazole, levofloxacin, or ciprofloxacin up front.

But continue avoiding po fosfomycin and nitrofurantoin for most cUTIs. Their drug levels in the kidney or blood aren't high enough.

Be ready for questions about when to use novel antibiotics.

We know many have come onto the scene to help target resistant bugs...IV cefiderocol, plazomicin, meropenem/vaborbactam, etc.

But avoid using these routinely as empiric IV options. Save them as backups for patients with sepsis AND resistance to typical antibiotics.

Plus they may have formulary restrictions and require consulting an ID colleague first to help optimize stewardship, dosing, and costs.

After starting empiric therapy, recommend an IV-to-po switch ASAP once patients are clinically improving on IV therapy, can take pills, and have po antibiotic options that will cover their bug.

Keep in mind, some newer po antibiotics have been FDA-approved to target resistant bugs (pivmecillinam, sulopenem etzadroxil/probenecid, etc). But these are only approved for UNcomplicated UTIs in women.

Then aim for an initial 7-day course for most cUTIs...even when there's gram-negative bacteremia. Durations can be different for prostatitis (10 to 14 days) or when using a quinolone (5 to 7 days).

Use our updated *Urinary Tract Infections* chart as a handy tool to identify different antibiotic options for cUTIs.

Key References:

- Trautner BW, Cortés-Penfield NW, Gupta K, et al. Clinical Practice Guideline by Infectious Diseases Society of America (IDSA): 2025 Guideline on Management and Treatment of Complicated Urinary Tract Infections:

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Executive Summary. July 17, 2025. <https://www.idsociety.org/globalassets/idsa/practice-guidelines/cuti/executive-summary.pdf> (Accessed August 1, 2025).

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