

GUIDELINES ON UROLOGICAL INFECTIONS

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Introduction

Infections of the urinary tract (UTIs) pose a serious health problem for patients at high cost for society. UTIs are also the most frequent healthcare associated infections.

E. coli is the predominating pathogen in uncomplicated UTIs while other *Enterobacteriaceae* and *Enterococcus spp* are isolated in higher frequency in patients with urological diseases. The present state of microbial resistance development is alarming and the rates of resistance are related to the amount of antibiotics used in the different countries. Particularly worrisome is the increasing resistance to broad spectrum antibiotics. It is thus essential to limit the use of antibiotics in general and fluoroquinolones and cephalosporins in particular, especially in uncomplicated infections and asymptomatic bacteriuria.

Classification and definitions

For practical clinical reasons, urinary tract infections (UTIs) and male genital tract infections are classified into entities defined by the predominant clinical symptoms (Table 1).

Table 1: Classification of urinary and male genital tract infections

Uncomplicated lower UTI (cystitis)

Uncomplicated pyelonephritis

Complicated UTI with or without pyelonephritis

Urosepsis

Urethritis

Prostatitis, epididymitis, orchitis

The definitions of bacteriuria and pyuria are listed in Table 2.

Table 2: Significant bacteriuria in adults

1. $\geq 10^3$ uropathogens/mL of midstream urine in acute uncomplicated cystitis in female.

2. $\geq 10^4$ uropathogens/mL of midstream urine in acute uncomplicated pyelonephritis in female.

3. $\geq 10^5$ uropathogens/mL in midstream urine of women or 10^4 uropathogens/mL of midstream urine in men (or in straight catheter urine in women) with complicated UTI.

4. In a suprapubic bladder puncture specimen, any count of bacteria is relevant.

Asymptomatic bacteriuria

Asymptomatic bacteriuria is defined as two positive urine cultures taken more than 24 hours apart containing 10^5 uropathogens/mL of the same bacterial strain (usually only the species can be detected).

Pyuria

The diagnostic requirement for pyuria is 10 white blood cells per high-power field (HPF) (x400) in the resuspended sedi-

ment of a centrifuged aliquot of urine or per mm³ in unspun urine. For routine investigation, a dipstick method can also be used, including a leukocyte esterase test and the assessment of haemoglobin and of nitrites.

Urethritis

Symptomatic urethritis is characterised by alguria and purulent discharge.

Classification of prostatitis/chronic pelvic pain syndrome (CPPS)

It is recommended that the classification according to NIDDK/NIH is used (Table 3).

I	Acute bacterial prostatitis (ABP)
II	Chronic bacterial prostatitis (CBP)
III	Chronic pelvic pain syndrome (CPPS)
	A. Inflammatory CPPS: WBC in EPS/voided bladder urine-3 (VB3)/semen
	B. Non-inflammatory CPPS: no WBC/EPS/VB3/semen
IV	Asymptomatic inflammatory prostatitis (histological prostatitis)

Epididymitis, orchitis

Most cases of epididymitis, with or without orchitis, are caused by common urinary pathogens. Bladder outlet obstruction and urogenital malformations are risk factors for this type of infection. Consider *Chlamydia trachomatis* infection in the younger male population.

Diagnosis

UTI (general)

A disease history, physical examination and dipstick urinalysis, including white and red blood cells and nitrite reaction, is recommended for routine diagnosis. Except in isolated episodes of uncomplicated lower UTI (cystitis) in premenopausal, healthy women, a urine culture is recommended in all other types of UTI before treatment, so allowing antimicrobial therapy to be adjusted if necessary.

Pyelonephritis

In cases of suspected pyelonephritis, it may be necessary to evaluate the upper urinary tract to rule out upper urinary tract obstruction or stone disease.

Urethritis

Pyogenic urethritis is indicated by a Gram stain of secretion or urethral smear that shows more than five leukocytes per HPF ($\times 1,000$) and in case of gonorrhoea gonococci are located intracellularly as Gram-negative diplococci. A positive leukocyte esterase test or more than 10 leukocytes per HPF ($\times 400$) in the first voiding urine specimen is diagnostic.

Prostatitis/CPPS

In patients with prostatitis-like symptoms, an attempt should be made to differentiate between bacterial prostatitis and CPPS. This is best done by the four glass test according to Meares & Stamey, if acute UTI and STD can be ruled out.

Table 4: Recommendations for antimicrobial therapy in urology

Diagnosis	Most frequent pathogen/species
Cystitis acute, uncomplicated	<ul style="list-style-type: none">• <i>E. coli</i>• <i>Klebsiella</i>• <i>Proteus</i>• Staphylococci
Pyelonephritis acute, uncomplicated	<ul style="list-style-type: none">• <i>E. coli</i>• <i>Proteus</i>• <i>Klebsiella</i>• Other enterobacteria• Staphylococci
UTI with complicating factors	<ul style="list-style-type: none">• <i>E. coli</i>• Enterococci• <i>Pseudomonas</i>• Staphylococci
Nosocomial UTI	<ul style="list-style-type: none">• <i>Klebsiella</i>• <i>Proteus</i>
Pyelonephritis acute, complicated	<ul style="list-style-type: none">• <i>Enterobacter</i>• Other enterobacteria• (<i>Candida</i>)

Initial, empirical antimicrobial therapy	Therapy duration
<ul style="list-style-type: none"> • TMP-SMX¹ • Nitrofurantoin • Fosfomycin trometamol • Pivmecillinam • Fluoroquinolone (altern.)^{2, 3} 	<p>3 days</p> <p>(5-)7 days</p> <p>1 day</p> <p>(3-)5 days</p> <p>(1-)3 days</p>
<ul style="list-style-type: none"> • Fluoroquinolone² • Cephalosporin (group 3a) <p>Alternatives:</p> <ul style="list-style-type: none"> • Aminopenicillin/BLI • Aminoglycoside 	<p>7-10 days</p>
<ul style="list-style-type: none"> • Fluoroquinolone² • Aminopenicillin/BLI • Cephalosporin (group 2) • Cephalosporin (group 3a) • Aminoglycoside <p>In case of failure of initial therapy within 1-3 days or in clinically severe cases:</p> <p>Anti-<i>Pseudomonas</i> active:</p> <ul style="list-style-type: none"> • Fluoroquinolone, if not used initially • Acylaminopenicillin/BLI • Cephalosporin (group 3b) • Carbapenem • ± Aminoglycoside <p>In case of <i>Candida</i>:</p> <ul style="list-style-type: none"> • Fluconazole • Amphotericin B 	<p>3-5 days after defeverescence or control/elimination of complicating factor</p>

Prostatitis acute, chronic	<ul style="list-style-type: none"> • <i>E. coli</i> • Other enterobacteria • <i>Pseudomonas</i>
Epididymitis acute	<ul style="list-style-type: none"> • Enterococci • Staphylococci • <i>Chlamydia</i> • <i>Ureaplasma</i>
Urosepsis	<ul style="list-style-type: none"> • <i>E. coli</i> • Other enterobacteria <p>After urological interventions - multi-resistant pathogens:</p> <ul style="list-style-type: none"> • <i>Pseudomonas</i> • <i>Proteus</i> • <i>Serratia</i> • <i>Enterobacter</i>
<p>¹Only in areas with resistance rate < 20% (for <i>E. coli</i>). ²Fluoroquinolone with mainly renal excretion (see text). ³Avoid Fluoroquinolones in uncomplicated cystitis whenever possible.</p>	

BLI = beta-lactamase inhibitor; UTI = urinary tract infection.

Treatment and Prophylaxis

Treatment of UTI depends on a variety of factors. Table 4 provides an overview of the most common pathogens, antimicrobial agents and duration of treatment for different conditions. Prophylactic treatment may be recommended for patients with recurrent UTI. The regimens shown in Table 5 have a documented effect in preventing recurrent UTI in women.

<ul style="list-style-type: none"> • Fluoroquinolone² 	Acute:
Alternative in acute bacterial prostatitis:	2-4 weeks
<ul style="list-style-type: none"> • Cephalosporin (group 3a/b) 	
In case of <i>Chlamydia</i> or <i>Ureaplasma</i> :	Chronic:
<ul style="list-style-type: none"> • Doxycycline • Macrolide 	4-6 weeks or longer
<ul style="list-style-type: none"> • Cephalosporin (group 3a/b) • Fluoroquinolone² • Anti-<i>Pseudomonas</i> active acylaminopenicillin/BLI • Carbapenem • ± Aminoglycoside 	3-5 days after defeverescence or control/elimination of complicating factor

Special situations

UTI in pregnancy

Asymptomatic bacteriuria is treated with a 7-day course based on sensitivity testing. For recurrent infections (symptomatic or asymptomatic), either cephalexin, 125-250 mg/day, or nitrofurantoin, 50 mg/day, may be used for prophylaxis.

UTI in postmenopausal women

In women with recurrent infection, intravaginal oestriol is recommended. If this is not effective, antibiotic prophylaxis could be considered.

UTI in children

Treatment periods should be extended to 7-10 days. Tetracyclines and fluoroquinolones should not be used because of adverse effects on teeth and cartilage.

Acute uncomplicated UTI in young men

Treatment should last at least 7 days.

Complicated UTI due to urological disorders

The underlying disorder must be managed if a permanent cure is to be achieved. Whenever possible, treatment should be guided by urine culture to avoid inducing resistant strains.

Sepsis in urology (urosepsis)

Patients with UTI may develop sepsis. Early signs of systemic inflammatory response (fever or hypothermia, tachycardia, tachypnoea, hypotension, oliguria, leukopenia) should be recognized as the first signs of possible multi-organ failure. As well as appropriate antibiotic therapy, life-support therapy in collaboration with an intensive care specialist may be necessary. Any obstruction in the urinary tract must be drained.

Table 5: Recommendations for antimicrobial prophylaxis of recurrent uncomplicated UTI

Agent ¹	Dose
Standard regimen	
Nitrofurantoin	50 mg/day
Nitrofurantoin macrocrystals	100 mg/day
TMP-SMX	40/200 mg/day or three times weekly
TMP	100 mg/day
Fosfomycin trometamol	3 g/10 day
'Breakthrough' infections	
Ciprofloxacin	125 mg/day
Norfloxacin	200-400 mg/day
Pefloxacin	800 mg/week
During pregnancy	
Cephalexin	125 mg/day
Cefaclor	250 mg/day
¹ Taken at bedtime.	

TMP = trimethoprim-sulphamethoxazole.

Follow-up of patients with UTI

- For routine follow-up after uncomplicated UTI and pyelonephritis in women, dipstick urinalysis is sufficient.
- In women with a recurrence of UTI within 2 weeks, repeated urinary culture with antimicrobial testing and urinary tract evaluation is recommended.
- In the elderly, newly developed recurrent UTI may warrant a full evaluation of the urinary tract.
- In men with UTI, an urological evaluation should be

performed in adolescent patients, cases of recurrent infection and all cases of pyelonephritis. This recommendation should also be followed in patients with prostatitis, epididymitis and orchitis.

- In children, investigations are indicated after two episodes of UTI in girls and one episode in boys. Recommended investigations are ultrasonography of the urinary tract supplemented by voiding cystourethrography.

Urethritis

The following guidelines for therapy comply with the recommendations of the Center for Disease Control and Prevention (2002). For the treatment of gonorrhoea, the following antimicrobials can be recommended:

First choice

Cefixime 400 mg orally
as a single dose

Ceftriaxone 1g im
as a single dose
(im with local anaesthetic)

Second choice

Ciprofloxacin 500 mg orally or
Ofloxacin 400 mg orally or
Levofloxacin 250 mg orally
as a single dose

As gonorrhoea is often accompanied by chlamydial infection, an antichlamydial active therapy should be added. The following treatment has been successfully applied in *Chlamydia trachomatis* infections:

First choice	Second choice
Azithromycin	Erythromycin
1 g (= 4 caps @ 250 mg) orally as single dose	4 times daily 500 mg orally for 7 days
Doxycycline	Ofloxacin 2 times daily
2 times daily 100 mg orally for 7 days	300 mg orally or Levofloxacin once daily 500 mg orally for 7 days

If therapy fails, infections with *Trichomonas vaginalis* and/or *Mycoplasma* spp. should be considered. These can be treated with a combination of metronidazole (2 g orally as a single dose) and erythromycin (500 mg orally, 4 times daily, for 7 days).

Prostatitis

Acute bacterial prostatitis can be a serious infection. The parenteral administration of high doses of bactericidal antibiotics, such as an aminoglycoside and a penicillin derivative or a third-generation cephalosporin, is required until defervescence occurs and infection parameters return to normal. In less severe cases, a fluoroquinolone may be given orally for at least 10 days.

In chronic bacterial prostatitis and inflammatory CPPS, a fluoroquinolone or trimethoprim should be given orally for 2 weeks after the initial diagnosis. The patient should then be reassessed and antibiotics only continued if the pretreatment cultures were positive or if the patient has reported positive effects from the treatment. A total treatment period of 4-6 weeks is recommended.

Table 6: Recommendations for peri-operative antibacterial

Procedure	Pathogens (expected)	Prophylaxis (standard)
<i>Diagnostic procedures</i>		
Transrectal biopsy of the prostate	Enterobacteriaceae (Anaerobes)	All patients
Cystoscopy Urodynamic study	Enterobacteriaceae Enterococci Staphylococci	No
Ureteroscopy	Enterobacteriaceae Enterococci Staphylococci	No
<i>Endourological surgery and ESWL</i>		
ESWL	Enterobacteriaceae Enterococci	No
Ureteroscopy for uncomplicated distal stone	Enterobacteriaceae Enterococci Staphylococci	No
Ureteroscopy of proximal or impacted stone and percutaneous stone extraction	Enterobacteriaceae Enterococci Staphylococci	All patients
TUR of the prostate	Enterobacteriaceae Enterococci	All patients

prophylaxis in urology

Antibiotics	Remarks
Fluoroquinolones TMP ± SMX Metronidazole ¹	Single dose effective in low risk. Consider prolonged course in risk patients
TMP ± SMX Cephalosporin 2 nd generation	Consider in risk patients
TMP ± SMX Cephalosporin 2 nd generation	No studies
TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI ²	In patients with stent or nephrostomy tube or other risk factor
TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI Fluoroquinolones	Consider in risk patients
TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI Fluoroquinolones	Short course, Length to be determined Intravenous suggested at operation
TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI	Low-risk patients and small-size prostate require no prophylaxis

TUR of bladder tumour	Enterobacteriaceae Enterococci	No
<i>Open or laparoscopic urological surgery</i> ³		
Clean operations	Skin-related pathogens, e.g. staphylococci Catheter-associated uropathogens	No
Clean-contaminated (opening of urinary tract)	Enterobacteriaceae Enterococci Staphylococci	Recommended
Clean-contaminated/ contaminated (use of bowel segments):	Enterobacteriaceae Enterococci Anaerobes Skin-related bacteria	All patients
Implant of prosthetic devices	Skin-related bacteria, e.g. staphylococci	All patients

BLI=beta-lactamase inhibitor; TMP ± SMX = trimethoprim with or resection.

¹No evidence for the use of metronidazole in prostate core biopsies.

²Gram-negative bacteria excluding *Pseudomonas aeruginosa*.

³Classifications of surgical field contamination (CDC).

TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI	Consider in risk patients and large tumours
	Consider in high-risk patients. Short post-operative catheter requires no treatment
TMP ± SMX Cephalosporin 2 nd or 3 rd generation Aminopenicillin/BLI	Single peri-operative course
Cephalosporin 2 nd or 3 rd generation Metronidazole	As for colonic surgery
Cephalosporin 2 nd or 3 rd generation Penicillin (penicillinase stable)	

without sulphamethoxale (co-trimoxazole); TUR = transurethral

Combination therapy with antibiotics and α -blockers:

Urodynamic studies have shown increased urethral closing pressure in patients with chronic prostatitis. Combination treatment with α -blockers and antibiotics has been reported to have a higher cure rate than antibiotics alone in inflammatory CPPS. This treatment option is favoured by many urologists.

Surgery: Generally, surgery should be avoided in the treatment of prostatitis, except for the drainage of prostatic abscesses.

Epididymitis, orchitis

Prior to antimicrobial therapy, a urethral swab and mid-stream urine sample should be obtained for microbiological investigation. The first choice of drug therapy should be fluoroquinolones, preferably those agents that react well against *C. trachomatis* (e.g. ofloxacin, levofloxacin), because of their broad antibacterial spectra and favourable penetration into urogenital tract tissues.

In cases caused by *C. trachomatis*, treatment may also be continued with doxycycline, 200 mg/day, for a total treatment period of at least 2 weeks. Macrolides are alternative agents. In cases of *C. trachomatis* infection, the sexual partner should also be treated.

Perioperative antibacterial prophylaxis in urological surgery

The main aim of antimicrobial prophylaxis in urology is to prevent symptomatic or febrile genitourinary infections, such as acute pyelonephritis, prostatitis, epididymitis and urosep-

sis, as well as serious wound infections. The recommendations for short-term peri-operative antibacterial prophylaxis in standard urological interventions are listed in table 6.

This short booklet is based on the more comprehensive EAU guidelines (ISBN 978-90-79754-70-0), available to all members of the European Association of Urology at their website, <http://www.uroweb.org>.