

# SUMMARY OF 2025 IDSA COMPLICATED URINARY TRACT INFECTION (CUTI) GUIDELINES

This guideline updates classifications of uncomplicated and complicated UTI based on the presence or absence of localized or systemic symptoms, particularly fever, that would suggest the infection has progressed beyond the bladder.

## THE FOUR STEP APPROACH TO SELECTING ANTIBIOTICS

### Assess Infection Severity

**1** Is the patient septic or not? Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. These patients can be identified using screening tools such as qSOFA or SIRS.

### Consider Resistance Risks

**2** If the patient has had a resistant urinary pathogen in the last 3-6 months, avoid using those same antibiotics. Avoid fluoroquinolones if the patient has been received fluoroquinolones in the past 12 months.

### Consider Other Patient Factors

**3** Consider drug allergies, contraindications, or drug-drug interactions.

### Consider Antibigram

**4** For septic patients, select an antibiotic with at least 90% susceptibility if they have shock, and at least 80% susceptibility if they do not have shock.

For nonseptic patients, IDSA does not routinely recommend using antibiogram. Routine use of broader-spectrum agents in suspected complicated UTI without sepsis may drive antimicrobial resistance without substantial patient benefit.

## NEW CLASSIFICATIONS

UNCOMPLICATED	COMPLICATED	NO UTI
Infection confined to the bladder in afebrile men or women	Infection beyond the bladder in women or men. For example: pyelonephritis, febrile or bacteremic UTI, catheter-associated UTI, prostatitis (not covered in the guidelines).	Patients with asymptomatic bacteriuria should NOT be treated unless pregnant or undergoing invasive urologic procedures.

## TREATMENT OPTIONS

SEVERITY	PREFERRED	ALTERNATIVE
Sepsis with or without shock**	third or fourth generation cephalosporins (e.g., ceftriaxone, cefepime), fluoroquinolones (ciprofloxacin or levofloxacin), or piperacillin-tazobactam.  Carbapenems may be used if Extended-Spectrum Beta-Lactamase (ESBL) resistance is suspected.	ceftolozane-tazobactam, ceftazidime-avibactam, or cefiderocol, or aminoglycosides
Without sepsis, IV route of therapy	third or fourth generation cephalosporins (e.g., ceftriaxone, cefepime), fluoroquinolones (ciprofloxacin or levofloxacin), or piperacillin-tazobactam.	carbapenems, ceftolozane-tazobactam, ceftazidime-avibactam, cefiderocol, or aminoglycosides
Without sepsis, oral route of therapy	ciprofloxacin, levofloxacin, or trimethoprim-sulfamethoxazole	amoxicillin-clavulanate or oral cephalosporins (cefuroxime, cephalexin, cefpodoxime)

Difficult-to-treat resistant pathogens may require use of drugs not listed here.

Reserve fluoroquinolones if possible.

## TREAT FOR

**5 TO 7 DAYS**

- If patients are improving clinically
- 5-7 days of a fluoroquinolone
  - 7 days of a non-fluoroquinolone
  - 7 days is effective even in patients with associated Gram-negative bacteremia.

## TRANSITION TO

**PO**

Patients with complicated UTI (including acute pyelonephritis or associated Gram-negative bacteremia) may transition to PO when:

- clinically improving
- tolerating PO medication
- an effective PO antibiotic is available

## SOURCES:

1. Infectious Diseases Society of America. Complicated Urinary Tract Infections (cUTI): Clinical Guidelines for Treatment and Management. July 17, 2025. Accessed July 21, 2025.

2. Gupta K, Hooton TM, Naber KG, et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: A 2010 update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases. Clin Infect Dis. 2011;52(5):e103-e120. doi:10.1093/cid/ciq257.

