



IV Jornada Malalties Infeccioses a l'AP

Actualització en infecció urinària

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Metgesses referents PROA Lleida (Grup P-ILEHRDA)



Barcelona, 4 de novembre de 2025



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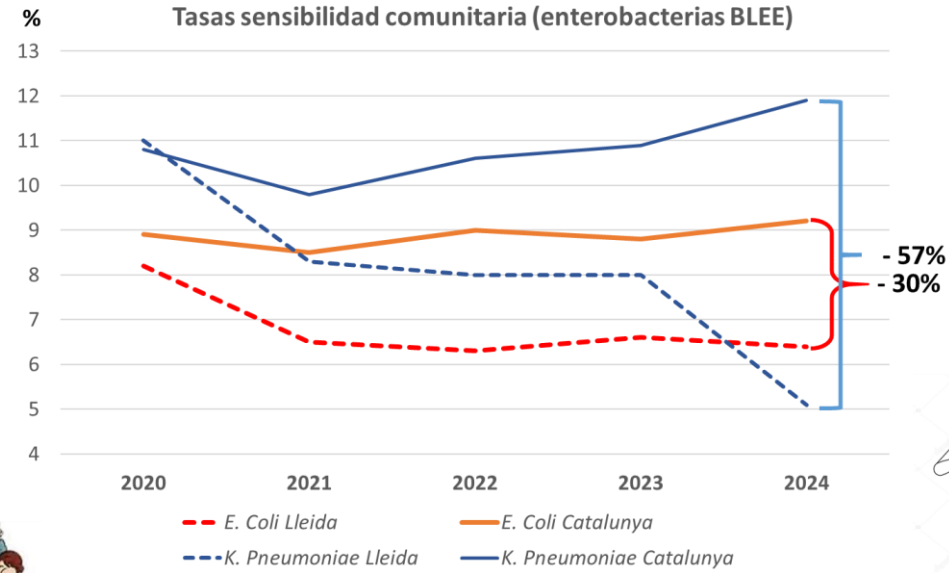


Figure 3. *E. coli*

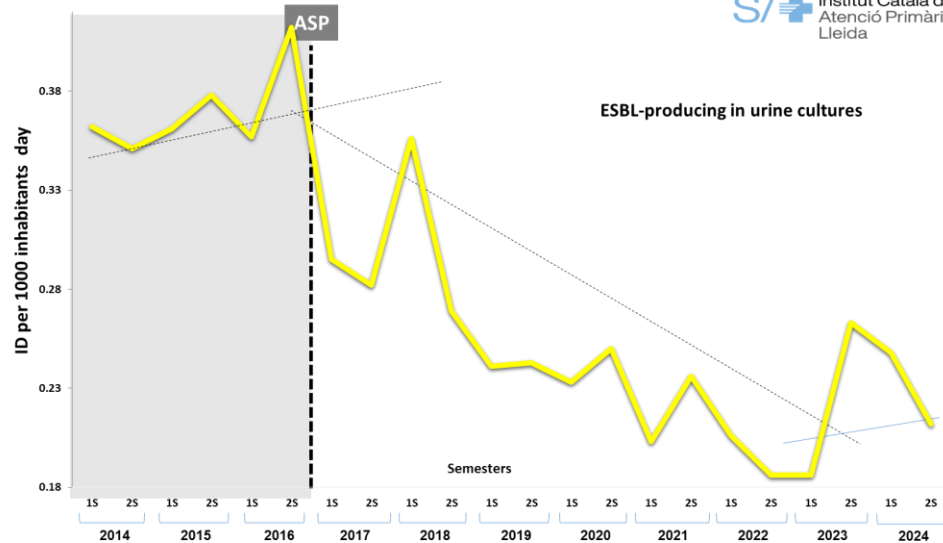
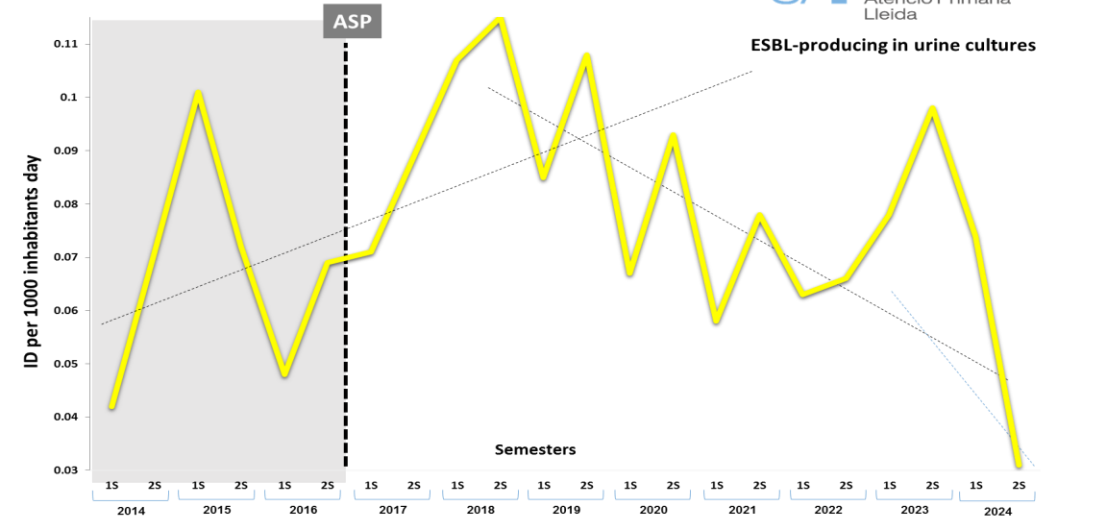


Figure 3. *K. pneumoniae*



Sensibilitat microbiològica

Bacteriúria asimptomàtica

Cistitis no complicada

Cistitis recurrent

Cistitis en l'embaràs

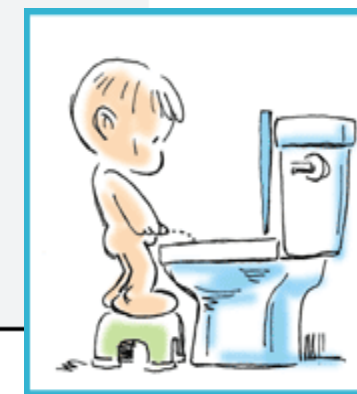
Prevenió

Punts clau

Etiología y sensibilidad de los uropatógenos identificados en infecciones urinarias bajas no complicadas de la mujer (Estudio ARESC): implicaciones en la terapia empírica

Etiología de la cistitis en función de la edad en el Estudio ARESC^a

Especies	Número total de mujeres (%)
<i>Escherichia coli</i>	515 (79,23%)
<i>Proteus mirabilis</i>	28 (4,31%)
<i>Klebsiella pneumoniae</i>	15 (2,3%)
Otras <i>Enterobacteriaceae</i> ^b	16 (2,46%)
<i>Staphylococcus saprophyticus</i>	29 (4,46%)
<i>Enterococcus faecalis</i>	21 (3,23%)
<i>Streptococcus agalactiae</i>	12 (1,84%)
Otros grampositivos ^c	14 (2,15%)
Total de muestras	650 (100%)



Palau J. Med Clin (Barc) 2011, 136: 1-7

Atribut antibiòtic	Total Catalunya		Lleida	
	N soques totals	% del atribut	N soques totals	% del atribut
<i>E. coli</i>				
% S a carbapenems	79.232	99,92%	2.500	100,00%
% S a cefalosporines 3a generació	81.003	90,20%	2.500	93,00%
% S a cefuroxima	78.018	87,20%	2.500	91,52%
% S a cotrimoxazol	76.442	76,63%	2.500	76,40%
% S a fosfomicina	77.334	96,15%	2.500	97,60%
% S a nitrofurantoïna	77.416	99,26%	2.500	99,64%
% S a quinolones	81.823	78,09%	2.500	84,44%
% casos BLEE	77.597	9,18%	2.500	6,36%



Tabla 1. Sensibilidad antimicrobiana de los BGN aislados en URINOCULTIVOS de Atención Primaria 2024

	Nº	AMC %S	AMP ¹ %S	CTX %S	CXM %S	CIP %S	FOS %S	NIT %S	%S
<i>E. coli</i> , total adultos	2500	87	51	94	92	86	98	99.5	77.5
<i>E. coli</i> , total niños	89	87	58	95	95	92	100	100	82
<i>K. pneumoniae</i> , total adultos	627	92	0	96	94	94	69	93	91.5

AMC: amoxicilina-clavulánico; AMP: Ampicilina; CFM: Cefixima; CTX: Cefotaxima; CXM: Cefuroxima; CIP: ciprofloxacino; FOS: Fosfomicina; NIT: nitrofurantoína; TMX: Trimetoprim/sulfametoxazol

¹Sensibilidad a ampicilina = sensibilidad a amoxicilina

NO utilizar antibióticos empíricamente
si prevalencia de R local >20 %



Sensibilitat microbiològica

Bacteriúria asimptomàtica

Cistitis no complicada

Cistitis recurrent

Cistitis en l'embaràs

Prevenió

Punts clau

Presència de bacteris amb $\geq 10^5$ UFC/mL en dos urocultius consecutius, separats 2 setmanes en dones asimptomàtiques ó en un únic en homes

Dones o homes asimptomàtics amb $\geq 10^2$ UFC/mL en un urocultiu després sondatge
Dones o homes asimptomàtics amb sondatge permanent amb $\geq 10^5$ UFC/mL en un sol

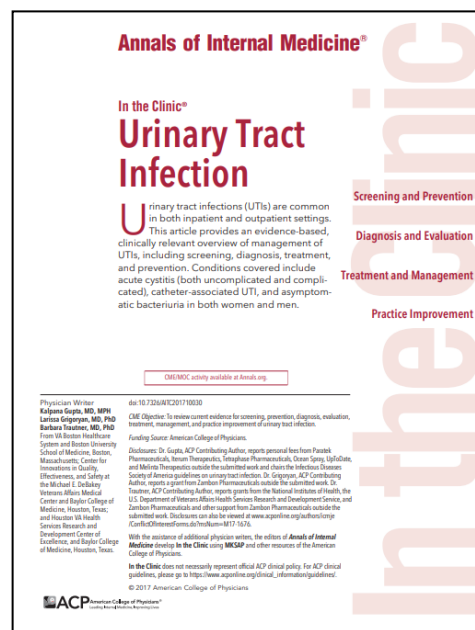
Colgan R et al. Asymptomatic bacteriuria. Am Fam Physician 2020; 102. 99-104

**NO RECOMANAT SCREENING NI TRACTAMENT
ATB**



*“Prevalence of bacteriuria in elderly institutionalized patients without indwelling catheters varies from **25–50% for women and 15–49% for men, and increases with age**”.*

<https://doi.org/10.7326/AITC201710030>



Revisiting diagnostics: discarding the urine dipstick is way overdue

Clin Microbiol Infect. 2025:S1198-743X(25)00211-3.



Article

Antimicrobial Agent Use for Urinary Tract Infection in Long-Term Care Facilities in Spain: Results from a Retrospective Analytical Cohort Analysis

La prevalença de l'ús de tires reactives (83%) i de l'urocultiu només el 16% va portar a un **possible sobrediagnòstic i sobretractament amb antibiòtics**.

Antibiotics 2024, 13, 152. <https://doi.org/10.3390/antibiotics13020152>



El cribado mediante tiras reactivas es solo una prueba orientativa (valor predictivo negativo)

Es desaconsella l'ús de tires reactives amb més de 65 anys o amb catèter vesical permanent



Clinical Infectious Diseases

MAJOR ARTICLE

Current pyuria cut-offs promote inappropriate UTI diagnosis in older women

At a cut-off of 264 leukocytes/ μ l, **sensitivity and specificity** of microscopy were **88%** (positive and negative likelihood ratio 7.2 and 0.1, respectively).

The commonly used cut-off of 10 leukocytes/ μ l had a **poor specificity** (36%) and a **sensitivity of 100%**

Conclusion: The degree of pyuria can help to distinguish UTI in older women from ASB and asymptomatic controls with pyuria. **Current pyuria cut-offs are too low and promote inappropriate UTI diagnosis in older women.**

Clin Infect Dis. 2023;76:2070-6.





Sensibilitat microbiològica

Bacteriúria asimptomàtica

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Indicacions de cribratge de bacteriúria asimptomàtica



Embarassades en 1^{er} trimestre



Pacients que seran sotmesos a procediments urològics invasius o endoscòpics.



Trasplantats renals durant el primer mes postrasplantament

NO TRACTAR la bacteriúria asimptomàtica

El tractament **NO** elimina la bacteriúria,

NO redueix els episodis febrils i **selecciona multiresistents**



Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update (IDSA). Clin Infect Dis. 2019;68:e83-e110.
Executive summary of the diagnosis and treatment of urinary tract infection: Guidelines SEIMC. Enferm Infecc Microbiol Clin. 2017;35: 314-20.

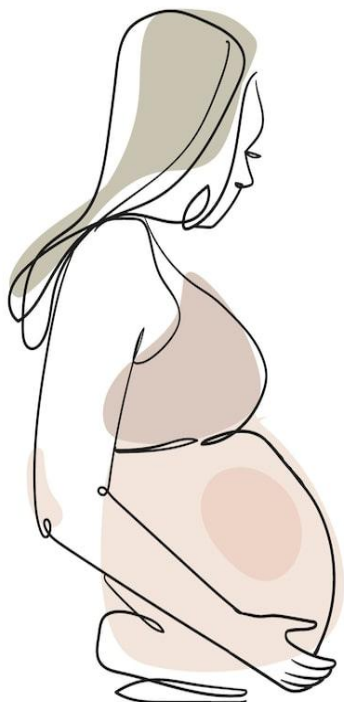
“El meu pacient té un urinocultiu positiu i...?”

Abans de tractar, tingueu en compte:

- 1 • La bacteriúria **NO** és una malaltia
- 2 • La bacteriúria o la piúria **NO** estableix el diagnòstic d'infecció
- 3 • Bacteriúria **SOLA, RARAMENT** és indicació d'antibiòtic
- 4 • El resultat de l'urinocultiu té **FALSOS POSITIUS**
- 5 • Els urinocultius **NO** s'han de fer de manera **RUTINÀRIA**

Bacteriúria asimptomàtica/cistitis en dones embarassades

Risc de pielonefritis, naixement baix pes i part prematur



**Tractament dirigit per antibiograma
prioritzant**

ELECCIÓ

Fosfomicina trometamol 3g DU

ALTERNATIVA

Nitrofurantoïna 100mg/vo/8h x 5 dies
(evitar en les 2 darreres setmanes de gestació)



Urinocultiu de control postractament



Cribatge de bacteriúria recurrent cada mes fins al part

Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update (IDSA). Clin Infect Dis. 2019;68:e83-e110.

Definició i epidemiologia

Diagnòstic

Tractament



Síndrome miccional (disúria, urgència miccional al llarg del dia, polaquiúria, dolor suprapúbic), amb **absència de secreció vaginal** sospitosa (ITS, vaginitis, cervicitis o uretritis) => **Índex predicció >90%**

Table 3. Diagnostic Testing Performance for Urinary Tract Infections^a

Test results	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)
Dipstick				
Positive leukocyte esterase	72-97	41-86	43-56	82-91
Positive nitrite	19-48	92-100	50-83	70-88
Positive leukocyte esterase or nitrite	46-100	42-98	52-68	78-98

En dones premenopàusiques amb cistitis no complicada **NO FER uronocultius** i **no sempre** cal realitzar tira reactiva per confirmar el diagnòstic.



Sensibilitat microbiològica

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Punts clau

Guidelines for the Prevention, Diagnosis, and Management of Urinary Tract Infections in Pediatrics and Adults. A WikiGuidelines Group Consensus Statement. Jama Open Network 2024

Criteris de selecció de l'antibiòtic empíric

- Espectre d'acció reduït i susceptibilitat a *Escherichia coli*
- Eficàcia clínica demostrada en cistitis no complicada
- Bona tolerabilitat i biodisponibilitat
- Mínim impacte ecològic i cost

ELECCIÓ

Fosfomicina trometamol 3g DU

ALTERNATIVA

Nitrofurantoïna 100mg/vo/8h x 5 dies



Hadidi MF. Antibiotics efficacy in clinical and microbiological cure of uncomplicated urinary tract infection: a systematic review and network meta-analysis. World J Urol. 2024;42(1):221.



NO utilitzar A-C per elevada resistència, pobra erradicació i baixa penetració en uroteli.



NO utilitzar FQ per elevada resistència, toxicitat i selecció resistències.

A-C: Amoxicil·lina-clavulànic
FQ: Fluoroquinolones

A global perspective on improving patient care in uncomplicated urinary tract infection: expert consensus and practical guidance

Results: Symptoms remain the cornerstone of uUTI diagnosis, and urine culture is necessary only when empirical treatment fails or rapid recurrence of symptoms or AMR is suspected. Specific antimicrobials are first-line therapy (typically nitrofurantoin, fosfomicin,

ASPECTE FONAMENTAL



NO fer urocultiu postractament en dones asimptomàtiques
L'urinocultiu de control no té impacte sobre el pronòstic



FOSFOMICINA

1. Administració durant l'embaràs i lactància



Es pot utilitzar durant l'embaràs



Es pot utilitzar durant l'alletament

2. Recomanacions d'administració



Estómac buit



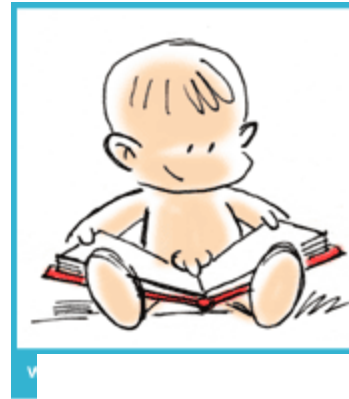
Bufeta buida



Abans d'anar a dormir



Beure molta aigua



NITROFURANTOÏNA

1. Administració durant l'embaràs i lactància



Evitar el seu ús en les dues últimes setmanes d'embaràs



Es pot utilitzar durant l'alletament

2. Recomanacions d'administració



Administrar amb els àpats

3. Altres



RESTRICCIONS D'ÚS



Només cistitis aguda a la dona



Tractaments de menys de 7 dies



Contraindicada amb FG < 45 mL/min

Cistitis en homes



Sensibilitat microbiològica

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Box 1 Patient characteristics qualifying UTI as complicated

Pregnancy

Recurrent

Male gender

Immunosuppression

Immunosuppressive agents, acquired immune deficiency syndrome (AIDS), others

Functional genitourinary abnormality

Indwelling urinary catheter, neurogenic bladder, others

Structural genitourinary abnormality

Renal stones, fistula from intestinal tract to bladder, polycystic kidney disease, renal transplant, other

Pathogens causing urinary tract infection in men
E. coli is also the most frequently identified pathogen in men (38%), followed by enterococci (16%), *Proteus mirabilis* (9%), and *Klebsiella pneumoniae* (8%)

Considerar la **possibilitat d'uretritis** en homes sexualment actius o **prostatitis** si es presenten símptomes de cistitis recurrents amb de dolor pèlvic.



Tractament dirigit per antibiograma prioritant

ELECCIÓ

Fosfomicina trometamol 3g 1º i 3º dia (dues dosis)*

ALTERNATIVA

Cotrimoxazol 160/800mg/vo/12h x 7 dies

*No experience with the use of this regimen in males with simple cystitis.



Urinocultiu de control postractament

Acute simple cystitis in men. Uptodate

https://www.uptodate.com/contents/acute-simple-cystitis-in-men?search=urinary%20tract%20infection%20men&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Schmiemann G et al. Diagnosis, Treatment, and Prevention of Recurrent Urinary Tract Infection. Dtsch Arztebl Int 2024; 121: 373–82

Sensibilitat microbiològica

Bacteriúria asintomàtica

Cistitis no complicada

Cistitis complicada

Cistitis recurrent

Prevenició

Punts clau



Infecció urinària recurrent (ITUr) es defineix únicament sobre patró temporal de reaparició de la malaltia, **cap canvi en els criteris diagnòstics**.

≥ 3 infeccions en un sol any, o dues en els darrers sis mesos

Prevalença anual de l'11% entre les dones majors de 16 anys.

Recidiva: Recurrència infecció pel **mateix microorganisme** abans de les 2 setmanes de finalitzar el tractament.

Reinfecció: Infecció que apareix després de 2 setmanes de finalitzar el tractament. **S'ha de considerar com a nou episodi**

Novel technologies for the diagnosis of urinary tract infections

TABLE 1 Summary of novel UTI diagnostic technologies

Method	Detection principle	Pros	Cons
Bacteriuria screen assays	Detects surrogate markers of infection; non-specific bacterial detection through light scattering technology	• High negative predictive value for positive urine culture	• Low positive predictive value of infection
Rapid molecular identification	Targets pathogen DNA/RNA; multiplex PCR options	• Can be used to enhance direct-from-urine MALDI-TOF identification • Rapid results • Antimicrobial resistance gene targets are included in most assays • Better able to detect fastidious organisms	• Does not reveal pathogen ID • Panels may have limited targets • Variable LOD between assays • Will not differentiate between pathogen and urinary microbiota
Next-generation sequencing	Detects all bacteria present via sequencing	• Most beneficial for patients of complicated or recurrent UTI • Can detect non-culturable microorganisms	• High likelihood of false-positive results • Not ideal for patients with uncomplicated UTI
Rapid phenotypic susceptibility tests	Measures growth in the presence of antibiotics	• Antimicrobial resistance gene targets are included in most assays • Rapid evaluation of antimicrobial susceptibility patterns • Innovation in methodology: single-cell imaging, light scattering, detection of enzymatic activity	• Majority are offered only by reference laboratory models • Does not reveal pathogen ID; current CAP accreditation standards require AST to be linked to a specific organism • Variability in scope of susceptibility targets between assays

No hi ha cap enfocament estàndard per a proves diagnòstiques addicionals en dones o homes amb infeccions recurrents del tracte urinari.

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Sensibilitat microbiològica

Bacteriúria asimptomàtica

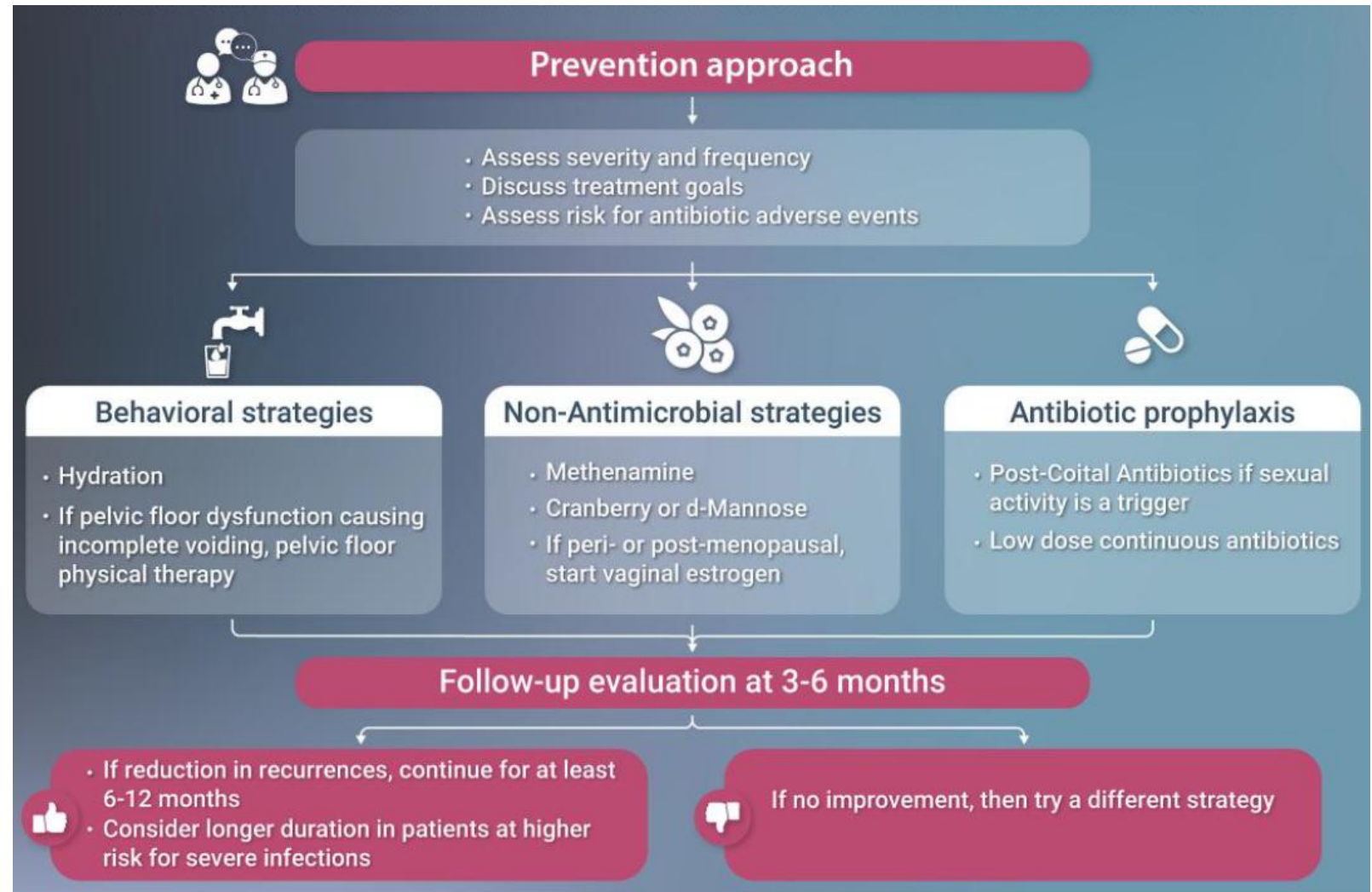
Cistitis no complicada

Cistitis complicada

Cistitis recurrent

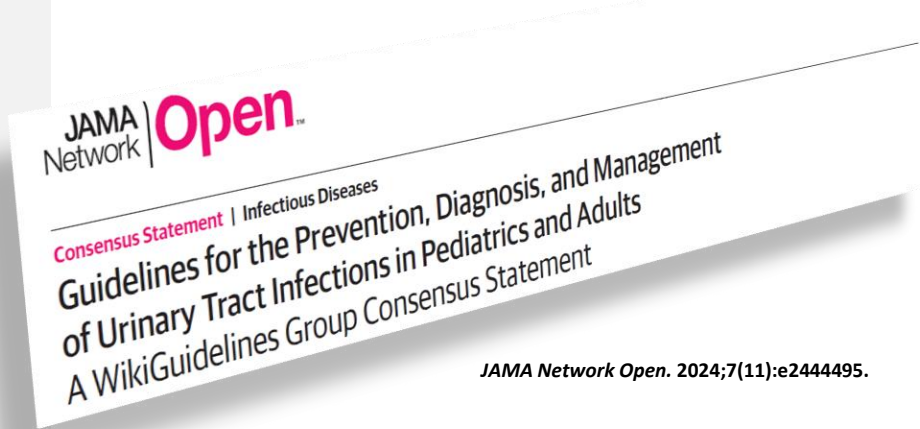
Prevenció

Punts clau



Advani SD. State-of-the-Art Review: Recurrent Uncomplicated Urinary Tract Infections in Women. Clin Infect Dis 2025;80(3):e31–42

Estratègies de comportament



JAMA Network Open. 2024;7(11):e2444495.

Increased water intake

Clinical review

Additional 1.5L of water



Open access BMJ Quality Improvement report

BMJ Open Quality **Reducing urinary tract infections in care homes by improving hydration**

Katie Lean,¹ Rasanat Fatima Nawaz,^{1,2} Sundus Jawad,³ Charles Vincent²

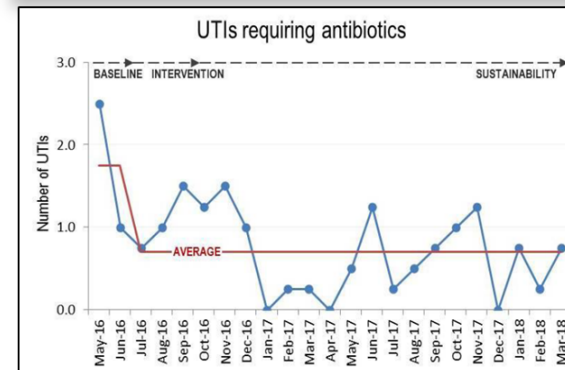


Figure 2 Average monthly numbers of urinary tract infections (UTIs) requiring antibiotics during the baseline, intervention and sustainability phase.

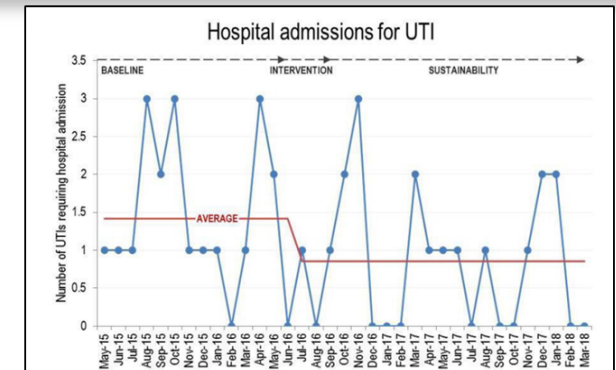


Figure 3 Average number of hospital admissions for urinary tract infections (UTIs) during the baseline, intervention and sustainability phase.

Siete rondas de bebidas estructuradas todos los días acompañado de formación del personal y sensibilización.

La **necesidad de antibiòtics se redujo en un 58%** y las infecciones urinarias que requirieron las **admisiones hospitalarias se redujeron en un 36%**.

Lean K, et al. BMJ Open Quality 2019;8:e000563. doi:10.1136/bmjoq-2018-000563

És raonable oferir aquesta intervenció a dones sanes amb ITU recurrents.
Evitar l'ús d'espermicides, netejar-se de davant cap enrere al bany.

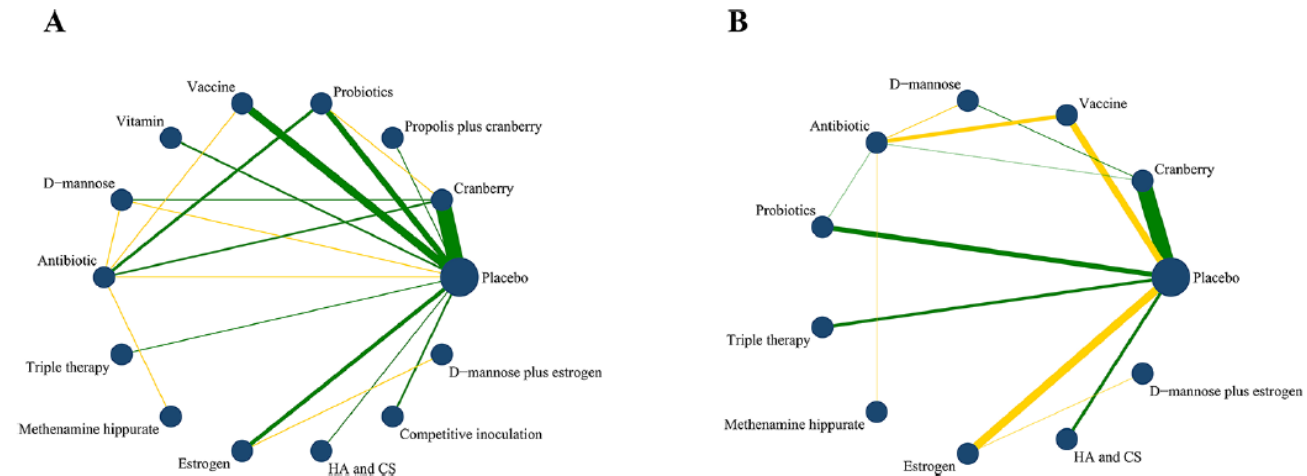
RESEARCH



Nonantibiotic prophylaxis for urinary tract infections: a network meta-analysis of randomized controlled trials

Zeyu Han¹ · Xianyanling Yi¹ · Jin Li¹ · Dazhou Liao¹ · Jianzhong Ai¹

Estratègies no antimicrobianes



50 RCTs comprising 10,495 subjects and investigating 14 interventions, were included.

Conclusions: D-mannose, triple therapy, vaccine, probiotics, and cranberry serve as potential nonantibiotic intervention options for clinical UTI prevention.

Strategy	Level of evidence	Intervention	Comments
 Cranberry products	Clear recommendation	Cranberry products containing proanthocyanidin levels of 36 mg	Cranberry products can reduce the recurrent UTIs in women, children, and individuals susceptible to UTIs. Data for older people, those with bladder emptying problems, or pregnant women is insufficient.
 Vaginal estrogen	Clear recommendation	Vaginal estrogen, such as vaginal rings, vaginal insert or vaginal cream	There is a wide variety of formulations and local delivery methods. Availability may vary in different countries or geographic regions.
0.1 mg/g cream every night × 2 wk, then 2× weekly 4 or 10 µg suppository every night × 2 wk, then 2× weekly 2 mg/g ring (standard dose: 7.5 µg/24 h); change ring every 3 mo (off-label approach) RESEARCH Open Access  Effectiveness of methenamine hippurate in preventing urinary tract infections: an updated systematic review, meta-analysis and trial sequential analysis of randomized controlled trials Hobaica <i>et al. BMC Urology</i> (2025) 25:30 https://doi.org/10.1186/s12894-025-01708-8			
 Methenamine hippurate	Clear recommendation	Methenamine hippurate: 1 g twice daily; methenamine mandelate: 1 g every 6 hours	Methenamine is an appealing antimicrobial-sparing intervention to reduce UTIs in patients without incontinence and a fully functional bladder.

PLOS PATHOGENS

PEARLS

It's uncomplicated: Prevention of urinary tract infections in an era of increasing antibiotic resistance

L'evidència clínica sòlida continua essent limitada, en particular els assajos rigorosos a gran escala (D-manosa versus placebo).

PLOS Pathogens 2024 <https://doi.org/10.1371/journal.ppat.1011930>

Table 1. Prevention and treatment strategies for uncomplicated UTIs.

Treatment/approach	How does it work?
PREVENTION	
D-mannose	Prevents the adhesion of <i>E. coli</i> , the most common UTI-causing bacteria, to the urothelium
Mannosides	Chemically modified versions of mannose that have high affinity for the FimH protein on <i>E. coli</i> fimbriae, blocking adhesion to the urothelium

Mannose is still a “can be offered”
German guideline and the Scottish guideline

Open Access Review Article

Intravesical Therapies for Recurrent Urinary Tract Infections: A Systematic Review

Cureus
Part of **SPRINGER NATURE**

Cureus 2024; 16(10): e72175. DOI
10.7759/cureus.72175

Les teràpies intravesicals, **han demostrat reduir significativament les taxes de recurrència** (pacients amb multirresistents); tanmateix, **calen més estudis** abans de poder extreure una conclusió definitiva.



Review – Infections

Bacterial Vaccines for the Management of Recurrent Urinary Tract Infections: A Systematic Review and Meta-analysis

EUROPEAN UROLOGY FOCUS 10 (2024) 761–9

Conclusions i implicacions clíniques: Hi ha proves limitades que suggereixin que les vacunes siguin efectives per reduir la recurrència ITU en dones adultes a curt termini.



Life 2024, 14, 111.

<https://doi.org/10.3390/life14010111>



Article

Autovaccine-Based Immunotherapy: A Promising Approach for Male Recurrent Urinary Tract Infections

Conclusió: El tractament amb autovacunes va reduir significativament el nombre d'episodis d'infecció urinària, amb un efecte acumulatiu sostingut.

Iftimie et al. BMC Infectious Diseases (2025) 25:117
<https://doi.org/10.1186/s12879-025-10524-2>

BMC Infectious Diseases

RESEARCH

Open Access

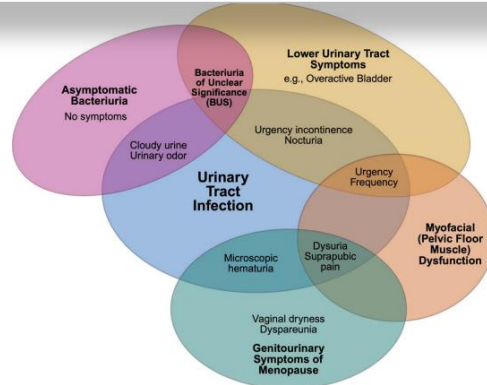
Evaluating the use of Uromune® autovaccine in recurrent urinary tract infections: a pilot unicenter retrospective study in Reus, Spain



Conclusió: L'autovacuna Uromune® es va associar amb una reducció significativa en la freqüència d'infeccions urinàries recurrents.



Efficacy of Probiotics as Prophylaxis for Urinary Tract Infections in Premenopausal Women: A Systematic Review and Meta-Analysis



Menopause: The Journal of The North American Menopause Society
Vol. 29, No. 7, pp. 767-794
DOI: 10.1097/GME.0000000000002028
© 2022 by The North American Menopause Society

NAMS POSITION STATEMENT

The 2022 hormone therapy position statement of The North American Menopause Society



Les **teràpies sense estrògens** aprovades per la **FDA** que milloren l'AVV en dones postmenopàusiques inclouen l'**ospemifè** i la **DHEA intravaginal**. (Nivell I)

Conclusions: Els probiòtics **NO van demostrar un benefici** significatiu en la reducció de la recurrència d'infeccions urinàries en comparació amb el placebo en dones premenopàusiques.

2021 Abdullatif et al. Cureus 13(10): e18843. DOI 10.7759/cureus.18843

Review

Review of current and emerging estrogen receptor agonists for vaginal atrophy

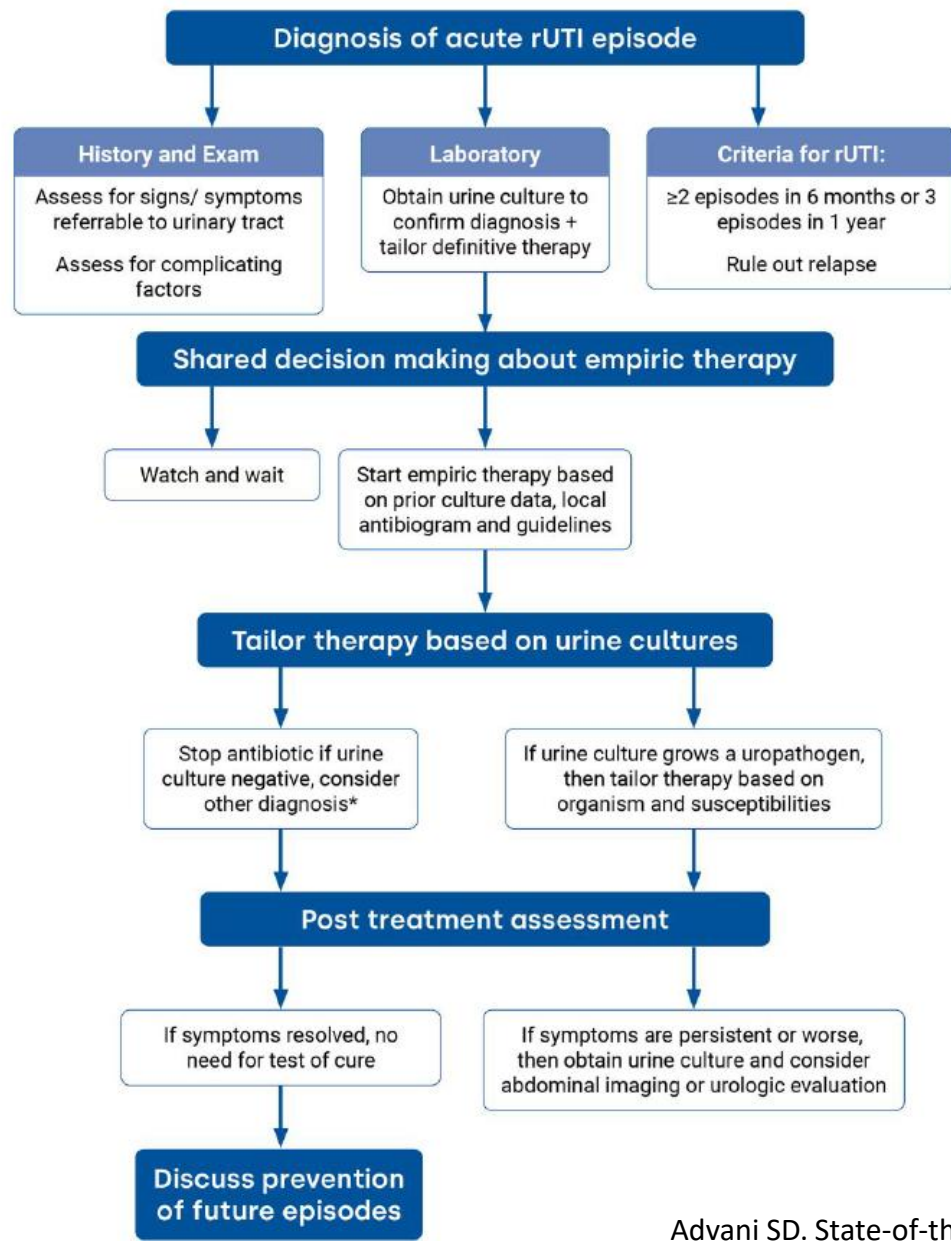
Gilbert G. G. Donders, Karolina Akinosoglou, Zoë Massie & And Sabriye Özçelik

Pages 249-255 | Received 16 Oct 2024, Accepted 06 Jan 2025, Accepted author version posted online: 07 Jan 2025, Published online: 08 Jan 2025



"Alternatives as ospemifene show promise **but need more long-term safety data**".

La Societat Nord-americana de Menopausa recomana l'**ospemifè** per a l'AVV de moderada a greu quan la **teràpia local amb estrògens és ineficaç** o inadequada



Profilaxi antibiòtica



Abans d'iniciar la profilaxi antibiòtica:

Efectes adversos associats a la profilaxi antibiòtica:

- Reaccions adverses
- Selecció de resistències
- Alteració del microbioma intestinal
- Infecció secundària per *Clostridioides*

**POSTCOITAL
(DU)**

**Fosfomicina trometamol 3g/semana ó
cotrimoxazol 80/400mg***

**Profilaxi
contínua**

**Fosfomicina trometamol 3g cada 10 dies
Cotrimoxazol 40/200 mg 3 dies/setmana* x 6 mesos**

*Si sensibilitat > 80% al àrea

Advani SD. State-of-the-Art Review: Recurrent Uncomplicated Urinary Tract Infections in Women. Clin Infect Dis 2025;80(3):e31–42



“NO tractem resultats,
tractem entitats”

Els diagnòstics d'ITU són
majoritàriament clínics.
“Evitem la tira”

“Fosfomicina és la nostra amiga”
*Evitem utilitzar Quinolones,
Cefalosporines de 3^aG i
Amox-clav*



“Res de screenings”
Recordem fer urinocultius
a ITU complicada

**El millor ATB és el que no cal
prescriure
“Menys és més”**

P-ILEHRDA

ALL YOU NEED IS PROA



PROA Lleida

Índice

Pielonefritis Aguda
Bacteriana

Prostatitis
Bacteriana Aguda

Prostatitis
Bacteriana Crónica

Puntos Clave

Infección de pelvis y parenquima renal

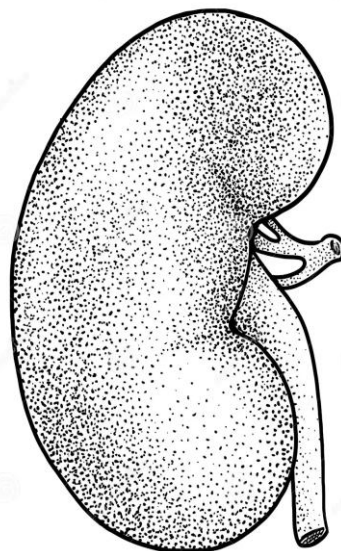
Síndrome miccional asociado a fiebre y/o dolor en fosa renal

Pielonefritis Aguda Bacteriana

Prostatitis Bacteriana
Aguda

Prostatitis Bacteriana
Crónica

Puntos Clave



Factores de Riesgo

Alteraciones anatómicas o funcionales de las vías
urinarias
Diabetes
Inmunosupresión
Insuficiencia renal
Gestación
Manipulación urológica
Sonda uretral
Tratamiento antibiótico previo (2 semanas)

Causa más frecuente de bacteriemia y shock séptico en el anciano

Pielonefritis Aguda
Bacteriana

Prostatitis B
Aguda

Prostatitis Ba
Crònica

Puntos Clave

Etiología

E. Coli (70-80 %)

Proteus mirabilis (litiasis coraliforme)
Klebsiella spp y otros Gram negativos

(semanas)

Causa más... y shock séptico en el anciano

Tabla 1. Sensibilidad antimicrobiana de los BGN aislados en URINOCULTIVOS de Atención Primaria 2024

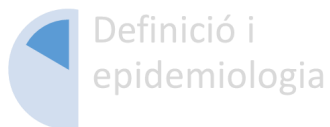
	Nº	AMC %S	AMP ¹ %S	CTX %S	CXM %S	CIP %S	FOS %S	NIT %S	TMX %S
<i>E. coli</i> , total adultos	2500	87	51	94	92	86	98	99.5	77.5
<i>E. coli</i> , total niños	89	87	58	95	95	92	100	100	82
<i>K. pneumoniae</i> , total adultos	627	92	0	96	94	94	69	93	91.5

AMC: amoxicilina-clavulánico; AMP: Ampicilina; CFM: Cefixima; CTX: Cefotaxima; CXM: Cefuroxima; CIP: ciprofloxacino; FOS: Fosfomicina; NIT: nitrofurantoína; TMX: Trimetoprim/sulfametoxazol

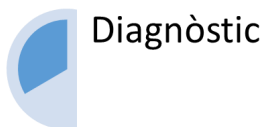
¹Sensibilidad a ampicilina = sensibilidad a amoxicilina

Tabla 2. Tipología de resistencias en BGN aislados en UROCULTIVOS de Atención Primaria 2024

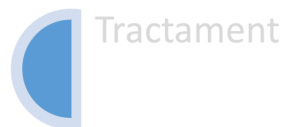
	Nº	BLEE N (%)	Carbapenemasas nº (%)		
			Clase A	Clase B	Clase D (oxa-48)
<i>E. coli</i> , adultos	2500	159 (6.3%)	0	0	0
<i>E. coli</i> , niños	89	4 (4.5%)	0	0	0
<i>K. pneumoniae</i> , adultos	627	32 (5%)	0	0	1 (0.15%)



Definició i
epidemiologia



Diagnòstic



Tractament

**Pielonefritis Aguda
Bacteriana**

Prostatitis Bacteriana
Aguda

Prostatitis Bacteriana
Crònica

Puntos Clave



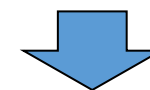
Bonkat G, et al. EAU Guidelines on Urological
Infections 2025.

A global perspective on improving patient care in uncomplicated urinary tract infection: expert consensus and practical guidance



No hay evidencia de que el urocultivo de control tenga impacto sobre el pronóstico

Síntomas Clínicos



URINOCULTIVO antes de iniciar el tratamiento



NO realizar pruebas de imagen, salvo sospecha de obstrucción del tracto urinario



NO realizar **URINOCULTIVO DE CONTROL**, excepto si los síntomas persisten más 48- 72 h de haber iniciado el tratamiento.

Pyelonephritis with or without risk factors, such as obstructive pyelonephritis, as the latter can rapidly lead to urosepsis. ***This differential diagnosis should be made by the appropriate imaging technique***



Blood Cultures for Women with Uncomplicated Acute Pyelonephritis: Are They Necessary?

Discordancia <1%

17%

25%

69%

Hemocultivos +

**Sospecha
Clínica de
Infección**

Sepsis

Sepsis Grave

**Fracaso
Multiorgánico**

Shock Séptico

Exitus Letalis

Blood culture may not be routinely required for the evaluation of uncomplicated pyelonephritis in women.



Systematic review

Short vs. long antibiotic treatment for pyelonephritis and complicated urinary tract infections: a living systematic review and meta-analysis of randomized controlled trials

Antimicrobial outpatient management of acute uncomplicated pyelonephritis ^a.

Antimicrobial	Dosing and Duration	Efficacy
<u>Fluoroquinolone:</u> Ciprofloxacin ^b Levofloxacin ^b	500 mg orally twice-daily or 1 g extended release orally once-daily × 7 days 750 mg orally once-daily × 5 days	• Clinical efficacy of ciprofloxacin 500 mg orally twice daily for 7 days: 96% • Clinical efficacy of levofloxacin 750 mg orally or intravenous once daily for 5 days: 86%; vs. ciprofloxacin 400 mg intravenous or 500 mg orally twice daily for 10 days: 81%; most subjects in both arms received
Trimethoprim-sulfamethoxazole ^b		• including • 92% clinical efficacy if <i>E. coli</i> (if not susceptible)
<u>Oral β-lactam</u> Specific agents are not listed in IDSA guidelines		• Data limited, but inferior efficacy vs. TMP-SMX and fluoroquinolones • Oral β-lactams should be used only when other recommended agents can't be used

**NO utilizar antibióticos empíricamente
si prevalencia de R local >10 %**



Enfermedades Infecciosas y Microbiología Clínica

www.elsevier.es/eimc



Original article

Are oral cefuroxime axetil, cefixime and cefditoren pivoxil adequate to treat uncomplicated acute pyelonephritis after switching from intravenous therapy? A pharmacokinetic/pharmacodynamic perspective



Table 1

Pharmacokinetic parameters for each antimicrobial agent from published studies carried out in healthy adults (mean $\pm$ standard deviation).

	Cefuroxime axetil	Cefixime	Cefditoren pivoxil
V/F (L)	50 $\pm$ 14		63.5 $\pm$ 16.63
V (L)		19.0 $\pm$ 3.0	
F		0.45 $\pm$ 0.045	
K_e (h ⁻¹)	0.54 $\pm$ 0.07	0.204 $\pm$ 0.020	0.53 $\pm$ 0.08
K_a (h ⁻¹)	0.58 ^a	0.55	0.48 $\pm$ 0.209
f_u	0.58	0.35	0.12
Reference	[14]	[11]	[10]

Conclusions: Of the three cephalosporins, cefixime 400 mg prove to be the best option in oral APN treatment, although this regimen is currently off label.

RESEARCH ARTICLE

A retrospective review of oral cephalosporins versus fluoroquinolones for the treatment of pyelonephritis

Table 4. Treatment failure by antibiotic.

CP Group–n/N (%)*			
Cephalexin	Cefuroxime	Cefpodoxime	Cefdinir
11/49 (22.4)	9/115 (7.8)	15/64 (23.4)	0/1 (0)
FQ Group–n/N (%)			
Ciprofloxacin	Levofloxacin		
16/104 (15.4)	3/5 (60)		

Conclusions

Oral CPs appear to be as safe and effective as FQs for the treatment of AUP. Fewer treatment failures were noted with 2GCs as compared to 3GCs and 1GCs.

MOLT ULL!!!!!! Cefuroxima axetilo 500mg/vo/8h

PRUEBAS DE SENSIBILIDAD

- ¿Para qué?
 - Evaluar respuesta *in vitro* de los microorganismos, para ver si son sensibles o resistentes a los antimicrobianos
- ¿Por qué?
 - Elegir el tratamiento óptimo
 - Esencial en la epidemiología de la resistencia bacteriana
- ¿Cómo?
 - Antibiograma: define la actividad *in vitro* de un antibiótico frente a un microorganismo determinado y refleja su capacidad para inhibir el crecimiento de una bacteria
 - Consisten en enfrentar un inóculo bacteriano estandarizado a una única o a diferentes concentraciones de antibiótico.



TRATAMIENTO EMPÍRICO



24h



IDENTIFICACIÓN:
¿Debo mantener o cambiar el tratamiento?

24h

TRATAMIENTO DIRIGIDO

Wells



48h

Cultivo de Orina

Urocultivo

Positivo

		<i>Escherichia coli</i>
		<i>Escherichia coli</i>
Ampicilina	>16	Resistente
Amoxicilina/Ac. clavulánico	16/8	Resistente
Piperacilina/Tazobactam	16	Intermedio
Cefazolina	<=8	Sensible
Cefuroxima	8	Sensible
Cefoxitina	<=8	Sensible
Cefotaxima	<=1	Sensible
Ceftazidima	<=1	Sensible
Cefepime	8	Resistente
Ertapenem	<=0.5	Sensible
Imipenem	<=1	Sensible
Gentamicina	<=2	Sensible
Tobramicina	<=2	Sensible
Fosfomicina	<=16	Sensible
Trimetoprim/Sulfametoxazol	>4/76	Resistente
Nitrofurantoina	<=32	Sensible
Ac. Nalidixico	>16	Resistente
Ciprofloxacino	>2	Resistente
Norfloxacina	>1	Resistente

Clasificación según la interpretación clínica

Valores de CMI, según los cuales las bacterias se pueden asignar a las categorías clínicas de:

Sensible: cepa bacteriana inhibida *in vitro* por una concentración de un agente antimicrobiano que se asocia con una alta probabilidad **de éxito terapéutico**

EI (sensibilidad exposición incrementada): cepa bacteriana que cuando se incrementa la exposición*, hay una alta probabilidad de **éxito terapéutico**

*ajuste del régimen de dosificación *por su tiempo en el lugar de la infección

Resistente: cepa bacteriana inhibida *in vitro* por una concentración de un agente antimicrobiano que se asocia con una alta probabilidad de **fracaso terapéutico**



Definició i
epidemiologia



Diagnòstic



Tractament

Pielonefritis Aguda Bacteriana

Prostatitis
Bacteriana Aguda

Prostatitis
Bacteriana Crònica

Puntos Clave

Tratamiento antibiótico EMPÍRICO

ELECCIÓN

Cefuroxima axetilo
500mgr/vo/8h/7días

Puede administrarse una 1ª dosis
de ceftriaxona 1-2g/IM-IV

ALTERNATIVO

(Alergia, intolerancia, etc)

Si peso <80kg
Amikacina (15-20mg/Kg/IV-IM, sin
sobrepasar el 1,5g/d) x 3-5 días
Si peso >80kg
Calcular los Kg según peso corporal
ajustado (PCA)

Tratamiento antibiótico DIRIGIDO (SÓLO SI RESISTENTE)

ELECCIÓN

ALTERNATIVO

(Alergia, intolerancia, etc)

Tratamiento dirigido con antibiograma:

1ª opción: Trimetropim-sulfametoxazol 160/800 mg/12 h X 8-10 días

2ª opción: Ciprofloxacino 500-750 mg/VO/12 h X 5-7 días

Pigrau C. Oral treatment of acute pyelonephritis: when, with which antimicrobial agent and for how long?. Enferm Infecc Microbiol Clin. 2020; 38(7): 303–5. <https://doi.org/10.1016/j.eimc.2019.12.017>



A Systematic Review of Single-Dose Aminoglycoside Therapy for Urinary Tract Infection: Is It Time To Resurrect an Old Strategy?

Single-dose aminoglycoside therapy appears to be an **effective** treatment option for UTI in nonseptic patients, with minimal toxicity. When resistance to first-line UTI agents is endemic, **aminoglycosides may serve as -lactam- and fluoroquinolone-sparing options.**

January 2019 Volume 63 Issue 1 e02165-18

Conclusion: Amikacin can be used once every 48 h to treat UTIs (3 doses), is less expensive and can be administered on an outpatient basis.

**Se debe calcular peso corporal ajustado (PCA), si el peso > 80 Kgr.
Monitorizar la función renal.**

RESEARCH NOTE

Open Access

Comparison of three doses of amikacin on alternate days with a daily dose of meropenem during the same period for the treatment of urinary tract infection with *E. coli*: a double-blind clinical trial



Mohsenpour et al. *BMC Research Notes* (2024) 17:38
<https://doi.org/10.1186/s13104-023-06654-y>

— P-ILEHRDA —

QUINOLONAS PAUTAR NO DEBES



—  —

PROA Lleida

> Ann Pharmacother. 2023 Mar;57(3):251-258. doi: 10.1177/10600280221106789. Epub 2022 Jun 25.

Use of Fluoroquinolones or Sulfamethoxazole-Trimethoprim Compared to B-Lactams for Oral Step-Down Therapy in Hospitalized Patients With Uncomplicated Enterobacterales Bacteremia

Tyler Mack ^{1 2}, Jon J Hiles ¹, Justin Wrin ¹, Armisha Desai

Conclusion and relevance: OBLs appear to be **non-inferior** to FQ/SXT in the rate of all-cause hospital readmission within 30 days.

Multicenter Study > Am J Health Syst Pharm. 2023 Feb 21;80(Suppl 1):S33-S41.
doi: 10.1093/ajhp/zxac202.

Oral β -lactams vs fluoroquinolones and trimethoprim/sulfamethoxazole for step-down therapy for Escherichia coli, Proteus mirabilis, and Klebsiella pneumoniae bacteremia

Michael J McAlister ¹, Dusten T Rose ², F Parker Hudson ³, Eimeira Padilla
Theresa C Jaso ⁵

Conclusion: We observed **no difference** in treatment failure rates for patients receiving an oral BL compared to an oral FQ or SXT for step-down therapy of BSIs due to E. coli, K. pneumoniae, and P. mirabilis.

Nitrofurantoina NO puede utilizarse para tratar infecciones urinarias **con fiebre** (pielonefritis o infecciones urinarias altas), debido a su escasa biodisponibilidad oral.



Definició i
epidemiologia



Diagnòstic



Tractament

**Pielonefritis Aguda
Bacteriana**

**Prostatitis
Bacteriana Aguda**

**Prostatitis
Bacteriana Crònica**

Puntos Clave

**Journal of
Antimicrobial
Chemotherapy**

J Antimicrob Chemother 2013; **68**: 2183–2191
doi:10.1093/jac/dkt177 Advance Access publication 21 May 2013

Duration of antibiotic treatment for acute pyelonephritis and septic urinary tract infection— 7 days or less versus longer treatment: systematic review and meta-analysis of randomized controlled trials

JAMA
Network | **Open**



Original Investigation | Infectious Diseases

**Seven vs Fourteen Days of Antibiotics for Gram-Negative Bloodstream Infection
A Systematic Review and Noninferiority Meta-Analysis**

CONCLUSIONS AND RELEVANCE In this systematic review and meta-analysis of patients with Gram-negative bloodstream infections and adequate source control, 7 days of antibiotic therapy had a high probability of being noninferior to 14 days. These findings support a shorter duration of antibiotic therapy for appropriately selected patients like those in the included RCTs.

JAMA Network Open. 2025;8(3):e251421. doi:10.1001/jamanetworkopen.2025.1421



Systematic review

Short vs. long antibiotic treatment for pyelonephritis and complicated urinary tract infections: a living systematic review and meta-analysis of randomized controlled trials

Clinical Microbiology and Infection 31 (2025) 1263–1271

Table 3
Summary of findings GRADE table

Certainty assessment							No. of patients		Effect		Certainty
No. of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Short	Long	Relative (95% CI)	Absolute (95% CI)	
Clinical success											
13	Randomised trials	Not serious ^a	Serious ^b	Not serious	Not serious	None	1055/1255 (84.1%)	1061/1263 (84%)	RR 1.01 (0.97–1.04)	8 more per 1000 (from 25 fewer to 34 more)	⊕⊕⊕○ Moderate ^{a,b}
Microbiological cure											
10	Randomised trials	Not serious ^a	Very serious ^{b,c,d}	Very serious ^e	Not serious	Publication bias strongly suspected ^f	673/823 (81.8%)	692/824 (84%)	RR 0.98 (0.94–1.02)	7 fewer per 1000 (from 51 fewer to 37 more)	⊕○○○ Very low ^{a,b,c,d,e,f}
Relapse/reinfection											
10	Randomised trials	Not serious ^a	Serious ^{c,d}	Not serious	Serious ^g	None	71/834 (8.5%)	57/846 (6.7%)	RR 1.19 (0.87–1.63)	13 more per 1000 (from 9 fewer to 42 more)	⊕⊕○○ Low ^{a,c,d,g}
Death											
8	Randomised trials	Not serious ^a	Not serious	Not serious	Serious ^{g,h}	None	100/1966 (5.1%)	115/2010 (5.7%)	RR 0.87 (0.68–1.13)	7 fewer per 1000 (from 18 fewer to 7 more)	⊕⊕⊕○ Moderate ^{a,g,h}
Clinical success—males											
4	Randomised trials	Not serious ^a	Serious ⁱ	Not serious	Serious ^j	None	276/355 (77.7%)	298/367 (81.2%)	RR 0.97 (0.91–1.04)	4 fewer per 1000 (from 73 fewer to 32 more)	⊕⊕○○ Low ^{a,i,j}

RR, risk ratio.

Conclusions: Treatment durations of 5-7 days for pyelonephritis or febrile cUTI were as effective as longer treatment durations.

Itay Zahavi, Clin Microbiol Infect 2025;31:1263

Infección de pelvis y parenquima prostático

Fiebre + escalofríos de inicio agudo con síntomas de ITU inferior



Disuria
Polaquiuria
Urgencia miccional
Dolor suprapúbico
Tenesmo
Hematuria
Alteraciones del flujo uretral
Vómitos



1 de cada 10 pacientes tendrá una prostatitis bacteriana y necesitará tratamiento **antibiótico**

10 % de todas las prostatitis. Edad 20-40 a (3.5%) y mayores de 70 a (5,4%)

Pielonefritis Aguda
Bacteriana

**Prostatitis
Bacteriana Aguda**

Prostatitis
Bacteriana Crónica

Puntos Clave



Síntomas Clínicos

✓ URINOCULTIVO antes de iniciar el tratamiento

✗ **No** realizar masaje prostático → Bacteriemia

✗ **No** es necesario practicar Hemocultivos

Si afectación del estado general / riesgo de sepsis



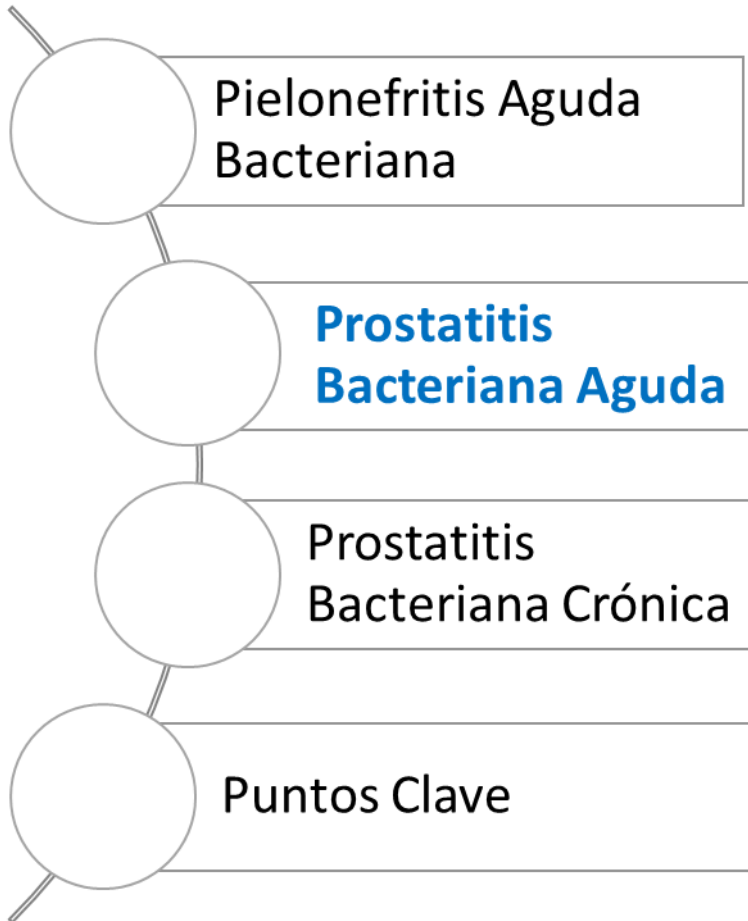
Schaeffer AJ et al. Urinary tract infections in older men. N. Engl J. Med. 2016; 374: 562-70.
Disponible en: <https://www.nejm.org/doi/full/10.1056/NEJMcp1503950>

Pielonefritis Aguda Bacteriana

Prostatitis Aguda

Prostatitis Crónica

Puntos Clave



Tratamiento antibiótico EMPÍRICO	
ELECCIÓN	ALTERNATIVO (Alergia, intolerancia, etc)
Ceftriaxona 1-2g/IM-IV/24h a la espera del resultado del urinocultivo vs Tratamiento alternativo	Fosfomicina trometamol 3g/24h a hasta resultado del urinocultivo (si sensible continuar pauta dirigida alternativa)
Tratamiento antibiótico DIRIGIDO	
ELECCIÓN	ALTERNATIVO (Alergia, intolerancia, etc)
Tratamiento dirigido con antibiograma: 1ª opción: Trimetropim-sulfametoxazol 160/800 mg/VO/12 h X 2 semanas 2ª opción: Ciprofloxacino 500-750 mg/VO/12 h X 2 semanas Si evolución inadecuada se puede incrementar a 4 semanas	Tratamiento dirigido con antibiograma: Fosfomicina trometamol 3g/48h x 3 semanas Si evolución inadecuada se puede incrementar a 6 semanas

Fosfomycin for Injection (ZTI-01) Versus Piperacillin-tazobactam for the Treatment of Complicated Urinary Tract Infection Including Acute Pyelonephritis: ZEUS, A Phase 2/3 Randomized Trial

Original Investigation | Infectious Diseases

Effectiveness of Fosfomycin for the Treatment of Multidrug-Resistant *Escherichia coli* Bacteremic Urinary Tract Infections A Randomized Clinical Trial

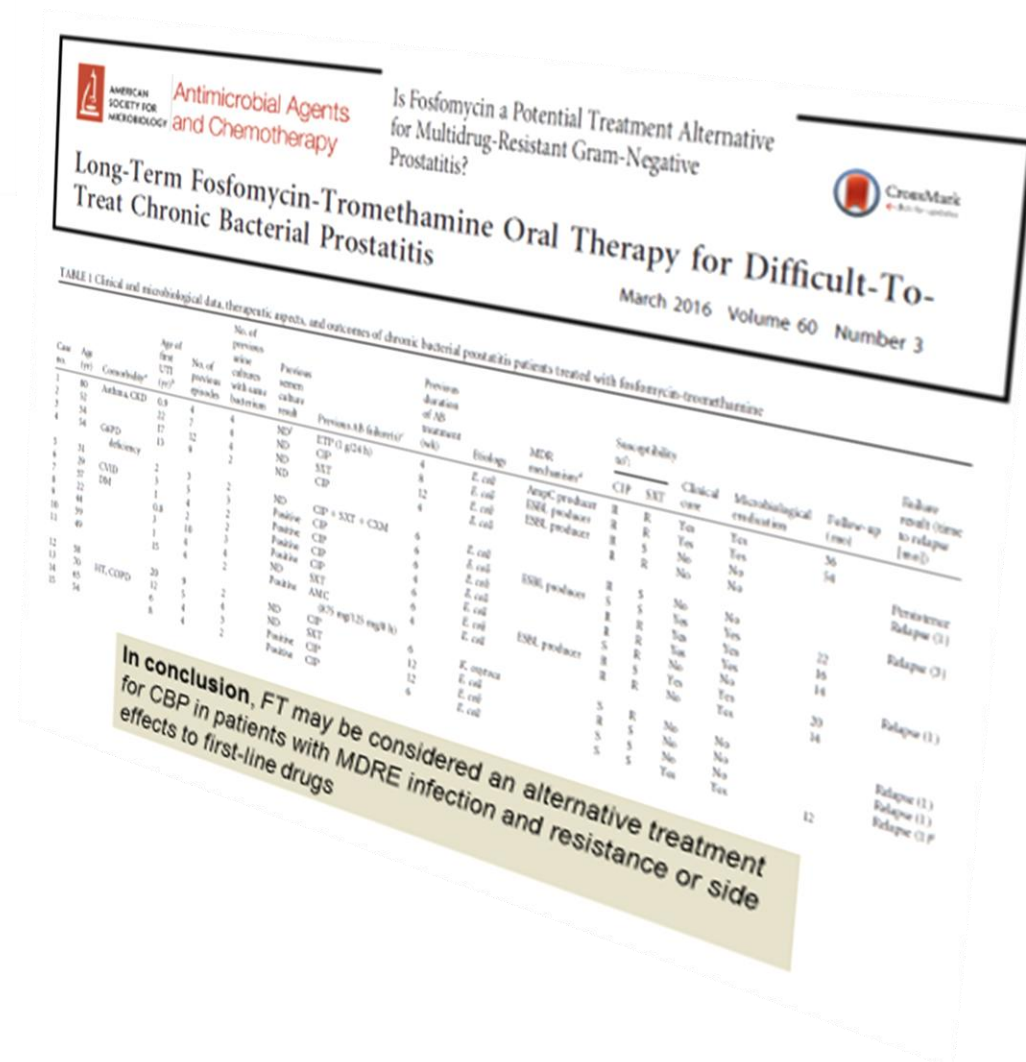
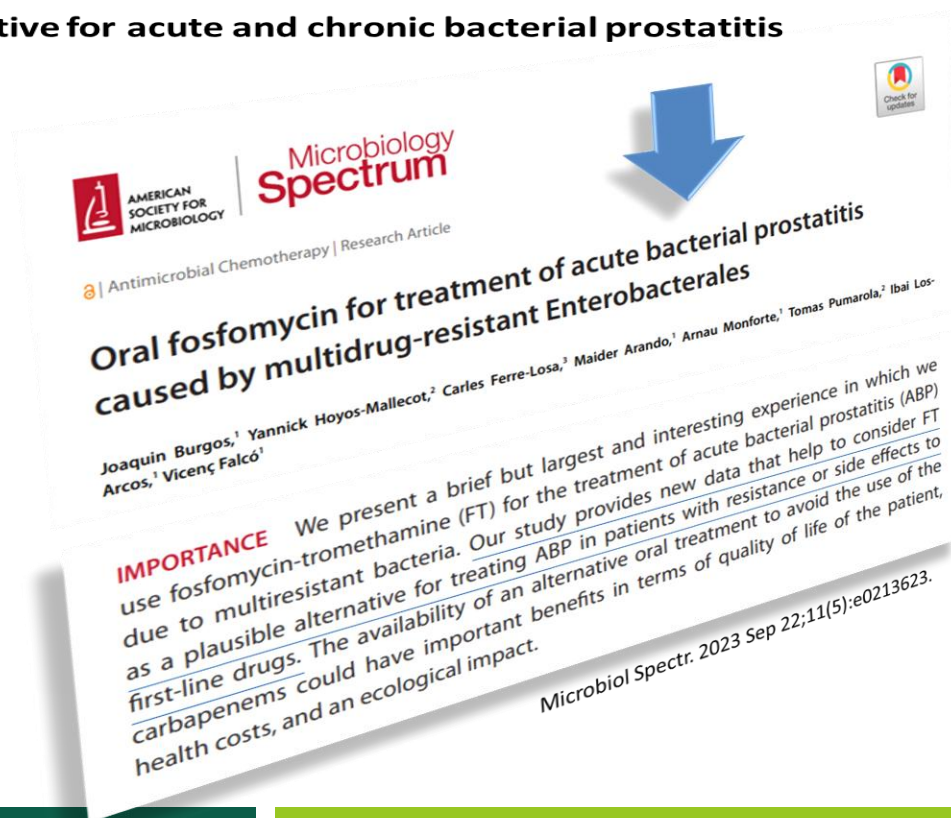
Jesús Sojo-Dorado, MD, PhD; Inmaculada López-Hernández, MD, PhD; Clara Rosso-Fernandez, MD, PhD; Isabel M. Morales, MD, PhD; Zaira R. Palacios-Baena, MD, PhD; Alicia Hernández-Torres, MD, PhD; Esperanza Merino de Lucas, MD, PhD; Laura Escolà-Vergé, MD, PhD; Elena Bereciartua, MD; Elisa García-Vázquez, MD, PhD; Vicente Pintado, MD, PhD; Lucía Boix-Palop, MD; Clara Natera-Kindelán, MD, PhD; Luisa Sorlí, MD, PhD; Nuria Borrell, MD, PhD; Livia Giner-Oncina, PharmD, PhD; Concha Amador-Prous, MD, PhD; Evelyn Shaw, MD, PhD; Alfredo Jover-Saenz, MD; Jose Molina, MD; Rosa M. Martínez-Alvarez, MD; Carlos J. Dueñas, MD; Jorge Calvo-Montes, MD; Jose T. Silva, MD, PhD; Miguel A. Cárdenes, MD; María Lecuona, MD, PhD; Virginia Pomar, MD, PhD; Lucía Valiente de Santis, MD; Genoveva Yagüe-Guirao, MD, PhD; María Angeles Lobo-Acosta, MD; Vicente Merino-Bohórquez, PharmD; Alvaro Pascual, MD, PhD; Jesús Rodríguez-Baño, MD, PhD; and the REIPI-GEIRAS-FOREST group

CONCLUSIONS AND RELEVANCE This study found that fosfomycin did not demonstrate noninferiority to comparators as targeted treatment of bUTI from MDR *E coli*; this was due to an increased rate of adverse event-related discontinuations. This finding suggests that fosfomycin may be considered for selected patients with these infections.



Alex C.F. Kwan, Nathan P. Beahm*

Fosfomycin has the potential to be considered as an effective first-line alternative for acute and chronic bacterial prostatitis



SABER "ESPERAR" ES GUANYAR



La teràpia diferida ens ha d'acompanyar.



PROA Lleida

Pharmacological aspects of the antibiotics used for urological diagnostic procedures

Table 7 Concentrations of oral penicillin and cephalosporins in prostatic tissue^{2,17,19-24}

Antibiotics	Dose (mg) and administration	Number of patients treated and sampling time (hours)	Mean serum concentrations (range) (mg/L)	Mean tissue concentrations (range) (mg/L)	C _{tiss} /C _s (%)
Ampicillin				4.0 (0.6-4.9)	45
Cefaclor				3.7 (1.0-4.3)	55
Cefadroxil				0.74 (0.24-1.94)	39
Cefpodoxime				0.68 (0.41-1.23)	37
Cefprozil				0.88 (0.09-3)	20
Cefprozil				< 5 (0.5-0)	

*Patients with infection.

Table 8 Concentrations of monobactams and parenteral cephalosporins in prostatic tissue^{2,17,25-29}

Antibiotics	Dose (mg) and administration	Number of patients treated and sampling time (hours)	Mean serum concentrations (range) (mg/L)	Mean tissue concentrations (range) (mg/L)	C _{tiss} /C _s (%)
Aztreonam	1000 i.v. single	8 (0.8-3)	31.4 (18-46.3)	8.0 (1.7-12.1)	25
Cefazolin	2000 i.v. single	14 (0.5)*	139.1 (± 39.68)	34.63±9.75	25
	1000 i.m. or i.v. single or multiple	38 (± 20)	14±14	22 (0.9)	37
Cefuroxime	1500 i.v. single	33 (1)	99.6 (40-210)	20.1 (6-35)	20
Cefotaxime	2000 i.v. single	25 (1.5)	45.2 (30-72)	22.9 (4-50)	51
	1000 i.m. multiple	7 (1-2)	19.5 (11-30)	2.8 (1-4)	15
Ceftriaxone	2000 i.v. single	5 (1.5)	106.4 (73-158)	41.4 (11.7-75.4)	39

None of the oral cephalosporins of the first (cefalexin), second (cefaclor), or third generations (cefpodoxime) reach adequate prostatic concentrations.

Cefalosporinas orales NO difunden en próstata

Consensus Statement | Infectious Diseases

Guidelines for the Prevention, Diagnosis, and Management of Urinary Tract Infections in Pediatrics and Adults A WikiGuidelines Group Consensus Statement

Table 4. Duration of Treatment Based on Syndrome and Antimicrobial Class Used (continued)

Syndrome and antimicrobial class	Duration of therapy (level of evidence)	Comments
Prostatitis ^f	Clinical review, not enough evidence to provide a clear recommendation for duration of treatment for either ABP or CBP.	There is a dearth of data for both acute and chronic bacterial prostatitis that precludes a clear recommendation for duration of treatment in either scenario. Historical durations range from 14 d for ABP to 6 weeks or longer for CBP.

JAMA | Review

Prostatitis A Review

Benjamin J. Borgert, MD, MPH; Eric M. Wallen, MD; Minh N. Pham, MD

JAMA September 16, 2025 Volume 334, Number 11

What Is First-Line Treatment for Acute Bacterial Prostatitis? First-line treatment for acute bacterial prostatitis typically consists of a 2- to 4-week

What Is First-Line Treatment for Chronic Bacterial Prostatitis? Chronic bacterial prostatitis should be treated with at least 4 weeks

Infección de pelvis y parenquima prostático

Pielonefritis Aguda
Bacteriana

Prostatitis Bacteriana
Aguda

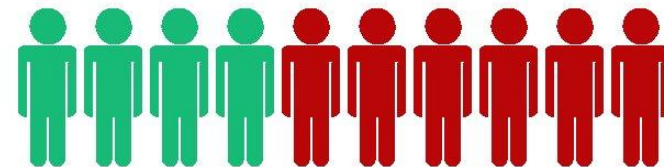
**Prostatitis
Bacteriana Crónica**

Puntos Clave

Comienzo insidioso. Dolor local, urinario y sexual (disfunción eréctil, hemospermia), más de 3 meses .

Factores de Riesgo

- Prostatitis aguda previa
- Cirugía o cateterismo uretral
- Estenosis uretral
- Relaciones anales sin protección
- TBC genitourinaria



4-10 % de los diagnósticos de
prostatitis crónica

JAMA. 2025;334(11):1003-1013. doi:[10.1001/jama.2025.11499](https://doi.org/10.1001/jama.2025.11499)
Published online August 11, 2025.

Pielonefritis Aguda
Bacteriana

Prostatitis Bacteriana
Aguda

**Prostatitis
Bacteriana Crònica**

Puntos Clave

Tratamiento antibiótico DIRIGIDO

ELECCIÓN	ALTERNATIVO (Alergia, intolerancia, etc)
Tratamiento dirigido con antibiograma: 1ª opción: Trimetropim-sulfametoxazol 160/800 mg/VO/12 h X 4-6 semanas 2ª opción: Ciprofloxacino 500-750 mg/VO/12 h X 4-6 semanas	Fosfomicina trometamol 3g/48h x 6 semanas

Schaeffer AJ et al. Urinary tract infections in older men. N. Engl J. Med. 2016; 374: 562-70.
Disponible en: <https://www.nejm.org/doi/full/10.1056/NEJMcp1503950>

RESEARCH ARTICLE

Open Access



The role of flower pollen extract in managing patients affected by chronic prostatitis/chronic pelvic pain syndrome: a comprehensive analysis of all published clinical trials

Conclusion:

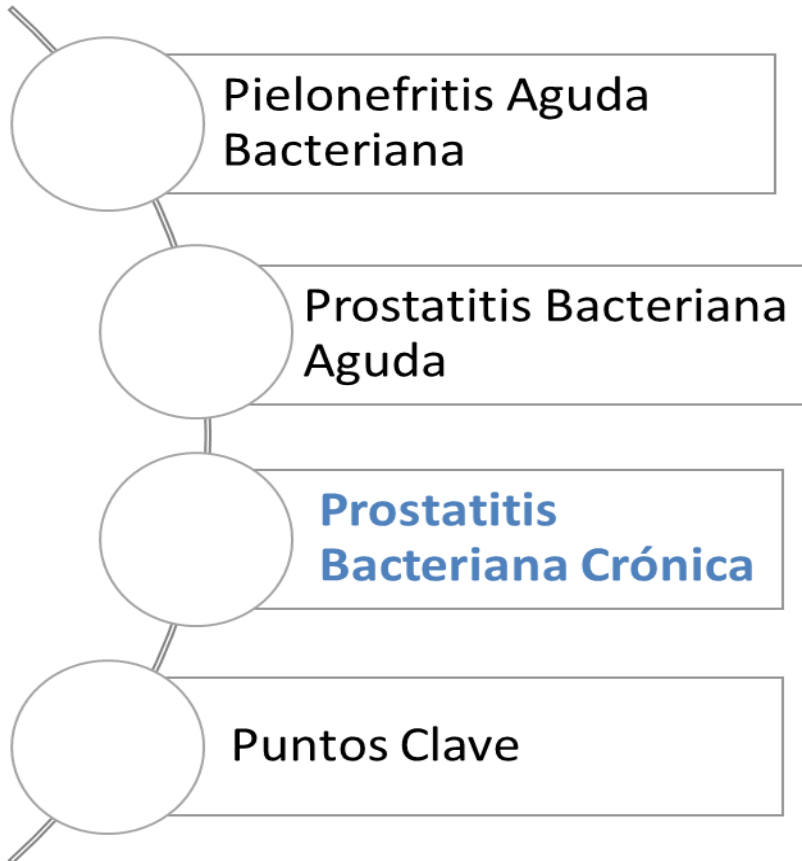
These studies suggest that the use of flower pollen extract for the management of CP/CPPS patients is beneficial. Future publications of robust evidence from additional RCTs and longer-term follow-up would provide more support



80-120mg/d x 3 meses

BMC Urology (2017) 17:32

Conclusions: A standardized pollen extract used alone or in combination with an alpha-blocker significantly improved CP/CPPS symptoms and reduced the need for NSAID rescue medication. These findings support its potential as a safe and effective therapeutic option.





PNF y prostatitis nos obligan a realizar un urinocultivo diagnóstico, pero **NO** de control post tratamiento

NO utilizaremos cefalosporinas orales para el manejo de una **prostatitis** debido a su escasa difusión tisular

Los betalactámicos como las cefalosporinas son de **ELECCIÓN empírica** en el manejo de las PNF.
Desechemos utilizar Quinolonas, cefalosporinas de 3ªG y Amox-clav

La **duración adecuada** de una PNF, siendo invasiva o no, son **7 días**.



Fosfomicina trometamol es una opción razonable en el manejo empírico de la prostatitis aguda lo mismo que **cotrimoxazol**.

Dos semanas de tratamiento en la prostatitis aguda y 4 en la crónica pueden ser suficientes.
Acordémonos de añadir alfa 1 selectivos.

Thank You
Very
molt/mucho

