Introducing

Acute pyelonephritis (aPN) is a severe form of urinary tract infection (UTI), which results from bacterial invasion of the renal parenchyma. The incidence of aPN is estimated at around 9-11 cases per 10,000 inhabitants and is four times more frequent in women than in men.\(^1\)

Diagnosis is based on clinical criteria (fever, costovertebral pain, and dysuria symptoms) and microbiological criteria [pyuria and a positive urine culture with ≥10\(^4\) colony-forming units (cfu) per milliliter of urine].\(^2\)

The most common causative pathogen is *Escherichia coli* (70-90% of uncomplicated UTIs and 21-54% of complicated UTIs).\(^3\) Other pathogens include *Proteus* species, *Klebsiella* species and *Enterococci*.\(^4\)

Bacteria usually reach the kidneys by ascending from the lower urinary tract or, more rarely, through the bloodstream.\(^5\)

Several factors may be involved in the etiology of aPN: anatomic or functional abnormalities of uri-
Section of randomized controlled trials (RCTs).

Complicated aPN was defined as aPN occurring in any male patient, in patients with functional or anatomical abnormalities of the urinary tract, immunosuppressed persons, patients with a single kidney, permanent bladder catheter, nephrostomy or double-J catheter, or those patients who had experienced urinary tract manipulation in the previous two weeks.9

Pyelonephritis becomes a potentially fatal disease when secondary conditions develop, such as emphysematous pyelonephritis (20-80% mortality rate), perinephric abscess (20-50% mortality rate), or one of the sepsis syndromes (>25% overall mortality rate).4 Pregnant women are more likely to develop pyelonephritis and pregnancy is associated with major risk of complications.10

The severity of aPN ranges from mild discomfort to life-threatening illness or death.11 Hospitalization may be required for up to 10-30% of cases.12

The extensive use of antibiotics has increased antibiotic resistance during recent years.13,14 For example Escherichia coli rates of resistance have reached 50%, 20%, and 10%-20%, respectively for ampicillin, fluoroquinolones, and trimethoprim/sulfamethoxazole (TMP-SMX).15 Given the high incidence of acute pyelonephritis in the community setting, measures should be taken to avoid further development of antimicrobial resistance.16

In the current International Clinical Practice Guidelines for the treatment of acute pyelonephritis, the recommended duration of treatment for pyelonephritis is 7 days for fluoroquinolones, 10-14 days for b-lactams and 14 days for TMP-SMX.17-19

No recommendation is provided for women or men hospitalized with acute pyelonephritis.20

The guidelines address only young, otherwise healthy women who are not pregnant. Best management for elderly individuals, men and patients with comorbidities remains unclear. Despite publication of the guidelines, studies demonstrate a wide variation in prescribing practices regarding the selection of antimicrobial agents and duration of therapy.21-23

A reduction in the duration of the administered regimes could minimize the selection pressure on potential pathogens, thereby reducing the risk for the emergence of new resistant strains.24

Under this perspective, we sought to compare short-course with long-course treatment with the same antibiotic regimes, administered by the same route and in the same total daily dosage for acute pyelonephritis, in terms of effectiveness and tolerability, by performing a systematic review and meta-analysis of randomized controlled trials (RCTs).

Section of antimicrobial agents and duration of therapy. 21-23

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Materials and Methods

Registered protocol

We registered the present study in PROSPERO database (CRD42016051105).

Inclusion criteria

We included RCTs that compared a long-course versus a short-course antibiotic therapy of the same antibiotic agents administered by the same route and in the same total daily dosage. Long course was defined as a therapy, which lasts at least 2 days longer than the corresponding short-course treatment. The participants were eligible for inclusion if they were 18 years and older with acute PN, diagnosed based on clinical criteria (fever, costovertebral pain, and dysuria symptoms) and microbiologic criteria (pyuria and a positive culture with >104 cfu per milliliter of urine). Pregnant women and patients, both hospitalized and outpatients, with anatomical or functional abnormalities of the urinary tract, permanent bladder catheter, immunosuppressed, oncolgical and diabetic were also considered. Trials with a mixed population were included in the systematic review if they provided separate data for aPN population.

Types of outcome measures and follow-up assessment

Our primary outcome was Clinical success, defined as a number of subjects with resolution of symptoms (fever, costovertebral pain and dysuria), signs (biohumoral tests as leukocyte count, inflammatory markers and renal function) and microbiologic criteria (pyuria and a positive culture with ≥104 cfu per milliliter of urine) at the end of treatment.

Secondary outcomes were: Microbiological success, at the end of treatment defined as yielding sterile urine cultures or positive cultures with <103 cfu/mL of urine at the end of therapy;24 Clinical relapse at 4-6 weeks after the end of treatment, defined as the reappearance of signs and symptoms.

Microbiological relapse, defined as the reappearance of the original strain in a urine culture at 4-6 weeks after the end of treatment, based on species identification and serotyping results; Microbiological recurrence or reinfection, defined as the appearance of another bacteriologic strain in a urine culture at 4-6 weeks after the end of treatment, based on species identification and serotyping results;24 Renal impairment, defined as a glomerular fraction rate <30 ml/min or creatinine increase >50% from baseline level; Intensive Care Unit requirement; Mortality for any cause occurring during the study; Readmission for the same cause until the end of the follow-up period; Patients with any Adverse event defined as any unto-
ward occurrence of any unfavorable and unintended clinically relevant medical sign, symptom or any disease temporally associated with the study, which did not necessarily have a causal relationship with the study procedure and patient withdrawals due to serious adverse events during the study.

**Search strategy**

We searched the following electronic databases: MEDLINE (PubMed) (January 1966 to June 2016), EMBASE (Elsevier, EMBASE.com) (January 1974 to June 2016) and CENTRAL (up June 2016) using the search strategy outlined in the Appendix.

We checked the reference lists of all studies included and of any systematic reviews we have identified during the search process.

We also searched the following clinical trial registries to identify ongoing trials: ClinicalTrials.gov (http://clinicaltrials.gov/) and Current Controlled Trials (http://www.controlledtrials.com/); we included studies written in English, French, Spanish and Italian.

**Selection of studies and data extraction**

Three pairs of authors (BF, ATM, PS, TL, TD, TM) screened titles and abstracts obtained by the search strategy. Then they independently assessed the full text of potentially relevant studies for inclusion. Any disagreement was solved by discussion with a further author (SM).

We adopted a standardized data collection form to extract the following information: number and characteristics of participants, setting, type of experimental and control intervention (antibiotic agent, length of treatment, any further treatment), length of follow-up, types of outcomes, country of origin, funding and conflict of interest, clinical success, bacteriologic efficacy, relapses, recurrences, any adverse events and/or patient withdrawals due to adverse events. We contacted authors if the reported data were insufficient or unclear.

**Risk of bias (quality) assessment**

Two authors (TL, TD) independently assessed the risk of bias of the included studies. Any disagreement was resolved by discussion with a further author (SM). We assessed the risk bias using the Cochrane criteria. We considered the following specific domains: sequence generation and allocation concealment (selection bias), blinding of participants and providers (performance bias), blinding of outcome assessors (detection bias) and attrition bias. Each domain was judged as high, low or unclear risk of bias.

To incorporate our assessment of risk of bias in the review process, we first plotted the intervention effects estimates, stratified by risk of bias for allocation concealment (selection bias), blinding of outcome assessors (detection bias) and attrition bias. If differences in the results were present among studies at different risks of bias, we performed sensitivity analysis by excluding studies with high risk of bias from the analysis.

**Data synthesis**

We analyzed dichotomous outcomes by calculating the risk ratio (RR) for each trial with the uncertainty in each result being expressed with a 95% confidence interval (CI).

We combined the outcomes from the individual trials through meta-analysis where possible using a random-effects model because a certain degree of heterogeneity was expected among trials. We analyzed heterogeneity by means of the I² statistic and the Chi² test. The cut-off points were I² value of more than 50% and a P value for the Chi² test of less than 0.1. If a very high heterogeneity was found (i.e., greater than 90%) no meta-analyses were performed and results were described narratively.

We planned to investigate the publication bias using visual inspection for asymmetry of funnel plots if there were at least 10 studies included in the meta-analysis. We assessed the overall quality of the evidence for the primary outcome using the GRADE methodology. The GRADE approach uses five dimensions (risk of bias, consistency of effect, imprecision, indirectness and publication bias) to assess the quality of the body of evidence. The evidence is downgraded from high quality by one level if serious, or by two levels if very serious limitations are found for each of the five dimensions. We developed a summary of findings table presenting the quality of the evidence, reasons for limitation and main findings for the primary outcome in simple tabular format.

**Results**

**Study selection**

A total of 725 articles were retrieved from PubMed, 608 from EMBASE, and 185 from CENTRAL. After 175 duplicates were removed we were left 1343 articles and following a preliminary screening by reading the titles and abstracts we removed other 1331 articles. Out of 12 articles assessed as potentially eligible, 6 were excluded for the following reasons: two studies were not RCT, one study considered patients with recurrent urinary-tract infections and not acute pyelonephritis; two studies did not compare two regimens with the same antibiotic and one study used two different routes of administration; two further studies were considered awaiting assessment: one study was published in Chinese language and one was a protocol in recruiting phase. We finally included 4 RCTs (Figure 1).
Characteristics of included studies

We included 4 RCTs\textsuperscript{23,38-40} with 439 participants conducted between 1987 and 2012. Three studies were conducted in European countries\textsuperscript{23,38,40} and one in the USA.\textsuperscript{40} All studies included patients \(\geq 15\) years with aPN. Three trials\textsuperscript{38-40} included only patients with aPN, while the remaining trial\textsuperscript{23} included patients with complicated urinary tract infections; we extracted data only for the subgroups (\(n=34\)) with aPN. The majority of patients were women (87%, range 66.7 to 100%); mean age was 50.75 years, range 16-94.

One study\textsuperscript{23} enrolled only patients who were hospitalized, two studies\textsuperscript{38,39} included both inpatients and outpatients and the last one\textsuperscript{40} involved only outpatients. One study\textsuperscript{40} analyzed two subgroups of population treated with different antibiotic and, in this review, we classified it as Stamm A and Stamm B.

The antibiotic drugs investigated were the following: ampicillin,\textsuperscript{40} trimethoprim-sulfathoxazole,\textsuperscript{40} \(\beta\)-lactams (pivampicillin/pivmecillinam);\textsuperscript{38} fluoroquinolones: fleroxacin\textsuperscript{23} and ciprofloxacin\textsuperscript{39}.

The duration of treatment for short antibiotic therapy ranged from 4 to 14 days. The duration for long therapy was \(\geq 7\) days (ranging from 7 to 42 days), but at least 2 days longer than the corresponding short-
course treatment. The timing of outcomes assessment varied among studies and ranged from end of treatment up to 180 days.

Three trials were funded by pharmaceutics company: one from Hoffmann La Roche, one from Leo Pharmaceutical and one from Bayer. One trial was partially funded by National Institutes of Health and by a grant from Burroughs Wellcome Foundation (Table 1).

Risk of bias assessment

Three studies reported an appropriate method of randomization. One study did not report sufficient information to permit judgment of low or high risk. Only one study reported an adequate procedure for allocation concealment, the others were at unclear risk of bias not reporting enough information to make a judgment. The main characteristics of the participants in the two groups were similar in all selected studies.

Two studies were double-blind (blinding of providers and patients) while the other two were open label and judged at high risk of performance bias. Two studies reported that the outcome assessors were blinded, while the fourth did not report sufficient information. All the studies were judged at high risk of attrition bias and at low risk of selective outcome reporting. Risk of bias assessment is presented in Figure 2. The risk of publication bias has not been evaluated because less than ten studies were included.

Effects of interventions

Clinical success at the end of treatment

We found no significant differences in clinical success between short and long antibiotic therapy at the end of treatment (RR 1.01, 95% CI 0.96-1.07, 4 studies, 250 participants) with a moderate quality of evidence (Figure 3A and Table 2).

Microbiological success at the end of treatment

We found no significant differences in the microbiological success at the end of antibiotic treatment between short or long-term therapy (RR 0.99, 95% CI 0.92-1.07, 2 studies, 190 participants) with low quality of evidence (Figure 3B and Table 2).

Clinical relapse at 4-6 weeks

We found no significant differences in clinical relapse at 4-6 weeks after the end of treatment between short and long-term therapy (RR 1.20, 95% CI 0.43-3.30, 2 studies, 218 participants) with very low quality of evidence (Figure 4A and Table 2).

Microbiological relapse at 4-6 week follow-up

The long-term therapy seemed to prevent recurrences of the same biological germ up to 4-6 weeks after the end of treatment compared to short-term therapy (RR 2.39, 95% CI 1.19-4.83, 2 studies, 95 participants) with very low quality of evidence (Figure 4B and Table 2).

Microbiological reinfection at 4-6 week follow-up

We found no significant differences between long- and short-term therapy in the prevention of re-infection by different germs from the one originally isolated (RR 2.40, 95% CI 0.68-8.49, 2 studies, 95 participants) with very low quality of evidence (Figure 4C and Table 2).

Number of patients with adverse effects

The number of patients with at least one adverse effect from antibiotic therapy seemed to be higher in the long-term therapy compared to that of short-term but the difference was not statistically significant (RR 0.63, 95% CI 0.39-1.02, 4 studies, 375 participants)
<table>
<thead>
<tr>
<th>Study (author, year)</th>
<th>Country</th>
<th>Population</th>
<th>Short therapy</th>
<th>Long therapy</th>
<th>Participants analyzed</th>
<th>Outcomes</th>
<th>Timing of outcome assessment</th>
<th>Funding and conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>De Gier et al. 1995</td>
<td>Netherlands</td>
<td>54 patients aged ≥18 years with complicated UTI diagnosed by clinical and microscopic and microbiologic data (≥10^5 cfu/mL) in hospitalized patients</td>
<td>Fleroxacin 400 mg ev for 3 days followed by 400 mg 1 cp/day for 4 days (tol 7 days); n: 26</td>
<td>Fleroxacin 400 mg ev for 3 days followed by 400 mg 1 cp/day for 11 days (tol 14 days); n: 28</td>
<td>34 (18 short therapy - 16 long therapy)</td>
<td>- Clinical success</td>
<td>5-9 days and 30-40 days</td>
<td>Hoffmann La Roche</td>
</tr>
<tr>
<td>Jernelius et al. 1988</td>
<td>Sweden</td>
<td>77 patients aged ≥15 years with clinical symptoms of acute days pyelonephritis and significant bacteriuria (≥10^5 cfu/mL) hospitalized and outpatients</td>
<td>Pivampicillin 0.25 g pivmecillinam 0.2 g 2 tb × 3/day for 7 + Placebo 1 tb × 2/day for 14 days; n: 38</td>
<td>Pivampicillin 0.25 g pivmecillinam 0.2 g 2 tb × 3/day for 7 days + pivampicillin 0.25 g pivmecillinam 0.2 g 1 tb × 2/day for 14 days; n: 39</td>
<td>61 (32 short therapy - 29 long therapy)</td>
<td>- Clinical relapse</td>
<td>14-21 days and 180 days</td>
<td>Leo Pharmaceutical</td>
</tr>
<tr>
<td>Sandberg et al. 2012</td>
<td>Sweden</td>
<td>248 women ≥18 with hospitalized and outpatients community-acquired acute pyelonephritis diagnosed by clinical and microbiological data (≥10^5 cfu/mL if E. coli or S. saprophyticus; ≥10^6 cfu/mL if other pathogens) Mean age 43.5 (23-62)% women: 100%</td>
<td>Ciprofloxacin 500 mg 2/day + placebo 2/day for 7 days; n: 126</td>
<td>Ciprofloxacin 500 mg 2/day for 14 days; n: 122</td>
<td>156 (73 short therapy - long therapy 84)</td>
<td>- Clinical success</td>
<td>10 days and 42-63 days</td>
<td>Strama, Swedish Institute for Infectious Disease Control, Solna, Sweden. Carina Alvfors and Eva Svensson at Uppsala Clinical Research Center for help with monitoring and data management, Bayer AB Solna, Sweden for providing study drugs</td>
</tr>
<tr>
<td>Stamm et al. 1987 - A</td>
<td>Washington, USA</td>
<td>27 women outpatients with acute renal infection Mean age 31.3 (21-42)% women: 100%</td>
<td>Ampicillin 500 mg/6 h given 2 weeks; n: 17</td>
<td>Ampicillin 500 mg/6 h given 6 weeks; n: 10</td>
<td>27 (17 short therapy - 10 long therapy)</td>
<td>- Clinical success</td>
<td>14 days and 42 days</td>
<td>In part by grant AI-18402 from the National Institutes of Health and by a grant from Barroghs Wellcome Foundation</td>
</tr>
<tr>
<td>Stamm et al. 1987 - B</td>
<td>Washington, USA</td>
<td>33 women outpatients with acute renal infection Mean age 31.3 (21-42)% women: 100%</td>
<td>Trimethoprim-sulfamethoxazole, 20 mg/d-I 600 mg/d, 3 twice daily given for 2 weeks; n: 21</td>
<td>Trimethoprim-sulfamethoxazole, 320 mg/d-1600 mg/d, twice daily given for 6 weeks; n: 12</td>
<td>33 (21 short therapy 12 long therapy)</td>
<td>- Clinical success</td>
<td>14 days and 42 days</td>
<td>In part by grant AI-18402 from the National Institutes of Health and by a grant from Barroghs Wellcome Foundation</td>
</tr>
</tbody>
</table>

UTI, urinary tract infection; cfu, colony-forming units.
Discussion

Summary of main results

This systematic review offers an update of results of all randomized trials that compare short- versus long-term antimicrobial therapy for acute pyelonephritis in adults. It is based on an extensive research, including incomplete data by attempting to contact all authors.

We found moderate quality evidence that short- and long-term treatments probably did not differ in terms of clinical success as well as in microbiological success at the end of treatment.

Conversely at 4-6 weeks after the end of treatment we found with a very low quality of evidence that microbiological relapse of the same biological germ may be more frequent with short-term therapy, but there may be no difference in the frequency of clinical relapse and re-infection by different germs.

Finally, we found that the incidence of any adverse effect seemed to be lower with the short-term therapy, though the results are not statistically significant and the quality of evidence is moderate. It was not possible to interpret the finding related to Mortality, Renal impairment, Intensive Care Unit requirement, Hospital readmission for the same cause since no data were reported in any of the included trials.

Strengths, limitations and uncertainties

The strengths of this review include the adherence to accepted standards for the conduct of systematic reviews and the use of extensive literature searches to identify relevant data. Moreover, we included studies written in English, French, Spanish and Italian, so reducing the risk of language bias.

The major limitation of this review is the small number of participants on which we could base our conclusions: we found only four randomized studies fulfilling our inclusion criteria and most of them had small sample size. Since aPN could be considered...
### Table 2. Quality of evidence-GRADE profile.

#### Short therapy compared to long therapy for acute pyelonephritis

**Patient or population:** patients with acute pyelonephritis  
**Settings:** inpatients and outpatients  
**Intervention:** short therapy  
**Comparison:** long therapy

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect</th>
<th>No. of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assumed risk</td>
<td>Corresponding risk</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Long therapy</td>
<td>Short therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical success end of treatment</td>
<td>868 per 1000</td>
<td>876 per 1000</td>
<td>RR 1.01 (0.96 to 1.07)</td>
<td>250 (3 studies)</td>
<td>Moderate°</td>
</tr>
<tr>
<td>Subject with resolution of symptoms, signs and microbiological criteria</td>
<td>(833 to 929)</td>
<td>(836 to 973)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up: 9-42 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Microbiological success end of treatment</td>
<td>909 per 1000</td>
<td>900 per 1000</td>
<td>RR 0.99 (0.92 to 1.07)</td>
<td>190 (2 studies)</td>
<td>Low#,*</td>
</tr>
<tr>
<td>Sterile urine cultures or positive cultures with &lt;10^3 cfu/mL of urine</td>
<td>(836 to 973)</td>
<td>(836 to 973)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Follow-up: 9-42 days</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Clinical relapse 4-6 week</td>
<td>62 per 1000</td>
<td>74 per 1000</td>
<td>RR 1.2 (0.43 to 3.3)</td>
<td>218 (2 studies)</td>
<td>Very low^,$</td>
</tr>
<tr>
<td>Reappearance of signs and symptoms</td>
<td>(27 to 204)</td>
<td>(20 to 214)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Follow-up: 4-6 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Microbiological relapse 4-6 weeks</td>
<td>178 per 1000</td>
<td>425 per 1000</td>
<td>RR 2.39 (1.19 to 4.83)</td>
<td>95 (2 studies)</td>
<td>Very low^,$</td>
</tr>
<tr>
<td>Reappearance of the original bacteriological strain</td>
<td>(212 to 859)</td>
<td>(452 to 952)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Follow-up: 4-6 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reinfection at 4-6 weeks</td>
<td>67 per 1000</td>
<td>160 per 1000</td>
<td>RR 2.4 (0.68 to 8.49)</td>
<td>95 (2 studies)</td>
<td>Very low^,$</td>
</tr>
<tr>
<td>Appearance of another bacteriologic strain in a urine culture</td>
<td>(45 to 566)</td>
<td>(65 to 77)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up: 4-6 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse events</td>
<td>189 per 1000</td>
<td>119 per 1000</td>
<td>RR 0.63 (0.39 to 1.02)</td>
<td>361 (4 studies)</td>
<td>Moderate°</td>
</tr>
<tr>
<td>Subjects with at least one adverse event</td>
<td>(74 to 192)</td>
<td>(70 to 190)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up: 9-42 days</td>
<td></td>
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</tbody>
</table>

CI, confidence interval; RR, risk ratio; cfu, colony-forming units. *The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI). GRADE Working Group grades of evidence: High quality: we are very confident that the true effect lies close to that of the estimate of the effect; Moderate quality: we are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; Low quality: our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; Very low quality: we have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect. °Two studies at high risk of performance bias, three studies at high risk of attrition bias; one study at high risk of performance bias, two studies at high risk of attrition bias; few number of events; two studies at high risk of attrition bias; very few number of events.
almost a rare condition because presented few cases every 10,000 habitants\textsuperscript{44} multicenter RCTs should be encouraged in order to increase the precision and the strength of the recommendation for the evidence of findings. Further studies should address this limitation by providing a larger sample size and improve the methodological quality of the studies, for example, opting for double-blind studies.

Furthermore, the retrieved evidence comes to studies - except Sandberg\textsuperscript{39} - that were >10 years old and some of the antibiotics used in the included studies (\textit{i.e.}, fleroxacin) are not available in a number of countries worldwide. The included studies did not provide data on mortality and only one\textsuperscript{40} reported information about the degree of severity of aPN.

In addition, we detected some deficiencies in the methodological quality of some of the included studies in this review. Only two trials were double blind and all were at high risk of attrition bias. Overall, the quality of evidence was judged from moderate to very low due to serious risk of bias and imprecision.

We could not assess the risk of publication bias by visual inspection for asymmetry of funnel plots because only four studies were included in meta-analy-

Figure 4. Forest plots of comparison short vs long course antibiotic therapy at 4-6 weeks from the end of treatment for A) clinical relapse, B) microbiological relapse, and C) microbiological reinfection.
sis. So, the risk of publication bias cannot be excluded though we performed a very sensitive search looking also for unpublished studies and studies published in languages other than English.

Agreements and disagreements with other studies or reviews

We obtained the same findings of previous meta-analyses.24,45 The review published in 2008 by Kyriakidou et al.24 included 4 studies with 283 patients (one double-blinded RCT and three open-label RCTs) comparing a short (defined as 7-14 days) versus a long arm (defined as 14-42 days) for the same antibiotic treatment. Authors found no significant difference between the short- and long-course regimens efficacy at the end of treatment or at follow-up. Another systematic review published in 2013 by Eliakim-Raz et al.45 investigated the duration of treatment for acute pyelonephritis including 2515 patients, 1239 treated for ≤7 days versus 1276 treated for >7 days. Five trials made comparisons using the same antibiotic, and three made comparisons using different antibiotics. They found out that seven days of treatment for acute pyelonephritis is equivalent to longer treatment in terms of clinical failure and microbiological failure, including bacteremic patients. In patients with urogenital abnormalities, the evidence, although weak, suggests that longer treatment is required.

Published Guidelines17 do not address the specific question of duration of treatment in acute pyelonephritis patients. However the following types of good clinical practice are performed: 7 days for fluoroquinolones, 10-14 days for β-lactams and 14 days for TMP-SMX.17,18 Since in our study we found no difference in terms of clinical and microbiological success or tolerability for short (from 4 to 14 days) and long course antibiotic therapy (ranging from 7 to 42 days), we can confirm the actual antibiotic recommendations even if the grade of recommendation is week for low quality of evidence due the paucity of patients and risk of bias of trials.

Finally, the reduction in patient exposure to antibiotics may also limit the increasing rates of antimicrobial drug resistance,46 decreasing costs,47 and may improve patient adherence and tolerability.

Conclusions

This review suggests that short-term treatment for acute pyelonephritis may be equivalent to longer-term treatment in terms of clinical success and microbiological success at the end of treatment adverse events may be slightly more frequent with the long therapy. The long-term therapy may be more effective for the prevention of microbiological relapse of the same biological germ up to 4-6 weeks after the end of treatment compared to short-term therapy.

Further high-quality research, through the launch of multicenter RCTs, is needed to confirm the clinical and microbiological equivalence of short and longer-term antibiotic treatment for aPN, including in patients with serious prognostic categories.

References

cessed: August 11, 2015.
30. Schaeffer EM. Re: Ciprofloxacin for 7 days versus 14 days in women with acute pyelonephritis: a randomised, open-label and double-blind, placebo-controlled, non-inferiority trial. J Urol 2013;559-60.


