Double-Blind Study Comparing 3-Day Regimens of Cefixime and Ofloxacin in Treatment of Uncomplicated Urinary Tract Infections in Women

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This double-blind randomized study compared 3-day regimens of cefixime (400 mg once daily) and ofloxacin (200 mg twice a day) in the treatment of urinary tract infections in women. The respective clinical cure rates for the two groups of women were 89 and 92% after 7 days and 81 and 84% after 4 weeks. The respective microbiological cure rates (free of bacteriuria) for the two groups of women were 83 and 86% after 7 days and 77 and 80% after 28 days. A 3-day cefixime regimen seems to be as efficient as a 3-day ofloxacin regimen in the treatment of uncomplicated cystitis in women.

A 3-day regimen of antibiotics appears to be the optimal treatment for uncomplicated cystitis in women. This regimen may be associated with cure rates comparable to those achieved with longer courses of therapy, along with an incidence of adverse effects as low as that seen with single-dose therapy (5).

Short-course, single-dose or 3-day regimens of cotrimoxazole and quinolones are as effective as longer courses of therapy (4); however, beta-lactam antibiotics were more effective when administered for 5 or more days than when given as a 3-day or single-dose course (6).

Cefixime is an oral cephalosporin, with a broad antibacterial spectrum against most community-acquired uropathogens. Peak concentrations in serum of 3 to 4 μg/ml are achieved after 4 to 6 h following a 400-mg tablet. The half-life in serum of 3 to 4 h is substantially longer than that of other oral beta-lactam antibiotics. In addition, urinary concentrations after a single daily dose of 400 mg are well above the MICs for 90% of the most common urinary pathogens (1).

The aim of the present study was to evaluate the efficacy of a 3-day regimen of cefixime and to compare it with a similar regimen of ofloxacin in the treatment of women with uncomplicated cystitis.

Women, 16 years of age or older, who had been referred to our Outpatient Clinic with the diagnosis of uncomplicated cystitis were included in this study. The diagnosis of uncomplicated cystitis was based upon both clinical symptoms (dysuria, frequency of urination, and absence of fever or flank pain) and laboratory findings (pyuria [at least 8 leukocytes per mm3/ml] and a positive urinary culture yielding ≥105 CFU/ml). Women with a history of pylonephritis or nephrolithiasis and pregnant or immunocompromised women were excluded from the study.

Clean, voided midstream urine samples were collected and cultured by the Uristest system (Hylab dip slides; Hylab, Rehovot, Israel). All isolates were identified by standard procedures and tested for susceptibility to antimicrobial drugs by the Kirby-Bauer method.

Treatment was given on a randomized and double-blind basis. The cefixime-treated patients received 400 mg of ce-
The efficacy of a 3-day treatment with oral narrow-spectrum cephalosporins is controversial. Sandberg et al. (7) reported similar cure rates (80% at an early follow-up, and 75 and 79% at late follow-up), with 1 g of cefadroxil once daily for 3 or 7 days. On the other hand, Greenberg et al. (3) obtained a 68% bacteriological cure rate after treatment with cefadroxil (0.5 g twice a day) for 3 days and a cure rate of 83% when it was given for 7 days, and after 4 weeks, the cure rates were 58 and 70%, respectively.

In an unpublished study with 0.5 g of cefalexin given four times a day for 3 days, we observed cure rates of 88.7% after 7 days and 66.2% after 28 days. However, fluoroquinolones appear to be highly efficient given as a 3-day regimen. Hooton et al. (4) obtained 92 and 89% bacteriological cure rates after 1 and 5 weeks, respectively, with 200 mg of ofloxacin once daily. Similar cure rates were achieved by us in an unpublished study with 100 mg of ofloxacin twice a day (97.5 and 80.2%).

### TABLE 1. Clinical characteristics of patients in the two treatment groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value for treatment group</th>
<th>Cefixime</th>
<th>Ofloxacin</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>49</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Mean age ± SEM (yr)</td>
<td>48.7 ± 18.4</td>
<td>48.3 ± 17.2</td>
<td></td>
</tr>
<tr>
<td>Age range (yr)</td>
<td>17–88</td>
<td>16–76</td>
<td></td>
</tr>
<tr>
<td>0–2 UTI/yr</td>
<td>34</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>&gt;3 UTI/yr</td>
<td>15</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>No. premenopausal</td>
<td>28</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>No. postmenopausal</td>
<td>21</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

* UTI, urinary tract infections.

Two previous studies showed lower cure rates when a single-dose ciprofloxacin (2) or ofloxacin (4) was given to women with *Staphylococcus saprophyticus* bacteriuria. In our study, one of two women with *S. saprophyticus* bacteriuria treated with cefixime and all three women treated with ofloxacin failed. Although there were only a few patients with *S. saprophyticus* who were treated with short-course therapy in this study, it seems that the short-course therapy is inadequate for the treatment of this bacteria.

The results of this study showed similar clinical and microbiological cure rates with both 3-day regimens, cefixime (400 mg once daily) and ofloxacin (200 mg twice a day) (Table 1). The observed small differences of 2 to 3% in the cure rates between the two regimens do not seem to be clinically significant, and this study was not designed to detect such a small difference. A large number of women in each group is needed in order to evaluate the true meaning of this difference.

The results obtained with cefixime in comparison to oral cephalosporins can probably be explained by its longer half-life and higher and prolonged concentration of the drug in urine (1).

The observed slight differences of 2 to 3% in the cure rates between the two regimens do not seem to be clinically significant. In order to define the exact role of cefixime as a short course in the treatment of uncomplicated cystitis in women, further studies are required.

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### REFERENCES