

incidence of pyelonephritis in pregnancy (3–5). Pyelonephritis has serious sequelae in pregnancy, including preterm birth, anemia, sepsis, disseminated intravascular coagulation, and ARDS. Two of the studies supporting ASB screening and treatment to prevent pyelonephritis also show a decrease in preterm birth with screening (3).

Acute cystitis is estimated to occur in 1–2% of pregnant patients (10), with a similar incidence of acute pyelonephritis seen in pregnant patients, 1–2% (11). Pyelonephritis occurs most frequently in the second trimester and is one of the most common medical causes for hospitalization during pregnancy.

Several anatomic and physiologic changes occur in the urinary tract during pregnancy that can predispose pregnant patients to UTIs. Progesterone-induced ureteral dilation, combined with mechanical compression of the ureter by the gravid uterus, leads to increased residual volume in the bladder and urinary stasis, resulting in vesicoureteral reflex. As a result, these changes increase the risk of bacterial colonization and ascending infection.

METHODS

This Clinical Consensus document was developed using an established protocol based on the Clinical Consensus methodology, published separately (12). The description below is specific to this Clinical Consensus document.

Literature search

A literature search was performed from 2000 to the present for identified clinical questions. American College of Obstetricians and Gynecologists' (ACOG) medical librarians searched Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE for human-only studies written in English. MeSH terms and keywords can be found in Appendix 1 (available online at <http://links.lww.com/AOG/D241>). Search terms for disparities and implicit bias in maternal and fetal outcomes for UTIs in pregnant individuals were incorporated into the literature review, and recommendations were drafted with the intent to promote health equity and reduce these disparities. A bridge literature search was completed in April 2023. Any updated literature was incorporated into the text and recommendations, as appropriate.

Study Selection

Qualifying studies passed both title and abstract screen and full-text screen and met the following inclusion criteria: conducted in countries ranked very high on the United Nations Human Development Index (4), included female participants, and included all study designs. Studies that passed full-text screen by the authors were included in a summary evidence map (Appendix 2, available online at <http://links.lww.com/AOG/D242>).

Consensus Voting and Recommendation Development

At a meeting of the Committee on Clinical Consensus–Obstetrics, a quorum of two-thirds of eligible voting members was met, and the committee held a formal vote for each proposed recommendation. All recommendation statements met or exceeded the 75% approval threshold required for consensus.

Use of Language

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>.

ASYMPTOMATIC BACTERIURIA

Diagnosis

Clinicians should screen for ASB with a urine culture once at a visit early in prenatal care. There is insufficient evidence to recommend for or against repeat screening during pregnancy after a negative initial culture result.

Screening for ASB has become accepted clinical practice to prevent pyelonephritis in pregnancy. However, the studies supporting ASB screening were mostly performed in the 1960s and 1970s, study quality is poor, and the antibiotic-treatment regimens do not reflect contemporary practice. Since ASB screening and treatment became routine practice, the incidence of pyelonephritis in pregnancy has decreased 20–35%, to 1–4% (3). Although this reduction supports an assertion that ASB screening and treatment are effective, the two most recent randomized trials of ASB treatment show only a 2.2–2.4% pyelonephritis rate in the group of patients receiving no treatment for ASB (13, 14). This suggests that, in at least some populations, the contemporary baseline rate of pyelonephritis is lower even without screening and treatment. Due to these limitations in the data, the U.S. Preventive Services Task Force in 2019 downgraded their recommendation for ASB screening in pregnancy from “A” (evidence of substantial benefit) to “B” (evidence of moderate benefit). Yet, because published trials have demonstrated a consistent association with a decrease in pyelonephritis, screening for and treatment of ASB in pregnancy is still recommended (4, 5).

Screening for ASB should be performed at a visit early in prenatal care (15). Pyelonephritis is most prevalent in the

