



New Daptomycin Breakpoint for Enterococci

- In January 2019, CLSI lowered the breakpoint for enterococci from an MIC \leq 4 mcg/mL to an MIC \leq 1 mcg/mL
- Isolates with MICs of 2 or 4 mcg/mL are now considered susceptible dose dependent (SDD)
- Linezolid is preferred for patients with SDD vancomycin-resistant *E. faecium* (VRE) infections, except for those with infective endocarditis or linezolid resistance/contraindication
- Recommended daptomycin dosing is based on MIC (doses below are for normal renal function):
 - MIC \leq 1 mcg/mL: 10 mg/kg
 - MIC = 2 mcg/mL: 10-12 mg/kg
 - MIC = 4 mcg/mL: 12 mg/kg \pm a 2nd agent
- Contact ASP to discuss dosing and regimens

Duration and Oral Therapy for Enterobacteriaceae Bacteremia

Duration

- Recent studies^{1, 2} including patients from JHH have shown that Enterobacteriaceae bacteremia with source control can be treated for 7 days. See the new bacteremia section in our Guidelines ([ASP Bacteremia Guidelines](#)).
- Patients with solid organ transplant and heme malignancy were not well represented in these studies and these recommendations may not be applicable.

Oral step-down therapy

- Switching to oral therapy should be considered in patients who have source control, are clinically improved, and are able to take oral medications as soon as susceptibilities are available.³ Oral options with high bioavailability include ciprofloxacin and TMP/SMZ.

ASP's Antibiotic Corner: Linezolid

Linezolid is bacteriostatic against enterococci and staphylococci and bactericidal against the majority of streptococci. Linezolid is now generic and thus more affordable for patients and hospitals; thus, the ASP has identified scenarios in which you should strongly consider the use of linezolid instead of vancomycin:

- As an alternative to vancomycin in hospitalized patients at risk for nephrotoxicity (age \geq 65, advanced CKD, AKI) with:
 - Moderate to severe purulent cellulitis
 - Non-purulent cellulitis and severe PCN allergy
 - Other skin/soft tissue infections (e.g., diabetic foot infection without osteomyelitis, surgical site infection)
- Pneumonia in which MRSA is strongly suspected (e.g., empiric treatment of necrotizing pneumonia) or confirmed
- Oral step-down therapy for treatment of MRSA infections in non-bacteremic patients

Coming soon: JHH ASP on Twitter!



References:

1. Chotiprasitsakul D et al. Comparing the Outcomes of Adults With Enterobacteriaceae Bacteremia Receiving Short-Course Versus Prolonged-Course Antibiotic Therapy in a Multicenter, Propensity Score-Matched Cohort. *Clin Infect Dis* 66:172, 2018
2. Yahav D et al et al. Seven versus fourteen Days of Antibiotic Therapy for uncomplicated Gram-negative Bacteremia: a Non-inferiority Randomized Controlled Trial. *Clin Infect Dis* 2018.
3. Tamma PD et al. Association of 30-Day Mortality With Oral Step-Down vs Continued Intravenous Therapy in Patients Hospitalized With Enterobacteriaceae Bacteremia. *JAMA Intern Med* 2019;