Nephrotoxicity Associated with Intravenous Colistin

To the Editor—It is with great interest that I read the article by Hartzell et al [1] about the nephrotoxic effects of colistin. As pointed out in the editorial commentary by Falagas and Rafailidis [2], the authors must be commended for this retrospective insight into a worrisome adverse effect of this old antibiotic that is becoming a more important tool in our armamentarium against multidrug-resistant gram-negative infections. In particular, polymyxin use is bound to further increase given the recent reports from several countries of increases in the number of Klebsiella pneumoniae carbapenemase–producing organisms [3].

I agree that colistin (or polymyxin E) and polymyxin B seem to be less nephrotoxic than was previously thought, which seems to be confirmed by the recent article by Hartzell et al [1]. However, I think that a limitation to this study should be pointed out—namely, that the population studied consisted of active-duty soldiers seen at the Walter Reed Army Medical Center (Washington, DC) and that the patients were therefore mostly previously healthy young adults, with a mean age of 27 years. In most other hospitals, patients with infection due to Acinetobacter baumannii or other multidrug-resistant gram-negative organisms that necessitate therapy with polymyxins are often older individuals with many comorbidities. It is thus important to point out the difficulty in extrapolating these results to the general population.

Further studies are necessary to better delineate the nephrotoxicity of polymyxins in the general population. However, as indicated by Falagas and Rafailidis [2], the quality of the data will be affected by the fact that randomized controlled trials will not be possible because of ethical concerns.

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References


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Criticality of HIV-Infected Patients: The Particular Case of Tuberculosis-Associated Immune Reconstitution Inflammatory Syndrome

To the Editor—Few modern diseases have experienced as rapid and dramatic changes in prognosis and treatment as human immunodeficiency virus (HIV) infection. The introduction of highly active antiretroviral therapy (HAART) and effective prophylaxis of opportunistic infections ushered in a new era in the treatment of HIV infection and the survival of HIV-infected patients; it also dramatically changed the natural history of the disease. However, the frequency of pulmonary, cardiac, gastrointestinal, and renal disorders that are not directly related to underlying HIV disease has increased [1, 2]. Coinciding with these changes, the rates of admission to intensive care units (ICUs) and intensive care mortality among patients with HIV infection have shifted repeatedly during the AIDS epidemic. Now, 4%–5% of hospitalized HIV-infected patients are admitted to an ICU, and the...