I believe that available data do not support the conclusion of the authors that vancomycin has to remain the standard of care for most infectious caused by methicillin-resistant *Staphylococcus aureus* (MRSA).

Most articles that have evaluated patients with infections caused by MRSA with high vancomycin minimum inhibitory concentrations (MICs) focused on severely ill patients. Mortality in those patients was not driven by antimicrobial therapy or by the infection itself. Bekaedt et al [2] recently reported that the intensive care unit (ICU) mortality attributable to ventilator-associated pneumonia was only about 1% on day 30 and 1.5% on day 60. This and other studies [3] highlight the difficulty to detect differences on mortality in severely ill patients, so other outcomes have to be evaluated. If we evaluate these other parameters, it would be difficult to find any justification for the use of vancomycin in the severely ill population.

I cannot agree with the authors’ conclusion that until further data are collected the Infectious Diseases Society of America guidelines remain relevant [1]. Those guidelines were issued in 2011 [4]. After those guidelines were issued, Wunderink et al [5] provided evidence derived from a randomized controlled trial (AIR evidence) about the superiority of linezolid vs vancomycin for the treatment of MRSA nosocomial pneumonia, with a significant proportion of patients treated with vancomycin developing renal failure compared to those treated with linezolid. Cianferoni et al [6] have recently published that the use of vancomycin in severely ill septic patients was associated with a high rate of development of acute kidney injury (AKI). Despite the strict daily monitoring and optimization of vancomycin therapy, 24% of patients developed AKI. Patients who developed AKI had increased length of stay in the ICU, increased need for renal replacement therapy, increase costs, and, what is more important, increased mortality (18% vs 40% for no-AKI and AKI, respectively; *P* < .05). Do we really need more evidence?

Regarding nonrespiratory infections, newer drugs have shown similar data. Fowler Jr et al [7] demonstrated that daptomycin (6 mg/kg/day) was noninferior compared with combination therapy with vancomycin plus gentamycin. Similar to studies on ventilator-associated pneumonia, daptomycin-treated patients had a significantly lower development of renal impairment (6.7% vs 20.4% for daptomycin and vancomycin, respectively; *P* = .009).

There are also recently published papers that support the use of newer agents. Murray et al [8] evaluated the effect of an early switch to daptomycin compared to maintaining vancomycin therapy in high vancomycin MIC MRSA bacteremia. Treatment with daptomycin resulted in a reduction in 30-day mortality (3.5% vs 12.9% for daptomycin and vancomycin, respectively; *P* = .047). These results are similar to those published before by Moore et al [9] that also found a reduction in mortality in daptomycin-treated patients (17% vs 31% for daptomycin and vancomycin, respectively; *P* = .046).

I do agree with the authors that emergence of resistance can be a serious problem, but after more than 10 years of clinical use, according to the ZAAPS program, 99% of strains are susceptible to linezolid [10]. Similarly, a recent international daptomycin surveillance program reported susceptibility rates for MRSA and methicillin-susceptible *Staphylococcus aureus* (MSSA) of 99.9% [11]. The pathway to protect these newer drugs cannot be through favoring the use of vancomycin, but through the implementation of adequate stewardship programs.

Finally, regarding economic data, I am sure that if drug-acquisition costs of vancomycin and newer agents were the same, very few clinicians would use vancomycin. Interestingly, despite what is currently believed, daily cost of the drug does not possess a significant participation in the overall cost of treatment [12].

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**Treating Patients With the Best Drugs**

**To the Editor—** I read with interest the article by van Hal and Fowler Jr. [1] recently published in the *Clinical Infectious Diseases*, and I would like to comment on some aspects that I considered of paramount importance.
A search using a particular agent and "cost-effectiveness" or "economical" retrieves more than 100 papers [12]. All these studies uniformly show that, compared to vancomycin, overall treatment costs derived by the use of newer agents are lower or therapy is cost-effective and, sometimes, even cost-saving [12–17].

Vancomycin has its indications; according to already commented clinical data and pharmacokinetic data [18]. I believe that non-severely ill patients with low MIC (≤1 mcg/mL) vancomycin MRSA infections can be safely treated with vancomycin, provided that close monitoring of vancomycin serum concentrations and renal function parameters can be performed. My concern, and I believe also the concern of many clinicians, is the obsession of some authors to prove that vancomycin is not that bad, instead of focusing on treating our patients with our best drugs to improve their outcome.

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J. Parra-Ruiz1,2

1Servicio de Enfermedades Infecciosas, Hospital Universitario San Cecilio, Granada, and 2Laboratorio de Investigación Anti Microbiana, Facultad de Medicina, Universidad de Granada, Spain

References


Correspondence: J. Parra-Ruiz, MD, PhD, Servicio de Enfermedades Infecciosas, Hospital Universitario San Cecilio, Avda Dr Olario 16, Granada 18012, Spain jordi@ugr.es.

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