Common Use of the Empirical Combination of Vancomycin and a \( \beta \)-Lactam for Staphylococcal Bacteremia

To the Editor—The recent discussion by McConeghy et al of treatment for staphylococcal bacteremia using an empirical combination of vancomycin and a \( \beta \)-lactam was insightful [1]. They and other investigators have speculated that using initial empirical coverage with activity against both methicillin-resistant \( \text{Staphylococcus aureus} \) and methicillin-susceptible \( \text{S. aureus} \) (MSSA) may lead to improved clinical outcomes [2, 3].

Empirical antibacterial coverage including vancomycin and \( \beta \)-lactam antibiotics with significant coverage for gram-negative pathogens has been reported with varying frequency [4, 5]. At our institution, we frequently encounter patients with a variety of indications (sepsis, fever, skin and skin structure infections, pneumonia, and others) who are receiving empirical therapy with vancomycin plus either piperacillin/tazobactam or cefepime. In discussions with multiple infectious disease physicians across the nation, we have commonly heard similar anecdotal observations, although published data in this regard are limited.

\( \beta \)-Lactam agents such as piperacillin/tazobactam and cefepime may offer significant coverage for MSSA as well as for gram-negative organisms [6, 7]. Although these \( \beta \)-lactam antibiotics may not usually be considered as antistaphylococcal drugs as are nafcillin, oxacillin, and cefazolin, their antistaphylococcal activity may already be achieving the objective as suggested by McConeghy et al [1]. Current clinical practice may thus have already accomplished part of the goal McConeghy et al outlined. We caution as well that pressure related to the goal of antimicrobial stewardship may lead to premature de-escalation to vancomycin monotherapy before susceptibility results are known, leading to less desirable clinical outcomes.
Potential conflicts of interest. All authors: No reported conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

Kerry O. Cleveland, Shirin A. Mazumder, and Michael S. Gelfand
Department of Medicine, Division of Infectious Diseases, University of Tennessee Health Science Center, Memphis

References


Correspondence: Kerry O. Cleveland, MD, University of Tennessee Health Science Center, 1325 Eastmoreland Ave, Ste 460, Memphis, TN 38104 (kcleveland@uthsc.edu).

Clinical Infectious Diseases 2014;58(7):1041–2
© The Author 2014. Published by Oxford University Press on behalf of the Infectious Diseases Society of America. All

1042 • CID 2014;58 (1 April) • CORRESPONDENCE