≥13 mm, and therefore suggested to use this diameter as the breakpoint for tigecycline susceptibility. In contrast, we used two agar-based methods, Etest and the Kirby–Bauer disc diffusion method, to evaluate the activity of tigecycline against a collection of 82 multidrug-resistant Acinetobacter isolates from Israel belonging to various clones. We found significantly higher MICs (MIC$_{50}$ 16 mg/L) and resistant percentage (66%) compared with data obtained from vast numbers of Acinetobacter baumannii strains performed in previous studies in different regions of the world. We used an inhibition zone diameter of ≥19 mm as a breakpoint and found excellent correlation with an MIC ≤2 mg/L by Etest. Re-examining our data using the 13 mm breakpoint would have resulted in major error of classifying resistant isolates (MIC 2 mg/L by Etest) as susceptible in 44% of the isolates.

How can the discrepancy between study results be elucidated? It is possible that Acinetobacter isolates from various parts of the world have different underlying mechanisms of resistance and thus may exhibit different susceptibilities. In addition, it is possible that there is an intrinsic difference in susceptibility testing of A. baumannii to tigecycline when tested by agar-based methods versus broth-based methods with the former yielding higher MICs. Indeed, Thamlikitkul et al. mention in their letter that MICs of tigecycline were 4-fold higher when tested by Etest than by broth microdilution.

Until further data are available, these conflicting results and discrepancies between susceptibility testing methods leave us confused regarding the appropriate method and breakpoints that should be used when testing A. baumannii for tigecycline susceptibility.

Transparency declarations

None to declare.

References


Comment on: Can mass media campaigns change antimicrobial prescribing? A regional evaluation study

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yielding a saving/cost ratio of 5.54.5,6 The effect on the prescribing of antibacterials per day (DID) decreased by 6.5% (P < 0.05) and 3.4% (non-significant) after the first and second campaigns, respectively, expressing antibacterial use in defined daily doses per 1000 inhabitants (Figure 1).

Before-and-after assessments showed a reduction in new antibacterial prescriptions per inhabitant over a 6 month period of 13% (19% in children aged under 15 years) 3 years after the start of public campaigns in France.5 In Belgium, the antibacterial use expressed in defined daily doses per 1000 inhabitants per day (DID) decreased by 6.5% (P < 0.05) and 3.4% (non-significant) after the first and second campaigns, respectively, yielding a saving/cost ratio of 5.54.5,6 The effect on the prescribing behaviour of ambulatory care physicians in Belgium might however be underestimated using DID as an outcome measure, because during these years, the content of an average pack increased (both by increase of strength and of pack size). After all, expressing antibacterial use in packages—a proxy for prescriptions—per 1000 inhabitants per day shows an average decrease of 6.9% (SD = 2.0) for 5 years since the start of the Belgian public campaigns in the 2000–01 winter season (Figure 1).

As their effect in the Northeast of England, France and Belgium is similar, we believe one can be quite confident that public campaigns are (cost)effective interventions to improve antibacterial prescribing on both regional and national levels.

Transparency declarations

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References


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Amphotericin B deoxycholate: no significant advantage of a 24 h over a 6 h infusion schedule

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Keywords: continuous infusion, nephrotoxicity, antifungals, antimycotic, empirical antifungal therapy

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Sir,

In a publication in this journal, Peleg and Woods1 described a retrospective analysis demonstrating reduced toxicity and improved survival in neutropenic patients receiving amphotericin B deoxycholate (AmB) by continuous infusion. AmB is a broad-spectrum antimycotic drug widely used for the therapy of fungal infections or therapy-resistant fever during neutropenia. During AmB therapy, severe side effects may occur, including nephrotoxicity and acute reactions with fever and chills. These side effects are one reason why AmB is increasingly replaced by newer drugs and new (liposomal) preparations of amphotericin B; however, the latter are all of considerably higher costs. Therefore, attempts were made to decrease AmB toxicity by modified application schemes. In 2001, Eriksson et al.2 reported that application of AmB by continuous infusion considerably decreased its toxicity and similar effects were reported by Peleg and Woods.1

Here, we report that a similar positive effect of continuous AmB infusions could not be reproduced in our institution. Similar to Peleg and Woods, we performed a retrospective analysis of AmB therapy before and after a switch of our AmB infusion regimens to continuous infusions. The major endpoint of our analysis was toxicity according to common toxicity criteria (CTC). Further endpoints were duration of AmB infusions and switch to second-line antifungics versus defervescence and death. On the basis of the results of Eriksson et al.,2 we adopted a 24 h infusion schedule in July 2001. Before this change in patient management, AmB was infused over 6 h. The 6 h schedule had been optimized beforehand in an attempt to minimize side effects of AmB. Regular supportive therapy included paracetamol (acetaminophen, 500 mg), pentoxyfylline (600 mg), dimethindene (4 mg, an H1 blocker) and 0.9% NaCl (500 mL) before start of infusion of AmB as well as a second infusion of 0.9% NaCl (500 mL) and two additional doses of pentoxyfylline (600 mg) after AmB infusion. Potassium and magnesium were substituted as indicated by regular serum controls. In the 24 h