Towards clinical Applications of PK-PD in specific situations

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with many things borrowed from

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http://www.isap.org

51th Interscience Conference on Antimicrobial Agents and Chemotherapy Chicago, Ill.
In a nutshell…

• Why dosing according to susceptibility (MIC) ?
  – Application for the **fluroquinolones** ?
  – Why do you need "good" breakpoints ?
  – Can you do it for intracellular bacteria ?

• Can you optimize **β-lactams**
  – T > MIC: practical approaches
  – Continuous infusion ?

• What about **vancomycin** ?
  – Continuous infusion ?
  – Where do we reach a limit ?
The problem ... #1 of many ... 

1. Infections are (most often) treated with the same dosing regimen irrespective of the absolute susceptibility of the micro-organism ...

<table>
<thead>
<tr>
<th>Cephalosporin</th>
<th>Usual Dose</th>
<th>Adults</th>
<th>Severe Disease</th>
<th>Children</th>
<th>Usual Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Generation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td>0.5-1 g q6-12h</td>
<td>2 g q6-8h</td>
<td></td>
<td>12.5-33 mg/kg q6-8h</td>
<td></td>
</tr>
<tr>
<td>Cephalothin</td>
<td>0.5-1 g q6h</td>
<td>2 g q4-6h</td>
<td></td>
<td>20-25 mg/kg q6h</td>
<td></td>
</tr>
<tr>
<td>Cephapirin</td>
<td>0.5-1 g q6h</td>
<td>2 g q4-6h</td>
<td></td>
<td>10-20 mg/kg q6h</td>
<td></td>
</tr>
</tbody>
</table>

What is s "severe disease?"
The problem ... #2 (of many)

2. Clinicians tend to ask only (and clinical microbiologists to provide only) "S – I – R" answers based on accepted breakpoints …

But, what is a breakpoint?
The problem as seen from a question of the FDA...

Same dose ?? And what about those ones ?

Breakpoints tend to set up quantic limits in what is fundamentally a continuous distribution ...
So, you need to know the enemy ...

For a fluoroquinolone....

MIC = .016 mg/L  Susceptible

MIC = 2.0 mg/L  Susceptible ?
Which parameter are you going to use in your hospital?

- $\text{AUC}_{24h} / \text{MIC}$
- $C_{\text{max}} / \text{MIC}$
- Time above MIC

Exercise with

- the fluoroquinolones
- the $\beta$-lactams
The saga of the AUC / MIC vs $C_{\text{max}}$ / MIC ratio for fluoroquinolones ...

AUC / MIC is the parameter ...

Forrest et al., AAC, 1993
AUC/MIC$_{24h}$ = 125 : a magical number??

125 was the limit below which failure rates became unacceptable because of either

   • a large MIC
   • or a too low dosage (AUC is proportional to the dosage)
   • was derived from studies on Gram-negative infections
Is 125 good for all ??

The saga of *S. pneumoniae* ...

![Graph showing mortality as a function of 24-hour AUC/MIC for non-neutropenic and neutropenic conditions.](image)
Conditions That Predispose to Pneumococcal Infection

Defective antibody formation
Primary Congenital agammaglobulinemia
Common variable (acquired) hypogammaglobulinemia
Selective IgG subclass deficiency
Secondary Multiple myeloma
Chronic lymphocytic leukemia Lymphoma
HIV infection
Defective complement (primary or secondary)
Decreased or absent C1, C2, C3, C4
Insufficient numbers of PMNs
Primary Cyclic neutropenia
Secondary Drug-induced neutropenia
Aplastic anemia
Poorly functioning PMNs
Alcoholism
Cirrhosis of the liver
Conditions That Predispose to Pneumococcal Infection

**Glucocorticosteroid treatment**
Renal insufficiency?

**Poorly avid receptors for FCγII (R131 allele)**

**Defective clearance of pneumococcal bacteremia**

**Primary Congenital asplenia, hyposplenia**

**Secondary Splenectomy**
Sickle cell disease (autosplenectomy)

**Multifactorial**

**Infancy and aging**
Malnutrition
Diabetes mellitus
Prior respiratory infection
Influenza
Cigarette smoking
Asthma
COPD

Browse Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases
Quinolones: to peak or not to peak?

- Three studies have shown AUC/MIC predictive for outcome.
- One prospective study showed Peak/MIC to be more predictive.

Modelling studies show that:
- Survival linked to Peak/MIC when ratio $> 10/1$.
- Survival linked to AUC/MIC when ratio $< 10/1$.
- The risk of resistance is minimized if the peak/MIC $> 10$. 

![Graph showing probability against peak/MIC ratio]
So, let us accept values with some degree of precaution with fluoroquinolones

If you wish to get a faster eradication and reduce mergence of resistant

<table>
<thead>
<tr>
<th>peak / MIC &gt; 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUC_{24h} / MIC: 30 to 125</td>
</tr>
</tbody>
</table>
1st Example:
You want to control fluoroquinolone dosing at the level of the patient

- Patient 60 yr, pneumonia and suspected bacteraemia/sepsis
- Ixacin 400 mg IV q8h ➔ AUC = 30
- Gram negative rod ...

- E-test MIC=0.01 mg/L
- 30/0.01 ➔ 3000 !
  ➢ 100 mg/day is plenty !

- E-test MIC = 1 mg/L
- 30/2 ➔ 30 !
  ➢ 400 mg q8h may fail

Mouton & Vinks, PW 134:816
Breakpoint issues ...

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage (mg/24h)</th>
<th>AUC/MIC* (24h)</th>
<th>peak / MIC** (24h)</th>
<th>CLSI &quot;S&quot; Bkpts</th>
</tr>
</thead>
<tbody>
<tr>
<td>norfloxacin</td>
<td>800</td>
<td>0.1</td>
<td>0.2</td>
<td>&lt; 4</td>
</tr>
<tr>
<td>ciprofloxacin</td>
<td>500</td>
<td>0.1</td>
<td>0.2</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>ofloxacin</td>
<td>400</td>
<td>0.2-0.4</td>
<td>0.3 - 0</td>
<td>&lt; 2</td>
</tr>
<tr>
<td>levofloxacin</td>
<td>500</td>
<td>0.4</td>
<td>0.4 - 0</td>
<td>&lt; 2</td>
</tr>
<tr>
<td>gatifloxacin</td>
<td>400</td>
<td>0.3</td>
<td>0.4</td>
<td>&lt; 2</td>
</tr>
<tr>
<td>moxifloxacin</td>
<td>400</td>
<td>0.4</td>
<td>0.4</td>
<td>&lt; 2</td>
</tr>
</tbody>
</table>

Based on US prescrib. inf. (adult of 60 kg) of NOROXIN®, CIPRO®, FLOXIN®, LEVAQUIN®, TEQUIN® and AVELOX®

* AUC/MIC = 125
** peak / MIC = 10
A proposal for PK/PD based-breakpoints for fluoroquinolones...

<table>
<thead>
<tr>
<th>Drug</th>
<th>Typical daily dosage$^a$</th>
<th>Typical PK values</th>
<th>Proposed PK/PD upper limit of sensitivity (μg/ml) for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$C_{\text{max}}$ in mg/L total/free (dose)</td>
<td>$AUC_{24;h}$ (mg × h/L) total/free</td>
</tr>
<tr>
<td>Norfloxacin</td>
<td>800 mg</td>
<td>1.4/1.1</td>
<td>14/11</td>
</tr>
<tr>
<td></td>
<td>(400 mg PO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>1000 mg</td>
<td>2.5/1.75</td>
<td>24/18</td>
</tr>
<tr>
<td></td>
<td>(500 mg PO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ofloxacin</td>
<td>400 mg</td>
<td>4/3</td>
<td>40/30</td>
</tr>
<tr>
<td></td>
<td>(400 mg PO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>500 mg</td>
<td>4/2.8</td>
<td>40/28</td>
</tr>
<tr>
<td></td>
<td>(500 mg PO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td>400 mg</td>
<td>3.1/1.8</td>
<td>35/21</td>
</tr>
<tr>
<td></td>
<td>(400 mg PO)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2\textsuperscript{d} example: you want to control fluoroquinolone choice and dosing for patients with CAP

- You have two Ixacins: L-xacin and M-xacin
- They have essentially the same pharmacokinetics and tolerance
- Which one will you recommend in YOUR set-up for CAP?
Application to pneumococci in Belgium

% susceptible strains

**Moxifloxacin** 400 mg 1x/d
- AUC [(mg/l)xh]: 48
  - MIC max: 0.5-1.5
- peak [mg/l]: 4.5
  - MIC$_{max}$: $\sim$ 0.5

**Levofloxacin** 500 mg 1x/d
- AUC [(mg/l)xh]: 47
  - MIC max: 0.5-1.5
- peak [mg/l]: 5
  - MIC$_{max}$: $\sim$ 0.5

MIC data: J. Verhaegen et al., ECCMID 2003
Similar values in 2009 (Vanhoof, ECCMID 2009)
Can you do that in another country?

Fig. 1. Distribution of fluoroquinolone MICs for *S. pneumoniae* blood isolates.
• formed in 1997
• convened by the main ad-hoc scientific and breakpoints committees in Europe
• sets common breakpoints for surveillance of antimicrobial resistance and harmonize clinical breakpoints for existing drugs
• sets breakpoints for all newly registered antimicrobials for inclusion in the labeling (SPC) through ongoing agreement with the European Medicines Agency (EMEA)

• all breakpoints are based on a combination of
  • PK/PD data (in vitro, animals, …)
  • PK in humans with Monte-Carlo simulations and target attainment rates with dose simulations
  • Clinical data
### Enterobacteriaceae

<table>
<thead>
<tr>
<th>Fluoroquinolones</th>
<th>MIC breakpoint (mg/L)</th>
<th>Disk content (µg)</th>
<th>Zone diameter breakpoint (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ciprofloxacin¹</td>
<td>0.5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td>0.5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Norfloxacin</td>
<td>0.5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Ofloxacin</td>
<td>0.5</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

All EUCAST data are freely available at http://www.eucast.org

This is now close to the PK/PD breakpoints
Can we define an intra-cellular breakpoint?

An exercise with moxifloxacin and intracellular S. aureus …

- Use a model of S. aureus phagocytized by macrophages *
- Take a collection of S. aureus with increased MIC towards moxifloxacin (MSSA, CA-MRSA, HA-MRSA, …)
- Test for activity over a wide range of extracellular concentration
- Plot the results against the MIC

Can we define an intra-cellular breakpoint?

```
<table>
<thead>
<tr>
<th>MIC (mg/L)</th>
<th>≤ 0.06</th>
<th>0.125</th>
<th>1.0</th>
<th>≥ 2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS192</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRS386</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA481</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KKH II-7924</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRS384</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

Can we define an intra-cellular breakpoint?

**EUCAST breakpoints**

<table>
<thead>
<tr>
<th>Fluoroquinolones</th>
<th>MIC breakpoint (mg/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( S \leq )</td>
</tr>
<tr>
<td>Ciprofloxacin(^1)</td>
<td>0.5</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>1</td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td>0.5</td>
</tr>
<tr>
<td>Norfloxacin</td>
<td>0.5</td>
</tr>
<tr>
<td>Ofloxacin</td>
<td>0.5</td>
</tr>
</tbody>
</table>

---

*EUCAST breakpoints*

- \( \log_{10} C_s \) (mg/L)
- \( E_{max} \) (\( \Delta \log_{10} CFU \))

---

2d example: $\beta$-lactams : $T > \text{MIC}$ …

You know it is "time above MIC", but…

- How much / How frequent ?
  (Static dose vs maximum effect ?)
- The same for all beta-lactams ?
  (Free fractions of the drug ($Fu$) ?)
- The same for all micro-organisms ?
- The same for all infections ?
- Can you apply to all patients ?
How much time above MIC?

- cefotaxime
- neutropenic mice
- *K. pneumoniae*
- pulmonary infection

100 % - Maximal effect?
Here is a proposal ...

- 40% Moderately severe infection in a non-immunospressed patient
- 100% Severe infection in an immunosuppressed patient

Log₁₀ cfu per lung at 24 hours

Time above MIC (%)
Fig. 7. Relationship between the change in log_{10} CFU per thigh or lung for various pathogens following 24 h of therapy with different doses of penicillins (△), cephalosporins (○) and carbapenems (□).

Andes & Craig Int.
J. Antimicrob. Agents
2002, 19: 261-268

The same for all β-lactams?
The same for all microorganisms?

T > MIC for static effect

<table>
<thead>
<tr>
<th>Drug</th>
<th>Enterobacteriaceae</th>
<th>S. pneumoniae</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone (free)</td>
<td>38 (34-42)</td>
<td>39 (37-41)</td>
</tr>
<tr>
<td>Cefotaxime</td>
<td>38 (36-40)</td>
<td>38 (36-40)</td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>36 (27-42)</td>
<td>39 (35-42)</td>
</tr>
<tr>
<td>Cefpirome</td>
<td>35 (29-40)</td>
<td>37 (33-39)</td>
</tr>
<tr>
<td>Meropenem</td>
<td>22 (18-28)</td>
<td></td>
</tr>
<tr>
<td>Imipenem</td>
<td>24 (17-28)</td>
<td></td>
</tr>
</tbody>
</table>
How do you adjust the dose for a given "Time > MIC"?

- "out of the package insert" PK data
- Monte-Carlo simulations and target attainment approaches
Typical pharmacokinetics of an IV β-lactam

<table>
<thead>
<tr>
<th>time (hours)</th>
<th>serum concentration for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.5 g</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>1.5</td>
</tr>
<tr>
<td>12</td>
<td>0.75</td>
</tr>
</tbody>
</table>

* Single administration unique; half-life 2h; $V_d = 0.2$ l/kg
## Reading the labeling (package insert)

<table>
<thead>
<tr>
<th>time (hours)</th>
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<tbody>
<tr>
<td></td>
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<td>2</td>
<td>25</td>
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<tr>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>1.5</td>
</tr>
<tr>
<td>12</td>
<td>0.75</td>
</tr>
</tbody>
</table>

* Single administration unique; half-life 2h; $V_d = 0.2$ l/kg

Where would you like to be?
Simple optimisation of IV β-lactams for "difficult" organisms

- 2 g every 12 h: $T > \text{MIC} = 100\%$ if $\text{MIC} \leq 3\text{ mg/L}$!
- 2 g every 8 h: $T > \text{MIC} = 100\%$ if $\text{MIC} \leq 12\text{ mg/L}$

More frequent administrations is the best way to increase the activity of β-lactams in difficult-to-treat infections...

PK / PD breakpoint for IV β-lactams: MIC < 8 μg/ml
### Cephalosporins

<table>
<thead>
<tr>
<th></th>
<th>MIC breakpoint (mg/L)</th>
<th>Disk content (µg)</th>
<th>Zone diameter breakpoint (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S ≤</td>
<td>R &gt;</td>
<td></td>
</tr>
<tr>
<td>Cefepime</td>
<td>1</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>1</td>
<td>2</td>
<td>30</td>
</tr>
</tbody>
</table>

1. The cephalosporin breakpoints for Enterobacteriaceae will detect all clinically important resistance mechanisms (including ESBL, plasmid mediated AmpC). Some strains that produce beta-lactamases are susceptible or intermediate to 3rd or 4th generation cephalosporins with these breakpoints and should be reported as found, i.e. the presence or absence of an ESBL does not in itself influence the categorization of susceptibility. In many areas, ESBL detection and characterization is recommended or mandatory for infection control purposes.

**Why so low?**

**To exclude ESBL ..**
But there are variation of PK in individuals...

Concentration-time profile of a beta-lactam in volunteers
$V_d = 20 \, \text{L}$, $k_a = 1.2 \, \text{h}^{-1}$, $k_e = 0.3 \, \text{h}^{-1}$

Unlike the Belgian 400 m sprint team, we are not all (almost) equal
Variation of PK in individuals...

Concentration-time profile of a beta-lactam in patients with a simulation with a coefficient var. of 20 %
Monte Carlo Simulations in pk/pd

• Have estimates of PK parameter values and a measure of their dispersion (usually SD)
• Simulate PK curves
• use MIC distribution values in the target population
• calculate a probability of attaining the desired target
• examine if this is feasible in clinical practice…
Target Concentration for β-lactams: continuous infusion

- Maximum effect time-kill at 4 x MIC
- Maximum effect in vitro model 4 x MIC
- Effect in endocarditis model 4 x MIC (Xiong et al 1994)
- Effect in pneumonia model dependent on severity of infection


The relationship follows a Hill-type model with a relatively steep curve; the difference between no effect (growth, here displayed as a negative kill rate) and maximum effect is within two to threefold dilutions. The maximum kill rate is attained at around four times the minimum inhibitory concentration (MIC). Modified with permission from [16].
Dose Calculations for continuous infusion

- Total Clearance estimate
- Elimination rate constant

\[ C_{ss} = \frac{K_o}{Cl} \]

- Serum concentration
- Clearance
- Infusion rate

- Volume of distribution for the initial loading dose (loading dose = \( C_{target} / Vd \))
Continuous infusion of β-lactams: an overview...

- The exact role of continuous infusion of β-lactam antibiotics in the treatment of severe infections remains unclear...

- However, increasing evidence is emerging that suggests potential benefits
  - better attainment of pharmacodynamic targets for these drugs
  - More reliable pharmacokinetic parameters in seriously ill patients
  - when the MIC of the pathogen is ≥4 mg/L (empirical therapy where the susceptibility of the pathogen is unknown)

- Clinical data supporting continuous administration are less convincing, but
  - Some studies have shown improved clinical outcomes from continuous infusion
  - none have shown adverse outcomes.
  - clinical and bacteriological advantage are visible in seriously ill patients requiring at least 4 days of antibiotic therapy.

- Seriously ill patients with severe infections requiring significant antibiotic courses (≥4 days) may be the subgroup that will achieve better outcomes with continuous infusion.

Problems with continuous infusion ...

- Clearance estimates
- Variations in clearance (ICU)
- Volume of distribution (ICU, burned patients, ...)
- Non-linear clearance
- Drug instability
Problems with continuous infusion ...

- Clearance estimates
- Variations in clearance (ICU)
- Volume of distribution (ICU, burned patients, ...)
- Non-linear clearance
- Drug instability

you may like to monitor the serum levels if MICs $\geq 4$
(also for discontinuous administration)

temocillin $>$ piperacillin $>$ ceftazidime $>$ cefepime ...

!! carbapenems are unstable (3-4h max.)
Continuous infusion with vancomycin?

2. Time-dependent antibiotics with weak concentration effect but with post-antibiotic effect

<table>
<thead>
<tr>
<th>AB</th>
<th>PK/PD Parameter</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>glycopeptides *</td>
<td>AUC_{24h} / MIC</td>
<td>Daily dose optimization</td>
</tr>
<tr>
<td>tetracyclines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>macrolides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>linezolid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>streptogramins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What can YOU do…?
Continuous infusion of vancomycin

Infusion will push music to its limits

- Will maximize antibiotic effects…
- Will allow for an easier administration scheme

<table>
<thead>
<tr>
<th>Studies *</th>
<th>indications</th>
<th>conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. controlled studies with clinical endpoints</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 <strong>a</strong></td>
<td>VAP, Gram + osteomyelitis, other serious infections (ICU, open heart surgery)</td>
<td>equivalence (6) superiority (3)</td>
</tr>
</tbody>
</table>

* Only papers in ‘peer-reviewed’ journals

Continuous versus Intermittent Infusion of Vancomycin in Severe Staphylococcal Infections: Prospective Multicenter Randomized Study

MARC WYSOCKI,1* FREDDERIQUE DELATOUR,2 FRANÇOIS FAURISSON,2 ALAIN RAUSS, YVES PEAN,4
BENOIT MISSET,5 FRANK THOMAS,6 JEAN-FRANÇOIS TIMSIT,7 THOMAS SIMILOWSKI,8
HERVE MENTEC,9 LAURENCE MIER,10 DIDIER DREYFUSS,10
AND THE STUDY GROUP†

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• 119 critical care patients with multi-resistant organisms (bacteriemia, 35%; pneumonia, 45%).
• Microbiological and clinical outcomes,
• Safety, pharmacokinetics, ease of administration, cost …

⇒ clinical outcome and safety: equivalence
⇒ target concentrations (20-25 mg/L) reached faster
⇒ less samples needed for blood levels follow up
⇒ AUC24h less varaible
⇒ costs: 23% less
Continuous infusion of vancomycine in daily practice …

• Loading dose

\[ C_t = \frac{\text{Dose}}{V_d} \]

\[ \text{Dose} = C_t \times V_d \]

- \( V_d \) (L/kg):
  - 0.5
  - 0.6
  - 0.7 *
  - 0.8

- Dose (mg/kg):
  - 12.5
  - 15.0
  - 17.5 *
  - 20.0

* Vdss of vancomycin: 0.39 to 0.97 L/kg

Results

**The target concentration was reached after 48 h with the help of the clinical pharmacist...**

**There was, however, a large inter- and intra-individual variability in vancomycin serum concentrations**

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*Ampe et al., in preparation*
Results: efficacy

Correlation between $AUC_{24h} / MIC$ (E-Test *) and clinical efficacy ($n=19$)
Which were the isolates where we failed?

AUC$_{24h}$/MIC distribution (E-test *)

Low "target attainment" in patients with organisms with MIC’s $\geq$ 1,5 mg/L

* E-test overestimates vancomycin MIC by $\sim$ 1 dilution

Ampe et al., in preparation
Conclusions … or what do you need with any antibiotic for "difficult to treat patients" or environments where susceptibility is no longer to its best… ?

• Obtain MIC distributions in YOUR clinical environment

• On this basis, construct nomograms to examine which doses (AUC *, peak *) and/or frequency of administration (time *) are necessary for the MIC you are interested in …

• Examine whether this is feasible for YOUR patients… with the drug you want to use

• The situation may be critical for "new" antibiotics (telavancin, doripenem, …) for which the EUCAST/FDA breakpoints are close to the upper limit of the wild type distribution…

* get this information from your pharmacist, the literature, and/or the Industry …
A clinical algorithm or a path to success...

Knowledge or ou “educated” suspicion of the causative agent

Pathology and epidemiology

Local MIC data

Is the organism probably highly susceptible?

yes

Use common dosage but with attention to PK/PD

no

Obtain an MIC

S / I / R is insufficient !!

Adjust the dosage on a full PK/PD basis
A clinical algorithm (follow.) ...

Success ?

no

re-evaluate
• the dosage
• the therapeutic scheme
• the antibiotic class
  based on PK/PD properties

yes

Consider step-down therapy
if acceptable on a microbiological
point of view

Use these pieces of information
to establish recommendations
based on local epidemiology,
knowledge of PK/PD properties
and awareness of the risk for
resistance, and
SHARE YOUR EXPERIENCE