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Dr Nahéma ISSA

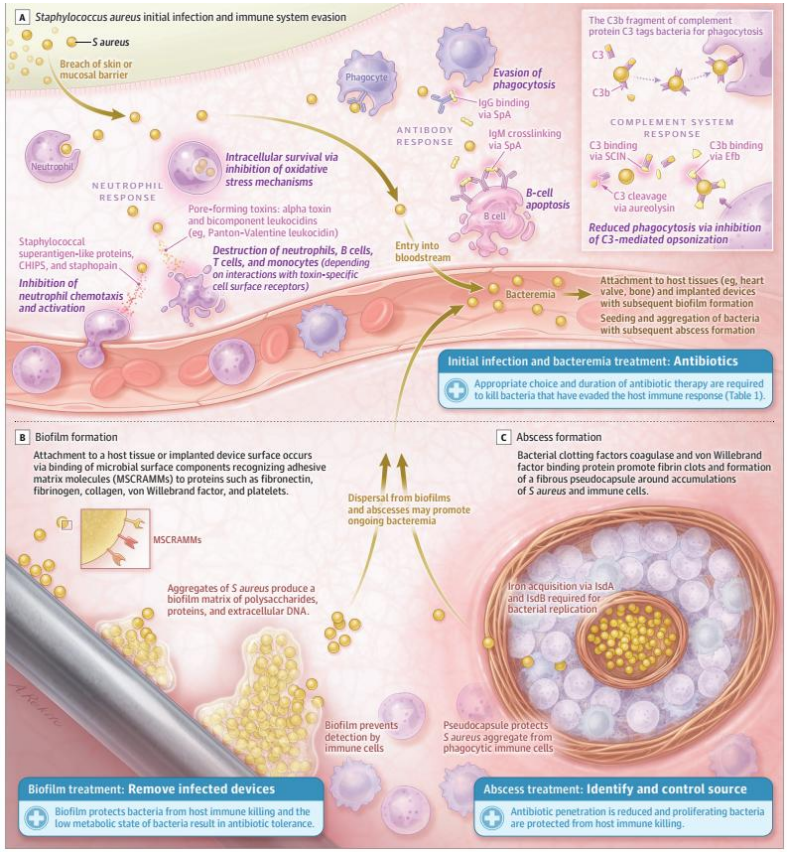
CHU BDX CENTRE HOSPITALIER UNIVERSITAIRE BORDEAUX

Bactériémie à SA

Management of *Staphylococcus aureus* Bacteremia
A Review

Steven Y. C. Tong, MBBS, PhD; Vance G. Fowler Jr, MD, MHS; Lesley Skalla, PhD, MSLS; Thomas L. Holland, MD, MSc

JAMA Network Open
Avril 2025



S aureus growth in blood culture

For all patients

- Perform thorough history and physical examination
- Repeat blood cultures every 24-48 h until clear
- Transthoracic echocardiography to evaluate for endocarditis
- Consult with infectious diseases

As clinically indicated

- **High risk for endocarditis (eg, VIRSTA score ≥3, persistent bacteremia, cardiac device):** transesophageal echocardiography
- **Back pain:** spinal magnetic resonance imaging (MRI) or spinal computed tomography (CT)
- **Neurologic deficits:** brain MRI or brain CT

For persistent bacteremia despite source control

- Positron emission tomography-CT where available

or

- Thoracoabdominal CT with contrast

Drug	Recommended dose
For methicillin-susceptible *S aureus*[b]	
Cefazolin	2 g every 8 h
Flucloxacillin	2 g every 6 h
Cloxacillin	2 g every 4 h
Nafcillin	2 g every 4 h
Oxacillin	2 g every 4 h
Benzylpenicillin	2.4 g (4 million U) every 4 h
For methicillin-resistant *S aureus*	
Vancomycin	Loading dose of 20-35 mg/kg (maximum, 3 g), then 15-20 mg/kg (maximum, 2 g) every 12 h[c]
Daptomycin	6-10 mg/kg once daily
Ceftobiprole	500 mg every 6 h for 8 d, then 500 mg every 8 h

What Is the Role of Oral Antibiotics in Treatment of *S aureus* Bacteremia?

In carefully selected circumstances, switching to oral antibiotics after an initial intravenous antibiotic phase may be considered. An important aspect of the randomized clinical trials comparing oral switch to continued intravenous therapy was the highly selected patient populations for trial inclusion among those with low-risk uncomplicated bacteremia or those with infective endocarditis. Results from these trials need to be replicated in larger studies and in patients with MRSA bacteremia before switching to oral antibiotics can be recommended more generally.

EI à SAMS: effet inoculum

Original Investigation | Infectious Diseases

β-Lactam Inoculum Effect in Methicillin-Susceptible *Staphylococcus aureus* Infective Endocarditis

Baptiste Jean, MD; Maelys Crolle, PharmD; Candice Pollani, PharmD; Adèle Le Guilloux; Guillaume Martin-Blondel, PhD; Pierre Tattevin, PhD; Audrey Le Bot, MD; David Luque Paz, MD; François Guérin, PhD; Vincent Cattoir, PhD; Laurence Armand-Lefevre, PhD; Signara Gueye; François-Xavier Lescure, PhD; Xavier Duval, PhD; Clémence Massip, PhD; Pierre Delobel, PhD

JAMA Network Open

Dec 2024

Méthode:

-Etude rétrospective multicentrique

-3 CHU français entre fév. 2016- fév. 2022

Rationnel:

-La plupart des isolats de SA sont porteurs du gène BlaZ qui code pour une β lactamase

-Certaines souches de SA blaZ+ ont un effet inoculum : ↗️ CMI en cas de fort inoculum

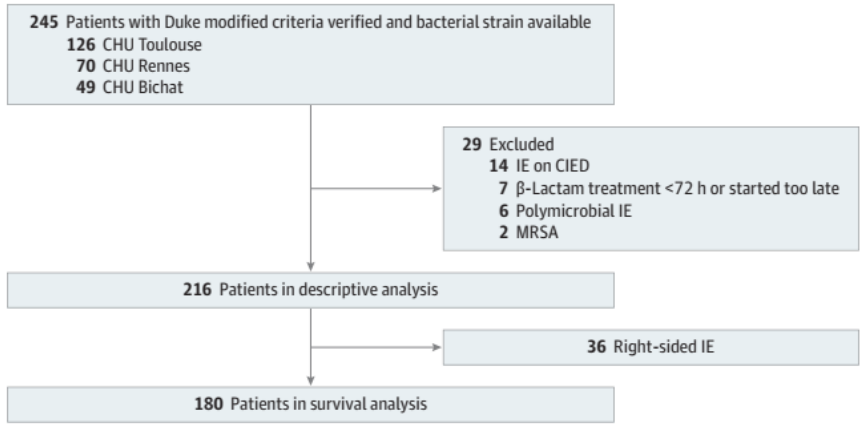
Critères d'inclusion:

-EI à SA certaine ou possible selon Duke 2015

Objectif :

Evaluer la mortalité à M1 dans les EI à SAMS du cœur gauche en fonction de la βlactamine utilisée et du phénotype de SA

Résultats:



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JAMA Network Open

Dec 2024

Résultats:

Bacteriological data	
blaZ presence	159 (73.6)
blaZ type	
Absence	57 (26.4)
A	57 (26.4)
B	57 (26.4)
C	44 (20.4)
D	1 (0.4)

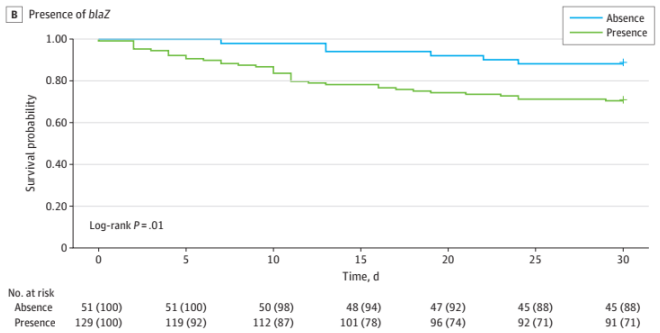
- Effet inoculum observé

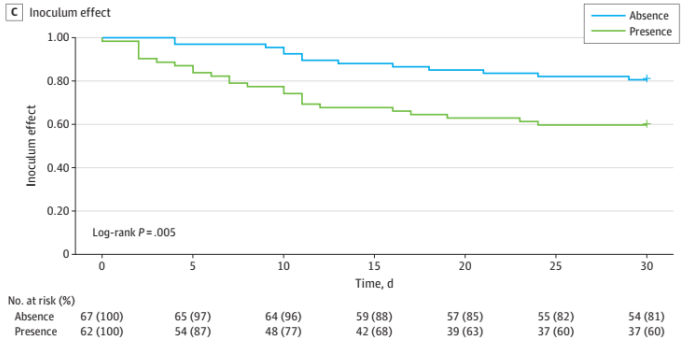
-Peni M: 82/159 SA blaZ+= 51,6%

-CEFAZO: 41/159 SA blaZ+= 25,8%

- Parmi les 159 souches blaZ+:

21,4% ont un effet inoculum pour Peni M et CEFAZO





Mortalité M1: 24,4% sans ≠ selon ATB

- 29,5% blaZ+
- 11,8% blaZ-

p= 0,01

Mortalité M1:

- 40,3% si effet inoculum
- 19,3% si pas d'effet inoculum

p= 0,005

→ La présence d'un effet inoculum aux βL est un FDR de mortalité à M1 (HR= 2,84)

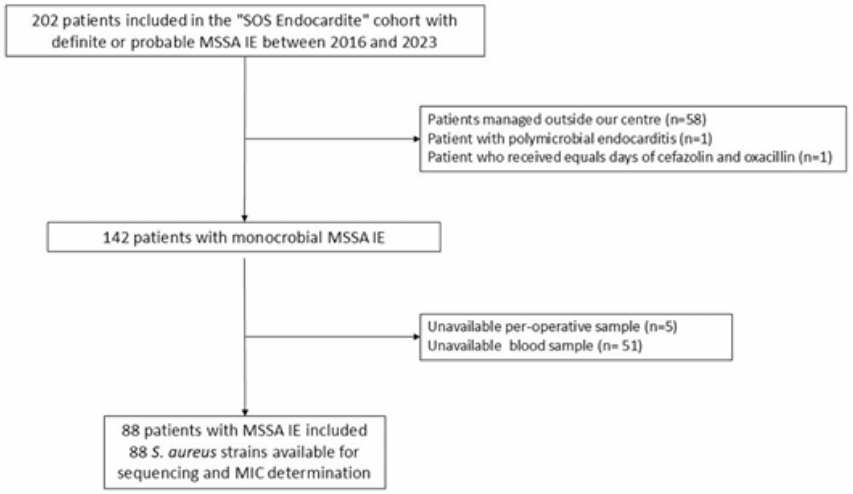
→ Phénotyper les isolats de SAMS et identifier un effet inoculum pourrait guider le choix de la βL

EI à SAMS: effet inoculum

Clinical features and medical–surgical management overweight the inoculum effect and genotypic characteristics of MSSA in infective endocarditis

Thiziri Tala-Ighil [1,2], Guilhem Royer [1,2], Raphaël Lepeule[2,3], Vincent Fihman [1,2], Adrien Galy[2,3], Pascal Lim [4], Christophe Rodriguez[5,6], Hervé Jacquier [1,2] and Paul-Louis Woerther [1,2*]

Journal of Antimicrobial Chemotherapy
Mars 2025



Results: Eighty-eight patients with MSSA IE were included. The most frequent clinical presentations were left-sided native valve IE (25/88), left-sided prosthetic valve IE (12/88) and right-sided IE (19/88). Day-90 mortality rate was 39% (34/88). Most patients were treated with antistaphylococcal penicillin as a primary antibiotic (60/88). The main MSSA clonal complexes identified were CC398 (17/88), CC30 (13/88) and CC5 (13/88). Cefazolin inoculum effect was observed in 18/88 strains, and oxacillin inoculum effect in 13/88. Overall, 15/88 isolates exhibited an inoculum effect on primary antibiotic therapy. Factors independently associated with improved outcomes included cardiac surgery [hazard ratio (HR) 0.34, 95% CI (0.13–0.89)] and source control [HR 0.21, 95% CI (0.03–0.53)]. Neither genetic background, *blaZ* carriage, nor *in vitro* inoculum effect to the primary antibiotherapy was associated with Day-90 mortality.

Conclusions: This cohort of MSSA IE did not find any microbiological factors correlated with Day-90 mortality. Clinical features and infection management appear to be the main factors in the prognosis of MSSA IE.

→ La présence d'un effet inoculum aux βL n'a pas d'effet délétère sur la mortalité à J90

Hémocultures

Time to *Staphylococcus aureus* Blood Culture Positivity as a Risk Marker of Infective Endocarditis: A Retrospective Cohort Study

Martin Strömdahl,[1,2] Karl Hagman,[3,4] Karolina Hedman,[5] Anna Westman,[1,5] Magnus Hedenstierna,[1,2] and Johan Ursing[1,2]

Clinical Infectious Diseases

Avril 2025

Méthode:

- étude rétrospective monocentrique, Stockholm
- 2011-2021

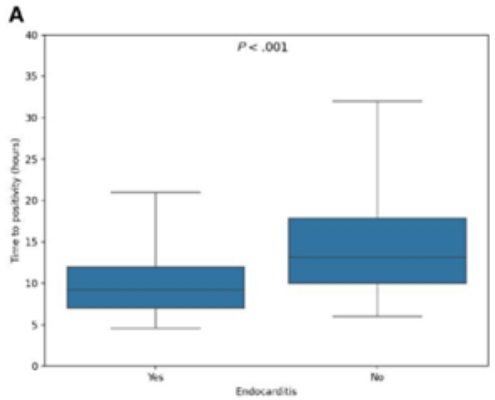
Objectif :

évaluer si le temps de positivité (TDP) de l'hémoculture est associée à une EI

Critère d'inclusion adulte et ≥ 1 hémoculture à SA

Résultats :

- 1703 épisodes de bactériémie à SA (1610 patients)
- 86,5% de SAMS
- 9% d'endocardites infectieuses
- ETT réalisée dans 65% des cas
- Mortalité 24%



- TDP = 9h [IQR, 7–12] si EI vs 13h sans EI [IQR, 10–18]; p < 0,001
- Risque d'EI ⬇️ de 11 %/heure : OR= 0,89 [95%IC, 0,54- 0,92] ; P < 0,001
- TDP médian <13h est associé une EI OR= 3,59 [95% CI, 2,35-5,3] ; P < .001
- La VPN du TDP > 13 h pour l'EI = 96%

→TDP pourrait être utilisé pour stratifier le risque d'IE

Hémocultures

Clinical Infectious Diseases

CORRESPONDENCE

IDSA OXFORD

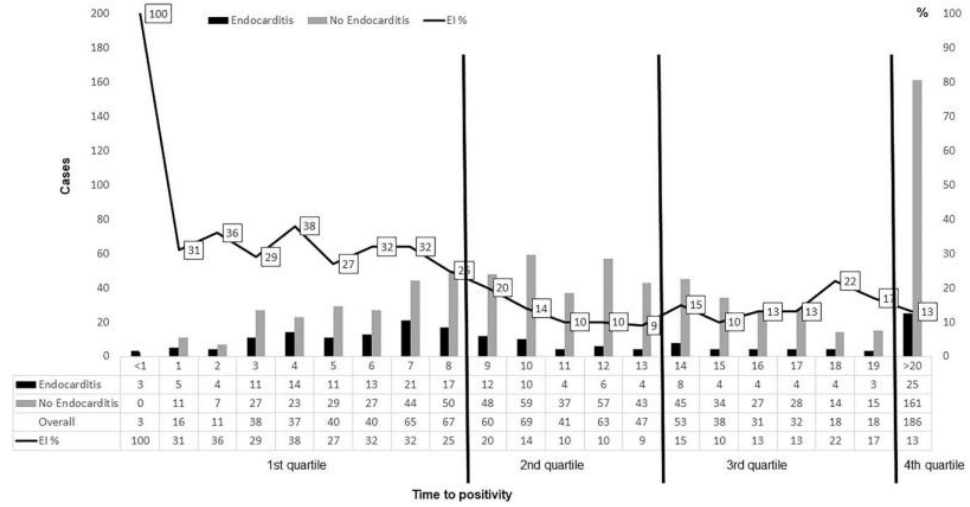
Is Time to Positivity in *Staphylococcus aureus* Bacteremia a Harbinger of Endocarditis?

To The Editor—We read with interest the study by Strömdahl et al [1] in which they assessed the value of time to positivity (TTP) of positive blood cultures (BCs) in discriminating between patients with and without infective endocarditis (IE) in cases of *Staphylococcus aureus* bacteremia (SAB). From their study, it might be inferred that a TTP >13 hours could serve as a cutoff to rule out IE in SAB patients, given that their study reported a negative predictive value (NPV) of 96% with this threshold.

In reading the article, we identified 2 main points of concern. First, the management of BCs at their center changed over time. During the second period of the study, the BCs were preincubated at 37°C before microbiological processing, which may alter TTP [2]. Second, the presence of IE was not systematically ruled out with echocardiography (ECHO) in their patients, as only 65% underwent this test. These considerations prompted us to analyze our experience with SAB in patients who systematically received ECHO. We think that our results may complement those obtained by Strömdahl et al.

We analyzed 973 episodes of SAB in a large tertiary hospital in Madrid, Spain, between 1 January 2005 and 31 December 2024. BCs arrived directly at the Microbiology Department throughout this period and were immediately incubated using the BD BACTEC FX Blood Culture System. All patients included in this assessment underwent ECHO for IE. Endocarditis was present in 187 of the 973 episodes (19.2%). In the entire cohort, the median TTP was 11.9 hours (interquartile range [IQR], 7.9–17.2). TTP was significantly shorter in patients with IE (8.6 hours; IQR, 5.9–14.5) compared to those without IE (12.4 hours; IQR, 8.5–17.5; $P < .01$). Figure 1 presents the hourly distribution of TTP among our SAB patients. Of the 187 patients with IE, 88 (47.1%) had a TTP >9 hours, 55 (29.4%) had a TTP >13 hours, and 25 (13.4%) had a TTP >19 hours. Upon analyzing the distribution of TTP, we could not identify an explicit cutoff for discriminating the risk of IE. Our cohort's NPV for a TTP of 13 hours was 86.6%. The lower NPV observed in our patients compared to that in the study by Strömdahl et al may be due to differences in the populations studied. Our cohort included only patients with SAB who underwent ECHO to rule out IE. It is possible that in the Swedish cohort, some cases of IE went unidentified due to the lack of ECHO.

In conclusion, we appreciate the interesting work by Strömdahl et al and agree that a very short TTP indicates a higher probability of IE. However, our data, derived from patients who underwent ECHO, suggest that a significant likelihood of IE exists even in patients with TTP >13 hours. Regardless, we believe TTP should be considered in multifactorial predictive scores [3].



	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	>20
Endocarditis	3	5	4	11	14	11	13	21	17	12	10	4	6	4	8	4	4	4	4	3	25
No Endocarditis	0	11	7	27	23	29	27	44	50	48	59	37	57	43	45	34	27	28	14	15	161
Overall	3	16	11	38	37	40	40	65	67	60	69	41	63	47	53	38	31	32	18	18	186
EI %	100	31	36	29	38	27	32	32	25	20	14	10	10	9	15	10	13	13	22	17	13

Figure 1. Distribution of patients with and without infective endocarditis (IE) by time to positivity (in hours).

- Dans l'étude réalisée à Madrid:

TDP + court si EI : 8,6 vs 12,4h

- Parmi les 184 patients avec une EI:

TDP> 13h : 29,4% des cas

TDP> 19h : 13,4% des cas

Hémocultures

Single- Versus Multiple-sampling Strategy for Blood Cultures in the Diagnosis of Infective Endocarditis: The Prospective Multicenter UniEndo Study

François Goehringer,[1] Marc Soudant,[2] Corentine Alauzet,[3] Christine Selton-Suty,[4] Nelly Agrinier,[2] Jean-Marc Virion,[2] Benjamin Lefevre,[1] Nejla Aissa,[5] François Alla,[6] Yvon Ruch,[7] Yohan N'Guyen,[8] Lionel Piroth,[9] Kevin Bouiller,[10] Pierre-Yves Royer,[11] Vincent Le Moing,[12] Bruno Hoen,[13,14,a] and Xavier Duval[15,16,a]; the UniEndo-AEPEI Study group

Clinical Infectious Diseases

Avril 2025

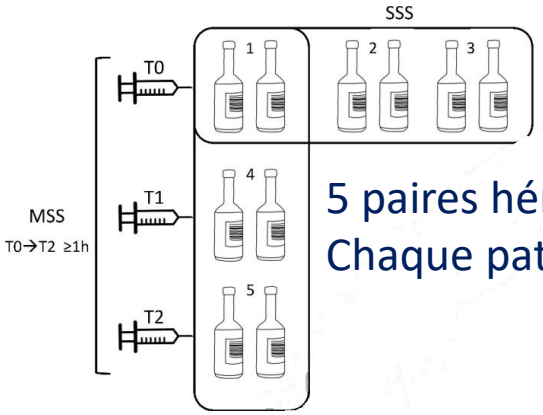
Méthode:

- étude prospective , française, observationnelle
- 8 centres
- 2017-2022

Objectif :

- Comparer la performance de l'hc unique vs multiple dans le dg de l'EI

Protocole :



5 paires hémocultures / patient
Chaque patient est son propre contrôle

Résultats:

- EI diagnostiquée chez 101 des 256 patients inclus
- Micro organismes: streptocoques (21,8%), staphylocoques (18,8%), entérocoques (12,9%)
- Hc unique *vs* Hc multiples:

Volume de sang ≥ 76,2% vs 71,1% (p= 0,003)

Durée de soins infirmiers + courte : 10min *vs* 16 min p < 0,001

Contamination : 3 dans chaque groupe

Performance

Se = 50,5 % (IC 95 % [40,7-60,2]) *vs* 45,5 % (IC 95 % [35,8-55,3]) (p=0,063)

Spé = 94,8 % (IC 95 % [91,4-98,3]) *vs* 95,5 % (IC 95 % [92,2-98,8]) (p=1)

→ L'hémoculture unique fait aussi bien que l'hémoculture multiple pour le diagnostic d'une EI

S.Lugdnensis et EI

INFECTIOUS DISEASES
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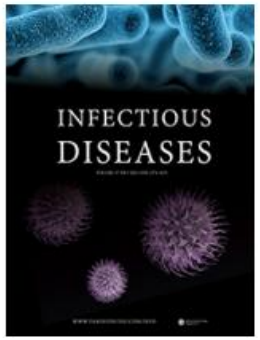
RESEARCH ARTICLE

Staphylococcus lugdunensis infective endocarditis: a multicentre international observational study

Benjamin Lefevre[a,b], Gilbert Habib[c], Bruno Hoen[b], Christine Selton-Suty[d], Mary Philip[c,e], Nahema Issa[f], Pierre Danneels[g], Marine De La Chapelle[h], Colin Deschanvres[i], Marie-Line Erpelding[j], Pierre Tattevin[k], Audrey Le Bot[k], Miguel Villamarín[l,m], Nuria Fernández-Hidalgo[l,m,n], Christophe Tribouilloy[o,p,q], Emilie Pluquet[r], Vincent Dubee[g], Margaret Hannan[s], Gabriela Dornikova[s], Emanuele Durante-Mangoni[t], Lorenzo Bertolino[t], Rinaldo Focaccia Siciliano[u], Anna Maria Amaral de Oliveira[v], Marcelo Goulart Correia[w], Frédérique Gouriet[c,e,x] and Cristiane Lamas[w,y]



Aout 2025

Etude multicentrique rétrospective entre 2010-2024, 17 centres

	n/N	%
Demographics		
Mean age in years (SD)	67(18)	
Male gender	76/112	67.9%
Comorbidities		
Hypertension	51/112	45.5%
Diabetes mellitus	31/112	27.7%
Chronic heart failure	28/112	25.0%
Malignant disease	25/112	22.3%
Chronic renal failure	24/111	21.6%
Coronary artery disease	23/112	20.5%
Autoimmune disease	14/112	12.5%
Cerebrovascular disease	13/112	11.6%
Chronic obstructive pulmonary disease	10/112	8.9%
Cirrhosis	10/112	8.9%
HIV infection	0/112	0.0%
Predisposition for IE		
Prosthetic valve	41/112	36.6%
Cardiac implantable electronic device	21/112*	18.8%
Rheumatic valve disease	19/112	17.0%
Previous IE	13/112	11.6%
Congenital heart disease	10/112	8.9%
Intravenous drug use	3/112	2.7%
Left or biventricular ventricular assist device	0/112	0.0%
Background		
Community- acquired IE	77/112	68.8%
Hospital- acquired IE	17/112	15.2%
Healthcare-associated nonhospital acquired IE	18/112	16.1%
Early prosthetic valvular IE	5/112	4.5%
Late prosthetic valvular IE	36/112	32.1%

Table 1. Features of *S.lugdunensis* IE in 112 episodes, 2010-2024.

Predictors	OR (95% CI)	P value
Age (years)*	1.19 (1.08- 1.31)	<.001
Malignancy	26.22 (3.78- 181.72)	<.001
New mitral regurgitation	17.10 (2.81- 104.09)	0.002
Paravalvular abscess	63.40 (6.24- 644.03)	<.001
High degree atrioventricular block	27.76 (2.49- 309.82)	0.007

Table 3. Multivariable analysis of risk factors associated with all-cause in-hospital mortality in *Staphylococcus lugdunensis* infective endocarditis.
Footnotes:AV= atrioventricular; OR=odds ratio; CI=confidence interval; *OR per one year increment

- ✓ 100% de souches MS
- ✓ PEC chirurgicale = 42%
- ✓ Mortalité hospitalière = 29,5%

→IE à SL
forme agressive
présentation clinique semblable SA
mortalité importante

Traitement SAMS

Cloxacillin versus cefazolin for meticillin-susceptible *Staphylococcus aureus* bacteraemia (CloCeBa): a prospective, open-label, multicentre, non-inferiority, randomised clinical trial

Charles Burdet, Nadia Saïdani, Céline Dupieux, Adrien Lemaignen, Etienne Canouï, Laure Surgers, Marc Olivier Vareil, Agnès Lefort, Raphaël Lepeule, Nathan Peiffer-Smadja, Alexandre Charmillon, Vincent Le Moing, David Boutoille, Violaine Tolsma, Sophie Abgrall, Michel Wolff, Pierre Tattevin, Marina Esposito-Farèse, François Vandenesch, Xavier Duval, Sarah Tubiana*, François-Xavier Lescure*, for the CloCeBa Study Group†*

Nov 2025

Méthode:

-Etude multicentrique, randomisée, non infériorité

-21 centres français entre 2018-2023

Critères d'inclusion

Bactériémie SAMS <72h , adultes

Critères d'exclusion:

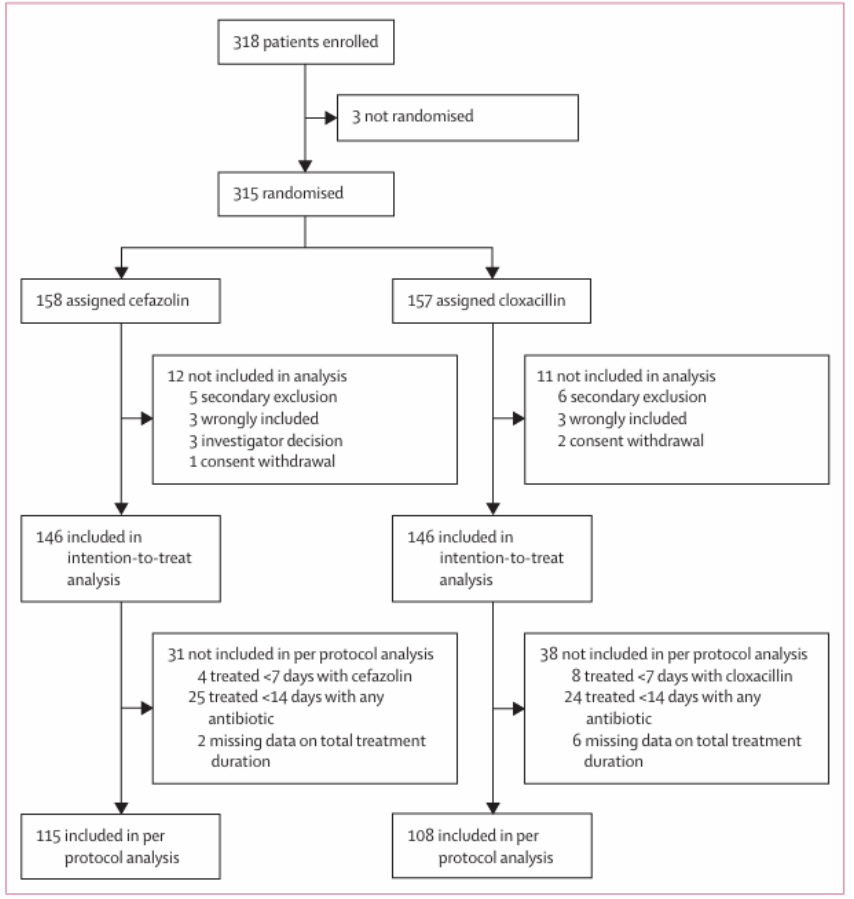
-Matériel endovasculaire

-Suspicion d'infection SNC

-Insuffisance rénale grade 4

CJP= succès thérapeutique à J90

-Critère composite : absence de récidive BSI, survie, succès clinique



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Nov 2025

	Cefazolin (n=146)	Cloxacillin (n=146)	Treatment difference (95% CI)	p value
Survival at day 90	134/146 (92%)	134/146 (92%)	0% (–7 to 7)	0·0005
Microbiological success at day 3 (or day 5 in participants with endocarditis)	136/146 (93%)	135/146 (92%)	1% (–6 to 7)	0·0002
Absence of relapse of bacteraemia at day 90	145/146 (99%)	144/146 (99%)	1% (–3 to 4)	<0·0001
Clinical success at day 90	116/144 (81%)	111/139 (80%)	1% (–9 to 10)	0·0041
Clinical success at day 7	105/142 (74%)	98/140 (70%)	4% (–6 to 14)	0·0013

Data are n/N (%), unless otherwise indicated. p values refer to the test for non-inferiority of cefazolin over cloxacillin.

Table 3: **Primary and secondary endpoints in the intention-to-treat population**

	Cefazolin (n=146)	Cloxacillin (n=146)	Treatment difference (95% CI)	p value
Any serious adverse event over the study course	51/146 (35%)	64/146 (44%)	–9% (–20 to 2)	0·12
Any serious adverse event by day 7	14/146 (10%)	30/146 (20%)	–11% (–19 to –3)	0·0090
Any serious adverse event by end of study treatment	22/146 (15%)	40/146 (27%)	–12% (–22 to –3)	0·010
Any serious adverse event by end of antimicrobial therapy	32/146 (22%)	48/146 (33%)	–11% (–21 to –1)	0·036
Premature discontinuation of study treatment due to an adverse event	5/146 (3%)	13/146 (9%)	–5% (–12 to 1)	0·052
Clostridioides difficile infection	3/146 (2%)	3/146 (2%)	0 (–4 to 4)	>0·99
Acute kidney injury by day 7	1/134 (1%)	15/128 (12%)	–11% (–18 to –6)	0·0002
Acute kidney injury by end of study treatment	4/111 (4%)	17/99 (17%)	–13% (–23 to –6)	0·0008

Data are n/N (%), unless otherwise indicated. p values refer to the test of superiority. Some participants had more than a single serious adverse event.

Table 4: **Severe adverse events and safety outcomes in the intention-to-treat population**

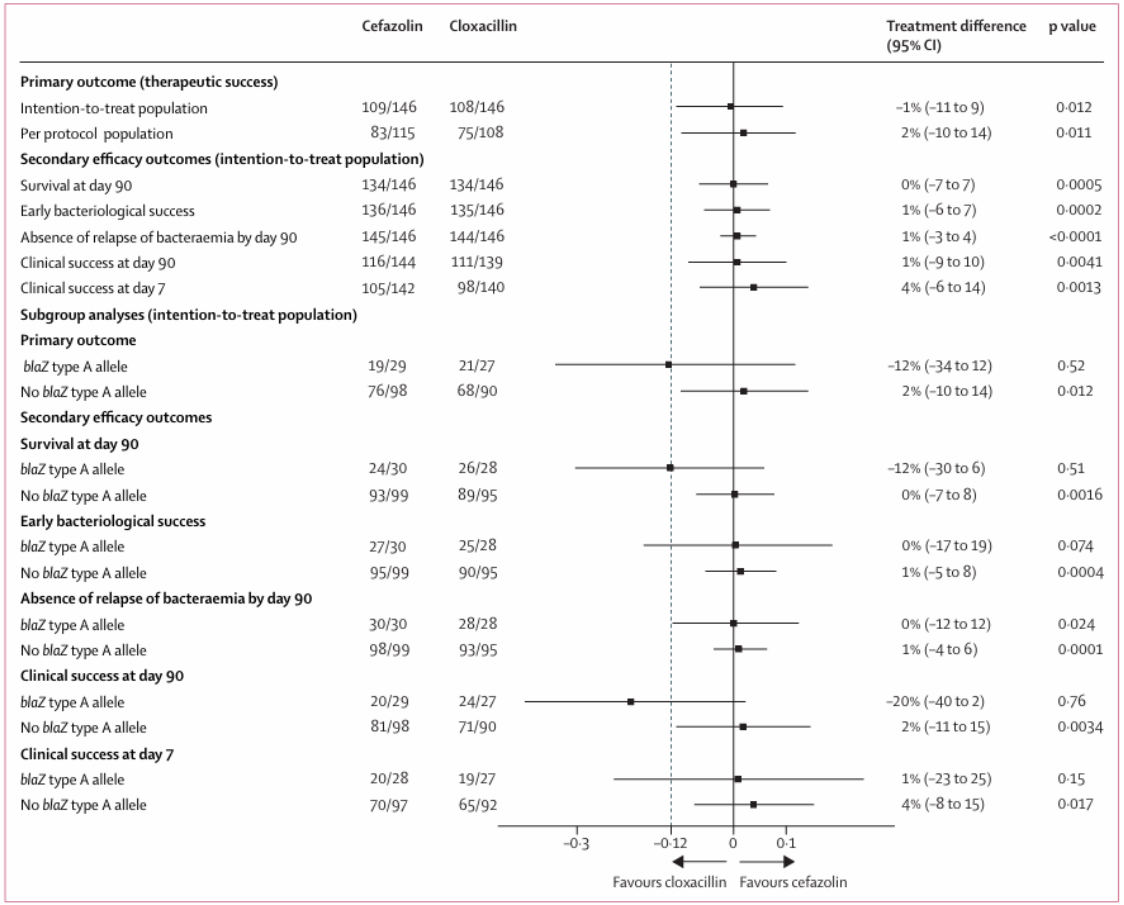


Figure 2: **Subgroup analyses of the efficacy outcomes in the intention-to-treat population**
Bacterial strains of 40 participants were not available for genetic analysis (17 from the cefazolin group; 23 from the cloxacillin group). The dotted line represents the non-inferiority margin.

→Non infériorité de la CEFAZO vs CLOXA ds BSI à SAMS

Traitement SAMS

Time to Reappraise the Antibiotic Treatment for Methicillin-Susceptible *Staphylococcus aureus* Infective Endocarditis: Data From the Experimental Model

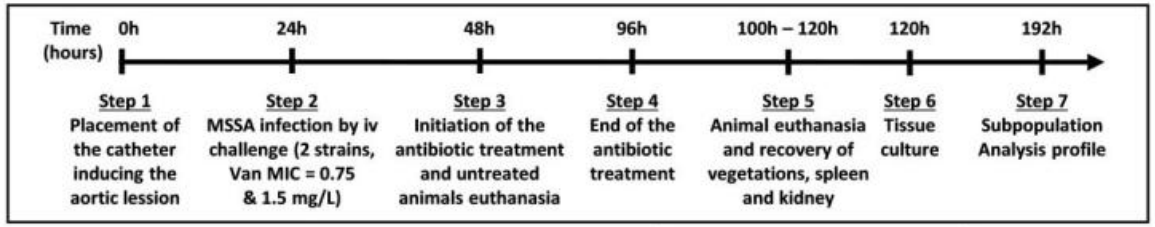
Cristina García-de-la-Mària,[1,a] Oriol Gasch,[2,a,©] María A. Cañas-Pacheco,[1] Javier García-González,[1] Francesc Marco,[3] Marta Hernández-Meneses,[1,©] Eduard Quintana,[1] Juan Ambrosioni,[1,4] Carles Falces,[1] José M. Tolosana,[1] Bárbara Vidal,[1] Juan M. Pericas,[1] Andrés Perissinotti,[1,5] Jaume Llopis,[6] Asunción Moreno,[1] Guillermo Cuervo,[1,4,b] and José M. Miró[1,4,7,b,©]; on behalf of the Hospital Clinic Endocarditis Study Group, Hospital Clínic–IDIBAPS, University of Barcelona, Barcelona, Spain

The Journal of Infectious Diseases

Mai 2025

- Comparer l'efficacité de la CLOXA, de la CEFTAROLINE et de la DAPTOMYCINE en monothérapie et de la DAPTO + β L dans un modèle d'endocardite à MSSA chez le lapin.

Design of a rabbit model for experimental MSSA endocarditis.



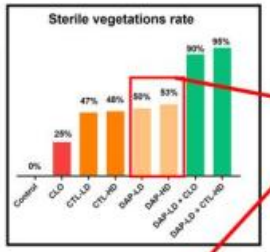
RESULTS

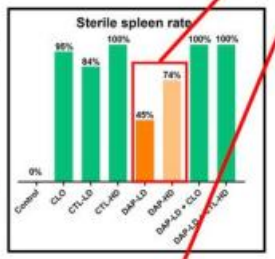
Female, New Zealand white rabbits (n=19-21 rabbits in each group)

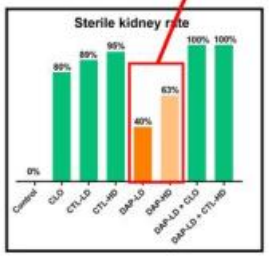
Valve vegetations

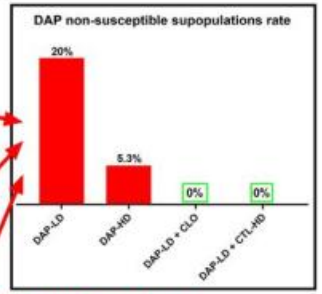
Spleen

Kidney









TAKE -HOME MESSAGES:

- The MSSA vancomycin MIC did not influence the efficacy of any antibiotic treatment.
- Cloxacillin, ceftaroline, and daptomycin as monotherapy showed similar activity ($p > 0.05$), although ceftaroline and daptomycin sterilized twice as many vegetations as cloxacillin. Cloxacillin and ceftaroline were more active than daptomycin in spleen and kidney tissues.
- Thirteen percent of animals treated with daptomycin monotherapy developed daptomycin non-susceptible (DNS, MIC = 2 mg/L) isolates in all tissues.
- Combinations of daptomycin with cloxacillin or ceftaroline showed significantly better activity than monotherapies in sterilizing vegetations (≥ 90%), spleen and kidney tissues (100%) and in preventing the development of DNS in all cases.

→Efficacité DAPTO +BL

DALBA et BSI

JAMA | Original Investigation

Dalbavancin for Treatment of *Staphylococcus aureus* Bacteremia
The DOTS Randomized Clinical Trial

Nicholas A. Turner, MD, MHSc; Toshimitsu Hamasaki, PhD; Sarah B. Doernberg, MD, MAS; Thomas P. Lodise, PharmD, PhD; Heather A. King, PhD; Varduhi Ghazaryan, MD, MPH; Sara E. Cosgrove, MD, MS; Timothy C. Jenkins, MD, MSc; Catherine Liu, MD; Shrabani Sharma, MSc; Smitha Zaharoff, PhD; Lana Wahid, MD; Valerie J. Renard, AGACNP; Paul Cook, MD; Issam Raad, MD; Ray Hachem, MD; Anne-Marie Chaftari, MD; Matthew Sims, MD, PhD; Carmen DeMarco, MD; Loren G. Miller, MD, MPH; Matthew W. McCarthy, MD; Caryn G. Morse, MD, MPH; Chris Lucasti, MD; Graeme N. Forrest, MBBS; Kartikeya Cherabuddi, MD; Christopher Polk, MD; Tasaduq Fazili, MD; Mark E. Rupp, MD; George R. Thompson III, MD; Kami Kim, MD; Luke Strnad, MD; Amanda E. Schnee, MD; James A. McKinnell, MD; Mayur Ramesh, MD; Fernanda P. Silveira, MD, MS; Todd P. McCarty, MD; Todd C. Lee, MD, MPH; Emily G. McDonald, MD, MSc; Kristopher Paolino, MD, MTM&H; Katie Wiegand, MEng; Alison Wall, MS; Todd Riccobene, PhD; Rinal Patel, PharmD; Urania Rappo, MD; Scott Evans, PhD; Henry F. Chambers, MD; Vance G. Fowler Jr, MD, MHS; Thomas L. Holland, MD, MSc; for the Antibacterial Resistance Leadership Group

Aout 2025

Méthode

RCT multicentrique USA et CANADA de phase 2b

Objectif

DALBA (2 doses, 1500mg, J1J8) vs ttt std BSI à SA compliquée

Inclusion

Adulte avec BSI à SA dans les 72h (< J10)

Exclusion: infections SNC, PVE, chirurgie, ID

CJP: **score composite DOOR à J70**

Efficacité cl, complications, AE, qualité de vie

A Desirability of outcome ranking and components by treatment group

Source	Participants, No. (%) Dalbavancin (n = 100)	Standard therapy (n = 100)	Desirability of outcome ranking probability, % (95% CI)
Desirability of outcome ranking			
With quality-of-life tiebreak (primary)			47.7 (39.8-55.7)
Without quality-of-life tiebreak			49.3 (42.0-56.6)
Desirability of outcome ranking components			
Clinical failure	20 (20.0)	22 (22.0)	51.0 (45.3-56.7)
Infectious complications	13 (13.0)	12 (12.0)	49.5 (44.8-54.2)
Nonfatal serious adverse events	40 (40.0)	34 (34.0)	47.0 (40.4-53.7)
Adverse events leading to discontinuation	3 (3.0)	12 (12.0)	54.5 (50.8-58.2)
Death	4 (4.0)	4 (4.0)	50.0 (47.1-52.9)

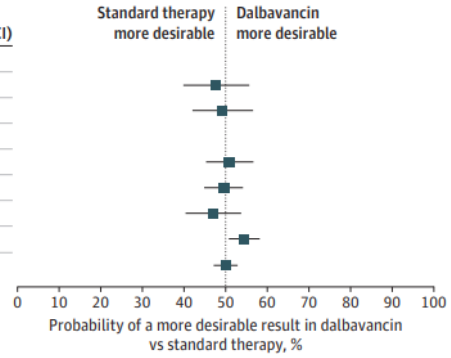


Table 2. Secondary and Exploratory Efficacy Analyses (As-Randomized Population)

Outcomes	No. (%) Dalbavancin (n = 100)	Standard therapy (n = 100)	Difference in proportions (95% CI)
Secondary outcome			
Clinical efficacy at day 70	73 (73)	72 (72)	1.0 (−11.5 to 13.5)[a,b]
Exploratory outcomes			
Microbiologic success at day 70	84/85 (98.8)	79/82 (96.3)	2.5 (−2.2 to 7.3)[c]

→DALBA n'a pas montré sa supériorité mais non inférieure au ttt standard

DAPTO et *E.faecium*

Daptomycin is associated with higher treatment failure rates than alternatives for *Enterococcus faecium* bloodstream infections in critically ill patients: a multicentric retrospective cohort

Simon Herbel[1,2], Guillaume Dumas[3], Louise Chantelot[4,5], Julien Massol[6], Sophie Nagle[7,8], Marie Lecronier[9], Matthieu Turpin[10], Quentin Moyon[11], Jean Damien Ricard[2], Matthieu Petit[12], Elie Azoulay[13], Caroline Hauw-Berlemont[14], Jacques Tankovic[15], Jeremie Joffre[1,16], Hafid Ait-Oufella[1,17], Eric Maury[1,18], Tomas Urbina[1*] and ENTERODAPTO Study Group

Critical Care

Nov 2025

Méthode:

Etude multicentrique rétrospective

11 ICU, 2017-2022, France

Objectif:

Decrire ttt des BSI *E. faecium* et fact d'échec

Inclusion:

Adulte avec BSI à *E. faecium*

Exclusion: infections: SNC, PVE, chirurgie, ID

CJP: **score composite**

Bact ≥3j, rechute J30, Ttt de sauvetage J30

Résultats

-166 patients inclus

-26 traités par DAPTO , dose médiane 10mg/kg/j

-140 autres ttt : 69% VANCO, 19%LINE

-CMI médiane DAPTO=3

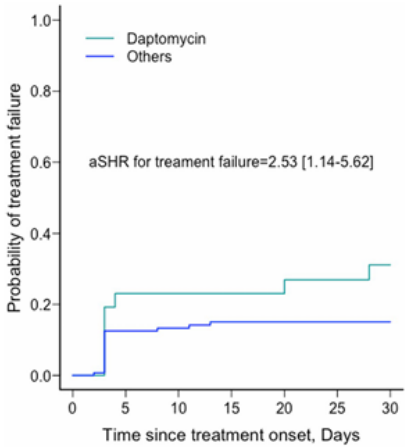


Fig. 1 Cumulative incidence of primary outcome according to definitive antibiotic regimen. The primary outcome was treatment failure as a composite of (1) bacteremia duration ≥3 days and/or (2) bacteremia relapse <30 days and/or (3) need for salvage antibiotic therapy. aSHR for an adjusted multivariate analysis using a Fine and Gray model

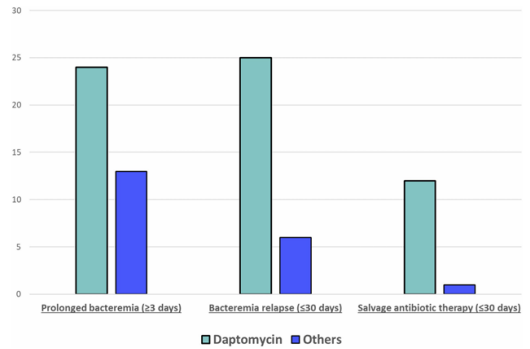


Fig. 2 Incidence of the individual items of the composite primary outcome according to definitive antibiotic regimen. p-value for an unadjusted univariate analysis by Fisher's exact test

Risque d'echec X 2,5 si DAPTO

Traitement SAMS

Subphenotype- and complication-guided adjunctive fosfomycin versus standard monotherapy in *Staphylococcus aureus* bacteraemia: pooled analysis of two randomised trials

Francesc Escrihuela-Vidal,[a,b,c] Julia García Larrauri,[a] Joaquín López-Contreras,[e,f,g] Gorane Euba,[h,i,j] Andrea Vázquez,[k] Silvia Gómez-Zorrilla,[c,l,m,n] Luis Eduardo López-Cortés,[c,o,p,q] Oriol Gasch,[r,s,t] Eduardo Aparicio-Minguijón,[u,v] Rosa Escudero-Sánchez,[c,w,x] María Teresa Pérez-Rodríguez,[y,z] Dolors Rodríguez-Pardo,[c,aa,ab] Alfredo Jover-Sáenz,[ac,ad,ae] Graciano García-Pardo,[c,af,ag] Jesús Rodríguez-Baño,[c,o,p,q] Miquel Pujol,[a,b,c] Jordi Carratalà,[a,b,c,d,*,ah] and Belén Gutiérrez-Gutiérrez,[c,o,p,q,ah] on behalf of the BACSAFO/FEN-AUREUS Group[ai]

The Lancet Regional Health - Europe
2026;62: 101611
Published Online 17 February 2026

Méthode:

Analyse post hoc de 2 études multicentrique randomisés

BACT SARM et SAFO

Objectif:

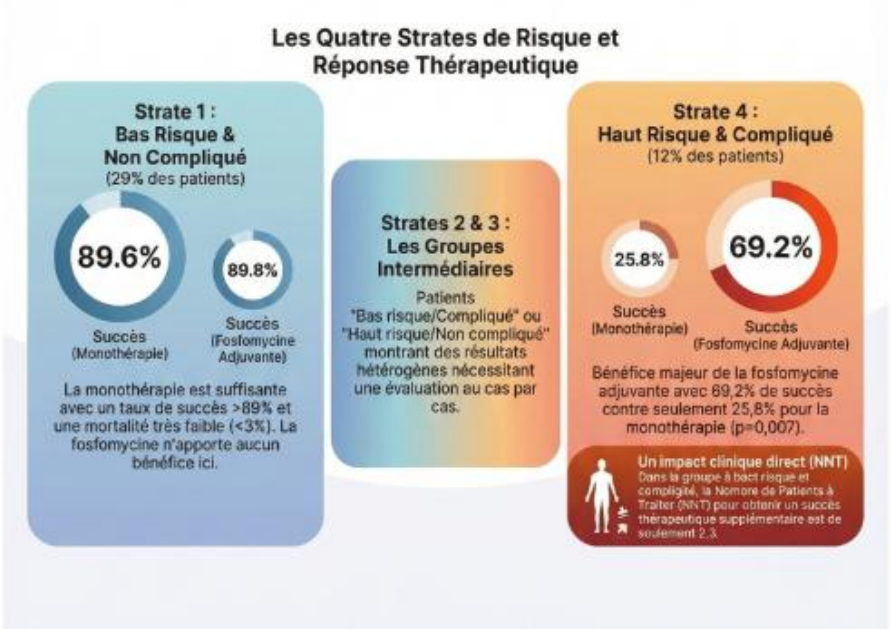
Evaluer l'impact de l'ajout de FOSFO dans les BSI à SA en classant les patients

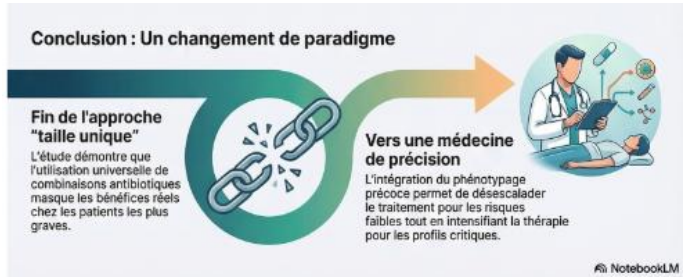
Inclusion:

Adulte avec BSI à SA

Exclusion: endocardite, cirrhose, survie > 24h

CJP: Evaluer l'association entre le phénotype , la bact compliquée et la mortalité à J30



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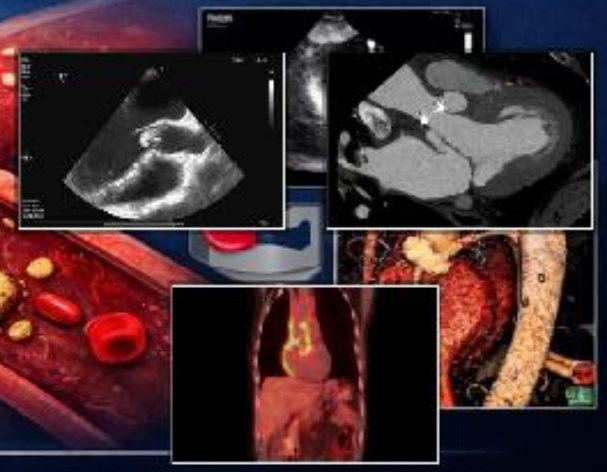

Coordination Université de Bordeaux, Nantes et Rennes