Case report

A 40-year-old white male with a previous history of intravenous drug abuse and hepatitis C was admitted to a local hospital for fever and shortness of breath. He was empirically treated with intravenous vancomycin (1 g i.v. q.12 h) starting 11/11/2006 (dates in American format throughout). The first set of blood cultures drawn on the day of admission turned positive after 12 h incubation. A subsequent transoesophageal echocardiogram showed native aortic valve endocarditis.

The first set of blood cultures grew meticillin-resistant Staphylococcus aureus (MRSA) with a vancomycin MIC of \( \leq 2 \text{\;µg\;ml}^{-1} \) (Microscan; Dode-Behring). The patient had repeat blood cultures on 11/17/2006, which were persistently positive for MRSA (with blood cultures turning positive after 20 h incubation), after 5 days of vancomycin therapy. No serum vancomycin levels were available from the local hospital.

Vancomycin was discontinued and intravenous daptomycin 6 mg kg\(^{-1}\) per day was started on 11/17/2006 at the local hospital. No baseline serum creatine phosphokinase level results were available. A computed tomography scan of the head to evaluate agitation revealed right temporal lesions, which were thought to be embolic in nature. The third set of repeat blood cultures dated 11/21/2006 also turned positive for MRSA after 12 h incubation.

The patient was transferred to our facility on 11/24/2006 with persistent MRSA bacteraemia, aortic valve endocarditis and intracranial haemorrhagic septic emboli. On examination, he was found to be tachypnoeic and in moderate respiratory distress with a respiratory rate of 44 min\(^{-1}\), pulse 131 beats min\(^{-1}\), blood pressure 135/83 mmHg, temperature 37 °C and weight of 176 lbs. Laboratory results showed a white blood cell count of 2200 cells µl\(^{-1}\), with 86% polymorphonuclear leukocytes; a platelet count of 73 000 cells µl\(^{-1}\); blood urea nitrogen level of 52 mg dl\(^{-1}\); creatinine level of 2.2 mg dl\(^{-1}\) (baseline creatinine 1.4); and bicarbonate level of 14 mg dl\(^{-1}\). His estimated creatinine clearance was 47.5 ml min\(^{-1}\) at the time of transfer.

Chest X-ray showed a mild cardiomegaly with bilateral oedema and basilar opacities. The patient was later intubated for respiratory distress and airway protection. Review of the blood culture and susceptibility testing results (11/11, 11/17, 11/21) from the local hospital revealed that the MRSA isolates were susceptible to vancomycin with an MIC of \( \leq 2 \text{\;µg\;ml}^{-1} \). Daptomycin therapy was discontinued on the day of transfer, and vancomycin (15 mg kg\(^{-1}\) i.v. q.12 h) and gentamicin (1 mg kg\(^{-1}\) i.v. q.24 h) were initiated.

Blood cultures drawn at our facility on 11/24/2006 turned positive after 9 h incubation with cultures finalized as MRSA. Review of the susceptibility results at our facility (Microscan; Dode-Behring) showed that the MRSA isolate (REF2145) was susceptible to vancomycin (MIC \( \leq 2 \text{\;µg\;ml}^{-1} \)), linezolid (MIC \( \leq 2 \text{\;µg\;ml}^{-1} \)), quinupristin/dalfopristin (MIC \( \leq 1 \text{\;µg\;ml}^{-1} \)), trimethoprim-sulfamethoxazole (MIC \( \leq 2 \text{\;µg\;ml}^{-1} \)) and gentamicin (MIC \( \leq 4 \text{\;µg\;ml}^{-1} \)), but non-susceptible to daptomycin (MIC 4 µg ml\(^{-1}\)). The susceptibility results were unchanged among all the isolates except for the daptomycin MIC in the REF2145 isolate. The E-test (AB Biodisk) confirmed the daptomycin MIC of 4 µg ml\(^{-1}\). Vancomycin E-test results demonstrated that all four MRSA isolates (11/11, 11/17, 11/21 and REF2145) had vancomycin MICs of 2 µg ml\(^{-1}\).

Abbreviation: MRSA, meticillin-resistant Staphylococcus aureus.
and dose adjustments were made to improve renal function (creatinine clearance >50 ml min\(^{-1}\)). Vancomycin and gentamicin trough levels were in the range of 15–22 µg ml\(^{-1}\) and 1–2 µg ml\(^{-1}\), respectively.

Neurosurgical and cardiothoracic surgery evaluation were obtained. A magnetic resonance angiogram and a diagnostic cerebral angiogram were unremarkable for arteriovenous malformations or aneurysms. Rifampin (600 mg per day) was added to the vancomycin and gentamicin regimen for persistent fever and MRSA bacteraemia. All the intravascular devices were changed.

The patient underwent aortic valve replacement with an Edwards-Magna pericardial prosthesis (on 12/1/2006) following 7 days of antibiotic therapy (vancomycin, gentamicin and rifampin) at our facility. His repeat blood cultures post-surgery remained negative from 12/3/2006 onwards. Rifampin and gentamicin were discontinued after a total of 2 weeks of therapy and vancomycin was continued for a total of 6 weeks. He was successfully weaned off the ventilator and subsequently underwent physical therapy and recovered with no neurological deficits.

The three additional MRSA blood culture isolates (11/1, 11/17 and 11/21) from the patient were available from the local hospital for further evaluation. This investigation demonstrated that the MIC for daptomycin was also elevated in one of these three isolates. Using E-test methodology, the MRSA isolates dated 11/11 (MRSA 11/11) and 11/17 (MRSA 11/17) had MICs to daptomycin of 1.0 µg ml\(^{-1}\). However, the MRSA isolate dated 11/21 (MRSA 11/21) had an MIC of 3 µg ml\(^{-1}\) to daptomycin. Using previously published methodology (Bannerman et al., 1995), all four isolates (MRSA 11/11, MRSA 11/17, MRSA 11/21 and REF2145) were indistinguishable by PFGE (data not shown). Subsequent comparative analysis (McDougal et al., 2003; Bionumerics software, Applied Maths) demonstrated that the SmaI restriction pattern of the four MRSA isolates, including REF2145, was consistent with USA 300. In agreement with these data, using previously published primers and methods, REF2145 was also shown to contain the Panton–Valentine leukocidin genes by PCR (Fey et al., 2003).

Oligonucleotide primers were designed to detect known mutations associated with reduced susceptibility to daptomycin (Friedman et al., 2006) in MRSA 11/11 (MIC=1 µg for daptomycin) and REF2145 (MIC=4 µg for daptomycin). These primers were designed to detect known single nucleotide changes in open reading frames of mprF (lysylphosphatidylglycerol synthetase), yycG (histidine kinase), rpoB (β-subunit of RNA polymerase) and rpoC (β′-subunit of RNA polymerase) (Friedman et al., 2006). Only the mutation T345A in mprF was detected in REF2145 as compared to MRSA 11/11. This mutation has been previously detected in daptomycin non-susceptible isolates (Friedman et al., 2006).

**Discussion**

We describe a patient with persistent MRSA bacteraemia while on daptomycin therapy. The MRSA isolates were noted to be community-associated as the patient had no exposure to health care in the preceding 1 year of the current hospitalization. Furthermore, PFGE analysis demonstrated that the genetic background of all four isolates was indistinguishable from USA 300, a common community-associated MRSA genetic background (Diep et al., 2006). In addition, two of the isolates (REF2145 and MRSA 11/21) were noted to be non-susceptible to daptomycin with MICs of 4 µg ml\(^{-1}\) and 3 µg ml\(^{-1}\), respectively.

Daptomycin is a semi-synthetic cyclic lipopeptide derived from *Streptomyces roseosporus* with a susceptibility breakpoint of ≤1 µg ml\(^{-1}\) for meticillin-sensitive *S. aureus* and MRSA and ≤4 µg ml\(^{-1}\) for vancomycin-susceptible *Enterococcus faecalis* (CLSI, 2007; Eisenstein, 2004). The mechanism of bactericidal action involves calcium-dependent entry into the bacterial cytoplasmic membrane, causing depolarization and potassium ion leakage (Alborn et al., 1991). This membrane disruption results in cessation of macromolecular synthesis and subsequent bacterial cell death (Silverman et al., 2003).

Development of decreased susceptibility to daptomycin during long-term therapy has been previously reported in patients with MRSA bacteraemia (Mangili et al., 2005). Similar reports of daptomycin resistance and treatment failure during daptomycin therapy for MRSA bacteraemia and osteomyelitis have also been described (Skiest, 2006; Marty et al., 2006).

Several recent reports have focused on the elucidation of the mechanism of resistance to daptomycin within *S. aureus*. The loss of an 81 kDa membrane protein correlated with decreased susceptibility to daptomycin (Kaatz et al., 2006). In addition, loss of this membrane protein was correlated with decreased binding of daptomycin to isolated cell membranes and resistance to daptomycin-mediated membrane potential dissipation. A recent report from Jones et al. (2008) has corroborated these data demonstrating significant changes in membrane structure/function in daptomycin non-susceptible isolates. In addition, vancomycin-intermediate *S. aureus* (VISA) isolates have reduced susceptibility to daptomycin; a potential explanation is that the thicker cell walls associated with VISA strains may provide a physical barrier for the daptomycin (Cui et al., 2006). Also, previous exposure of *S. aureus* to vancomycin and/or daptomycin may also affect daptomycin susceptibility (Sakoulas et al., 2006). Finally, using complete genome comparison, Friedman et al. (2006) demonstrated that mutations within four genes, mprF, yycG, rpoB and rpoC, correlate with decreased susceptibility to daptomycin. In agreement with this report, we identified one mutation (T345A) in REF2145 as compared to MRSA 11/11. The contribution of each one
of these genes to the mechanism of decreased susceptibility to daptomycin is not known at this time.

CA-MRSA USA 300 has been identified as the major cause of epidemic MRSA skin and soft-tissue infections in the United States in addition to more serious infections such as necrotizing pneumonia (Diep et al., 2006). The USA 300 genotype is preliminarily distinguished from other MRSA backgrounds by the presence of Panton–Valentine leukocidin and the ACME (arginine catabolic mobile element) island containing the arginine deiminase gene cluster (Diep et al., 2006; Naimi et al., 2003). Fortunately, CA-MRSA USA 300 isolates generally remain susceptible to clindamycin, doxycycline, trimethoprim–sulfamethoxazole and also fluoroquinolones.

Development of daptomycin non-susceptible MRSA isolates in both hospital-associated and community-associated settings is a concern. Further studies are needed to provide a better insight into the development of daptomycin non-susceptibility in S. aureus.

References


