Clinical Practice Variation in the Management of Staphylococcus aureus Bacteremia: Results from an Emerging Infections Network Survey

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Results

• Of 1,286 EIN physician members with an adult ID practice, 723 (56%) responded to this survey.

• Respondents were varied in their practice experience:
  - Clinical experience since ID fellowship: ≤ 5 years 146 (20.2%), 5-14 years 228 (31.5%), ≥ 15 years 411 (55.3%)
  - Primary hospital type for inpatient work: University 260 (36.0%), VA hospital 50 (7.0%)

• 54 (7%) answered they did not manage patients with SAB and were thus excluded from the analysis.

• Consensus in management by > 2/3 of respondents:
  - Treatment of SAB due to a skin and soft tissue source with 2 weeks of intravenous (IV) antibiotics
  - Treatment of any single positive blood culture for S. aureus as a true pathogen rather than a contaminant

• Heterogenous practice patterns were identified for:
  - Daptomycin dosing (Table 1)
  - Use of TEE (Figure 1)
  - Criteria for extended treatment duration (Figure 3)
  - Treatment of persistent MRSA bacteremia (Figure 4)

• Although there are some areas of consensus, there is significant variability in clinical management of common SAB scenarios.

Methods

• Design: Prospective electronic survey using case vignettes

• Survey format: 11 question survey using clinical vignettes and multiple choice answers targeting areas in the management of SAB where data are limited or controversial

• The survey was developed by the study authors with beta-testing by fellows and faculty at five academic institutions (UCSF, Fred Hutch, UW, OHSU, UI).

• The web-based survey was then distributed to all members of the EIN with an adult ID practice.

• Study period: The survey was open between January 5, 2017 and January 30, 2017.

• All data analysis was performed by the study authors.

Results Continued

Table 2: Treatment of MRSA bacteremia with a vancomycin MIC > 2

<table>
<thead>
<tr>
<th>Treatment Option</th>
<th>n  = 665</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat with vancomycin as long as patient demonstrates clinical and microbiologic response</td>
<td>50.5%</td>
</tr>
<tr>
<td>Treat with daptomycin</td>
<td>37.3%</td>
</tr>
<tr>
<td>Treat with ceftaroline</td>
<td>4.6%</td>
</tr>
<tr>
<td>Treat with daptomycin or ceftaroline</td>
<td>3.2%</td>
</tr>
<tr>
<td>Treat with linezolid</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

Discussion

• SAB is a severe disease commonly encountered by ID providers, but this survey highlights the significant practice variability for this condition amongst survey respondents who represent a wide breadth of ID practitioners in North America.

• One interesting finding of the survey is that practice variation was equally present for scenarios for which there are some data and expert consensus and situations where there are not.

• There is also a minority but notable divergence from traditional ID dogma in areas such as the use of oral antibiotics for SAB, repeat blood cultures to document SAB clearance, and TTE in all cases of SAB.

• Qualitative comments are currently under analysis.

Conclusion

• Although there are some areas of consensus, there is significant variability in clinical management of common SAB scenarios.

• This variability highlights both the disease complexity and the need for ongoing research in this domain.

• Clinical practice guidelines will likely be of significant importance for this common and morbid condition in which the appropriate management of many common scenarios is unclear.

References