

2018

# A Review of Combination Antimicrobial Therapy for *Enterococcus Faecalis* Bloodstream Infections and Infective Endocarditis

Maya Beganovic

*University of Rhode Island*, [maya\\_beganovic@uri.edu](mailto:maya_beganovic@uri.edu)

Megan K. Luther

*University of Rhode Island*

*See next page for additional authors*

Follow this and additional works at: [https://digitalcommons.uri.edu/php\\_facpubs](https://digitalcommons.uri.edu/php_facpubs)

**The University of Rhode Island Faculty have made this article openly available.  
Please let us know how Open Access to this research benefits you.**

This is a pre-publication author manuscript of the final, published article.

Terms of Use

This article is made available under the terms and conditions applicable towards Open Access Policy Articles, as set forth in our [Terms of Use](#).

## Citation/Publisher Attribution

Maya Beganovic, Megan K Luther, Louis B Rice, Cesar A Arias, Michael J Rybak, Kerry L LaPlante; A Review of Combination Antimicrobial Therapy for *Enterococcus faecalis* Bloodstream Infections and Infective Endocarditis, *Clinical Infectious Diseases*, Volume 67, Issue 2, 2 July 2018, Pages 303–309, <https://doi.org/10.1093/cid/ciy064>

Available at: <http://dx.doi.org/10.1093/cid/ciy064>

This Article is brought to you for free and open access by the Pharmacy Practice at DigitalCommons@URI. It has been accepted for inclusion in Pharmacy Practice Faculty Publications by an authorized administrator of DigitalCommons@URI. For more information, please contact [digitalcommons@etal.uri.edu](mailto:digitalcommons@etal.uri.edu).

---

**Authors**

Maya Beganovic, Megan K. Luther, Louis B. Rice, Cesar A. Arias, Michael J. Rybak, and Kerry L. LaPlante

1 **Title:** A review of combination antimicrobial therapy for *Enterococcus faecalis* bloodstream  
2 infections and infective endocarditis

3

4 **Running Title:** Treatment for *E. faecalis* infections

5

6 Maya Beganovic<sup>1,2</sup>, Megan K. Luther<sup>1,2,10</sup>, Louis B. Rice<sup>3,4</sup>, Cesar A. Arias<sup>5,6</sup>, Michael J. Rybak<sup>7-9</sup>,  
7 Kerry L. LaPlante<sup>1, 2,4,10</sup>

8

- 9 1. College of Pharmacy, University of Rhode Island, Kingston, RI, United States
- 10 2. Infectious Diseases Research Program, Providence Veterans Affairs Medical Center,  
11 Providence, RI, United States
- 12 3. Rhode Island Hospital, Providence, RI
- 13 4. Warren Alpert Medical School of Brown University, Division of Infectious Diseases,  
14 Providence, RI
- 15 5. Center for Antimicrobial Resistance and Microbial Genomics, Division of Infectious Diseases,  
16 Department of Internal Medicine and Department of Microbiology and Molecular Genetics, UT  
17 Health McGovern Medical School, Houston, TX.
- 18 6. Molecular Genetics and Antimicrobial Resistance Unit, International Center for Microbial  
19 Genomics, Universidad El Bosque, Bogota, Colombia.
- 20 7. Anti-Infective Research Laboratory, Department of Pharmacy Practice, Eugene Applebaum  
21 College of Pharmacy and Health Sciences, Wayne State University
- 22 8. Department of Medicine, Division of Infectious Diseases, School of Medicine, Wayne State  
23 University
- 24 9. Department of Pharmacy Services, Detroit Receiving Hospital, Detroit, Michigan
- 25 10. Center of Innovation in Long-Term Services and Supports, Providence Veterans Affairs  
26 Medical Center, Providence, RI, United States.

27

28 **Address Correspondence:** Kerry L. LaPlante, Pharm.D., FCCP, FIDSA Professor, University  
29 of Rhode Island, College of Pharmacy, 7 Greenhouse Rd, Suite 295A, Kingston, RI 02881, 401-  
30 874- 5560 (office); [KerryLaPlante@uri.edu](mailto:KerryLaPlante@uri.edu)

31

32 **Keywords:** *Enterococcus faecalis*, infective endocarditis, antimicrobials

33

34 **Summary:** The purpose of this review to highlight available treatment options, their limitations,  
35 and provide direction for future investigative efforts to aid in the treatment of severe *E. faecalis*  
36 infections, namely infective endocarditis.

37 **ABSTRACT**

38 Enterococci, one of the most common causes of hospital-associated infections, are responsible  
39 for substantial morbidity and mortality. *Enterococcus faecalis*, the more common and virulent  
40 species, cause serious high-inoculum infections, namely infective endocarditis, that are  
41 associated with cardiac surgery and mortality rates that remained unchanged for the last 30 years.  
42 The best cure for these infections are observed with combination antibiotic therapy; however,  
43 optimal treatment has not been fully elucidated. It is the purpose of this review to highlight  
44 treatment options, their limitations, and provide direction for future investigative efforts to aid in  
45 the treatment of these severe infections. While ampicillin plus ceftriaxone has emerged as a  
46 preferred treatment option, mortality rates continue to be high, and from a safety standpoint,  
47 ceftriaxone, unlike other cephalosporins, promotes colonization with vancomycin resistant-  
48 enterococci due to high biliary concentrations. More research is needed to improve patient  
49 outcomes from this high mortality disease.

## 50 INTRODUCTION

51 Severe enterococcal infections including infective endocarditis (IE), are associated with mortality  
52 rates as high as 20-40% and have remained unchanged for the last three decades despite  
53 advances in antimicrobial therapy.[1] Although *Enterococcus faecalis* and *Enterococcus faecium*  
54 are the two most clinically relevant species, *E. faecalis* accounts for approximately 97% of all IE  
55 cases predominantly impacting the elderly and patients with comorbidities.[2] *E. faecalis*, unlike  
56 *E. faecium*, is less frequently multidrug resistant.[2] However, lack of bactericidal activity of beta-  
57 lactams[3], and ability to form biofilm at higher rates than *E. faecium* (87-95% vs. 16-29%,  
58 respectively)[4, 5], makes treatment of *E. faecalis* infections particularly challenging, and may  
59 contribute to the unchanging mortality rates. Consequently, combination antimicrobial therapy is  
60 required for deep-seated *E. faecalis* infections, and with over 50% of isolates expressing  
61 aminoglycoside resistance, treatment options are becoming limited.[6] It is the purpose of this  
62 review to highlight available treatment options, their limitations, and provide direction for  
63 investigation of future novel combination therapies including ampicillin plus non-ceftriaxone beta-  
64 lactams and daptomycin combination therapy, to further aid in the treatment of *E. faecalis* IE.

65

## 66 METHODS

67 Studies were identified by conducting PubMed, and EMBASE searches using the following  
68 keywords in one or more combinations with '*Enterococcus faecalis*': infective, endocarditis,  
69 bacteremia, bloodstream, infection, treatment, guideline, antibiotic, combination, synergy,  
70 resistant, biofilm, clinical, diagnosis, epidemiology, in vitro, in vivo, simulated endocardial  
71 vegetation, experimental, and beta-lactamase. Manual searches of reference lists of relevant  
72 articles found from initial searches were also conducted. No limitation was placed on publication  
73 time period. Studies were selected based on authors' (MB and MKL) judgment of relevance to  
74 topic.

75

## 76 **ORIGIN OF COMBINATION THERAPY**

77 For serious *E. faecalis* infections, such as IE, bactericidal agents often as combination therapy  
78 are preferred.[2] Beta-lactam antibiotics lack bactericidal activity against enterococci when used  
79 as monotherapy, making treatment of systemic infections particularly challenging.[3] Although *E.*  
80 *faecalis* are often susceptible to ampicillin, treatment failure of 60%, and lack of bactericidal  
81 activity of cell-wall active agents (i.e. penicillin G, ampicillin, vancomycin) prompted efforts to  
82 identify combination therapies that would yield a bactericidal effect in severe infections.[1-3]  
83 Originally, penicillin or ampicillin was combined with gentamicin or streptomycin to facilitate intra-  
84 cellular uptake of aminoglycosides.[3] The recognition of in vitro bactericidal synergism between  
85 beta-lactams and aminoglycosides was supported by observational clinical data and led to  
86 improvements in IE cure rates up to 75%.[3] However, rising high-level aminoglycoside resistance  
87 (HLAR), which may range to up to 63%[1, 6, 7] prompted the need for alternative therapy.  
88 Subsequently, dual beta-lactam combination therapy emerged as a viable, safe treatment option  
89 for severe infections with *E. faecalis*.

90

## 91 **DUAL BETA-LACTAM THERAPY**

### 92 *In Vitro and Experimental Animal Data*

93 In 1995, Mainardi and colleagues were the first to report synergy between amoxicillin and  
94 cefotaxime in *E. faecalis*. [8] The results showed that the MIC for amoxicillin decreased  
95 substantially in the presence of cefotaxime, as did the MIC of cefotaxime in the presence of  
96 amoxicillin. The proposed mechanism of synergy is that partial saturation of essential penicillin  
97 binding proteins (PBPs) 4 and 5 by amoxicillin, coupled with complete saturation of non-essential  
98 PBPs 2 and 3 by cefotaxime leads to a bactericidal effect.[8] Taken together, the combination of  
99 cefotaxime and amoxicillin exploits the optimal inactivation of PBPs 2, 3, 4 and 5, thereby  
100 producing synergism on *E. faecalis*. Presumably the marked impairment in cell wall synthesis is  
101 the basis for this effect.

102

103 In 1999, Gavalda and colleagues further explored beta-lactam combinations by evaluating the  
104 activity of ampicillin plus ceftriaxone (AC) against *E. faecalis* strains with HLAR.[9] They confirmed  
105 Mainardi's synergistic findings, and observed up to a fourfold reduction in ampicillin MIC in the  
106 presence of ceftriaxone. Furthermore, rabbits treated with AC in HLAR *E. faecalis* endocarditis  
107 had lower bacterial vegetation counts than rabbits treated with ampicillin alone.[9] In 2003,  
108 Gavalda et al. evaluated the utility of AC versus ampicillin plus gentamicin (AG) against *E. faecalis*  
109 with or without HLAR in rabbits with catheter-induced endocarditis.[10] They determined that the  
110 two combinations were comparable in efficacy, and further concluded that AC may be an  
111 alternative to AG particularly in special populations, such as patients with renal insufficiency  
112 (Table 1).[10]

113

#### 114 *Human Data*

115 Clinical data have since evaluated the combination of AC against HLAR and non-HLAR *E. faecalis*  
116 IE.[6, 11, 12] In 2007, Gavalda et al. assessed the efficacy and safety of AC in 21 patients with  
117 HLAR, and 22 patients with non-HLAR *E. faecalis* IE in a multicenter, open-label clinical trial.[6]  
118 In this observational study of enterococcal IE, it was concluded that in addition to AC being a safe  
119 and effective treatment option for HLAR IE, it is a reasonable alternative for patents at risk for  
120 nephrotoxicity infected with non-HLAR organisms.[6] Subsequently, Fernandez-Hidalgo and  
121 colleagues conducted a large, non-randomized, multicenter, cohort study comparing the safety  
122 and efficacy of AC and AG in 246 episodes (159 subjects in AC group; 87 subjects in AG group)  
123 of IE caused by *E. faecalis*.[11] The authors concluded that the two combinations were equally  
124 effective as there was no difference in mortality while on antimicrobial treatment and during the  
125 3-month follow-up, relapse, or treatment failures requiring alternate therapy. However, patients  
126 treated with AG had significantly higher rates of adverse events (i.e. renal impairment) requiring  
127 therapy withdrawal.[11] These findings coincide with a retrospective study of prospectively

128 collected data that evaluated 69 episodes of IE caused by *E. faecalis* (30 subjects in AG group;  
129 39 subjects in AC group).[12] Similar to Fernandez-Hidalgo and colleagues, the authors did not  
130 observe a difference in in-hospital mortality or 1-year mortality between AG and AC groups, and  
131 found that patients on AG had higher rates of treatment-induced renal failure than patients  
132 receiving AC. Interestingly, the authors captured epidemiologic data that demonstrates a  
133 significant increase in IE caused by HLAR-producing *E. faecalis* over the course of 14 years,  
134 along with an increase in AC therapy, although the small sample size limits definite conclusions  
135 (Table 1).[12]

136

### 137 *Clinical trials are limited in IE*

138 As a result of these two clinical studies [6, 11], the 2015 national IE guidelines have been updated  
139 to recommend double beta-lactam therapy (i.e. AC) as a treatment option for HLAR infections,  
140 and a reasonable alternative to aminoglycosides for non-HLAR *E. faecalis* infections (Class IIa;  
141 Level of Evidence B recommendation).[2] Of note, isolates with gentamicin resistance may be  
142 susceptible to streptomycin, and vice versa, although monitoring for streptomycin concentrations  
143 is often difficult and inefficient for clinicians since it is not available within most hospitals. The  
144 guideline recognizes that the AC regimen has several limitations – notably 1) all data were  
145 retrospectively collected without randomization, 2) treatment recommendations were center-  
146 dependent; therefore, unmeasured confounding factors as well as treatment and indication bias  
147 impacting these results cannot be ruled out and 3) gentamicin dosing and therapeutic drug  
148 monitoring were not consistent across all centers, and higher levels may have contributed to the  
149 observed increase in renal impairment.[11, 12] While data supporting the use of AC has  
150 limitations, it is important to note that studies recommending AG treatment are observational and  
151 have similar limitations.[2, 3]

152



153 As it currently stands, data providing support for optimal drug, dose and duration for the currently  
154 available treatment options remain controversial. A recent study investigated optimal gentamicin  
155 treatment duration in 84 patients with non-HLAR *E. faecalis* IE by comparing two groups: patients  
156 admitted prior to the Danish 2007 guideline modification versus patients admitted after guideline  
157 modification that recommended reducing gentamicin treatment duration from 4-6 weeks to 2  
158 weeks.[13] Forty-one patients received gentamicin for a median of 28 days (IQR, 18-42), and 43  
159 patients received a median of 14 days (IQR, 7-15). There was no difference between groups for  
160 the primary outcome of 1-year event-free survival (27 [66%] vs. 29 [69%],  $p = 0.75$ ) measured  
161 from the end of treatment. No differences in complications, relapse, in-hospital mortality, baseline  
162 renal function, and 14-day renal function were observed between groups. However, patients  
163 receiving 14-day treatment with gentamicin therapy experienced a significantly lower reduction in  
164 renal function at discharge compared to those receiving the full course, as measured by estimated  
165 glomerular filtration rate (median -11 versus -1mL/min,  $p = 0.009$ ).[13] They concluded that  
166 patients may be adequately treated with two weeks of gentamicin, thereby avoiding renal  
167 impairment that is associated with long duration of aminoglycoside therapy.[13] However, this  
168 study was limited by a small sample size, and insufficient power, thereby leaving the optimal  
169 duration of therapy unclear.

170

171 Interestingly, other studies demonstrate that toxicity resulting in gentamicin discontinuation  
172 occurred after approximately two weeks of treatment.[11, 12] Although Fernández-Hidalgo did not  
173 directly evaluate a shorter gentamicin treatment duration, the authors describe outcomes of  
174 gentamicin treatment failure due to adverse events, namely renal dysfunction. For the 25% of  
175 patients that failed AG therapy, the median duration of therapy with gentamicin was 14 days (IQR,  
176 12–20 days).[11] Furthermore, ten patients did not receive combination therapy after stopping  
177 gentamicin and completed their treatment course with ampicillin monotherapy.[11] Pericas et al.  
178 reported that 43% of patients in the AG group had to discontinue treatment due to toxicity; thirteen

179 patients were switched to AC therapy after a median of 18 days (range, 5-30 days; IQR, 15-24.5  
180 days).[12] Overall these data indicate that gentamicin toxicity is associated with longer treatment  
181 durations, and a two-week treatment course may be reasonable.

182

### 183 **CONCERN FOR DEVELOPMENT OF RESISTANCE**

184 Enterococcal resistance to beta-lactams is primarily acquired by overproduction of PBP5, and by  
185 amino acid substitutions that result in altered binding site and reduced beta-lactam interaction  
186 with PBP5.[14] Additionally, rare isolates of *E. faecalis* produce beta-lactamase enzymes, which  
187 in theory could compromise beta-lactam therapy against enterococcal endocarditis, and further  
188 limit the available treatment options.[3, 15] While the impact of enterococcal beta-lactamase in  
189 low-inoculum infections is difficult to detect, the impact in high-inoculum infections, such as  
190 endocarditis, has not been fully elucidated. Data suggest that although most beta-lactamase  
191 enzymes are inducible, enterococcal beta-lactamase is produced constitutively, and at  
192 substantially lower amounts.[3, 15] Furthermore, the enzyme remains membrane-bound, making  
193 detection of phenotypic resistance difficult unless high-inocula are used.[3, 15]

194

### 195 **CEFTRIAXONE SAFETY AND ADVERSE EVENTS CONCERNS**

196 Currently, AC combination therapy is the only tested option for the treatment of IE and bacteremia  
197 due to HLAR *E. faecalis* with supportive clinical data. While seemingly safe as compared to AG,  
198 safety risk associated with ceftriaxone use should not be negated. In addition to being an  
199 independent risk-factor for *Clostridium difficile* infections[16] numerous clinical and observational  
200 studies implicate ceftriaxone as a major risk factor for occurrence of vancomycin resistant *E.*  
201 *faecium* (VRE) infection, including bacteremia.[17, 18] This is in addition to a wealth of animal  
202 studies that have linked ceftriaxone use to promotion of gastrointestinal (GI) colonization by  
203 VRE.[19, 20] It is suggested that the high biliary excretion of ceftriaxone, with levels that exceed  
204 GI concentrations of 5,000 µg/ml, promote overgrowth of ampicillin- and vancomycin-resistant *E.*

205 *faecium*, whose MIC for ceftriaxone typically exceeds 10,000 µg/ml.[20] This ability of ceftriaxone  
206 to “select” for drug-resistant enterococci poses not only a risk to individual patients, but also  
207 threatens public health by contributing to developing of resistance in multiple organisms in the  
208 hospital environment. Consequently, studies investigating alternative treatment options,  
209 particularly novel beta-lactam combinations, are crucial to expand the therapeutic armamentarium  
210 against these organisms.

211

## 212 **OTHER COMBINATION THERAPIES AND FUTURE RESEARCH POTENTIAL**

### 213 *Novel Dual Beta-Lactam Combinations*

214 Unlike ceftriaxone, other cephalosporin antibiotics, such as cefepime [19] and ceftaroline [21] do  
215 not appear to promote VRE colonization. When cefepime, cefotetan, ceftriaxone and ceftazidime  
216 were studied in the GI tract of mice, it was noted that cefepime was the least likely of the four to  
217 cause VRE colonization (no difference in colonization compared to 0.9% sodium chloride), while  
218 ceftriaxone and cefotetan reached the highest levels of colonization.[19] This is presumably a  
219 result of minimal biliary excretion of cefepime and ceftaroline, and lack of antianaerobic effect of  
220 cefepime. The combination of ampicillin plus ceftaroline demonstrated efficacy similar to AC in  
221 several in vitro pharmacodynamics studies.[22, 23] A recent in vitro study evaluated high-  
222 inoculum *E. faecalis* against ampicillin in combination with ceftaroline, cefepime, and ceftriaxone  
223 in an in vitro pharmacodynamic model simulating human concentration-time profiles.[22] The data  
224 indicated that AC activity was similar to ampicillin plus ceftaroline, and ampicillin plus cefepime.  
225 Although ceftaroline and cefepime are not associated with VRE colonization, their utilization  
226 necessitates careful evaluation for safety and development of resistance. Dual beta-lactam  
227 therapy warrants further investigation, not only for efficacy, but also for the development of  
228 resistance and optimal dosing.

229

### 230 *Daptomycin plus Beta-Lactam Therapy*

231 Daptomycin, a lipopeptide antibiotic with activity against Gram-positive bacteria, is of interest in  
232 treating enterococcal infections due to its activity against *E. faecalis* and *E. faecium*, including  
233 VRE. Recent data has indicated that the combination of daptomycin with beta-lactam antibiotics  
234 has synergistic effects.[24, 25] Daptomycin activity can be potentiated due to beta-lactam-  
235 mediated shifts in surface charge of enterococci, causing increased uptake of the drug. While  
236 daptomycin combination therapy is more often observed in patients with resistant strains of *E.*  
237 *faecium*, case reports of successful utilization of daptomycin combination therapy in patients with  
238 severe *E. faecalis* infections have been published.[24, 26]

239  
240 Sierra-Hoffman et al. report using daptomycin (6mg/kg Q48h) in combination with ampicillin (1g  
241 Q6h) for the treatment of mitral valve IE in an 89-year-old female with stage 4 chronic kidney  
242 disease.[26] The patient was not a surgical candidate, and received 6 weeks of treatment.  
243 Subsequent surveillance blood cultures 2 weeks after cessation of therapy remained negative,  
244 and patient remained alive without signs or symptoms of IE at her 1-year follow up.[26] Although  
245 this case report used a 6mg/kg/day dose, several in vitro, in vivo and clinical outcome studies  
246 suggest higher doses (10-12mg/kg/day) are associated with better patient outcomes, particularly  
247 in severe infections [27-29]. This suggests that synergistic combinations may be daptomycin  
248 dose-sparing. Further studies exploring dosing for synergistic combinations of daptomycin and  
249 beta-lactams are warranted.

250  
251 Daptomycin (8 mg/kg/day) plus ceftaroline was successfully used in a case report of a 63-year-  
252 old male with recurrent aortic valve endocarditis caused by HLAR *E. faecalis*.[24] Therapy was  
253 initiated after patient failed 6 weeks of AC therapy as evidenced by recurrent signs and symptoms  
254 of IE, and doubling in vegetation size from 5mm to 10mm. This combination was selected due to  
255 unpublished observations of synergy against several bacteremia-causing enterococci.[24] A  
256 fourfold reduction in daptomycin MIC, as well as increased daptomycin binding to the

257 enterococcal cell membrane in the presence of ceftaroline was observed.[24] Smith and  
258 colleagues evaluated several beta-lactams in combination with daptomycin.[25] Similar to  
259 Sakoulas et al., the authors found that ceftaroline demonstrated the greatest daptomycin MIC  
260 reduction (average 19.1+/-17.6 –fold [baseline daptomycin MIC/ daptomycin combination MIC]),  
261 followed by (in decreasing order) cefepime, ceftriaxone, ampicillin, ertapenem, ceftazidime and  
262 ceftazidime.[25] Time-kill studies demonstrated synergy with daptomycin in combination with  
263 ceftaroline, ampicillin, ertapenem, ceftriaxone, and cefepime. Inconsistent synergy was noted with  
264 daptomycin and ceftazidime. No synergy was observed with daptomycin in combination with  
265 ceftazidime, possibly due to differences between PBP binding profiles of beta-lactam antibiotics.[25]

266

#### 267 *Fosfomycin Combinations*

268 Fosfomycin demonstrated synergy in combination with daptomycin in in vitro studies.[30]  
269 However, a follow-up in vivo aortic valve endocarditis study in rats infected with HLAR, beta-  
270 lactamase producing strain of *E. faecalis* demonstrated no difference between the number of  
271 valves sterilized by daptomycin-alone versus daptomycin plus fosfomycin when administered as  
272 a continuous infusion through the left internal jugular vein.[31] More recent in vitro data  
273 demonstrated synergy with fosfomycin in combination with ceftriaxone[32], rifampin, tigecycline,  
274 and teicoplanin (unavailable in the US), and antagonism with ampicillin.[33] Teicoplanin is  
275 particularly interesting for further investigation as previous in vitro data demonstrate advantage  
276 over vancomycin against *E. faecalis*. [34] Despite in vitro synergy, current fosfomycin use is limited  
277 to uncomplicated UTIs and should not be used to treat severe infections due to limited systemic  
278 absorption when administered orally.[35] Intravenous formulations of fosfomycin are currently  
279 unavailable in the US, but may have future utility. A recent study of in vitro and in vivo (guinea pig  
280 model) use of intraperitoneal fosfomycin demonstrated promising activity against both planktonic  
281 and biofilm-forming *E. faecalis* when fosfomycin was used in combination with gentamicin, and  
282 daptomycin [36] demonstrating a need for further investigation.

283

284 *Miscellaneous Combinations*

285 Several other in vitro and in vivo studies have been conducted evaluating combination  
286 therapy.[37-40] Synergistic combinations and their respective study designs are summarized in  
287 Table 2. Of particular interest, Arias et al. evaluated a beta-lactamase stable cephalosporin,  
288 ceftobiprole (currently unavailable in the US), and observed efficacy against bla+ and VanB-  
289 resistant strains of *E. faecalis* in addition to synergy when used in combination with  
290 aminoglycosides.[37] Overall, ceftobiprole demonstrates high affinity for enterococcal PBPs, and  
291 requires further exploration in human subjects.

292

293 **CONCLUSION**

294 Although aminoglycoside-containing regimens have been the standard of enterococcal IE  
295 treatment, the rise in resistance and availability of less nephrotoxic agents have led to novel  
296 treatment options.[2] Double beta-lactam therapies have emerged as a novel strategy in the  
297 treatment of serious high-inoculum enterococcal infections due of their favorable side effect  
298 profiles, and tolerability during long-term use. Currently, AC is the only combination beta-lactam  
299 therapy supported by clinical data for the treatment of IE and bacteremia due to HLAR  
300 enterococci. However, AC combination is not without risk (i.e. resistance, VRE colonization).  
301 Therefore, there is a critical need to investigate novel drug combinations, and explore dosing  
302 strategies that optimize dose and overall exposure needed to improve efficacy and suppress the  
303 emergence of resistance.

304 **Disclaimer**

305 The views expressed are those of the authors and do not necessarily reflect the position or policy  
306 of the United States Department of Veterans Affairs.

307

308 **Potential Conflict of Interest**

309 This work has been supported in part by the Office of Academic Affiliations, Department of  
310 Veterans Affairs, and with resources and the use of facilities at Providence VA Medical Center.

311 K.L.L. has received research funding or acted as an advisor, or consultant for Merck,

312 Davol/BARD, Actavis, Melinta Therapeutics, The Medicines Company, and Pfizer Inc. C.A.A. has

313 received research support from Merck, Allergan, the Medicines Company and Theravance

314 Pharmaceuticals, and has served as consultant or as part of the speaker's bureau to Pfizer, Bayer,

315 Allergan, and The Medicines Company. L.B.R. has served as a consultant for Zavante

316 Therapeutics and for Macrolide Pharmaceuticals. He also served on a Data Safety Monitoring

317 Board for Zavante Therapeutics. MJR is a grant recipient of, consultant for, an advisory board

318 member or has participated in speaker's bureau for Allergan, Archogen, Bayer, Merck & Co., The

319 Medicines Company, and Theravance and Zvante and is supported in part by NIH grant R01

320 AI109266-01. M.B., and M.K.L., have no actual or potential conflicts of interest to disclose.

321  
322  
323  
324  
325  
326  
327  
328  
329  
330  
331  
332  
333  
334  
335  
336  
337  
338  
339  
340  
341  
342  
343  
344  
345  
346

## REFERENCES

1. Miro JM, Pericas JM, del Rio A, Hospital Clinic Endocarditis Study G. A new era for treating *Enterococcus faecalis* endocarditis: ampicillin plus short-course gentamicin or ampicillin plus ceftriaxone: that is the question! *Circulation* **2013**; 127(17): 1763-6.
2. Baddour LM, Wilson WR, Bayer AS, et al. Infective Endocarditis in Adults: Diagnosis, Antimicrobial Therapy, and Management of Complications: A Scientific Statement for Healthcare Professionals From the American Heart Association. *Circulation* **2015**; 132(15): 1435-86.
3. Baddour LM, Wilson WR, Bayer AS, et al. Infective endocarditis: diagnosis, antimicrobial therapy, and management of complications: a statement for healthcare professionals from the Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease, Council on Cardiovascular Disease in the Young, and the Councils on Clinical Cardiology, Stroke, and Cardiovascular Surgery and Anesthesia, American Heart Association: endorsed by the Infectious Diseases Society of America. *Circulation* **2005**; 111(23): e394-434.
4. Di Rosa R, Creti R, Venditti M, et al. Relationship between biofilm formation, the enterococcal surface protein (Esp) and gelatinase in clinical isolates of *Enterococcus faecalis* and *Enterococcus faecium*. *FEMS Microbiol Lett* **2006**; 256(1): 145-50.
5. Dupre I, Zanetti S, Schito AM, Fadda G, Sechi LA. Incidence of virulence determinants in clinical *Enterococcus faecium* and *Enterococcus faecalis* isolates collected in Sardinia (Italy). *J Med Microbiol* **2003**; 52(Pt 6): 491-8.
6. Gavalda J, Len O, Miro JM, et al. Brief communication: treatment of *Enterococcus faecalis* endocarditis with ampicillin plus ceftriaxone. *Ann Intern Med* **2007**; 146(8): 574-9.
7. Caballero-Granado FJ, Cisneros JM, Luque R, et al. Comparative study of bacteremias caused by *Enterococcus* spp. with and without high-level resistance to gentamicin. The



- 347 Grupo Andaluz para el estudio de las Enfermedades Infecciosas. *J Clin Microbiol* **1998**;  
348 36(2): 520-5.
- 349 8. Mainardi JL, Gutmann L, Acar JF, Goldstein FW. Synergistic effect of amoxicillin and  
350 cefotaxime against *Enterococcus faecalis*. *Antimicrob Agents Chemother* **1995**; 39(9):  
351 1984-7.
- 352 9. Gavalda J, Torres C, Tenorio C, et al. Efficacy of ampicillin plus ceftriaxone in treatment  
353 of experimental endocarditis due to *Enterococcus faecalis* strains highly resistant to  
354 aminoglycosides. *Antimicrob Agents Chemother* **1999**; 43(3): 639-46.
- 355 10. Gavalda J, Onrubia PL, Gomez MT, et al. Efficacy of ampicillin combined with  
356 ceftriaxone and gentamicin in the treatment of experimental endocarditis due to  
357 *Enterococcus faecalis* with no high-level resistance to aminoglycosides. *J Antimicrob*  
358 *Chemother* **2003**; 52(3): 514-7.
- 359 11. Fernandez-Hidalgo N, Almirante B, Gavalda J, et al. Ampicillin plus ceftriaxone is as  
360 effective as ampicillin plus gentamicin for treating *enterococcus faecalis* infective  
361 endocarditis. *Clin Infect Dis* **2013**; 56(9): 1261-8.
- 362 12. Pericas JM, Cervera C, del Rio A, et al. Changes in the treatment of *Enterococcus*  
363 *faecalis* infective endocarditis in Spain in the last 15 years: from ampicillin plus  
364 gentamicin to ampicillin plus ceftriaxone. *Clin Microbiol Infect* **2014**; 20(12): O1075-83.
- 365 13. Dahl A, Rasmussen RV, Bundgaard H, et al. *Enterococcus faecalis* infective  
366 endocarditis: a pilot study of the relationship between duration of gentamicin treatment  
367 and outcome. *Circulation* **2013**; 127(17): 1810-7.
- 368 14. Arbeloa A, Segal H, Hugonnet JE, et al. Role of class A penicillin-binding proteins in  
369 PBP5-mediated beta-lactam resistance in *Enterococcus faecalis*. *J Bacteriol* **2004**;  
370 186(5): 1221-8.
- 371 15. Arias CA, Contreras GA, Murray BE. Management of multidrug-resistant enterococcal  
372 infections. *Clin Microbiol Infect* **2010**; 16(6): 555-62.

- 373 16. Owens RC, Jr., Donskey CJ, Gaynes RP, Loo VG, Muto CA. Antimicrobial-associated  
374 risk factors for Clostridium difficile infection. Clin Infect Dis **2008**; 46 Suppl 1: S19-31.
- 375 17. Amberpet R, Sistla S, Parija SC, Thabah MM. Screening for Intestinal Colonization with  
376 Vancomycin Resistant Enterococci and Associated Risk Factors among Patients  
377 Admitted to an Adult Intensive Care Unit of a Large Teaching Hospital. J Clin Diagn Res  
378 **2016**; 10(9): DC06-DC9.
- 379 18. McKinnell JA, Kunz DF, Chamot E, et al. Association between vancomycin-resistant  
380 Enterococci bacteremia and ceftriaxone usage. Infect Control Hosp Epidemiol **2012**;  
381 33(7): 718-24.
- 382 19. Lakticova V, Hutton-Thomas R, Meyer M, Gurkan E, Rice LB. Antibiotic-induced  
383 enterococcal expansion in the mouse intestine occurs throughout the small bowel and  
384 correlates poorly with suppression of competing flora. Antimicrob Agents Chemother  
385 **2006**; 50(9): 3117-23.
- 386 20. Rice LB, Hutton-Thomas R, Lakticova V, Helfand MS, Donskey CJ. Beta-lactam  
387 antibiotics and gastrointestinal colonization with vancomycin-resistant enterococci. J  
388 Infect Dis **2004**; 189(6): 1113-8.
- 389 21. Panagiotidis G, Backstrom T, Asker-Hagelberg C, Jandourek A, Weintraub A, Nord CE.  
390 Effect of ceftaroline on normal human intestinal microflora. Antimicrob Agents  
391 Chemother **2010**; 54(5): 1811-4.
- 392 22. Luther MK, Rice LB, LaPlante KL. Ampicillin in Combination with Ceftaroline, Cefepime,  
393 or Ceftriaxone Demonstrates Equivalent Activities in a High-Inoculum Enterococcus  
394 faecalis Infection Model. Antimicrob Agents Chemother **2016**; 60(5): 3178-82.
- 395 23. Werth BJ, Shireman LM. Pharmacodynamics of Ceftaroline plus Ampicillin against  
396 Enterococcus faecalis in an In Vitro Pharmacokinetic/Pharmacodynamic Model of  
397 Simulated Endocardial Vegetations. Antimicrob Agents Chemother **2017**; 61(4).

- 398 24. Sakoulas G, Nonejuie P, Nizet V, Pogliano J, Crum-Cianflone N, Haddad F. Treatment  
399 of high-level gentamicin-resistant *Enterococcus faecalis* endocarditis with daptomycin  
400 plus ceftaroline. *Antimicrob Agents Chemother* **2013**; 57(8): 4042-5.
- 401 25. Smith JR, Barber KE, Raut A, Aboutaleb M, Sakoulas G, Rybak MJ. beta-Lactam  
402 combinations with daptomycin provide synergy against vancomycin-resistant  
403 *Enterococcus faecalis* and *Enterococcus faecium*. *J Antimicrob Chemother* **2015**; 70(6):  
404 1738-43.
- 405 26. Sierra-Hoffman M, Iznola O, Goodwin M, Mohr J. Combination therapy with ampicillin  
406 and daptomycin for treatment of *Enterococcus faecalis* endocarditis. *Antimicrob Agents*  
407 *Chemother* **2012**; 56(11): 6064.
- 408 27. Carugati M, Bayer AS, Miro JM, et al. High-dose daptomycin therapy for left-sided  
409 infective endocarditis: a prospective study from the international collaboration on  
410 endocarditis. *Antimicrob Agents Chemother* **2013**; 57(12): 6213-22.
- 411 28. Hall AD, Steed ME, Arias CA, Murray BE, Rybak MJ. Evaluation of standard- and high-  
412 dose daptomycin versus linezolid against vancomycin-resistant *Enterococcus* isolates in  
413 an in vitro pharmacokinetic/pharmacodynamic model with simulated endocardial  
414 vegetations. *Antimicrob Agents Chemother* **2012**; 56(6): 3174-80.
- 415 29. Kullar R, Davis SL, Levine DP, et al. High-dose daptomycin for treatment of complicated  
416 gram-positive infections: a large, multicenter, retrospective study. *Pharmacotherapy*  
417 **2011**; 31(6): 527-36.
- 418 30. Rice LB, Eliopoulos GM, Moellering RC, Jr. In vitro synergism between daptomycin and  
419 fosfomycin against *Enterococcus faecalis* isolates with high-level gentamicin resistance.  
420 *Antimicrob Agents Chemother* **1989**; 33(4): 470-3.
- 421 31. Rice LB, Eliopoulos CT, Yao JD, Eliopoulos GM, Moellering RC, Jr. In vivo activity of the  
422 combination of daptomycin and fosfomycin compared with daptomycin alone against a

- 423 strain of *Enterococcus faecalis* with high-level gentamicin resistance in the rat  
424 endocarditis model. *Diagn Microbiol Infect Dis* **1992**; 15(2): 173-6.
- 425 32. Farina C, Russello G, Chinello P, et al. In vitro activity effects of twelve antibiotics alone  
426 and in association against twenty-seven *Enterococcus faecalis* strains isolated from  
427 Italian patients with infective endocarditis: high in vitro synergistic effect of the  
428 association ceftriaxone-fosfomycin. *Chemotherapy* **2011**; 57(5): 426-33.
- 429 33. Tang HJ, Chen CC, Zhang CC, et al. In vitro efficacy of fosfomycin-based combinations  
430 against clinical vancomycin-resistant *Enterococcus* isolates. *Diagn Microbiol Infect Dis*  
431 **2013**; 77(3): 254-7.
- 432 34. Ziglam HM, Finch RG. Limitations of presently available glycopeptides in the treatment  
433 of Gram-positive infection. *Clin Microbiol Infect* **2001**; 7 Suppl 4: 53-65.
- 434 35. Patel SS, Balfour JA, Bryson HM. Fosfomycin tromethamine. A review of its antibacterial  
435 activity, pharmacokinetic properties and therapeutic efficacy as a single-dose oral  
436 treatment for acute uncomplicated lower urinary tract infections. *Drugs* **1997**; 53(4): 637-  
437 56.
- 438 36. Oliva A, Furustrand Taffin U, Maiolo EM, Jeddari S, Betrisey B, Trampuz A. Activities of  
439 fosfomycin and rifampin on planktonic and adherent *Enterococcus faecalis* strains in an  
440 experimental foreign-body infection model. *Antimicrob Agents Chemother* **2014**; 58(3):  
441 1284-93.
- 442 37. Arias CA, Singh KV, Panesso D, Murray BE. Time-kill and synergism studies of  
443 ceftobiprole against *Enterococcus faecalis*, including beta-lactamase-producing and  
444 vancomycin-resistant isolates. *Antimicrob Agents Chemother* **2007**; 51(6): 2043-7.
- 445 38. Holmberg A, Morgelin M, Rasmussen M. Effectiveness of ciprofloxacin or linezolid in  
446 combination with rifampicin against *Enterococcus faecalis* in biofilms. *J Antimicrob*  
447 *Chemother* **2012**; 67(2): 433-9.

- 448 39. Luther MK, Arvanitis M, Mylonakis E, LaPlante KL. Activity of daptomycin or linezolid in  
449 combination with rifampin or gentamicin against biofilm-forming *Enterococcus faecalis* or  
450 *E. faecium* in an in vitro pharmacodynamic model using simulated endocardial  
451 vegetations and an in vivo survival assay using *Galleria mellonella* larvae. *Antimicrob*  
452 *Agents Chemother* **2014**; 58(8): 4612-20.
- 453 40. Silvestri C, Cirioni O, Arzeni D, et al. In vitro activity and in vivo efficacy of tigecycline  
454 alone and in combination with daptomycin and rifampin against Gram-positive cocci  
455 isolated from surgical wound infection. *Eur J Clin Microbiol Infect Dis* **2012**; 31(8): 1759-  
456 64.
- 457