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Activities of Daptomycin and Vancomycin Alone and in Combination with Rifampin and Gentamicin against Biofilm-Forming Methicillin-Resistant *Staphylococcus aureus* Isolates in an Experimental Model of Endocarditis

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The findings of clinical and in vitro research support the theory that infective endocarditis (IE)-causing bacteria form biofilms and that biofilms negatively affect treatment outcomes. The purpose of the present study was to quantify the biofilm formation of methicillin (meticillin)-resistant *Staphylococcus aureus* (MRSA) isolates obtained from patients with IE and to evaluate the in vitro activities of daptomycin and vancomycin alone and in combination with rifampin (rifampicin) or gentamicin while monitoring the isolates for the development of resistance. A high-inoculum, stationary-phase infection model of IE was used to simulate the pharmacokinetics in humans of daptomycin at 6 mg/kg of body weight/day, vancomycin at 1.25 g every 12 h (q12h) alone and in combination with rifampin at 300 mg every 8 h, and gentamicin at 1.3 mg/kg q12h. Two randomly selected clinical MRSA isolates were obtained from patients with IE; both MRSA isolates quantitatively produced biofilms. The time to bactericidal activity in the presence of daptomycin was isolate dependent but was achieved by 24 h for both MRSA isolates. Vancomycin did not achieve bactericidal activity throughout the experiment. At 24, 48, and 72 h, daptomycin-containing regimens had significantly more activity (greater declines in the mean number of CFU/g) than any of the vancomycin-containing regimens \((P = 0.03)\). Rifampin and gentamicin antagonized or delayed the bactericidal activity of daptomycin (against MRSA B346846 for rifampin and against both isolates for gentamicin) in the first 24 h. Increases in the daptomycin and vancomycin MICs were not observed. We conclude that in an IE model of biofilm-forming MRSA, daptomycin monotherapy has better in vitro activity than daptomycin in combination with rifampin or gentamicin or any vancomycin-containing regimen studied within the first 24 h. Further investigations are needed to understand the initial delay in bactericidal activity observed when gentamicin or rifampin is combined with daptomycin.

Biofilm-forming *Staphylococcus aureus* isolates are frequently found on prosthetic devices and in deep tissue infections (21, 43), and both prosthetic devices and deep tissue infections serve as common sources for bacteremia. Clinical research supports the theory that infective endocarditis (IE)-causing bacteria form biofilms (14, 19) and that *S. aureus* isolates recovered from the blood of patients with IE tend to produce biofilms at a high inoculum and during the stationary phase of growth (24, 43). These isolates also typically carry accessory gene regulator (agr) groups I and II, which regulate the production of autolysins that promote biofilm formation (21, 43, 44). Despite this information, there are limited data about the biofilm-forming capabilities of *S. aureus* isolates that cause IE (SAIE).

Until recently, effective antimicrobial therapy for methicillin (meticillin)-resistant *S. aureus* (MRSA) bacteremia and IE was limited to vancomycin. Although vancomycin has commonly been used since the 1980s for the treatment of MRSA infections, including endocarditis, several published studies indicate that it has limited efficacy because of bacterial resistance, bacterial tolerance, and poor tissue penetration (8, 22, 36). Patients with SAIE treated with vancomycin alone may still be bacteremic (as indicated by positive blood cultures) after 7 to 10 days of therapy (25, 26). Guidelines for the treatment of SAIE recommend the use of combination therapy with vancomycin plus gentamicin or rifampin (rifampicin) (2, 3, 41). However, these combinations can be problematic because gentamicin increases the risk of nephrotoxicity and rifampin increases the potential for drug interactions via its induction of cytochrome P450 metabolism. In addition, this recommendation is based on limited clinical data.

Daptomycin, a novel lipopeptide antimicrobial agent, received FDA approval in May 2006 for the treatment of bacteremia and right-sided SAIE caused by methicillin-susceptible and -resistant strains (12). The FDA indication is for monotherapy against gram-positive pathogens; however, the guidelines recommend combination therapy for SAIE. Data to support the optimal dose of daptomycin required for it to have activity when it is combined with commonly used synergistic agents such as gentamicin and rifampin are lacking. In addition, limited information about the activity of daptomycin in the pres-
ence of biofilm-forming *S. aureus* has been published (23, 32, 35, 37).

The purpose of this study was to quantify the biofilm formation of *S. aureus* isolates obtained from patients with SAIE, to assess the in vitro activities of daptomycin and vancomycin alone and in combination with rifampin or gentamicin, and to evaluate the development of resistance in a high-inoculum, stationary-phase bacterial (biofilm) model of IE.

(This work has been presented in part at the 108th General Meeting of the American Society for Microbiology, Boston, MA, 1 to 5 June 2008 [abstr. A-076].)

**MATERIALS AND METHODS**

**Bacterial strains.** Clinical MRSA isolates B346846 and B341002 were obtained from the Cubicin bacteremia and IE registration trial (ClinicalTrials.gov number NCT00093067) and were supplied by Cubist Pharmaceuticals, Inc. (Lexington, MA) (17). Both isolates are mecA positive and were baseline bloodstream isolates from patients with documented IE. Previous testing identified isolate B346846 as having the adaptive variants-antigen 1, spa type 17, and staphylococcal chromosomal cassette mec (SCC mec) type IV and isolate B341002 as carrying antigen type II, spa type 2, and SCC mec type II.

**Antimicrobial agents.** Vancomycin (lot no. 087K0694), rifampin (lot no. 087K1871), and gentamicin (lot no. 016K1120) were purchased from Sigma Chemical Company, St. Louis, MO. Daptomycin (lot no. CDCX01) was obtained from Cubist Pharmaceuticals, Inc. Stock solutions of each antibiotic were freshly prepared at the beginning of each week and were kept frozen at −80°C.

**Medium.** Mueller-Hinton broth (Becton Dickinson and Co., Sparks, MD) supplemented with calcium and adjusted to physiologic conditions of 50 mg/liter calcium chloride (ionized Ca; 1.03 to 1.23 mmol/liter) and 12.5 mg/liter magnesium was used for all in vitro pharmacodynamic models. Bacto tryptic soy broth (Becton Dickinson and Co.) supplemented with 1% glucose and 50 mg/liter calcium chloride was used to optimize biofilm production in the minimal biofilm eradication concentration (MBEC) assay (38). Calcium quantification was verified in all test broths by the Providence Veterans Affairs Medical Center (Providence, RI) in-house clinical laboratory with an Abbott (Abbott Park, IL) Architekt c8000 apparatus. Colony counts were determined by using tryptic soy agar (TSA; Difco, Becton Dickinson).

**Susceptibility.** The MICs of the study antimicrobial agents were determined by the Etest methodology and broth microdilution according to the guidelines of the Clinical and Laboratory Standards Institute (10, 11). The MICs were also determined at a high inoculum (10⁶ CFU/ml), as described previously (24), and in the presence of 4 g/dl of human albumin (Rhode Island Blood Bank, Providence), which contained free fatty acids to more closely mimic normal human protein binding (William Craig, University of Wisconsin—Madison, personal communications). The minimum bactericidal concentrations were determined by plotting the time-kill curves. Activity defined.

**In vitro pharmacodynamic infection model with SEVs.** A previously described simulated endocardial vegetation (SEV) model was used to evaluate several antibiotic regimens. *S. aureus* was used at a high inoculum to represent the organism density often associated with sequestered infections such as endocarditis (20, 24). A bacterial inoculum of approximately 10⁸ CFU/g was achieved in the SEVs by beginning of each week and were kept frozen at 80°C until they were ready for analysis. Daptomycin concentrations were determined by a homogeneous particle-enhanced turbidimetric immunoassay (Architect, Multigen; Abbott Diagnostics, Abbott Park, IL) at the Providence Veterans Affairs Medical Center. The gentamicin assay has a range of detection of 0.3 to 10.0 µg/ml and a between-day sample precision and a coefficient of variation of 1.35% and ±2.75%, respectively. The vancomycin assay has a detection range of 0.5 to 80.0 µg/ml and a between-day sample precision and coefficient of variation of 1.6% and ±5.0%, respectively. Rifampin concentrations were determined by HPLC (National Jewish Medical and Research Center, Denver, CO), as described previously (30). The half-life, AUIC, Cₘₐₓ, and Cₘᵦₙₜ of the antibiotics were determined by the trapezoidal method with PK Analyst software (version 1.10; MicroMath Scientific Software, Salt Lake City, UT).

**Resistance and MIC increases.** Changes in the MICs were evaluated for the nonbiofilm and the combined therapy models (24, 27) to assess the development of resistance. 100-µl samples were collected at these time points and were plated on TSA plates containing two-, four-, and eightfold the MIC of the respective antibiotic. In addition, MIC testing was conducted for rifampin, daptomycin, vancomycin, and gentamicin by Etest. Samples were evaluated di-
The limit of detection was 2.4 CFU/ml. For growth after 24 and 48 h of incubation at 37°C, the plates were examined directly from the model to prevent the passing of bacteria on antibiotic-containing plates and to optimize the detection of MIC changes. The plates were examined with Tukey’s post-hoc test. A 72 h and the time to 99.9% killing were compared by two-way analysis of variance.

Pharmacokinetic parameters of the antimicrobial agents were previously published studies (24). In the presence of human albumin (4 g/dl), the MICs for daptomycin and rifampin increased eight- and twofold, respectively. In the presence of human albumin (4 g/dl), the MICs for daptomycin were evaluated in the presence of albumin and/or at high inocula. This is also consistent with the findings presented in other reports (24) and may be explained by the relatively high and moderate levels of protein binding exhibited by daptomycin (93%) and vancomycin (55%), respectively (15, 27). There was a minimal increase in the gentamicin and vancomycin MICs and rifampin MBECs were 256 to 512 μg/ml and 0.0625 μg/ml, respectively, for the biofilm-forming clinical isolates, thus indicating that rifampin demonstrates activity in a preformed biofilm assay.

The antimicrobial activities of daptomycin and vancomycin were evaluated alone and in combination with gentamicin or rifampin against a high inoculum (10⁹ CFU/g) of biofilm-forming MRSA isolates in a simulated IE vegetation model (Table 3; Fig. 1). Daptomycin monotherapy achieved bactericidal activity against MRSA isolates in a simulated IE vegetation model (Table 1). The antimicrobial activities of daptomycin and vancomycin, gentamicin, and rifampin were active against both of the biofilm-forming MRSA clinical isolates evaluated in this study (Table 1).

### TABLE 1. MIC results obtained with standard and high inocula for clinical isolates and MBEC results for all isolates

<table>
<thead>
<tr>
<th>Antimicrobial</th>
<th>Standard inoculum</th>
<th>High inoculum</th>
<th>Standard inoculum</th>
<th>High inoculum</th>
<th>MRSA B341002</th>
<th>MRSA B346846</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daptomycin</td>
<td>0.5</td>
<td>8</td>
<td>0.5</td>
<td>8</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Daptomycin with albumin</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>0.5</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>128</td>
<td>64</td>
</tr>
<tr>
<td>Vancomycin with albumin</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>0.5</td>
<td>0.5</td>
<td>0.25</td>
<td>0.5</td>
<td>256</td>
<td>256</td>
</tr>
<tr>
<td>Gentamicin with albumin</td>
<td>0.5</td>
<td>0.25</td>
<td>0.125</td>
<td>0.25</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Rifampin</td>
<td>&lt;0.02</td>
<td>0.25</td>
<td>0.06</td>
<td>0.5</td>
<td>0.0625</td>
<td>0.0625</td>
</tr>
<tr>
<td>Rifampin with albumin</td>
<td>&lt;0.06</td>
<td>&lt;0.06</td>
<td>&lt;0.06</td>
<td>&lt;0.06</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

a For antimicrobials with albumin, albumin was added to the broth at 4 g/dl.
b The standard inoculum was 5 × 10⁵ CFU/ml, and the high inoculum was 5 × 10⁹ CFU/ml.
c A Calif game biofilm device was used to determine the antimicrobial activity in a formed biofilm. The values were obtained by determination of the plate counts, and the limit of detection was 2.4 CFU/ml.
d NA, not applicable.

### TABLE 2. Targeted values and values of pharmacokinetic parameters obtained with SEV infection model

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Cmax (μg/ml)</th>
<th>Half-life (h)</th>
<th>AUC_{0-24} (μg h/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daptomycin, 6 mg/kg every 24 h</td>
<td>98.6 ± 0.35</td>
<td>8</td>
<td>7.16 ± 0.59</td>
</tr>
<tr>
<td>Vancomycin, 15 mg/kg every 12 h</td>
<td>45</td>
<td>6</td>
<td>6.04 ± 0.17</td>
</tr>
<tr>
<td>Gentamicin, 1.3 mg/kg every 12 h</td>
<td>6</td>
<td>2</td>
<td>2.91 ± 0.87</td>
</tr>
<tr>
<td>Rifampin, 300 mg every 8 h</td>
<td>10.5</td>
<td>4</td>
<td>5.24 ± 0.29</td>
</tr>
</tbody>
</table>

a The regimens are based on those for a 75-kg patient.
b The values obtained are means ± standard deviations.
mycin’s activity against MRSA B346846, and gentamicin antagonized daptomycin’s activity against both isolates. There were no significant differences in activity between daptomycin alone and daptomycin plus rifampin or gentamicin at 48 or 72 h, nor was synergy or antagonism noted by 48 or 72 h.

Vancomycin monotherapy did not achieve bactericidal activity against either clinical isolate tested at any time point. There was also no significant difference between vancomycin monotherapy and the regimens of vancomycin plus rifampin or vancomycin plus gentamicin at any time point during the 72-h experiment. At 24, 48, and 72 h, the daptomycin-containing regimens had significantly (\(P < 0.05\)) more activity (as measured by a decline in the mean numbers of CFU/g) than any of the vancomycin-containing regimens (Table 3). Gentamicin and rifampin monotherapies did not demonstrate any significant activity during the study. Resistance (defined as an MIC of \(>32 \mu g/ml\)) occurred in the rifampin monotherapy models by 24 h, and the gentamicin MICs increased fourfold within 24 h. The vancomycin and daptomycin MICs varied at each time point but never exceeded 2 \(\mu g/ml\).

**DISCUSSION**

Left-sided IE is a sequestered infection that often yields a high bacterial density (\(10^8\) to \(10^{10}\) organisms per gram of tissue) (4). IE can develop when an organism attaches to the heart valve and forms a vegetation. The limited blood supply to this area and the high bacterial load result in a blunted immune response and limited antimicrobial drug access. As the infection progresses, the rates of bacterial metabolism and cell division are reduced and biofilms may develop as a result of nutrient limitation and autolysin production. Clinical cure can be achieved, but the prolonged administration of bactericidal antibiotic agents is required to sterilize the vegetation. Treatment success depends on multiple factors, including patient comorbidities, the location of the vegetation (right-sided versus left-sided endocarditis), and surgical intervention (17, 18). Limited antibiotic penetration into the vegetation partially explains why left-sided IE is considered a disease which must be treated surgically. The exact cause of most treatment failures is unknown; however, it is likely related to the ability of the bacteria to form biofilms (14, 19). The bacteria embedded in a biofilm are less susceptible to antibiotics by virtue of their reduced growth rates, nutrient limitation, and adaptive stress responses (6, 42).

We report here the findings of studies of daptomycin and vancomycin monotherapies and combination therapy with rifampin or gentamicin in an in vitro model of endocarditis caused by biofilm-forming clinical isolates. The addition of gentamicin or rifampin did not significantly improve the activity of daptomycin or vancomycin (Fig. 1). Daptomycin had significantly better activity than vancomycin against both of the biofilm-forming MRSA isolates, and no MIC shifts were observed. Of interest, during the first 24 h, rifampin antagonized and delayed the bactericidal activity of daptomycin against MRSA B346846, and gentamicin antagonized and delayed the bactericidal activity of daptomycin against both isolates. Although contradictory results can often be found in the literature (31), antagonistic activity is often observed when rifampin is added to bactericidal agents in high-inoculum infections and against biofilm-forming S. aureus (29, 31, 34). In addition, the inhibition of bacterial RNA synthesis may be responsible for delaying the killing activities of cell-wall-active agents. Clinical studies have rarely demonstrated bactericidal activity with rifampin combination therapy for the treatment of SAIE (25, 31).

In this study, antagonistic or delayed bactericidal activity was observed during the first 24 h when gentamicin was added to daptomycin. This has been observed in clinical studies (16) and in vitro studies (34) with vancomycin, but to our knowledge, this has not yet been observed with daptomycin. We believe that this effect may be isolate dependent and may be due to the biofilm.

The biofilm formation by two MRSA isolates obtained from patients with SAIE was quantified. Both clinical isolates produced 38 to 49\% more biofilm than a characterized non-biofilm-forming control (strain ATCC 12228) and slightly less biofilm (5 to 12\%) than a characterized biofilm-forming isolate (strain ATCC 355556). The daptomycin MBECs in a 24-h mature biofilm of the clinical isolates were 8 to 16 \(\mu g/ml\), which are 4 to 5 serial dilutions higher than the MIC for planktonic bacteria; these concentrations are clinically achievable with a 6-mg/kg dose (\(C_{max}\) 98 \(\mu g/ml\)). For vancomycin, the MBECs were 64 to 128 \(\mu g/ml\), which is 6 to 8 serial dilutions higher than the MICs for planktonic bacteria; these concentrations are not clinically achievable by the use of traditional doses. The rifampin and gentamicin MBECs were 0.062 and 256 \(\mu g/ml\), respectively.
FIG. 1. Activities of antimicrobials tested alone and in combination against MRSA B341002 (a) and B346846 (b). Dapto, daptomycin; Vanco, vancomycin; Gent, gentamicin; Rif, rifampin.
respectively. The observed increase in the MBECs relative to the MICs is consistent with previous reports of antimicrobial resistance when bacteria transition from the planktonic form to the biofilm form (9).

Overall, the daptomycin and vancomycin MICs for both clinical isolates were higher when they were grown in a high inoculum or in the presence of 4 g/dl of albumin. The gentamicin and rifampin MICs were minimally affected by the high inoculum or albumin, consistent with the findings of other published studies (24, 34). Daptomycin and vancomycin exhibited high to moderate levels of protein binding; thus, albumin and a high bacterial inoculum (such as in a biofilm or vegetation) decrease the free drug concentration, which reduces the AUC/MIC ratio and decreases the antimicrobial activity.

In the presence of a high inoculum and albumin, the increase in the daptomycin and vancomycin MICs and the preservation of the rifampin and gentamicin MICs were not correlated with activity in the in vitro model.

In conclusion, both of the clinical MRSA isolates obtained from patients with IE quantitatively produced biofilms. The addition of gentamicin or rifampin to either vancomycin or daptomycin did not increase their antibacterial activities in a sequestered high-inoculum model of biofilm-forming MRSA IE. and rifampin and gentamicin were shown to delay the bactericidal activity of daptomycin during the first 24 h. Overall, daptomycin monotherapy had significantly better activity against both of the biofilm-forming MRSA isolates than vancomycin.

A limitation of this study is the use of only two clinical MRSA isolates. In addition, we cannot conclude that our results will hold true with treatment durations longer than 72 h. Our findings on the activities of daptomycin and vancomycin monotherapies are consistent with those obtained with clinical, in vitro, and animal models published previously; however, until now, biofilm formation has not been quantified (16, 25, 33, 34). To our knowledge, this is the first study to evaluate the activities of these agents against biofilm-forming MRSA in a sequestered high-inoculum model of IE. The results support the use of daptomycin monotherapy for the treatment of biofilm-forming MRSA in a simulated endocarditis vegetation. Nonetheless, our results should be applied to clinical practice with caution. Confirmation of these results in clinical studies is needed before these regimens can be adopted for use for the care of patients.

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