Durées de prescription des antibiotiques

Marion Baldeyrou

Maladies Infectieuses et Réanimation médicale

CHU Rennes

1ᵉᵐᵉ journée régionale des référents antibiotiques bretons

4 mai 2017

Réduire les durées d'antibiothérapie

◆ Pourquoi faire plus court?

◆ Les nouvelles propositions de la SPILF

◆ Conclusion

Pourquoi faire plus court?

Antibiotic use and microbiome function

Manuel Ferrer [a,*], Celia Méndez-García [b], David Rojo [c], Coral Barbas [c], Andrés Moya [d]

[a] Institute of Catalysis, Consejo Superior de Investigaciones Científicas (CSIC), Madrid, Spain
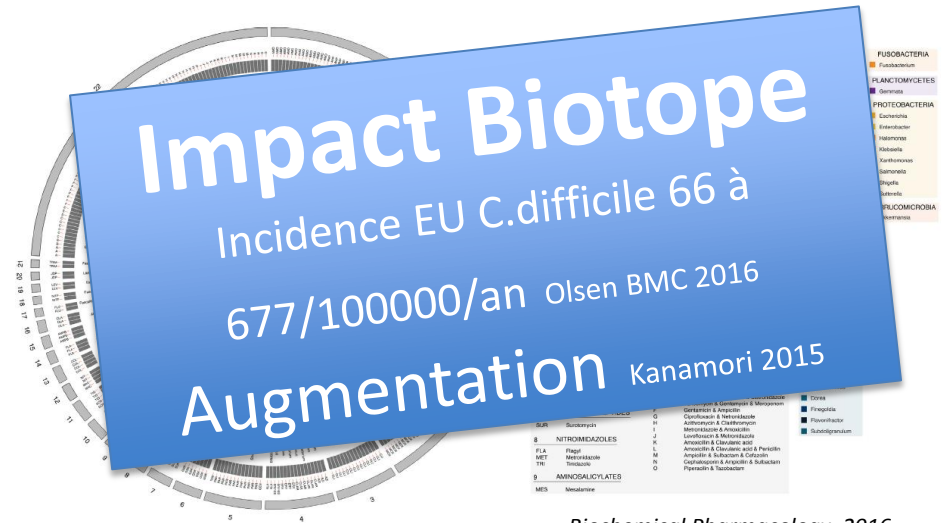[b] Carl R. Woese Institute for Genomic Biology, Urbana, USA
[c] Centro de Metabolómica y Bioanálisis (CEMBIO), Facultad de Farmacia, Universidad CEU San Pablo, Campus Montepríncipe, Madrid, Spain
[d] Foundation for the Promotion of Health and Biomedical Research in the Valencian Community Public Health (FISABIO), Valencia, Spain
[e] Network Research Center for Epidemiology and Public Health (CIBER-ESP), Madrid, Spain
[f] Instituto Cavanilles de Biodiversidad y Biología Evolutiva (Universidad de Valencia), Valencia, Spain

Compliance
au traitement
Durée <7j

Impact Biotope
Incidence EU C.difficile 66 à
677/100000/an Olsen BMC 2016
Augmentation Kanamori 2015

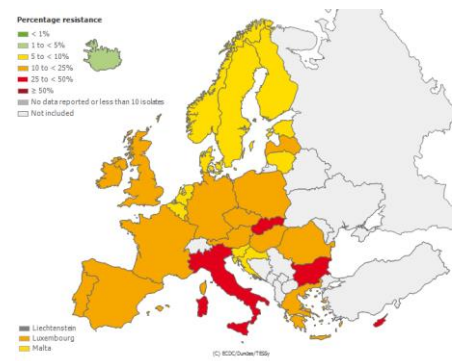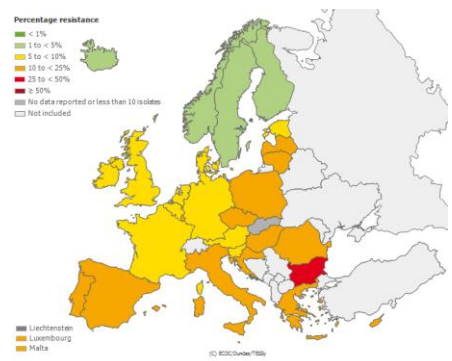*Biochemical Pharmacology, 2016*

PHARMACOEPIDEMIOLOGY REPORT
Antibiotic Noncompliance and Waste in Upper Respiratory Infections and Acute Diarrhea

Hortensia Reyes,* Hector Guiscafre, Onofre Muñoz,
Ricardo Perez-Cuevas, Homero Martinez, and Gonzalo Gutierrez
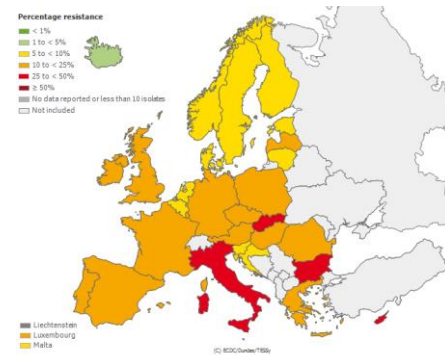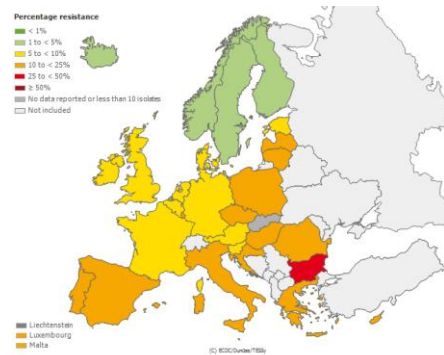INTERINSTITUTIONAL HEALTH SYSTEMS RESEARCH GROUP:
MINISTRY OF HEALTH, SOCIAL SECURITY MEXICAN INSTITUTE, COL. DEL VALLE, MEXICO

J Clin Epidemiol, 1997

Proportion of 3rd gen. cephalosporins Resistant (R+I) Escherichia coli Isolates in Participating Countries in 2010

Proportion of 3rd gen. cephalosporins Resistant (R+I) Escherichia coli Isolates in Participating Countries in 2013

Augmentation des Résistances

Proportion of 3rd gen. cephalosporins Resistant (R+I) Escherichia coli Isolates in Participating Countries in 2010

Proportion of 3rd gen. cephalosporins Resistant (R+I) Escherichia coli Isolates in Participating Countries in 2013

Augmentation des Résistances

Augmentation significative de la mortalité

E.Coli R aux C3G/FQ: mortalité J30x2
K.Pneumoniae R aux C3G/carbapénèmes

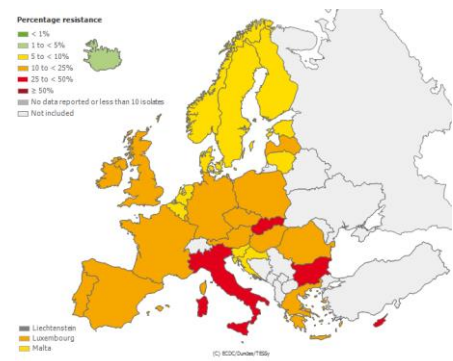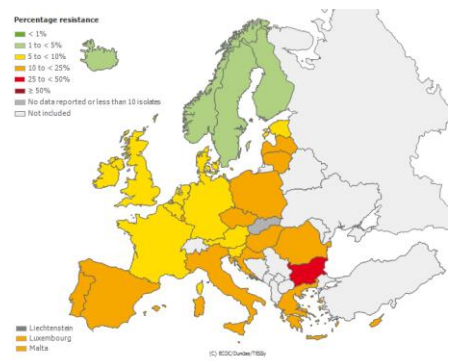ANTIMICROBIAL RESISTANCE
Global Report on Surveillance

2014

Augmentation des Résistances

Augmentation significative de la mortalité

E.Coli R aux C3G/FQ: mortalité J30x2

K.Pneumoniae R aux C3G/carbapénèmes

2014

Figure 6: Correlation between penicillin use and prevalence of penicillin non-susceptible S pneumoniae
AT, Austria; BE, Belgium; HR, Croatia; CZ, Czech Republic; DK, Denmark; FI, Finland; FR, France; DE, Germany; HU, Hungary; IE, Ireland; IT, Italy; LU, Luxembourg; NL, The Netherlands; PL, Poland; PT, Portugal; SI, Slovenia; ES, Spain; UK, England only.

Corrélation écologique Consommation/Résistance

Propositions du groupe de travail spécial pour la préservation des antibiotiques

Tous ensemble, sauvons les antibiotiques

Rapporteurs : Dr Jean CARLET et Pierre LE COZ

Augmentation des Résistances

Limiter les durées de prescriptions

ion écologique
mation/Résistance

Jusqu'où peut-on aller?
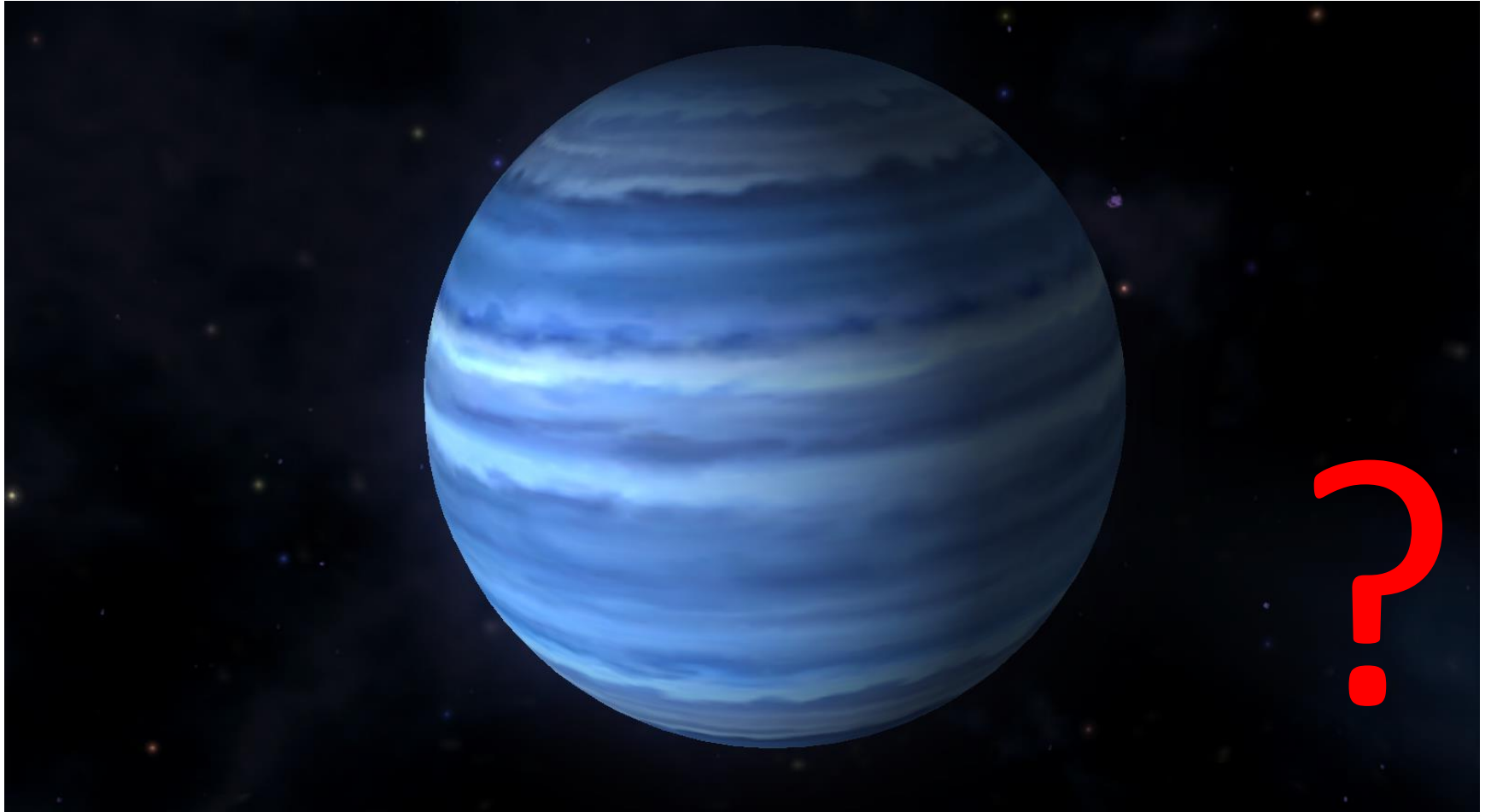
Sur quoi portent les nouvelles propositions de la SPILF?

Original article

Proposal for shorter antibiotic therapies

Propositions pour des antibiothérapies plus courtes

C. Wintenberger[a], B. Guery[b], E. Bonnet[c], B. Castan[d], R. Cohen[e], S. Diamantis[f], P. Lesprit[g], L. Maulin[h], Y. Péan[i], E. Peju[j], L. Piroth[j], J.P. Stahl[k], C. Strady[l], E. Varon[m], F. Vuotto[b], R. Gauzit[n,*], Recommendation Group of the SPILF

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Infections les plus fréquentes: Pyogènes

◆ Champignons

◆ Germes à croissance lente

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Infections les plus fréquentes: Pyogènes

◆ Champignons

◆ Germes à croissance lente

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

1. Spondylodiscite

Antibiotic treatment for 6 weeks versus 12 weeks in patients with pyogenic vertebral osteomyelitis: an open-label, non-inferiority, randomised, controlled trial

Louis Bernard, Aurélien Dinh, Idir Ghout, David Simo, Valerie Zeller, Bertrand Issartel, Vincent Le Moing, Nadia Belmatoug, Philippe Lesprit, Jean-Pierre Bru, Audrey Therby, Damien Bouhour, Eric Dénes, Alexa Debard, Catherine Chirouze, Karine Fèvre, Michel Dupon, Philippe Aegerter, Denis Mulleman, on behalf of the Duration of Treatment for Spondylodiscitis (DTS) study group*

◆ Méthodologie

- 2006-2011; 359 patients
- Multicentrique, ouverte
- Pyogène
- Exclues: fongiques, intracellulaire, non documentées, récidive, matériel, durée de vie < 1an
- Critère principal: guérison à 1 an

Lancet 2005

	6-week regimen (n=176)	12-week regimen (n=175)	Total (n=351)
Age, years	62 (16)	60 (17)	61 (17)
Female	61 (35%)	48 (27%)	109 (31%)
Comorbidity			
Immunodepression	5 (3%)	11 (6%)	16 (5%)
Diabetes	36 (20%)	18 (10%)	54 (15%)
Clinical characteristics			
Fever	87 (49%)	95 (54%)	182 (52%)
Back pain	172 (98%)	165 (94%)	337 (96%)
Duration of infection, days	34 (19–58)	34 (18–57)	34 (18–58)
Number of sites of vertebral osteomyelitis			
1	159 (90%)	154 (88%)	313 (89%)
≥2	17 (10%)	21 (12%)	38 (11%)
Type of site of vertebral osteomyelitis			
Cervical level	28 (16%)	24 (14%)	52 (15%)
Thoracic level	46 (26%)	50 (29%)	96 (27%)
Lumbar level	125 (71%)	121 (69%)	246 (70%)
Sacral level	19 (11%)	26 (15%)	45 (13%)
Associated endocarditis*			
Duke definite	23/127 (18%)	28/130 (22%)	51/257 (20%)
Probable	4/127 (3%)	1/130 (1%)	5/257 (2%)
Neurological signs	25 (14%)	32 (18%)	57 (16%)
Radiological biological characteristics			
MRI	157 (89%)	159 (91%)	316 (90%)
CT scan	88 (50%)	80 (46%)	168 (48%)
C-reactive protein concentration			
Absolute concentration, mg/L	118 (103)	126 (108)	122 (105)
Concentration >10 mg/L	157 (89%)	161 (92%)	318 (91%)
Microbiological diagnosis			
Blood culture	119 (68%)	121 (69%)	240 (68%)
CT-vertebral biopsy	67 (38%)	71 (41%)	138 (39%)
Perioperative surgical biopsy	9 (5%)	10 (6%)	19 (5%)
Microbiological identification			
Staphylococcus aureus†	69 (39%)	76 (43%)	145 (41%)
Coagulase-negative Staphyloccocus‡	29 (16%)	32 (18%)	61 (17%)
Streptococcus spp	32 (18%)	31 (18%)	63 (18%)
Enterococcus spp	11 (6%)	15 (9%)	26 (7%)
Enterobacterial spp	22 (13%)	16 (9%)	38 (11%)
Anaerobia	7 (4%)	6 (3%)	13 (4%)
Other Gram-negative bacteria	6 (3%)	4 (2%)	10 (3%)
Other Streptococcus	4 (2%)	4 (2%)	8 (2%)

Majoritairement

- ❑ Localisation unique
- ❑ Lombaire
- ❑ Diagnostic sur hémoculture
- ❑ *Staphylococcus aureus*

Lancet 2005

◆ Résultats

- Non infériorité à 1 an
- 91% de guérison à 1 an
- 7% de mortalité à 1 an
- 1% C. difficile

Critères de guérison clinique et biologique

	6-week regimen	12-week regimen	Difference in proportion of patients*	95% CI
Intention-to-treat analysis, n	176	175		
Cured	160 (90·9%)	159 (90·9%)	+0·1	−6·2 to 6·3
Cured and alive†	156 (88·6%)	150 (85·7%)	+2·9	−4·2 to 10·1
Cured without further antibiotic treatment‡	142 (80·7%)	141 (80·6%)	+0·1	−8·3 to 8·5
Per-protocol analysis, n	146	137		
Cured	137 (93·8%)	132 (96·4%)	−2·5	−8·2 to 2·9
Cured and alive†	133 (91·1%)	126 (92·0%)	−0·9	−7·7 to 6·0
Cured without further antibiotic treatment‡	NA	NA	NA	NA

Data are number, or number (%) unless otherwise specified. 32 patients (16 in the 6-week group and 16 in the 12-week group) were classified as cases of probable failure of treatment by the independent validation committee. Of 68 protocol violations excluded from the per-protocol population, 18 cases were classified as failure and 50 as cure in the intention-to-treat population. *6-week group minus 12-week group. †Death in cases classified as probable cure by the independent validation committee were classified as failure. ‡Further antibiotic treatment was regarded as a treatment failure. NA=not applicable.

Table 2: Primary outcome analyses of patients with vertebral osteomyelitis according to duration of antibiotic treatment

	6-week regimen (n=176)	12-week regimen (n=175)	Total (n=351)	p value
Back pain at 1 year	44/145 (30%)	41/138 (30%)	85/283 (30%)	1
Fever at 1 year (no=0, yes=1)	0	1 (1%)	1 (<1%)	0·48
C-reactive protein concentration at 1 year, mg/L	4·2 (1·9–7·2)	3·2 (1·8–6)	4 (1·8–6·3)	0·22
Adverse events	51 (29%)	50 (29%)	101 (29%)	1
Death	14 (8%)	12 (7%)	26 (7%)	0·85
Cardiorespiratory failure	7 (4%)	12 (7%)	19 (5%)	0·33
Digestive tract bleeding	4 (2%)	2 (1%)	6 (2%)	0·68
Clostridium difficile infection	2 (1%)	2 (1%)	4 (2%)	1
Antibiotic intolerance	12 (7%)	9 (5%)	21 (6%)	0·66
Other infection (not vertebral osteomyelitis)	5 (3%)	7 (4%)	12 (3%)	0·76
Device infection	1 (1%)	2 (1%)	3 (1%)	0·62
Neurological complications	7 (4%)	3 (2%)	10 (3%)	0·34
Endocarditis	3 (2%)	4 (2%)	7 (2%)	0·72

Data are number of patients with at least one event (%) or median (IQR), unless otherwise specified.

Table 3: Secondary outcomes and adverse events

◆ Résultats

- Non infériorité à 1 an
- 91% de guérison à 1 an
- 7% de mortalité à 1 an
- 1% C. difficile

	6-week regimen	12-week regimen	Difference in proportion of patients*	95% CI
Intention-to-treat analysis, n	176	175		
Cured	160 (90·9%)	159 (90·9%)	+0·1	−6·2 to 6·3
Cured and alive†	156 (88·6%)	150 (85·7%)	+2·9	−4·2 to 10·1
Cured without further antibiotic treatment‡	142 (80·7%)	141 (80·6%)	+0·1	−8·3 to 8·5
Per-protocol analysis, n	146	137		
Cured	137 (93·8%)	132 (96·4%)	−2·5	−8·2 to 2·9
Cured and alive†	133 (91·1%)	126 (92·0%)	−0·9	−7·7 to 6·0
Cured without further antibiotic treatment‡	NA	NA	NA	NA

Data are number, or number (%) unless otherwise specified. 32 patients (16 in the 6-week group and 16 in the 12-week group) were classified as cases of probable failure of treatment by the independent validation committee. Of 68 protocol violations excluded from the per-protocol population, 18 cases were classified as failure and 50 as cure in the intention-to-treat population. *6-week group minus 12-week group. †Death in cases ... ‡ ... cure by the independent validation committee ...

Critère ... biologique

Spondylodicite= 6 semaines

	6-week regimen	12-week regimen		value
		(50%)		1
	0	1 (1%)	1 (<1%)	0·48
C-reactive protein concentration at 1 year, mg/L	4·2 (1·9–7·2)	3·2 (1·8–6)	4 (1·8–6·3)	0·22
Adverse events	51 (29%)	50 (29%)	101 (29%)	1
Death	14 (8%)	12 (7%)	26 (7%)	0·85
Cardiorespiratory failure	7 (4%)	12 (7%)	19 (5%)	0·33
Digestive tract bleeding	4 (2%)	2 (1%)	6 (2%)	0·68
Clostridium difficile infection	2 (1%)	2 (1%)	4 (2%)	1
Antibiotic intolerance	12 (7%)	9 (5%)	21 (6%)	0·66
Other infection (not vertebral osteomyelitis)	5 (3%)	7 (4%)	12 (3%)	0·76
Device infection	1 (1%)	2 (1%)	3 (1%)	0·62
Neurological complications	7 (4%)	3 (2%)	10 (3%)	0·34
Endocarditis	3 (2%)	4 (2%)	7 (2%)	0·72

Data are number of patients with at least one event (%) or median (IQR), unless otherwise specified.

Table 3: Secondary outcomes and adverse events

A venir

Treatment of the infections on osteo-articular prostheses by 6 versus 12 weeksof antibiotherapy (DATIPO)

❑ Multicentric Study, of Non Inferiority, Randomized, Opened, to Evaluate the Two Durations Effectiveness of Antibiotherapy (6 Weeks Versus 12 Weeks) in the Treatment of Osteo-articular Prostheses Infections, With Prosthetic Change (in 1 Time or 2 Long Times) or Not (Articular Washin)

❑ https://clinicaltrials.gov/ct2/show/NCT01816009

2011-2017: Résultats à venir

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

2. Infections intra abdominales

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

Péritonites communautaires

Localisées

A Prospective, Double-Blind, Multicenter, Randomized Trial Comparing Ertapenem 3 Vs ≥5 Days in Community-Acquired Intraabdominal Infection

Antonio Basoli · Piero Chirletti · Ercole Cirino ·
Nicola G. D'Ovidio · Giovanni Battista Doglietto ·
Domenico Giglio · Stefano M. Giulini · Alberto Malizia ·
Mario Taffurelli · Jelena Petrovic · Maurizio Ecari ·
Italian Study Group

Prospective randomisée

Double aveugle

Multicentrique

Infections intra-abdo **opérées**
2005-2006

Chirurgie<24h de l'admission

Short (3 days) vs. Standard (5-14 days) Therapy of Intra-abdominal Infections with Localized Disease

Clinical Improvement criteria:
1. Afebrile for ≥ 24 hours
2. Improved Abd. signs & symptoms with the presence of bowel sound
3. White blood cell count returns to normal with no left shift (no bands)

Randomization (For those patients who meet Clinical Improvement criteria)

Enrollment & Stratification
→ STOP → TOC
Yes → 5-14 days → TOC
No → TOC

Day 0   3   No   Clinical outcome will be followed throughout the course of ertapenem & 2-weeks post-therapy of ertapenem

TOC = Test-of-cure time-point (2 weeks after discontinuation of therapy)
LFU = Late follow-up (4 weeks after discontinuation)

A Prospective, Double-Blind, Multicenter, Randomized Trial Comparing Ertapenem 3 Vs ≥5 Days in Community-Acquired Intraabdominal Infection

Antonio Basoli · Piero Chirletti · Ercole Cirino ·
Nicola G. D'Ovidio · Giovanni Battista Doglietto ·
Domenico Giglio · Stefano M. Giulini · Alberto Malizia ·
Mario Taffurelli · Jelena Petrovic · Maurizio Ecari ·
Italian Study Group

Prospective randomisée
Double aveugle
Multicentri...

Pas de différ...
Pas de différ...
complication... ...taité à S2 et
S4 après arrêt traitement

50% appendicite
Peu de patients (N=90)
Peu grave (score APACHE 2 <10=90%)

Péritonite localisée communautaire opérée: 3j
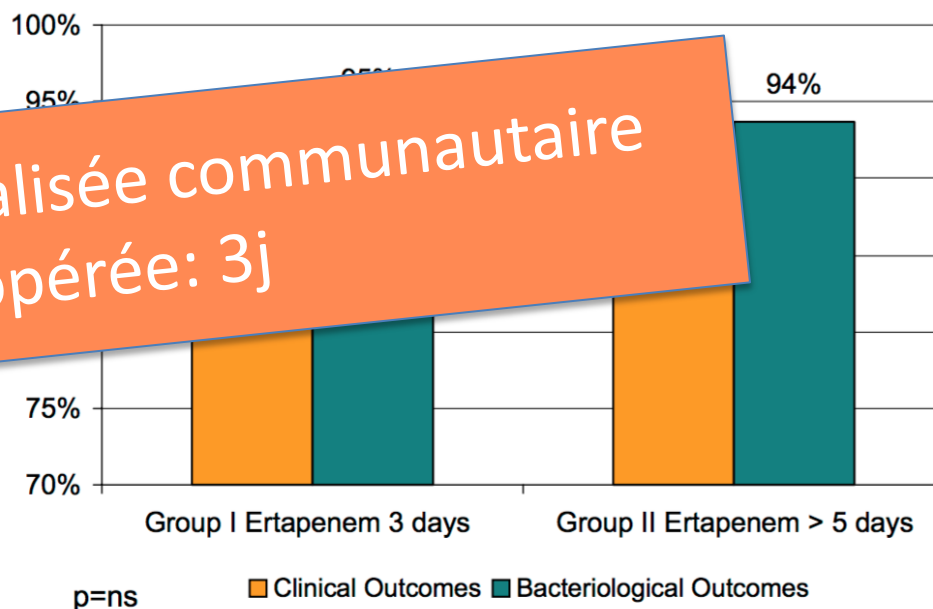
Figure 1 Clinical and bacteriological outcomes.

94%

p=ns

☐ Clinical Outcomes ■ Bacteriological Outcomes

Group I Ertapenem 3 days   Group II Ertapenem > 5 days

Infections intra abdo compliquées

Trial of Short-Course Antimicrobial Therapy for Intraabdominal Infection

R.G. Sawyer, J.A. Claridge, A.B. Nathens, O.D. Rotstein, T.M. Duane, H.L. Evans, C.H. Cook, P.J. O'Neill, J.E. Mazuski, R. Askari, M.A. Wilson, L.M. Napolitano, N. Namias, P.R. Miller, E.P. Dellinger, C.M. Watson, R. Coimbra, D.L. Dent, S.F. Lowry,* C.S. Cocanour, M.A. West, K.L. Banton, W.G. Cheadle, P.A. Lipsett, C.A. Guidry, and K. Popovsky

Table 1. Baseline Demographic and Clinical Characteristics, According to Study Group.*

Variable	Control Group (N=260)	Experimental Group (N=258)
Age — yr	52.2±1.0	52.2±1.0
Male sex — no. (%)	145 (55.8)	144 (55.8)
Race or ethnic group — no. (%)†		
White	208 (80.0)	196 (76.0)
Black	43 (16.5)	51 (19.8)
Asian	5 (1.9)	6 (2.3)
American Indian or Alaskan Native	2 (0.8)	1 (0.4)
Hispanic — no. (%)	20 (7.7)	15 (5.8)
Other	2 (0.8)	4 (1.6)
Characteristics of index infection		
APACHE II score‡	9.9±0.4	10.3±0.4
Maximum white-cell count — per mm³	15,600±0.4	17,100±0.7
Maximum body temperature — °C	37.8±0.1	37.7±0.1
Organ of origin — no. (%)		
Colon or rectum	80 (30.8)	97 (37.6)
Appendix	34 (13.1)	39 (15.1)
Small bowel	31 (11.9)	42 (16.3)
Source-control procedure — no. (%)		
Percutaneous drainage	86 (33.1)	86 (33.3)
Resection and anastomosis or closure	69 (26.5)	64 (24.8)
Surgical drainage only	55 (21.2)	54 (20.9)
Resection and proximal diversion	27 (10.4)	37 (14.3)
Simple closure	20 (7.7)	12 (4.7)
Surgical drainage and diversion	3 (1.2)	4 (1.6)

Prospective randomisée ouverte multicentrique

2008-2013

15% appendicite

Nombre de patients (N=518)

Peu grave (score APACHE 2 =10)

Inclusion: contrôle de la source

Randomisation: ATB poursuivis jusque :

- o J4 post chirurgie ou
- o J2 après résolution SRIS (maj 10j)

NEJM, 2015

Infections intra abdo compliquées

Trial of Short-Course Antimicrobial Therapy for Intraabdominal Infection

R.G. Sawyer, J.A. Claridge, A.B. Nathens, O.D. Rotstein, T.M. Duane, H.L. Evans, C.H. Cook, P.J. O'Neill, J.E. Mazuski, R. Askari, M.A. Wilson, L.M. Napolitano, N. Namias, P.R. Miller, E.P. Dellinger, C.M. Watson, R. Coimbra, D.L. Dent, S.F. Lowry,* C.S. Cocanour, M.A. West, K.L. Banton, W.G. Cheadle, P.A. Lipsett, C.A. Guidry, and K. Popovsky

Table 1. Baseline Demographic and Clinical Characteristics, According to Study Group.*

Variable	Control Group (N=260)	Experimental Group (N=258)
Age — yr	52.2±1.0	52.2±1.0
Male sex — no. (%)	145 (55.8)	144 (55.8)
Race or ethnic group — no. (%)†		
White	208 (80.0)	196 (76.0)
Black	43 (16.5)	51 (19.8)
Asian		
American Indian or Al		
Hispanic — no. (%)		
Other		
Characteristics of index inf		
APACHE II score‡		
Maximum white-cell cou		
Maximum body tempera	37.8±0.1	37.7±0.1
Organ of origin — no. (%)		
Colon or rectum	80 (30.8)	97 (37.6)
Appendix	34 (13.1)	39 (15.1)
Small bowel	31 (11.9)	42 (16.3)
Source-control procedure — no. (%)		
Percutaneous drainage	86 (33.1)	86 (33.3)
Resection and anastomosis or closure	69 (26.5)	64 (24.8)
Surgical drainage only	55 (21.2)	54 (20.9)
Resection and proximal diversion	27 (10.4)	37 (14.3)
Simple closure	20 (7.7)	12 (4.7)
Surgical drainage and diversion	3 (1.2)	4 (1.6)

Péritonite communautaire généralisée opérée/infection drainée: 4j

Table 2. Primary and Major Secondary Outcomes.*

Variable	Control Group (N=260)	Experimental Group (N=257)	P Value
Primary outcome: surgical-site infection, recurrent intraabdominal infection, or death — no. (%)	58 (22.3)	56 (21.8)	0.92
Surgical-site infection	23 (8.8)	17 (6.6)	0.43
Recurrent intraabdominal infection	36 (13.8)	40 (15.6)	0.67
Death	2 (0.8)	3 (1.2)	0.99
Time to event — no. of days after index source-control procedure			
Diagnosis of surgical-site infection		.4	<0.001
Diagnosis of rec		.4	<0.001
		.5	0.66
			0.62
			0.11
			0.65
			0.71
	(1.2)	3 (1.2)	0.99
	1 (0.4)	4 (1.6)	0.36
Vascular catheter	0 (0)	2 (0.8)	0.47
Clostridium difficile infection — no. (%)	3 (1.2)	5 (1.9)	0.71
Extraabdominal infection with resistant pathogen — no. (%)	6 (2.3)	2 (0.8)	0.29
Duration of outcome — days			
Antimicrobial therapy for index infection			<0.001
Median	8	4	
Interquartile range	5–10	4–5	
Antimicrobial-free days at 30 days			<0.001
Median	21	25	
Interquartile range	18–25	21–26	
Hospitalization after index procedure			0.48
Median	7	7	
Interquartile range	4–11	4–11	
Hospital-free days at 30 days			0.22
Median	23	22	
Interquartile range	18–26	16–26	

* Plus–minus values are means ±SE.
† Some patients had extraabdominal infections at more than one site.

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

Péritonites postopératoires

Duration of antibiotic therapy in post-operative peritonitis: the Durapop study

Philippe Montravers*[1], Florence Tubach[2], Marina Esposito-Farese[2], Sigismond Lasocki[3], Thomas Lescot[4], Benoit Veber[5], Philippe Seguin[6], Catherine Paugam[7], Herve Dupont[8], For the Durapop Study Group[2]

ESCMID 2016

Péritonite généralisée post opératoire opérée: 8j

Prospective randomisée ouverte multicentrique

Prospective randomisée ouverte

2011-2015

Age médian

Score charlson 5

Nombre de patients (N=249)

Peu grave (score APACHE 2 =10)

Randomisation à J8 de la reprise chirurgicale: placebo vs +7j

... J28 après (meilleure si groupe 8j)

Critère II:

○ décès toute cause J28 (identique, 93% survie)

○ ré-opération J28 (20%, identique)

○ durée hospitalisation (12j)

○ émergence de portage germe résistants (55%)

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

3. Méningites

Prise en charge des méningites bactériennes aiguës communautaires (à l'exclusion du nouveau-né)

Bactérie, sensibilité	Durée totale (jours)	Durée totale (jours)
Streptococcus pneumoniae		
CMI amoxicilline < 0,1 mg/l	10 à 14**	7 jours
CMI amoxicilline ≥ 0,1 mg/l		
Neisseria meningitidis		
CMI amoxicilline < 0,1 mg/l	4 à 7***	5 jours
CMI amoxicilline ≥ 0,1 mg/l		
Listeria monocytogenes	21	21
Streptococcus agalactiae	14 à 21	14 jours
Escherichia coli	21	21

ORIGINAL ARTICLE

Short course intravenous benzylpenicillin treatment of adults with meningococcal disease

S. BRIGGS, R. ELLIS-PEGLER, S. ROBERTS, M. THOMAS and A. WOODHOUSE

Infectious Diseases Unit, Auckland Hospital, Auckland, New Zealand

**Rétrospectif
1998- 2002**
88 patients
médiane 27 ans
3j de traitement
peniG
7% DC
Pas de rechute

Short versus long duration of antibiotic therapy for bacterial meningitis: a meta-analysis of randomised controlled trials

D E Karageo... ...E Falagas[1,2,3]

**Méningite méningocoque 5j
Méningite pneumocoque 7j**

**Prospectives randomisées
1995-2002**
Europe
<7j (4-7j) versus >7j (7-14j)
Pneumo/meningo/haemophilus
Pas de différence guérison
Pas de différence complications long terme, mortalité

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

4. Autres

ELSEVIER

CLINICAL RESEARCH STUDY

Efficacy of Short-Course Antibiotic Regimens for Community-Acquired Pneumonia: A Meta-analysis

Jonathan Z. Li, MD,[a] Lisa G. Winston, MD,[a,b] Dan H. Moore, PhD,[c] Stephen Bent, MD[d]

[a]Department of Medicine, [b]Infectious Diseases Division, [c]Department of Epidemiology and Biostatistics, and [d]General Internal Medicine Section, San Francisco VA Medical Center, University of California, San Francisco.

◆ **Méthodologie**

o < 7j vs >7j

Pneumonie communautaire
7 jours

o Macrolides, FQ, Betalactamines

o Pneumocoque, intracellulaire

◆ **Résultats: pas d'infériorité**

Effectiveness of discontinuing antibiotic treatment after three days versus eight days in mild to moderate-severe community acquired pneumonia: randomised, double blind study

Rachida el Moussaoui, Corianne A J M de Borgie, Peterhans van den Broek, Willem N Hustinx, Paul Bresser, Guido E L van den Berk, Jan-Werner Poley, Bob van den Berg, Frans H Krouwels, Marc J M Bonten, Carla Weenink, Patrick M M Bossuyt, Peter Speelman, Brent C Opmeer, Jan M Prins

◆ **Méthodologie**

o Multicentrique double aveugle

o Amoxicilline 3g: 3j vs 7j

Futur: 3j ?

Characteristic	Three day treatment group (n=56)	Eight day treatment group (n=63)
Men	34 (61)	37 (59)
Women	22 (39)	26 (41)
Median (interquartile range) age (years)	54 (40-70)	60 (40-74)
Conditions:		
Underlying disease*	39 (70)	40 (64)
Chronic obstructive pulmonary disease		16 (25)
		11 (18)
		6 (10)
		7 (11)
		13 (21)
		17 (27)
		11 (18)
		26 (41)
		17 (27)
		9 (14)
		(24-57)
		8 (1.0)
	17·7 (7.6)	15·5 (5.2)
Radiological findings:		
Unilateral infiltrate	51 (91)	56 (89)
Bilateral	5 (9)	7 (11)
Single lobe	47 (84)	52 (83)
Multiple lobe	9 (16)	11 (18)
Pleural effusion	7 (13)	2 (3·2)
Detected pathogen at study entry:	33 (59)	31 (49)
Streptococcus pneumoniae	19 (6)‡	18 (8)‡
Haemophilus influenzae	6	4
Moraxella catharrhalis	1	3
Haemophilus parainfluenzae	0	1
Influenza A or B	2	2
Chlamydia pneumoniae	1	1
Mycoplasma pneumoniae	0	0
Legionella pneumophila	0	0
Other	4	2

Fig 3 Proportion of patients considered clinical successes in intention to treat population. Day 3=day of randomisation

Dermohypodermite

Comparison of Short-Course (5 Days) and Standard (10 Days) Treatment for Uncomplicated Cellulitis

MAJ Matthew J. Hepburn, MC, USA; COL David P. Dooley, MC, USA;
MAJ Peter J. Skidmore, MC, USA; MAJ Michael W. Ellis, MC, USA;
MAJ William F. Starnes, MSC, USA; LTC William C. Hasewinkle, MC, USA

Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the ...

Denni... ...orbach,[6]
Jan W...

Dermohypodermite: 7 jours

15. ...ended duration of antimicrobial therapy is 5 days, but treatment should be extended if the infection has not improved within this time period (strong, high).

Ciprofloxacin for 2 or 4 Weeks in the Treatment of Febrile Urinary Tract Infection in Men: A Randomized Trial with a 1 Year Follow-up

PETER ULLERYD & TORSTEN SANDBERG

Scand J Med 2009

Pyelonéphrite aigue simple: 7j
Prostatite aigue : 14j

...of
...g Once-Daily for Five Days With Ciprofloxacin 400/500 mg Twice-Daily for 10 Days for the Treatment of Complicated Urinary Tract Infections and Acute Pyelonephritis

Janet Peterson, Simrati Kaul, Mohammed Khashab, Alan C. Fisher, and James B. Kahn

Urology, 2007

A venir

Antibiotic Treatment for 7 days Versus 14 Days in Patients With Acute Male Urinary Tract Infection due to Fluoroquinolones Susceptible Bacteria (PROSTASHORT)

❑ A Multicentre, Non-infériority, Double Blind, Randomized Placebo- controlled Trial

2015-2018: Résultats 2019

Sur quoi portent les nouvelles propositions de la SPILF?

◆ Données fondées sur EBM

◆ Avis d'experts

G. Ralph Corey [a,b*], Martin E. Stryjewski [a,c], Richard J. Everts [d]

[a] Division of Infectious Diseases, Duke Clinical Research Institute, 2400 Pratt Street, Durham, NC 27705, USA
[b] Duke University Medical Center, Durham, NC, USA
[c] Centro de Educación Médica e Investigaciones Clínicas (CEMIC), Buenos Aires, Argentina
[d] Nelson Hospital, Nelson, New Zealand

Bactériémies primaires

- PAS endocardite infectieuse/localisation secondaire/matériel

- **5 jours :** SCN, streptocoques oraux

- **7 jours** : entérobactéries, entérocoques

- **10 jours** : BGN non ferrmentants

- **14 jours** : *S. aureus et S. lugdunensis.*

Bactériémies sur KTC

- **5 jours :** SNC après retrait du cathéter

- **7 jours :** streptocoques, entérocoques, BGN après retrait du cathéter

- **10 jours** (+ verrou local d'antibiotiques) : si cathéter laissé en place, SAUF *S. aureus*

- **14 jours** : BLC à *S. aureus*, après retrait du cathéter

- **21 jours** : thrombose suppurée

Short-course therapy for bloodstream infections in immunocompetent adults

G. Ralph Corey [a,b,*], Martin E. Stryjewski [a,c], Richard J. Everts [d]

[a] Division of Infectious Diseases, Duke Clinical Research Institute, 2400 Pratt Street, Durham, NC 27705, USA
[b] Duke University Medical Center, Durham, NC, USA
[c] Centro de Educación Médica e Investigaciones Clínicas (CEMIC), Buenos Aires, Argentina
[d] Nelson Hospital, Nelson, New Zealand

Bactériémies primaires

- PAS endocardite infectieuse/localisation secondaire/matériel

- **5 jours :** SGN...

- **7 j**...en...

- **10 jours** : BGN non ferrmentants

- **14 jours** : *S. aureus et S. lugdunensis.*

Bactériémies sur KTC

- **5 jours :** SNC après retrait du cathéter

- **7 jours :** streptocoques, entérocoques, BGN après retrait du cathéter

- ...ter laissé en...

- ...após retrait du cathéter

- **21 jours** : thrombose suppurée

Antibiotic treatment duration (7 vs 14 days) comparison in blood stream infection causes by Enterobacteriaceae

Résultats 2017

Les autres changements

◆ Bactériémie sur sonde de pace maker
  - o Explantation PM: 7j
  - o Explantation PM + SA: 14j
  - o Explantation PM+ endocardite sur sonde: 4 semaines
  - o PM non explanté: 6 semaines

◆ Neutropénie fébrile
  - o Sans documentation et >48h apyrexie: 3j
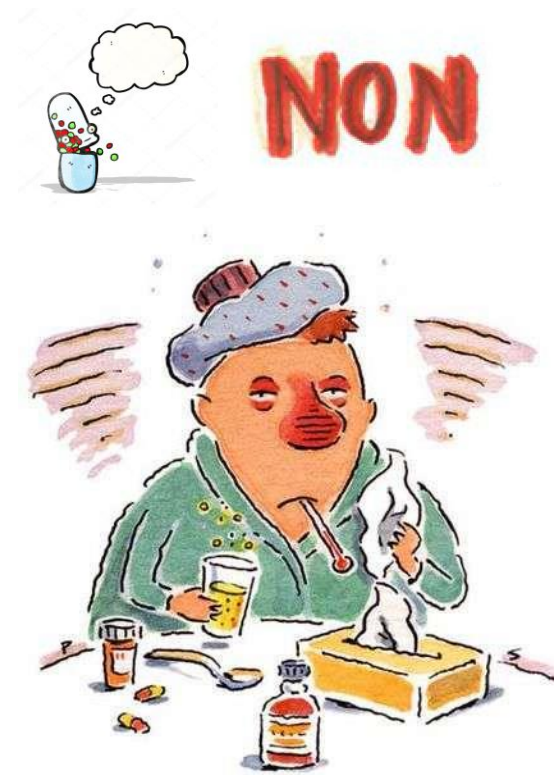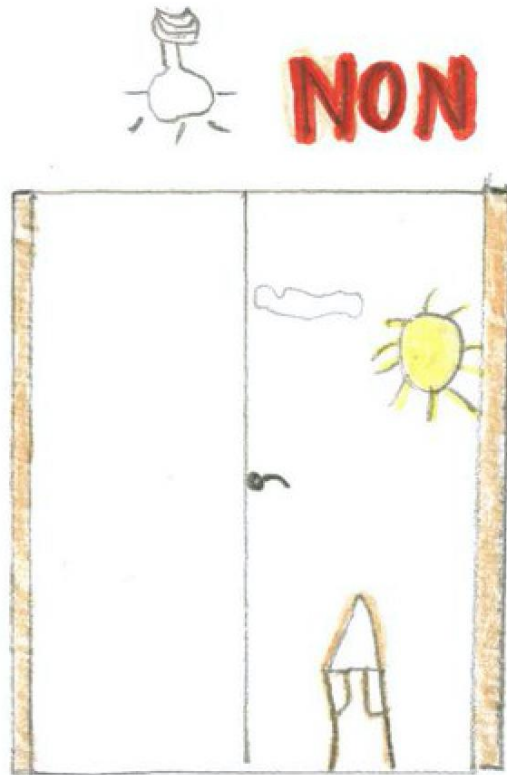 - o Documentation microbiologique et >4j apyrexie: 7j

◆ Angiocholite drainée 3j

◆ Sinusite maxillaire adulte 5 jours

◆ Infection cutanée superficielle 3j

Conclusion

◆ 1ère question: Faut-il des antibiotiques?

Conclusion

◆ 1ère question: Faut-il des antibiotiques?

◆ Nouvelles reco sur les durées de prescription: preuves solides +++

◆ Durée selon réponse clinique +++ : raccourcir encore

Merci pour votre attention