Letter to the Editor

Antibiotic Treatment of Enterococcal Infection

Dr. Murray (B. E. Murray, Letter, Antimicrob. Agents Chemother. 33:1411, 1989) asks me to justify certain statements about the clinical efficacy of trimethoprim in urinary infections caused by enterococci. Although one of the major manufacturers of trimethoprim-sulfamethoxazole in the United Kingdom admitted to having nothing on its computer on this topic, a casual search through my collection of literature has revealed 47 cases of documented infections with enterococci as sole pathogens treated with trimethoprim alone or in combination.

Details are as follows. Trimethoprim alone was used in 7 cases (1, 4), trimethoprim-sulfamethoxazole was used in 27 cases (2, 5–7), and trimethoprim-sulfadiazine was used in 13 cases (6). In 38 of these cases (81%), cure was reported. We also have records of at least six further cases treated with trimethoprim alone that were not included in formal trials; five of these patients were cured.

The largest clinical trial which was devoted solely to enterococcal urinary infections I have seen reported involved 50 patients treated with carbenicillin (3). Lack of a large series for trimethoprim is not surprising, considering the relative rarity of the condition and the fact that the antibiotics of first and second choice must be ampicillin (or amoxicillin) and nitrofurantoin, respectively. Thus, I consider the evidence I have produced to be strongly suggestive that trimethoprim, either alone or in combination, is at least worth considering for the treatment of enterococcal urinary infection. Undoubtedly, a full and systematic search of the literature would produce many more cases, and it would be of interest to hear the experiences of other workers.

I am not in a position to answer Dr. Murray’s question as to whether the U.S. Food and Drug Administration would accept the available evidence as sufficient to license trimethoprim for use in enterococcal urinary infections. In the United Kingdom there is no contraindication in the officially approved drug literature (Data Sheets) to treating enterococcal urinary infections with trimethoprim alone or in combination. Thus, it can be assumed that The Committee on Safety of Medicines (the approval board equivalent to the Food and Drug Administration) did not disapprove of such usage. It could even be that trimethoprim might qualify as an “orphan drug” in this indication, in which case special dispensation would presumably become available.

Whether or not trimethoprim-sulfamethoxazole is regularly bactericidal in vitro does not seem to me to be of crucial importance. Bactericidal activity is an interesting in vitro phenomenon but as Dr. Murray rightly states, it is highly dependent upon experimental conditions. Its relevance to clinical performance is, at best, marginal except in certain clear-cut conditions, such as endocarditis, and its importance has not been shown in urinary infections.

Thus, I stand by my view that there is sufficient evidence that trimethoprim alone or in combination may be effective enough treatment for enterococcal urinary infections to warrant cautious usage. If we waited to use a drug until it had been proven to be effective, no clinical trials would ever be done and progress in the treatment of infectious diseases would come to a standstill.

LITERATURE CITED


J. M. T. Hamilton-Miller
Department of Medical Microbiology
Royal Free Hospital and School of Medicine
Pond Street
London NW3 2QG
England