Optimal meropenem concentrations to treat multi-drug resistant *Pseudomonas aeruginosa* septic shock

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Abstract.

A patient with septic shock due to extensively-drug resistant (XDR) *Pseudomonas aeruginosa* was cured by optimizing the meropenem (MEM) regimen to obtain at least 40% of the time between two administrations in which drug levels were four times above the minimal inhibitory concentration (MIC) of the pathogen. As standard drug dose did not achieve these optimal concentrations, MEM regimen was progressively increased up to 12g/day (3g q6h in 3-hour extended infusion), which eventually resulted in sepsis resolution. High MEM dosage may represent a valuable therapeutic option for infection due to MDR strains and drug monitoring would allow rapid regimen adjustment in clinical practice.

**Keywords:** sepsis, meropenem, *Pseudomonas aeruginosa*, multi-drug resistance, pharmacokinetics
Introduction.

_Pseudomonas aeruginosa_ infections are associated with increased morbidity and mortality in critically ill patients. Moreover, the increasing frequency of extensively-drug resistant (XDR) strains of this pathogen is a considerable therapeutic challenge for clinicians (5, 11). Broad-spectrum β-lactams are the first therapeutic option for the treatment of _P. aeruginosa_ infections; however, in case of XDR strains, colistin or aminoglycosides remain the last therapeutic option, but their effectiveness has been poorly demonstrated in this setting (6).

The epidemic spread of XDR bacteria and the lack in the development of new drugs active against these pathogens have forced clinicians to optimize the antimicrobial activity of the available antibiotics (14). We report herein a case of septic shock due to _P. aeruginosa_ that was successfully treated by adapting the meropenem (MEM) regimen to the serum drug concentrations and the _in vitro_ pathogen susceptibility.

Case report.

A 70-year old obese man (body weight, BW = 120 kg; body mass index, BMI = 35) was transferred to the Intensive Care Unit (ICU) from another hospital for a ventilator-associated pneumonia, developed few days after an elective tracheostomy. The patient had prolonged mechanical ventilation (MV) after pulmonary oedema complicating an episode of acute heart failure one month before and his tracheal aspirates were colonized by _P. aeruginosa_.

At ICU admission, controlled volume MV was initiated and norepinephrine titrated to achieve a mean arterial pressure of at least 70 mmHg; initial serum creatinine levels were 2.7 mg/dL and, because of concomitant oliguria, fluid resuscitation consisted of 5200 mL during the first day of therapy. Blood cultures, as well as cultures from endotracheal aspirate, showed _P. aeruginosa_, which was resistant to several antibiotics (including aztreonam, ceftazidime, cefepime and piperacillin-tazobactam) except MEM (minimal inhibitory concentration, MIC...
amikacin, ciprofloxacin and colistin. Patient received MEM (1g q8h) and ciprofloxacin (400 mg q8h). MIC of *P. aeruginosa* for MEM was determined by the E-test method (BioMérieux, Marcy-l’Etoile, France). Creatinine levels rapidly decreased below 1 mg/dL and creatinine clearance measured on 24-hour urinary excretion went up to more than 200 ml/min, while no improvement of respiratory and hemodynamic status was remarked after the first 5 days of treatment. On day 2 and 5 of therapy, two samples for serum MEM levels monitoring were taken during the elimination phase after a 30-minute IV administration. Method and validation for MEM assay have been previously published (16).

The adequacy of MEM therapy was assessed by calculating the time that drug levels remained above four times the MIC of the isolate (T > 4 x MIC) for an extensive period between two doses; T > 4 x MIC was considered to be optimal if > 40% of the dose interval (13). In both measurements, drug concentrations were below this threshold (Table 1). Because of persistent septic shock, a broncho-alveolar lavage was performed at day 6 and yielded again *P. aeruginosa*, which was *in vitro* intermediate to MEM (MIC = 4 mg/L), resistant to ciprofloxacin and only susceptible to colistin (MIC = 2 mg/L) and amikacin (MIC = 8 mg/L). The dose of MEM was then increased at 2g q8h in a 3-hour extended infusion and combined with colistin (6*10⁶ IU q12h). C-reactive protein levels initially decreased, but the patient still needed MV and norepinephrine infusion. With this treatment, MEM serum concentrations remained below the threshold of efficacy. Few days later, *P. aeruginosa* was recovered in another endotracheal aspirate and was now resistant to MEM (MIC = 8 mg/L). Meropenem regimen was then increased to 3g q6h as 3-hour extended infusion (total daily dose of 12g) while colistin was discontinued. The T > 4 x MIC raised then to nearly 50%. Patient clinical status improved thereafter with resolution of signs of sepsis and reduction of inflammatory parameters (Figure 1). No adverse events were observed; an electroencephalogram performed at day 16 showed no abnormalities. The patient was discharged from the ICU ten days after
the end of therapy (33 days) to the floor.

Discussion.

We described the case of successful treatment of XDR-"P. aeruginosa" septic shock with an antimicrobial strategy using a higher than recommended regimen of MEM. The daily dose of MEM was adapted using repeated drug concentrations monitoring and considering the increasing MIC of the pathogen to optimize the antimicrobial activity of the drug. This case illustrates the difficult task in antibiotic prescription for critically ill patients, as several factors that may alter drug concentrations were concomitantly present. First, sepsis alters the pharmacokinetic (PK) parameters of antibiotics, such as volume of distribution and elimination and degradation processes, so that standard regimens derived from patients with less severe infections or healthy volunteers may not be applicable in this setting (14). Second, the increased cardiac output and the large amount of fluid needed during the infectious episode can result in an increased renal blood flow and glomerular hyperfiltration, leading to an increased antibiotic clearance and potentially sub-therapeutic drug concentrations (18). Third, obesity may have a significant impact on antimicrobials PKs and further alter drug concentrations when standard regimens are administered (7). Moreover, achieving therapeutic drug concentrations is particularly difficult when infections are caused by some pathogens, such as "P. aeruginosa" and gram-negative rods, with naturally reduced susceptibility to antimicrobials and the presence of a XDR strain resulted in another reason for inadequate MEM concentrations during initial therapy (6).

Experimental studies have demonstrated that β-lactams have a slow continuous kill characteristic that is almost entirely related to the time during which serum concentrations exceed the MIC for the infecting organism (1); in these models, maximal bacterial killing was obtained with drug concentrations of 4-5 times the MIC (19). For human infections, the
optimal β-lactam strategy (T>MIC or T>4-5 x MIC) has not yet been identified. Although it has been shown that, in patients treated with cephalosporins, T>MIC of 100% had significantly greater clinical cure and bacteriological eradication than T > MIC less than 100% (12), carbapenems have different PK properties and, because of a post-antibiotic effect, do not need a so prolonged time of concentrations exceeding the MIC to be effective (13). Interestingly, MEM regimens resulted in a T>MIC of almost 100% for the different regimens in our patient but clinical success was obtained only when drug concentrations exceeded 4 times the MIC for at least 40% of the dosing interval.

Human studies on serum concentrations of broad-spectrum β-lactams, such as cephalosporins or piperacillin, have already reported that drug levels are insufficient in patients with severe infections to treat less susceptible strains, while serum MEM concentrations were found to be adequate in most of the critically ill patients with sepsis (17). Nevertheless, all of these studies considered only strains susceptible to the drug (MIC < 2 mg/L), while for less susceptible pathogens a higher than recommended regimen using extended infusion would be necessary to optimize the efficacy of the drug (8). Importantly, as shown in the present case, the low serum concentrations obtained with recommended doses may have induced emergence of resistant strains and a favourable outcome can be obtained only when serum concentrations reached levels corresponding to PK properties of β-lactams (4). We did not measure colistin levels and cannot exclude any synergistic effect of meropenem and colistin in the treatment of this XDR P. aeruginosa strain; however, patient did not improve with this combination therapy and only the increase of meropenem regimen to 12g/day allowed the resolution of the septic process.

According to population modelling simulation, continuous or extended β-lactam infusions (CI/EI) are required to optimize pathogen exposure to bactericidal concentrations of β-lactams (15). There are still some limitations to this strategy. First, clinical data that have
shown a better outcome using this strategy have come just from retrospective studies in critically ill populations with pneumonia (9, 10). Second, when high doses are used to cure less susceptible strains, over-dosing and toxicity of β-lactams could also be a concern so that drug monitoring is mandatory in this setting to correctly adjust the dose (3). However, larger than recommended carbapenem regimens have already been used in other diseases, such as cystic fibrosis, to treat XDR pathogens, resulting in clinical success and being well tolerated (2). Large prospective cohorts are needed to assess the influence on morbidity and mortality of CI/EI administration, especially in patients with sepsis and infections caused by XDR pathogens.

Conflicts of interest.

The authors do not have any conflicts to declare related to this manuscript.
References


Figures Legend.

Figure 1. Evolution of C-reactive protein (CRP) and creatinine clearance measured on urinary excretion during the ICU stay. MEM = meropenem; $T > 4 \times MIC$ = time above four times the minimal inhibitory concentration of the pathogen.
Table 1. Meropenem regimens, concentrations and pharmacodynamics during therapy.

<table>
<thead>
<tr>
<th>Day of therapy</th>
<th>MEM dose</th>
<th>Time sampling</th>
<th>MEM concentrations (mg/L)</th>
<th>MIC (mg/L)</th>
<th>% T &gt; 4 x MIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1g q8h</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>1g q8h</td>
<td>2h 8h</td>
<td>12.3</td>
<td>&lt;2.0</td>
<td>2 37</td>
</tr>
<tr>
<td>5</td>
<td>1g q8h</td>
<td>2h 8h</td>
<td>13.4</td>
<td>&lt;2.0</td>
<td>2 39</td>
</tr>
<tr>
<td>9</td>
<td>2g EI q8h</td>
<td>3h 8h</td>
<td>17</td>
<td>3</td>
<td>4 39</td>
</tr>
<tr>
<td>15</td>
<td>3g EI q6h</td>
<td>3h 6h</td>
<td>43</td>
<td>19</td>
<td>8 51</td>
</tr>
</tbody>
</table>

EI = extended infusion (over 3-hour period); MEM = meropenem; MIC = minimal inhibitory concentration; 2h, 3h, 6h and 8h = 2, 3, 6 and 8 hours after the onset of MEM administration; T > 4 x MIC = time above 4 times the MIC