contain some contentious issues relating to antibiotic choice.

There is a consensus recommendation made at the highest level (A1) for the use of rifampicin in *Staphylococcus aureus* prosthetic joint infection (PJI), both in combination in the initial phase with intravenous agents then for prolonged oral use with another antibiotic [1].

We are concerned that the available data do not meet the A1 level recommendation as they are based on a single randomized controlled trial. This widely cited and influential study [2] is, to our knowledge, not complemented by any other randomized controlled studies of PJI [3]. The routine use of rifampicin for PJI presents challenges that require clear evidence of its benefit.

Development of rifampicin resistance in *S. aureus*, particularly methicillin-resistant *S. aureus* (MRSA), is our major concern, but induced resistance in coinfecting *Mycobacterium tuberculosis* strains [4] (and as has also been documented in the “opposite” direction in MRSA after tuberculosis treatment) [5] is also a possible consequence of adherence to these guidelines.

Vancomycin does not protect against the development of rifampicin resistance in vitro to the same degree as antistaphylococcal penicillins [6] or in animal models as well as daptoomycin [7]. Ciprofloxacin is not a suitable companion drug for treatment of PJI in our clinical setting because of widespread resistance of staphylococci [8]. There are no clinical data to support the use of combination of β-lactams and rifampicin for staphylococcal PJI [3]. Fusidic acid and rifampicin combination MRSA therapy is commonly used in Australia to protect against rifampicin resistance in the prolonged oral therapy of PJI and other bony infections.

Rifampicin use has other measurable “costs” in drug acquisition, interactions, and toxicity [9]. We suggest that more justification is needed from the authors of the PJI clinical practice guidelines for the A1 recommendation for rifampicin use. We believe that more, supportive, randomized controlled trial data are the only basis for such a recommendation in IDSA guidelines for this important disease.

**Note**

**Potential conflicts of interest.** Both authors: No reported conflicts.

Both authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

**Damon P. Eisen and Justin S. Denholm**

Victorian Infectious Diseases Service, Royal Melbourne Hospital, Parkville, Victoria, Australia

**References**


Correspondence: Damon Eisen, MBBS, MD, FRACP, Victorian Infectious Diseases Service, Royal Melbourne Hospital, Grattan St, Parkville, Victoria 3050, Australia (damon.eisen@mh.org.au).

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