Reply to DiNubile

To the Editor—We thank Dr DiNubile for his letter and his insights. We also agree with him that in many instances vancomycin is inferior to subsequent surgical procedures in the treatment of serious methicillin-susceptible Staphylococcus aureus (MSSA) infections such as bacteremia [1].

The slippery slope of noninferiority of biocreep has been much talked about but rarely, if ever, demonstrated in the treatment of S. aureus cutaneous infections. Biocreep occurs after several iterations of comparative trials using the newly approved numerically (but not statistically) inferior antibacterial as the next comparator.

Choosing vancomycin repeatedly as the comparator agent does not lead to biocreep, nor has it led to demonstration of inferiority, as vancomycin has never, to our knowledge, been shown to be inferior to a comparator in a properly designed and executed randomized blinded acute bacterial skin and skin structure infection (ABSSSI) trial.

In addition, with the early Food and Drug Administration–established endpoints, the identification of S. aureus susceptibilities in a routine hospital microbiology laboratory is often determined just as the 48- to 72-hour time point is reached. Thus, we would contend that vancomycin is optimal and not an inferior antibiotic for the treatment of S. aureus ABSSSI where methicillin-resistant S. aureus is responsible for a significant percentage of cutaneous infections. The risk of failure to treat this pathogen is greater than the theoretical risk of biocreep. It is also worth mentioning that current ABSSSI trials exclude patients with severe sepsis and life-threatening, metastatic, and invasive infections [2–5]. Therefore, patients with serious MSSA infections are not exposed to unnecessary risks. Until a drug is found to be superior to vancomycin, many of us will continue to use it in both clinical practice and in noninferiority trials without buyer’s fear or remorse.

Note

Potential conflicts of interest. G. R. C. reports the following financial relationships: Cerexa, Theravance, Pfizer, Cempra, Cubist, GlaxoSmithKline, DRL, Merck, Trius, and The Medicines Company. All other authors report no potential conflicts of interest.

All 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.

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