Colistin and rifampicin in the treatment of multidrug-resistant 
Acinetobacter baumannii infections

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Objectives: The increased incidence of nosocomial infections by multidrug-resistant organisms has 
motivated the re-introduction of colistin in combination with other antimicrobials in the treatment of 
infections. We describe the clinical and microbiological outcomes of patients infected with multidrug-
resistant Acinetobacter baumannii who were treated with a combination of colistin and rifampicin.

Patients and methods: Critically ill patients with pneumonia and bacteraemia caused by A. baumannii 
resistant to all antibiotics except colistin in medical and surgical intensive care units were enrolled. 
Clinical and microbiological responses and safety were evaluated.

Results: Twenty-nine patients (47 ± 14 years and APACHE II score 17.03 ± 3.68), of whom 19 were 
cases of nosocomial pneumonia and 10 were cases of bacteraemia, were treated with intravenous 
colistin sulphomethate sodium (2 million IU three times a day) in addition to intravenous rifampicin 
(10 mg/kg every 12 h). All A. baumannii isolates were susceptible to colistin. The mean duration of 
treatment with intravenous colistin and rifampicin was 17.7 (± 10.4) days (range 7–36). Clinical and 
microbiological responses were observed in 22 of 29 cases (76%) and the overall infection-related mor-
tality was 21% (6/29). Three of the 29 evaluated patients (10%) developed nephrotoxicity when treated 
with colistin, all of whom had previous renal failure. No cases of renal failure were observed among 
patients with normal baseline renal function. No neurotoxicity was noted.

Conclusions: Colistin and rifampicin appears to be an effective and safe combination therapy for 
severe infections due to multidrug-resistant A. baumannii.

Keywords: ICU, multiresistant, nephrotoxicity, bacteraemia, ventilator-associated pneumonia

Introduction

Acinetobacter baumannii is a Gram-negative cocccobacillus, widespread in nature, that has emerged as an important noso-
comial pathogen in recent years, and hospital outbreaks caused 
by this organism have increased worldwide.1,2 Its ability to 
acquire resistance to almost all groups of available antibiotics is 
a problem of great concern. Recent reports showed that most 
A. baumannii strains isolated in hospitals, especially in intensive 
care units (ICUs), are highly resistant to β-lactams, aminoglyco-
sides, fluoroquinolones and carbapenems.3 Colistin is an old 
antimicrobial belonging to the polymyxins and is widely applied 
ownadays for the management of infections caused by multidrug-resistant Gram-negative pathogens.5 Colistin should 
therefore be considered as a treatment option for critically ill 
patients in the ICU with infections caused by multiresistant A. baumannii,5 owing to its favourable properties of rapid bact-
terial killing, a narrow spectrum of activity and an associated 
slow development of resistance.6

A recent study had demonstrated that the in vitro activity of 
colistin was increased significantly by the presence of rifampicin 
and the combination was effective in prolonging survival in an
experimental model of infection by multidrug-resistant *A. baumannii*.2

We describe the clinical and microbiological outcomes of patients infected with multidrug-resistant *A. baumannii* who were treated with the colistin and rifampicin combination, as well as the adverse events seen with this combination.

**Patients and methods**

The study is a prospective uncontrolled case series that took place in two medical and surgical ICUs in Liguria Region in Italy between January 2006 and July 2007. We considered patients with the following inclusion criteria: critically ill patients with ventilator-associated pneumonia (VAP) or bacteraemia caused by *A. baumannii* resistant to all drugs tested (except colistin) admitted in medical and surgical ICUs. Diagnosis of infection was based on clinical findings and the isolation of bacteria, either from a normally sterile site or from quantitative cultures of bronchoalveolar lavage (BAL) according to the literature.8 More specifically, the clinical prerequisites or the diagnosis of VAP was as follows: the presence of at least two episodes of fever (>38.3°C), leucocytosis or leucopenia, purulent bronchial secretions, plus a new or persistent infiltrate on chest radiography. Polymicrobial infection was a criterion for exclusion. All the patients were treated with colistin sulphomethate sodium (Bellon; Rhône-Poulenc Rorer, France) administered intravenously at the dosage of 6 million units (~100 000 U/kg) divided into three doses associated with intra-venous rifampicin (10 mg/kg every 12 h). All causative microorganisms were identified using routine microbiological methods. Susceptibility testing was performed using the agar dilution method. Disc susceptibility testing was performed and interpreted according to the guidelines published by CLSI.9 Pan-drug resistance was defined as resistance of the isolate to anti-pseudomonal penicillins, cephalosporins, carbapenems, quinolones and aminoglycosides. VAP and bacteraemia were considered to have clinical and microbiological favourable outcomes if there was remission of sepsis-related symptoms (fever, leucocytosis or leucopenia), radiological resolution of VAP (decrease or disappearance of presenting findings on chest X-ray), and if BAL and blood cultures became negative. Renal function was monitored by daily measurement of the serum creatinine level. In patients with normal renal function (serum creatinine level, <1.2 mg/dL, or 110 µM), nephrotoxicity was defined as a serum creatinine value of >2 mg/dL (171 µM), as a reduction in the calculated creatinine clearance of 50% relative to the value at antibiotic therapy initiation. In patients with pre-existing renal dysfunction, nephrotoxicity was defined as an increase of ≥50% of the baseline creatinine level, as a reduction in the calculated creatinine clearance of 50% relative to the value at antibiotic therapy initiation. The study was approved by the Ethics Committee and did not require signatures of informed consent from the patients.

**Results**

Twenty-nine critically ill patients with multiresistant *A. baumannii* infections (age 47 ± 14 years) were studied: 19 patients had nosocomial pneumonia and 10 had bacteraemia. All the patients that matched the inclusion criteria were included in the study. Twenty-two were receiving mechanical ventilation (mean length of ventilation 24 ± 5.5 days). The APACHE II score was 17.03 ± 3.68. Data on the 29 patients are presented in Table 1. All *A. baumannii* isolates were tested against colistin and rifampicin and were susceptible. The mean duration of treatment was 17.7 (± 10.4) days (range 7–36). The mean length of hospital stay was 33.2 (± 15.8) days (range 12–74). The mean length of the ICU stay was 19.5 (± 7.9) days (range 11–56). Clinical and microbiological favourable responses were observed in 22 of 29 cases (76%) and the overall infection-related mortality was 21% (6/29 cases). The 30 day in-hospital mortality was 31% (9/29 cases). We did not observe any cases of development of resistance to rifampicin and colistin. Three of the 29 (10%) evaluated patients developed nephrotoxicity when treated with colistin (all of them had previous renal failure). Among the treated patients, none required dialysis. No cases of renal failure were observed among patients with normal baseline renal function. No neurotoxicity was noted.

**Discussion**

The emerging problem of nosocomial infections by multidrug-resistant *A. baumannii* has focused clinical attention on colistin, an old antimicrobial that is active against that species.4 The efficacy of colistin for the management of these infections may only be established by prospective double-blind, placebo-controlled trials; however, our prospective clinical experience confirmed that the combination of colistin plus rifampicin is safe and effective in the treatment of multidrug-resistant *A. baumannii* infections. To the best of our knowledge, this is the largest clinical trial of *A. baumannii* infections in critically ill patients treated with the colistin/rifampicin combination published in the literature.10,11 The first study, by Petrosillo et al.,10 evaluated the clinical outcome of carbapenem-resistant *A. baumannii*-infected patients treated with a combination of colistin (same dosage as our experience) and rifampicin in 14 mechanically ventilated critically ill patients with pneumonia due to *A. baumannii*. Of the 14 treated patients, 7 recovered from *A. baumannii* infections and 9 had microbiological clearance.10 Another study with combination therapy of colistin plus rifampicin was that of Motauakkil et al.,11 who conducted an observational study to evaluate the efficacy of intravenous (same dosage as our experience) and aerosolized colistin combined with rifampicin in the treatment of critically ill patients with nosocomial infections caused by multiresistant *A. baumannii* in a medical ICU. The clinical outcome was favourable for all patients. Despite the limited number of treated patients, our clinical and microbiological response rate (76%) was better than that of other similar studies.10,11 In recent years, many studies have been published showing that colistin may be a good therapeutic option for the treatment of severe infections caused by multidrug-resistant organisms.12–14 In these reports, favourable clinical response ranged between 57% and 73%.

The main adverse effects of colistin are nephrotoxicity (acute tubular necrosis) and neurotoxicity (dizziness, weakness, facial paraesthesia, vertigo, visual disturbances, confusion, ataxia and neuromuscular blockade, which can lead to respiratory failure or apnoea).3 In our series, no cases of renal failure were observed among patients with normal baseline renal function, as recently observed by Kallel et al.14 Among patients with previous renal impairment, 10% experienced nephrotoxicity during treatment.
Colistin was developed several decades ago, and no studies were ever performed to characterize its pharmacokinetic profile in critically ill patients. The optimal dosing regimen for critically ill patients is unknown. The synergy between colistin and rifampicin has certainly been demonstrated in vitro against multiresistant *A. baumannii*. In our study, colistin in combination with rifampicin showed very interesting clinical and microbiological results. Although this is by no means a definitive outcome study, it is an important one, adding to the body of the literature.

Despite the lack of a control group and the limited number of patients, colistin in association with rifampicin appears to be relatively safe and effective in treating critically ill patients with infections caused by multidrug-resistant *A. baumannii*.

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### Transparency declarations

None to declare.

### References


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**Table 1. Patients treated with colistin and rifampicin: clinical characteristics and outcome**

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VAP, ventilator-associated pneumonia; AHS, acute haemorrhagic stroke; AIS, acute ischaemic stroke; BSI, bloodstream infection; AML, acute myeloid leukaemia; LLA, lymphatic leukaemia acute.


