a day. Vancomycin showed trough levels of 4.9 and 7.2 mg/L on two occasions, and the dose was adjusted accordingly a few times. He presented 2 weeks later with worsening symptoms of the right knee, including redness, swelling and pain. He was switched to 10 mg/kg telavancin intravenously every 24 h and rifampicin was continued. The MIC of telavancin was 0.25 mg/L. During the 6 week therapy with telavancin, the patient showed rapid improvement of symptoms and signs at 2, 4 and 6 week follow-up visits, and antibiotic was discontinued at 6 weeks with resolution of infection. His WBC count returned to normal, C-reactive protein (CRP) decreased from 7 to 0.2 mg/L and the erythrocyte sedimentation rate (ESR) decreased from 60 to 8 mm/h. He had no significant side effects. The patient was symptom free on his subsequent visits at 6 months and 1 year after finishing therapy, with normal WBC count, ESR and CRP.

Coagulase-negative staphylococci (30%–43%) followed by Staphylococcus aureus (12%–23%) are the most commonly cultured microorganisms in prosthetic joint infections. Telavancin is a semi-synthetic lipoglycopeptide derived from vancomycin with activity against Gram-positive bacteria, including strains with reduced susceptibility to vancomycin. It exerts its antibacterial activity by two mechanisms: by inhibiting cell wall synthesis and increasing membrane permeability. Telavancin retains potent activity against methicillin-resistant S. aureus isolates with vancomycin MICs of 2 mg/L. It displays concentration-dependent bactericidal killing, a 7.5 h half-life and a post-antibiotic effect of 4–6 h, allowing for once-daily dosing. Taste disturbance, nausea, headache, foamy urine and reversible kidney injury are the most commonly observed adverse events. We believe this is the first reported case in the literature using telavancin successfully for the treatment of prosthetic knee joint infection without removal of the hardware, which is usually needed for eradication of the infection.

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No funding was required. Data were generated during the course of routine patient care.

Transparency declarations
None to declare.

References
parameters were within the normal range. The patient gave written informed consent for the publication of these data.

Haemolysis is not reported as a side effect of artesunate treatment in the cited trials (only some expected cases of black-water fever occurred immediately after treatment). Nonetheless, subclinical haemolysis could be undiagnosed in such settings. Zoller et al.4 recently published a case series in European travellers with artesunate-treated imported malaria, including six cases with haemolysis occurring 14–31 days and resolving 3–6 weeks after treatment. The event was more frequent when high doses were used.

In the reported case, an LDH flare and decrease in haemoglobin reappeared after parasite and fever clearance, and were associated with fever (37.5–38°C) and conjunctival jaundice, indicating a haemolytic syndrome. A direct drug toxicity is unlikely, given the short half-life of the molecule (time to final detection: 2 h);5 although, due to the drug’s production outside European standards of good manufacturing practice, the presence of contaminants cannot be excluded. A further possibility is haemolysis due to lumefantrine, which has a longer half-life; however, this has never been reported, despite the long-term worldwide use of artemether/lumefantrine.

Overall, a clear explanation for the haemolysis in this reported case is lacking. Since unexplained haemolysis has been repeatedly observed, specific surveillance in artesunate-treated patients is required.

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This study was carried out as part of our routine work.

Transparency declarations
None to declare.

References