

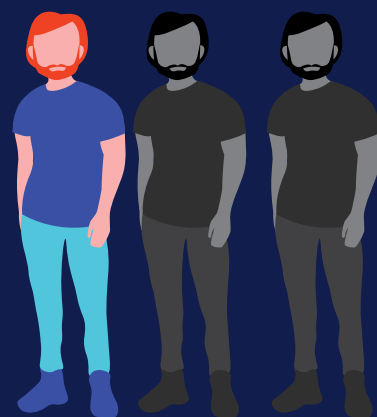
# My top 5 takes on a paper titled

The Role of Ertapenem for the Treatment of Complicated Intra-abdominal Infections With a Positive Culture for *Enterococcus faecalis*.

UP TO 1 IN EVERY 3

with intra-abdominal infections has *Enterococcus faecalis* (EF) isolated from their samples. Do we treat this especially if it is mixed with other organisms?

In this study, ertapenem Rx was used as a proxy to answer the above question since ertapenem has limited activity against EF.



Study Design:  
Multi-center.

The centers are part of a large network called John Hopkins Health System.  
2 arms in this study:  
A and B



Ertapenem

95% received 1 gram OD dose



Pip-tazobactam

All received 3.375 gram QID (30 mins)

WOULD YOU TREAT ENTEROCOCCUS IN INTRA-ABDOMINAL INFECTIONS?

YES *or* NO

## Who got included

Patients  $\geq 13$  yo  
Underwent appropriate source control  
Culture + for EF

Excluded if;

In arm A but received agent active for EF > 24 hours  
Received antibiotic < 4 days of studied ABX  
Poor source control within 4 days of presentation  
Additional organisms were resistant to A and B

216 subjects were included with a ratio of 30%:70% subjects in arm A and B.



Median Rx for both the arms were 10 days in total and 7 after source control.  
The source control was performed on the 3rd day (median) for arm A and 2nd for arm B.

NIL difference in the 2 arms of mortality, unplanned additional surgical intervention, readmission.

NIL difference too if EF was mono/polymicrobial.

This paper reignites the debate on EF role in intra-abdominal infection especially when source control has been performed.

**Are you ready to disregard *Enterococcus faecalis* in intra-abdominal infection?**