

**P1093 KPC-producing *Klebsiella pneumoniae* gut decolonization as a collateral effect of ceftazidime/avibactam-based association therapy**

Novella Carannante<sup>1</sup>, Carlo Pallotto<sup>1,2</sup>, Adriano Grossi<sup>1</sup>, Vittorio Attanasio<sup>1</sup>, Giovanni DI Caprio<sup>3</sup>, Ciro Pempinello<sup>4</sup>, Carlo Tascini\*<sup>1</sup>

<sup>1</sup>AZIENDA OSPEDALIERA DEI COLLI, First Division of Infectious Diseases, Cotugno Hospital, Napoli, Italy, <sup>2</sup>Università degli Studi di Perugia, Clinica delle Malattie Infettive, Perugia, Italy, <sup>3</sup>Università degli Studi della Campania "Luigi Vanvitelli", Section of Infectious Diseases, Department of Mental Health and Public Medicine, Caserta, Italy, <sup>4</sup>San Giovanni Bosco/Presidio Ospedaliero, Department of Orthopaedic Surgery and Traumatology, Napoli, Italy

**Background:** Multidrug-resistant *Enterobacteriaceae* are nowadays one of the main matter of concern of medical community. Ceftazidime/avibactam is a recently approved beta-lactam/beta-lactamase inhibitor combination with activity especially against Ambler class A and C enzymes. To our knowledge, no studies have been published about its effectiveness in gut decolonization.

**Materials/methods:** We retrospectively analyzed all patients treated with ceftazidime/avibactam because of a KPC-producing *Klebsiella pneumoniae* (KPC-Kp) infection from May to August 2017. Ceftazidime/avibactam was administered as compassionate use. KPC-Kp gut colonization was determined by culture, phenotypic rapid immunocromatographic and molecular tests on rectal swabs. The same tests were performed to detect decolonization. Antimicrobial combination therapy has been chosen after in vitro evaluation of antibiotic synergistic activity. Other 8 KPC-Kp infected and colonized patients treated with different regimens were evaluated as controls

**Results:** As described in table 1, 4 patients were treated with a ceftazidime/avibactam-meropenem-fosfomicin combination therapy and all of them were cured and decolonized after a median period of 9.5 days. The 8 control patients didn't achieve gut decolonization.

**Conclusions:** Ceftazidime/avibactam nowadays can be defined as the most important drug against KPC-Kp and other multidrug-resistant *Enterobacteriaceae*. In addition to this, in particular cases like patients to be undergone surgery, treatment with ceftazidime/avibactam might be useful– in association with other antibiotic such as fosfomicin and meropenem – for decolonization strategies.

Table 1

<b>Patient</b>	<b>Infection</b>	<b>Therapy</b>	<b>Rectal decolonization</b>
<b>Patient 1 – M</b>	ABSSSI	Ceftazidime/avibactam meropenem and fosfomicin	Yes
<b>Patient 2 – F</b>	cIAI and sepsis	Ceftazidime/avibactam meropenem and fosfomicin	Yes
<b>Patient 3 – F</b>	Spondylodiscitis	Ceftazidime/avibactam meropenem and fosfomicin	Yes
<b>Patient 4 – F</b>	Surgical wound infection	Ceftazidime/avibactam meropenem and fosfomicin	Yes
<b>Control 1 – F</b>	Sepsis	Imipenem and tigecycline	No

<b>Control 2 – M</b>	Surgical wound infection	Colistin, rifampin and tigecycline	No
<b>Control 3 – F</b>	Sepsis	Colistin, fosfomycin and tigecycline	No
<b>Control 4 – M</b>	Catheter-associated UTI	Colistin, imipenem, fosfomycin and tigecycline	No
<b>Control 5 – F</b>	HAP	Tigecycline and fosfomycin	No
<b>Control 6 – F</b>	Surgical wound infection	Tigecycline and gentamycin	No
<b>Control 7 – F</b>	Sepsis	Tigecycline and gentamycin	No
<b>Control 8 – F</b>	Sepsis	Colistin, meropenem and amikacin	No