

# *Staph aureus* Bacteremia: Key Principles

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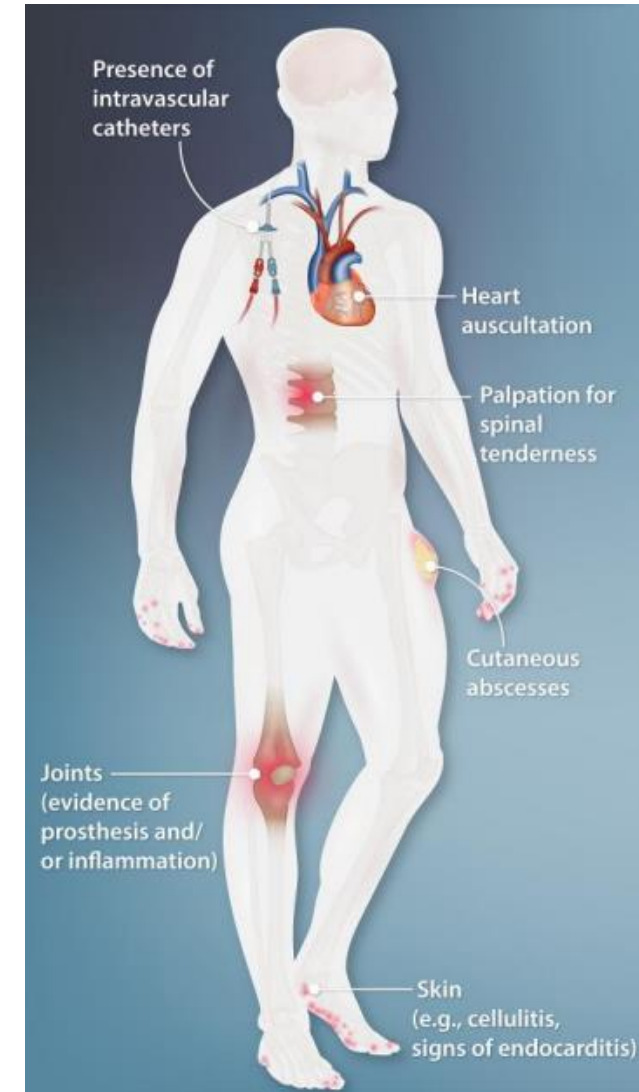
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# Why is this different?

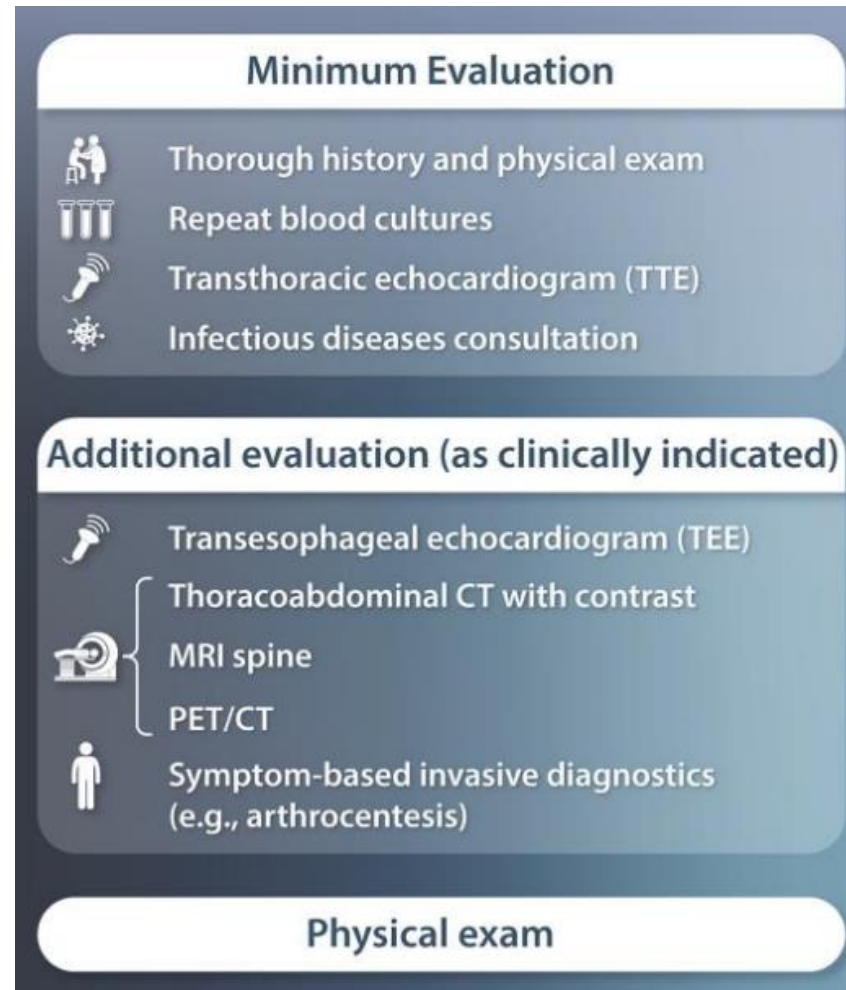
- HIGH mortality (up to 30% 1 year, all cause)
- Can persist, and each day of + blood cultures -> mortality
- HIGH morbidity – endocarditis, osteomyelitis, long LOS, high readmission
- MRSA > MSSA

# Where did it come from? Where did it go?

- Symptom onset
- IDU



# Essential Work-Up



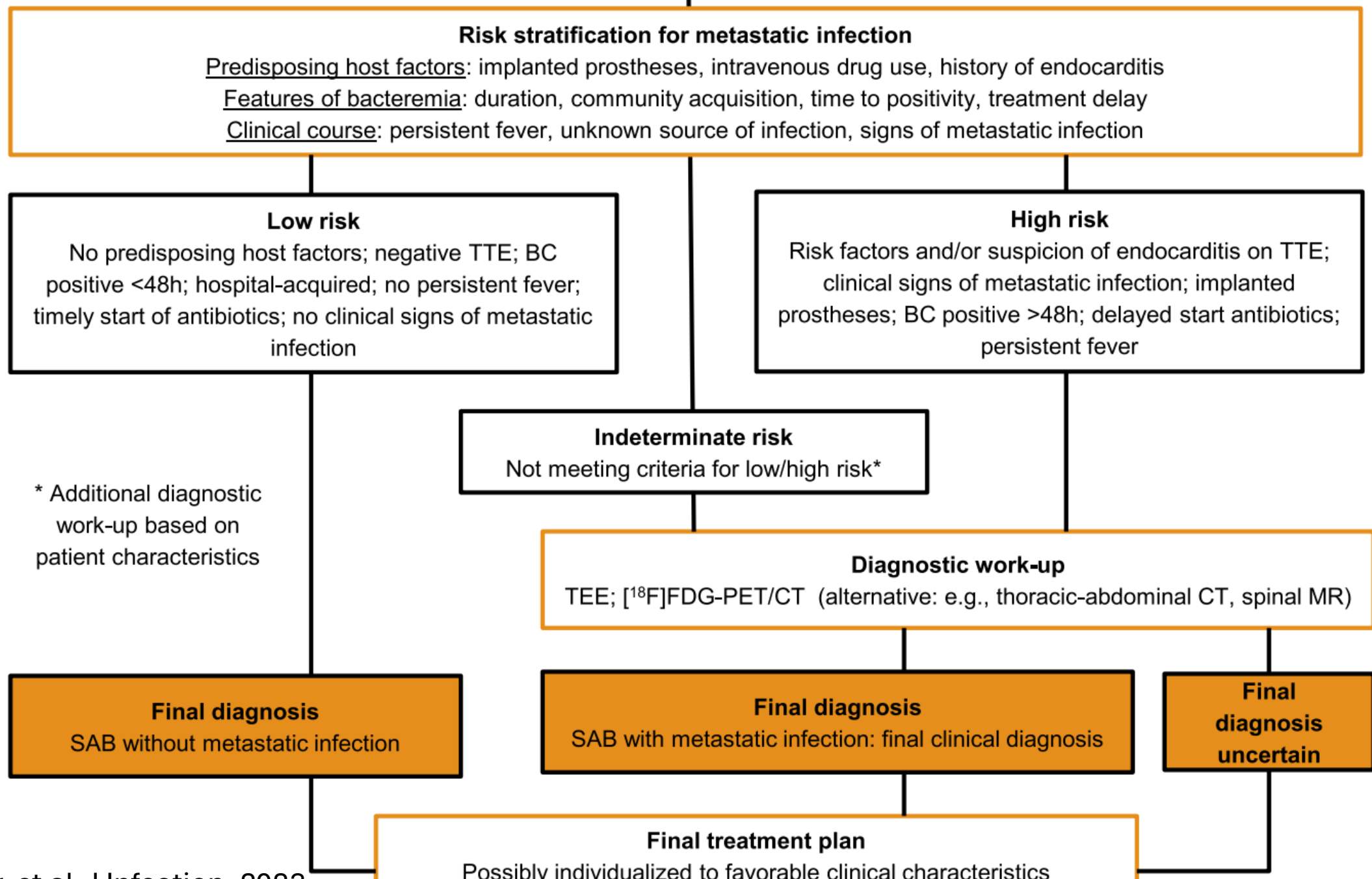
# Essentials of treatment

- Start appropriate antibiotics
  - MSSA: cefazolin, ?ASP (oxacillin or nafcillin)
    - Vancomycin is inferior
    - SNAP trial – coming soon
  - MRSA: vancomycin, daptomycin (8-10mg/kg)
- Source control – the earlier the better
  - Remove lines, drain abscesses
  - Other things often require specialist involvement – e.g. CIED, orthopedic hardware
- Document blood culture clearance



## Preliminary Results ESCMID 2025

- 4000+ recruited
- MSSA Bacteremia
  - 1341 enrolled
  - Cefazolin noninferior to flucloxacillin
  - Endpoint: 90-day mortality
  - AKI lower in cefazolin



# Salvage Therapy – when to escalate?

## MSSA

- ASP
- Combo therapy

## MRSA

- Ceftaroline + daptomycin



# Duration

NO DEEP-SEATED INFECTION,  
NO METASTATIC FOCI

- 2 weeks

YES DEEP INFECTION OR  
METASTATIC FOCI

- 4-6 weeks

# Non-traditional Strategies

- Dalbavancin: pending publication of DOTS
  - 1500mg IV day 1 and 8 for “complicated” SAB including right-sided IE
- Oral antibiotics
  - SABATO trial – only very low risk patients (5% of evaluated pt population)
- We do these all the time!

# Take Aways

- Staph aureus bacteremia is different
  - High-stakes
  - Complex and thorough work-up required
  - Treatment is longer
- Pharmacists
  - Critical for optimizing antibiotic
- Not everyone needs to be stuck on IV