

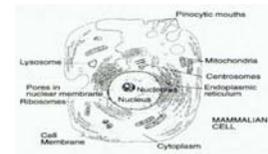
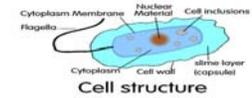
## Simplifying Systemic Antibiotics

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## Principles of Antimicrobial Therapy

- Structural and biochemical differences exist between humans and microorganisms. Antimicrobial therapy takes advantage of these differences, e.g.
  - Bacterial cell wall
  - Bacterial ribosomes



## Avoiding Resistance

- Bacterial resistance is a natural result of mutation.
- Antibiotics cause a faster rate of selection against these resistant bacteria if not prescribed correctly.
  - Avoid prescribing for non-bacterial infections.
  - Avoid sublethal doses (attack to kill all).
  - Avoid intermittent use.
  - Always complete the full dosage for an appropriate length of time.
  - NEVER TAPER AN ANTIBIOTIC below recommended dosing schedule!



## Preventing Resistance

- The IDSA suggests five to seven days is long enough to treat a bacterial infection without encouraging resistance in adults, though children should still get the longer course
  - this is different than previous guidelines of treating infections from 10-14 days.

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## MRSA

- Healthcare-associated methicillin-resistant *Staphylococcus aureus* (HA-MRSA) is associated with severe, invasive disease in hospitalized patients
- Community-associated methicillin-resistant *S. aureus* (CA-MRSA) is most often associated with skin and soft tissue infections in young, healthy individuals with no recent healthcare exposure



## MRSA

- Additional risk factors for CA-MRSA infection include:
  - skin trauma (eg, lacerations, abrasions, tattoos, injection drug use),
  - cosmetic body shaving,
  - incarceration,
  - HIV infection, and
  - sharing equipment that is not cleaned or laundered between users.

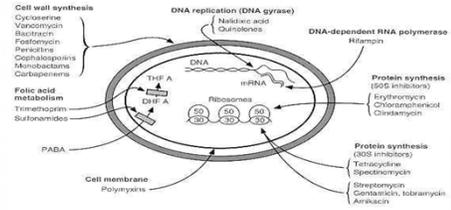


## ARMOR

- Antibiotic Resistance Monitoring in Ocular Microorganisms (ARMOR)
- Approximately 42% of isolates were determined to be MRSA
- Newer fluoroquinolones have better activity than earlier generations
- Besivance has the lowest MIC values of all the fluoroquinolones
- Vancomycin is drug of choice if MRSA present
- Azithromycin had very poor activity against Staph



## Sites of Antimicrobial Actions

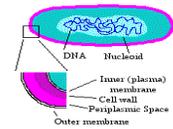


## Inhibitors of Cell Wall Synthesis



## Inhibitors of Cell Wall Synthesis

- Human cells do not possess a cell wall like bacteria do
  - it is a very selective way to interfere with bacterial growth.
- To be maximally effective, the inhibitors require actively proliferating bacteria
  - they are ineffective against non-dividing bacteria.
- The most important members of this group are:
  - **B-lactam antibiotics** and
  - **vancomycin.**



## B-Lactam Antibiotics

- This group includes:
  - penicillins,
  - cephalosporins,
  - carbapenems and monobactams.
- All PCN's have short  $\frac{1}{2}$  lives
- **B-lactamase inhibitors** are sometimes added in combination to reduce a bacteria's ability to overcome the activity of the antibiotic
  - E.g potassium clavulanate (clavulanic acid)



## Penicillins

- Among the most widely effective and least toxic
  - increased resistance has limited their use
  - they are bactericidal
- Interfere with the last step of bacterial wall synthesis, resulting in cell lysis.
- Therapeutic application in gram (+) cocci and bacilli, gram (-) cocci, anaerobic, spirochetes (syphilis).
- **The most common side effects include hypersensitivity and diarrhea.**



## Penicillins: Augmentin

- Augmentin is amoxicillin with potassium clavulanate (clavulanic acid 125 mg).
- Clavulanate is a B-Lactamase inhibitor which reduces a bacteria's ability to negate the effect of the amoxicillin by inactivating penicillinase (enzyme that inactivates the antibiotic effect).



## Penicillins: Augmentin

- **Augmentin is very effective for skin and skin structure infections** such as:
  - dacryocystitis,
  - internal hordeola,
  - pre-septal cellulitis.
- Treatment of:
  - otitis media,
  - sinusitis,
  - lower respiratory and urinary infections.
- Given prophylactically to dental surgery patients.



## Penicillins: Augmentin

- It has **low**:
  - GI upset,
  - allergic reaction and anaphylaxis.
- Serious complications include:
  - anemia,
  - pseudomembranous colitis and
  - Stevens-Johnson syndrome.



## Stevens-Johnson Syndrome

- Stevens-Johnson syndrome is a rare, serious disorder of the skin and mucous membranes.
  - reaction to a medication or an infection
  - begins with flu-like symptoms, followed by a painful red or purplish rash that spreads and blisters. Then the top layer of the affected skin dies and sheds.



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## Stevens-Johnson Syndrome

- medical emergency that usually requires hospitalization.
- treatment focuses on eliminating the underlying cause, controlling symptoms and minimizing complications.
- recovery can take weeks to months, depending on the severity.
- if it was caused by a medication, the patient will need to permanently avoid that drug and others closely related to it.

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## Penicillins: Augmentin.



- Adults:
- 250-500 mg tab q 8hr (tid) (also available in chewable tablets and suspension)
  - or 875 mg q 12hr (bid)
  - 1000 mg XR: q12 hr and not for use in children <16
- Peds: <3 mos 30mg/kg/day divided q12hrs using suspension
- >3 mos 45-90mg/kg/day divided q12hrs



## Penicillins: Hordeola:

- **Internal** are secondary to a staph infection of the meibomian glands
- **External** are an infection of the Zeis or Moll glands
  - Patients present with tenderness and swelling of affected area.
- Standard treatment includes:
  - good lid hygiene with warm compresses and lid washes
  - **Augmentin 500 mg bid-tid for 5-7 days.**
  - may consider topical AB ung on external hordeolum.



## Penicillins: Dacryocystitis

- **infection of the lacrimal sac usually secondary to an obstruction.**
- in pediatric patients:
  - the obstruction usually resolves by age 9-12 months.
  - many pediatric ophthalmologists will wait until after this age to probe the ducts to free the obstruction.



## Penicillins: Dacrocystitis

- Treatment includes:
  - **Augmentin 500/125 mg (500 mg amoxicillin/125 mg clavulanic acid) TID**
    - or 875/125 mg BID for 7 days or



## Preseptal Cellulitis

- Infection and inflammation located anterior to the orbital septum and limited to the superficial periorbital tissues and eyelids.
- Usually follows sinus infection or internal hordeolum (possibly trauma)
- Eyelid swelling, redness, ptosis, pain and low grade fever.



## Differentiating Orbital vs. Preseptal

FINDING	ORBITAL	PRESEPTAL
Visual Acuity	Decreased	Normal
Proptosis	Marked	Absent
Chemosis and Hyperemia	Marked	Rare/Mild
Pupils	RAPD	Normal
Pain and Motility	Restricted and Painful	Normal
IOP		Normal
Temperature	102 - 104	Normal/mild elevation
HA and Assoc. Symptoms	Common	Absent

Treatment: Orals for Preseptal, Often IV for Orbital



## Preseptal Cellulitis

- Tx:
  - **Augmentin 500 mg TID or 875 mg BID for 5-7 days**
  - **Keflex 500 mg QID 5-7 days**
  - or if moderate to severe IV Fortaz (cefazidime) 1-2 g q8h.
  - If MRSA possible, consider Bactrim/Septa



## Cephalosporins

- Closely related structurally and functionally to the penicillins,
  - **have the same mode of action,**
  - affected by the same resistance mechanisms.
  - tend to be more resistant to B-lactamases.
- classified as 1st, 2nd, 3rd, 4<sup>th</sup> and now 5th generation based largely on their bacterial susceptibility patterns and resistance to B-lactamases.
- Typically administered IV or IM, poor oral absorption.
- Risk of cross sensitivity with PCN's is higher for 1<sup>st</sup> generation, but often overestimated for later medications.



## Cephalosporins

- 1st generation: cefadroxil (Duricef), cefazolin (Ancef), cephalexin (Keflex), and cephalothin
- 2nd generations: cefaclor (Ceclor), cefprozil, cefuroxime (Zinacef), cefotetan, cefoxitin
- 3rd generation: cefdinir (Omnicef), cefixime, cefotaxime (Claforan), ceftazidime (Fortaz), ceftibuten, ceftizoxime, ceftriaxone (Rocephin IM/IV).
- 4th generation: cefepime
- **Keflex, Ceclor, Omnicef** (all orally administered) are effective against most gram positive pathogens and especially good for skin and soft tissue infections.



## Cephalosporins

- Keflex (cephalexin) 1<sup>st</sup> Generation:
  - treatment of respiratory, GI, skin and skin structure, and bone infections as well as otitis media
  - Adults: 250-1000 mg every 6 hours
    - - typical dosing 500 every 6 hours
  - Children: 25-100 mg/kg/day divided 6-8 hours
  - Available:
    - 250 mg
    - 500 mg
    - 750 mg (pricey 750 mg (20): \$153.80 generic, brand 750 mg (50): \$521.56)
      - Typically a BID dosing
      - Not commonly used



## Cephalosporins

- Cefaclor (Ceclor) (2<sup>nd</sup> generation):
  - Immediate-release: 250 to 500 mg every 8 hours
  - Extended-release: 500 mg every 12 hours

**Note:** An extended-release tablet dose of 500 mg twice daily is clinically equivalent to an immediate-release capsule dose of 250 mg 3 times daily; an extended-release tablet dose of 500 mg twice daily is **NOT** clinically equivalent to 500 mg 3 times daily of other cefaclor formulations.

- Mild preseptal cellulitis = 250-500 mg TID in adults and 20-40 mg/kg/day in three divided doses for children

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## Cephalosporins

- Cefzon or Omnicef (cefdinir):
  - 3<sup>rd</sup> generation
  - Oral: 300 mg twice daily **or** 600 mg once daily for 10 days.
  - Indicated for maxillary sinusitis and otitis media
  - Also indicated for soft tissue infections (uncomplicated)
  - Pricey

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## Cephalosporins

- Dacryocystitis Tx:
  - Keflex 250-500 mg po QID,
  - In febrile cases:
    - IV cefazolin (Ancef) 1g q8h or
    - IV cefuroxime (Zinacef) 1.5g q8h.
- Preseptal cellulitis:
  - Mild:
    - Ceclor (cefaclor) 250-500mg q8h
  - Moderate to severe:
    - IM Rocephin (ceftriaxone) 1-2 grams/day or
    - IV Fortaz (ceftazidime) 1-2 g q8h.



### Cephalosporins: Orbital Cellulitis

- infection and inflammation within the orbital cavity producing orbital SS&S.
- most commonly secondary to ethmoid sinusitis.
- Staph and Strep most common isolates.
- Signs and Symptoms include:
  - decreased VA,
  - pain,
  - red eye,
  - HA,
  - diplopia,
  - bulging eye,
  - APD,
  - EOM restriction,
  - lid swelling and
  - fever (generally 102 degrees F or higher)



### Cephalosporins: Orbital Cellulitis Treatment

**Vancomycin:** 5 to 20 mg/kg IV per day every 8 to 12 hours

**PLUS:** (one of the following)

- Ceftriaxone (Rocephin): 2 g IV every 24 hours **or**
- Cefotaxime: 2 g IV every four hours **or**
- Ampicillin-sulbactam: 3 g IV every six hours



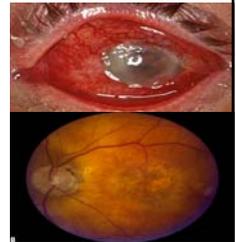
### Orbital Cellulitis

- IV therapy continued until improvement noticed (minimum 3-5 days)
- Switch to oral antibiotics (2-3 weeks):
  - Clindamycin 300 mg every 8 hours
  - Clindamycin or Bactrim/Septra PLUS
    - Augmentin 875 mg every 12 hours or
    - Cefpodoxime 400 mg every 12 hours or
    - Cefdinir 300 mg twice daily

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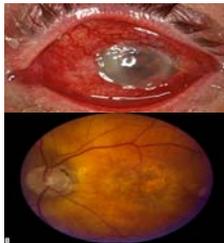
### Endophthalmitis

- intraocular infection involving anterior/posterior segments usually secondary to postoperative infection (0.1% risk post-op cataract).
  - 95% gram +ve bacteria including
    - staph (80%), strept (10%) with about 6% gram -ve organisms (these infections to be more virulent and have worse prognosis)



### Endophthalmitis

- Signs/symptoms typically present:
  - Post-trauma: 12-24 hours
  - Post-surgery: day 2 (or later)
  - Post-intravitreal injection: 1-6 days (av 3.4 days)



### Endophthalmitis

- Patients' present with:
  - decreased VA (95%)
  - pain (75%),
  - red eye (80%),
  - hypopyon (>80%)
  - discharge, proptosis,
  - corneal edema, injection,
  - KP's,
  - vitritis, photophobia,



## Post-operative Endophthalmitis Treatment

### Post-operative endophthalmitis:

- Endophthalmitis Vitrectomy Study (EVS), vitrectomy decreased the rate of severe vision loss from 47% (tap group) to 20% (vitrectomy group) in patients who presented with the worst vision (light perception only)
- **Intravitreal:**
  - vancomycin 1 mg/0.1ml and ceftazidime (Fortaz) 2.25 mg/0.1 ml (or amikacin)
  - if no improvement after 48 hours a repeat injection of either vancomycin or Fortaz (but not amikacin secondary to retinal toxicity issues)
  - Intravitreal steroids maybe considered



## Post-traumatic Endophthalmitis Treatment

### Post-traumatic endophthalmitis: (in addition to intravitreal)

- **Subconjunctival:**
  - vancomycin 25mg and ceftazidime (Fortaz) 100mg (gentamicin) and dexamethasone 12-24mg,
- **Topical:**
  - fortified vancomycin (Vancocin HCl 2.5% Ophthalmic) and ceftazidime (Fortaz) 50mg/ml/hr, topical steroid and cycloplegic,
- controversial IV systemic AB.



## Vancomycin/Bacitracin

- Vancomycin and bacitracin both inhibit cell wall synthesis.
- Vancomycin is increasingly important as it is effective against multiple drug-resistant organisms (such as MRSA/MRSE and enterococci)
  - used in patients who have penicillin allergies
  - often considered the drug of last resort, though overuse has brought about resistance.
- Bacitracin is active against a wide variety of gram (+) organisms
  - restricted to topical use due to its potential for nephrotoxicity.



## Vancomycin

- Vancomycin is typically administered systemically as an infusion due to its poor oral absorption
  - complications are minimized when it is administered at less than 10 mg/min
    - **topical fortified vancomycin can be compounded (25-50 mg/ml) (Vancocin HCl 2.5% Ophthalmic Drops)**
- Complications include:
  - anaphylaxis (hypotension, wheezing, dyspnea, urticaria, pruritis),
  - upper body flushing,
  - pain secondary to muscle spasm, nausea, diarrhea, headache.
  - typically the most serious complication is nephrotoxicity but it is an infrequent complication.



## Vancomycin

- Treatment:
  - Orbital Cellulitis
  - Endophthalmitis



## Bacitracin

- Due to nephrotoxicity, **bacitracin not used as a systemic med.**
- Bacitracin useful for bacterial lid disease (staph blepharitis)
  - has a low rate of allergy and toxicity.
- **Primarily gram + activity** so usually found in combination with a gram - compound
  - e.g. polymixin B (Polysporin).



## Protein Synthesis Inhibitors

## Protein Synthesis Inhibitors

- These antibiotics work by targeting the bacterial ribosome.
  - they are structurally different from mammalian ribosomes,
  - in higher concentrations many of these antibiotics can cause toxic effects.
- This group includes:
  - (a) tetracyclines, (b) aminoglycosides, (c) macrolides,
  - (d) chloramphenicol, (e) clindamycin, (f) quinupristin/dalfopristin and (g) linezolid

## Tetracyclines

- Nonresistant strains concentrate this antibiotic intracellularly resulting in inhibition of protein synthesis.
- Broad spectrum, bacteriostatic,
  - effective against gram (+) and (-) bacteria and against non-bacterial organisms
  - widespread resistance has limited their use.
- Drug of choice for Rocky Mountain Spotted Fever, Cholera, Lyme disease, mycoplasma pneumonia, and chlamydial infections.
  - Doxy can be used to treat MRSA skin infections with a known susceptibility

## Side Effects of Tetracyclines

- Side effects include gastric discomfort, phototoxicity, effects on calcified tissues, vestibular problems, pseudotumor.
- **Pregnancy Category D.**
  - Tetracyclines are attracted to embryonic and growing bone tissue.
    - Depress growth of long bones in pregnant women/children.
    - Cause changes in both deciduous and permanent teeth during the time of tooth development (Includes discoloration and increased cavities)
- **Contraindicated in:**
  - Women in the last half of pregnancy
  - Lactating women
  - Children under 8 years of age



## Tetracyclines

- This group includes:
  - Tetracycline (250mg - 500 mg cap BID-QID) needs to be taken 1 hour before or 2 hours after a meal.
  - Minocycline (100 mg cap BID)
  - Doxycycline (20mg - 100 mg cap or tab BID)
    - In Canada doxy comes in 100 mg tablets (Apo-Doxy, Novo-Doxylin and Vibra-Tabs)
    - Aprilon (30 mg doxy + 10 mg slow release doxy)

## Tetracyclines

- **Rules of Thumb with Doxy:**
  - Do not take before lying down (>2 hours before)
  - Do not take with calcium and avoid antacids
  - Do not take with dairy
  - Do take with food
  - Do recommend sun protection

## Tetracyclines: Acne Rosacea

- Acne rosacea:
  - affects females > males after 30 with peak incidence 4-7th decade of Celtic/Northern European descent. Males more disfigured.
- 4 subtypes with classic signs of flushing, papules or pustules usually in crops, telangiectasia.
  - secondary ocular complications (85% of patients) and often precede other skin manifestations include erythema, itching and burning.



## Acne Rosacea and Demodex

- Demodex is a natural part of human microbiome
- *Demodex folliculorum* live in hair follicles, primarily on the face, as well as in the meibomian glands of the eyelids;
- *Demodex brevis* live in the sebaceous glands of the skin.

## Acne Rosacea and Demodex

- *Demodex folliculorum* frequently occur in greater numbers in those with rosacea and this overabundance is thought to trigger an immune response or possibly certain bacteria associated with the Demodex

## Tetracyclines: Acne Rosacea

- Mainstay oral Tx is Oracea (40 mg in morning) or
  - doxycycline 50 mg po or minocycline 100 mg po for 4-12 wks.
- NOTE: Oracea is subantimicrobial therapy
- May want to consider Tea Tree oil wipes/foam for the face and lids to try and reduce the role Demodex plays



## Tetracyclines: Adult Inclusion Conjunctivitis

- occurs in sexually active adults
- women are more susceptible than men.
- usually transmitted through hand-to-eye spread of infected genital secretions.
- incubation period is one to two weeks
- Signs and Symptoms:
  - ocular irritation, watering, mucopurulent discharge and positive nodes
  - often a unilateral disease but can involve both eyes
  - follicles inferior fornix, mixed papillary/follicular on upper lid, subepithelial infiltrates, SPK.



## Tetracyclines: Adult Inclusion Conjunctivitis Treatment

- Mainstay oral treatment is:
  - Doxycycline 100 mg po BID for 7 days.
  - Or
  - Azithromycin 1 gram single dose
  - Topical AB therapy is done concurrently.



## Tetracyclines: Ocular Conditions

- **Hordeola:**
  - doxycycline 50-100 mg po BID for 2-3 weeks.
  - may consider topical AB ung on external hordeolum.
- **Meibomian Gland Dysfunction:**
  - good lid hygiene with warm compresses and lid scrubs in conjunction with
  - doxycycline 50 mg po for 2-3 months.
- **Recurrent Corneal Erosion**
  - treat with doxycycline 50 mg po BID for 2-3 months
    - include use of topical steroid bid-tid for 6-8 weeks.



## Macrolides

- Erythromycin was the first of these drugs, as an alternative to penicillin. Bacteriostatic though at [higher] maybe cidal
- Macrolides bind to the bacterial ribosome and inhibit protein synthesis.
  - have same spectrum of action as penicillins so are used in those patients who are allergic to that group.
- **Resistance to erythromycin is becoming a serious clinical problem.**
- Adverse effects include:
  - epigastric distress, jaundice, ototoxicity and contraindicated in patients with hepatic disease.



## Macrolides

- This group includes:
  - Erythromycin (125 or 250 mg cap, enteric coated) dosing 250mg q 6h or 500 q12h
  - Clarithromycin
  - **Azithromycin (Z-pak) (500mg first day, then 250 mg for next 4 days)**
  - Telithromycin



## Clarithromycin (Biaxin)

- Derivative of Erythromycin that is more stable in gastric acid with a ½ life that is nearly twice that of Erythromycin.
- Used for respiratory and skin infections as well as the treatment of H. Pylori ulcers, but can be used for Chlamydia if needed.
- BIAXIN is available as immediate-release tablets, extended-release tablets, and granules for oral suspension.



## Macrolides

- Azithromycin (Z-pak) is active against respiratory infections due to H. influenzae and Moraxella.
  - It was a costly medication (generic now available),
  - now a preferred therapy for urethritis by chlamydia.
  - excellent for soft tissue infections.
  - use with caution in patients with impaired liver function and no controlled studies for use in pregnancy.



## Azythromycin

- Hyperacute conjunctivitis:
  - Secondary to Chlamydia or Gonorrhea
- Adult inclusion conjunctivitis
  - Secondary to chlamydial infection
- **MGD/Blepharitis:**
  - 500 mg/day for 3 days for three- four weeks



## Macrolides: Ocular Indications

- Erythromycin can be used as alternative treatment in patient with:
  - internal hordeola,
  - pre-septal cellulitis,
  - dacryocystitis
- remember high incidence of staph resistance.



## Macrolides: Ocular Indications

- Erythromycin available in topical ointment form
  - Ilotycin
  - for treatment of superficial infections
    - blepharitis and prophylaxis of ophthalmia neonatorum



## Clindamycin

- Inhibits protein synthesis by binding to a portion of the 50S ribosome subunit.
- Available IV, IM, and orally.
- High levels of side effects such as serious pseudomembranous colitis and superinfections have limited use.



## Clindamycin

- Occasionally used in the treatment of Ocular Toxoplasmosis but not FDA approved.
- Another option for use in the treatment of MRSA ocular infections:
  - 450 mg TID for Adults
  - 10 – 30 mg/kg/day in three doses for kids
- Main use is in patients allergic to Sulfa drugs.

## Inhibitors of Nucleic Acid Synthesis/Function

## May 2016

- The US Food and Drug Administration (FDA) states that unless they lack other treatment options, patients with uncomplicated infections should not receive fluoroquinolones, given the risk for disabling and potentially permanent adverse events.
- The FDA will update the labels to state that the serious risks posed by fluoroquinolones generally outweigh their benefits for patients with sinusitis, bronchitis, and uncomplicated urinary tract infections that are treatable by other means.

## Ocular Indications

- Hyperacute conjunctivitis (gonococcal): Oral or IM fluoroquinolone (only indicated if unable to use cephalosporin)
- Cat Scratch Disease: ciprofloxacin 500-750 mg po q 12h for 10-14 days.
- Orbital cellulitis: IV ciprofloxacin
- Majority of the use of fluoroquinolones in ocular use is in the form of topical drops and ointments. Used in all forms of infections and prophylaxis in ocular surgeries.

## Inhibitors of Metabolism

## Inhibitors of Metabolism

- Folic acid is required for the synthesis of precursor molecules for RNA, DNA and other compounds necessary for cellular growth.
  - in the absence of folic acid, cells cannot grow or divide.
- (a) Sulfonamides and (b) trimethoprim are folic acid antagonists and interfere with an infecting bacteria's ability to divide.
- Compounding the two has made a synergistic compound used for effective treatment of a variety of bacterial infections.

## Sulfonamides

- Sulfa drugs are seldom prescribed alone except in the developing countries, where they are used because of their low cost and efficacy in certain infections such as trachoma.
- With the combination with trimethoprim, co-trimoxazole there was a renewed interest in the sulfa drugs.
- Sulfa drugs are bacteriostatic,
  - active against selective enterobacteria in the urinary tract.
  - resistance exists in those bacteria that don't synthesize folic acid and in any PABA producing bacteria (purulent producing bacteria).

## Sulfonamides

- Adverse effects include:
  - hypersensitivity reactions such as rashes,
  - angioedema,
  - Stevens-Johnson syndrome are fairly common.
  - may also result in nephrotoxicity, hemolytic anemia,
  - drug potentiation
    - Ex. increased effect of hypoglycemic effect of tolbutamide or anticoagulant of warfarin

## Trimethoprim and Pyrimethamine

- Similar antibacterial spectrum as sulfonamides, though has a 20-50 fold more potent effect than the sulfonamides.
- Trimethoprim may be used on its own to treat acute UTI's and in the treatment of bacterial prostatitis (fluor preferred though) and vaginitis
  - been found to be an effective treatment option for MRSA
- Pyrimethamine is used for prophylaxis and Tx of malaria.
- Resistance does exist, and adverse effects include several blood anemias which can be reversed by administering folic acid.

### Trimethoprim: Ocular Indications

- Combined with sulfa (Bactrim/Septra) indicated for MRSA suspected infections
- Trimethoprim is found in combination with polymixin B in a topical eye drop.
  - Trimethoprim has both gram +/- activity but not effective against pseudomonas so Polymixin B is added.
- Low rate of allergic and toxic reactions, and approved for children >2 months.



### Co-Trimoxazole (Bactrim/Septra)

- Combination of trimethoprim and sulfamethoxazole
  - shows greater antimicrobial activity than equivalent quantities of either drug alone.
- Has broader spectrum of action than the sulfa's and is effective in treating:
  - UTIs and respiratory tract infections
  - often considered for treatment of MRSA skin infections



### Co-Trimoxazole (Bactrim/Septra)

- Resistance is more difficult because has to develop resistance to both drugs.
- Adverse effects include:
  - severe potential for dermatologic reactions,
  - GI upset,
  - blood disorders, and
  - drug potentiation.



### Co-Trimoxazole (Bactrim/Septra)

- Available:
  - **Bactrim/Septra tablets:**
    - contains 80 mg trimethoprim and 400 mg sulfamethoxazole
    - dosing 2 tablets every 12 hours
  - **Bactrim DS/Septra DS (Double Strength)**
    - contains 160 mg trimethoprim and 800 mg sulfamethoxazole
    - Dosing 1 tablet every 12 hours



### Inhibitors of Cell Membrane Function



### V: Inhibitors of Cell Membrane Function

- Isoniazid is the most potent of the anti-tubercular drugs and interferes with the production of mycobacterial cell walls
  - Classified as a narrow spectrum antibiotic as only used in the treatment of TB
- Mycobacteria is a slow growing organism and treatment is often required from 6 months to several years.
  - due to poor compliance, resistance has developed and therefore treatment is never given as a single agent.
- Multi-drug therapy is given and maybe changed on a regular basis in order to effectively treat the patient.

