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The recent *Medical Letter* article on vancomycin dosing and monitoring briefly mentioned use of an alternative antibiotic for treatment of methicillin-resistant *Staphylococcus aureus* (MRSA) with reduced susceptibility to vancomycin. Some readers have asked for more information on this subject.

**REDUCED SUSCEPTIBILITY TO VANCOMYCIN** — Microbiology laboratories generally report isolates of MRSA as “susceptible” to vancomycin when the minimum inhibitory concentration (MIC) is $<2$ mg/L. Recent guidelines suggest considering an alternative antibiotic when the MIC is $\geq2$ mg/L.

**ALTERNATIVES TO VANCOMYCIN** — For complicated skin or soft tissue infections caused by MRSA with reduced susceptibility to vancomycin, either daptomycin (Cubicin) or linezolid (Zyvox) would be a reasonable choice. Linezolid, which is available for both oral and IV use, is bacteriostatic and may not be effective for treatment of endocarditis; it is not recommended for use in catheter-associated bacteremias. Linezolid can cause bone marrow suppression, particularly if it is used for more than 10 days.

When bacteremia is present, especially when it is due to right-sided endocarditis, daptomycin, which is given IV, would be a better choice, unless the patient has concomitant pneumonia (daptomycin is inactivated by surfactant). Daptomycin is rapidly bactericidal, but some *S. aureus* strains with decreased susceptibility to vancomycin have decreased susceptibility to daptomycin as well.

Other drugs that may be effective against some strains of MRSA include quinupristin-dalfopristin (Synercid), which causes thrombophlebitis and has substantial potential for adverse drug interactions, and tigecycline (Tygacil), which achieves only low serum concentrations and is bacteriostatic. Another alternative is trimethoprim-sulfamethoxazole (Bactrim, *Septra*, and others), but experience with its use in serious MRSA infections is limited.
