Taurolidine is effective in the treatment of central venous catheter-related bloodstream infections in cancer patients

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Abstract

Taurolidine is an antimicrobial agent that was originally used in the local treatment of peritonitis and was shown to be effective in the prevention of catheter-related bloodstream infections (CR-BSI). In this pilot study, we used taurolidine solution as an intravenous (i.v.) lock into the totally implantable intravascular devices of 11 consecutive oncological patients with catheter-related bloodstream infections not responding to systemic antimicrobial chemotherapy. All patients recovered completely from the infection. No adverse drug effects were seen. Three patients were successfully retreated for a recurrent infection. Our data suggest a beneficial role of taurolidine i.v. lock for the therapy of catheter-related bloodstream infections in oncological patients. Taurolidine i.v. lock application is feasible and could especially be useful in infections resistant to antibiotic chemotherapy.

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1. Introduction

Venous access is a critical issue in the care and management of many malignancies since these patients frequently require not only i.v. cytostatic chemotherapy but parenteral nutrition and hydration, analgesic therapy, treatment of infections and repetitive laboratory work up. Thus, the placement of indwelling central catheters such as Broviac and Hickman catheters or of port catheter systems enabling safe and permanent venous access is strongly recommended due to physical and psychological factors associated with repeated venepuncture secondary to the loss of peripheral venous access \cite{1,2}. The use of permanent central venous access systems has increased steadily in the last two decades but was accompanied by a simultaneous increase of complications, mainly by a variety of local and systemic catheter-related infections \cite{3-5}. Catheter-related bacteraemia or sepsicaemia may be secondary to a local infection at the site of skin puncture, haematogenous seeding of bacteria from a distant focus or may be associated with contamination of the solution or administration set (fluids or parenteral nutrition mixtures).

In about two-thirds of cases, the organisms causing catheter-related bloodstream infections (CR-BSI) are skin commensals such as coagulase negative staphylococci emphasising the relevance of proper skin care and hand washing for adequate prevention \cite{6}.

New approaches to make intravascular catheters more resistant to bacterial colonization are under investigation. These include antisepsic or antibiotic coating of the catheter surface, impregnation of cuffs with silver ions and antisepsic hubs \cite{7}. The antisepsic agent taurolidine is a derivative of taurinamide, a naturally occurring aminosulphonic acid, and formaldehyde. Taurolidine has an exceptionally broad spectrum of antimicrobial activity including activity against Gram negative and Gram positive bacteria and fungi. Emergence of bacterial resistance to taurolidine has not been demonstrated. The antimicrobial properties of taurolidine have been ascribed...
to the biologically active methylol taurinamide which reacts with cell wall constituents of microbial pathogens via methyl-
le lamine iminium ions preventing bacterial adhesion to biological
surfaces [8,9]. Additional proposed mechanisms of action of
taurolidine include the capability to reduce tumour necrosis
factor (TNF)-α synthesis and activity [10,11] and interaction
with cell surface structure and function [12]. Taurolidine has
been shown to be non-toxic to human and animals. It has a
short half-live and is metabolised to taurine, carbon dioxide
and water. The extent of its antimicrobial activity in vitro
and in vivo is well documented in several studies [8,13–17].

Recent clinical publications report that taurolidine is effec-
tive in the prevention of urinary tract infections subsequent
to urinary catheterisation and haemodialysis catheter-related
infections and that its intravenous and intraperitoneal ad-
ministration is not associated with noteworthy side effects
[18–22]. The efficacy of taurolidine in infected indwelling
central venous catheters or port catheter systems has only
been described in a few case reports and has not yet been
analysed in a greater panel of patients within the scope of a
randomised or non-randomised clinical study [23].

2. Patients and methods

Our trial was designed as an open non-randomised single
centre pilot study and was conducted at the Department of
Haematology, Oncology and Immunology, St. Johannes Hos-
pital Düsseldorf, Germany. Hospitalised adult patients with
proven CR-BSI related to totally implantable intravascular
devices (TID) who did not respond to 48–72 h of i.v. antibi-
totic regimes following the antibiogram were initiated and
antibiotic treatment received a taurolidine i.v. lock in addition
to systemic antibiotic chemotherapy according to the antibi-
ogram. We administered 3 ml taurolidine-ringer 0.5% into the
device and left them closed for 24 h. Hereafter, the device
was flushed with 10 ml NaCl 0.9%. In order to evaluate the
effect of repeated taurolidine administration, in two patients
the treatment was repeated after 24 h and in three patients
after 24 and 48 h.

3. Assessment of CR-BSI

CR-BSI was diagnosed on the basis of typical clinical
signs of bloodstream infection (temperature >38 °C, chills,
arterial hypotension and a raised or lowered peripheral white
blood count (WBC)) with the catheter as the only obvious
source of infection. In addition, isolation of the same organ-
ism (identical species and antibiogram) from catheter culture
and peripheral blood culture was regarded as direct evidence.

In patients with clinically suspected CR-BSI repetitive, pe-
ripheral blood samples and catheter swabs were collected for
culture. Isolated organisms were identified by standard mi-
crobiological methods. Before administration of taurolidine,
a complete physical examination was performed as well as
laboratory workup including differential WBC, electrolytes,
liver function tests, creatinine and C-reactive protein (CRP).

After taurolidine administration, the course of CR-BSI was
monitored by clinical assessment and close-meshed investi-
gation of central and peripheral venous blood cultures.

4. Treatment of CR-BSI

Patients with proven CR-BSI who did not respond to i.v.
antibiotic treatment received a taurolidine i.v. lock in addition
to systemic antibiotic chemotherapy according to the antibi-
ogram. We administered 3 ml taurolidine-ringer 0.5% into the
device and left them closed for 24 h. Hereafter, the device
was flushed with 10 ml NaCl 0.9%. In order to evaluate the
effect of repeated taurolidine administration, in two patients
the treatment was repeated after 24 h and in three patients
after 24 and 48 h.

5. Results

5.1. Microbial isolates and treatment

Microbial isolates from peripheral blood and devices of
patients with CR-BSI included coagulase negative Staphy-
lococcus spp. (n = 4), Acinetobacter baumannii (n = 2),
Stenotrophomonas maltophilia (n = 1), Staphylococcus au-
reus (n = 1), Escherichia coli (n = 1), Pseudomonas picketti
(n = 1) and Pseudomonas aeruginosa (n = 1). Systemic anti-
biotic regimes following the antibiogram were initiated and
taurolidine i.v. lock solutions were administered as described
above.

5.2. Treatment response

Six patients received a single course of 1 × 3 ml tauroli-
dine, two patients received 1 × 3 ml taurolidine on two con-
secutive days and three patients received 1 × 3 ml taurolidine
on three consecutive days as a lock solution into the devices
(Table 1). All patients recovered completely from CR-BSI
(disappearance of clinical symptoms, normalization of CRP
values, negative blood cultures) without replacement of the
devices (Table 2).

A recurrent episode of CR-BSI was observed in three
patients during the study period and was again success-
fully treated with taurolidine i.v. lock (Table 3). The first
case was a patient with A. baumannii and oxacillin resistant
Staphylococcus spp. isolates in the device during the first
episode that had been treated with one injection of tauroli-
dine. Two months later A. baumannii and coagulase negative
Table 1

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Microbial isolates</th>
<th>Antimicrobial treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Catheter Peripheral blood</td>
<td>Antibiotics</td>
</tr>
<tr>
<td>1</td>
<td>Not done</td>
<td>Pseudomonas aeruginosa</td>
</tr>
<tr>
<td>2</td>
<td>A. baumannii, oxacillin rest. Staphylococcus spp.</td>
<td>No growth</td>
</tr>
<tr>
<td>3</td>
<td>A. baumannii</td>
<td>A. baumannii</td>
</tr>
<tr>
<td>4</td>
<td>Coagulase negative Staphylococcus spp.</td>
<td>Coagulase negative</td>
</tr>
<tr>
<td>5</td>
<td>E. coli</td>
<td>E. coli</td>
</tr>
<tr>
<td>6</td>
<td>A. baumannii</td>
<td>A. baumannii</td>
</tr>
<tr>
<td>7</td>
<td>A. baumannii</td>
<td>A. baumannii</td>
</tr>
<tr>
<td>8</td>
<td>Coagulase negative Staphylococcus spp.</td>
<td>Coagulase negative</td>
</tr>
<tr>
<td>9</td>
<td>Coagulase negative Staphylococcus spp.</td>
<td>Coagulase negative</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Sex (m/f)</th>
<th>Mean age (years) (range)</th>
<th>Diagnosis</th>
<th>Before taurolidine</th>
<th>Mean WHO performance status (range)</th>
<th>Mean WHO fever grade (range)</th>
<th>After taurolidine</th>
<th>Mean WHO performance status (range)</th>
<th>Mean WHO fever grade (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>3/8</td>
<td>64.5 (41–76)</td>
<td>Solid tumour</td>
<td>2.4</td>
<td>(1–3)</td>
<td>(1–2)</td>
<td>2.8</td>
<td>1.5</td>
<td>(0–3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Leukaemia</td>
<td>1.9</td>
<td></td>
<td></td>
<td>2.8</td>
<td>1.5</td>
<td>(0–3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lymphoma</td>
<td></td>
<td></td>
<td></td>
<td>2.8</td>
<td>1.5</td>
<td>(0–3)</td>
</tr>
</tbody>
</table>

Staphylococcus spp. were detected within the device. The second patient had been treated with taurolidine i.v. locks on three consecutive days for an A. baumannii positive CR-BSI. Three months after initial treatment she had a new CR-BSI with Stenotrophomonas maltophilia within the device. In the third case, the device was reinfected with the same isolate (coagulase negative Staphylococcus spp.) four months after the initial treatment with taurolidine injections into the device on three consecutive days. After re-treatment with taurolidine i.v. lock application all three patients recovered completely from the CR-BSI.

5.3. Side effects of taurolidine

None of our patients showed local or systemic hypersensitivity reactions, haematological side effects or other organ toxicities associated with the use of taurolidine. In particular, no differences were observed between patients who

Table 3

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Microbial isolates</th>
<th>Antimicrobial treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>A. baumannii</td>
<td>A. baumannii</td>
</tr>
<tr>
<td>4</td>
<td>Stenotrophomonas maltophilia</td>
<td>Stenotrophomonas maltophilia</td>
</tr>
<tr>
<td>10</td>
<td>Coagulase negative Staphylococcus spp.</td>
<td>Coagulase negative Staphylococcus spp.</td>
</tr>
</tbody>
</table>
6. Discussion

TID are frequently used in patients with oncological diseases. CR-BSI is a major complication of TID which often leads to hospital readmission. For the prevention of these infections, sterile handling of the catheter is crucial. Recent comparative studies have shown that the use of central venous catheters impregnated either with minocycline and rifampicin or with chlorhexidine and silver sulfadiazine is associated with lower rates of catheter colonization and bloodstream infection than the use of unimpregnated catheters [24,25]. Being confronted with nosocomial organisms, often resistant to multiple therapeutic agents, it is important to avoid the prophylactic use of agents used in the treatment of CR-BSI, such as glycopeptides, β-lactams, aminoglycosides, quinolones and azoles [26]. Longuet et al. [27] reported a limited efficacy of treatment with antibiotic lock technique in patients with CR-BSI. The standard therapy consists of systemic antibiotic chemotherapy and often the central venous catheter will be removed. However, in many of these cases the removal of the TID is not necessarily the only therapeutic choice especially taking into consideration that the morbidity associated with insertion of a new central line is significant. The clinical experiences with recurrent CR-BSI suggest that conventional therapy with systemic antibiotics such as vancomycin complemented with antibiotic lock technique and possibly catheter replacement is not successful in stopping recurrence and avoidance of fungal infections. Thus, there is a strong clinical need for alternative treatment approaches in order to improve the management of this dangerous complication in critically ill patients. Taurolidine has been used clinically extensively due to its antimicrobial and antifungal properties, particularly in peritonitis [28,29]. Experiences with taurolidine in combination with citric acid and other agents have been reported by Sodemann et al. in patients with end stage renal disease undergoing haemodialysis via subcutaneous port systems [20,30]. The addition of taurolidine to total parenteral nutrition solutions at a concentration above the minimum inhibitory concentration of the commonly encountered staphylococci could be a way of introducing bactericidal conditions against contaminating organisms so protecting against many of the frequent septic complications associated with total parenteral nutrition [31,32]. In our study, taurolidine proved to be a promising agent for the treatment of CR-BSI being successful in all 11 cases including a patient with a line that had previously been endoluminally infected. In addition, an antimicrobial response was also observed in three patients who had prior exposure to taurolidine and a recurrent CR-BSI several months later. No adverse effects were documented.

Our observations suggest a beneficial role of taurolidine i.v. lock application for the therapy of CR-BSI in oncology patients. It acts synergistically with systemic antibiotic chemotherapy resulting in a high rate of complete recovery without replacement of the device. A single injection of taurolidine into the device is sufficient to be effective but repeated administration in patients with recurrent CR-BSI is possible with apparently no loss of efficacy. Taurolidine is characterised by an extraordinary broad antimicrobial activity associated with excellent tolerability in the absence of side effects and drug interactions. Its non-toxic and therapeutic effectiveness justifies its use in patients with CR-BSI and it could be especially useful in infections resistant to antibiotic chemotherapy. Further randomised studies with larger patient numbers will be required to verify the efficacy of taurolidine in this setting.

Acknowledgement

We would like to dedicate this article to Martin Westerhausen (Director of Medizinische Klinik II, St. Johannes Hospital Duisburg, Germany) on the occasion of his 70th birthday.

References


