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Pharmacokinetics/pharmacodynamics of cefiderocol administered by continuous infusion in a case series of critically ill patients with carbapenem-resistant *Acinetobacter baumannii* infections undergoing continuous venovenous haemodiafiltration (CVVHDF)

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1 **Pharmacokinetics/pharmacodynamics of cefiderocol administered by continuous infusion in a case**  
2 **series of critically ill patients with carbapenem-resistant *Acinetobacter baumannii* infections undergoing**  
3 **continuous venovenous haemodiafiltration (CVVHDF)**

4

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23

24 **Abstract**

25 **Objectives:** To assess the pharmacokinetics/pharmacodynamics (PK/PD) of cefiderocol administered by  
26 continuous infusion (CI) in a case series of critically ill patients with carbapenem-resistant *Acinetobacter*  
27 *baumannii* (CRAB) infections undergoing continuous venovenous haemodiafiltration (CVVHDF).

28 **Methods:** Critically ill patients receiving CI cefiderocol during CVVHDF for documented bloodstream  
29 infections (BSIs), ventilator-associated pneumonia (VAP), and/or complicated intrabdominal infections  
30 (cIAIs) caused by CRAB and undergoing therapeutic drug monitoring (TDM) from February 2022 to January  
31 2023 were retrospectively assessed. Cefiderocol concentrations were determined at steady-state, and the free  
32 fraction ( $fC_{ss}$ ) was calculated. Cefiderocol total clearance ( $CL_{tot}$ ) was determined at each TDM assessment.  
33  $fC_{ss}/MIC$  ratio was selected as PD determinant of cefiderocol efficacy and defined as optimal if  $>4$ , quasi-  
34 optimal if between 1 and 4, and suboptimal if  $<1$ .

35 **Results:** Five patients with documented CRAB infections (two BSI+VAP, two VAP, and one BSI+cIAI) were  
36 included. The maintenance dose of cefiderocol was always of 2g q8h over 8h by CI. Median average  $fC_{ss}$  was  
37 26.5 mg/L (21.7-33.6 mg/L). Median  $CL_{tot}$  was 4.84 L/h (2.04-5.22 L/h). Median CVVHDF dose was 41.1  
38 mL/kg/h (35.5-44.9 mL/kg/h), and residual diuresis was reported in 4/5 cases. Optimal PK/PD target was  
39 attained in all cases with a median cefiderocol  $fC_{ss}/MIC$  ratio of 14.9 (6.6-33.6).

40 **Conclusion:** CI administration of full doses could be a useful strategy for attaining aggressive PK/PD targets  
41 with cefiderocol for the treatment of severe CRAB infections among critically ill patients undergoing high-  
42 intensity CVVHDF and having residual diuresis.

43 **Keywords:** cefiderocol; continuous infusion; continuous renal replacement therapy; continuous venovenous  
44 haemodiafiltration; PK/PD target attainment; carbapenem-resistant *Acinetobacter baumannii*

45 **Background**

46 *Acinetobacter baumannii* represents a major cause of healthcare-associated infections in critically ill  
47 patients [1]. Nowadays, the widespread emergence of carbapenem-resistance among *A. baumannii* clinical  
48 isolates makes the treatment of carbapenem-resistant *A. baumannii* (CRAB)-related infections extremely  
49 challenging, causing high rates of clinical failure and mortality [1].

50 Cefiderocol is a recently licensed novel beta-lactam highly active against CRAB [2]. Recent real-world  
51 studies showed that cefiderocol could be a promising option in the management of severe CRAB infections  
52 [3,4]. According to recent findings, attaining aggressive pharmacokinetic/pharmacodynamic (PK/PD)  
53 targets defined as  $100\%T_{>4-8\times MIC}$  could not only maximize clinical efficacy of treatment with beta-lactams but  
54 also grant microbiological eradication with minimization of the likelihood of resistance development [5].

55 Renal replacement therapy (RRT) is a procedure that may replace the normal blood-filtering function  
56 of the kidney in patients with renal dysfunction. It may be applied by means of several different modalities,  
57 which may impact to a various extent on the pharmacokinetic behavior of renally cleared antibiotics, such as  
58 the beta-lactams [6]. Continuous veno-venous hemodiafiltration (CVVHDF) is one of the continuous renal  
59 replacement therapy (CRRT) modalities potentially applicable for managing acute kidney injury in critically  
60 ill patients with hemodynamic instability [6]. CVVHDF may make the attainment of aggressive PK/PD target  
61 with beta-lactams extremely challenging [7], and the PK/PD profile of cefiderocol under CVVHDF was  
62 assessed only in few single cases during standard administration by extended infusion (EI) over 3h [8–10].

63 The aim of this study was to assess the PK/PD of cefiderocol administered by continuous infusion (CI)  
64 in a case series of critically ill patients with CRAB infections undergoing therapeutic drug monitoring (TDM)  
65 while being on CVVHDF.

## 66 **Methods**

67 This was a retrospective case series of critically ill renal patients who, while undergoing CVVHDF at  
68 the general intensive care unit (ICU) or at the transplant ICU of the IRCCS Azienda Ospedaliero-Universitaria  
69 of Bologna in the period between 01<sup>st</sup> February 2022 and 31<sup>st</sup> January 2023, received cefiderocol administered  
70 by CI for the treatment of documented CRAB infections and underwent TDM. Demographic and  
71 clinical/laboratory data were collected for each patient. Data on isolated pathogens with punctual MIC values  
72 for cefiderocol, type/site of infection, dosage, and treatment duration with cefiderocol, use of monotherapy or  
73 combination therapy with other antibiotics active against CRAB isolates were retrieved. CVVHDF operative  
74 conditions (i.e., type of filter, blood flow rate [ $Q_b$ ], pre-blood pump [PBP] fluid rate, dialysate flow rate [ $Q_d$ ],  
75 percentage of pre-/post-dilution, replacement fluid rate, net removal rate per hour) and status of renal function  
76 were retrieved at each TDM assessment. The total effluent flow rate was defined based on the following  
77 equation: pre-filter replacement fluid rate + post-filter replacement fluid rate + net removal rate + PBP fluid  
78 rate +  $Q_d$ . CVVHDF dose intensity was calculated by normalizing the total effluent flow rate for body weight.  
79 At each TDM assessment, cefiderocol total CL ( $CL_{tot}$ ) was calculated based on the following formula:  $CL_{tot}$   
80 (L/h) = infusion rate (mg/h) /  $C_{ss}$  (mg/L). Area under concentration-time curve (AUC) was calculated by means  
81 of the following formula:  $AUC$  (mg·h/L) = dose (mg/24h) / CL (L/h).

82 The types of infection were defined according to the following standard criteria: documented  
83 bloodstream infection (BSI) was defined by means of CRAB isolation from blood cultures. Documented  
84 ventilator-associated pneumonia (VAP) was defined by means of CRAB isolation with a bacterial load  $\geq 10^4$   
85 CFU/mL in the bronchoalveolar lavage (BAL) fluid culture after >48 hours from endotracheal intubation and  
86 starting mechanical ventilation in patients with a new or progressive lung infiltrate [11]. Complicated  
87 intrabdominal infection (cIAI) was defined by means of CRAB isolation from peritoneal fluid patients with  
88 infection extended beyond a single organ into the peritoneal space [12].

89 Antimicrobial susceptibility testing for cefiderocol was performed by means of broth microdilution  
90 method with iron-depleted cation-adjusted Mueller-Hinton broth (ID-CAMHB), as previously described [13].  
91 The MIC of cefiderocol against CRAB isolates was determined according to the EUCAST guidelines by  
92 evaluating the relative growth reduction (button of <1 mm) in comparison to the ID-CAMHB growth control

93 well. CRAB strains showing an MIC value  $> 2$  mg/L were deemed resistant according to the EUCAST PK/PD  
94 non-species related breakpoints [14].

95 Cefiderocol was prescribed as first-line or rescue therapy at the discretion of the infectious disease  
96 consultant in accordance with current clinical practice guidelines implemented at the IRCCS Azienda  
97 Ospedaliero-Universitaria of Bologna. Treatment was always started with a loading dose (LD) of 2g over 2h  
98 infusion followed by a maintenance dose (MD) of 2g q8h administered over 8h (namely by CI). For this  
99 purpose, aqueous solutions were reconstituted every 8h [15].

100 Blood samples for measuring cefiderocol steady-state concentrations ( $C_{ss}$ ) were collected firstly after  
101 at least 24 hours from CVVHDF initiation and then reassessed whenever feasible. Total serum cefiderocol  
102 concentrations were determined by means of a validated liquid chromatography-tandem mass spectrometry  
103 method [16].

104 As only total cefiderocol concentrations were measured, the free fraction ( $f$ ) was calculated by  
105 considering a plasma protein binding of 58%, as reported in the literature [2]. The time with serum cefiderocol  
106  $fC_{ss}$  above the MIC was selected as PD parameter of efficacy and expressed as  $fC_{ss}/MIC$  ratio. The  $fC_{ss}/MIC$   
107 ratio was defined as optimal if  $\geq 4$ , quasi-optimal if between 1 and 4, and suboptimal if  $< 1$ , as previously  
108 reported [13,17].

109 Continuous data were presented as median and interquartile range (IQR), whereas categorial variables  
110 were expressed as count and percentage. The study was approved by the Ethics Committee of IRCCS Azienda  
111 Ospedaliero-Universitaria of Bologna (n. 442/2021/Oss/AOUBo approved on 28<sup>th</sup> June 2021).

## 112 **Results**

113 Overall, a total of five critically ill patients with CRAB infections receiving treatment with CI  
114 cefiderocol while undergoing CVVHDF were included (**Table 1**). Median (IQR) age was 64 years (43-71  
115 years). All patients were male, underwent invasive mechanical ventilation and required haemodynamic support  
116 with vasopressors.

117 CVVHDF was always performed by means of Prisma Flex System equipped with an AN69 high-flux  
118 ST-150 filter membrane. The operative conditions are summarized in **Table 2**. Median (IQR)  $Q_b$  and total  
119 effluent flow rate were 150 mL/min (150-150 mL/min) and 2,900 mL/h (2,840-3,590 mL/h), respectively.  
120 Median (IQR) CVVHDF dose was 41.1 mL/kg/h (35.5-44.9 mL/kg/h). Four out of the five patients (80%) had  
121 residual diuresis with a median (IQR) 24-h urinary output of 297.5 mL (283.8-337.5 mL).

122 Types of infections were BSI plus VAP and VAP in two cases each, and BSI plus cIAI in one case  
123 patient. Overall, three out of the five CRAB isolates had an MIC of 4 mg/L, and were considered resistant to  
124 cefiderocol. The MD of cefiderocol was always of 2 g q8h over 8h by CI. The median (IQR) duration of  
125 treatment was 11 days (10-14 days), and the median (IQR) CVVHDF duration was 10 days (7-11 days). TDM  
126 of cefiderocol was assessed more than once during CVVHDF in 2 out of 5 cases. Cefiderocol was administered  
127 as monotherapy in two cases, and as combination therapy in the other three (with fosfomycin in two patients  
128 and with ampicillin-sulbactam in the other).

129 Median (IQR) average cefiderocol  $fC_{ss}$  was 26.5 mg/L (21.7-33.6 mg/L). Median (IQR)  $CL_{tot}$  of  
130 cefiderocol was 4.84 L/h (2.04-5.22 L/h). Optimal PK/PD targets were attained in all of the five patients, the  
131 median (IQR)  $fC_{ss}/MIC$  being 14.9 (6.6-33.6).

## 132 Discussion

133 Our study may add some knowledge about the changeable PK behaviour of cefiderocol under different  
134 CVVHDF conditions and may provide firstly evidence about the likelihood of attaining aggressive PK/PD  
135 targets with CI administration in the treatment of critically ill patients with severe CRAB infections while  
136 undergoing CVVHDF.

137 In our case series, the median  $CL_{tot}$  of cefiderocol (4.84 L/h) was 1.5- to 2- fold higher than observed  
138 previously in three separated cases [8–10]. Kobic *et al.* [8] found a  $CL_{tot}$  of 2.33 L/h in an anuric patient having  
139 a bacteraemic VAP due to DTR *Pseudomonas aeruginosa* and undergoing CVVHDF with a total effluent flow  
140 rate of 1,750 mL/h. Fratoni *et al.* [10] reported a cefiderocol  $CL_{tot}$  of 2.7 L/h in an anuric patient affected by  
141 bacteraemic pneumonia due to *Stenotrophomonas maltophilia* and undergoing CVVHDF with a total effluent  
142 flow rate of 2,200 mL/h. Finally, Kobic *et al.* [9] found a cefiderocol  $CL_{tot}$  of 3.4 L/h in an anuric patient with  
143 VAP due to CRAB undergoing CVVHDF with a total effluent flow rate of 3,500 mL/h.

144 Overall, our PK results may be explained by two rationales. First, the quite high effluent rates and  
145 CVVHDF dose intensities that were applied in our series [18], in agreement with the findings of an *ex vivo*  
146 model showing that cefiderocol  $CL_{tot}$  may increase proportionally to CRRT dose intensity [19]. Second, the  
147 presence of residual diuresis in most of our cases, in agreement with the estimation that a residual creatinine  
148 clearance of 15-30 mL/min could promote a theoretical increase in cefiderocol  $CL_{tot}$  of 1.36–2.18 L/h [8,10].

149 The finding of changeable  $CL_{tot}$  of cefiderocol under different CVVHDF operative conditions may  
150 support the contention that adopting a “patient-center” approach should be the way forward for optimizing  
151 antimicrobial treatment during CRRT [7].

152 The choice of administering full MD of cefiderocol by CI, namely 2g q8h over 8h, allowed us to attain  
153 aggressive PK/PD targets in all of the included patients, even in those having infections sustained by CRAB  
154 strains with an MIC of 4 mg/L, namely theoretically *in vitro* resistant to cefiderocol according to the EUCAST.  
155 This may be very valuable from the clinical standpoint, since attainment of aggressive PK/PD targets of  
156  $100\%fT_{>4.8 \times MIC}$  is actually considered mandatory with beta-lactams for granting microbiological eradication  
157 and minimizing the risk of resistance development [5,20]. Noteworthy, no patient suffered from cefiderocol-

158 related adverse event. Overall, these findings may support the contention that, among patients undergoing  
159 high-intensity CVVHDF and having residual diuresis, a dosing regimen of 2g q8h over 8h (namely by CI)  
160 could be appropriate for attaining aggressive PK/PD targets with cefiderocol against all CRAB strains with an  
161 MIC value up to or even higher than the EUCAST PK/PD non-species related breakpoint (namely 2 mg/L).  
162 Of course, larger prospective studies are warranted for confirming our hypothesis. Furthermore, it is  
163 noteworthy that our findings could be applicable only in ICUs in which high-intensity CVVHDF is usually  
164 implemented. Indeed, the adoption of different CRRT modalities and the variations in effluent flow rate may  
165 strongly impact on beta-lactam clearance, including cefiderocol [6,7]. CVVHDF, by combining convection  
166 and diffusion properties, usually represents the most efficient RRT modality in terms of drug removal [6].  
167 Consequently, it could not be ruled out that our cefiderocol dosing regimen may be not appropriate in patients  
168 undergoing other CRRT modalities or in which lower effluent flow rate is delivered.

169 We recognize that our study has some limitations. The retrospective monocentric study design and the  
170 limited sample size should be acknowledged. Total cefiderocol concentrations were measured, and the free  
171 fraction were only estimated. We recognize that measuring 24-hour urinary creatinine clearance would have  
172 allowed a better estimate of residual renal function. Finally, we admit that our findings could not be reliable in  
173 addressing correctly the issue among patients undergoing low-intensity CVVHDF.

174 In conclusion, this study may provide evidence about the usefulness that CI administration of full doses  
175 may have in attaining aggressive PK/PD targets with cefiderocol for the treatment of severe CRAB infections  
176 among critically ill patients undergoing high-intensity CVVHDF and having residual diuresis. Large  
177 prospective confirmatory studies are warranted for assessing clinical and microbiological outcome.

178

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186 potential conflicts of interest for this work.

187 **Ethical approval:** The study was conducted according to the guidelines of the Declaration of Helsinki and  
188 approved by the Ethics Committee of IRCCS Azienda Ospedaliero-Universitaria of Bologna (n.  
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257

ID case	Age	Underlying disease	Pathogen	MIC	Infection	Dose	Average $fC_{ss}$	$fC_{ss}/MIC$	Cefiderocol PK/PD target	Treatment duration	CVVHDF treatment duration while on cefiderocol	Microbiological eradication BSI	Microbiological eradication VAP/IAI	Combination therapy
#1	64/M	ARDS in COVID-19	CRAB	4	BSI + VAP	2g LD 2g q8h CI	59.7	14.9	Optimal	14	14	Yes	Yes (VAP)	No
#2	29/M	Polytrauma	CRAB	0.125	VAP	2g LD 2g q8h CI	21.7	173.3	Optimal	14	10	//	Yes (VAP)	No
#3	43/M	Acute-on-chronic liver failure	CRAB	1	VAP	2g LD 2g q8h CI	33.6	33.6	Optimal	10	3	//	Yes (VAP)	Ampicillin/sulbactam (6g/3g LD 6g/3g q8h CI)
#4	71/M	Abdominal perforation	CRAB	4	BSI + cIAI	2g LD 2g q8h CI	26.5	6.6	Optimal	11	11	Yes	No (cIAI)	Fosfomycin (6g LD 16g/day CI)
#5	74/M	Septic shock in COVID-19	CRAB	4	BSI + VAP	2g LD 2g q8h CI	17.6	4.4	Optimal	7	7	Yes	No (VAP)	Fosfomycin (6g LD 16g/day CI)

ARDS: acute respiratory distress syndrome; BSI: bloodstream infection; CI: continuous infusion; cIAI: complicated intrabdominal infection; CRAB: carbapenem-resistant *Acinetobacter baumannii*;  $C_{ss}$ : steady-state concentrations; LD: loading dose; MIC: minimum inhibitory concentration; PK/PD: pharmacokinetic/pharmacodynamic; VAP: ventilator-associated pneumonia. //: not applicable. Green box: microbiological eradication; red box: microbiological failure. Microbiological failure was defined as the persistence of the same bacterial pathogen in the primary site of infection (documented in blood, BAL, and/or peritoneal fluid cultures depending on case-by-case) after  $\geq 7$  days from starting cefiderocol treatment.

**Table 2** – CVVHDF (equipped with AN-69 ST150 filter membrane and application of citrate regional anticoagulation) operative conditions and cefiderocol CL and AUC at each TDM assessment

ID case	Sampling time after starting FDC therapy (day)	Weight (Kg)	Q <sub>b</sub> rate (mL/min)	PBP rate (mL/h)	Q <sub>d</sub> rate (mL/h)	Pre/Post-dilution	Replacement fluid rate (mL/h)	Net removal (mL/h)	CVVHDF dose intensity (mL/kg/h)	Residual diuresis (mL/24h)	Total effluent flow rate (mL/h)	FDC CL (L/h)	FDC AUC (mg*h/L)
#1	12	100	150	1250	800	0/100	800	80	29.3	280	2930	1.76	3409.1
#2	4	70	150	1250	1300	0/100	1000	140	52.7	300	3690	5.22	1149.4
#2	8	70	150	1250	500	0/100	1000	140	41.3	350	2890	2.04	2941.2
#2	11	70	150	1250	1300	0/100	1000	140	52.7	295	3690	4.99	1202.4
#3	10	80	180	500	2500	0/100	500	90	44.9	830	3590	1.97	3045.7
#4	2	80	150	1250	500	0/100	1000	150	36.3	0	2900	7.84	765.3
#4	5	80	150	1250	500	0/100	1000	90	35.5	0	2840	4.84	1239.7
#4	6	80	150	1250	500	0/100	1000	90	35.5	0	2840	3.97	1511.3
#5	6	65	150	1250	500	0/100	800	120	41.1	225	2670	5.95	1008.4

AUC: area under concentration-time curve; CL: clearance; CVVHDF: continuous venovenous haemodiafiltration; FDC: cefiderocol; PBP: pre-blood pump flow rate; Q<sub>b</sub>: blood flow rate; Q<sub>d</sub>: dialysate flow rate; TDM: therapeutic drug monitoring