Should we stop using intravenous gentamicin in patients with cystic fibrosis?

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Patients with cystic fibrosis (CF) have shown continual annual improvement in survival in many countries. The improvements in outcome have been attributed to better treatments and a multidisciplinary approach to care focused in care centres with specific expertise in CF. As survival improves, we may start increasingly to see adverse events related to intensive treatments used to battle the chronic airway infections and airway inflammation in CF.

Because of chronic lung infections, patients with CF receive repeated courses of oral, inhaled and intravenous antibiotics, some of which are known to be nephrotoxic drugs such as aminoglycosides. The primary defect in CF, the cystic fibrosis transmembrane regulator protein (CFTR), is expressed in the kidney but its function is unknown. In this issue of Thorax, Smyth and colleagues present data on the association of intravenous aminoglycosides—particularly gentamicin—and acute renal failure (ARF) in the UK (see page 532). The authors have published a previous report in Thorax in which they established an incidence of ARF in CF of 4.6–10.5 cases per 10,000 patients per year. The associated use of aminoglycosides and renal failure in this population seemed clear, and most of the patients with ARF had received intravenous gentamicin treatment. In their current paper the authors have moved forward to assess these associations more formally by conducting a case-control study to determine which factors were associated with an increased risk of ARF in these patients. They found that intravenous aminoglycoside use (particularly gentamicin) was associated with ARF, with an odds ratio of 81.8 (95% CI 4.7 to 186.6). Interestingly, they did not find a relationship between cumulative exposure to aminoglycosides in the preceding year and the development of ARF.

These findings are certainly a concern for patients with CF and their care providers. But is the strength of this evidence enough to markedly reduce intravenous aminoglycoside use and, more specifically, to abandon the use of gentamicin?

WHAT IS KNOWN ABOUT RENAL FAILURE IN CF?

Patients with CF clearly have risk factors for developing ARF, given their repeated doses of nephrotoxic agents (particularly aminoglycosides), the moderate rates of CF-related diabetes and the predisposition for salt imbalances and dehydration. Previous case reports have noted cases of ARF associated with oral ciprofloxacin, inhaled tobramycin and intravenous aminoglycosides (both tobramycin and gentamicin). More comprehensive studies of renal function in patients with CF are limited and include one study which carefully documented creatinine clearance in a population of patients with CF in Liverpool, UK. Al-Aloul and colleagues found 42.5% of a consecutive cohort of patients with CF had a 24 h creatinine clearance rate below the normal range and there was an inverse association between the number of antibiotic courses and the creatinine clearance rate. This same group also found eight cases of ARF associated with an epidemic strain of Pseudomonas not noted in their centre. Smyth and colleagues have added substantially to this area of CF care by first conducting a careful prevalence study of ARF across CF centres as noted above, and then by following this with a case-control study in this issue of Thorax.

WHAT ARE THE LIMITATIONS OF CASE-CONTROL STUDIES?

To decide how to weigh the merits of any given study, one must fully understand the strengths and weaknesses inherent to the study design. Case-control studies are ideal for evaluating rare outcomes (such as ARF in CF) and can provide an efficient and economical method to assess a potential association between a covariate and an outcome. Case-control studies yield odds ratios (OR) (a term often confused by readers as synonymous with risk ratios or relative risks) and, unfortunately, suffer from more opportunities for the introduction of bias and mistaken inference. Case-control studies start with the outcome and work backwards to the predictor. This retrospective assessment of the predictor is one of the potential limitations of this study design. Other important limitations of the study design relate to the selection of controls and the assessment of the predictors of interest or exposures. Ideally, the cases are all those with the outcome in a population (however, often it represents a sample of this population). The controls should be drawn from the same population and be at risk for the outcome; controls also need to be chosen independent of exposure. Assessment of the exposure in both the cases and controls can be fraught with biases including recall bias and information bias. The primary means of addressing this limitation if a study involves chart review is standardised assessments of the chart review and blinding of chart reviewers to the status of the subject (case or control).

As in all observational studies, another problematic issue is confounding. Confounders are characteristics of study subjects that are associated with the exposure and the outcome that can have an impact on the association between the predictor and the outcome. To address confounding in case-control studies, investigators either restrict the population (if gender is a confounder, only evaluate one gender), matching on confounder (can no longer assess the impact of the confounder) or adjustment in the analysis using logistic regression or stratification with Mantel-Haenszel approaches. One of the methodologies frequently used in case-control studies is matching; matching in this study design has been shown potentially to increase bias due to misclassification or overmatching. Whenever matching is done in case-control studies, investigators must adjust for the matching variables to ensure no bias is...
iadventently introduced into the study.21 24 If potential confounders were not collected during data acquisition or cannot be collected retrospectively, the confounding could be affected by residual confounding.

Smyth and colleagues10 have conducted a careful case-control study with attention to these potential limitations. They first conducted a national survey to find cases,11 defined as those with a raised

IS THERE ENOUGH EVIDENCE TO INITIATE A MORATORIUM ON THE USE OF INTRAVENOUS GENTAMICIN IN CF?

I believe that, while the present evidence is concerning, it does not support the call to ban the use of intravenous gentamicin in the CF population. Other countries should carefully evaluate their data regarding ARF and aminoglycoside use (particularly gentamicin) to see if similar associations are noted. Similar findings would raise concern that, indeed, something is unique about the ability of gentamicin to be more nephrotoxic than tobramycin.

Intravenous aminoglycosides remain an important treatment option for patients with CF. The anti-pseudomonal activity of this class of agents will continue to be important until more alternatives are available. What is clear from this work is that more careful assessment of renal function is warranted in patients with CF who receive intravenous aminoglycosides. Pre-existing risk factors for renal dysfunction should be mitigated before initiating aminoglycosides. All treatments have side effects, many of which only occur rarely. As the person-years of observation on those treatments increase, clinical researchers in CF must vigilantly reassess all of our interventions to ensure that we fully understand the risks that such treatments pose to our patients.

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REFERENCES


