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Erratum to "Linezolid versus Vancomycin for the Treatment of Methicillin-Resistant *Staphylococcus aureus* in Hospital-Acquired, Entilator-Associated, and Healthcare-Associated Pneumonia at Tertiary Care Hospital", [Advances in Infectious Diseases 7 (2017) 11-18]

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The original online version of this article (Hamdan, E.M. and AL-Attas, M. (2017) Linezolid versus Vancomycin for the Treatment of Methicillin-Resistant *Staphylococcus aureus* in Hospital-Acquired, Ventilator-Associated, and Healthcare-Associated Pneumonia at Tertiary Care Hospital. *Advances in Infectious Disease*, **7**, 11-18. https://doi.org/10.4236/aid.2017.71002) unfortunately contains some mistake. The author wishes to correct the errors in Abstract.

Abstract

Background: Methicillin-resistant *Staphylococcus aureus* (MRSA) pneumonia spread widely in the past ten years in Saudi Arabia. It is associated with significant morbidity and mortality of hospitalized patients, increased length of hospital stay and increased cost of treatment. Infectious Diseases Society of America (IDSA) recommended either vancomycin or linezolid in treatment of MRSA as first line of therapy [1]. Although, a lot of clinical trials were published to compare vancomycin and linezolid in treatment of MRSA pneumonia, it is still uncertain which one should be superior.

Aim: To evaluate morbidity and mortality rate, clinical cure rate and cost of

linezolid versus vancomycin in patients who have hospital-acquired pneumonia (HAP), ventilator-associated pneumonia (VAP) or Healthcare-associated pneumonia (HCAP) caused by methicillin-resistant *Staphylococcus aureus* (MRSA). Study design: Retrospective analysis data. Data were collected for adult patients admitted to King Faisal Specialist Hospital and Research Centre-Jeddah (KFSH & RC-J) from January 2010 to May 2015. Method: A total of 88 patients with HAP, VAP and HCAP caused by MRSA treated with vancomycin (IV) or linezolid (IV or PO) either as empirically or directed therapy ≥ 7 days. They are retrospectively evaluated and analyzed. The primary end points are morbidity and mortality rate as well as clinical cure rate. The secondary end point is the cost analysis for each medication. Results: A total of 40 patients (ICU, n = 13 (32.5% and non ICU, n = 27 (67.5%)) were included in the study. Among vancomycin, n = 21 (52.5%); age (54.95 ± 18.255) and linezolid, n = 19 (74.5%); age (48.684 ± 25.593), there was no statistical differences in mortality and morbidity rate (P = 0.375). Clinical cure rate (fever improvement, 12 (57.1%) vs 12 (63.2%); P = 0.698, leukocytosis improvement, 15 (71.4%) vs 14 (73.7%); P = 0.873, purulent sputum improvement, 6 (28.6%) vs 4 (21.1%); P = 0.429, dyspnea improvement, 8 (38.1%) vs 3 (15.8%); P = 0.115, cough improvement 4 (19.0%) vs 4 (21.1%); P = 0.592, microbiological eradication of MRSA from sputum culture, 2 (9.5%) vs 6 (31.6%); P = 0.089 and improvement of radiographic finding (pulmonary infiltration), 17 (81.0%) vs 16 (84.2%); P = 0.559) of vancomycin vs linezolid, respectively. The cost analysis in the treatment of MRSA pneumonia with linezolid is statistical.