**Background.** Vancomycin dosing guidelines recommend loading doses (LDs) (25–30 mg/kg TBW), and a maintenance regimen, usually started after a time period equal to the dosing interval. Studies of vancomycin exposure and nephrotoxicity conclude that a 0 to 24-hour area under the serum concentration–time curve (0–24AUC) > 677 mg·hour/l, results in a 3- to 4-fold increased risk of nephrotoxicity (Zasowski EG, Antimicrob Agents Chemother 2018). For vancomycin LDs we compare the calculated LD and the maintenance dose, and delay initiation of the maintenance regimen when the LD exceeds the daily maintenance dose by ≥ 50%. This study assessed the pharmacokinetics outcomes from this technique.

**Methods.** We retrospectively reviewed 68 consecutive adult patients receiving therapeutic doses of vancomycin. Patient age, sex, height, weight, serum creatinine, and indication were used to calculate the daily dose/interval for a steady-state 24-hr AUC of 400 or 600 mg·hour/l. The total 0–24AUC was calculated by adding the 0–24AUC from a 25 mg/kg LD (max 3 gm) to the 0–24AUC(s) for maintenance dose(s) within the first 24 hours. We compared the total 0–24AUC when the first maintenance dose was timed for the next dosing interval (“scheduled”) to that when the maintenance dose was delayed according to our protocol (“delayed”). We tested the proportion of patients who would be exposed to a vancomycin 0–24AUC > 677 mg·hour/l using the “scheduled” process and in none of the patients using the “delayed” protocol.

**Results.** 16/68 patients were diagnosed with SSTI (goal 24 hr AUC: 400 mg·hour/l) and 52/68 with sepsis, bacteremia/endocarditis, or pneumonia (24 hr AUC: 600 mg·hour/l). Median daily maintenance dose was 1756 mg (range: 675–4000 mg).

**Discussion.** For patients with severe gram-positive bacterial infections, the need for improved therapy. To address this, we standardized a nebulization method for delivering drug to the kidneys.

**Nephrotoxic treatment for murine pulmonary aspergillosis since it achieved significantly lower fungal burden in lungs vs. all other AmBi treatments (Gp1), 5 days of 10 min/day neb AmBi (Gp2), 20 min/day neb AmBi days 0, 1, 3, 5, 7 +1). Mice were challenged d0 with 9 x 10⁶ (Antimicrob Agents Chemother. 2015. 59:1759–1766). We also tested minimum fungicidal concentrations (MFC).

**Conclusion.** We identified seven two-drug combinations of antifungals efficacious against drug-resistant C. auris strains. The modified BMD combination susceptibility testing could be used by the clinical laboratories to assist providers with the selection of optimal treatment for C. auris candidemia.