Emerging treatment options for acute bacterial skin and skin structure infections: focus on intravenous delafloxacin

Abstract: The increase in hospitalization due to acute bacterial skin and skin structure infections (ABSSSI) caused by resistant pathogens supports the need for new treatment options. Antimicrobial options for ABSSSI that provide broad-spectrum coverage, including gram-negative pathogens and multidrug-resistant gram-positive bacteria, such as methicillin-resistant Staphylococcus aureus (MRSA), are limited. Delafloxacin is a novel fluoroquinolone available as intravenous and oral formulations and is characterized by an increased efficacy in acidic environments and activity on bacterial biofilm. Delafloxacin displays enhanced in vitro activity against MRSA, and enterococci, while maintaining efficacy against gram-negative pathogens and anaerobes. Delafloxacin has been studied for the treatment of ABSSSI and respiratory infections. Phase III studies have demonstrated noninferiority of delafloxacin compared to vancomycin, linezolid, tigecycline, and the combination of vancomycin plus aztreonam in the treatment of ABSSSI. Due to its favorable pharmacokinetic characteristics, the wide spectrum of action, and the potential for sequential therapy, delafloxacin represents a promising option in the empirical and targeted treatment of ABSSSI, both in hospital- and in community-based care.

Keywords: bacterial skin and skin structure infections, multidrug-resistant bacteria, methicillin-resistant Staphylococcus aureus, delafloxacin

Current scenario of complicated skin and soft tissue infections

The clinical spectrum of skin infections is highly variable and ranges from mild forms to life-threatening diseases.1 Among these, acute bacterial skin and skin structure infections (ABSSSI), formerly referred to as complicated skin and soft tissue infections, represent a frequent reason for hospital admission and a common cause of morbidity in the community.2,3 A nearly 3-fold increase in ABSSSI visit rates had been documented among patients presenting to the emergency departments with skin abscesses and cellulitis in the USA.2,4

Staphylococcus aureus represents the most common cause of ABSSSI, and methicillin-resistant S. aureus (MRSA) is often the most frequently isolated pathogen in complicated forms.3,5 In Europe, despite a high variability in prevalence, MRSA isolation can reach up to 25% in ABSSSI, especially in those areas where antimicrobial resistance represents a concern (e.g., Italy, Greece, and Eastern Europe).6,7 In the USA, community-acquired (CA) MRSA strains are endemic and frequently associated with skin infections and purulent skin abscesses, with reported outbreaks in military
recruits, athletes, and prisoners. MRSA prevalence among patients with ABSSSI undergoing microbiological cultures was reported as high as 75%–80% in the USA. The increase in hospital admissions required to treat ABSSSI with intravenous (IV) antibiotics along with the spread of multidrug-resistant (MDR) bacteria have caused a considerable impact on hospital stay and patient’s morbidity, reinforcing the need for new treatment options.

New therapeutic options for the treatment of ABSSSI have recently become available and offer advantages such as MRSA coverage as well as the possibility for outpatient treatment (e.g., IV to oral switch and/or infrequent administration).

### New therapeutic options for complicated skin and soft tissue infections

Antimicrobials that are commonly used in the treatment of ABSSSI due to methicillin-susceptible *S. aureus* (MSSA) include beta-lactams, especially oxacillin and flucloxacinil, fluoroquinolones (e.g., moxifloxacin and levofloxacin), and clindamycin. MRSA is suspected in the presence of several risk factors, including nosocomial or health care-associated infection, previous MRSA infection or colonization, recent exposure to antimicrobial agents, and abscesses.

Vancomycin has been considered for decades as the drug of choice for ABSSSI caused by MRSA. In two European surveys documenting the choices of antibiotics for the treatment of ABSSSI, vancomycin was found to be the most used antimicrobial in both 2010 and 2015. Various studies, however, have now highlighted that vancomycin presents several limitations in the treatment of MRSA. First, a progressive increase in vancomycin minimum inhibitory concentrations (MICs) over the years was observed in *S. aureus* and was associated with less favorable clinical outcomes compared to isolates with MIC below 1 mg/L. Second, a decreased efficacy of vancomycin has been documented in severe infections caused by MSSA compared to MRSA. Third, in order to achieve adequate plasmatic concentrations, therapeutic drug monitoring is needed to minimize the risk of nephrotoxicity.

Several novel therapeutic options have become available for the treatment of ABSSSI caused by MDR bacteria, including strains with increased vancomycin MICs (Table 1).

Data on the efficacy of new agents for ABSSSI are mainly derived from noninferiority trials and do not directly compare the efficacy of newer compounds. Nevertheless, several characteristics of newly studied molecules appear promising for ABSSSI treatment, including wide spectrum of action, favorable pharmacokinetics (PK) and pharmacodynamics, and high tolerability.

Characteristics and limitations of the molecules that are currently available and under investigation for the treatment of ABSSSI are reported in Table 1.

### Table 1 Characteristics of antimicrobials that are available or in late stage of development for the treatment of ABSSSI

<table>
<thead>
<tr>
<th>Bactericidal activity</th>
<th>Prolonged half-life</th>
<th>MRSA activity</th>
<th>Equal activity on MRSA and MSSA</th>
<th>Oral and IV formulation</th>
<th>Gram-negative activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal drug</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Available for use</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Oxacillin</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Limited</td>
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<tr>
<td>Moxifloxacin</td>
<td>Yes</td>
<td>Yes (OD)</td>
<td>No</td>
<td>Yes</td>
<td>Moderate</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Moderate</td>
</tr>
<tr>
<td>Trimethoprim/sulfamethoxazole</td>
<td>Yes</td>
<td>No</td>
<td>Yes/No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>Yes</td>
<td>No</td>
<td>Yes/No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Daptomycin</td>
<td>Yes</td>
<td>Yes (OD)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tigecycline</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Linezolid</td>
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<td>Yes</td>
<td>No</td>
</tr>
<tr>
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<td>No</td>
<td>Yes</td>
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<td>No</td>
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<tr>
<td>Dalbavancin</td>
<td>Yes</td>
<td>Yes (OW)</td>
<td>Yes</td>
<td>No</td>
<td>Moderate</td>
</tr>
<tr>
<td>Oritavancin</td>
<td>Yes</td>
<td>Yes (OW)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Tedizolid</td>
<td>No</td>
<td>Yes (OD)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Phase III trials completed</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Telavancin</td>
<td>Yes</td>
<td>Yes (OD)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Delafloxacin</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Abbreviations:** ABSSSI, acute bacterial skin and skin structure infections; MRSA, methicillin-resistant *Staphylococcus aureus*; MSSA, methicillin-susceptible *Staphylococcus aureus*; OD, once daily; OW, once weekly.
Delafloxacin
Newer quinolones and delafloxacin

Delafloxacin belongs to the quinolone class of antibiotics, synthetic antimicrobials developed in the 1960s. The quinolones exert their activity by generating a complex between a DNA molecule and two enzymes (e.g., DNA gyrase and topoisomerase IV), thus inhibiting bacterial DNA supercoiling and synthesis.22,23 Since the discovery of nalidixic acid, the first quinolone agent produced, several new agents have been manufactured by alteration of the bicyclic quinolone ring. Specifically, the addition of fluorine to the chemical structure led to the generation of the widely used fluoroquinolones (e.g., ciprofloxacin, levofloxacin, moxifloxacin, and so on), characterized by a wider antibacterial spectrum compared to the first generation of quinolones.24 Resistance to ciprofloxacin and levofloxacin, however, has developed starting from the 1990s, especially among gram-negative bacteria, thus becoming a prevalent clinical issue that is threatening the efficacy of these drugs.25 Studies analyzing the relationship between quinolone prevalence and drug resistance in clinical isolates have shown that the first generation of quinolones is effective against a wide range of pathogens, including both gram-positive and gram-negative bacteria.26

Newer quinolones such as delafloxacin have been developed to overcome the limitations of the first generation of quinolones. Delafloxacin displays a broad spectrum of activity against a variety of gram-positive pathogens, including MSSA, MRSA, Streplococcus pyogenes, and enterococci.31 Against quinolone-susceptible Streptococcus pneumoniae, delafloxacin showed MIC$_{90}$ of 0.015 μg/mL and was 32-, 64-, and 128-fold more effective than moxifloxacin, levofloxacin, and ciprofloxacin, respectively. Against quinolone-resistant strains of S. pneumoniae, the MIC$_{90}$ of delafloxacin was 0.12 μg/mL compared to MIC$_{90}$ of 8, 16, and 64 μg/mL for trovafloxacin, levofloxacin, and ciprofloxacin, respectively.31

Here, we review the characteristics and potential use of delafloxacin in clinical practice.

Chemical structure and properties

Delafloxacin has a molecular weight of 440.763 g/mol and presents a larger molecular surface compared to other quinolones due to a heteroaromatic substitution at N-1. Delafloxacin presents a weak acid character caused by the absence of the strongly basic C-7 group that is typical of the quinolone structure. Furthermore, this molecule is characterized by a strong electron-withdrawing effect on the aromatic ring due to the presence of a chlorine atom at C-8 position. Delafloxacin has an excellent in vitro activity against staphylococci, showing MIC$_{90}$ ranging from 0.12 to 0.5 μg/mL for MRSA and 0.25 μg/mL for coagulase-negative staphylococci.32,33 Compared with moxifloxacin, delafloxacin showed superiority toward both levofloxacin-susceptible and levofloxacin-resistant MRSA strains. The in vitro activity of delafloxacin compared to levofloxacin and ciprofloxacin was recently reported from two global Phase III studies investigating 685 S. aureus isolates. According to Clinical and Laboratory Standards Institute breakpoints, 34% of S. aureus isolates were levofloxacin resistant. The delafloxacin MIC$_{90}$ value against levofloxacin-non-susceptible S. aureus, MRSA, and MSSA isolates was 0.25 μg/mL.34

Delafloxacin was more active than other quinolones against quinolone-susceptible enterococci, showing MIC$_{90}$ for Enterococcus faecalis of 0.03 μg/mL and an MIC$_{50}$ for Enterococcus faecium of 0.25 μg/mL.31

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Figure I Chemical structure of delafloxacin. Notes: Three characteristics differentiate delafloxacin from other quinolones: 1) the lack of a protonatable substituent group in position 7 that confers a weak acid character to the molecule; 2) the presence of a chlorine atom in position 8 that reduces the reactivity of the heterocycle, stabilizing the molecule; and 3) the aromatic ring attached to N1 that increases the surface of the molecule.
Against quinolone-susceptible Enterobacteriaceae, delafloxacin showed comparable activity to levofloxacin and ciprofloxacin, while increased activity was shown against quinolone-resistant strains of *Haemophilus influenzae*, *Moraxella catarrhalis*, *Legionella* spp., *Pseudomonas aeruginosa*, and *Helicobacter pylori.*

Delafloxacin is active against microorganisms responsible for sexually transmitted diseases, such as *Chlamydia trachomatis*, *Ureaplasma urealyticum*, and *Mycoplasma hominis*. Low MICs have also been shown against *Neisseria gonorrhoeae*, including ciprofloxacin-resistant strains.

**Delafloxacin activity in acidic environments and on biofilm**

In acidic environments, the activity of delafloxacin appears enhanced. In a study including 35 strains of *S. aureus* with clinically relevant resistance mechanisms, delafloxacin showed significantly lower MICs (3–5 log₂ dilutions) compared to moxifloxacin. Delafloxacin's superiority was further enhanced at lower pH (pH 5.5) with the MIC decreasing by 5 log₂ dilutions. Compared to moxifloxacin, whose activity is enhanced at lower pH (pH 5.5) with the MIC decreasing by 5 log₂ dilutions. Compared to moxifloxacin, whose activity is reduced by the acidic pH present in vacuolar subcellular compartments, accumulation of delafloxacin increased 10-fold in bacteria and at an intracellular level. These data support the use of delafloxacin for the treatment of staphylococcal infections in acidic environments such as biofilm-associated infections and abscesses. In these environments, antibiotics have usually reduced activity. Delafloxacin use could be promising in other environments characterized by acidic pH, such as skin and urinary infections.

Against the strains of Enterobacteriaceae collected from patients with urinary tract infection with pH of 6.5 or less, MICs of delafloxacin were 2- to 5-fold lower than those of ciprofloxacin.

Besides its direct antibacterial effect, the inhibition of *S. aureus* biofilm production has also been documented. Due to the acidic environment within biofilms, delafloxacin activity can be enhanced, such that it shows superiority compared to other compounds and similar activity of that of daptomycin. Delafloxacin was able to reduce bacterial viability of over 50% against both MSSA and MRSA, was able to decrease biofilm depth, and appeared more potent compared to daptomycin against MRSA strains.

**Delafloxacin PK**

Hoover et al summarized the pharmacokinetic properties, safety, and tolerability of single and multiple doses of IV delafloxacin through three Phase I clinical trials, including two randomized, double-blind, placebo-controlled studies and one open-label, randomized, crossover study. In the first study, single ascending doses of IV delafloxacin (from 300 to 1200 mg) were administered to 62 healthy volunteers (52 active, 10 placebo). In the second study, IV delafloxacin was given to 12 healthy volunteers (8 active, 4 placebo) as a single dose of 300 mg on day 1, followed by twice-daily dosing on day 2 through day 14. In the third two-period, two-sequence study, 56 healthy volunteers were randomly assigned to one of two sequences of a single oral dose of delafloxacin (450 mg tablet) or IV delafloxacin (300 mg) in order to determine the absolute bioavailability of the oral formulation of delafloxacin.

Overall, the three studies encompassed 94 healthy volunteers and showed that delafloxacin’s half-life ranged from 8.2 to 17.7 hours (with a mean half-life of 12 hours) and had a dose-independent volume of distribution (Vₚ) of ~35 L (range, 30.2–38.5 L). Delafloxacin Cₘₚₚ and area under the concentration–time curve (AUC) values increased proportionally and more than proportionally with increasing doses, respectively.

Accumulation of delafloxacin appeared minimal after multiple doses, showing an accumulation ratio of 1.09 after 14 days of twice-daily IV administration of 300 mg. Mean delafloxacin renal clearance was comparable on day 1 (14.1 L/hour) and day 14 (13.8 L/hour). Delafloxacin undergoes minimal oxidative metabolism and has a renal excretion predominantly (65%). A mass balance study using radiolabeled delafloxacin in healthy male volunteers studied the excretion of delafloxacin after a single 300 mg IV dose. Overall, 66% of the dose was recovered in the urine, mainly as unchanged delafloxacin. Approximately 29% was recovered in the feces due to biliary excretion and/or transintestinal elimination.

Delafloxacin plasma protein binding (mainly albumin) was ~84% and was not significantly affected by renal impairment. A double-blind, placebo-controlled, Phase I clinical trial investigated the effect of sex and age on delafloxacin PK. The results showed that delafloxacin PK was comparable in men and women, while significantly higher Cₘₚₚ and AUC₀–∞ were observed in elderly compared to younger patients, probably due to different creatinine clearance values among groups.

Renal impairment appeared to significantly affect delafloxacin clearance. A dosage reduction to 200 mg IV every 12 hours is recommended in the presence of severe renal impairment (creatinine clearance <30 mL/min).

A Phase I, open-label study investigated the PK and safety of a single IV dose of 300 mg delafloxacin in 18 subjects with...
mild, moderate, and severe hepatic impairment (Child–Pugh class A, B, and C, respectively) compared with 18 healthy controls. 

Mean delafloxacin AUC$_{0-\infty}$, $C_{\text{max}}$, exposure, and clearance among patients with liver impairment did not significantly differ from the healthy subjects. Based on these data, dose adjustment of delafloxacin in patients with hepatic impairment is not needed.

**Delafloxacin drug–drug interactions**

In vitro studies confirmed that delafloxacin does not exert inhibitory effects on hepatic enzymes, except for a mild induction of CYP3A4 enzymes. A Phase I study enrolling 22 healthy subjects investigated the clinical relevance of delafloxacin drug interactions on CYP3A4. Two doses of midazolam were administered in the absence and after 6 days of delafloxacin treatment (450 mg every 12 hours). The 24-hour AUCs of midazolam and its metabolite did not differ before and after delafloxacin administration, suggesting that delafloxacin does not have clinically relevant effects on cytochrome P450 3A4.

**Clinical efficacy**

**Animal models**

Studies on animal models identified the AUC/MIC ratio as the most reliable parameter to predict delafloxacin efficacy. 

A murine model of lung infection including MRSA, penicillin-resistant *S. pneumoniae*, and ESBL-producing *Klebsiella pneumoniae* investigated the efficacy of delafloxacin administered IV (300 mg) or orally (450 mg) twice daily. The results confirmed the efficacy of delafloxacin on resistant strains.

**Clinical studies**

Delafloxacin has been approved by the US Food and Drug Administration for the treatment of ABSSSI in June 2017. Two Phase II and two Phase III trials have analyzed the efficacy of delafloxacin vs comparators in these infections (Table 2).

A Phase II, double-blind clinical trial compared two doses of delafloxacin (300 and 450 mg IV every 12 hours) with tigecycline (100 mg IV followed by 50 mg every 12 hours) administered for 5–14 days in 150 patients with ABSSSI including cellulitis, abscesses, and wound infections. 

*S. aureus* was isolated in 86.5% of cases, of which ~70% were MRSA and 63% were levofloxacin-resistant strains. Cure rates were 94.3%, 92.5%, and 91.2% among patients treated with delafloxacin 300 mg every 12 hours, delafloxacin 450 mg every 12 hours, and tigecycline 50 mg every 12 hours, respectively.

Another Phase II trial was conducted in a population of 256 adult patients with ABSSSI including cellulitis (45%), abscesses (28.5%), wound infections (25%), and burns (1.5%) to evaluate the efficacy of IV delafloxacin compared to linezolid and vancomycin. Delafloxacin cure rate was 70.4% and was comparable to linezolid (64.9%) and significantly higher than vancomycin (54.1%, p=0.03). Clinical cure rates were similar in the group of patients with MRSA infections, while higher cure rates were achieved by delafloxacin among patients with body mass index ≥30 kg/m$^2$.

Two Phase III studies, defined as PROCEED, encompassing 660 and 860 patients with ABSSSI and comparing delafloxacin with vancomycin plus aztreonam have been recently conducted. The studies analyzed the efficacy and microbiological response of delafloxacin among subjects with various infections including resistant *S. aureus* and gram-negative pathogens. Patients received delafloxacin 300 mg IV every 12 hours or delafloxacin 300 mg IV every 12 hours for 3 days with a mandatory blinded switch to oral delafloxacin 450 mg every 12 hours or vancomycin 15 mg/kg IV with aztreonam between 5 and 14 days. In both studies, the primary European Medicines Agency (EMA) endpoint was the reduction of lesion size in the first 48–72 hours and the clinical response

<table>
<thead>
<tr>
<th>Study type</th>
<th>Patients (n)</th>
<th>Delafloxacin arm</th>
<th>Comparator(s)</th>
<th>Outcome</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase II</td>
<td>150</td>
<td>Two IV doses (300 and 450 mg q12h)</td>
<td>Tigecycline (100 mg first dose, then 50 mg q12h)</td>
<td>Cure rates: 94.3% delafloxacin 300 mg, 92.5% 450 mg, 91.2% tigecycline</td>
<td>48</td>
</tr>
<tr>
<td>Phase II</td>
<td>256</td>
<td>300 mg q12h</td>
<td>Linezolid (600 mg IV q12h); vancomycin (15 mg/kg q12h)</td>
<td>Cure rates: 70.4% delafloxacin, 64.9% linezolid, 54.1% vancomycin</td>
<td>49</td>
</tr>
<tr>
<td>Phase III</td>
<td>660</td>
<td>300 mg q12h</td>
<td>Vancomycin (15 mg/kg q12h) ± aztreonam</td>
<td>Objective response: 78.2% delafloxacin, 80.9% vancomycin/aztreonam</td>
<td>57</td>
</tr>
</tbody>
</table>

**Abbreviations:** ABSSSI, acute bacterial skin and skin structure infections; IV, intravenous; q12h, every 12 hours.
at 28 days. Evaluation of outcomes occurred at 14 and 21–28 days (late follow-up). Compared to the combination of vancomycin plus aztreonam, delafloxacin demonstrated noninferiority in reducing lesion size at the primary infection site at 48–72 hours. Delafloxacin showed noninferiority on assessment of signs and symptoms of infection at the follow-up visit. The outcome of delafloxacin treatment in patients with ABSSSI due to gram-negative pathogens (97 patients, 19%) has been recently reported. K pneumoniae was the most frequent gram-negative isolate (MIC\textsubscript{50}, MIC\textsubscript{90}, and MIC ranges were 0.12, 0.25, and 0.03–4 μg/mL, respectively). Clinical response rates among patients treated with delafloxacin compared to vancomycin/aztreonam at 48–72 hours, day 14, and day 21–28 were 85.6% vs 88.3%, 98.7% vs 97.6%, and 97.3% vs 97.4%, respectively. Among gram-positive infections (n=987), objective response rates at 48–72 hours, day 14, and day 21–28 were 87.9% vs 87%, 97.9% vs 98.1%, and 97.2% vs 97.5% in the delafloxacin and comparator arms, respectively. Microbiological eradication rates for infections due to MRSA were 98.1% and 98.0% for patients treated with delafloxacin and vancomycin, respectively.

Delafloxacin is also under investigation for respiratory infections. A Phase II trial in acute exacerbation of COPD demonstrated comparable efficacy to levofloxacin. Delafloxacin is currently being studied in CA pneumonia in comparison to moxifloxacin.

**Delafloxacin safety**

Phase I studies have shown that the occurrence of adverse effects (AEs) is associated with delafloxacin dose. In the dose escalation study, IV delafloxacin doses of 800 mg or more were associated with adverse reactions in over 50% of the participants. AEs were mainly gastrointestinal (e.g., diarrhea). Oral administration of delafloxacin, however, was well tolerated across the dose range (from 50 to 1600 mg).

In the Phase II trial comparing two doses of delafloxacin and tigecycline in ABSSSI, the administration of IV delafloxacin 300 mg every 12 hours was not associated with significant drug toxicity. AEs, mainly nausea and IV infusion-related effects, were more frequent among patients receiving tigecycline and high delafloxacin dose (450 mg every 12 hours). In this study, delafloxacin appeared to be associated with a decrease in glucose plasma levels, although this AE has not been confirmed by other trials.

In the comparative study of delafloxacin, linezolid, and vancomycin in treating ABSSSI, the highest number of AEs was reported in the delafloxacin arm (74.4% compared to 72% for linezolid and 64.6% for vancomycin). Nausea was the most frequent AE. Two cases of elevation of the alanine transaminase and aspartate transaminase levels were reported (one in the delafloxacin and the other in the vancomycin group).

Delafloxacin showed a similar tolerability profile to vancomycin/aztreonam in patients with ABSSSI according to the two recent registrational Phase III trials. Rates of treatment-emergent AEs were similar in patients receiving delafloxacin to those receiving vancomycin/aztreonam (47.7% vs 45.1%, respectively). Gastrointestinal-related events including nausea (4.3% vs 6.1%, respectively) and diarrhea (2.0% vs 6.1%, respectively) were the most common treatment-emergent AEs reported. Discontinuation of treatment was reported in 2.4% of patients receiving vancomycin/aztreonam and in 0.8% of patients receiving delafloxacin. Serious AEs were similar in the delafloxacin and vancomycin/aztreonam groups (3.6% vs 3.5%, respectively). No treatment-related deaths were reported in the studies.

To date, no safety study has reported cases of Clostridium difficile diarrhea associated with delafloxacin use. This could be related to delafloxacin activity against anaerobes, showing MICs below 0.015 g/mL against C difficile. No AEs at the level of central nervous system, tendons muscles, joints, and nerves have been reported. No clinically relevant phototoxicity has been demonstrated for delafloxacin.

A randomized, double-blind, placebo-controlled, four-period, crossover study in 52 healthy adults assessed the effect of delafloxacin administered at 300 and 900 mg IV compared to moxifloxacin on the corrected QT interval. No positive relationship between delafloxacin plasma concentrations and corrected QT was demonstrated.

**Delafloxacin use in clinical practice**

Similar to other fluoroquinolones, delafloxacin presents favorable PK/pharmacodynamics characteristics (e.g., high volume of distribution, good bioavailability) along with a bactericidal activity against both gram-positive and gram-negative pathogens, representing an attractive option for use in clinical practice.

Unique characteristics of delafloxacin include an extended spectrum of activity against MRSA and anaerobes, the enhanced activity in acidic environments, and a favorable tolerability profile demonstrated in clinical trials (Table 3).

**Delafloxacin in ABSSSI**

Delafloxacin represents a promising option in the empirical and targeted treatment of ABSSSI, including cellulitis, skin
Table 3 Delafloxacin unique characteristics compared to older quinolones

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Potential effect in clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak acid character</td>
<td>Enhanced activity in low pH environments including inflammatory cells and infected tissues such as biofilm-associated infections, abscesses, skin and urinary infections</td>
</tr>
<tr>
<td>Dual target (gyrase and topoisomerase IV)</td>
<td>Broader spectrum of action (gram-positive and gram-negative bacteria) and reduced selection of resistance</td>
</tr>
<tr>
<td>In vitro activity against MRSA, fluoroquinolone-resistant gram-negative anaerobes</td>
<td>Empirical and targeted use in ABSSSI and potential use in other infections (e.g., respiratory infections, intra-abdominal infections, urinary tract infections)</td>
</tr>
<tr>
<td>Mild CYP3A4 induction</td>
<td>No clinically relevant drug–drug interactions</td>
</tr>
<tr>
<td>Favorable safety profile in clinical trials</td>
<td>Potential use in infections requiring prolonged treatment (e.g., &gt;2 weeks)</td>
</tr>
</tbody>
</table>

Abbreviations: ABSSSI, acute bacterial skin and skin structure infections; CYP, cytochrome P450; MRSA, methicillin-resistant Staphylococcus aureus.

Delafloxacin in ABSSSI

Delafloxacin is a new quinolone characterized by a broad spectrum of activity against gram-positive pathogens, such as MRSA, and gram-negative bacteria including quinolone-resistant Escherichia coli and K. pneumoniae. Delafloxacin has the potential to be used in sequential therapy due to the availability of an oral formulation. Clinical studies have demonstrated excellent results in the treatment of ABSSSI against heterogeneous bacterial populations, showing similar efficacy to comparators such as vancomycin, linezolid, and tigecycline. New studies are ongoing to support the use of delafloxacin in various infections, while real-world data are awaited to consolidate delafloxacin use as the empirical and targeted therapy of ABSSSI, both in the community and in nosocomial settings.

Conclusion

High pulmonary diffusion (including high penetration in the epithelial lining fluid) along with delafloxacin increased efficacy against MRSA and anaerobes justify its use in respiratory infections, including nosocomial pneumonia and pulmonary abscesses. So far, delafloxacin has been successful in treating COPD exacerbations in comparison with levofloxacin and is currently being tested in CA pneumonia with moxifloxacin or linezolid as comparators.54,55

Delafloxacin use in other infections

The high concentration of quinolones in the urinary tract and prostate tissue makes delafloxacin a potential option for sequential therapy of complicated urinary tract infections and prostatitis, which may require prolonged treatment.64

Conclusion

Delafloxacin is a new quinolone characterized by a broad spectrum of activity against gram-positive pathogens, such as MRSA, and gram-negative bacteria including quinolone-resistant Escherichia coli and K. pneumoniae. Delafloxacin has the potential to be used in sequential therapy due to the availability of an oral formulation. Clinical studies have demonstrated excellent results in the treatment of ABSSSI against heterogeneous bacterial populations, showing similar efficacy to comparators such as vancomycin, linezolid, and tigecycline. New studies are ongoing to support the use of delafloxacin in various infections, while real-world data are awaited to consolidate delafloxacin use as the empirical and targeted therapy of ABSSSI, both in the community and in nosocomial settings.

Disclosure

The authors report no conflicts of interest in this work.
References


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