

Activity of Eravacycline and Comparators against 6,380 Pathogens Isolated from Canadian Hospitals: CANWARD 2014 and 2015

G.G. ZHANEL¹, H. ADAM^{1,2}, M. BAXTER¹, B. WESHNOWESKI², R. VASHISHT¹, S. BIJU¹, A. GOLDEN¹, A. DENISUIK¹, A. WALKTY², P. LAGACÉ-WIENS^{1,2}, J.A. KARLOWSKY^{1,2} and D.J. HOBAN^{1,2}
¹University of Manitoba and ²Health Sciences Centre, Winnipeg, Canada

ABSTRACT

Background: Eravacycline (ERV) is a novel, fully synthetic fluorocycline antibiotic of the tetracycline class with broad-spectrum activity being developed for the treatment of serious infections, including those caused by multidrug-resistant (MDR) pathogens. The activity of this synthetic fluorocycline was compared to a variety of comparators including meropenem (MER) and piperacillin-tazobactam (PTZ) against Gram-negative and Gram-positive pathogens causing infections in Canadian hospitals. Methods: From January 2014 - October 2015, inclusive, 13 sentinel hospitals submitted pathogens from patients attending hospital clinics, emergency rooms, medical and surgical wards, and intensive care units as part of an ongoing national surveillance program in Canadian hospitals. 6,380 total isolates were collected for 2014 and 2015. Susceptibility testing was performed using CLSI broth microdilution methods. Results: The activity (µg/mL) of ERV, MER and PTZ against select pathogens is described below:

Table with 4 columns: Organism (# isolates), ERV MIC50/MIC90, MER MIC50/MIC90, PTZ MIC50/MIC90. Lists various organisms like S. agalactiae, S. pneumoniae, etc.

Conclusions: Eravacycline displayed broad-spectrum activity against recent pathogens from Canadian hospitals including MRSA, VRE, ESBL-producing Enterobacteriaceae and A. baumannii.

INTRODUCTION

Eravacycline is a synthetic, broad-spectrum intravenous and oral fluorocycline antibiotic for the treatment of multidrug-resistant infections [1]. It has completed enrollment in Phase 3 clinical trials for the treatment of complicated urinary tract infections (cUTI) and complicated intra-abdominal infections (cIAI) [1,2]. The activity of eravacycline was compared to comparators, including meropenem (MER) and piperacillin-tazobactam (PTZ) against Gram-negative and Gram-positive pathogens causing infections in Canadian hospitals.

PURPOSE

To determine the in vitro activity of eravacycline along with comparators versus Gram-negative and Gram-positive pathogens isolated from patients in Canadian hospitals from January 2014 to October 2015.

MATERIALS & METHODS

Study Background and Bacterial Isolates

The isolates tested in this study were obtained from January 2014 to October 2015, inclusive, from an ongoing cross-Canada surveillance study (CANWARD; www.can-r.ca) organized by the investigators [3]. The goal of the CANWARD study was to assess pathogens and antimicrobial resistance patterns associated with lower respiratory tract, skin/skin structure, urinary, and bacteremic infections in Canadian patients on medical wards, surgical wards, intensive care units, and presenting to emergency rooms and hospital clinics [3]. In CANWARD 2014 and 2015, 13 sentinel hospital sites in Canada were recruited. These centres were in major population centres in 8 of the 10 provinces in Canada. These sites were geographically distributed in a population based fashion: (British Columbia [1 site], Alberta [1 site], Saskatchewan [1 site], Manitoba [1 site], Ontario [4 sites in 2014, 3 sites in 2015], Quebec [3 sites in 2014, 4 sites in 2015], Maritimes [2 sites]).

All isolates of MRSA were typed using staphylococcal protein A (spa) typing to assess whether the isolates were community-associated or healthcare-associated [3]. Isolates with a spa type associated with CMRSA7 or CMRSA10 were considered CA-MRSA. Isolates with a spa type associated with CMRSA1, CMRSA2, CMRSA4, CMRSA5, CMRSA3/6, CMRSA8 or CMRSA9 were considered HA-MRSA [3].

Potential E. coli or Klebsiella spp. ESBL-producers were identified as isolates with a ceftriaxone and/or ceftazidime MIC of 1 µg/mL or greater and confirmed using the CLSI double disk diffusion method, as previously described [3].

Antimicrobial Susceptibility Testing Methodology Isolates were tested for antimicrobial susceptibilities using in-house prepared (Department of Clinical Microbiology, Health Sciences Centre, Winnipeg, Canada) 96-well broth microdilution panels according to CLSI (2015) guidelines [3,4]. The antimicrobial agents tested were obtained as laboratory grade powders from their respective manufacturers.

Stock solutions were prepared and dilutions made, as described by the CLSI [4] in cation-adjusted Mueller-Hinton broth (MHB). Following 2 subcultures from frozen stock, the MICs of the antimicrobial agents for the isolates were determined by the CLSI broth microdilution method. Colony counts were performed periodically to confirm inocula. Quality control was performed using ATCC organisms including: S. aureus ATCC 29213, E. faecalis ATCC 29212, E. coli ATCC 25922, and P. aeruginosa ATCC 27853.

CONCLUSIONS

- Eravacycline demonstrated in vitro activity versus Gram-negative bacilli.
Eravacycline demonstrated potent in vitro activity against Enterobacteriaceae including ESBL-producing E. coli and K. pneumoniae and its activity was unaffected by the presence of ESBL phenotype.
Compared to tigecycline, eravacycline was 4 fold more active versus P. mirabilis and 4 fold more active versus Acinetobacter baumannii.
Eravacycline demonstrated potent in vitro activity against Stenotrophomonas maltophilia.
Eravacycline was the most potent agent versus Gram-positive cocci.
Eravacycline demonstrated potent in vitro activity against MSSA and MRSA, including both CA-MRSA and HA-MRSA.
Eravacycline demonstrated potent in vitro activity against all streptococci.
Eravacycline demonstrated potent in vitro activity against E. faecalis and E. faecium, including VRE.

ACKNOWLEDGMENTS

The authors would like to thank the participating centres, investigators and laboratory site staff for their support. Financial support for the CANWARD study was provided in part by the University of Manitoba, National Microbiology Laboratory and Tetraphase Inc.

Bacterial Isolates Collected

- 6,380 clinical isolates were collected for CANWARD 2014 and 2015.
2546 (39.9%) were from blood, 2554 (40.0%) from respiratory sources, 646 (10.1%) were from urine, and 634 (10.0%) were from wounds
3513 (55.1%) collected from male patients; 2866 (44.9%) female patients (1 isolate unknown: 0.02%)
887 (13.9%) from patients ≤ 17 years of age, 2694 (42.2%) 18-64 years, and 2798 (43.9%) ≥ 65 years (1 isolate unknown: 0.02%)
2098 (32.9%) were from patients on medical wards, 1447 (22.7%) from emergency rooms, 1151 (18.0%) from intensive care units, 1203 (18.9%) from hospital clinics, and 481 (7.5%) from surgical wards
5,644 Gram-negative and Gram-positive pathogens were tested with eravacycline and the results are listed below:

Table 1. In vitro activities of eravacycline and comparators versus Gram-negative bacilli

Large table with 7 columns: Organism (no. tested)/antimicrobial agent, MIC (µg/mL) 50%, 90%, Range, % S, % I, % R. Includes organisms like Escherichia coli, Klebsiella pneumoniae, etc.

RESULTS

Table 2. In vitro activities of eravacycline and comparators versus Gram-positive cocci

Large table with 7 columns: Organism (no. tested)/antimicrobial agent, MIC (µg/mL) 50%, 90%, Range, % S, % I, % R. Includes organisms like Staphylococcus aureus, Enterococcus faecium, etc.

CA-MRSA – community associated MRSA; HA-MRSA – healthcare associated MRSA; VRE – vancomycin resistant enterococcus. NA – not applicable. Interpretive breakpoints defined by FDA (tigecycline) where applicable.

Table 3. Distribution of eravacycline MICs versus Gram-negative organisms

Table with 2 columns: Organism agent, Number of isolates for which the eravacycline MIC (µg/mL) was: ≤0.015, 0.03, 0.06, 0.12, 0.25, 0.5, 1, 2, 4, 8, 16, 32, ≥64.

Table 4. Distribution of eravacycline MICs versus Gram-positive organisms

Table with 2 columns: Organism agent, Number of isolates for which the eravacycline MIC (µg/mL) was: ≤0.015, 0.03, 0.06, 0.12, 0.25, 0.5, 1, 2, 4, 8, 16, 32, ≥64.

REFERENCES

- Zhanel GG, Cheung D, Adam H, Zelenitsky S, Golden A, Schweizer F, Gorityala B, Lagace-Wiens PR, Walky A, Gin AS, Hoban DJ and Karlowsky JA. Review of eravacycline: A novel fluorocycline antibacterial agents. Drugs 2016 Apr;76(5):567-88.
Solomkin JS, Ramesh MK, CNSaunas G, Novikov N, Stefanova P, Sutcliffe JK, Walpole SM, Horn PT. Phase 2, randomized, double-blind study of the efficacy and safety of two dose regimens of eravacycline versus etrapenem for adult community-acquired complicated intra-abdominal infections. Antimicrob Agents Chemother. 2014;58(4):1847-54.
Zhanel GG, Adam HJ, Baxter MR, Fuller J, Nichol KA, Denisuk AJ, Lagace-Wiens PR, Walky A, Karlowsky JA, Schweizer F, Hoban DJ and the Canadian Antimicrobial Resistance Alliance (CARA). Antimicrobial Susceptibility of 22,746 Pathogens from Canadian Hospitals: Results of the CANWARD 2007-2011 Study. Journal of Antimicrobial Chemotherapy 2013;68(Suppl 1):7-22.
Clinical and Laboratory Standards Institute (CLSI). Methods for Dilution Antimicrobial Susceptibility Tests for Bacteria that Grow Aerobically – Ninth Edition: Approved Standard M07-A10. Wayne, PA: CLSI; 2015.