A Randomized, Double-Blind Phase 2 Study Comparing the Efficacy and Safety of an Oral Fusidic Acid Loading-Dose Regimen to Oral Linezolid for the Treatment of Acute Bacterial Skin and Skin Structure Infections

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Fusidic acid (CEM-102), an orally bioavailable fusidane antibiotic with a unique mode of action, is under development for treatment of acute gram-positive bacterial skin and skin structure infections, including those caused by methicillin-susceptible and methicillin-resistant Staphylococcus aureus and streptococci. A phase 2, adaptive design, randomized, double-blind, multiple-center study of 198 adult patients with cellulitis or wound infections was conducted to evaluate an oral CEM-102 loading-dose regimen (1500 mg twice per day on day 1 followed by 600 mg twice per day) compared with oral linezolid (600 mg twice per day) administered for 10–14 days. The CEM-102 loading-dose regimen demonstrated efficacy, safety, and tolerability that was comparable to linezolid for the treatment of acute gram-positive bacterial skin and skin structure infections.

Clinical Trials registration. NCT00948142.

Acute bacterial skin and skin structure infections (ABSSSI) are common and range in severity from simple cutaneous abscesses and impetigo, which may be treated with local measures alone, to more serious and extensive infections that require systemic antibacterial therapy, sometimes combined with significant surgical intervention. These infections are frequently caused by gram-positive bacteria—in particular Staphylococcus aureus, Streptococcus pyogenes, and other β-hemolytic streptococci [1].

S. aureus strains with a variety of antibiotic-resistance features have been isolated throughout the antimicrobial era, with resistance to penicillin first reported in 1942 [2] and to methicillin in 1961 [3]. Methicillin-resistant S. aureus (MRSA) is now commonly isolated in acute bacterial skin and skin structure infections originating in both health care settings and, more recently, community settings [4, 5, 6, 7]. The evolving and variable resistance patterns in these pathogens limit treatment options and can present considerable challenges in the successful management of these infections [8]. Additional treatment options—in particular, orally bioavailable agents—are needed for safe and successful treatment of patients with ABSSSI.

Fusidic acid (CEM-102) is an orally bioavailable fusidane antibiotic with a unique mode of action relative to all other currently available agents [9]. Despite the use of fusidic acid for decades outside of the United States, contemporary global surveillance studies demonstrate its continued in vitro activity against the gram-positive pathogens that cause ABSSSI [10].

A phase 2, adaptive design, randomized, double-blind, multiple-center study was conducted to evaluate the efficacy, safety, and tolerability of an oral
CEM-102 loading dose regimen recommended by pharmacokinetic (PK)/pharmacodynamic (PD) modeling [11] versus oral linezolid, each administered for 10–14 days for the treatment of gram-positive ABSSSI, including those caused by methicillin-susceptible \textit{S. aureus} (MSSA), MRSA, and streptococci.

**PATIENTS, MATERIALS, AND METHODS**

This clinical study was conducted at 16 centers in the United States from August 2009 through March 2010, enrolling 198 patients.

**Patient Population**

Eligible patients were adult men or nonpregnant women aged \( \geq 18 \) years with ABSSSI of \(< 7 \) days duration that was suspected or proven to be caused, at least in part, by a gram-positive pathogen. Eligible ABSSSI included cellulitis (measuring at least 10 cm length and width or 100 cm\(^2\)), with or without a focal abscess, and surgical or traumatic wound infections, all expected to require 10–14 days of systemic antibacterial therapy. Patients were required to have at least 3 of the following local and/or systemic symptoms and/or signs of infection: purulent or seropurulent drainage and/or discharge, erythema, fluctuance, heat and/or localized warmth, pain and/or tenderness to palpation, swelling and/or induration, regional lymph node swelling or tenderness, temperature \( \geq 138^\circ \text{C} \), increased white blood cell count, or bandemia.

Patients were excluded if they had superficial (eg, impetigo) or minor infections; had involvement of human or animal bites, burns, or chronic diabetic foot ulcers; had suspected polymicrobial infection involving \textit{Pseudomonas aeruginosa}; had significant hepatic or renal dysfunction; or had received prior potentially effective antimicrobial therapy for the ABSSSI, unless that therapy had failed after 48 h or the patient was infected with a gram-positive pathogen that was not susceptible to prior therapy identified as a causative pathogen.

**Study Design and Antibacterial Treatment**

Patients were stratified by type of infection (cellulitis vs wound) and, through the first 127 patients, were randomized in a 1:1:1 ratio to receive a CEM-102 non–loading-dose regimen (CEM-102 600 mg twice per day), a CEM-102 loading-dose regimen (CEM-102 1500 mg twice per day on Day 1 followed by 600 mg twice per day), or linezolid (600 mg twice per day), each administered orally for 10–14 days. After interim analysis of the initial 127 patients demonstrated comparable safety and tolerability of the 2 CEM-102 regimens, the CEM-102 non–loading-dose regimen was dropped in favor of the loading dose regimen, as supported by PK/PD modeling; the remaining patients were randomized in a 1:1 ratio to receive the CEM-102 loading-dose regimen or the linezolid regimen.

All patients received active and placebo study medication prepackaged in 7-day supply blister packs. The 300-mg CEM-102 tablets and CEM-102 placebo tablets were similar in appearance and weight, as were the 600-mg linezolid tablets (Pfizer) and linezolid placebo tablets. For patients with proven or suspected polymicrobial infection, concomitant treatment with aztreonam and/or metronidazole was permitted, as administered by the study sites per their standard practice.

**Clinical and Microbiologic Evaluations**

Clinical assessments were performed at baseline, Day 3, Day 7, Day 10, end-of-therapy (EOT; within 2 days of completion of study medication administration), and test-of-cure (TOC; 7–14 days after EOT). A late follow-up contact was conducted by telephone, unless a clinic follow-up was indicated by the patient’s status (LFU; 7–21 days after TOC and \( \geq 30 \) days after the first dose of study medication). At study visits, the Investigator assessed signs and symptoms and photographed the infection site, recorded measures of surface inflammation, performed physical examinations, reviewed adverse events and the use of concomitant medications, and (at pre-specified visits) obtained laboratory and electrocardiographic data for safety assessments. Infection site specimens were obtained at baseline for Gram stain, culture, and susceptibility testing, as were blood specimens, with subsequent specimens obtained as clinically indicated. All gram-positive pathogens were sent to a central laboratory (JMI Laboratories, North Liberty, IA) for confirmation of genus and species and determination of susceptibility to CEM-102, linezolid, and a panel of other gram-positive antibacterial drugs.

**Analysis Populations**

The 4 patient populations for efficacy analyses were intent-to-treat (ITT; all randomized patients), microbiological ITT (MITT; all ITT patients with \( \geq 1 \) gram-positive pathogen isolated at baseline), clinically evaluable (CE; ITT patients who met all enrollment criteria, received a pre-defined minimum course of study drug, and had a clinical response of cure or failure at TOC), and microbiologically evaluable (ME; CE patients with a gram-positive pathogen isolated at baseline). All patients who received at least one dose of study medication were included in the safety analysis.

**Clinical Response**

Clinical response was classified by the Investigator at Day 7, Day 10, EOT, TOC, and LFU. The co-primary end points were clinical response at TOC in the ITT and in the CE populations. Clinical success was defined as total resolution of local and systemic signs and symptoms of the ABSSSI such that no further antibiotic therapy was required. All clinical failures at the EOT
were also considered failures at the TOC. Reasons for failure included inadequate response to study medication therapy, any treatment-limiting adverse event, and all cause mortality through Day 30. Patients who did not present for evaluation at either EOT or TOC, and those who did not receive at least 3 days of study drug, were classified as indeterminate response, and their responses were included as failures in the ITT analyses.

Safety Evaluations
Safety assessments included recording of adverse events, with intensity and potential relationship to study medication, as assessed by the Investigator. Vital signs, clinical laboratory tests for hematology, chemistry, urinalysis (analyzed at a central laboratory, ACM Medical Laboratory, Rochester, New York), coagulation tests (analyzed at local laboratories), and physical examinations were performed at baseline, at pre-specified visits and as clinically indicated throughout the study. Electrocardiograph (ECG) data were recorded at baseline prior to study medication administration and on Day 3, Day 7, and EOT 3 h after the morning dose of study medication, at the expected maximum plasma concentration of CEM-102. ECG data were read in a blinded fashion in a central ECG laboratory (eResearch Technology, Philadelphia, Pennsylvania).

Statistical Analysis
This study was designed as an adaptive study that provided for transition to a phase 3 noninferiority study, of one of the CEM-102 regimens versus linezolid, if certain predictive criteria were met. Interim analyses were performed after 90, 127, and 181 patients were enrolled and evaluated for the primary outcome of clinical response at the TOC visit as well as for safety and tolerability. Bayesian analyses were used to calculate the predictive probabilities that the CEM-102 loading-dose regimen and the CEM-102 non–loading-dose regimen would be proven non-inferior to linezolid in the phase 3 study. For the Bayesian analysis, clinical response rates are not compared directly; rather, the available results for each treatment group at the interim analysis time points are used to determine the predictive probabilities. This Bayesian analysis paradigm has potential advantages, including facilitation of frequent interim analyses, without inflating the overall \( \alpha \) level, and enabling modification of the study during the conduct of the trial in response to data that arise in the trial itself. At each of the interim analyses, the criteria for dropping the CEM-102 non–loading-dose regimen were either a predictive probability of phase 3 success of < .10 or demonstration of comparable safety and tolerability for the 2 CEM-102 regimens. The criterion for terminating the phase 2 study and taking the CEM-102 loading dose to the phase 3 study was a predictive probability of phase 3 success of > .80.

Continuous data were summarized using descriptive statistics (number, mean, standard deviation, median, minimum, and maximum), and categorical data were summarized using frequency counts and percentages. For the primary efficacy outcome, 2-sided exact 95% confidence intervals were calculated for the clinical success rates in each treatment group using the Clopper-Pearson method.

RESULTS

Interim Analyses
At the 127-patient interim analysis, the CEM-102 non–loading-dose and loading dose regimens showed comparable safety and tolerability and thus the non–loading-dose treatment group was closed to further enrollment. At the 181-patient interim analysis, the predictive probability of clinical success in the CE population in phase 3 was .89, which exceeded the threshold for transitioning to the phase 3 study; therefore, when these results were available, enrollment in the phase 2 study was terminated.

Study Population and Baseline Characteristics
A total of 198 patients were randomized (ie, the ITT population), and all received \( \geq 1 \) dose of study medication; 43 patients received the CEM-102 non–loading-dose regimen before discontinuation of enrollment in that treatment group, 78 patients received the CEM-102 loading-dose regimen, and 77 patients received linezolid. The primary comparison was made between the 2 treatment groups carried forward to completion of this study: the CEM-102 loading-dose and linezolid.

These 2 treatment groups were comparable with regard to demographic characteristics, baseline characteristics (Table 1), and percentages of patients in the ITT population in the MITT, CE, and ME populations (Table 2). Comparable percentages of patients in each treatment group completed study drug therapy (CEM-102 loading-dose group, 73 [94%] of 78; linezolid group, 76 [99%] of 77). The mean duration of study drug exposure was similar in the 2 groups (CEM-102, 11.3 days; linezolid, 11.5 days).

Baseline Pathogens
Baseline cultures of specimens from the ABSSSI site identified at least 1 gram-positive pathogen in 59 (76%) of 78 patients in the CEM-102 loading-dose group and in 58 (75%) of 77 patients in the linezolid group. Of the 121 gram-positive isolates, 111 were S. aureus, including 78 MRSA isolates, whereas 10 were \( \beta \)-hemolytic streptococci (Table 3). Four patients had polymicrobial gram-positive bacterial infections, with both MSSA and streptococci isolated from the infection site at baseline. One patient had both a gram-positive and a gram-negative pathogen isolated from the ABSSSI site at baseline. Two patients had bacteremia discovered after they were receiving treatment (one with MSSA, and the other with MRSA), and both recovered rapidly.
Table 1. Demographics and Baseline Characteristics of the Intent-to-Treat Population

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>CEM-102 loading-dose group (n = 78)</th>
<th>Linezolid group (n = 77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male 56 (72)</td>
<td>Female 50 (65)</td>
</tr>
<tr>
<td>Age, years</td>
<td>Male 22 (28)</td>
<td>Female 27 (35)</td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>41.5 ± 16.7</td>
<td>40.6 ± 11.8</td>
</tr>
<tr>
<td>Range</td>
<td>18–80</td>
<td>19–74</td>
</tr>
<tr>
<td>Race</td>
<td>White 57 (73)</td>
<td>Black 55 (71)</td>
</tr>
<tr>
<td>Body mass index&gt;30 kg/m²</td>
<td>28 (36)</td>
<td>30 (39)</td>
</tr>
</tbody>
</table>

NOTE. Data are no. (%) of subjects, unless otherwise indicated. ABSSSI, acute bacterial skin and skin structure infections; SD, standard deviation.

Outcomes

The clinical success rates for the CEM-102 loading-dose regimen were comparable to those for linezolid regimen in the ITT, MITT, CE and ME populations (Table 4). Respective clinical success rates at the TOC in the CEM-102 loading-dose and linezolid treatment groups in the ITT population were 85.9% (67 of 78) and 94.8% (73 of 77); in the MITT population, they were 88.1% (52 of 59) and 93.1% (54 of 58); in the CE population, they were 92.3% (60 of 65) and 98.5% (67 of 68); and in the ME population, they were 96.0% (48 of 50) and 98.0% (48 of 49). In patients with documented S. aureus infection at baseline, clinical success rates were 96% (46 of 48) and 98% (47 of 48) in the ME population in the CEM-102 loading-dose and linezolid groups, respectively; with MRSA, the rates were 97% (30 of 31) and 100% (37 of 37), respectively. Results were similar at the EOT. In ITT patients with baseline surface area inflammation of >75 cm², comparison of baseline and Day 3 measures of surface inflammation and body temperature demonstrated a successful early clinical response as proposed by the recent US Food and Drug Administration draft guidance for studies of ABSSSI [12] in 60 (95%) of 63 patients in the CEM-102 group and 63 (97%) of 65 in the linezolid group.

No patient who experienced treatment failure in either treatment group had evidence of decreased susceptibility of the causative pathogen after therapy to either sodium fusidate or linezolid. One patient in the CEM-102 group with a successfully treated lower extremity wound infection with surrounding cellulitis had superficial swab specimens for culture before and during therapy demonstrating MSSA, with an increase in sodium fusidate minimum inhibitory concentration (MIC) from 0.12 μg/mL at baseline to 8 μg/mL on treatment Day 11 of 14. The MSSA isolates appeared to be genetically related, showing great similarity by pulsed-field gel electrophoresis, by automated ribotyping (Riboprinter Microbial Characterization System; Qualicon), and by single locus (spa) typing. The latter isolate demonstrated a significant decrease in fitness in laboratory studies exhibited by failure to reach log phase growth after 10 h of incubation, compared with a mass doubling time of 90 min in the pretreatment strain, and displayed a mutation on fusiE that generated a stop codon in the L6 protein. The clinical relevance,

Table 2. Study Populations

<table>
<thead>
<tr>
<th>Population</th>
<th>No. (%) of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CEM-102 loading-dose group (n = 78)</td>
</tr>
<tr>
<td>Intent-to-treat and safety</td>
<td>78 (100)</td>
</tr>
<tr>
<td>Microbiological intent-to-treata</td>
<td>59 (76)</td>
</tr>
<tr>
<td>Clinically evaluableb</td>
<td>65 (83)</td>
</tr>
<tr>
<td>Microbiologically evaluablec</td>
<td>50 (64)</td>
</tr>
</tbody>
</table>

a Excluded patients did not have a gram-positive pathogen present at baseline.

b Exclusion reasons (13 subjects in the CEM-102 loading-dose group and 9 in the linezolid group): test of cure not within 7–14 days after last dose, did not meet inclusion/exclusion criteria, indeterminate clinical outcome, received prohibited antibiotic treatment, or did not receive appropriate gram-negative coverage.

c Excluded patients if excluded from clinically evaluable or modified intent-to-treat populations, as above.

Table 3. Baseline Gram-positive Pathogens for the Microbiological Intent-to-Treat Population

<table>
<thead>
<tr>
<th>Organism</th>
<th>CEM-102 loading-dose group (n = 59)</th>
<th>Linezolid group (n = 58)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus aureus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>55 (93)</td>
<td>56 (97)</td>
</tr>
<tr>
<td>Methicillin-susceptiblea</td>
<td>21 (36)</td>
<td>12 (21)</td>
</tr>
<tr>
<td>Methicillin-resistanta</td>
<td>34 (58)</td>
<td>44 (76)</td>
</tr>
<tr>
<td>Streptococcus pyogenes</td>
<td>1 (2)</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Streptococcus agalactiae</td>
<td>5 (8)c</td>
<td>0</td>
</tr>
<tr>
<td>Other β-hemolytic Streptococcus species (not typed)</td>
<td>1 (2)</td>
<td>0</td>
</tr>
</tbody>
</table>

a Differences between groups are statistically significant (ie, p < .05).

b One patient was coinfected with methicillin-susceptible S. aureus.

c Three patients were coinfected with methicillin-susceptible S. aureus.
if any, of the decrease in susceptibility of this colonizing strain in light of the demonstrated fitness cost is not clear.

**Safety and Tolerability**

Adverse events were reported in 62% of patients in the CEM-102 loading-dose group and in 64% of patients in the linezolid group. There were no clinically relevant differences between treatment groups in the types or frequency of adverse events, including gastrointestinal events (Table 5). Notably, the frequency and intensity of nausea and/or vomiting were similar in the CEM-102 loading-dose and the linezolid treatment groups. There were more nervous system adverse events reported for linezolid (16.9% vs 10.3%) than for CEM-102, the majority of which were headaches.

Three patients in the CEM-102 loading-dose group had at least 1 serious adverse event, none of which (herpes simplex, pyelonephritis, and head injury and back pain) were considered related to study medication by the Investigator. Three patients in the CEM-102 loading-dose group discontinued the study medication due to adverse events (nausea and chills; blister and maculopapular rash; and nausea, vomiting, and anorexia).

There were no clinically important changes or trends in laboratory values for hematology, chemistry, coagulation, or urinalysis in either treatment group. ECG review by a blinded, central ECG laboratory demonstrated no post-baseline QT interval Fridericia correction >60 msec in either treatment group.

**DISCUSSION**

These phase 2 study data demonstrate comparable efficacy, safety, and tolerability of the oral CEM-102 loading-dose regimen and oral linezolid for the treatment of ABSSSI. Baseline pathogens were isolated in three-quarters of patients in this study of cellulitis, with or without an associated abscess, and infected surgical and traumatic wounds, with MRSA being the most common isolate.

Treatment options for ABSSSI serious enough to warrant systemic antibacterial therapy have become more limited in recent years as resistance patterns in *S. aureus* have evolved, resulting in a greater proportion of these infections involving MRSA [13, 14, 15]. This change has been most remarkable over the past decade in patients with no classic risk factors for infections with health care–associated pathogens, occurring in a broad range of settings and patient populations [6, 7, 16, 17]. This fact, along with limitations of a clinician’s ability to reliably identify specific epidemiologic or clinical features to distinguish between infections caused by MSSA and those caused by MRSA, resulted in an increasing need for effective and safe empirical antibiotic treatment choices with demonstrated efficacy in treating both MRSA and MSSA infections [18]. Effective use of
available oral antibiotic candidates for treatment of these infections remains limited by lack of efficacy [19, 20] and by concerns regarding safety, tolerability, and cost. In medically complex patients and in patients with multiple drug intolerances, effective, safe, and well-tolerated oral systemic antibiotic treatment options are particularly limited.

Fusidic acid offers a potentially valuable systemic treatment option for ABSSSI, including for medically complex patients. It has a broad gram-positive antimicrobial spectrum [10, 21]; oral bioavailability [22]; a long safety history, including in patients receiving prolonged courses of treatment [23, 24]; and a mechanism of action that is not shared with any other available antibiotic agent [9].

As shown in Table 3, there are some imbalances between the 2 treatment groups. The CEM-102 group had more MSSA and fewer MRSA infections than did the linezolid group (21 [36%] of 59 vs 12 [21%] of 59 for MSSA and 34 [58%] of 59 vs 44 [76%] of 58 for MRSA); these differences were statistically significant ($p = .036, \chi^2$ test). There were also fewer *Streptococcus pyogenes* and more *Streptococcus agalactiae* in the CEM-102 group. Because the eradication rates for both MSSA (96% vs 98%) and MRSA (97% vs 100%) were similar, it does not appear that this was clinically significant. *S. agalactiae* had a 50% eradication rate in the CEM-102 group, but there were very few, and treatment may have been affected by other confounding effects. With only 10 β-hemolytic streptococci in this study, it is difficult to draw any conclusions.

One concern that has been associated with fusidic acid therapy has been the development of resistance. In this study, we observed the clinical isolates carefully to see whether this would occur. One isolate of MSSA from a patient receiving fusidic acid had an MIC that rose from 0.12 μg/mL at baseline to 8 μg/mL on treatment Day 11 of 14. This patient was cured, the isolate was characterized, and it displayed a mutation in *fusE* that generated a stop codon in the L6 protein. This isolate showed a significant decrease in fitness when studied in the laboratory, and clinically, the patient fully recovered. Farrell et al [25] characterized the resistance mechanisms that are found globally and *fusE* is a low-level, spontaneous chromosomal mutation that has not been associated with therapeutic failures. With the loading-dose regimen used in this study, the trough levels are significantly higher than the MIC of 8 μg/mL. This isolate did not appear to have any clinical significance.

Three of the 78 patients in the CEM-102 loading-dose group discontinued the study medication because of adverse events (nausea and chills; blister and maculopapular rash; and nausea, vomiting, and anorexia). These patients were considered treatment failures. There were no discontinuations in the linezolid group associated with adverse events. The adverse events in the CEM-102 group did not appear to have a common underlying cause or to be a significant concern for future development of a drug with >30 years of safety experience.

The loading-dose regimen of oral fusidic acid evaluated in this study was chosen on the basis of PK/PD models and in vitro

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### Table 5. Adverse Events Reported in ≥5% of Patients in Either Treatment Group of the Safety (Intent-to-Treat) Population

<table>
<thead>
<tr>
<th>Event</th>
<th>Treatment group, no. (%) of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CEM-102 loading dose ($n = 78$)</td>
</tr>
<tr>
<td>Any adverse event</td>
<td>48 (62)</td>
</tr>
<tr>
<td>Serious adverse event</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Discontinued treatment due to adverse event</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>17 (22)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>10 (13)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>10 (13)</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>6 (8)</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>8 (10)</td>
</tr>
<tr>
<td>Injury, poisonings, and procedural complications</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Metabolism and nutrition disorders</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td>8 (10)</td>
</tr>
<tr>
<td>Headache</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Respiratory, thoracic, and mediastinal disorders</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>7 (9)</td>
</tr>
</tbody>
</table>

**NOTE.** All terms expressed according to the *Medical Dictionary for Regulatory Activities*, version 12.0.

* system organ class.

* preferred term.
pharmacodynamic models, with the intent of optimizing plasma and tissue levels early in the treatment course to provide effective treatment of both staphylococcal and β-hemolytic streptococcal infections; to lower the potential for development of resistance on therapy [11]; and to maintain fusidic acid’s well-documented favorable safety and tolerability profile. These phase 2 results support proceeding to phase 3 registration studies comparing these 2 oral regimens in the treatment of ABSSSI.

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