

# Bad Bugs, No Drugs: No ESKAPE! An Update from the Infectious Diseases Society of America

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The Infectious Diseases Society of America (IDSA) continues to view with concern the lean pipeline for novel therapeutics to treat drug-resistant infections, especially those caused by gram-negative pathogens. Infections now occur that are resistant to all current antibacterial options. Although the IDSA is encouraged by the prospect of success for some agents currently in preclinical development, there is an urgent, immediate need for new agents with activity against these panresistant organisms. There is no evidence that this need will be met in the foreseeable future. Furthermore, we remain concerned that the infrastructure for discovering and developing new antibacterials continues to stagnate, thereby risking the future pipeline of antibacterial drugs. The IDSA proposed solutions in its 2004 policy report, “Bad Bugs, No Drugs: As Antibiotic R&D Stagnates, a Public Health Crisis Brews,” and recently issued a “Call to Action” to provide an update on the scope of the problem and the proposed solutions. A primary objective of these periodic reports is to encourage a community and legislative response to establish greater financial parity between the antimicrobial development and the development of other drugs. Although recent actions of the Food and Drug Administration and the 110th US Congress present a glimmer of hope, significant uncertainty remains. Now, more than ever, it is essential to create a robust and sustainable antibacterial research and development infrastructure—one that can respond to current antibacterial resistance now and anticipate evolving resistance. This challenge requires that industry, academia, the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the US Department of Defense, and the new Biomedical Advanced Research and Development Authority at the Department of Health and Human Services work productively together. This report provides an update on potentially effective antibacterial drugs in the late-stage development pipeline, in the hope of encouraging such collaborative action.

## BACKGROUND

Infections caused by antibiotic-resistant bacteria continue to challenge physicians in 2008. We face growing

resistance among gram-positive and gram-negative pathogens that cause infection in the hospital and in the community [1–3]. Rice [2] recently reported these as the “ESKAPE” pathogens *Enterococcus faecium*,

The IDSA is a national medical society that represents infectious diseases physicians, scientists, and other health care professionals dedicated to promoting health through excellence in infectious diseases research, education, prevention, and patient care. The Society, which has >8400 members, was founded in 1963 and is based in Arlington, VA. For more information, visit <http://www.idsociety.org/>. This work was developed by the IDSA's Antimicrobial Availability Task Force (AATF): John Bartlett (chair) and Helen W. Boucher, John S. Bradley, John E. Edwards Jr, David Gilbert, W. Michael Scheld, Brad Spellberg, George H. Talbot, and Robert Guidos (AATF staff). The IDSA Board of Directors approved the report on 3 September 2008.

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*Staphylococcus aureus*, *Klebsiella pneumoniae*, *Acinetobacter baumannii*, *Pseudomonas aeruginosa*, and *Enterobacter* species) to emphasize that they currently cause the majority of US hospital infections and effectively “escape” the effects of antibacterial drugs. Data from the Centers for Disease Control and Prevention (CDC) show rapidly increasing rates of infection due to methicillin-resistant *S. aureus* (MRSA), vancomycin-resistant *E. faecium* (VRE), and fluoroquinolone-resistant *P. aeruginosa* [4]. More people now die of MRSA infection in US hospitals than of HIV/AIDS and tuberculosis combined [5, 6]. Furthermore, panantibiotic-resistant infections now occur. Several highly resistant gram-negative pathogens—namely *Acinetobacter* species, multidrug-resistant (MDR) *P. aeruginosa*, and carbapenem-resistant *Klebsiella* species and *Escherichia coli*—are emerging as significant pathogens in both the United States and other parts of the world. Our therapeutic options for these pathogens are so extremely limited that clinicians are forced to use older, previously discarded drugs, such as colistin, that are associated with significant toxicity and for which there is a lack of robust data to guide selection of dosage regimen or duration of therapy [4, 7–10]. The growing number of elderly patients and patients undergoing surgery, transplantation, and chemotherapy and dramatic increases in population in neonatal intensive care units will produce an even greater number of immunocompromised individuals at risk of these infections [11].

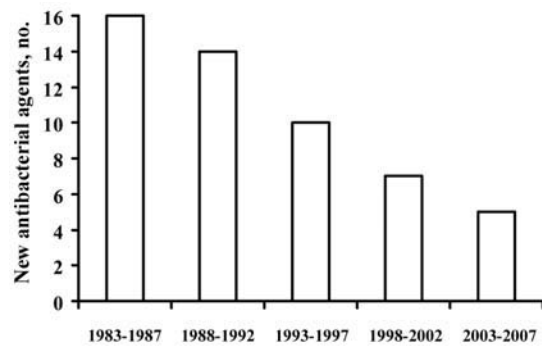
Over the past several years, the Infectious Diseases Society of America (IDSA) has worked with US Congress, the Food and Drug Administration (FDA), the National Institutes of Health, the CDC, and other stakeholder groups to highlight this problem. Most recently, the IDSA issued a “Call to Action for the Medical Community” in the hope of raising awareness [3].

Despite ongoing efforts and some successes, only 1 new antibacterial—doripenem—has been approved since our earlier report (figure 1), and the number of new antibacterial drugs approved for marketing in the United States continues to decrease [12]. This report updates the 2006 report [12].

## METHODS

Sources were reviewed to identify antibacterial drug candidates in the development pipeline, as follows:

1. The 2007 Pharmaceutical Research and Manufacturers of America (PhRMA) report “Medicines in Development for Infectious Diseases” [13]
2. Abstracts from the 2006 and 2007 Interscience Conference on Antimicrobial Agents and Chemotherapy, which were searched for investigational antimicrobials
3. Interviews conducted by the IDSA Antimicrobial Availability Task Force (AATF) of leaders of 13 major pharmaceutical and 6 of the largest biotechnology companies



**Figure 1.** New antibacterial agents approved in the United States, 1983–2007, per 5-year period [2, 3].

identified by Spellberg et al. [14]; Web sites of these companies were also accessed, and data on drugs in development were reviewed

4. The ClinicalTrials.gov Web site was accessed and searched by condition, with a disease heading of “bacterial infections.” Identified compounds were confirmed by accessing the Web site of the innovator company. Because of the high failure rate of compounds that have not successfully navigated phase 1 studies, only compounds in phases 2 or 3 of development are discussed.
5. The PubMed database was searched for relevant literature published from September 2005 through December 2007 by using the search terms “antimicrobial drug development,” “investigational antimicrobials,” and “novel antimicrobials.”

As in our earlier report, we focus on new orally or intravenously administered antibacterial drugs that have progressed to phase 2 or 3 of development, because these agents are more likely to reach the clinic and are associated with substantial investment by pharmaceutical sponsors. Excluded were non-absorbable antimicrobials administered via the gastrointestinal tract and new indications or formulations of approved drugs.

## RESULTS

Table 1 includes 16 antimicrobial compounds in late-stage clinical development (phase 2 and later). Of these, 8 have activity against gram-positive organisms (hereafter, “anti-gram-positive drugs”). Telavancin has a dual mechanism and affects both cell wall and cell membrane. A second anti-gram-positive drug, TD-1792, is new since our 2006 report. TD-1792 is a multivalent cephalosporin that combines the activities of a glycopeptide and a  $\beta$ -lactam in 1 molecule [15]. According to a manufacturer-issued press release, a phase 2 study of TD-1792 showed efficacy comparable to that of vancomycin for complicated skin and skin-structure infection (cSSSI) caused by

gram-positive bacteria [16]. However, these data have not yet been published in a peer-reviewed context.

Three of the anti-gram-positive drugs—ceftobiprole, telavancin, and dalbavancin—are in continuing regulatory review following the issuance of approvable letters by the FDA for a cSSSI indication; all 3 reportedly met the prespecified end points in pivotal phase 3 studies [17–19]. Dalbavancin was deemed approvable in September 2005 and again in December 2007. Ceftobiprole was deemed approvable on 19 March 2008, subject to completion of study-site inspections, assessment of clinical and microbiological data provided by the sponsor to the FDA but not yet reviewed, and further characterization of diabetic patients with foot infections [20]. A Theravance press release noted that the FDA had concerns about “study monitoring issues at a single site” and planned further inspections [21]. A public FDA advisory committee meeting to review telavancin, oritavancin, and iclaprim occurred 18–20 November 2008 [22].

The final 2 anti-gram-positive drugs have an oral formulation: (1) iclaprim, with a mechanism of action similar to that of trimethoprim, and (2) RX-1741, a second-generation oxazolidinone. However, according to our interview with a senior executive at Arpida, iclaprim’s manufacturer, development of the oral formulation is significantly behind that of the intravenous formulation.

Eight compounds have activity against both gram-positive and gram-negative organisms. Five of these compounds are new to the list. Of note, another 5 were discovered by Japanese innovator companies.

Doripenem is a carbapenem with greater in vitro potency than meropenem against *P. aeruginosa*; doripenem’s activity against extended-spectrum  $\beta$ -lactamase (ESBL)-producing gram-negative organisms is similar to that of meropenem. The FDA recently approved doripenem for treatment of complicated intra-abdominal infection and complicated urinary tract infection [23]. Pivotal studies included patients with *P. aeruginosa* infection [24]. Results from 2 studies of hospital-acquired pneumonia (HAP), including ventilator-associated pneumonia (VAP), demonstrated the noninferiority of doripenem to imipenem and piperacillin-tazobactam, respectively. The HAP-VAP indication was recently reviewed at an FDA Anti-Infective Drug Advisory Committee meeting, where it received a split vote that narrowly favored approval [25, 26].

Tomopenem [27] is a carbapenem with in vitro activity against *P. aeruginosa* (MIC<sub>90</sub>, 4  $\mu$ g/mL) but with less activity against imipenem-resistant strains (MIC<sub>90</sub>, 16  $\mu$ g/mL) [28]. Tomopenem has advanced to phase 2 of development for treatment of cSSSI and HAP (B. Dannemann, personal communication with G.H.T.), but its subsequent release by Roche to the Japanese innovator leaves its US development status in question [27].

The intravenous and oral aminomethylcycline PTK-0796 is being developed by Paratek Pharmaceuticals [29]. Like tige-cycline, the spectrum of PTK-0796 includes MRSA, VRE, and some resistant gram-negative pathogens, including *A. baumannii* (MIC<sub>90</sub>, 8  $\mu$ g/mL) [30, 31]. A phase 2 study of PTK-0796 versus linezolid for treatment of cSSSI was recently completed [29]. Hopefully, these data will provide insight into the potential usefulness of this drug in the treatment of infection due to resistant bacteria, especially gram-negative pathogens.

Several other compounds in earlier stages of development may address the unmet need for antimicrobials that are active against resistant gram-negative pathogens. ME 1036, an intravenous carbapenem in phase 1 development, shows in vitro potency against resistant gram-positive organisms, including MRSA and VRE, and ESBL-producing *E. coli* and *K. pneumoniae* but no activity against *P. aeruginosa* [32–34]. PZ-601, an intravenous carbapenem manufactured by Protez, demonstrates potency against a broad spectrum of gram-positive (including MRSA) and gram-negative pathogens other than *P. aeruginosa* and *A. baumannii* [35, 36]. Recently, Novartis announced plans to acquire Protez, and a phase 2 cSSSI study began enrolling patients in May 2008 [37]. Sulopenem, an intravenous and oral penem being developed by Pfizer, is a broad-spectrum antibacterial with activity against gram-negative pathogens, including ESBL-producing Enterobacteriaceae, gram-positive pathogens, and anaerobes; it was initially developed in Japan.

BAL 30376 is a novel  $\beta$ -lactam- $\beta$ -lactamase inhibitor combination developed by Basilea [38, 39]. This tripartite compound includes a siderophore monobactam with stability to class B  $\beta$ -lactamases, a bridged monobactam that inhibits class C  $\beta$ -lactamases, and the  $\beta$ -lactamase inhibitor clavulanate that inhibits class A  $\beta$ -lactamases. In vitro studies demonstrate the activity of BAL 3076 against a broad spectrum of gram-negative pathogens, including *Acinetobacter* species, nonfermenting bacilli (e.g., *P. aeruginosa* and *S. maltophilia*), and Enterobacteriaceae with known  $\beta$ -lactamases. This antibacterial potentially provides single-drug therapy for serious nosocomial gram-negative infections [38–40].

Another early-stage metallo- $\beta$ -lactamase inhibitor, ME1071 (CP3242), which is being developed by Meiji Seika Kaisha, has shown clinically relevant in vitro and in vivo activity against *A. baumannii* (and *P. aeruginosa*) [41–43].

None of these agents addresses the growing need created by the emergence of carbapenemases. We found no antibacterial drugs with a pure gram-negative spectrum that have reached phase 2 development.

Table 2 shows an update of antistaphylococcal vaccines and immunoglobulins. Unfortunately, development of most of them has been terminated, and results of clinical studies are not yet public for the remaining few. Despite the enthusiasm

**Table 1. Antibacterial compounds undergoing clinical development in phase 2 or later studies.**

Spectrum and product (company)	New to list	Class (mechanism of action)	Novel mechanism of action	Formulation	Status	Innovator	Comments
Gram positive Ceftibiprole medocartil (Basilea/Johnson and Johnson)	No	Cephalosporin (cell wall synthesis inhibitor)	No	IV	Phase 3 HAP met end points, failed in VAP subset; positive CAP results; NDA for cSSSI approvable March 2008	Peninsula Pharmaceuticals	In-licensed by Johnson and Johnson, 2005
Ceftaroline fosamil (Cerexa/Forest)	No	Cephalosporin (cell wall synthesis inhibitor)	No	IV	Phase 3	Takeda Pharmaceutical	PPI-0903, TAK-599
Telavancin (Theravance)	No	Lipoglycopeptide (cell wall synthesis inhibitor)	Yes	IV	Approvable October 2007 for cSSSI, phase 3 HAP trials met end points (ECCMID 2008)	Theravance	
Dalbavancin (Pfizer)	No	Lipoglycopeptide (cell wall synthesis inhibitor)	No	IV	NDA approvable September 2005, December 2007	Vicuron Pharmaceuticals	Pfizer acquired by purchase of Vicuron Pharmaceuticals
Oritavancin (Targanta)	No	Glycopeptide (cell wall synthesis inhibitor)	No	IV	cSSSI NDA filed February 2008	Lilly	Licensed from InterMune
Iclaprim (Arpida)	No	Diaminopyrimidine (dihydrofolate reductase inhibitor)	No	IV, oral	Phase 2 HAP/phase 3 cSSSI IV, phase 1 oral; IV cSSSI NDA filed March 2008	Arpida	...
TD-1792 (Theravance)	Yes	Multivalent vanco-cephalosporin	Unknown	IV	Phase 2 cSSSI met end points	Theravance	...
RX-1741 (Rib-X)	Yes	Oxazolidinone	No	Oral	Phase 2 uncomplicated skin infection completed enrollment; phase 2 CAP enrolling	Rib-X	...
Gram positive and gram negative Faropenem (Replidyne)	No	Penem (cell wall synthesis inhibitor)	No	Oral	Phase 3; not approvable October 2006; phase 3 acute exacerbation of chronic bronchitis trials terminated April 2008; development terminated	Daiichi Suntary Pharmaceuticals	Additional studies (superiority) required and ongoing; licensed from Daiichi Suntary Pharmaceuticals (now Asubio Pharma) March 2004

PZ-601 (Protez)	Yes	Carbapenem with MRSA activity (cell wall synthesis inhibitor)	No	IV	Phase 2 cSSSI enrolling	Dainippon Sumitomo	Licensed from Dainippon Sumitomo; also known as SMIP-216601; agreement for purchase by Novartis announced June 2008
Tomopenem (Daiichi Sankyo)	No	Carbapenem with MRSA activity (cell wall synthesis inhibitor)	No	IV	Phase 2; status of US development to be clarified	Daiichi Sankyo	Released by Roche to innovator; Daiichi Sankyo, formerly RO4908463, CS-023, and R-115685
Cethromycin (Advanced Life Sciences)	No	Macrolide (protein synthesis inhibitor)	No	Oral	Phase 3 CAP met end points; NDA planned for third quarter 2008	Advanced Life Sciences	Oral respiratory pathogen spectrum
EDP-420 (Enanta)	Yes	Bicyclic; bridged macrolide structure (protein synthesis inhibitor)	No	Oral	Phase 2 CAP in Japan met end points; phase 2 in the United States to be confirmed	Enanta	Oral respiratory pathogen spectrum
PTK 0796 (Paratek)	Yes	Aminomethylcyclycline (protein synthesis inhibitor)	No	IV, oral	Phase 2 cSSSI completed	Paratek	...
NXL 103 (Novexel)	Yes	Streptogramin (protein synthesis inhibitor)	No	Oral	Phase 2	Sanofi-Aventis	Oral respiratory pathogen spectrum; formerly XRP2868
RX-3341 (Rib-X)	Yes	Quinolone with MRSA activity	No	IV	Phase 2 cSSSI initiated	Rib-X	Licensed in 2006 from Wakunaga Pharmaceuticals; formerly WQ- 3034 and ABT-492

**NOTE.** CAP, community-acquired pneumonia; cSSSI, complicated skin and skin-structure infections; ECCMID, European Congress of Clinical Microbiology and Infectious Diseases; HAP, hospital-acquired pneumonia; IV, intravenous; MRSA, methicillin-resistant *Staphylococcus aureus*; NDA, new drug application; VAP, ventilator-associated pneumonia.

**Table 2. Antistaphylococcal vaccines and immunoglobulins undergoing clinical development in phase 2 or later studies.**

Product (company)	Mechanism of action	Formulation	Status	Comments
StaphVAX (NABI)	Polysaccharide conjugate vaccine	IM	Terminated	Phase 3 failed
Altastaph (NABI)	Hyperimmune, polyclonal immunoglobulin	IV	Terminated	Phase 2 study: prevention of infection in patients undergoing hemodialysis and low birth-weight infants; adjunctive therapy of persistent <i>Staphylococcus aureus</i> bacteremia; development halted
Aurexis (Inhibitex)	Humanized monoclonal antibody	IV	Terminated	Phase 2; no benefit over placebo
INH-A21 (Veronate, Inhibitex)	Donor-selected polyclonal human immune globulin enriched in antibody to cell surface adhesion proteins	IV	Phase 3	Prevention of infection in very low birth-weight infants; phase 3 failed
BSYX-A110 (Pagibaximab, Medimmune)	Antilipoteichoic acid monoclonal antibody	IV	Terminated	Prevention of infection in low birth-weight infants; acquired from GlaxoSmithKline and Biosynexus; phase 2 study complete 2004; Medimmune acquired by Astra-Zeneca 2007; development terminated (J. Rex, personal communication)
<i>S. aureus</i> genetically recombinant antibody (Aurograb; Neutec)	Human genetically recombinant antibody fragment that binds to the immunodominant cell surface antigen, GrfA, a staphylococcal ATP-binding cassette transporter protein	IV	Phase 3	Adjunctive study of staphylococcal infection; study completed June 2006; Neutec acquired by Novartis in 2006
<i>S. aureus</i> vaccine V710 (Merck)	Protein- or antigen-based vaccine	IM	Phase 2	Phase 2 study to evaluate the efficacy, immunogenicity, and safety of a single dose of V710 in adult patients scheduled for cardiothoracic surgery

**NOTE.** ATP, adenosine triphosphate; IM, intramuscular; IV, intravenous.

for these toxin- or virulence factor-based interventions, issues with manufacturing, study design, and patient selection have plagued development, which leaves the future of such strategies uncertain [44–47].

The results of our interviews with leaders of anti-infective development at Abbott, AstraZeneca, Bayer, GlaxoSmithKline, Lilly, Merck, Novartis, Ortho McNeil/Johnson & Johnson, Pfizer, Roche, Sanofi Aventis, Schering Plough, and Wyeth were disappointing. From these 13 pharmaceutical leaders, just 3 new compounds are in advanced clinical development: ceftobiprole and dalbavancin (under regulatory review) and PTK-0796. The small number of antibacterials in phase 2 or 3 development at these major companies, which once were the international leaders in anti-infective drug discovery and development, reflects the companies' decreased investment in this therapeutic area [3].

The 2007 PhRMA report includes 388 infectious diseases medicines and vaccines and 83 antibacterial drugs in development [13]. Careful review of these data reveals that most are preclinical and phase 1 compounds. Also included are topical and nonabsorbable antimicrobials, which we do not consider here, and several compounds for which development has been terminated. Finally, the PhRMA report does not focus on new molecular entities, and many of the listed drugs are previously approved agents that are being studied for new indications.

## ANTIMICROBIAL DRUG-DEVELOPMENT NEEDS

The IDSA's AATF identified the following development needs for the particularly problematic ESKAPE pathogens [2].

### **E. faecium (VRE)**

Consistently identified as the third most frequent cause of nosocomial bloodstream infection (BSI) in the United States, enterococcal BSIs remain a significant problem [48, 49]. Vancomycin resistance likewise continues to increase, with a rate of ~60% among *E. faecium* isolates [48]. Despite growing incidence, there is a paucity of meaningful data that address efficacy of our newer agents, such as linezolid, daptomycin, and tigecycline, in the therapy of these infections, and tolerability remains problematic [50–52].

### **S. aureus (MRSA)**

Despite the addition of several new agents to treat MRSA infection, clinicians are routinely faced with treatment challenges involving patients with invasive disease. Although criteria for treating skin and skin-structure infection due to community-associated MRSA are evolving [53], the need is great for oral agents for step-down therapy for the group of patients who require initial parenteral therapy. Because of the prominence of toxin activity in these infections, protein synthesis inhibition may also be desirable [54, 55]. Novel classes are clearly needed for MRSA, because current drug classes exhibit treatment-limiting toxicities and emerging resistance [56–58]. Nondrug therapies, including vaccines and antibodies, are particularly attractive, because they may allow targeted preventive or adjunctive therapy for populations at particular risk, such as dialysis-dependent patients or surgical patients at high risk (e.g., cardiac surgery). Unfortunately, studies to date have failed to demonstrate efficacy for these agents.

**K: ESBL-producing *E. coli* and *Klebsiella* species**

Infection due to ESBL-producing *E. coli* and *Klebsiella* species continue to increase in frequency and severity. The number of enzymes and the number of organisms that exhibit cross-resistance to other classes of antimicrobials is growing, which makes selection of therapy even more challenging [4, 11, 27, 59, 60].

The impact of these infections was initially difficult to ascertain. However, a recent single-center study showed that BSI due to an ESBL-producing organism was an independent predictor of mortality, prolonged length of stay, delay in initiation of appropriate antimicrobial therapy, and increased hospitalization costs. In a meta-analysis of 16 studies reported for 1996–2003, ESBL-producing BSI was significantly associated with delayed initiation of effective therapy and increased crude mortality [61, 62].

Despite this growing, serious problem, the molecules in late-stage development, as well as the recently approved doripenem, represent only incremental advances over existing carbapenems [63].

**More K: *K. pneumoniae* Carbapenemase-Hydrolyzing  $\beta$ -Lactamases**

Carbapenem-resistant Enterobacteriaceae are increasingly recognized as the cause of sporadic and outbreak infections in the United States and Europe [64–69]. Plasmid-encoded carbapenemases were initially described in *K. pneumoniae* and were later recognized in *E. coli* and other Enterobacteriaceae [64, 70]. These organisms cause severe infections among residents of long-term-care facilities and are not easily detected in the clinical microbiology laboratory [71]. Little is known with regard to optimal antimicrobial therapy, and few drugs demonstrate activity. Tigecycline and the polymyxins, including colistin, have been used in individual cases with variable success [9]. Aggressive infection-control practices are required in aborting these outbreaks, and there are currently no antibacterials in advanced development for these resistant pathogens [66, 72].

**A: *A. baumannii***

The incidence of infection due to MDR *Acinetobacter* species continues to increase globally [73, 74]. Recent studies of patients in the intensive care unit who had BSI and burn infection due to carbapenem-resistant *Acinetobacter* species demonstrate an increased mortality (crude mortality, 26%–68%), as well as increased morbidity and length of stay in the intensive care unit [75].

Tigecycline shows in vitro activity against gram-positive and gram-negative organisms, including MRSA, and *Acinetobacter* isolates. Although successful treatment of *A. baumannii* infection has been reported, reports of breakthrough infections have

led to some caution with regard to the use of this newer agent to treat infection caused by this pathogen [74, 76–79].

Tigecycline received FDA approval in 2005 for treatment of cSSSI and complicated intra-abdominal infections. Although community-acquired pneumonia trials met primary end points, the HAP/VAP study was unsuccessful, thus leaving Tigecycline's role in HAP/VAP treatment unclear [27, 80].

Unfortunately, as in 2006, we cannot identify candidate compounds in late-stage development for treatment of MDR *Acinetobacter* infection; this pathogen is emblematic of the mismatch between unmet medical needs and the current antimicrobial research and development pipeline [75].

**P: *P. aeruginosa***

Rates of infection due to resistant *P. aeruginosa* continue to increase in the United States and globally, as does resistance to both the quinolones and carbapenems. Aminoglycoside resistance is emerging as a significant problem [4, 81, 82]. Recent reports also document resistance to the polymyxins. Patients at risk include those in intensive care units, particularly if they are ventilator dependent, and individuals with cystic fibrosis [1, 27, 60]. To date, no drugs in clinical development address the issue of carbapenem resistance or MDR or offer a less toxic alternative to the polymyxins.

**E: *Enterobacter* Species**

*Enterobacter* species cause an increasing number of health care-associated infections and are increasingly resistant to multiple antibacterials [83, 84]. Infection due to *Enterobacter* species, especially BSI, is associated with significant morbidity and mortality [85]. As with other members of the Enterobacteriaceae, resistance occurs via ESBLs and carbapenemases (including *K. pneumoniae* carbapenemase-hydrolyzing  $\beta$ -lactamases) and inducible chromosomal cephalosporinases [83, 86]. Other than colistin and perhaps tigecycline, few antibacterials are active against these resistant organisms, and we found no drug in late-stage development for these pathogens [87, 88].

**DISCUSSION**

The number of antibacterials in phase 2 or 3 of clinical development remains disappointing, and the absence of agents designed to treat infection due to resistant gram-negative bacilli places patients with these infections in danger. At this time, there are no systemically administered antimicrobials in advanced development that have activity against either a purely gram-negative spectrum or bacteria already resistant to all currently available antibacterials.

Ascertaining the true number of compounds in development remains challenging. Although PhRMA reported 388 medicines and vaccines in testing, 83 of which are antibacterials, we found significantly fewer than 83 new molecular entities in advanced

clinical development. Because no comprehensive survey of antibiotic development was undertaken before the IDSA's reports of 2004 and 2006 [12, 14], we cannot determine whether the 388 medications and vaccines reported in development by PhRMA—or even just the new, systemic antibacterials listed in the present report—reflect an increase or decrease in the development pipeline over the past few years. What is certain is that the number of new antibacterials that make it through the complete development process and ultimately receive FDA approval has precipitously decreased over the past 25 years. Indeed, we found a 75% decrease in systemic antibacterials approved by the FDA from 1983 through 2007, with evidence of continued decrease in approvals, even during the most recent 5-year period (2003–2007) [3]. These data do not suggest a significant recent increase in antibacterial development. Recent reports about the decrease in discovery research efforts in large pharmaceutical companies and the decrease in antibacterial trials, most notably “early phase” clinical trials, further highlight the diminishing industry focus on antibacterial drug research and development [89, 90]. Only 5 major pharmaceutical companies—GlaxoSmithKline, Novartis, AstraZeneca, Merck, and Pfizer—still have active antibacterial discovery programs, and the number of antibacterial trials registered at ClinicalTrials.gov decreased between 2005 and 2007 [89, 90].

We do observe some small signs of success. The approval of doripenem is encouraging; its increased in vitro potency against *P. aeruginosa* may translate into clinical advantage. Positive results in phase 3 studies for telavancin, ceftobiprole (although not for the VAP subset in the HAP studies), and cethromycin are encouraging, although the regulatory delays are troubling. Several compounds in early development appear promising, but phase 2 clinical studies are not yet under way. We found evidence of potentially increased interest among large pharmaceutical companies in the recent announcements of collaborations between Mpex Pharmaceuticals and GlaxoSmithKline, Novoxel and Forest Laboratories, and Protez and Novartis [37, 91, 92]. These relationships reflect some signs of renewed investment interest that must be nurtured very carefully if we hope to see a productive pipeline. Looking forward over the next 5–10 years, it is possible that the number of approved antibacterials will plateau at a level similar to that of the past 5 years (i.e., ~1 drug per year).

It is critical to emphasize that focusing on just the number of approved antibacterials does not necessarily “tell the full story” of the overall clinical impact of the new drugs. New antimicrobials should provide clear advances in treatment of infection, compared with already available therapies. As in our earlier report, the number of truly novel compounds with a new mechanism of action remains small. Most antibacterial drugs that are currently in the late-stage pipeline do not augur a major advance in our ability to treat infection due to resistant

pathogens, and the overall number of compounds in development to treat gram-negative infection is small. The fact that much of the discovery effort is based in Japan is also noteworthy [27]. The IDSA is concerned about the lack of an active international drug-discovery infrastructure and the attendant consequences—in particular, the decrease in US- and European-based antibacterial discovery infrastructure.

### **IDSA's Proposed Strategy and Solutions**

The IDSA's goal is to enable industry—in cooperation with academia, the National Institutes of Health, the FDA, the CDC, the Department of Defense, and the new Biomedical Advanced Research and Development Authority at the Department of Health and Human Services—to create a sustainable research and development infrastructure that can both respond to current antimicrobial resistance and anticipate evolving resistance. This effort requires attention to the specifics of microbial pathogenicity and the microbial epidemiology of human disease and must be coupled with appropriate acknowledgement of drug-development time lines and regulatory milestones, as well as appropriate legislative incentives.

To succeed, key stakeholders will need to adopt a long-term outlook and maintain ongoing consultation with infectious diseases experts, with the goal of establishing sustainable research and development programs to meet public health needs. Novel intravenous and oral drugs to treat both hospitalized and community-based patients are needed, as opposed to “me too” drugs that provide minimal improvement over existing therapies. Priority should be given to antimicrobials with the potential to treat serious infections that are resistant to current antibacterial agents.

A solution requires ongoing and increasing investment by pharmaceutical sponsors, both “big pharma” and innovative but typically smaller biotechnology companies; this will require mitigation of the current disincentives, as well as creation of new incentives, to make developing antibacterials a viable option for these companies. The AATF interviews with company leaders revealed the need for such incentives. Establishing targeted new incentives will allow development teams within large companies to compete more equitably with programs from other therapeutic areas that are developing drugs that treat chronic conditions (e.g., hypercholesterolemia) for finite research and development resources. For biotechnology companies, such incentives will make antibacterial development a viable option for venture capitalists and other investors.

**Regulatory challenges, guidance, and progress.** Over the past several years, the regulatory debate about development and approval of new antimicrobials focused on noninferiority study design, especially the appropriate size of the noninferiority margin for a given indication. The industry leaders whom we interviewed voiced concerns about large sample sizes leading to



cost-prohibitive studies, perceived demands for placebo-controlled trials in diseases for which antibacterials are part of treatment guidelines (and for which ethics committees would not permit use of placebo), and the inability to define acceptable outcome measures. Representatives of both large pharmaceutical and smaller biotechnology companies also reported the difficulty caused when the FDA seemed to “change the rules” after providing advice on development programs.

A clear need remains for specific regulatory guidance. Every company representative interviewed by AATF members listed “regulatory uncertainty,” or a lack of clear regulatory guidance, as a major disincentive to anti-infective drug development. A welcome advance that will, hopefully, remove some uncertainty is a draft FDA guidance that addresses how susceptibility testing interpretive criteria that are presented in product inserts (labeling) can be updated to reflect changes in the epidemiology of bacterial resistance [93]. In addition, in January 2008, FDA and the IDSA cosponsored a workshop focused on the design of trials for community-acquired pneumonia [94]. This meeting provided a venue for a full scientific discussion of many of the evolving issues in trial design for new community-acquired pneumonia therapies; the proceedings were published in the recent *Clinical Infectious Diseases* supplement on treatment of community-acquired pneumonia [95, 96]. The IDSA hopes that this was the first of many such exchanges and that these interactions and the resultant decisions will lead to clarity about issues of both trial design and overall program requirements for the development of new antimicrobial agents.

**Appropriate incentives.** Over the past 5 years, the IDSA has advocated federal action to spur new antibiotic development. The IDSA continues to work with federal policy makers and members of Congress to encourage the elimination of disincentives and encourage responsible incentives. The greatest need is for incentives that produce a sustainable research and development infrastructure that can both respond to current antimicrobial resistance and anticipate evolving resistance. Also needed is legislation that will strengthen the overall US approach to antimicrobial resistance—a “major blooming public health crisis” [89, p. 357].

We have seen small signs of success in partnerships and in recent congressional action. For example, in 2007, the Wellcome Trust awarded GlaxoSmithKline £4 million (~US\$7.4 million) to accelerate development of compounds for treating infection with gram-negative pathogens. This public-private partnership illustrates a creative means to stimulate antibacterial drug development [97].

Moreover, in September 2008, Congress enacted IDSA-supported legislation that would provide a 3-year market exclusivity period for approval of a new indication for an already approved “older” antibacterial drug and a 5-year market exclusivity period for approval of a previously unapproved “older”

antibacterial drug. Such exclusivity already has been available for other therapeutic categories. This provision will create parity for antibiotics. (Contained in S. 3560, the QI Program Supplemental Funding Act passed the US Senate on 25 September 2008 and passed the US House of Representatives on 27 September 2008. It was presented to the President on 29 September 2008.) Other pending legislation, S. 2351/H.R. 4200, if enacted, would provide a 50% research and development tax credit to developers of new infectious diseases products. Enactment of this incentive should be valuable for larger, profitable companies. To make this incentive relevant to start-up biotechnology companies, the incentive must be modified to permit the tax credit to be redeemed in future years when a profit is realized; alternatively, the credit must be sellable.

Additional legislative incentives specifically targeting priority antibacterial therapies (e.g., awards, grants, and longer terms of market exclusivity) and other helpful tools (diagnostics, vaccines) must be considered and enacted [3]. Other important legislative measures currently pending in Congress include the Strategies to Address Antimicrobial Resistance (STAAR) Act (S. 2313–H.R. 3697)—which is intended to strengthen federal antimicrobial resistance surveillance, prevention, control, and research efforts—and the Preservation of Antibiotics for Medical Treatment Act (S. 549–H.R. 962)—which is intended to phase out the use of antibacterials of critical clinical importance in human medicine for nontherapeutic (i.e., growth promotion) use in animals. The IDSA and many other medical, health care, and public health organizations have endorsed these bills. Ironically, although decreased inappropriate antibacterial use (e.g., antibiotic stewardship) is likely to decrease the problem of resistance, decreased antibacterial use also will lead, logically, to decreased interest by pharmaceutical companies in new drug development.

## Conclusions

As in our earlier report, the late-stage clinical development pipeline for antibacterials remains unacceptably lean. Although some important molecules are in late-stage development for treatment of infection due to problematic pathogens, such as MRSA, few novel molecules have been advanced for treatment of the other ESKAPE pathogens. Importantly, no drugs have reached advanced stages of development for infection due to MDR gram-negative bacilli, such as *A. baumannii* and *P. aeruginosa*, and none represents more than an incremental advance over currently available therapies.

IDSA supports strengthening current approaches to antimicrobial resistance, to protect effectiveness of the drugs currently available. We must maximize hospital infection-control practices, to limit the spread of resistance. And most importantly, the United States must make the development of a sustainable antibacterial drug research and development infra-

structure a national priority. Only this will ensure a steady stream of new antibacterials to meet the needs of both our current patients and those of their children.

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