### RESULTS

- **Lefamulin demonstrated potent antipseudomonal activity against tested CAP pathogens and this activity was unaffected by resistance to other antibiotic classes.**

#### S. pneumoniae

- **S. pneumoniae isolates showed considerable resistance to macrolides (23.2% penicillin-resistant [PR]) and clindamycin (31.2% PR).** Other common causes included Streptococcus pyogenes (22.2% PR), Staphylococcus aureus (20.4% PR), and Enterobacteriaceae (19.1% PR). (Table 1)

- **Lefamulin inhibited S. pneumoniae, with all isolates inhibited at ≤0.5 mg/L, and all resistant isolates showing minimal concentration in which 50% or 80% of the isolates were inhibited (MIC ≤0.06 mg/L to ≤0.5 mg/L), for both broth (≤0.5 mg/L) and broth microdilution (≤0.06 mg/L to ≤0.5 mg/L), for both broth (≤0.5 mg/L) and broth microdilution (≤0.06 mg/L to ≤0.5 mg/L),** as shown in Table 2.

#### S. aureus

- **A. aures isolates were predominantly resistant to the tested cephalosporins and fluoroquinolones (69.3% resistant to moxifloxacin; 68.4% resistant to levofloxacin; 77.0% resistant to ceftriaxone; 91.0% resistant to cefazolin; 71.9% resistant to clindamycin; 71.9% resistant to trimethoprim-sulfamethoxazole.)** (Table 3)

#### M. catarrhalis

- **M. catarrhalis isolates were largely susceptible to all comparators except for amoxicillin (38.2% resistant) and ciprofloxacin-meropenem (32.4% resistant).** (Table 4)

### CONCLUSIONS

- **Lefamulin demonstrated potent in vitro activity against the typical pathogens that commonly cause CAP collected in Europe in 2017, and our data are consistent with surveillance results from previous years.**

- **The activity of lefamulin was unaffected by resistance to other antibiotic classes, including macrolides, fluoroquinolones, fosfomycin, linezolid, and tetracyclines.**

- **These data—together with the previously reported activity against clinical CAP pathogens such as S. pneumoniae, M. pneumoniae, C. pneumoniae, and L. pneumophila—support the ongoing clinical development of lefamulin as an empiric IV and oral monotherapy for the treatment of CAP and other respiratory tract infections.**

### METHODS

- **In vitro activities were determined by CLSI standard methods** and susceptibility was determined using the CLSI microdilution method. Testing 20% broth microdilution.

### REFERENCES


6. Nabriva Therapeutics, Vienna, Austria; Nabriya Therapeutics Inc., King of Prussia, PA, USA; JMI Laboratories, North Liberty, IA, USA.

7. The author Mark R. Rebel for for contributions to the Expert Panel for development of this poster. The authors are employees of C4 MedSolutions, LLC. Nabriva Therapeutics and JMI in Europe are companies of Nabriva Therapeutics plc. Nabriva Therapeutics plc is an employee of C4 MedSolutions, LLC. The work was conducted by the authors themselves.