



Short Communication

Single-dose dalbavancin and patient satisfaction in an outpatient setting in the treatment of acute bacterial skin and skin structure infections[☆]

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ABSTRACT

Objectives: Treatment of acute bacterial skin and skin structure infections (ABSSSIs) in the outpatient setting has potential advantages. We performed a subanalysis of outcomes for patients treated as outpatients versus inpatients with dalbavancin, a long-acting lipoglycopeptide, in a phase 3 clinical trial of ABSSSI.

Methods: The study was a double-blind trial of patients with ABSSSI randomised to receive dalbavancin 1500 mg intravenously as a single dose or two doses (1000 mg followed by 500 mg a week later). The primary endpoint was $\geq 20\%$ reduction in erythema at 48–72 h after the start of therapy. Patient satisfaction and preference for antibiotic treatment and care setting were measured using the 10-item Skin and Soft Tissue Infection (SSTI) questionnaire at Day 14.

Results: A total of 698 patients were randomised (386 treated as outpatients and 312 as inpatients). Outpatients were more likely to be younger and to have major abscess or traumatic wound infection; inpatients were more likely to have cellulitis as the type of ABSSSI, to meet SIRS criteria and to have elevated plasma lactate at baseline. Efficacy and safety outcomes at 48–72 h, Days 14 and 28 were similar between patients treated in the outpatient and inpatient setting with either the single-dose or two-dose regimen. Outpatients reported significantly greater convenience and satisfaction with antibiotic treatment and care setting compared with inpatients ($P < 0.001$).

Conclusion: Single-dose dalbavancin is an effective treatment option for outpatients with ABSSSI and is associated with a high degree of patient treatment satisfaction and convenience.

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1. Introduction

Acute bacterial skin and skin structure infections (ABSSSI) are a significant healthcare burden, causing substantial morbidity

both in inpatient and outpatient settings [1,2]. Rising rates of ABSSSI in the community setting, particularly those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), have been associated with higher rates of emergency department visits [1,2]. Higher rates of MRSA have also led to more outpatient treatment failures for ABSSSI as well as higher rates of hospital admission, longer length of stay and greater use of healthcare resources [3]. Thus, shifting treatment of ABSSSI to the outpatient setting may reduce costs and healthcare resource use while improving patient satisfaction [3–5].

Dalbavancin is a long-acting lipoglycopeptide antibiotic with a terminal half-life of 15.5 days that is approved by the US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) for the treatment of ABSSSI in adults [6–10]. The antibiotic is administered as a 30-min intravenous (i.v.) infusion

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as a single 1500 mg dose or as a two-dose regimen of 1000 mg followed 1 week later by 500 mg, eliminating the need for a peripherally inserted central catheter and its associated complications. Dalbavancin has potent activity against Gram-positive pathogens responsible for ABSSSI, including MRSA and streptococci [8,9].

In a recent phase 3 clinical trial, a single 1500 mg infusion of dalbavancin was found to have similar efficacy and safety to a two-dose dalbavancin regimen [9]. The unique pharmacokinetic and pharmacodynamic properties of dalbavancin make it optimal for use in the outpatient setting by allowing completion of treatment with a single dose.

Limited research exists regarding patient satisfaction or preference for ABSSSI treatment by healthcare setting (inpatient or outpatient) and types of antibiotic therapy (e.g. duration of infusion, number of doses). Patient satisfaction and preference are increasingly important, and patient-centric outcomes have been emphasised by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) programme, a value-based incentive payments programme of the Centers for Medicare and Medicaid Services [11]. There are no recent studies to indicate patient satisfaction with current standards of care for ABSSSI [12,13]. Therefore, we sought to assess the efficacy, safety and patient satisfaction of dalbavancin in patients with ABSSSI treated in the outpatient and inpatient setting.

2. Materials and methods

2.1. Study design

This was a post-hoc analysis of a previously published, randomised, double-blind, phase 3 clinical trial in 698 adult patients with ABSSSI conducted between April 2014 and March 2015 at 60 centres across the USA, Eastern Europe, Russia and South Africa (ClinicalTrials.gov ID: NCT02127970) [9]. The protocol was approved by the institutional review boards at each centre, and all patients provided written informed consent.

The study design, including randomisation method, has been described previously [9]. Patients were randomised 1:1 to receive either dalbavancin 1500 mg as a single i.v. infusion over 30 min followed by a placebo infusion a week later, or as a two-dose regimen (1000 mg i.v. followed by 500 mg i.v. a week later) with dose adjustment for patients with creatinine clearance <30 mL/min who were not on regular dialysis. Patients were treated as outpatients or inpatients at the discretion of the investigator.

2.2. Patients

The study included adults (aged 18–85 years) with ABSSSI, defined as an infection involving deeper soft tissue or requiring significant surgical intervention, suspected or confirmed to be caused by Gram-positive bacteria. ABSSSI was classified as a major cutaneous abscess, cellulitis or traumatic wound/surgical site infection. Patients were required to have an area of erythema of $\geq 75 \text{ cm}^2$, at least two localised signs or symptoms of ABSSSI (purulent drainage, fluctuance, localised warmth, tenderness to palpation and swelling/induration) and at least one systemic sign of infection (white blood cell count $>12\,000 \text{ cells/mm}^3$, $\geq 10\%$ immature neutrophils on a peripheral smear or an elevated body temperature $\geq 38^\circ \text{C}$ ($\geq 100.4^\circ \text{F}$)).

For this analysis, inpatients were defined as those who were hospitalised when the first dose of study drug was administered or were hospitalised within 24 h of the first dose; everyone else was considered an outpatient.

2.3. Outcome measures

The primary endpoint was defined as a $\geq 20\%$ reduction in erythema associated with the infection at 48–72 h after the start of treatment in the intent-to-treat population. Patients who received supplementary rescue antibacterial therapy before this assessment were considered to be non-responders. Secondary outcome measures included clinical success, defined as improvement in lesion size from baseline, and resolution or improvement of clinical signs and symptoms. Clinical success required $\geq 80\%$ reduction in lesion area on Day 14 and $\geq 90\%$ reduction on Day 28 and was assessed in the intent-to-treat and the clinically evaluable populations. An investigator assessment of cure was performed on Days 14 and 28; success was defined as the resolution or improvement of all signs and symptoms of ABSSSI to such a degree that no further antibacterial therapy was given.

Patient satisfaction and preference were evaluated using the Skin and Soft Tissue Infection (SSTI) questionnaire. This 10-item questionnaire was administered ca. 14 days after the first dose of dalbavancin at the end-of-therapy visit. The survey analysis population consisted of all randomised subjects who received at least one dose of dalbavancin and completed at least one item of the SSTI questionnaire. The survey completion rate was assessed for the survey analysis population and was defined as the proportion of patients who completed all 10 survey items.

2.4. Statistical analysis

Determination of sample size has been previously described for the primary analysis [9]. Differences between outpatient and inpatient treatment groups with respect to patient demographics and disease characteristics were calculated using Fisher's exact test for categorical variables and Wilcoxon rank-sum test for continuous variables. A 95% confidence interval (CI) was computed using the Miettinen & Nurminen method with Cochran–Mantel–Haenszel stratum weights. For the SSTI questionnaire, χ^2 testing (or Fisher's exact test if needed) was used to evaluate the difference in proportions between outpatient and inpatient populations for each survey item.

3. Results

3.1. Patient demographics and disease characteristics

Of the 698 patients randomised in the original study, 386 were treated as outpatients and 312 were treated as inpatients (Table 1). Patients treated in the outpatient setting were more likely to be younger, enrolled in North America, have a history of intravenous drug use and have an MRSA infection compared with those admitted to hospital for the treatment of ABSSSI. There were also differences in the types of infection between outpatients and inpatients, with outpatients more likely to have major abscess and traumatic wound/surgical site infection and inpatients more likely to have cellulitis. In addition, more inpatients met systemic inflammatory response syndrome (SIRS) criteria and had plasma lactate $>4 \text{ mmol/L}$ at baseline. The patient disposition is shown in Supplementary Fig. S1.

3.2. Efficacy outcomes

For the primary efficacy outcome measure ($\geq 20\%$ reduction of erythema at 48–72 h), dalbavancin showed similar efficacy as a single dose and a two-dose regimen in the outpatient and inpatient subgroups (Table 2). Among outpatients, 82.1% of those in the single-dose group and 82.7% in the two-dose group were responders at 48–72 h (difference, -0.5% , 95% CI -8.3% to 7.1%).

Table 1
Baseline patient and disease characteristics in the intent-to-treat population (n = 698).^a

Characteristic	Outpatients (n = 386)	Inpatients (n = 312)	P-value ^b
Age (years) (mean ± S.D.)	45.3 ± 13.2	51.7 ± 15.8	<0.0001
Female sex	152 (39.4)	139 (44.6)	0.19
Race			<0.001
White	320 (82.9)	303 (97.1)	
Black or African-American	52 (13.5)	7 (2.2)	
Other	14 (3.6)	2 (0.6)	
Intravenous drug use	209 (54.1)	3 (1.0)	<0.001
Diabetes mellitus	35 (9.1)	41 (13.1)	0.089
CL _{Cr} ≥ 30 mL/min [n/N (%)]	384/384 (100)	303/312 (97.1)	0.001
BMI (kg/m ²) (mean ± S.D.)	28.4 ± 7.3	29.3 ± 7.5	0.054
BMI			0.10
<25 kg/m ²	143 (37.0)	94 (30.1)	
25–30 kg/m ²	122 (31.6)	100 (32.1)	
>30 kg/m ²	121 (31.3)	118 (37.8)	
Location of trial centre			<0.001
North America	312 (80.8)	6 (1.9)	
Rest of world	74 (19.2)	306 (98.1)	
Infection type			<0.001
Cellulitis	133 (34.5)	198 (63.5)	
Major cutaneous abscess	129 (33.4)	50 (16.0)	
Traumatic wound/surgical site infection	124 (32.1)	64 (20.5)	
Temperature ≥38 °C [n/N (%)]	279/383 (72.8)	294/312 (94.2)	<0.001
WBC count >12 000 cells/mm ³ [n/N (%)]	149/380 (39.2)	109/310 (35.2)	0.30
Immature (band) neutrophils ≥10% [n/N (%)]	32/298 (10.7)	70/233 (30.0)	<0.001
Infection area (cm ²) [median (range)] ^c	292.8 (76.5–3120)	300.0 (56.0–4235)	0.37
SIRS ^d	134 (34.7)	169 (54.2)	<0.001
CRP (mg/L) [median (range)] ^e	47.9 (0.6–300)	66.3 (0.2–300)	0.021
Plasma lactate (mmol/L) (mean ± S.D.)	1.5 ± 0.75	1.9 ± 1.1	<0.0001
Plasma lactate >4 mmol/L [n/N (%)]	1/345 (0.3)	12/277 (4.3)	<0.001
Pathogen at baseline			
MRSA [n/N (%)]	90/242 (37.2)	7/188 (3.7)	<0.001
MSSA [n/N (%)]	79/242 (32.6)	120/188 (63.8)	<0.001
Gram-negative aerobic organism [n/N (%)]	28/242 (11.6)	19/188 (10.1)	0.65
Survey analysis population	359 (93.0)	303 (97.1)	0.016

S.D., standard deviation; CL_{Cr}, creatinine clearance; BMI, body mass index; WBC, white blood cell; SIRS, systemic inflammatory response syndrome; CRP, C-reactive protein; MRSA, methicillin-resistant *Staphylococcus aureus*; MSSA, methicillin-susceptible *S. aureus*.

^a Data are n (%) unless otherwise stated.

^b Differences between treatment groups were analysed using Fisher's exact test for categorical variables and Wilcoxon rank-sum test for continuous variables.

^c Infection area measurements were available for 383 outpatients and 312 inpatients.

^d SIRS is defined as having at least two of the following: temperature <36 °C or >38 °C; heart rate >90 bpm; respiratory rate >20 breaths/min; WBC count <4000 cells/mm³ or >12 000 cells/mm³ or >10% immature (band) neutrophils.

^e CRP levels were available for 383 outpatients and 312 inpatients.

Efficacy was similar in inpatients who received a single dose (80.5%) or the two-dose regimen (86.3%) (difference, –5.8, 95% CI –14.1% to 2.6%). Secondary outcome parameters of clinical success were also similar in outpatients and inpatients at Days

14 and 28, with no significant differences between the single- or two-dose regimens in either subgroup; the exception was the investigator assessment of cure at Day 28, which was slightly higher among inpatients receiving a single dose (100%) compared

Table 2
Efficacy of dalbavancin at various time points for outpatients and inpatients.

Outcome	Outpatients (n = 386)		Inpatients (n = 312)	
	Single dose	Two doses	Single dose	Two doses
48–72 h				
Treatment response (ITT) [n/N (%)] ^a	156/190 (82.1)	162/196 (82.7)	128/159 (80.5)	132/153 (86.3)
Difference [% (95% CI)]		–0.5 (–8.3 to 7.1)		–5.8 (–14.1 to 2.6)
Day 14				
Clinical success (CE) [n/N (%)] ^b	142/162 (87.7)	151/169 (89.3)	125/140 (89.3)	119/133 (89.5)
Difference [% (95% CI)]		–1.7 (–8.8 to 5.3)		–0.2 (–7.7 to 7.5)
Investigator assessment of cure (CE) [n/N (%)] ^b	154/162 (95.1)	164/169 (97.0)	138/140 (98.6)	128/132 (97.0)
Difference [% (95% CI)]		–2.0 (–6.9 to 2.5)		1.6 (–2.4 to 6.3)
Day 28				
Clinical success (CE) [n/N (%)] ^b	136/150 (90.7)	139/150 (92.7)	114/121 (94.2)	108/117 (92.3)
Difference [% (95% CI)]		–2.0 (–8.6 to 4.5)		–1.9 (–4.8 to 9.0)
Investigator assessment of cure (CE) [n/N (%)] ^b	142/150 (94.7)	146/150 (97.3)	121/121 (100)	112/116 (96.6)
Difference [% (95% CI)]		–2.7 (–7.9 to 2.0)		3.4 (0.3 to 8.5)

ITT, intent-to-treat; CI, confidence interval; CE, clinically evaluable; ABSSSI, acute bacterial skin and skin structure infection.

^a The ITT population included all randomised patients regardless of whether or not they received the study drug.

^b The CE population included patients who met the inclusion criteria, did not have Gram-negative bacteraemia at baseline, received dalbavancin as randomised, received one or fewer doses of another systemic antibacterial agent with documented activity against the causative pathogen for a non-ABSSSI, received the appropriate adjunctive antibacterial therapy if the ABSSSI included at least one Gram-negative aerobic or anaerobic pathogen on culture, and had a clinical assessment in the required time frame.

with inpatients receiving a two-dose regimen (96.6%) (difference, 3.4%, 95% CI 0.3%–8.5%) (Table 2).

3.3. Patient treatment satisfaction

The SSTI questionnaire analysis population was comparable with the main study population and included 359 outpatients and 303 inpatients. Overall, 99.2% (356/359) of outpatients and 75.2% (228/303) of inpatients completed all 10 questions on the survey. The survey results are summarised in Table 3. A greater number of outpatients reported being ‘very satisfied’ or ‘extremely satisfied’ with their antibiotic treatment, care received, effect of the antibiotic on the infection and the location (i.e. outpatient or inpatient setting) of the care they received compared with inpatients ($P < 0.001$). In terms of patient convenience, a greater number of outpatients versus inpatients reported that antibiotic treatment did not interfere at all with daily activities (74% vs. 42%; $P < 0.001$) and that they were easily able to modify their schedule to receive antibiotic therapy (97% vs. 76%; $P < 0.001$). The most common response both in outpatients and inpatients regarding how often they were concerned about receiving their antibiotic treatment was ‘none of the time’ (43% and 44%, respectively); a greater number of outpatients versus inpatients reported concern ‘all of the time’ (19% vs. 1%; $P < 0.001$, respectively).

Preference for the location of care for ABSSSI treatment (i.e. hospital or outpatient setting) differed between outpatients and inpatients; the majority preferred the care setting in which they were treated, with 67% of outpatients preferring outpatient care and 77% of inpatients preferring to be treated in the hospital ($P < 0.001$). The majority both of outpatients and inpatients preferred a 30-min single dose i.v. regimen (67% and 83%, respectively) over other antibiotic treatment choices (Table 3). The second most preferred regimen was consistent with the dalbavancin two-dose therapy, i.e. a 30-min infusion once a week for 2 weeks (29% and 14%, respectively). Less commonly preferred regimens included a 3-h infusion once (1% and 1%, respectively), two 1-h infusions per day for a week (2% and 2% respectively), and a combination of i.v. and oral therapy over a week (1% and 0%, respectively).

3.4. Safety

Dalbavancin was well tolerated both by outpatients and inpatients, with a similar safety profile in both settings (Supplementary Table S1). Treatment-emergent adverse events (TEAEs) occurred in 23.7% of outpatients receiving a single dose and in 21.2% of outpatients receiving the two-dose regimen. Corresponding values for inpatients were 15.7% and 18.3%, respectively. Rates of drug-related TEAEs, serious TEAEs, and TEAEs leading to premature discontinuation of study drug were also similar between outpatients and inpatients and between the single- and two-dose regimens.

4. Discussion

There is a need for safe, effective and convenient antibacterial therapies for ABSSSI that can be provided in the outpatient setting, a cost-saving setting, versus the inpatient setting. Increased emphasis on healthcare quality and reduced costs, as well as an increased prevalence of MRSA as a causative pathogen in community-acquired ABSSSI, further highlights this need.

The safety and efficacy of dalbavancin in the treatment of ABSSSI have been established in large clinical trials [8,9]. The clinical trial on which this analysis was based demonstrated that dalbavancin administered as a single 1500 mg i.v. dose was non-inferior to the two-dose regimen given as 1000 mg followed by 500 mg 1 week later [9]. This analysis confirms that the clinical

outcome rates at 48–72 h, Days 14 and 28 with either regimen for the treatment of ABSSSI are similar whether the patient is treated in the outpatient (community) or inpatient (hospital) setting. Among inpatients, investigator assessment of cure rates at Day 28 tended to be higher among those who received a single dose compared with the two-dose regimen, although both regimens were highly effective [121/121 (100%) vs. 112/116 (96.6%)]. Similar cure rates were found for outpatients in this study, despite a majority having risk factors for severe infection: over one-half were intravenous drug users, over one-third met SIRS criteria, and they had higher rates of MRSA and abscess or traumatic wound/surgical site infection compared with inpatients. Healthcare setting was left to the treating physician’s discretion in this trial, supporting the ability of physicians to choose the appropriate healthcare setting in which to administer long-acting antibiotic therapy for patients.

Long-acting agents such as dalbavancin that are active against common ABSSSI pathogens should be considered antibiotics of choice to effectively treat patients in the outpatient setting while decreasing health resource use [14]. Dalbavancin is an abbreviated course of outpatient parenteral antibiotic therapy (OPAT), a treatment pathway supported to be both clinically effective and cost saving in a variety of infections, including ABSSSI [4,12,13,15–17]. For example, Ektare et al. reported that shifting care for ABSSSI to the outpatient setting could result in medical cost savings of >50% [4], highlighting potential cost savings of outpatient care for the treatment of ABSSSI.

In the current study, the choice of setting was left to the treating physician’s discretion as there are no widely accepted criteria for selecting patients to be treated in the outpatient or inpatient setting. Practice guidelines suggest that patients can be treated as outpatients in the absence of certain presentations and comorbidities such as haemodynamic instability, necrotizing fasciitis, unstable co-morbidities (e.g. diabetic ketoacidosis, severely immunocompromised state), complicated wounds requiring surgical intervention, severe sepsis, and social and personal factors that would interfere with successful outpatient care [3,15,18]. An analysis of more than 600 000 ABSSSI patients from 520 hospitals found that 60% of those hospitalised had no significant co-morbid conditions or systemic symptoms and thus could potentially have been treated on an outpatient basis [19]. In addition, Talan et al. found that the most common reason for admission in 85% of ABSSSI patients presenting to the emergency department was the need for i.v. antibiotics [20]. Therefore, treatment with dalbavancin as a single dose or two-dose regimen could possibly avoid hospitalisations if the only reason for admission is the need to administer daily i.v. antibiotics.

With respect to patient treatment satisfaction and preference, the majority of outpatients and inpatients preferred an antibiotic regimen consistent with dalbavancin administration over other antibiotic treatments and found treatment to be convenient. Although there are limited data regarding patient satisfaction with outpatient treatment of ABSSSI, these results are consistent with other studies reporting high levels of patient satisfaction with OPAT [12,13,16,17]. Given the increased emphasis on patient-reported outcomes, treatment satisfaction and preference for dalbavancin over other therapies is an important factor in ABSSSI treatment choice.

The primary limitation of this study is that it is a subgroup analysis of a larger clinical trial and limited inferences can be drawn. Another limitation is that the SSTI questionnaire was not internally or externally validated as it was specifically designed to capture the potential impact of the unique pharmacokinetic properties of dalbavancin, given the unavailability of an applicable validated questionnaire; therefore, the results may not be generalisable to a broader ABSSSI population.

Table 3
Skin and Soft Tissue Infection (SSTI) questionnaire results for outpatients and inpatients.

Item	Response	Outpatients [n/N (%)]	Inpatients [n/N (%)]	P-value ^a
Feelings related to the overall antibiotic treatment				
Question 1. How often were you concerned about receiving your antibiotic treatment?				<0.001
Responses	None of the time	153/359 (43)	132/303 (44)	
	A little of the time	59/359 (16)	84/303 (28)	
	Some of the time	44/359 (12)	70/303 (23)	
	Most of the time	33/359 (9)	14/303 (5)	
	All of the time	70/359 (19)	3/303 (1)	
Outpatient treatment convenience				
Question 2. Did receiving your antibiotic treatment interfere with your usual daily activities?				<0.001
Responses ^{b,c}	Significantly	2/356 (1)	8/228 (4)	
	Moderately	31/356 (9)	44/228 (19)	
	Slightly	61/356 (17)	80/228 (35)	
	Not at all	262/356 (74)	96/228 (42)	
Question 3. Were you easily able to modify your schedule to take your antibiotic treatment?				<0.001
Responses ^{b,c}	Yes	350/359 (97)	173/228 (76)	
	No	9/359 (3)	55/228 (24)	
Treatment regimen satisfaction and preference				
Question 4. Overall, how satisfied were you with your antibiotic treatment?				<0.001
Responses ^b	Extremely satisfied	245/358 (68)	121/303 (40)	
	Very satisfied	89/358 (25)	143/303 (47)	
	Moderately satisfied	18/358 (5)	37/303 (12)	
	Slightly satisfied	2/358 (1)	2/303 (1)	
	Not at all satisfied	4/358 (1)	0/303 (0)	
Question 5. In terms of your experience with your antibiotic treatment, would you recommend for yourself or others the same antibiotic treatment again?				<0.001
Responses ^b	Definitely yes	318/358 (89)	184/303 (61)	
	Probably	27/358 (8)	86/303 (28)	
	Maybe	11/358 (3)	32/303 (11)	
	Probably no	1/358 (0)	1/303 (0)	
	Definitely no	1/358 (0)	0/303 (0)	
Question 6. If you had the choice between the following antibiotic treatments, which one would you prefer?				<0.001
Responses ^b	One 30-min infusion once	240/358 (67)	252/303 (83)	
	One 3-h infusion once	4/358 (1)	2/303 (1)	
	One 30-min infusion once a week for 2 weeks	104/358 (29)	43/303 (14)	
	Two 1-h infusions per day for a whole week	8/358 (2)	6/303 (2)	
	A few days of two 60-min infusions per day and then one pill 3–4 times per day the rest of the week	2/358 (1)	0/303 (0)	
Feelings related to the overall antibiotic treatment				
Question 7. Overall, how satisfied were you with the care you received?				<0.001
Responses	Very satisfied	350/359 (97)	271/303 (89)	
	Neutral	9/359 (3)	29/303 (10)	
	Very or quite dissatisfied	0/359 (0)	3/303 (1)	
Question 8. Were you satisfied with the effect of the intravenous antibiotic on your infection?				<0.001
Responses	Very satisfied	337/359 (94)	264/303 (87)	
	Neutral	17/359 (5)	36/303 (12)	
	Very or quite dissatisfied	5/359 (1)	3/303 (1)	
Question 9. Overall, how satisfied were you with the location of the care you received (hospital, outpatient, or both)?				<0.001
Responses	Very satisfied	339/359 (94)	238/303 (79)	
	Neutral	19/359 (5)	58/303 (19)	
	Very or quite dissatisfied	1/359 (0)	7/303 (2)	
Question 10. Where do you think it is preferable to receive the kind of care you were provided?				<0.001
Responses	In the hospital	59/359 (16)	232/303 (77)	
	In the community (as an outpatient)	239/359 (67)	51/303 (17)	
	No preference	61/359 (17)	20/303 (7)	

^a The χ^2 test (or Fisher's exact test where needed) was used to test for a difference in proportions between subgroups (outpatient and inpatient populations) for each survey item.

^b Response rate was <100% for the item, i.e. fewer respondents for the item than survey sample size (outpatient group, n=359; inpatient group, n=303).

^c Subjects were directed to skip item if they were currently hospitalised.

5. Conclusions

Single-dose dalbavancin was associated with similar success rates as the two-dose regimen for the treatment of ABSSSI regardless of treatment in the outpatient or inpatient setting. The majority of patients preferred a single-dose i.v. antibiotic regimen provided over 30 min above other antibiotic treatment options, irrespective of treatment setting. Outpatients had higher levels of satisfaction with their care compared with inpatients, including increased convenience. The availability of a single, convenient, 30-min infusion appears to be an effective treatment option for outpatients with the potential to improve clinical outcomes and decrease healthcare costs by avoiding hospital admission.

Data statement

Data are available from the author upon reasonable request.

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Competing interests

UR, PLG, KK and PG are employees of Allergan and may hold stock in the company; SP was an employee of Allergan at the time of study conduct and analysis and holds stock in the company, and her current affiliation is with Iterum Therapeutics; KA was an independent consultant at time of study conduct and analysis, and his current affiliation is with Iterum Therapeutics; YL was an employee of Allergan at the time of study conduct and analysis, and her current affiliation is with Johnson & Johnson; MWD was an employee of Allergan at the time of study conduct and analysis, and his current affiliation is with Iterum Therapeutics.

Ethical approval

The study protocol was approved by the institutional review boards or independent ethics committee at each participating centre, and all patients provided written informed consent.

Clinical trial information

This is a post-hoc analysis of ClinicalTrials.gov registration no. NCT02127970.

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.jgar.2019.02.007>.

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