Dalbavancin or Oritavancin for Skin Infections

TO THE EDITOR: Boucher et al. (June 5 issue)1 report the results of DISCOVER 1 and DISCOVER 2, and in the same issue Corey et al.2 report the results of SOLO I. These randomized trials investigated the efficacy of oritavancin and dalbavancin in acute bacterial skin and skin-structure infections. We are concerned that the design of these studies and that of other pivotal studies are not consistent with clinical management of acute bacterial skin and skin-structure infections and that their results are thus not useful for clinical decisions in real life — at least in Europe and some other areas of the world. First, vancomycin may not be an adequate comparison drug. Beta-lactam antibiotics remain the mainstay drugs for the treatment for methicillin-susceptible Staphylococcus aureus and streptococci, which are the main causes of these infections in most areas, as shown in a recent observational study in Europe.3 Second, most patients with these complicated acute bacterial skin and skin-structure infections are not admitted to the hospital but rather are treated at home with oral antibiotics after surgical drainage of the infected area. In fact, it is difficult for most hospitals in western European countries to include patients in trials with these inclusion criteria.

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TO THE EDITOR: In their studies based on intention-to-treat analyses, Boucher et al. and Corey et al. concluded that the new treatments were not inferior to the conventional treatment. Although these are reasonable conclusions, problems such as high dropout rates, which are detrimental to a superiority trial, can be advantageous in a noninferiority study.1 This is because an intention-to-treat analysis is more likely to narrow the difference between the treatment groups and yield a