subgroups were defined by any medical history of diabetes (type 1, type 2, or unspecified), or no medical history of diabetes. Efficacy outcomes were early clinical response (ECR) and investigator’s assessment of clinical response at post-treatment evaluation (PTE), as defined for each indication. Safety was assessed by treatment-emergent adverse events (TEAEs) and laboratory measures, and data were pooled across the three studies.

**Results.** A total of 2,136 patients were included, of whom 238 (11.3%) had any history of diabetes (n = 105 for ABSSSI, n = 133 for CABP). In the pooled ABSSSI studies and the CABP study, clinical success at ECR and PTE was similar between patients with or without diabetes, and between OMC and the respective comparator (figure). TEAEs and serious TEAEs, respectively, were reported in similar numbers of OMC, LEF, and MOX-treated patients with diabetes (41.8–43.9%, 4.5–7.0%) and without (41.2–48.3%, 1.6–6.9%). Rates of nausea and vomiting, respectively, in patients with diabetes were similar across treatment arms: OMC (5.0%, 5.9%), LEF (7.5%, 6.0%), MOX (7.0%, 2.8%).

**Conclusion.** Demonstrated efficacy and safety were similar and consistent in patients with or without diabetes.

Disclosures. All authors: No reported disclosures.

701. Comparison of MIC Results for Gepotidacin by Agar Dilution and Broth Microdilution Methods

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**Session:** 68: Novel Antimicrobials and Approaches Against Resistant Bugs

**Thursday, October 3, 2019: 12:15 PM**

**Background.** Gepotidacin (GSK214944) is a novel triazacenaphthylene bactericidal type II topoisomerase inhibitor in clinical development for the treatment of gonorrhea and uncomplicated UTI (acute cystitis). Gepotidacin selectively inhibits bacterial DNA gyrase and topoisomerase IV by a unique mechanism not utilized by any currently approved therapeutic agent and demonstrates in vitro activity against most target pathogens resistant to established antibacterials, including fluoroquinolones. This study tested the equivalency of minimal inhibitory concentrations (MICs) obtained by 2 reference susceptibility testing methods, agar dilution (AD) and broth microdilution (BMD), for gepotidacin against Gram-positive and Gram-negative organisms.

**Methods.** Susceptibility testing for both methods was performed on a total of 733 clinical isolates recovered largely in 2016 from over 120 medical centers worldwide. For *N. gonorrhoeae*, only the AD method is recommended by CLSI, therefore BMD was performed using Fastidious Broth for comparison purposes. Essential agreement (EA) based on evaluable results was calculated as the number of isolates with MICs within one 2-fold dilution of the reference method divided by the total number of results. Equivalency was defined using the 95% criteria from the FDA class II controls document.

**Results.** The EA observed for gepotidacin with these 2 methods was 85.8% overall and 98.3% when *H. influenzae* and *N. gonorrhoeae* isolates were excluded. Slightly higher gepotidacin MICs were observed when tested by BMD as compared to AD for each of these species/groups; this trend was especially prominent for *E. coli* and *S. pyogenes*. Gepotidacin tested against *H. influenzae* (73.1%) or *N. gonorrhoeae* (28.6%) species had much lower EAs.

**Conclusion.** EA >95% was established between AD and BMD methods for determining gepotidacin susceptibility results against *Staphylococcus spp.*, *Streptococcus spp.*, and *E. coli*. However, for *N. gonorrhoeae* and *H. influenzae*, equivalency between the 2 methods was not established; therefore, future antimicrobial susceptibility testing for gepotidacin against these organisms should adhere to the methods for which quality control ranges and breakpoints are approved.

Disclosures. All authors: No reported disclosures.