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Bacteriocins: Antibiotics in the Age of the Microbiome

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Key words: Bacteriocin, Microbiome, Antibiotic, Probiotic, Antimicrobial Resistance

Running title: Bacteriocins as therapeutic antimicrobials in the context of the microbiome.
Abstract

Antibiotics have revolutionised the treatment of infectious disease and improved the lives of billions of people worldwide over many decades. With the rise in antimicrobial resistance (AMR) and corresponding lack of antibiotic development, we find ourselves in dire need of alternative treatments. Bacteriocins are a class of bacterially produced, ribosomally synthesised, antimicrobial peptides that may be narrow or broad in their spectrums of activity. Animal models have demonstrated the safety and efficacy of bacteriocins in treating a broad range of infections, however, one of the principal drawbacks has been their relatively narrow spectra as compared with small molecule antibiotics. In an era where we are beginning to appreciate the role of the microbiota in human and animal health, the fact that bacteriocins cause much less collateral damage to the host microbiome makes them a highly desirable therapeutic. This review makes a case for the implementation of bacteriocins as therapeutic antimicrobials, either alone or in combination with existing antibiotics to alleviate the AMR crisis and to lessen the impact of antibiotics on the host microbiome.
Abbreviations used: AAD, Antibiotic Associated Diarrhoea; AMR, Antimicrobial Resistance; AOM, Acute Otitis Media; CDAD, *Clostridium difficile* Associated Disorder; CDC, Centres for Disease Control and Prevention; EcN, *Escherichia coli* Nissle; GI, Gastrointestinal tract; MIC, Minimum Inhibitory Concentration; VRE, Vancomycin Resistant *Enterococci*. 
Introduction

Antimicrobial resistance (AMR) has been recognised as one of the major threats to public health in the 21st century. In a report commissioned by the UK government in 2014, it was estimated that AMR could be responsible for 10 million deaths worldwide by 2050, with a global financial cost of $100 trillion (1). Meanwhile the Centers for Disease Control and Prevention (CDC) estimates the annual cost of AMR in the US to range from $20 billion in direct healthcare costs to $35 billion in additional costs to society due to lost productivity (2). Apart from the human and financial costs associated with AMR, there are also ethical considerations that need to be addressed surrounding how we as a society respond and deal with the AMR crisis (3). There are multiple reasons for the present AMR crisis, but significant factors include the incorrect/indiscriminate administration and use of antibiotics and a dry antibiotic development pipeline (4, 5). The CDC also recently estimated that in the US approximately 50% of antibiotics are incorrectly prescribed. Moreover, the use of antibiotics in agriculture has continued, despite undeniable evidence that this practice adds to the antimicrobial resistance crisis. Resistance to a key “last-resort” antibiotic, colistin, has been observed in the US, Europe and Asia (6-8). We have also seen the rapid spread of resistance to another “last resort” class of antibiotics, the carbapenems (9). With the emergence of these new resistant strains and the emergence of pan-resistant bacteria, it is safe to say we have truly arrived in the much predicted post-antibiotic era (10).

It is important that we acknowledge that broad-spectrum antibiotic therapy has revolutionised the treatment of infectious diseases within the last century, but we must also admit to unintended consequences of antibiotic use, such as potentially negative
effects on the host microbiome and their potential toxicity (5, 11). Although the field of microbiome research is in its infancy relative to that of antibiotic therapy, evidence strongly suggests that the composition of the microbiome can be an indicator of health and is likely to be involved in many aspects of human health and disease (12). Strides in DNA sequencing technology and bioinformatics have increased our understanding of the role of the microbiome in a variety of disease states. Indeed the administration of antibiotics in early life and the subsequent disruption of the microbiota may contribute to risk of obesity in later life (13, 14). Furthermore, when subjected to broad-spectrum antibiotic therapy, non-target commensal microbes may evolve and/or acquire resistance mechanisms to evade the effects of the antibiotic, thereby contributing to the antibiotic resistance crisis.

Bacteriocins represent a class of powerful antimicrobial peptides that may provide at least part of a solution to the AMR crisis. We aim to demonstrate their efficacy in the treatment of infectious disease and their reduced impact on the host microbiome by comparison to broad-spectrum antibiotic therapy.

**Bacteriocins: potent antimicrobial peptides**

Many excellent reviews have been written about bacteriocins (11, 15, 16), but in brief they are a diverse group of peptides that may be classified into three distinct groups; class I (modified), class II (unmodified or cyclic) and Class III (>10kDa peptides). Apart from their potent antimicrobial activity (with minimum inhibitory concentrations [MIC’s] often in the nanomolar range) they have also been shown to have antiviral (17), anticancer (18) and immunomodulatory properties (19). Bacteriocins typically have a narrow spectrum of activity, but broad-spectrum
peptides are also present in this class of antimicrobials (e.g. nisin and lacticin 3147 inhibit a wide range of Gram-positive bacteria). As a result these peptides may be suitable for treating infections of unknown aetiology, using broad-spectrum bacteriocins, or may allow more precise targeting of known infectious agents using highly active narrow spectrum bacteriocins. Bacteriocins are gene encoded, which makes them amenable to genetic alterations to improve functional characteristics. Furthermore, their toxicity is low and they may be administered as either purified peptide or produced in situ by bacteriocin producing probiotic bacteria (11). Bacteriocins are also known to interact with a variety of receptors, which are different to those targeted by antibiotics, making cross-resistance less likely (20). Although a more targeted approach may still ultimately lead to resistance development in the infectious agent, it does reduce the likelihood of resistance development in commensal populations outside of the target range of the bacteriocin. Resistance mechanisms involving the class II receptors, the mannose phosphotransferase system (Man-PTS), have been identified (21) along with a variety of resistance mechanisms to the class I lantibiotics (22).

**The microbiota perspective**

The term “superorganism” or “holobiont” has commonly been applied to describe the relationship that exists between humans and its commensal microbes and viruses (23). Understanding the role of the microbiota in health and protecting its diversity during the treatment of infectious disease is a key element of why bacteriocins may be suitable as alternatives to antibiotics.
The two-peptide sactibiotic bacteriocin, Thuricin CD, is a narrow spectrum bacteriocin. Thuricin CD is highly active against one of the main causative agent of antibiotic associated diarrhoea (AAD), *Clostridium difficile*, which is responsible for 20-30% of AAD cases (24). Briefly, AAD is caused by a disruption of the microbiota (often referred to as dysbiosis) following broad spectrum antibiotic treatment, and notably has a recurrence rate of 15-60% (25). Thuricin CD was shown to exhibit comparable activity to both vancomycin and metronidazole (two antibiotics used for the treatment of AAD which has progressed to *C. difficile* associated disease, CDAD). Importantly, it showed almost no effect on microbial diversity when compared to both metronidazole and vancomycin in a distal colon model (26). The modified R-Type bacteriocin, Av-CD291.2, has also been shown to prophylactically prevent colonization of *C. difficile* in a mouse model without perturbing the microbiota (27).

There are other broad spectrum bacteriocins which are attractive therapeutic agents by virtue of their activity against *C. difficile*, but while the broad spectrum lantibiotic lacticin 3147 is effective at killing *C. difficile*, it has a significant impact on the resident microbiome populations such as *Bifidobacterium*, *Lactobacillus* and *Enterococcus* species (28). It has also been shown that a commercially available product containing the lantibiotic nisin, Nisaplin®, can eliminate a *C. difficile* infection when added at a concentration of 20X MIC in a simulated human colon model. However a significant decrease in the total microbiota count was observed, with Gram-positives being adversely affected (29).

Notably, in recent years the emergence of Vancomycin Resistant *Enterococci* (VRE) has become a great concern and therefore raises the issues surrounding the efficacy of treating CDAD with vancomycin if it presents a risk to the general population and the
spread of antibiotic resistance. In this light, the treatment of CDAD with bacteriocins
could be a valuable alternative to vancomycin. When VRE development has taken
place, it has been shown that mice colonised with VRE can be decolonized through
the use of an *Enterococcus* probiotic containing a conjugation defective plasmid
which produces a bacteriocin named Bac-21 (30).

A defensin-like bacteriocin, bactofencin A, displays *in vitro* activity against *L.
monocytogenes* and *S. aureus* (31, 32). Although one might expect this medium to
broad spectrum antimicrobial peptide to cause drastic changes in the host
microbiome, this was in fact not the case and it was observed that the bactofencin
peptide only subtly modulated an *ex vivo* host microbiome (distal colon model) when
introduced as a bacteriocin producing probiotic or purified peptide. While the purified
peptide resulted in higher levels of beneficial microbes such as *Bifidobacterium*, it
was also associated with lower levels of *Clostridium*, which has been linked to
obesity and gut pathogenesis. Interestingly, although bactofencin does not show
inhibitory activity *in vitro* against strains from the genera *Clostridium, Fusobacterium*
and *Bacteroides*, the reduction of these populations in the bactofencin treated faecal
samples indicates that the consequence of bactofencin altering the overall microbiota
structure impacts, directly or indirectly, on these normally insensitive populations
when in the gut environment (33).

It has also been shown, using bacteriocin producing probiotic strains and their
isogenic mutants, that the production of bacteriocins can aid the colonisation of a
murine host (34). Sequencing data revealed that although bacteriocin production by
the probiotics did not affect bacterial diversity at the phylum level, broad spectrum
bacteriocins (enterocins and garvicin ML) had a more significant impact on the genus/family diversity of the host microbiome than narrow spectrum bacteriocins (sakacin A, plantaricins and pediocin PA-1).

**Bacteriocins in animal models**

Bacteriocins have been shown to be effective in the treatment of variety of infectious bacteria using two delivery methods, either as purified peptides (Table 1) or when delivered *in situ* by probiotics.

It has been hypothesized that there are three mechanisms by which bacteriocins mediate their producers probiotic properties (42); (i) **Competitive Inhibition**: bacteriocins may support colonization of the host through competitive inhibition of the autologous microbiota, (ii) **Pathogen Inhibition**: bacteriocins may interact directly on a pathogenic target, or (iii) **Immunomodulation**: bacteriocins may act as signalling peptides, recruiting other bacteria or recruiting immune cells to the site of infection to aid elimination of the pathogen (*Figure 1*).

**Preventing infection**

The concept of oral replacement therapy is another interesting example of prophylactic probiotic therapy, which has been investigated using the mutacin 1140 producing *streptococcus mutans* BCS3-L1. This bacteriocin producing strain is suitable for replacement therapy as it has reduced cariogenic potential because it does not produce lactic acid, mediated through the removal of its entire lactic acid dehydrogenase operon (43). Another interesting probiotic that has shown promise in
the limitation of dental caries, plaque accumulation and acidification is *Streptococcus salivarius* M18. This strain has 3 plasmid and 1 chromosomally encoded bacteriocins, which is perhaps why it can colonise the oral cavity so effectively. It also produces two enzymes, urease and dextranase, which reduce saliva acidity and counteract plaque formation (44). In a clinical trial, both the safety and efficacy of this strain’s probiotic potential was demonstrated, and it was shown to significantly reduce plaque formation in subjects who received the probiotic, over those who received the placebo (45). Furthermore, the treatment of children who have a high risk of dental caries development, with an oral formulation of the *S. salivarius* M18 probiotic (Carioblis®) was shown to reduce the likelihood of new dental caries development (46).

It has been demonstrated that dosing mice orally with the bacteriocin producer *Lb. salivarius* UCC118 three days prior to infection with *L. monocytogenes* resulted in a significant reduction in subsequent infection by *L. monocytogenes* (47). Nisin Z and pediocin AcH have also been shown to reduce and prevent the colonisation of a mouse model with vancomycin resistant *Enterococci* (VRE), where the bacteriocinogenic probiotic was administered 8 days prior to infection (48). It has also been demonstrated using a porcine model that *Salmonella enterica* serovar *typhimurium* shedding is reduced and disease symptoms of infection are alleviated when a mix of five probiotic strains was administered 6 days before infection (49). One of the probiotics, *L. salivarius*, produces salivaricin P, which can kill the other 4 strains in the probiotic mix. Interestingly, this bacteriocinogenic strain dominated in the ileum (the primary attachment site of the infecting *Salmonella*) whereas it was only detected as a minor component in the faeces of the same animals. This suggests that bacteriocin production may play a role where colonisation can occur along the
gastrointestinal (GI) tract (50). The concept of using prophylactic probiotics to competitively colonise a pathogens niche could be an effective strategy in agriculture to reduce antibiotic usage. If, as expected, regulations limiting the use of antibiotics in agriculture come into force, probiotics may be invaluable alternative.

Acute otitis media (AOM) is a type of inflammatory disease of the middle ear, characterised typically by rapid inflammation, potential tympanic membrane perforation, along with fullness and erythema. It has been reported that the levels of normal α-haemolytic *Streptococcus* colonising the nasopharynx of otitis prone children is much lower than in healthy individuals and that recolonization can significantly reduce the episodes of AOM (51, 52). It has been demonstrated treating otitis prone children with a history of AOM, with a nasal spray containing safe *Streptococcus salivarius* 24SMB (a strain which produces a bacteriocin-like substance), reduces the incidences of AOM over the placebo treated group (53).

*Treating infection*

*Helicobacter pylori* infection and colonisation results in a variety of disease states and may even lead to the development of gastric carcinoma. More recently, the prevalence of antibiotic resistant *H. pylori* has been increasing, creating a need for a new therapeutic agent (54). It has been shown in mice that eradication of *H. pylori* was achieved using a bacteriocinogenic probiotic treatment of *P. acidilactici* BA28 (55). Using a mixture of cranberry juice and the bacteriocin producing probiotic culture *Lactobacillus johnsonii* str. La1 supernatant, the carriage of *H. pylori* was also reduced in children after three weeks of treatment (56).
One barrier to the use of probiotics as a therapeutic is their ability to survive and colonise the area of infection. It has been shown that *Pediococcus acidilactici* UL5 and *Lactococcus lactis* ATCC 11454 can produce the bacteriocins pediocin PA-1 and nisin, respectively, *in situ* under simulated upper gastric conditions (57). Interestingly, the *in vitro* activity of a bacteriocin does not always correspond to the *in vivo* activity, where the bacteriocin is sometimes more or less active in an animal model, as is the case with mersacidin which is more active *in vivo* than *in vitro* (58).

**Bacteriocins against Gram-negatives**

Comparatively speaking, Gram-negative bacteria are relatively insensitive to bacteriocins compared to their Gram-positive counterparts, largely owing to the outer membrane which acts as a physical barrier. Until recently the treatment of Gram-negative infections with bacteriocins has not been favoured due to the efficacy of conventional antibiotics in the treatment of these infections. The rise of antibiotic resistant Gram-negative bacteria to the last line of antibiotics (6) means the treatment of Gram-negative infections using bacteriocins can no longer be ignored.

Widespread use requires a solution to the relative insensitivity of Gram-negative microorganisms. One possibility is to use bacteriocins in combination with other antimicrobial agents, including conventional antibiotics. Although conventional antibiotics will have an impact on the host microbiota (as previously discussed), certain bacteriocin/antibiotic combinations can be synergistic (59-62) and therefore lead to a reduced dose of both antimicrobial agents needed to treat an infection,
thereby lowering the potential effect on the host microbiome, the cytotoxic effects on the host and may potentially reduce the development of resistance.

Success of antibiotics is also hindered by Gram-negative bacteria residing within biofilms, where they are highly resistant to antibiotic treatments. Bacteriocin/antibiotic combinations have shown great promise in overcoming biofilm mediated resistance for important Gram-negative pathogens such as *Pseudomonas aeruginosa* (63) and *Escherichia coli* (64).

Although this review mainly focuses on Gram-positive bacteriocins, it is important to also to identify Gram-negative bacteriocins which may have potential therapeutic significance. Microcins are ribosomally-synthesized peptides commonly produced by Gram-negative bacteria which are active against Gram-negative strains, and are an interesting alternative to Gram-positive bacteriocins. They have been shown to display potent antimicrobial activity *in vitro* (65, 66) and more recently also *in vivo* (67). It has been demonstrated that the microcin producer *E. coli* Nissle 1917 (EcN) can prevent colonisation of competing *Enterobacteriaceae* in the gut, whilst still having a minimal impact on the diversity of the gut microbiota. However, EcN microcins exhibit their mechanism of action by targeting specific siderophore receptors on other *Enterobacteriaceae* which are only displayed during iron starvation, making their spectrum of activity quite narrow. Additionally to its prophylactic applications, EcN has also been demonstrated to reduce inflammation and weight loss associated with *Salmonella* infections. Another microcin produced by *E. coli* G3/10, microcin S, has been shown to inhibit other *E. coli* strains and
Furthermore can prevent the adherence of Enteropathogenic *E. coli* (EPEC) to intestinal epithelial cells (68).

**Overcoming the limitations/outlook**

In previous decades significant emphasis was placed on functional characteristics of bacteriocins, such as spectrum of activity, pH and temperature stability, which were essential for the use of bacteriocins in food applications. For their use as therapeutics additional characteristics such as proteolytic resistance, stability and solubility of bacteriocins will also be important.

With advancements in the field of bioengineering many intrinsic limitations have been overcome, and it has been shown using the prototypic lantibiotic, nisin, that bioengineering strategies can improve functional qualities such as antimicrobial activity (69-72), solubility (73, 74) diffusion properties (75) and effectiveness against Gram-negative bacteria (71). Indeed, similar bioengineering strategies could be applied to other bacteriocins once suitable expression systems have been developed.

Although the sensitivity of bacteriocins to proteolytic cleavage was previously regarded as a desirable trait when using these peptides as food preservatives, it does represent a major concern with regard to their administration and widespread use, both orally and intravenously. Bioengineering strategies could be once again used to manipulate peptide residues so they are no longer recognisable by host proteases and therefore are not proteolytically cleaved, thereby improving peptide functional qualities (76). Notably, the therapeutic application of the prototypic bacteriocin, nisin, has been in part hampered by its sensitivity to host proteases (77. Other approaches include prospecting for bacteriocins that display innate resistance to proteases, as was
achieved with pseudomycoicidin (78), which is naturally resistant to trypsin due to the presence of a thioether ring structure. The field of bioinformatics and the use of such programs as BAGEL 3.0 (79) and antiSMASH (80) could be a fundamental aspect of this prospecting, as these bacteriocin amino acid prediction tools from genome sequences may also allow researchers to identify protease resistant peptides before investing large amounts of time and effort in characterising such bacteriocins. Finally, understanding bacteriocin pharmacodynamics and pharmacokinetics are also essential to their safe implementation as therapeutics, which has been under investigated in comparison to other aspects of bacteriocin research. If bacteriocins are indeed to become an alternative to conventional antibiotics, a greater emphasis must be placed on research surrounding these host-drug interactions, such as was achieved with MU1140 (81). Addressing these limitations of bacteriocin research to date could provide a turning point for the flagging interest of the pharmaceutical industry and make bacteriocins an attractive therapeutic alternative to current antibiotics (10).

Although there is considerable evidence that narrow spectrum bacteriocins have a minimal effect on the host microbiome by comparison to current broad-spectrum antibiotics, it should also be recognised that more work in this regard is needed to strengthen the argument for the use of bacteriocins as antibiotics, along with overcoming the previously outlined limitations. Ultimately, we believe given the safe history of use of bacteriocins in food and the large body of literature surrounding this field, that they are useful candidates for antimicrobial therapeutics as the AMR crisis continues to worsen.
Summary

- Antimicrobial resistance (AMR) is a major threat to public health requiring immediate attention.
- Bacteriocins are potent antimicrobial peptides, active in the nanomolar range and have a reduced impact on the host microbiota.
- Bacteriocins may be used to treat a broad range of infections and can be delivered as purified peptides or as bacteriocinogenic probiotics.
- Combining antibiotics and bacteriocins is a strategy to reduce the negative impacts on the host microbiota and also alleviate the AMR crisis.
- Overcoming the current limitations of bacteriocin-based therapeutics should be a key goal of bacteriocin research in the future.
Declarations of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.
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Author Contribution statement

KE drafted the manuscript. RR and CH revised and approved the final manuscript.


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Automated identification of genes encoding bacteriocins and (non-)bactericidal


Figure 1: Bacteriocinogenic probiotics can be utilized either prophylactically or therapeutically to treat an infection. M, M cell; Mac, macrophage; Mu, mucous; T, T cell; IEC, intestinal epithelial cell; DC, dendritic cell.
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<td>Immunosuppressed Wistar rats</td>
<td>Semi-pure</td>
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<td></td>
<td><em>S. aureus</em></td>
<td>Brushite cement in BALB/c mice</td>
<td>Semi-pure</td>
<td>(36)</td>
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<td>Lacticin NK34</td>
<td>*S. aureus/<em>S. simulans</em></td>
<td>ICR mice</td>
<td>Semi-pure</td>
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<tr>
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<td>Pure</td>
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<td><em>L. monocytogenes</em></td>
<td>BALB/c mice</td>
<td>Pure</td>
<td>(39)</td>
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<tr>
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<td>Pure</td>
<td>(40)</td>
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<td>Methicillin-resistant <em>Staphylococcus aureus</em> (MRSA)</td>
<td>BALB/cA mice</td>
<td>pure</td>
<td>(41)</td>
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**Table 1.** Bacterial infections in animal models successfully treated using purified bacteriocins.