Brief Communication

Antifungal susceptibilities of Cryptococcus species complex isolates from AIDS and non-AIDS patients in Southeast China

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ARTICLE INFO

Article history:
Received 19 October 2011
Accepted 11 December 2011

Keywords:
Cryptococcus neoformans
Cryptococcus gattii
Antifungal agents

ABSTRACT

Cryptococcus spp. are common causes of mycoses in immunocompromised patients. To determine the drug susceptibilities of clinical Cryptococcus spp. isolates, the characteristics of 61 clinical Cryptococcus spp. complex isolates and their antifungal susceptibilities were investigated, including 52 C. neoformans and 9 C. gattii isolates collected at Shanghai between 1993 and 2009. Antifungal susceptibility of clinical isolates to amphotericin B, fluconazole, itraconazole, and flucytosine were determined by the microdilution method M27-A2 and the ATB FUNGUS 3 kit. The 90% minimum inhibitory concentration (MIC90) and susceptibility ranges were as follows: 1 (0.0625-1) μg/mL for amphotericin B, 4 (0.125-16) μg/mL for fluconazole, 0.25 (0.0313-4) μg/mL for itraconazole, and 4 (0.125-8) μg/mL for flucytosine. Fluconazole, itraconazole, and flucytosine have excellent in vitro activity against all tested clinical Cryptococcus spp., and we also found a high rate of tolerance to amphotericin B (MICs ranging from 0.55-1 μg/mL). Furthermore, C. neoformans isolates from acquired immune deficiency syndrome (AIDS) patients were less susceptible to fluconazole and flucytosine than those from non-AIDS patients. These data suggest that use of amphotericin B may lead to tolerance or resistance of the pathogen over time. There were also no significant associations between species, genotypes, and in vitro susceptibilities of these clinical isolates.

Infections by opportunistic pathogenic fungi, particularly Candida spp., Cryptococcus spp., and Aspergillus fumigatus, have become a serious medical problem in immunocompromised patients, who are highly susceptible to such infections. The Cryptococcus species complex consists of fatal fungal pathogens, which remain the most important cause of cryptococcal meningitis worldwide, in spite of the introduction of highly active antiretroviral treatment (HAART) to acquired immunodeficiency syndrome (AIDS) patients, in 1996.\textsuperscript{1} Cryptococcus neoformans and C. gattii are recognized within the Cryptococcus spp. complex, and they are closely related to basidiomycetous yeasts.\textsuperscript{2} C. neoformans contains C. neoformans
var. neoformans (serotype D), the hybrid isolates (serotype AD), and C. neoformans var. grubii (serotype A), which most commonly may cause meningoencephalitis, predominantly in immunocompromised hosts. C. gattii is divided into serotypes B and C, which are probable causes of cryptococcosis in immunocompetent hosts. Recently, PCR fingerprint patterns based on M13 or (GACA)4 primers have been used as the major genotyping technique in the ongoing global molecular epidemiologic survey of the Cryptococcus spp. complex, dividing over 600 clinical and environmental isolates into eight major molecular types: VNI (var. grubii, serotype A), VNII (var. grubii, serotype A), VNIII (serotype AD), VNIV (var. neoformans, serotype D), VGI, VGII, VGIII, and VGIV (C. gattii, serotypes B and C).³

Cryptococcosis is mainly found in AIDS patients worldwide, but in China it occurs most commonly in non-AIDS patients, and the proportion of non-AIDS patient cases were reportedly between 80.5-91.5%. The declining incidence of cryptococcosis in developed countries can be attributed to effective antiretroviral therapy. However, the rate of infection is still increasing in developing countries, especially in China, which is mainly caused by a growing immunocompromised population resulting from immunosuppressive therapies and AIDS.

Several classes of antifungal drugs effectively treat cryptococcal infections, but the pathogen can develop resistance to these agents. In developed countries, many studies on the in vitro antifungal susceptibility of clinical strains of C. neoformans and C. gattii have been performed.⁶ Clinical isolates of Cryptococcus spp. were shown to remain highly susceptible (99%) to amphotericin B at a minimum inhibitory concentration (MIC) of ≤ 1 μg/mL, susceptible to flucytosine at a MIC of ≤ 4 μg/mL, susceptible to fluconazole at a MIC of ≤ 8 μg/mL. Despite the apparent importance of drug resistance of clinical pathogens, its surveillance in developing countries is still poor or ignored in comparison with developed countries. In China, there have been few studies on the drug susceptibility of C. neoformans. Clinical isolates of C. neoformans from Taiwan were serotyped and their in vitro susceptibility to amphotericin B, fluconazole, and voriconazole were analysed.⁷ In 2004, Zhu et al. tested the 50% minimum inhibitory concentration (MIC50) of 81 C. neoformans isolates from mainland China: 4 (2-128) μg/mL for fluconazole and 0.03 (0.002-0.13) μg/mL for flucytosine, and estimated the fungicidal effects between different drug combinations.⁸

There have been some reports of resistant C. neoformans isolates that are not susceptible to amphotericin B, fluconazole, flucytosine, oritraconazole during treatment. The emergence of resistance to these antifungal drugs suggests the need for vigilance and large-scale surveillance of the in vitro chemosensitivity of clinical strains. Therefore, it is important to obtain susceptibility data of various clinical isolates at different times. The current study aimed to evaluate the in vitro susceptibility of clinical isolates of C. neoformans and C. gattii from mainland Chinese against four commonly used antifungal drugs. We also sought to determine if there was any correlation between origin, genotypes, and in vitro susceptibility in Cryptococcus spp. complex isolates.

A total of 61 clinical Cryptococcus species complex isolates were collected mainly from the southeast regions of mainland China, comprising Shanghai (n = 20), Guangdong (n = 12), Jiangsu (n = 9), Zhejiang (n = 5), Henan (n = 5), Anhui (n = 2), Jiangxi (n = 2), Fujian (n = 2), Sichuan (n = 2), Beijing (n = 1), Heilongjiang (n = 1), and these samples were recovered from the cerebrospinal fluid (n = 57), sputum (n = 2), feces (n = 1) and skin ulcer (n = 1). These clinical isolates were collected from patients with either cryptococcal meningitis or cryptococcal infection (one isolate per patient). All patients were admitted to our hospital between 1993 and 2009. Initial isolates were obtained at diagnosis. The majority was isolated from the cerebrospinal fluid. All isolates were identified by standard methods, including cafeic acid agar, positive urease test, or the API-20C AUX system (bioMérieux – France), and were maintained in frozen stock vials at −70°C. Each isolate was recovered at least twice from the frozen stock vials onto Sabouraud glucose agar (SDA) to ensure purity and viability, and a single colony was selected for analysis. The molecular type of the isolates was identified. The clinical Cryptococcus spp. were evaluated based on molecular characterization of genotype. The proportion of each genotype using the PCR fingerprint method was compared with previous Chinese report. Among the strains isolated, 52 strains of C. neoformans were assigned to VNI-III (45 of VNI, five of VNII and two of VNIII) and nine of C. gattii to VGI.

The in vitro activities of amphotericin B, itraconazole, fluconazole, and flucytosine were tested using the microdilution method M27-A2 (CLSI 2002).³ Standard antifungal powders of all tested drugs were obtained from Sigma (St. Louis, USA). Fluconazole and flucytosine were dissolved in sterile water; amphotericin B and itraconazole in dimethyl sulphoxide (DMSO); and before use, they were further diluted in RPMI 1640 medium (Sigma – St. Louis, USA) and buffered to a pH of 7.0 with morpholinepropanesulfonic acid (MOPS). The final concentrations of the different antifungal agents were 0.0313-16 μg/mL for amphotericin B and itraconazole, and 0.125-64 μg/mL for fluconazole and flucytosine. Suspensions of yeast from 72-h cultures were prepared in sterile saline (0.85%) adjusted using a spectrophotometer reading at a 530 nm wavelength to a cell density of approximately 1.5 x 10⁶ cfu/mL. To perform the assay, 20 μL of the cell suspension was transferred into an ampule of ATB F2 medium.
and 135 μL ATB F2 medium was dispensed into the ATB FUNGUS 3 strips which consist of 16 pairs of cupules, of which 15 pairs contained five antifungal agents at several concentrations, and a positive growth control was included that was free of any agent. The five agents investigated were flucytosine, amphotericin B, fluconazole, itraconazole, and voriconazole. The concentrations of these agents were 4 and 16 μg/mL for flucytosine, 0.5-16 μg/mL for amphotericin B, 1-128 μg/mL for fluconazole and 0.125-4 μg/mL for itraconazole, and 0.08-6 μg/mL for voriconazole. These strips were incubated at 35°C for 72 h and the MICs read visually, according to the manufacturer’s instructions.

Microdilution testing of four antifungal agents was performed using microdilution method M27-A2. The results obtained from the ATB FUNGUS 3 kit were similar to those obtained by the microdilution method. Table 1 shows MIC, MIC50, and MIC90 ranges of the four antifungals tested against 61 Cryptococcus species complex isolates. Most Cryptococcus spp. showed uniform patterns of susceptibility to the four tested agents. When all strains were taken into consideration, they were susceptible to fluconazole, itraconazole, and flucytosine. The individual MIC ranges and MIC90 were 0.0313-4 μg/mL and 0.25 μg/mL for itraconazole, 0.125-16 μg/mL and 4 μg/mL for fluconazole, 0.125-8 μg/mL and 4 μg/mL for flucytosine.

The difference in MIC90 for fluconazole between AIDS and non-AIDS patients had been previously reported, but there were no data about the effect of flucytosine. When isolates were analyzed according to the origin of the patients (Table 1), 45 isolates from HIV-negative patients showed a lower geometric mean for fluconazole (1.1589/3.1228; p = 0.001) and flucytosine (1.4038/2.9720; p < 0.001), compared with the 16 isolates from AIDS patients. Remarkably, there were no significant differences in susceptibility between the species for four agents (data not shown).

Very few studies have compared the susceptibilities of C. neoformans and C. gattii among specific genotypes. The MICs for all isolates of each genotype against four agents are shown in Table 2. Although the geometric mean MICs were different, there was no statistically significant difference (p > 0.05) observed between genotypes VNI and VGI. The other genotypes, VNI and VNIII, were not compared because the number of isolates was too small. We found that within the VNI genotype group there were some isolates

### Table 1 - In vitro susceptibility of Cryptococcus spp. isolates to amphotericin B, itraconazole, fluconazole, and flucytosine according to origin

<table>
<thead>
<tr>
<th>Isolates and antifungal agents</th>
<th>Mic range (μg/mL)</th>
<th>MIC&lt;sub&gt;50&lt;/sub&gt; (μg/mL)</th>
<th>MIC&lt;sub&gt;90&lt;/sub&gt; (μg/mL)</th>
<th>GM (μg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-AIDtS 45 isolates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphotericin B</td>
<td>0.0625–1</td>
<td>0.5</td>
<td>1</td>
<td>0.5463</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>0.0313–0.5</td>
<td>0.125</td>
<td>0.25</td>
<td>0.1095</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>0.125–4</td>
<td>1</td>
<td>4</td>
<td>1.1589</td>
</tr>
<tr>
<td>Flucytosine</td>
<td>0.125–4</td>
<td>2</td>
<td>4</td>
<td>1.4038</td>
</tr>
<tr>
<td><strong>AIDS 16 isolates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphotericin B</td>
<td>0.125–1</td>
<td>0.5</td>
<td>1</td>
<td>0.4310</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>0.0313–4</td>
<td>0.125</td>
<td>0.5</td>
<td>0.1683</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>0.5–16</td>
<td>4</td>
<td>8</td>
<td>3.1228</td>
</tr>
<tr>
<td>Flucytosine</td>
<td>0.25–8</td>
<td>4</td>
<td>4</td>
<td>2.9720</td>
</tr>
<tr>
<td><strong>Total (non-AIDS+AIDS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphotericin B</td>
<td>0.0625–1</td>
<td>0.5</td>
<td>1</td>
<td>0.5173</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>0.0313–4</td>
<td>0.125</td>
<td>0.25</td>
<td>0.1208</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>0.125–16</td>
<td>2</td>
<td>4</td>
<td>1.4550</td>
</tr>
<tr>
<td>Flucytosine</td>
<td>0.125–8</td>
<td>2</td>
<td>4</td>
<td>1.6675</td>
</tr>
</tbody>
</table>

Significance was determined using the Student’s t-test (p < 0.05).

### Table 2 - In vitro susceptibility of Cryptococcus spp. isolates to amphotericin B, itraconazole, fluconazole, and flucytosine according to genotypes

<table>
<thead>
<tr>
<th>Genotype</th>
<th>Amphotericin B</th>
<th>Itraconazole</th>
<th>Fluconazole</th>
<th>Flucytosine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mic range (μg/mL)</td>
<td>MIC&lt;sub&gt;50&lt;/sub&gt; (μg/mL)</td>
<td>MIC&lt;sub&gt;90&lt;/sub&gt; (μg/mL)</td>
<td>GM (μg/mL)</td>
</tr>
<tr>
<td></td>
<td>Mic range (μg/mL)</td>
<td>Mic range (μg/mL)</td>
<td>Mic range (μg/mL)</td>
<td>Mic range (μg/mL)</td>
</tr>
<tr>
<td>VNI</td>
<td>0.0625–1</td>
<td>0.5</td>
<td>1</td>
<td>0.5156</td>
</tr>
<tr>
<td>VNII</td>
<td>0.25–1</td>
<td>0.5</td>
<td>1</td>
<td>0.4353</td>
</tr>
<tr>
<td>VNIII</td>
<td>0.125–1</td>
<td>0.5</td>
<td>1</td>
<td>0.3536</td>
</tr>
<tr>
<td>VGI</td>
<td>0.125–1</td>
<td>1</td>
<td>1</td>
<td>0.6300</td>
</tr>
</tbody>
</table>
from HIV-positive patients, while there were none from the VGI genotype group. To minimize interfering factors, we compared the VNI and VGI groups again, after removing the strains isolated from HIV-positive patients in VNI group, and still there was no significant difference (p > 0.05).

The lowest MIC50 and MIC90 (0.125/0.25 μg/mL) values were found for itraconazole, which were similar to the results of published studies from Asia, such as 0.032/0.125 μg/mL from India,10 0.125/0.5 μg/mL from Malaysia,11 except that there was one isolate with a MIC of 4 μg/mL for itraconazole.

The MIC values for fluconazole documented in our study were similar to those previously reported. One study from India showed that the MIC50 and MIC90 of fluconazole were 4/16 μg/mL,10 which were also similar to another Malaysian study;11 two studies from Taiwan have shown that the MIC90 of fluconazole were 2 and 8 μg/mL; while many other studies showed higher MIC values and increasing rates of resistance to fluconazole, such as one study from the mainland China with high MICs (2-128 μg/mL).12

The MICs for flucytosine in our study were consistent with that of previous reports, but lower than some other studies. A study from Taiwan found a high MIC50 and susceptibility ranges of 16 (0.125-16) μg/mL. Compared with these Asian reports, our results found a lower MIC50 and susceptibility ranges of 4 (0.125-8) μg/mL; however, there was one study from Malaysia that showed a much lower value of MIC50 and MIC90 (0.02/0.05 μg/mL), which was compatible to one study presenting median MIC and susceptibility ranges 0.06 (0.008-2) μg/mL from mainland China.

In previous evaluations of the effect of amphotericin B on Cryptococcus spp., most isolates appeared significantly susceptible to this agent.13 A study from Malaysia showed low MIC50 and MIC90 (0.25/0.38 μg/mL). A similar result was reported from Taiwan, where the MIC50 and susceptibility ranges were 0.5 (0.125-1) μg/mL, in agreement with results obtained by Chandenier et al.,14 who reported that both Asian and African isolates are susceptible to amphotericin B, whose MIC values did not exceed 0.125 μg/mL against the tested isolates. However, the results reported here show a slightly higher MIC than previous studies, with the MIC50 and susceptibility ranges of 1 (0.0625-1) μg/mL, respectively.

Our data are consistent with the results from the following report. A study from Brazil, using the time-kill method, showed that seven isolates (17.5% of all) were tolerant to amphotericin B (MICs ranged from 0.25-1 μg/mL) and correlated well with in vitro susceptibility and clinical response.15

Some studies have shown even higher MICs compared to our results, such as another study from Brazil displaying a high rate of resistance to amphotericin B (> 1 μg/mL), including 40% of C. gattii and 12% of C. neoformans isolates. Lozano-Chui et al.16 defined three isolates from 12 clinical strains as resistant to amphotericin B, with MICs of 3.0-4.0 μg/mL that were subsequently found to be associated with therapeutic failure in the USA. Perkins et al.17 reported 17 strains among Spanish clinical isolates (5.3% of all) that had MICs for amphotericin B of ≥ 2 μg/mL.

For these four agents, there were no significant differences in susceptibility between the species. This was consistent with the largest published series assessing species-specific MICs, which also showed no differences.18 However, other studies have described species-specific differences in antifungal susceptibility that may lead to higher rate of complications, slower response, and longer duration of treatment for patients with C. gattii infection. There was only one previous study about the correlation of genotypes and antifungal susceptibilities of C. gattii, and it found significant differences in MICs between some subtypes.19

Amphotericin B deoxycholate has remained the mainstay of treatment for invasive fungal infections for many years since it is active against a wide variety of fungi, including C. neoformans. Amphotericin B targets the ergosterol in the fungal plasma membrane to form a channel where the cell leaks potassium ions, resulting in a disruption of the proton gradient. In addition to this action, amphotericin B causes oxidative damage to the plasma membrane.

Although there are no breakpoints defined by the CLSI for amphotericin B and C. neoformans, it has been suggested an MIC value of 2 μg/mL is the resistance threshold for amphotericin B and the susceptibility pattern of C. neoformans strains is predictable, with MICs ranging from 0.12-0.5 μg/mL. Although our study did not identify any isolates with amphotericin B resistance, our data described elevated average MICs to amphotericin B, which was rarely observed in previous studies using Asian isolates. Unfortunately, very little was known about the clinical prognoses and outcomes of patients infected with these relatively high-MIC amphotericin B isolates. It was reported that treatment with amphotericin B may induce the development of clinical and in vitro amphotericin B resistance.20 However, the reason for the low susceptibility to amphotericin B was not apparent in this study, and we suspect that the tolerant strains were isolated from patients that had likely been previously exposed to amphotericin B. These data suggest that the use of amphotericin B may lead to tolerance or resistance of the pathogen over time. We are currently gathering related clinical data to analyze the apparent cause of these tolerant strains and investigate the correlation between susceptibility results and clinical outcome.

Acknowledgements

We are thankful for the funds provided by the National Natural Science Foundation of China under Grants 81071335 and 90813010, and by the Shanghai Natural Science Foundation under Grant 08ZR1401400; Shanghai Science and Technology Commission Fund (No. 10dz2220100).

Conflict of interest

All authors declare to have no conflict of interest.

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