Drug Resistance in *Mycobacterium tuberculosis*

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Abstract

Anti-tuberculosis drugs are a two-edged sword. While they destroy pathogenic *M. tuberculosis* they also select for drug resistant bacteria against which those drugs are then ineffective. Global surveillance has shown that drug resistant Tuberculosis is widespread and is now a threat to tuberculosis control programs in many countries. Application of molecular methods during the last decade has greatly changed our understanding of drug resistance in tuberculosis. Application of molecular epidemiological methods was also central to the description of outbreaks of drug resistance in Tuberculosis. This review describes recommendations for Tuberculosis treatment according to the WHO guidelines, the drug resistance problem in the world, mechanisms of resistance to first line and second line drugs and applications of molecular methods to detect resistance causing gene mutations. It is envisaged that molecular techniques may be important adjuncts to traditional culture based procedures to rapidly screen for drug resistance. Prospective analysis and intervention to prevent transmission may be particularly helpful in areas with ongoing transmission of drug resistant strains as recent mathematical modeling indicate that the burden of MDR-TB cannot be contained in the absence of specific efforts to limit transmission.

Introduction

**Drug resistance and global surveillance: history**

Shortly after the first anti-tuberculosis (TB) drugs were introduced, streptomycin (STR), para-aminosalicylic acid (PAS), isoniazid (INH) resistance to these drugs was observed in clinical isolates of *Mycobacterium tuberculosis* (Crofton and Mitchison, 1948). This led to the need to measure resistance accurately and easily. The Pasteur Institute introduced the critical proportion method in 1961 for drug susceptibility testing in TB and this method became the standard method of use (Espinal, 2003). Studies on drug resistance in various countries in the 1960s showed that developing countries had a much higher incidence of drug resistance than developed countries (Espinal, 2003). By the end of the 1960s rifampicin (RIF) was introduced and with the use of combination therapy, there was a decline in drug resistant and drug susceptible TB in developed countries. This led to a decline in funding and interest in TB control programs. As a result, no concrete monitoring of drug resistance was carried out for the following 20 years (Espinal, 2003). The arrival of HIV/AIDS in the 1980s resulted in an increase in transmission of TB associated with outbreaks of multi-drug-resistant TB (MDR-TB) (Edlin et al., 1992; Fischl et al., 1992) i.e. resistant to INH and RIF. In the early 1990s drug resistance surveillance was resumed in developed countries, but the true incidence remained unclear in the developing world (Cohn et al., 1997).

The WHO/IUATLD global project on drug-resistance surveillance

In 1994 the Global Project on Drug-Resistance Surveillance was initiated to monitor the trends of resistance. The first report was published in 1997 and contained data from 35 geographical settings for the period 1994–1996 (World Health Organization, 1997; Pablos-Mendez et al., 1998). The report showed that drug resistance was present globally, and that MDR-TB ranged from 0% to 14% in new cases (median: 1.4%) and 0% to 54% in previously treated cases (median: 13%). A second report for the period 1996–1999, followed in 2000 and included surveillance data from 58 geographical sites (Espinal, 2003; World Health Organization, 2000). This report confirmed that drug resistant TB was a sufficient problem since MDR-TB ranged from 0–16% (median: 1%) among new cases and from 0% to 48% (median: 9%) in previously treated cases. The recently published third report has data on 77 geographical sites, collected between 1999 and 2002, representing 20% of the global total of new smear-positive TB cases (World Health Organization, 2003). Eight countries did not report any MDR-TB amongst new cases, while the highest incidence of MDR-TB amongst new cases occurred in Kazakhstan and Israel (14%). Significant increases in MDR-TB prevalence were seen in Estonia, Lithuania, Tomsk Oblast (Russian Federation) and Poland and significant decreasing trends in Hong Kong, Thailand and the USA. The highest prevalence of MDR-TB among previously treated cases was reported in Oman (58.3%, 7/12) and Kazakhstan (56.4%, 180/319). The annual incidence of MDR-TB in most Western and Central European Countries was estimated to be fewer than 10 cases each. Alarmingly, it is estimated that the annual incidence of MDR-TB for 2 provinces in China (Henan and Hubei) is 1000 and for Kazakhstan and South Africa it is more than 3000. According to the report, the most effective means to prevent the emergence of drug resistance is by implementing the direct observed therapy strategy (DOTS) (World Health Organization, 2003).

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Expert scientists critically review the current and most recent advances in the genomics and molecular biology of mycobacteria. The focus is on the topical and most relevant aspects and the authors aim to give readers an insight into the current understanding of the subject and the future direction of research. Topics covered include strain variation and evolution, hypervirulent strains, electron transport and respiration, lipid biosynthesis, DNA repair, oxygen signaling, sulphur metabolism, protein secretion, the protein kinase family, and much more.

A valuable reference text for all microbiology laboratories and essential reading for all scientists and researchers involved with mycobacteria.

Reviews:

“This very timely book reviews the current knowledge about the genetics and cell biology of the mycobacterium species. It is clear that this information will lead to new treatment options and preventive strategies that may cure or prevent the serious disease of tuberculosis.” from Doody's (2009)

"a select collection of reviews of mycobacterial 'hot topics' written by leaders in the respective fields. Each chapter is a thorough treatment of the topic, summarizing current understanding and highlighting gaps in knowledge. ... an excellent introduction to the topics covered and will be valuable for all mycobacteriologists." from Microbiology Today
Current recommendations for TB treatment by WHO

TB persists as a global public health problem and the main focus for the twentieth century is firstly to cure the individual patient and secondly to minimize the transmission of M. tuberculosis to other persons (World Health Organization, 2003; Blumberg et al., 2003). The ongoing TB problem has been due to the neglect of TB control by governments, inadequate access and infrastructure, poor patient adherence to medication, poor management of TB control programs, poverty, population growth and migration, and a significant rise in the number of TB cases in HIV infected individuals. Treatment of patients with TB is most successful within a comprehensive framework based upon the following five key components:

- government commitment
- case detection by sputum smear microscopy
- standardized treatment regimen of six to eight months
- a regular, uninterrupted supply of all essential anti-TB drugs
- a standard recording and reporting system.

These five key elements are the recommended approach by the World Health Organization (WHO) to TB control and are called the DOTS strategy (Walley, 1997). DOTS is an inexpensive strategy for the detection and treatment of TB. DOTS was implemented as part of an adherence strategy in which patients are observed to swallow each dose of anti-TB medication, until completion of the therapy. Monthly sputum specimens are taken until 2 consecutive specimens are negative. Currently there are four recommended regimens for treating patients with TB infection by drug-susceptible organisms. Each regimen has an initial phase of 2 months intensive phase followed by a choice of several options for the continuation phase of either 4 or 7 months. The recommended regimens together with the number of doses specified by the regimen are described in Table 1.

Since the introduction of the DOTS strategy in the early '90s by the WHO, considerable progress has been made in global TB control (Sterling et al., 2003). In 1997, the estimated average treatment success rate world wide was almost 80%. However, less than 25% of people who are sick with TB are treated through the DOTS strategy (Bastian et al., 2000). A total of 180 countries (including both developed and undeveloped countries) had adopted and implemented the DOTS strategy by the end of 2002 and 69% of the global population was living in areas covered by the DOTS strategy (Blumberg et al., 2003). However, even though DOTS programs are in place, treatment success rates are very low in developed countries due to poor management of TB control programs and patient non-compliance (Lienhardt and Ogden, 2004; Bastian et al., 2003). Furthermore, the effectiveness of DOTS is facing new challenges with respect to the spread and increase of MDR-TB and the co-epidemic of TB/HIV (World Health Organization, 2003). WHO and partners have addressed these new challenges and have developed a new strategy called DOTS-Plus for the treatment of MDR-TB and its co-epidemic TB/HIV. The goal of DOTS-plus is to prevent further development and spread of MDR-TB and is a comprehensive management initiative built upon the DOTS strategy (Table 2). It is important to note that DOTS-Plus should only be implemented in areas were the DOTS strategy is in place as there can be no DOTS-Plus without an effective DOTS program.

Drug susceptibility testing

Drug susceptibility testing is carried out on sub-cultured bacteria after the initial positive culture is obtained for diagnosis. It usually takes 3–6 weeks to obtain the initial positive culture with an additional 3 weeks for

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<th>Table 1. Drug Regimen for Culture-Positive Pulmonary TB Caused by Drug-Susceptible Organisms</th>
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<tr>
<td><strong>Intensive Phase</strong></td>
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INH-isoniazid; RIF-rifampicin; RPT-rifapentine; PZA-pyrazinamide.

Note: Streptomycin (STR) efficiency is equal to that of EMB and was use as an interchangeable drug with EMB in the initial phase of treatment. Due to the increase of resistance the drug is rendered less useful. Thus, STR is not recommended to be interchangeable with EMB unless the organism is known to be susceptible to the drug or the patient is from a community in which STR resistance is unlikely. Extracted from Blumberg et al (Blumberg et al., 2003).
susceptibility testing (reduced to about 15 days when using the BACTEC system) (Rastogi et al., 1989; Siddiqi et al., 1985; Snider, Jr. et al., 1981; Tarrand and Groschel, 1985). Thus, susceptibility testing is time consuming and costly, and there are numerous problems associated with the standardization of tests and the stability of the drugs in different culture media (Martin-Casabona et al., 1997; Victor et al., 1997). The slow diagnosis of drug resistance may be a major contributor to the transmission of MDR-TB (Victor et al., 2002). The WHO recommended that drug susceptibility testing is done by the proportion method on Löwenstein-Jensen medium, but other media, such as Middlebrook 7H10, 7H11, 7H12 (BACTEC460TB) and other methods, including the absolute concentration and resistance ratio methods, may also be used (World Health Organization, 2001). For the ratio method, serial dilutions are cultured on 2 control media (without the drug) and 2 test media (with two different drug concentrations). The colonies on the different slants are counted after 21 and 40 days of growth. The proportion of resistant bacilli is calculated by comparing colony counts on drug free and drug containing media. For a resistant isolate the calculated proportion is higher and for a susceptible strain the calculated proportion is lower than the critical proportion (World Health Organization, 2001).

**Molecular mechanisms of drug resistance**

In order to control the drug resistance epidemic it is necessary to gain insight into how *M. tuberculosis* develops drug resistance. This knowledge will help us to understand how to prevent the occurrence of drug resistance as well as identifying genes associated with drug resistance of new drugs. The development of clinical drug resistance in TB is summarized in Fig. 1 and is classified as acquired resistance when drug resistant mutants are selected as a result of ineffective treatment or as primary resistance when a patient is infected with a resistant strain. Mutations in the genome of *M. tuberculosis* that can confer resistance to anti-TB drugs occur spontaneously with an estimated frequency of $3.5 \times 10^{-6}$ for INH and $3.1 \times 10^{-6}$ for RIF. Because the chromosomal loci responsible for resistance to various drugs are not linked, the risk of a double spontaneous mutation is extremely low: $9 \times 10^{-14}$ for both INH and RIF (Dooley and Simone, 1994). MDR-TB defined as resistance to at least INH and RIF will thus occur mainly in circumstances where sequential drug resistance follows sustained treatment failure. Treatment can be divided into first line and second line drugs according to the WHO TB treatment regimen and the mechanisms of these will be discussed separately.

**First line drugs**

Any drug used in the anti-TB regiment is supposed to have an effective sterilizing activity that is capable of shortening the duration of treatment. Currently, a four-drug regiment is used consisting of INH, RIF, pyrazinamide (PZA) and ethambutol (EMB). Resistance to first line anti-TB drugs has been linked to mutations in at least 10 genes; katG, *inhA*, ahpC, *kasA* and *ndh* for INH resistance; *rpoB* for RIF resistance, *embB* for EMB resistance, *pncA* for PZA resistance and *rpsL* and *rrs* for STR resistance.

**Isoniazid**

KatG. INH or isonicotinic acid hydrazide, was synthesized in the early 1900s but its anti-TB action was first detected in 1951 (Heym et al., 1999; Slayden and Barry, III, 2000; Rattan et al., 1998). INH enters the cell as a prodrug that is activated by a catalase peroxidase encoded by *katG*. The peroxidase activity of the enzyme is necessary to activate INH to a toxic substance in the bacterial cell (Zhang et al., 1992). This toxic substance subsequently affects intracellular targets such as mycolic acid biosynthesis which are an important component of the cell wall. A lack of mycolic acid synthesis eventually results in loss of cellular integrity and the bacteria die (Barry, III et al., 1998). Middlebrook et al. initially demonstrated that a loss of catalase activity can result in INH resistance (Middlebrook, 1954). Subsequently genetic studies demonstrated that transformation of INH-resistant *Mycobacterium smegmatis* and *M. tuberculosis* strains with a functional *katG* gene restored INH susceptibility and that *katG* deletions give rise to INH resistance (Zhang et al., 1992; Zhang et al., 1993). However, mutations in this gene are more frequent than deletions in clinical isolates and these can lower the activity of the enzyme. Most mutations are found between codons 138 and 328 with the most commonly observed gene alteration being at codon 315 of the *katG* gene (Slayden and Barry, III, 2000). The Ser315Thr substitution is estimated to occur in 30–60% of INH resistant isolates (Ramawamy and Musser, 1998; Musser et al., 1996; Slayden and Barry, III, 2000). The *katG* 463 (CGG-CTG) (Arg-Leu) amino acid substitution is the most common polymorphism found in the *katG* gene and is not associated with INH resistance.

**ahpC.** It has been observed that a loss of *katG* activity due to the S315T amino acid substitution is often accompanied by an increase in expression of an alkyl hydroperoxide reductase (*ahpC*) protein that is capable of detoxifying damaging organic peroxides (Sherman et al., 1996). Five different nucleotide alterations have been identified in the

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<th>Table 2. DOTS Compared to DOTS-Plus Strategy</th>
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<td><strong>DOTS</strong></td>
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<td>DOTS prevent emergence of drug resistant TB and MDR-TB</td>
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<td>Make primarily use of 1st line drugs that are less expensive</td>
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<td>DOTS-plus needed in areas where MDR-TB has emerged due to previous inadequate TB control</td>
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promoter region of the *ahpC* gene, which lead to overexpression of *ahpC* and INH resistance (Ramaswamy and Musser, 1998). *AhpC* overexpression exerts a detoxifying effect on organic peroxides within the cell and protects the bacteria against oxidative damage but does not provide protection against INH. *KatG* expression can also be up regulated under conditions of oxidative stress. The correlation between polymorphic sites in the *ahpC* regulatory region with INH resistance in *M. tuberculosis* requires further examination.

*pasA*. One of the targets for activated INH is the protein encoded by the *pasA* locus. *PasA* is an enoyl–acyl carrier protein (ACP) reductase which is proposed to be the primary target for resistance to INH and ethionamide (ETH) (Banerjee et al., 1994). ETH, a second line drug, is a structural analog of INH that also thought to inhibit mycolic acid biosynthesis and several studies have suggested that low-level INH resistance is correlated with resistance to ETH. Activated INH binds to the *InhA*-NADH complex to form a ternary complex that results in inhibition of mycolic acid biosynthesis. Six point mutations associated with INH resistance within the structural *inhA* gene have been identified (Ile16Thr, Ile21Thr, Ile21Val, Ile47Thr, Val78Ala and Ile95Pro) (Ramaswamy and Musser, 1998; Basso and Blanchard, 1998). A Ser94Ala substitution results in a decreased binding affinity of *inhA* for NADH, resulting in mycolic acid inhibition. Although these mutations in the structural *InhA* gene are associated with INH resistance, it is not frequently reported in clinical isolates. *InhA* promoter mutations are more frequently seen and are present at positions -24(G-T), -16(A-G), or -8(T-G/A) and -15(C-T). These promoter mutations result in over expression of *inhA* leading to low level INH resistance. To date approximately 70–80% of INH resistance in clinical isolates of *M. tuberculosis* can be attributed to mutations in the *katG* and *inhA* genes (Ramaswamy and Musser, 1998).

There seems to be considerable dispute within the literature as to the role of *kasA* as a possible target for INH resistance (Sherman et al., 1996). This gene encodes a β-ketoacyl-ACP synthase involved in the synthesis of mycolic acids. Mutations have been described in this gene that confer low levels of INH resistance. Genotypic analysis of the *kasA* gene reveals 4 different amino acid substitutions involving codon 66 (GAT-AAT), codon 269 (GGT-AGT), codon 312 (GCT-AGC) and codon 413 (TTC-TTA) (Ramaswamy and Musser, 1998; Mdluli et al., 1998). However, similar mutations were also found in INH susceptible isolates (Lee et al., 1999; Piatek et al., 2000). Nevertheless, the possibility of *kasA* constituting an additional resistance mechanism should not be completely excluded.

**Rifampicin**

RIF was first introduced in 1972 as an anti-TB drug and has excellent sterilizing activity (Rattan et al., 1998; Ramaswamy and Musser, 1998). The action of RIF in combination with PZA has allowed a shortening of routine TB treatment from 1 year to 6 months. RIF in combination with INH forms the backbone of short-course chemotherapy. It is interesting to note that mono resistance to INH is common but mono resistance to RIF is quite rare. It has thus been proposed that resistance to RIF can be used as a surrogate marker for MDR-TB as nearly 90% of RIF resistant strains are also INH resistant (Somoskovi et al., 2001). RIF interferes with transcription by the DNA-dependent RNA polymerase. RNA polymerase is composed of four different subunits (α, β, β′ and σ) encoded by *rpoA*, *rpoB*, *rpoC* and *rpoD* genes respectively. RIF binds to the β′-subunit hindering transcription and thereby killing the organism. Extensive studies on the *rpoB* gene in RIF resistant isolates of *M. tuberculosis* identified a variety of mutations and short deletions in the gene. A total of 69 single nucleotide changes; 3 insertions, 16 deletion and 38 multiple nucleotide changes have been reported (Herrera et al., 2003). More than 95% of all missense mutations are located in a 51bp core region (Rifampicin resistance determining region) of the *rpoB* gene between codons 507–533 with the most common changes in codons Ser531Leu, His526Tyr and Asp516Val. These changes occur in more than 70% of RIF resistant isolates (Rattan et al., 1998; Ramaswamy and Musser, 1998; Herrera et al., 2003). Furthermore, the minimal
inhibitory concentration (MIC) showed that high level of RIF resistance is associated with mutations in codon 526 and 531, whereas alterations in codon 511,516, 518 and 522 result in low level RIF resistance.

**Pyrazinamide**

PZA, a nicotinamide analog, was first discovered to have anti-TB activity in 1952. PZA targets an enzyme involved in fatty-acid synthesis and is responsible for killing persistent tubercle bacilli in the initial intensive phase of chemotherapy (Somoskovi et al., 2001). However, during the first two days of treatment, PZA has no bactericidal activity against rapidly growing bacilli (Zhang and Mitchison, 2003). PZA on the other hand has effective sterilizing activity and shortens the chemotherapeutic regimen from 12 to 6 months. PZA is a prodrug which is converted to its active form, pyrazinoic acid (POA) by the pyrazinamidase (PZase) encoded by pncA. The activity of PZA is highly specific for *M. tuberculosis* as it has no effect on other mycobacteria. *Mycobacterium bovis* is naturally resistant to PZA due to a unique C-G point mutation in codon 169 of the pncA gene. PZA is only active against *M. tuberculosis* at acidic pH where POA accumulates in the cytoplasm due to an ineffective efflux pump. Accumulation of POA results in the lowering of intracellular pH to a level that inactivates a vital fatty acid synthase (Zimhony et al., 2003). PZA on the other hand has effective sterilizing activity and shortens the chemotherapeutic regimen. PZA is highly active against *M. tuberculosis* but is less effective against *M. avium* (Mitchison, 2003). PZA is only active against *M. tuberculosis* at acidic pH where POA accumulates in the cytoplasm due to an ineffective efflux pump. Accumulation of POA results in the lowering of intracellular pH to a level that inactivates a vital fatty acid synthase (Zimhony et al., 2003). Cloning and characterization of the *M. tuberculosis* pncA gene by Scorpio et al. (Scorpio and Zhang, 1996) showed that pncA mutations conferred PZA resistance. Various pncA mutations have been identified in more than 70% of PZA resistant clinical isolates scattered throughout the pncA gene but thus far no mutational hot spot has been identified (Scorpio and Zhang, 1996; Sreevatsan et al., 1997b; Scorpio et al., 1997). In a study from Peru it was found that 59% of MDR patients also had *M. tuberculosis* resistant to PZA (Saravia et al., 2005). PZA susceptibility testing is not done routinely in many countries due to technical difficulties. Thus the extent of PZA resistance globally is largely unknown. A study done by Louw et al. (Louw et al., 2006) showed that PZA resistance is common amongst drug-resistant clinical *M. tuberculosis* isolates from South Africa. PZA resistance was shown to be strongly associated with MDR-TB and therefore it was concluded that PZA should not be relied upon in managing patients with MDR-TB in this setting. PZA resistant isolates have diverse nucleotide changes scattered throughout the pncA gene. Mutations in the pncA gene correlate well with phenotypic resistance to PZA. However, PZA resistant isolates without pncA mutations were also observed suggesting that another mechanism may be involved in conferring PZA resistance in these isolates. In addition, not all mutations (e.g. Thr<sub>114</sub>Met) were associated with PZA resistance. In summary, the complexity of PZA resistance makes the development of molecular methods for rapid diagnosis difficult.

**Streptomycin**

STR, an aminocyclitol glycoside, is an alternative first line anti-TB drug recommended by the WHO (Cooksey et al., 1996). STR is therefore used in the retreatment of TB cases together with the four drug regimen that includes INH, RIF, PZA and EMB (Brzostek et al., 2004). The effect of STR has been demonstrated to take place at the ribosomal level (Telenti et al., 1993). STR interacts with the 16S rRNA and S12 ribosomal protein (*rrs* and *rpsL*) (Escalante et al., 1998; Finken et al., 1993; Sreevatsan et al., 1996; Abbadi et al., 2001), inducing ribosomal changes, which cause misreading of the mRNA and inhibition of protein synthesis. Although STR is a recommended anti-TB drug, it is less effective against *M. tuberculosis* than INH and RIF. Point mutations in STR resistant isolates have been reported in *rrs* and *rpsL* genes in 65–67% of STR resistant isolates (Ramaseswamy and Musser, 1998). In the *rrs* gene a C-T transition at positions 491, 512 and 516, and a A-C/T transversion at position 513 were observed in the highly conserved 530 loop. The 530 loop region is part of the aminoacyl–tRNA binding site and is involved in the decoding process (Carter et al., 2000). The C-T transition at codon 491 is not responsible for resistance to STR as it occurs in both STR resistant and susceptible isolates but is strongly associated with the global spread of *M. tuberculosis* with a Western Cape F11 genotype (van Rie et al., 2001; Victor et al., 2001). Other mutations in the 915 loop [903 (C-A/G) and 904 (A-G)] have also been reported to have an association with STR resistance (Carter et al., 2000). Mutations in the *rpsL* gene at codon...
43 (AAG-AGG/ACG) (Lys-Arg/Thr) and codon 88 (AAG-AGG/CAG) (Lys-Arg/Gln) are associated with STR resistance. MIC analysis of STR resistant isolates indicate that amino acid replacements in the rpsL genes correlate with a high level of resistance, whereas mutations in the rrs gene correlate with an intermediate level of resistance (Cooksey et al., 1996; Meier et al., 1996). In addition, it has been suggested that low levels of STR resistance are also associated with altered cell permeability or rare mutations which lie outside of the rrs and rpsL genes.

**Second line drugs used in TB treatment**

According to the WHO the following drugs can be classified as second line drugs: aminoglycosides (kanamycin and amikacin) polypeptides (capreomycin, viomycin and enniomycin), fluoroquinolones (ofloxacin, ciprofloxacin, and gatifloxacin), D-cycloserine and thionamides (ethionamide and prothionamide) (World Health Organization, 2001). Unfortunately, second-line drugs are inherently more toxic and less effective than first-line drugs (World Health Organization, 2001). Second line drugs are mostly used in the treatment of MDR-TB and as a result prolong the total treatment time from 6 to 9 months (Cheng et al., 2004). The current understanding of molecular mechanisms associated with resistance to second line drugs are summarized in Table 3. The phenotypic methods to detect resistance to second line drugs are less well established and the molecular mechanisms of resistance are also less defined.

**Fluoroquinolones**

Ciprofloxin (CIP) and ofloxacin (OFL) are the two fluoroquinolones (FQs) used as second-line drugs in MDR-TB treatment (World Health Organization, 2001). The quinolones target and inactivate DNA gyrase, a type II DNA topoisomerase (Cynamon and Sklaney, 2003; Ginsburg et al., 2003; Rattan et al., 1998). DNA gyrase is encoded by gyrA and gyrB (Rattan et al., 1998; Takiff et al., 1994) and introduces negative supercoils in closed circular DNA molecules (Rattan et al., 1998; Ramaswamy and Musser, 1998). The quinolone-resistance-determining region (QRDR) is a conserved region in the gyrA (320bp) and gyrB (375bp) genes (Ginsburg et al., 2003) which is the point of interaction of FQ and gyrase (Ginsburg et al., 2003). Missense mutations in codon 90, 91, and 94 of gyrA are associated with resistance to FQs (Takiff et al., 1994; Xu et al., 1996). A 16-fold increase in resistance was observed for isolates with a Ala90Val substitution, a 30-fold increase for Asp94Asn or His94Tyr and a 60-fold increase for Asp94Gly (Xu et al., 1996). A polymorphism at gyrA codon 95 is not associated with FQ resistance, and is used, with the katG463 polymorphism, to classify M. tuberculosis into 3 phylogenetic groups (Sreevatsan et al., 1997a).

**Aminoglycosides**

Kanamycin (KAN) and Aminokacin (AMI) are aminoglycosides which inhibit protein synthesis and thus cannot be used against dormant M. tuberculosis. Aminoglycosides bind to bacterial ribosomes and disturb the elongation of the peptide chain in the bacteria. Mutations in the rrs gene encoding for 16s rRNA are associated with resistance to KAN and AMI. Nucleotide changes at positions 1400, 1401 and 1483 of the rrs gene have been found to be specifically associated with KAN resistance (Suzuki et al., 1998). An A→G change at codon 1400 in the rrs gene showed resistance to KAN of MICs more that 200 μg/ml (Taniuguichi et al., 1997; Suzuki et al., 1998).

**Ethionamide**

Ethionamide (ETH) is an important drug in the treatment of MDR-TB, and is mechanistically and structurally analogous to INH. Like INH, ETH is also thought to be a produg that is activated by bacterial metabolism. The activated drug then disrupts cell wall biosynthesis by inhibiting mycolic acid synthesis. Mutations in the promoter of the inhA gene are associated with resistance to INH and ETH (Morlock et al., 2003). EthA catalyses a two step activation of ETH and gene alterations leading to reduced EthA activity lead to ETH resistance (Engohang-Ndong et al., 2004; Morlock et al., 2003; Vannelli et al., 2002). The expression of ethA is under the control of the neighbouring ethR gene encoding a repressor. EthR negatively regulates the expression of ethA, by binding upstream of ethA to suppress ethA expression (Engohang-Ndong et al., 2004).

**D-Cycloserine**

D-cycloserine (DCS) is a cyclic analog of D-alanine which is one of the central molecules of the cross linking step of peptidoglycan assembly (Ramaswamy and Musser, 1998; Feng and Barletta, 2003; David, 2001; Caceres et al., 1997). DCS inhibits cell wall synthesis by competing with D-Alanine for the enzymes D-alanyl-D-alanine synthetase (Ddl) and D-alanine racemase (Air) and also inhibiting the synthesis of these proteins. Over expression of air cause DCS resistance. A G→T transversion in the air promoter may lead to the overexpression of air (Feng and Barletta, 2003; Ramaswamy and Musser, 1998).

**Peptides**

Viomycin (VIO) and capreomycin (CAP) are basic peptide antibiotics that inhibit prokaryotic protein synthesis and are used as second-line anti-TB drugs. Earlier studies have shown that resistance to VIO in M. smegmatis is caused by alterations in the 30S or 50S ribosomal subunits (Taniuguichi et al., 1997). Mutations in the rrs gene that encodes the 16S rRNA is associated with resistance to VIO and CAP, specifically a G→A or G→T nucleotide change at codon 1473 (Taniuguichi et al., 1997).

**Molecular methods to predict drug resistance**

M. tuberculosis is a very slow growing organism and the use of molecular methods for the identification of mutations in resistance-causing genes may offer a means to rapidly screen M. tuberculosis isolates for antibiotic resistance. Mutation screening methods are fast and include methods such as DNA sequencing, probe based hybridization methods, PCR-RFLP, single-strand conformation polymorphism (SSCP), heteroduplex analysis (HA), molecular beacons and ARMS-PCR (Victor et al., 2002). The end results for each of these methods are given as a combined photo in Fig. 2.
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<th>Second-line drug</th>
<th>Gene locus</th>
<th>Gene product</th>
<th>Known polymorphism</th>
<th>Most frequently mutated codons associated with resistance</th>
<th>MIC ^ a (µg/ml)</th>
<th>Methods for genotypic detection of resistance</th>
<th>Reference</th>
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<tr>
<td>Fluoroquinolones</td>
<td>gyrA</td>
<td>DNA gyrase</td>
<td>gyrA 95</td>
<td>gyr 90, 91, 94</td>
<td>OFL: 1.0–2.0 CIP: 0.5–4.0</td>
<td>Cloning &amp; expression PCR-SSCP&lt;sup&gt;b&lt;/sup&gt; DNA sequencing</td>
<td>(Takiff et al., 1994; Pletz et al., 2004; Rattan et al., 1998; Ginsburg et al., 2003; Cheng et al., 2004)</td>
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</tr>
<tr>
<td>Aminoglycosides</td>
<td>rrs</td>
<td>16 S rRNA</td>
<td>rrs 1400</td>
<td>KAN: &gt; 200 AMI: &gt; 256</td>
<td></td>
<td>IS610-RFLP PCR-RFLP&lt;sup&gt;c&lt;/sup&gt;</td>
<td>(Ramaswamy and Musser, 1998; Takiff et al., 1994; Taniguchi et al., 1997; Suzuki et al., 1998; Ramaswamy et al., 2004; Vannelli et al., 2002)</td>
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<tr>
<td>Kanamycin</td>
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<tr>
<td>Amikacin</td>
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<tr>
<td>Ethionamide</td>
<td>inhA</td>
<td>Enoyl-ACP reductase</td>
<td>inhA21, 94, 44</td>
<td>≥ 25</td>
<td></td>
<td>DNA Sequencing</td>
<td>(Baulard et al., 2000; Morlock et al., 2003; Cynamon and Sklaney, 2003)</td>
</tr>
<tr>
<td></td>
<td>ethA</td>
<td>Flavin monooxygenase</td>
<td></td>
<td>≥200</td>
<td></td>
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<tr>
<td></td>
<td>ethR</td>
<td>Transcriptional repressor</td>
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<tr>
<td>D-cycloserine</td>
<td>alr</td>
<td>D-alanine racemase</td>
<td>≥ 300</td>
<td>Cloning &amp; expression DNA Sequencing</td>
<td></td>
<td></td>
<td>(Cañares et al., 1997; Feng and Barletta, 2003)</td>
</tr>
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<td></td>
<td>ddl</td>
<td>D-alanine: D-alanine ligase</td>
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<tr>
<td>Viomycin</td>
<td>rrs</td>
<td>16S rRNA</td>
<td>20</td>
<td>DNA Sequencing</td>
<td></td>
<td></td>
<td>(Ramaswamy and Musser, 1998; Taniguchi et al., 1997; Suzuki et al., 1998)</td>
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</table>

a) Minimum inhibitory concentration. b) Polymerase chain reaction- single strand conformation polymorphism. c) Polymerase chain reaction- Restriction fragment length polymorphism.
Sequencing
PCR amplification followed by DNA sequencing is the most widely used technique to identify mutations associated with drug resistance in TB (Victor et al., 2002). This technique is costly and require expertise, which make it unpractical for use in routine laboratories, especially in developing countries, where simple, cost effective drug susceptibility testing is needed (Victor et al., 2002).

Probe-based hybridization methods
In these assays, amplified PCR products of genes known to confer drug resistance are hybridized to an allele-specific labeled probe that is complementary to the wild type or mutant sequence of the gene. This can then be visualized by autoradiography, enhanced chemiluminescence, alkaline phosphatase or other detection systems. These methods include the Dot-blot and Line blot essays and the commercially available INNO-LIPA RIF-TB test (Innogenetics, Belgium) (Victor et al., 1999; Mokrousov et al., 2004).

PCR-restriction fragment length polymorphism (PCR-RFLP)
Mutations associated with resistance can be identified by digestion of amplified PCR products with a restriction enzyme that cuts at the specific polymorphic DNA sequence followed by gel electrophoresis. Since not all mutations result in the gain or loss of a restriction site, general use of RFLP to screen for mutations associated with drug resistance is limited (Victor et al., 2002).

Single stranded conformation polymorphism analysis (SSCP)
SSCP is a gel based method that can detect short stretches of DNA approximately 175–250bp in size. Small changes in a nucleotide sequence result in differences in secondary structures as well as measurable DNA mobility shifts that are detected on a non-denaturing polyacrylamide gel. To date various studies have applied PCR-SSCP to identify mutational changes associated with drug resistance in M. tuberculosis for frontline drugs like, RIF and INH (Kim et al., 2004; Cardoso et al., 2004; Fang et al., 1999; Heym et al., 1995; Pretorius et al., 1995). However, PCR-SSCP analysis has been found to be technically demanding and not sufficiently sensitive. Furthermore SSCP conditions must be carefully evaluated since not all mutations will be detected under the same conditions.

Heteroduplex analysis (HA)
HA depends on the conformation of duplex DNA when analysed in native gels. Heteroduplexes are formed when PCR amplification products from known wild type and unknown mutant sequences are heated and re-annealed. The DNA strand will form a mismatched heteroduplex if there is a sequence difference between the strands of the wild type and tested DNA. These heteroduplexes have an altered electrophoretic mobility when compared to homoduplexes, since the mismatches tend to retard the migration of DNA during electrophoresis. There are two types of heteroduplexes. The “bubble” type is formed between DNA fragments with single base differences and the bulge type is formed when there are deletions.
or insertions present within the two fragments. Recently, temperature mediated HA has been applied to the detection of mutations associated with mutations in \( \text{rpoB, katG, rpsL, embB} \) and \( \text{pncA} \) genes (Mohamed et al., 2004; Cooksey et al., 2002). Neither HA nor the SSCP analysis are 100% sensitive although Rosetti et al. found that HA detected more mutants (Nataraj et al., 1999). However, HA has certain disadvantages in that it has been found to be insensitive to G-C rich regions and is very time consuming (Nataraj et al., 1999).

**Molecular beacons**

Molecular beacons are single-stranded oligonucleotide hybridization probes which can be used as amplicon detector probes in diagnostic assays. A beacon consists of a stem-loop structure in which the stem contains a fluorophore on one arm and a quencher on the other end of the arm. The loop contains the probe which is complementary to the target DNA. If the molecular beacon is free in a solution it will not fluoresce, because the stem places the fluorophore so close to the non-fluorescent quencher that they transiently share electrons, eliminating the ability of the fluorophore to fluoresce. However, in the presence of complementary target DNA the probe undergo a conformational change that enables them to fluoresce brightly. Different colored fluorophores (different primers) can be used simultaneously to detect multiple targets (each target will give a different color) in the same reaction. Molecular beacons are very specific and can discriminate between single nucleotide substitutions. Thus they are ideally suited for genotyping and have been used in the detection of drug resistance in \( M. \text{tuberculosis} \) (El Hajj et al., 2001; Platek et al., 2000; Platek et al., 1998).

**Amplification refractory mutation system (ARMS)-PCR**

ARMS also known as allelic specific PCR (ASPCR) or PCR amplification of specific alleles (PASA) is a well established technique used for the detection of any point mutation or small deletions (Newton et al., 1989). ARMS-PCR, is usually a multiplex reaction where three (or more) primers are used to amplify the same region simultaneously. One of the three primers is specific for the mutant allele and will work with a common primer during amplification. The mismatch is usually located at or near the 3’ end of the primer. The third primer will work with the same common primer to generate an amplified fragment which is larger than the fragment from the mutant allele primer – this serves as an internal control for amplification. Amplification is detected by gel electrophoresis and the genotypic classification is determined by assessing which amplification products are present. An amplification product should always be present in the larger internal control amplified fragment; if this is the case then the absence or presence of the smaller product will indicate the presence or absence of a mutant allele. This technique has successfully been used for the detection of mutations associated with \( \text{rif} \) resistance in \( M. \text{tuberculosis} \) (Fan et al., 2003). Fig. 2A indicates how the amplified products in the multiplex reaction are distinguished on a gel.

**Applications**

One of the major advantages of PCR based methods is the speed by which the result can be obtained (Siddiqi et al., 1985; Snider, Jr. et al., 1981; Tarrand and Groschel, 1985). It is envisaged that molecular techniques may be important adjuncts to traditional culture based procedures to rapidly screen for drug resistance. Prospective analysis and intervention to prevent transmission may be particularly helpful in areas with ongoing transmission of drug resistant strains as reported previously (van Rie et al., 1999). In addition, molecular prediction may also be useful in drug surveillance studies to further improve the confidence limit of the data in these studies if this test is performed on a subset of the samples. Enhanced efforts are necessary to better understand the molecular mechanisms of resistance to second line anti-TB drugs in clinical isolates. However, implementation for both rapid diagnosis and surveillance requires proper quality control guidelines and controls, which is currently not in place yet for molecular prediction of drug resistance in TB. Although molecular methods are more rapid, and can be done directly from a clinical sample there are important limitations when compared to conventional phenotypic methods. These include a lack of sensitivity since not all molecular mechanisms leading to drug resistance are known, therefore not all resistant isolates will be detected. Molecular methods may also predict resistance genotypes that are expressed at levels that may not clinically be relevant (Victor et al., 2002).

**Transmission and epidemic drug resistant strains**

There is much debate about the relative contribution of acquired and primary resistance to the burden of drug resistant TB in different communities. This controversy focuses on whether MDR strains are transmissible or whether the mutations that confer drug resistance also impair the reproductive function of the organism (fitness of the strain). Evidence that MDR strains do have the potential for transmission comes from a series of MDR-TB outbreaks that have been reported over the past decade. These have been identified in hospitals (Fischl et al., 1992; Edlin et al., 1992; Bifani et al., 1996; Cooksey et al., 1996), amongst health care workers (Beck-Sague et al., 1992; Pearson et al., 1992; Jereb et al., 1995) and in prisons (Valway et al., 1994) and have focused attention on MDR-TB as a major public health issue. Application of molecular epidemiological methods was central to the identification and description of all these outbreaks.

The most extensive MDR-TB outbreak reported to date occurred in 267 patients from New York, who were infected by Beijing/W genotype (Frieden et al., 1996). This cluster of cases included drug resistant isolates that were resistant to all first-line anti-TB drugs. The authors speculate that the delay in diagnosis and administering appropriate therapy resulted in prolonging infectiousness and placed healthcare workers and other hospital residents (or contacts) at risk of infection for nosocomial infection. This difficult-to-treat strain has subsequently disseminated to other US cities and Paris and the authors showed by using molecular methods, how this initially fully drug susceptible strain clonally expanded to result in a MDR phenotype by sequential acquisition of resistance conferring mutations in several genes (Bifani et al., 1996). Since then, the drug resistant Beijing/W genotype has been the focus of extensive investigations and Beijing drug resistant and susceptible genotypes have been found.
to be widely spread throughout the world (Glynn et al., 2002), including in South Africa (van Rie et al., 1999) and Russia (Mokrousov et al., 2002a). Beijing/W genotypes can be identified by their characteristic multi-banded IS6110 restriction fragment-length polymorphism (RFLP) patterns, a specific spoligotype pattern characterized by the presence of spoligotype spacers 35–43 (Bifani et al., 2002) and resistance conferring gene mutations. Although these data led many to propose that Beijing/W strains behaved differently from other strains, more recent work suggests that MDR outbreaks are not limited to the Beijing/W genotype. Smaller outbreaks involving other MDR-TB genotypes have been reported in other settings such as the Czech Republic, Portugal and Norway (Kubin et al., 1999; Portugal et al., 1999). However, since much of the MDR burden falls in developing countries in which routine surveillance does not usually include molecular fingerprinting, little is known about the characteristics of circulating drug resistant strains in much of the world. It is therefore possible that there are other MDR strains, as widespread as Beijing/W, which have not been recognized and reported as such.

Future
Enhanced efforts are necessary to better understand the molecular mechanisms of resistance in second line anti-TB drugs in clinical isolates. The next generation of molecular methods for the prediction of drug resistance in M. tuberculosis will possibly consists of matrix hybridization formats such as DNA oligonucleotide arrays on slides or silicon micron chips (Castellino, 1997; Vernet et al., 2004), particularly if these systems can be fully automated and re-used. This may be particularly useful for mutations in the rpoB gene, which can serve as a marker for MDR-TB (Watterson et al., 1998) and also for the multiple loci that are involved in INH resistance (Table 1). Selection of a limited number of target mutations which enable the detection of the majority of drug resistance (van Rie et al., 2001) would be useful in this strategy. It is essential that developments for new techniques must consider the fact that the majority of drug resistant cases occur in resource-poor countries (Raviglione et al., 1995) and therefore the methodologies must not only be cheap but also robust.


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