Frequency of Decreased Susceptibility and Resistance to Echinocandins among Fluconazole-Resistant Bloodstream Isolates of Candida glabrata


The echinocandin class of antifungal agents is considered to be the first-line treatment of bloodstream infections (BSI) due to Candida glabrata. Recent reports of BSI due to strains of C. glabrata resistant to both fluconazole and the echinocandins are of concern and prompted us to review the experience of two large surveillance programs, the SENTRY Antimicrobial Surveillance Program for the years 2006 through 2010 and the Centers for Disease Control and Prevention population-based surveillance conducted in 2008 to 2010. The in vitro susceptibilities of 1,669 BSI isolates of C. glabrata to fluconazole, voriconazole, anidulafungin, caspofungin, and micafungin were determined by CLSI broth microdilution methods. Fluconazole MICs of ≥64 μg/ml were considered resistant. Strains for which anidulafungin and caspofungin MICs were ≥0.5 μg/ml and for which micafungin MICs were ≥0.25 μg/ml were considered resistant. A total of 162 isolates (9.7%) were resistant to fluconazole, of which 98.8% were nonsusceptible to voriconazole (MIC > 0.5 μg/ml) and 9.3%, 9.3%, and 8.0% were resistant to anidulafungin, caspofungin, and micafungin, respectively. There were 18 fluconazole-resistant isolates that were resistant to one or more of the echinocandins (11.1% of all fluconazole-resistant isolates), all of which contained an acquired mutation in fks1 or fks2. By comparison, there were no echinocandin-resistant strains detected among 110 fluconazole-resistant isolates of C. glabrata tested in 2001 to 2004. These data document the broad emergence of coreistance over time to both azoles and echinocandins in clinical isolates of C. glabrata.

Resistance to the echinocandin antifungal agents, anidulafungin, caspofungin, and micafungin, among the broad population of Candida spp. causing invasive candidiasis (IC), is distinctly uncommon (1, 18, 39, 46, 48, 55–58, 62). Among 15,269 clinical isolates of Candida spp. tested at the University of Iowa (Iowa City), only 25 (0.2%) showed resistance to one or more echinocandins using the Clinical and Laboratory Standards Institute (CLSI) broth microdilution (BMD) method and interpretive criteria (39, 44). As such, the echinocandin class of antifungal agents is recommended as first-line therapy for candidemia and IC, especially in patients with severe sepsis, those previously exposed to azoles, and/or those infected with Candida glabrata (35).

Ever since the introduction of fluconazole in 1990 for the treatment of candidiasis, including IC, empirical antifungal therapy has been driven by fear of C. glabrata (56, 57). Decreased susceptibility of C. glabrata to fluconazole and cross-resistance to other azoles are well known (21, 22, 32, 35, 41, 43, 45, 56, 57). In the United States, C. glabrata has increased as a cause of IC from 18% of all bloodstream infections (BSI) isolates in the time period of 1992 to 2001 to 25% in 2001 to 2007, with a concomitant increase in fluconazole resistance from 9% to 14% (45). Given the distinct differences between the mechanisms of action and resistance for the azoles and the echinocandins (37, 38), the documented lack of cross-resistance between the two classes (27, 31, 42) is not surprising, and thus the recommendation that the echinocandins be used for treatment of IC in patients with prior exposure to azoles and/or infection with C. glabrata is well founded (2, 20, 28, 36, 51, 55).

Although documentation of acquired resistance to the echinocandins remains sporadic (3, 18, 37, 44, 48, 58, 62), several recent reports of acquired resistance in clinical isolates of C. glabrata focus concern on this species (5, 7, 11–15, 18, 19, 48, 58, 59, 62). Data from global surveys demonstrate that the frequency of echinocandin resistance among clinical isolates of C. glabrata ranges from 1 to 3% and is higher among isolates from North America (3%) than among those from Europe (1%), Latin America (0.0%), or the Asia-Pacific region (0.0%) (39, 47). It is now clear that clinical isolates of C. glabrata with decreased susceptibility to one or more echinocandins harbor mutations in fks1 and/or fks2 and are also resistant clinically (5, 15, 37, 48, 59, 62). Chapeland-Leclerc et al. (5) reported a case of IC due to C. glabrata in which the infecting strain acquired resistance to fluconazole, fluconazole, voriconazole, and caspofungin through successive independent events following prolonged exposure to each class of antifungal agent. The recovery of different isolates exhibiting clonality for microsatellite markers but genetic diversity for antifungal resistance markers (three unique resistance mechanisms) demonstrates the high propensity of C. glabrata to readily mutate in vivo.

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RESULTS AND DISCUSSION

Frequency of resistance to fluconazole and voriconazole. Among 1,669 BSI isolates of \textit{C. glabrata} collected during the course of the two surveillance programs, 162 (9.7\%) were resistant to fluconazole, including 62 of 847 (7.3\%) isolates from the SENTRY Program (years 2006 to 2010) and 100 of 822 (12.2\%) isolates from the CDC population-based surveillance (years 2008 to 2010). Among the 162 fluconazole-resistant isolates, 160 (98.8\%) were NS to voriconazole (MIC $> 0.5 \, \mu g/ml$) (40).

Decreased susceptibility to echinocandins among fluconazole-resistant \textit{C. glabrata} isolates. Among the 162 fluconazole-resistant isolates of \textit{C. glabrata}, there were 21 isolates (13.0\%) that were either I or R to one or more of the echinocandins (Table 1): 3.7\% and 9.3\% were I or R, respectively, to anidulafungin, 3.7\% and 9.3\% to caspofungin, and 4.9\% and 8.0\% to micafungin. Mutations in either \textit{fks}1 or \textit{fks}2 were detected in 19 of the 21 (90.5\%) echinocandin I or R isolates (Table 1). There were 18 fluconazole-resistant isolates (11.1\% of all fluconazole-resistant isolates) that were R to one or more of the echinocandins (MIC $\geq 0.25 \, \mu g/ml$ [micafungin] or $\geq 0.5 \, \mu g/ml$ [anidulafungin and caspofungin]), all (100.0\%) of which demonstrated an acquired mutation in \textit{fks}1 or \textit{fks}2.

Table 2 provides a comparison of the frequency of I or R among 110 fluconazole-resistant strains of \textit{C. glabrata} collected from diverse medical centers worldwide between 2001 and 2004 (27, 42) and that of the present collection, representing the time period 2006 to 2010. Results from the two time periods were obtained with CLSI reference methods in different laboratories; however, quality control procedures were rigorously performed during all studies, suggesting that testing conditions did not influence the differences noted.

Whereas there were no echinocandin-resistant strains among 110 fluconazole-resistant isolates of \textit{C. glabrata} tested between 2001 and 2004, a period where only caspofungin was available, there were 18 echinocandin-resistant strains (11.1\%) among the 162 fluconazole-resistant isolates representing the latter time period. All of these had mutations in \textit{fks} (Tables 1 and 2).

These data document for the first time the broad emergence of resistance over time to both azoles and echinocandins in clinical isolates of \textit{C. glabrata}. Whereas resistance to azoles in isolates of \textit{C. glabrata} has been documented to be due to the overexpression of \textit{CDR} efflux pumps (52, 53), there is little or no evidence that efflux pumps are involved in resistance to the echinocandins (31, 50). The documentation of \textit{fks} mutations in isolates of \textit{C. glabrata} showing in vitro resistance to both azoles and echinocandins suggests the sequential accumulation of acquired resistance mechanisms as demonstrated by Chapelard-Leclerc (5). The lack of co-resistance in \textit{C. glabrata} in the 2001-to-2004 time period is not surprising given that among the echinocandins only caspofungin was available, having been just approved in the United States and Europe in 2001. Since that time, the overall use of echinocandins in the United States has increased significantly, from 7.7 $\pm$ 5.3 days of therapy (DOT) per 1,000 patient-days in 2004 to 13.1 $\pm$ 8.6 DOT per 1,000 patient-days in 2008 (mean $\pm$ standard deviation [SD]) ($P < 0.001$) (33). During the same time period (2004 to 2008), the use of azoles increased as well, from 67.6 $\pm$ 29 to 72 $\pm$ 33 DOT per 1,000 patient-days, but this change was not significant ($P = 0.1570$) (33).

Whereas a shift to non-\textit{albicans} species of \textit{Candida}, particularly
C. glabrata has been a cause for alarm among clinicians caring for profoundly ill patients in the hospital (23, 26, 61), others have suggested that this is not a concern in the current “echinocandin era” (16, 56, 57). Prior to the availability of the echinocandins, concern over the reduced azole susceptibility of C. glabrata was a major issue for clinicians (10, 22, 29, 32, 54). Both in vitro and clinical studies have documented excellent activities of the echinocandins against C. glabrata and other potentially azole-resistant species, and the echinocandins have been rapidly replacing the azoles as first-line therapy for IC (4, 17, 18, 24, 30, 33, 35, 55, 58). For both drugs, preexposure was associated with a decreased prevalence of C. albicans in favor of less drug-susceptible species (C. glabrata and C. krusei) for the latter; for the former; C. parapsilosis, C. glabrata, and C. krusei for the latter; P = 0.001). Not only did the species distribution change in patients with recent exposure to fluconazole and caspofungin, but the overall susceptibilities of the isolates to these drugs decreased. Notably, two C. glabrata isolates recovered from patients previously exposed to caspofungin during incident candidemia had high caspofungin MICs and harbored mutations in fks1 (24). The authors caution

Exposure to fluconazole is recognized by some (6, 22, 25, 49, 60) but not all (10, 54) investigators as a risk factor for fluconazole-resistant C. glabrata. Aside from reports of breakthrough fungemias, some involving fks mutations, there is little comparable data for the echinocandins and their influence on species distribution or resistance patterns in IC (58). Recently Lortholary et al. (24) examined the effect of exposure to fluconazole (n = 159) or caspofungin (n = 61) on the proportions of the five major species of Candida. For both drugs, preexposure was associated with a decreased prevalence of C. albicans in favor of less drug-susceptible species (C. glabrata and C. krusei) for the latter; for the former; C. parapsilosis, C. glabrata, and C. krusei for the latter; P = 0.001). Not only did the species distribution change in patients with recent exposure to fluconazole and caspofungin, but the overall susceptibilities of the isolates to these drugs decreased. Notably, two C. glabrata isolates recovered from patients previously exposed to caspofungin during incident candidemia had high caspofungin MICs and harbored mutations in fks1 (24). The authors caution

### TABLE 1 Fluconazole-resistant bloodstream isolates of C. glabrata with decreased susceptibility to one or more echinocandin agent as determined by CLSI broth microdilution methods

<table>
<thead>
<tr>
<th>Isolate no.</th>
<th>Yr</th>
<th>Location</th>
<th>Gender/age (yr) of patient</th>
<th>MIC (µg/ml)</th>
<th>FKS mutation(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS08-0016</td>
<td>2008</td>
<td>Georgia</td>
<td>M/47</td>
<td>ANF 1, CSF 0.5, MCF 1</td>
<td>S629P(1)</td>
</tr>
<tr>
<td>127F</td>
<td>2008</td>
<td>NA</td>
<td>F/49</td>
<td>ANF 2, CSF 16, MCF 2</td>
<td>S629P(1)</td>
</tr>
<tr>
<td>CAS11-3112</td>
<td>2010</td>
<td>Georgia</td>
<td>M/47</td>
<td>ANF 0.5, CSF 0.25, MCF 0.12</td>
<td>S629P(1)</td>
</tr>
<tr>
<td>CAS11-2978</td>
<td>2010</td>
<td>Maryland</td>
<td>F/70</td>
<td>ANF 0.5, CSF 0.5, MCF 0.12</td>
<td>S629P(1)</td>
</tr>
<tr>
<td>CAS11-3129</td>
<td>2010</td>
<td>Maryland</td>
<td>F/70</td>
<td>ANF 4, CSF &gt;16, MCF 2</td>
<td>S629P(1)</td>
</tr>
<tr>
<td>CAS09-1437</td>
<td>2009</td>
<td>Georgia</td>
<td>F/66</td>
<td>ANF 0.25, CSF 0.25, MCF 0.5</td>
<td>R631G(1)</td>
</tr>
<tr>
<td>CAS09-1680</td>
<td>2009</td>
<td>Georgia</td>
<td>F/65</td>
<td>ANF 0.25, CSF 0.5, MCF 1</td>
<td>R631G(1)</td>
</tr>
<tr>
<td>748F</td>
<td>2008</td>
<td>Washington</td>
<td>M/58</td>
<td>ANF 0.25, CSF 0.25, MCF 0.12</td>
<td>D632Y(1)</td>
</tr>
<tr>
<td>3001IF</td>
<td>2010</td>
<td>NA</td>
<td>NA</td>
<td>ANF 0.25, CSF 0.5, MCF 0.03</td>
<td>D632Y(1)</td>
</tr>
<tr>
<td>10956A</td>
<td>2006</td>
<td>Virginia</td>
<td>F/69</td>
<td>ANF 1, CSF 2, MCF 0.12</td>
<td>F659V(2)</td>
</tr>
<tr>
<td>CAS09-0869</td>
<td>2009</td>
<td>Maryland</td>
<td>M/39</td>
<td>ANF 1, CSF 2, MCF 0.25</td>
<td>F659Y(2)</td>
</tr>
<tr>
<td>CAS08-0425</td>
<td>2008</td>
<td>Maryland</td>
<td>F/23</td>
<td>ANF 2, CSF 16, MCF 4</td>
<td>S663P(2)</td>
</tr>
<tr>
<td>CAS08-0094</td>
<td>2008</td>
<td>Georgia</td>
<td>NA</td>
<td>ANF 4, CSF &gt;16, MCF 4</td>
<td>S663P(2)</td>
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<td>CAS09-1786</td>
<td>2009</td>
<td>Georgia</td>
<td>NA</td>
<td>ANF 2, CSF &gt;16, MCF 2</td>
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<td>ANF 4, CSF &gt;16, MCF 4</td>
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<td>2009</td>
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<td>F/51</td>
<td>ANF 0.5, CSF 0.25, MCF 0.12</td>
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<tr>
<td>36670F</td>
<td>2010</td>
<td>Washington</td>
<td>NA</td>
<td>ANF 0.25, CSF 0.25, MCF 0.06</td>
<td>NM</td>
</tr>
<tr>
<td>53301F</td>
<td>2010</td>
<td>NA</td>
<td>NA</td>
<td>ANF 0.25, CSF 0.12, MCF 0.12</td>
<td>NM</td>
</tr>
<tr>
<td>CAS10-2732</td>
<td>2010</td>
<td>Maryland</td>
<td>M/38</td>
<td>ANF 0.12, CSF 0.25, MCF 0.015</td>
<td>NM</td>
</tr>
</tbody>
</table>

\(^a\) M, male; F, female; ANF, anidulafungin; CSF, caspofungin; MCF, micafungin; NA, data not available.

\(^b\) Value in parentheses indicates FKS1 (1) or FKS2 (2); NM, no mutation.

### TABLE 2 Comparison of the activities of anidulafungin, caspofungin, and micafungin against fluconazole-resistant isolates of C. glabrata from two time periods, 2001 to 2004 and 2006 to 2010

<table>
<thead>
<tr>
<th>Time period (yr)</th>
<th>Antifungal agent</th>
<th>No. of isolates tested</th>
<th>No. (%) of isolates</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–2004</td>
<td>Anidulafungin</td>
<td>110</td>
<td>2 (1.8)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td></td>
<td>Caspofungin</td>
<td>110</td>
<td>4 (3.6)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td></td>
<td>Micafungin</td>
<td>110</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>2006–2010</td>
<td>Anidulafungin</td>
<td>162</td>
<td>6 (3.7)</td>
<td>15 (9.3)</td>
</tr>
<tr>
<td></td>
<td>Caspofungin</td>
<td>162</td>
<td>6 (3.7)</td>
<td>15 (9.3)</td>
</tr>
<tr>
<td></td>
<td>Micafungin</td>
<td>162</td>
<td>8 (4.9)</td>
<td>13 (8.0)</td>
</tr>
</tbody>
</table>

\(^a\) All isolates were tested in accordance with CLSI document M27-A3 (8). Fluconazole resistance was defined as an MIC of ≥64 µg/ml.

\(^b\) Number of isolates for which the echinocandin MICs were intermediate (I) (anidulafungin and caspofungin MIC of 0.25 µg/ml; micafungin MIC of 0.12 µg/ml) or resistant (R) (anidulafungin and caspofungin MIC of ≥0.5 µg/ml; micafungin MIC of ≥0.25 µg/ml).
that a new episode of sepsis after a recent prescription of antifungals may be due to isolates with decreased susceptibility to the prescribed drugs, including caspofungin (24). In light of this, it should be noted that among the CDC isolates of *C. glabrata* with *fks* mutations for which epidemiological data were available, all came from patients with prior exposure to an echinocandin (62).

In summary, we have documented the emergence of coresistance to the echinocandins among BSI isolates of fluconazole-resistant *C. glabrata*. Among the 18 fluconazole-resistant isolates with coresistance to the echinocandins, all were from the United States, consistent with our previous observations concerning the geographic distribution of echinocandin resistance in *C. glabrata*, where the highest frequency of resistance was seen in North America (3%) versus Europe (1%), Latin America (0.0%), and the Asia-Pacific region (0.0%) (47). The increased use of both azoles and echinocandins will most certainly bring selection pressure to bear against *C. glabrata*, a species that appears to be unique in its ability to sequentially acquire and express resistance mutations. Specifically, the targeted use of echinocandins in severely immunocompromised individuals with prior exposure to azoles and/or infection with *C. glabrata* will ensure that this dual drug pressure is maintained. Although the vast majority of *C. glabrata* isolates remain highly susceptible to the echinocandin class of antifungal agents, the increase in MDR *C. glabrata* strains is a serious concern and argues for continued close resistance surveillance and the increased application of standardized antifungal susceptibility testing. Heightened awareness, rather than complacency, concerning the importance of *C. glabrata* should be the watchword for those caring for patients at risk for IC.

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**REFERENCES**


