EUCAST technical note on anidulafungin

M. C. Arendrup¹, J.-L. Rodriguez-Tudela², C. Lass-Flörl³, M. Cuenca-Estrella², J. P. Donnelly⁴, W. Hope⁵ and The European committee on antimicrobial susceptibility testing - subcommittee on antifungal susceptibility testing (EUCAST-AFST)*

 Unit of Mycology, Department of Microbiological Surveillance and Research, Statens Serum Institute, Copenhagen, Denmark, 2) Mycology Reference Laboratory, National Center for Microbiology, Instituto de Salud Carlos III, Majadahonda, Spain, 3) Division of Hygiene and Microbiology, Innsbruck Medical University, Innsbruck, Austria, 4) Department of Haematology, Radboud University Nijmegen Medical Centre & Nijmegen University Centre for Infectious Diseases, Radboud University, Nijmegen, the Netherlands and 5) The University of Manchester, Manchester, UK

Abstract

The European Committee on Antimicrobial Susceptibility Testing-Subcommittee on Antifungal Susceptibility Testing has determined breakpoints for anidulafungin for *Candida* spp. This Technical Note is based on the EUCAST anidulafungin rationale document (available at: http://www.eucast.org). Species-specific breakpoints for *C. albicans* are S ≤ 0.03 mg/L and R > 0.03 mg/L and for *C. glabrata, C. tropicalis* and *C. krusei* S ≤ 0.06 mg/L and R > 0.06 mg/L. *C. parapsilosis* was not regarded a good target for anidulafungin. There are insufficient data to set breakpoints for other species. The breakpoints are based upon pharmacokinetic data, epidemiological cut-off values and clinical experience. Breakpoints will be reviewed regularly.

Keywords: Anidulafungin, breakpoints, EUCAST Technical Note, susceptibility testing

Original Submission: 31 May 2011; Revised Submission: 28 July 2011; Accepted: 8 August 2011 Editor: E. Roilides Article published online: 17 August 2011 Clin Microbiol Infect 2011; 17: E18–E20 10.1111/j.1469-0691.2011.03647.x Corresponding author: M. C. Arendrup, Unit of Mycology, Department of Microbiological Surveillance and Research, Statens Serum Institute, Artillerivej 5, DK-2300 Copenhagen, Denmark E-mail: maiken@arendrup.dk

*EUCAST-AFST: M. C. Arendrup (Chairman, Denmark),
W. W. Hope (Secretary), C. Lass-Flörl, Steering Committee (Austria),
M. Cuenca-Estrella, Steering Committee (Spain), S. Arikan (Turkey),
F. Barchiesi (Italy), J. Bille (Switzerland), E. Chryssanthou (Sweden),
E. Dannaoui, (France), P. Gaustad (Norway), H. Järv (Estonia),
N. Klimko (Russia), C. B. Moore (UK), A. Schmalreck (Germany),
A. Velegraki (Greece), P. Verweij (the Netherlands).

Anidulafungin is an echinocandin antifungal agent active against most *Candida* species. Anidulafungin is predominantly used for the treatment of disseminated candidiasis in nonneutropenic adult patients. Most data regarding anidulafungin *in vitro* susceptibility are derived from patients with candidaemia and a smaller number of patients with deep-seated organ infection.

The European Committee on Antimicrobial Susceptibility Testing-Subcommittee on Antifungal Susceptibility Testing (EUCAST-AFST) has determined breakpoints for anidulafungin for *Candida* spp. This Technical Note is based on the EUCAST anidulafungin rationale document (available on the EUCAST website: http://www.eucast.org). The rationale document includes more detail and published references related to the selection of EUCAST-AFST breakpoints (http:// www.srga.org/eucastwt/MICTAB/EUCAST%20clinical%20MIC %20breakpoints%20-%20antimicrobials%20for%20Candida%20 infections.htm).

The breakpoints are based on dosages of 200 mg/kg on day I, then 100 mg/kg/day, and were established using MIC values from many sources. Wild-type isolates exhibit MICs of C. albicans ≤0.03 mg/L, C. glabrata, C. krusei and C. tropicalis $\leq 0.06 \text{ mg/L}$ and C. parapsilosis $\leq 4 \text{ mg/L}$. Isolates with mutations in the hot spot regions of the target gene have been associated with clinical failures or breakthrough infections during echinocandin treatment [1-3]. The anidulafungin MICs of such mutant isolates are as follows: C. albicans >0.03 mg/L, C. glabrata >0.06 mg/L, C. tropicalis >0.06 mg/L and C. krusei >0.03 mg/L [4]. However, it should be noted that most of the data on breakthrough infections derive from studies with caspofungin as caspofungin has been in use the longest (approved in Europe in 2001, whereas anidulafungin was approved in 2007). The clinical data from three clinical trials were used [5-7]. These studies did not include MICs by the EUCAST method so a correlation of in vitro MICs with clinical outcome is not possible.

The EUCAST breakpoints (Table I) are based on pharmacokinetic and microbiological data and clinical experience TABLE I. Species-specific anidulafungin EUCAST breakpoints

Species ^{a,b}	Species-related breakpoints ^{b,c} (mg/L)	
C. albicans	S ≤0.03	R >0.03
C. glabrata	S ≤0.06	R >0.06
C. tropicalis	S ≤0.06	R >0.06
C. krusei	S ≤0.06	R >0.06

^aThere is insufficient evidence to set non-species-related breakpoints.

 ^{b}C . parapsilosis was considered a poor target for anidulafungin therapy and for that reason did not receive breakpoints. There is insufficient clinical evidence to set breakpoints for other species than those listed.

^cMICs for *C. guilliermondii* are approximately 8 two-fold dilutions higher than those for *C. albicans*. There is insufficient evidence to indicate whether the wildtype population of this pathogen can be considered susceptible to anidulafungin. Hence, for *C. guilliermondii* there is insufficient evidence (IE) to set breakpoints.

[4–9]. Breakpoints for anidulafungin will be reviewed regularly. A number of *in vitro* studies on susceptibility of the fungus, of the target enzyme itself or in animal models have demonstrated cross-resistance between the three currently available echinocandins (anidulafungin, caspofungin and micafungin) for isolates with hot spot mutations in the target gene [3,10–15]. Hence, isolates categorized as anidulafungin susceptible can be regarded as susceptible to caspofungin and micafungin until drug-specific breakpoints are available for these two compounds.

Acknowledgements

None.

Transparency Declaration

The authors do not have any potential conflicts of interests related particularly to this paper. MCA has received research grants and acted as speaker for Astellas, Gilead, MSD and Pfizer, and been a consultant for Gilead, MSD and Pcovery. JLRT has received grant support from Astellas Pharma, Gilead Sciences, Merck Sharp and Dohme, Pfizer, Schering Plough, Soria Melguizo SA, the European Union, the Spanish Agency for International Cooperation, the Spanish Ministry of Culture and Education, The Spanish Health Research Fund, The Instituto de Salud Carlos III, The Ramon Areces Foundation and The Mutua Madrileña Foundation. He has been an advisor/consultant to the Panamerican Health Organization, Gilead Sciences, Merck Sharp and Dohme, Mycognostica, Pfizer and Schering Plough. He has been paid for talks on behalf of Gilead Sciences, Merck Sharp and Dohme, Pfizer and Schering Plough. CLF has research grants, consultant and/or speakers bureau, for Pfizer, Astellas, Gilead and Merck. MCE has received grant support from Astellas Pharma, bioMerieux, Gilead Sciences, Merck Sharp and Dohme, Pfizer, Schering Plough, Soria Melguizo SA, the European Union, the ALBAN programme, the Spanish Agency for International Cooperation, the Spanish Ministry of Culture and Education, The Spanish Health Research Fund, The Instituto de Salud Carlos III, The Ramon Areces Foundation and The Mutua Madrileña Foundation. He has been an advisor/consultant to the Panamerican Health Organization, Gilead Sciences, Merck Sharp and Dohme, Pfizer and Schering Plough. He has been paid for talks on behalf of Gilead Sciences, Merck Sharp and Dohme, Pfizer and Schering Plough. JPD has been a consultant for Astellas, Gilead, Merck and Pfizer, received research grants from Pfizer and is on the speakers bureau for Gilead, Merck and Pfizer. WWH has research grants, consultant and/or speakers bureau, for Pfizer, Astellas, Gilead, Merck, Vectura and F2G.

References

- Pfeiffer CD, Garcia-Effron G, Zaas AK, Perfect JR, Perlin DS, Alexander BD. Breakthrough invasive candidiasis on micafungin. J Clin Microbiol 2010; 48: 2373–2380.
- Dannaoui E, Desnos-Ollivier M, Garcia-Hermoso D et al. Infections due to Candida spp. with reduced susceptibility to caspofungin in France. European Conference on Clinical Microbiology and Infectious Diseases. Abstract O346. *Clin Microbiol Infect* 2010; 16 (Suppl 2): S77.
- Arendrup MC, Garcia-Effron G, Buzina W et al. Breakthrough Aspergillus fumigatus and Candida albicans double infection during caspofungin treatment: laboratory characteristics and implication for susceptibility testing. Antimicrob Agents Chemother 2009; 53: 1185– 1193.
- Arendrup MC, Garcia-Effron G, Lass-Florl C et al. Echinocandin susceptibility testing of Candida species: comparison of EUCAST EDef 7.1, CLSI M27-A3, Etest, disk diffusion, and agar dilution methods with RPMI and isosensitest media. Antimicrob Agents Chemother 2010; 54: 426–439.
- Reboli AC, Rotstein C, Pappas PG et al. Anidulafungin versus fluconazole for invasive candidiasis. N Engl J Med 2007; 356: 2472– 2482.
- Vazquez JA, Schranz JA, Clark K, Goldstein BP, Reboli A, Fichtenbaum C. A phase 2, open-label study of the safety and efficacy of intravenous anidulafungin as a treatment for azole-refractory mucosal candidiasis. J Acquir Immune Defic Syndr 2008; 48: 304–309.
- Krause DS, Simjee AE, van RC et al. A randomized, double-blind trial of anidulafungin versus fluconazole for the treatment of esophageal candidiasis. Clin Infect Dis 2004; 39: 770–775.
- Damle BD, Dowell JA, Walsky RL, Weber GL, Stogniew M, Inskeep PB. In vitro and in vivo studies to characterize the clearance mechanism and potential cytochrome P450 interactions of anidulafungin. *Antimicrob Agents Chemother* 2009; 53: 1149–1156.
- Dowell JA, Knebel W, Ludden T, Stogniew M, Krause D, Henkel T. Population pharmacokinetic analysis of anidulafungin, an echinocandin antifungal. J Clin Pharmacol 2004; 44: 590–598.

- Laverdiere M, Lalonde RG, Baril JG, Sheppard DC, Park S, Perlin DS. Progressive loss of echinocandin activity following prolonged use for treatment of *Candida albicans* oesophagitis. J Antimicrob Chemother 2006; 57: 705-708.
- 11. Garcia-Effron G, Park S, Perlin DS. Correlating echinocandin MIC and kinetic inhibition of fks1 mutant glucan synthases for *Candida albicans*: implications for interpretive breakpoints. *Antimicrob Agents Chemother* 2009; 53: 112–122.
- Garcia-Effron G, Lee S, Park S, Cleary JD, Perlin DS. Effect of Candida glabrata FKS1 and FKS2 mutations on echinocandin sensitivity and kinetics of 1,3-{beta}-D-glucan synthase: implication for the existing susceptibility breakpoint. Antimicrob Agents Chemother 2009; 53: 3690– 3699.
- Desnos-Ollivier M, Bretagne S, Raoux D, Hoinard D, Dromer F, Dannaoui E. Mutations in the fksI gene in *Candida albicans, C. tropicalis* and *C. krusei* correlate with elevated caspofungin MICs uncovered in AM3 medium using the EUCAST method. *Antimicrob Agents Chemother* 2008; 52: 3092–3098.
- Baixench MT, Aoun N, Desnos-Ollivier M et al. Acquired resistance to echinocandins in Candida albicans: case report and review. J Antimicrob Chemother 2007; 59: 1076–1083.
- 15. Pfaller MA, Diekema DJ, Andes D et al. Clinical breakpoints for the echinocandins and Candida revisited: integration of molecular, clinical, and microbiological data to arrive at species-specific interpretive criteria. Drug Resist Updat 2011; 14: 164–176.