Therapeutic drug monitoring: how to improve drug dosage and patient safety in tuberculosis treatment

Giovanni Sotgiu a, Jan-Willem C. Alffenaar b, Rosella Centis c, Lia D’Ambrosio c, Antonio Spanevello d,e, Andrea Piana a, Giovanni Battista Migliori c,*

a Clinical Epidemiology and Medical Statistics Unit, Department of Biomedical Sciences, University of Sassari – Research, Medical Education and Professional Development Unit, AOU Sassari, Sassari, Italy
b University of Groningen, University Medical Centre Groningen, Department of Clinical Pharmacy and Pharmacology, Groningen, Netherlands
c World Health Organization Collaborating Centre for Tuberculosis and Lung Diseases, Fondazione S. Maugeri, IRCCS, Via Roncaccio 16, 21049, Tradate, Italy
d Pneumology Unit, Fondazione Maugeri, IRCCS, Tradate, Italy
e Department of Clinical and Experimental Medicine, University of Insubria, Varese, Italy

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SUMMARY
In this article we describe the key role of tuberculosis (TB) treatment, the challenges (mainly the emergence of drug resistance), and the opportunities represented by the correct approach to drug dosage, based on the existing control and elimination strategies. In this context, the role and contribution of therapeutic drug monitoring (TDM) is discussed in detail. Treatment success in multidrug-resistant (MDR) TB cases is low (62%, with 7% failing or relapsing and 9% dying) and in extensively drug-resistant (XDR) TB cases is even lower (40%, with 22% failing or relapsing and 15% dying). The treatment of drug-resistant TB is also more expensive (exceeding €50 000 for MDR-TB and €160 000 for XDR-TB) and more toxic if compared to that prescribed for drug-susceptible TB. Appropriate dosing of first- and second-line anti-TB drugs can improve the patient’s prognosis and lower treatment costs. TDM is based on the measurement of drug concentrations in blood samples collected at appropriate times and subsequent dose adjustment according to the target concentration. The ‘dried blood spot’ technique offers additional advantages, providing the rationale for discussions regarding a possible future network of selected, quality-controlled reference laboratories for the processing of dried blood spots of difficult-to-treat patients from reference TB clinics around the world.

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1. Introduction

In this article we describe the key role of tuberculosis (TB) treatment, the challenges (mainly the emergence of drug resistance), and the opportunities represented by the correct approach to drug dosage based on the existing strategies of the World Health Organization (WHO). In this context, the role and contribution of therapeutic drug monitoring (TDM) is discussed in detail.

The European Respiratory Society (ERS) and the WHO developed the Framework for Tuberculosis Elimination in Low-incidence Countries1 in Rome, Italy in July 2014: this is focused on the concept of pre-elimination (defined as <10 TB cases per million population) and TB elimination (defined as <1 TB case per million population).2–5 The vision of a TB-free world (zero death, disease, and suffering due to TB) is consistent with the new post-2015 WHO global TB strategy, which has been named the ‘End TB Strategy’.6 The overall goal of the strategy is to end the global TB epidemic, with corresponding 2035 targets of a 95% reduction in TB deaths and a 90% reduction in TB incidence (both compared with 2015). The strategy also includes a target of zero catastrophic costs for TB-affected families by 2020.

To reach this goal, a set of coherent additional actions needs to be implemented in order to improve access to high-quality TB services (prevention, diagnostic, and treatment), especially for vulnerable groups. Also, efforts should be made to address the underlying determinants that put people at risk of TB.

A recent ERS/WHO survey demonstrated that several actions or ‘areas’ relevant to TB elimination, particularly in the clinical field, are not fully covered in Europe;7 thus, any information that sheds light on the best clinical and public health practices contributing to improved clinical management will favour TB elimination.

TDM is a tool that may be of help in optimizing TB treatment and is thereby likely to support TB elimination strategies. The aim
of this study was to pinpoint the role of TDM for the most urgent cases and to present a TDM strategy that could be implemented in a programmatic setting with the scope of controlling and eliminating TB.

2. Methods

By exploring the recent literature we sought to detect TB subpopulations with the highest burden of disease or consuming the greatest health care budget. We subsequently evaluated whether TDM could be of help to solve the problems in this TB population and how it could be implemented in a programmatic treatment setting.

3. Results

A challenge to the attainment of TB elimination is represented by multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB. In 2013, the WHO estimated that there were 9 million TB incident cases globally, equivalent to 126 cases per 100,000 population; out of these, an estimated 480,000 cases were affected by MDR Mycobacterium tuberculosis strains. Among newly diagnosed patients, approximately 3.5% were infected with MDR-TB strains. Of particular worry, however, is that the prevalence of MDR-TB among new cases in some of the Former Soviet Union countries exceeds 30%.6–10 XDR-TB has been identified in 100 countries, and the average proportion of MDR-TB cases with an XDR-TB pattern is 9.0%.11 Furthermore, an additional problem is the emergence and spread of mycobacterial strains with 'total drug resistance'.10–12 A term currently not recognized by the WHO and replaced with 'drug resistance beyond XDR'.13

In the largest MDR-TB cohort ever analyzed,14 the proportion of cases treated successfully was 62%, with 7% failing or relapsing, 9% dying, and 17% defaulting. In the XDR-TB subgroup, treatment outcomes were even worse: 40% achieved treatment success and 22% failed treatment or relapsed, 15% died, and 16% defaulted.15

The treatment of drug-resistant TB is more expensive and more toxic compared to that prescribed for drug-susceptible TB, and currently takes up to 2 years of therapy.16 The cost per patient to treat MDR-TB cases is incredibly high,17,18 and in spite of international public health efforts, the treatment outcome is not very promising.13–15 Diel et al. showed that direct treatment-related costs for MDR-TB patients can amount to €52,259 in Germany.19 The same group demonstrated that the average cost to treat an XDR-TB case in Europe largely exceeds €160,000.

One of the most important causes of the emergence of drug resistance is the pharmacokinetic variability of anti-TB drugs resulting in the exposure of M. tuberculosis strains to subtherapeutic drug concentrations.20,21 This also applies for patients on treatment for MDR-TB. A recent study showed that patients without baseline resistance acquired fluoroquinolone resistance and second-line injectable drug resistance, with 8.9% acquiring extensively drug-resistant TB.22 Appropriate dosing of the few and less effective antibacterial options remaining could dramatically influence the prognosis. TDM is based on the measurement of drug concentrations in blood samples collected at appropriate times and subsequent dose adjustment according to the target concentration.23–25 Based on pharmacokinetic and pharmacodynamic principles it can indirectly assess the effect of the drugs on the bacterial target.26 Details of the pharmacokinetic and pharmacodynamic targets for second-line drugs have been published elsewhere.27

In addition to the pharmacokinetic variability of the anti-TB drugs, an inadequate dose or dosing frequency and non-adherence to the prescribed regimen are also deemed to be responsible for the development of drug-resistant TB.28–30 Although the recent introduction of new diagnostics has allowed the rapid detection of drug resistance,31 TDM has not been implemented properly for the management of TB therapy,32 thereby providing opportunities to adjust the dosing in the case of a low serum concentration.32–34

Furthermore, TDM can indirectly change the prognosis when less than five effective drugs are available. It can help prevent the development of further resistance as a result of low serum exposure; moreover, the detection of high blood levels can allow adjustment of the dosage and thus reduce the occurrence of adverse events that could decrease patient adherence.

Additional information on the implementation of TDM is reported in Table 1.

Conventional TDM is characterized by the determination of drug concentrations in plasma or serum. Many assays describing the optimal analytical procedure can be found in the current literature. However, an assay enabling the measurement of multiple drugs in a single sample is preferable.35 Nevertheless, many laboratories have single drug assays that require a trained

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TDM, therapeutic drug monitoring; DBS, dried blood spot; MIC, minimum inhibitory concentration; PK/PD, pharmacokinetic/pharmacodynamic; IV, intravenous.
nurse to obtain a blood sample of 4–6 ml per time point, making this procedure not too invasive for the patient.

An easier and less expensive approach is the use of the ‘dried blood spot’ (DBS; Figure 1).36 The DBS, used successfully in other infectious disease fields (e.g., human cytomegalovirus), is an innovative methodological approach, allowing smaller blood volume collection and easier sampling, storage, and transportation. The latter features can be particularly helpful in low-income countries. The DBS has already been developed and evaluated clinically for important second-line drugs including moxifloxacin27 and linezolid,28 and also for clarithromycin.29

4. Discussion

Although TDM for second-line drugs seems reasonable to optimize the treatment of MDR-TB, a lack of data from prospective studies, logistical issues, and costs are still hindering its implementation and scale-up, even in high-income countries. Only a few laboratories perform the technique and interpret TDM results.23,40 However, in Europe a group of scientists from Nijmegen and Groningen, the Netherlands, have set up a proficiency testing programme aimed at improving the overall quality of TDM.

The cost of TDM, within country and laboratory variability, is estimated to be US$560 to test four drugs at two time points, but will likely fall with the implementation of analytical methods that can measure all drugs using a single procedure.35 Further costs are related to the collection and shipment of the samples to the referral laboratory.23,41 Despite this financial imbalance, a comprehensive analysis cannot take into account the costs following the occurrence of adverse events, unsuccessful outcomes, and the transmission of drug-resistant mycobacteria in the population.17–19

A network of national reference laboratories similar to that adopted for the surveillance of drug-resistance42 could also be considered for TDM. DBS are easier and cheaper to send than infectious materials (M. tuberculosis strains), so the ordinary mail system could be used at really low cost. Selected, quality-controlled reference laboratories could receive the DBS of difficult-to-treat patients from reference MDR-TB clinics.

The reasons for its implementation, as previously discussed (including the savings related to the preservation of the safety and efficacy of current anti-TB regimens for drug-resistant cases), appear to open the door to the future involvement of low-income countries, even if further scientific evidence is needed16,43,44

A health technology assessment may represent the most rapid way to obtain a clear response in an era in which the sustainability of healthcare systems (including those in high-income countries) needs to be demonstrated.

On this basis, we support the rationale of gaining further evidence not only on the clinical use of TDM, but also on the possible development of a well-organized public health vision, allowing more and more patients to benefit from this test.

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References


Figure 1. Procedure to obtain a dried blood spot (DBS). Images courtesy of Remco Koster. (a) Use a commercially available DBS card; ensure that the card type selected is one that your laboratory is able to analyze. (b) Pre-clean and warm the finger, prick the finger, and discard the first drop of blood. (c) Let the drop of blood ‘fall’ onto the DBS card; do not touch or smear the blood onto the DBS card. (d) Let the DBS card dry in air for the specified time period, store it in a zip lock bag with desiccant, and send to the laboratory.