MOLECULAR EPIDEMIOLOGY OF MALARIA IN YAOUNDE, CAMEROON. IV. EVOLUTION OF PYRIMETHAMINE RESISTANCE BETWEEN 1994 AND 1998

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Abstract. Pyrimethamine, in combination with sulfadoxine, is currently one of the major alternative drugs used for the treatment of chloroquine-resistant Plasmodium falciparum malaria infections in Africa. The mechanism of pyrimethamine resistance has been strongly associated with a single, key point mutation in the dihydrofolate reductase–thymidylate synthase gene, resulting in the substitution of the wild-type allele Ser-108 by either Asn-108 or Thr-108. The pyrimethamine-resistant phenotype and/or genotype were determined in 273 Cameroonian clinical isolates obtained in Yaounde by in vitro assays and polymerase chain reaction–restriction fragment length polymorphism over a 5-year period. The in vitro assays showed that 42% (18 of 43) and 63% (69 of 110) of the isolates obtained in 1994–1995 and 1997–1998, respectively, were resistant to pyrimethamine (50% inhibitory concentration [IC50] > 100 nM). The polymerase chain reaction showed that 43% (55 of 127) and 59% (50 of 85) of the isolates in 1994–1995 and 1997–1998, respectively, had the mutant Asn-108 allele. The pyrimethamine-resistant genotype (Asn-108) corresponded with the pyrimethamine-resistant phenotype (IC50 ≥ 100 nM) in a large majority (> 95%) of the isolates. The results of our study suggest an increasing prevalence of pyrimethamine resistance in Yaounde. Our study further suggests that pyrimethamine resistance can be monitored by a technique that can be adopted by malaria research centers in Africa.

Pyrimethamine, in combination with sulfadoxine, is one of the major antimalarial drugs currently used in Africa.1 Pyrimethamine, a 2,4-diaminopyrimidine derivative, was synthesized and tested for antimalarial activity in the United Kingdom during the Second World War.2 Because of its relatively slow action and the availability of chloroquine, pyrimethamine was mainly used for malaria chemoprophylaxis from the late 1940s to 1960s. Numerous cases of prophylactic failure were reported in the 1950s, usually within 1 or 2 years after pyrimethamine was massively used in an endemic region for monoprophylaxis.3,4 The discovery of the synergistic effect of pyrimethamine and sulfonamides or sulfofanes, which can overcome a moderate level of pyrimethamine resistance, led to the use of this combination for both prophylaxis and treatment of chloroquine-resistant Plasmodium falciparum in the late 1960s and 1970s.5 However, resistance to sulfadoxine-pyrimethamine combination became widespread in South America and Southeast Asia in the 1980s, and its use for chemoprophylaxis was discontinued due to the potentially serious side effects associated with sulfofanes.6 In the 1990s, the spread of chloroquine resistance has led to an increasing use of sulfadoxine-pyrimethamine to treat chloroquine-resistant P. falciparum infections in Africa.6

Sulfadoxine-pyrimethamine is currently the first-line drug in several east African countries and second-line drug in west and central Africa, including Cameroon. Its characteristic features include a high efficacy against chloroquine-resistant P. falciparum parasites, good tolerance, high compliance due to the single-dose therapy, and safety in young children. Pyrimethamine is one of the few antimalarial drugs whose biochemical and genetic mechanism of action and mechanism of resistance have been well established.2,7 Early biochemical studies in bacteria, mammals, and malaria parasites have shown that pyrimethamine, a structural analog of dihydrofolate, inhibits folate metabolism by binding to dihydrofolate reductase (DHFR) with a high affinity.8,9 The molecular basis of the selection of pyrimethamine-resistant P. falciparum was elucidated when the gene coding for DHFR was isolated, cloned, and sequenced.11,12 A single point mutation in the amino acid residue 108, resulting in the substitution of the wild-type allele Ser by the mutant allele Asn (or Thr), was shown to be associated with drug resistance.7,13–15

In our previous study, we have shown that 43% of the isolates in Yaounde were carriers of the mutant Asn-108 allele and that a similar proportion of the parasites were resistant in vitro to pyrimethamine.16 In the present study, we analyzed the key DHFR allele of the clinical isolates obtained in 1997–1998 with the aim to 1) monitor pyrimethamine resistance by techniques that could be performed in African malaria reference centers and 2) establish whether there is any change in the proportion of the pyrimethamine-resistant isolates in Yaounde.

MATERIALS AND METHODS

Patients. The study was part of the clinical trials conducted in Yaounde, Cameroon since 1994.17,18 A total of 273 venous blood samples from malaria-infected Cameroonian patients residing in Yaounde were analyzed. The results of 136 samples collected in 1994–1995 were presented in our earlier work.16 These data were compared with those of the samples collected during 1997 and 1998. Similar patient populations were studied during the 5-year period by applying the same inclusion criteria to screen symptomatic patients presenting spontaneously at the Nlongkak Catholic missionary dispensary in Yaounde. Inclusion criteria included an age ≥ 5 years old, fever at consultation (or history of fever within the past 24 hr), mono-infection with P. falciparum (parasite density > 5,000 asexual parasites/μL of blood), no recent history of self-medication with antimalarial drugs, as confirmed by a negative Saker-Solomons urine test result,19 easy access to health services in Yaounde for daily

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monitoring, and informed consent by the patient and/or patient’s guardian in the case of children. Our previous studies have shown that clinical parameters and hematologic and blood biochemistry do not differ significantly between the adult population (> 15 years old) and the pediatric population (between 5 and 15 years old); thus, the patients constitute a homogeneous population for our clinical studies.17,18 Patients with signs and symptoms of severe and complicated malaria, as defined by the World Health Organization,20 severe anemia (hemoglobin < 5.0 g/dl), and moderate and severe malnutrition, were excluded. The patients were treated with chloroquine, amodiaquine, pyronaridine, or sulfadoxine-pyrimethamine and, for those responding with a therapeutic failure, quinine or halofantrine. The study was approved by the Cameroonian National Ethics Committee and the Cameroonian Ministry of Public Health.

Parasite DNA. The FCR3/Gambia strain was maintained in a continuous culture according to the standard technique described by Trager and Jensen.21 This strain was used as a control for the Thr-108 residue in the DHFR-thymidylate synthase (TS) gene since this amino acid residue appears to be a rare mutation in African isolates.22–25 Clinical isolates of P. falciparum were obtained by venipuncture before treatment. Venous blood samples (5–10 ml of whole blood) were collected in a Vacutainer tube coated with an anticoagulant (EDTA) (Terumo Europe N. V., Leuven, Belgium) and washed 3 times in folate- and EDTA (Terumo Europe N. V., Leuven, Belgium) and moderate and severe malnutrition, were excluded. The patients were treated with chloroquine, amodiaquine, pyronaridine, or sulfadoxine-pyrimethamine and, for those responding with a therapeutic failure, quinine or halofantrine. The study was approved by the Cameroonian National Ethics Committee and the Cameroonian Ministry of Public Health.

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and 1997±1998 (black columns). For samples collected during 1997 and 1998, the difference in the proportions of pyrimethamine resistance, determined by the chi-square test. Samples with mixed Ser and Asn-108 alleles (n = 16) were not taken into consideration in the statistical analysis.

RESULTS

The in vitro pyrimethamine sensitivity was determined in 153 clinical isolates during 1994–1995 and 1997–1998. Twenty-five (58%) of 43 isolates obtained in 1994–1995 and 41 (37%) of 110 isolates obtained in 1997–1998 were sensitive to pyrimethamine (IC$_{50}$ < 100 nM) (Figure 1). The amino acid residue of the key allele at position 108 of the DHFR-TS gene was determined in a total of 212 Cameroonian isolates obtained in Yaounde. Of 127 isolates obtained in 1994–1995, 66 (52%), 55 (43%), and 6 (5%) presented the wild-type allele Ser-108, mutant type allele Asn-108, and mixed alleles, respectively. For both phenotypic and genotypic markers of pyrimethamine resistance, there was a statistically significant increase (P < 0.05) in the proportion of drug resistance in 1997–1998 compared with 1994–1995. Except for the polymerase chain reaction product amplified from the FCR3 strain, none of the 85 samples obtained in 1997–1998 yielded a digestion product after treatment with ScrF I, indicating the absence of the Thr-108 amino acid residue among our clinical isolates.

The in vitro activity of pyrimethamine and DHFR allele were determined for 58 of 85 isolates collected during 1997 and 1998. The distribution of the pyrimethamine IC$_{50}$ value in relation to the key DHFR allele 108 is shown in Figure 2. Nineteen of 20 isolates carrying the wild-type Ser allele were pyrimethamine sensitive, and 30 of 31 isolates carrying the mutant Asn allele were pyrimethamine resistant. One pyrimethamine-sensitive isolate (IC$_{50}$ = 104 nM) and 1 pyrimethamine-resistant isolate (IC$_{50}$ = 71 nM) displayed discordant IC$_{50}$ values, but these values were close to the borderline value. Except for one polyclonal isolate, clinical isolates with mixed alleles (n = 7) were resistant to pyrimethamine.
DISCUSSION

Based on earlier clinical studies in the 1950s and 1960s, pyrimethamine resistance has been known to emerge rapidly in malaria endemic areas where pyrimethamine alone had been distributed in a large scale. Selection of resistant parasites under massive drug pressure has been hypothesized to be the underlying cause of this phenomenon. The results of recent molecular studies on field isolates originating from various geographic regions strongly indicate that the first and key genetic event involved in the acquisition of pyrimethamine-resistant phenotype is a single Ser-to-Asn point mutation at position 108 of the gene. Additional mutations at positions 51, 59, and/or 164 are associated with a higher level of pyrimethamine and/or cycloguanil resistance. Further experimental proofs have been provided by gene expression in a heterologous system and transfection of malaria parasites with DHFR-TS genes carrying different combinations of mutations. These observations suggest that the genetic basis of the rapid spread of pyrimethamine resistance is associated with the relative ease in selecting parasites carrying Asn-108 allele in an endemic area where pyrimethamine (or trimethoprim), alone or in combination with sulfonamides, is used for antimalarial (or antibacterial) treatment.

The key amino acid substitution at position 108 can be detected rapidly with precision using a combination of polymerase chain reaction and restriction fragment length polymorphism. Using this technique, we have demonstrated the presence of pyrimethamine-resistant clinical isolates in Yaounde. As in our previous studies, there was a strong association between the key DHFR-TS allele at position 108 and in vitro sensitivity and resistance to pyrimethamine. With the exception of a few isolates, the threshold IC50 value of 100 nM for pyrimethamine allowed the separation of 2 discrete populations of clinical isolates, those with a Ser-108 allele and those carrying an Asn-108 allele. However, parasites with mixed alleles cannot be readily assigned to one of these groups. In our previous studies, there were as many mixed populations of parasites with both alleles that were sensitive and resistant to pyrimethamine. The IC50 values of mixed populations may be determined by the phenotype of dominant subpopulations. Unless quantitative polymerase chain reaction or cloning of the initial isolate is performed, we cannot determine the approximate proportion of Asn-108 carriers in relation to Ser-108 carriers in a given isolate.

Our comparative study over a 5-year period in similar patient populations in Yaounde revealed an alarming trend. Our in vitro surveillance showed an increase in the proportion of pyrimethamine-resistant isolates, from 42% in 1994–1995 to 63% in 1997–1998. In parallel, our polymerase chain reaction-based technique showed a similar increase (from 43% in 1994–1995 to 59% in 1997–1998) in the proportion of isolates carrying the mutant Asn-108 allele. We may deduce from our data that there is an increasing prevalence and spread of pyrimethamine resistance in Yaounde during the 5-year period. Our data are also in agreement with the intense drug pressure exerted in Cameroon, as suggested by the volume of sales of antimalarial drugs containing pyrimethamine that are imported in the country (Ducret J-P, unpublished data). Thus, our study seems to reveal the dynamic evolution of the development of pyrimethamine resistance, which may reflect the underlying genetic cause involved in the past, rapid development of pyrimethamine resistance in Asian and South American continents.

At present, pyrimethamine resistance detected in Cameroon by both in vitro and molecular assays has not yet been correlated with in vivo resistance. There is a clear need to establish whether there is a direct correspondence between in vitro and in vivo tests for pyrimethamine resistance. Two possible factors, however, may confound the results of these studies in the field. First, the synergistic effect of pyrimethamine-sulfadoxine combination may overcome drug resistance and mask low to moderate level of pyrimethamine resistance. Second, semi-immune patients may be capable of eliminating residual, drug-resistant parasites by mounting an effective immune response. Despite these potential problems in the interpretation of results, additional molecular, in vitro, and in vivo surveillance is required to gain further insight into the dynamics involved in the spread of antifolate resistance.

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