Early bactericidal activity of ethambutol, pyrazinamide and the fixed combination of isoniazid, rifampicin and pyrazinamide (Rifater) in patients with pulmonary tuberculosis

F. J. H. Botha, F. A. Sirgel, D. P. Parkin, B. W. van de Wal, P. R. Donald, D. A. Mitchison

The early bactericidal activity (EBA) of ethambutol, pyrazinamide and the fixed combination of isoniazid, rifampicin and pyrazinamide (Rifater; Mer National) was evaluated in patients with pulmonary tuberculosis who were sputum-positive on microscopy for acid-fast bacilli. Twenty-eight patients (mean age 33 years and weight 51 kg on average; range 40 - 59 kg) were studied. The fall in viable counts of Mycobacterium tuberculosis in sputum collections during the 2 days following the start of treatment was estimated from counts of colony-forming units (CFUs) of M. tuberculosis per ml of sputum cultured on selective 7H10 agar medium. The EBA for ethambutol determined in 9 patients was 0.246 ± 0.046, log10 CFU/ml sputum/day, that for pyrazinamide was 0.003 ± 0.014 log10 CFU/ml sputum/day and that for Rifater 0.558 ± 0.054 log10 CFU/ml sputum/day. The results obtained are similar to those reported in a previous study of the first 2 days of treatment, but in smaller numbers of patients, and confirm the moderate EBA of ethambutol while pyrazinamide is again shown to have very little EBA. Rifater has a marked EBA which may be due mainly to the action of isoniazid. This methodology may be valuable in the rapid evaluation of the bactericidal activity of new antituberculosis agents and the comparison of different dose sizes of agents of the same class.


Material and methods

Patients

Twenty-eight patients with previously untreated pulmonary tuberculosis whose sputum was positive for acid-fast bacilli on microscopy were studied. Patients were between 18 and 60 years of age (mean 33 years; median 44 years) and weighed 51 kg on average (range 40 - 59 kg). In 25 patients (89%), multicavitary disease was present which in 24 (86%) involved an area larger than the right upper lobe. None of the patients suffered from other complicating medical conditions and none of the women was pregnant.

Patients were allocated consecutively to groups receiving daily doses of ethambutol 1.2 g, pyrazinamide 2 g, or fixed-combination tablets (Rifater) each containing isoniazid 80 mg, rifampicin 120 mg and pyrazinamide 250 mg, administered at a dose of 1 tablet for every 10 kg body weight. At the conclusion of the study, patients were placed on the treatment regimen currently recommended by the South African Tuberculosis Control Programme, i.e. isoniazid, rifampicin and pyrazinamide for 6 months.

A 16-hour collection of sputum was made between 16h00 on day 1 and 08h00 the next day (S1). After the first collection was complete, the first drug dose was administered at least 60 minutes before breakfast and this procedure was repeated twice more on subsequent days to give S2 and S3 sputum collections. This procedure is summarised in Fig. 1. Because of the slow onset of bactericidal activity in the case of pyrazinamide, a third dose of the drug was given followed by an S4 sputum collection. Sputum specimens were sent by air courier to Pretoria for analysis in the laboratories of the South African Tuberculosis Research Programme.
Microbiological evaluation

Conventional smear, culture, sensitivity testing and CFU count were carried out as described previously except that after 2 ml homogenised sputum were mixed with 3 ml 1:10 dithiothreitol (Sputolysin: Hoechst), 20 μl of the dilutions were set up without preliminary centrifugation on duplicate slopes of selective 7H10 medium in universal 28 ml screw-capped containers for CFU counting. Statistical evaluation was by means of t-tests.

The study protocol was approved by the Ethical Committee of the Medical Faculty of the University of Stellenbosch.

Results

A total of 35 patients was studied of whom 7 were excluded, 6 because they had negative or contaminated cultures and 1 because of initial drug resistance. The viable counts in the sputum collections from the remaining 28 patients obtained before chemotherapy (S1) and at daily intervals thereafter (S2 and S3) are given as means in Table I and illustrated for individual patients in Fig. 2. In patients given Rifater, there was only a slight fall on the first day of treatment (day 0 to day 1) but a large and abrupt fall the next day (day 1 to day 2), indicating a delay before the start of the bactericidal activity of the combination. The counts of patients given ethambutol declined slowly and to a similar extent between day 0 (S1) and day 1 (S2) and between day 1 and day 2 (S3). No decline in counts was seen in patients given pyrazinamide, even though treatment was extended by a third day. The error standard deviation from the analyses of variance (the patients x days of interaction) was greatest for the Rifater group and lowest in the pyrazinamide group.

The EBA was calculated as (log S1 count – log S3 count)/2 and is therefore the fall in log CFU/ml sputum/day. The mean EBA values found in the treatment groups of the present study are compared with those found in the Nairobi study in Table II. The mean EBA for the combined tablet (Rifater) group was 0.558 log CFU/ml/day (± 0.054), the highest found; it can be compared with 0.685 log CFU/ml/day for the group in the Nairobi study that received

<table>
<thead>
<tr>
<th>Drug</th>
<th>No. of patients</th>
<th>Viable count log CFU/ml sputum</th>
<th>Error</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>S1</td>
<td>S2</td>
<td>S3</td>
</tr>
<tr>
<td>Rifater</td>
<td>9</td>
<td>6.76</td>
<td>6.53</td>
</tr>
<tr>
<td>Ethambutol</td>
<td>9</td>
<td>6.96</td>
<td>6.78</td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td>10</td>
<td>6.56</td>
<td>6.63</td>
</tr>
</tbody>
</table>

Fig. 1. Procedure for collection of sputum specimens S1, S2 and S3 and administration of antituberculosis agents.

Fig. 2. Colony counts of M. tuberculosis in sputum in three groups of 9 patients each with pulmonary tuberculosis during the first 2 days of treatment with Rifater and with ethambutol and pyrazinamide. Interrupted lines represent mean values.
the same three drugs plus streptomycin, though it must be remembered that streptomycin was thought to increase the EBA when given with pyrazinamide, and 0.598 log$_{10}$ CFU/ml/day was the mean of all combinations of isoniazid with rifampicin and/or pyrazinamide. The mean EBA for ethambutol was lower at 0.245 log$_{10}$ CFU/ml/day (± 0.046), while pyrazinamide with an EBA of 0.003 log$_{10}$ CFU/ml/day (± 0.014) showed no apparent bactericidal activity during the 3-day treatment period. The estimates in the present study on larger groups of patients are thus similar to those found in the earlier Nairobi study. The standard deviations of the variations between patients in EBA were 0.161 for the combined tablet group, 0.152 for the ethambutol group and 0.041 for the pyrazinamide group. Similar results were obtained in a previous study.1 The standard deviation for the group given isoniazid alone was 0.19 and the tendency for groups with a high EBA to have high standard deviations was also found.

No associations were found between the EBA and the S1 viable count, the radiographic severity of disease, degree of cavitation, or the weight, age or sex of the patient.

Discussion

The results obtained in the present study agreed well with those obtained in Nairobi.2 Very low values for pyrazinamide were found in both studies, though pyrazinamide was found to kill bacilli slowly but steadily throughout the 14-day period of the Nairobi study.3 Ethambutol had a moderately high EBA, similar to the Nairobi estimates for rifampicin and p-aminosalicylic acid. No direct comparison can be made for Rifater since this was not available at the time that the Nairobi study was done. However, in the Nairobi study, all combinations of isoniazid with other drugs gave values no higher than the particularly high EBA found with isoniazid alone, suggesting that other drugs given with isoniazid, except perhaps streptomycin, did not influence the EBA of combinations. The EBA of Rifater in our study was similar to the value for all combinations that did not include streptomycin, and only slightly lower than the value for the streptomycin-containing combination in the Nairobi study.

It is important to realise that during the first 2 days of treatment EBA is directed against bacilli in the sputum that arise from the very large bacterial population in cavity walls, distant from any phagocytic cells and therefore predominantly extracellular.1 Those bacilli that are multiplying rapidly are also those that are killed most rapidly by bactericidal drugs and it is therefore their death that is measured by EBA. The EBA thus estimates the activity of a drug against rapidly dividing extracellular bacilli and is closely related to the conventional in vitro measure of bactericidal activity, viz. the fall in CFU counts during exposure of a culture in the logarithmic phase of growth to a drug. It can be used to compare the activities of different doses of the same drug or to compare closely related drugs, each tested at several dose levels.3,4

There are two fundamental measures of the activity of an antituberculosis drug: its ability to prevent the emergence of resistance to another drug and its sterilising activity.5 The EBA is a measure of drug activity during the critical period when drug-resistant mutants are most likely to be selected from the large initial viable bacterial population. However, the ability of a drug to prevent the emergence of resistance is unlikely to be directly related to its EBA, since high bactericidal activity is not essential or even desirable for preventing resistance. Ability to prevent resistance might be better measured by the extent to which the EBA is maintained as the size of the drug dose is decreased, since this would indicate whether the drug is active throughout the different lesions within the lungs, despite variation in penetration into the lesions or in local drug activity.

While appropriate measurement of the EBA may indicate the value of a drug in preventing resistance, it does not measure its sterilising activity, which is the ability of a drug to kill persistent bacilli that are metabolically inactive and consequently survive drug action until the later stages of treatment. These bacilli are not necessarily extracellular and indeed, evidence from EBA studies with rifabutin1-4 and from the known likelihood of a breakdown of immunity in AIDS patients to cause reactivation of dormant organisms, suggests that they are probably intracellular or at least closely associated with immune effector cells. Sterilising activity is measured by the relapse rate during follow-up after chemotherapy has been completed and also by the rate at which sputum cultures are converted at about 2 months after its start.1 It is of course of much greater practical importance than the EBA since it determines the period that treatment must be given to obtain a satisfactorily low relapse rate. There is little correlation between the EBA and the sterilising activity of drugs.1 Rifampicin and pyrazinamide are therefore the most effective sterilising drugs and the backbone of modern short-course regimens, yet pyrazinamide has a very low EBA and rifampicin only a moderate EBA. On the other hand, ethambutol has a moderate EBA, as again demonstrated in this study, but has no sterilising activity. It is therefore only of value in preventing the emergence of drug resistance and not in shortening the duration of treatment.

Table II. Early bactericidal activity of ethambutol, pyrazinamide and Rifater as estimated in Nairobi5 and in the present study

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Nairobi mean (± SD)</th>
<th>Present study (± SD)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Fall in log$_{10}$ CFU/ml sputum/day (No. of patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rifater</td>
<td>0.685* (4)</td>
<td>0.558 (9)</td>
<td>0.682 (4)</td>
</tr>
<tr>
<td></td>
<td>0.598† (28)</td>
<td></td>
<td>0.435</td>
</tr>
<tr>
<td>Ethambutol</td>
<td>0.308 (4)</td>
<td>0.245 (9)</td>
<td>0.361 (1)</td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td>0.044 (8)</td>
<td>0.004 (10)</td>
<td>0.032 (2)</td>
</tr>
</tbody>
</table>

* Nairobi patients received separate daily doses of isoniazid 300 mg, rifampicin 12 mg/kg, pyrazinamide 2 g and streptomycin 1 g.
† Mean value for Nairobi patients given all combinations of isoniazid 300 mg with rifampicin 12 mg/kg and/or pyrazinamide 2 g.
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Effect of an immunisation campaign in Natal and KwaZulu on vaccination coverage rates, 1990 - 1991

J. J. Dyer, K. N. Naidoo, S. Knight, T. Mjekvu,
G. Munro, A. Robinson

In 1990 the Department of National Health and Population Development of South Africa launched a nationwide immunisation campaign targeted mainly at measles. In order to measure the effect of the campaign on vaccination coverage rates for children, pre- and post-campaign vaccination coverage surveys were undertaken using a modified Expanded Programme for Immunisation technique, stratified for race and urban/rural residence.

The results in KwaZulu-Natal showed no significant increase in measles vaccination coverage for any age group after the campaign (as documented by Road-to-Health cards). There was a decrease in coverage of the black population. However, when a history of measles vaccination was accepted, the results showed an increase in coverage.

The results call into question the effectiveness of immunisation campaigns as a strategy for raising vaccination coverage levels, as well as their having a sustained impact on the incidence of measles. Alternative strategies, such as the strengthening and expansion of existing primary health care services, should be considered.

In 1990 the Department of National Health and Population Development launched a nationwide immunisation campaign aimed primarily at measles, but which also emphasised the need to increase coverage rates of vaccination against all the diseases of the Expanded Programme for Immunisation (EPI).

Despite the progress of the EPI, only 59% of children worldwide under 1 year of age were estimated to have received the measles vaccine in 1988, and measles still causes an estimated 1.5 million deaths per year. Before the campaign, coverage rates were estimated to be between 50% and 88% for the black population, and around 80% for white and coloured children aged between 12 and 23 months. In 1989, the year before the campaign, 18-123 cases of measles were notified in South Africa. This is probably an underestimate of the actual number of cases, not all having been notified; hence, the true incidence cannot be ascertained. However, given the notification data, estimates of annual incidence rates for blacks for 1989 varied from 1.9/100 000 in Bophuthatswana and 3.8/100 000 in the Orange Free State, to 72.9/100 000 in the Eastern Cape and 86.9/100 000 in Lébowa. Case fatality rates varied from 0.9% to 8.0% in the different regions. In most regions the incidence appeared to be declining.

Because of the high childhood morbidity and mortality, the national immunisation campaign of May/June 1990 was launched. The intention was to reduce the incidence of measles and increase vaccination coverage rates through a high-profile campaign intended to direct attention and resources to preventive health care and immunisation services, thereby producing effects which would be sustained after the campaign proper was over. In KwaZulu-Natal the campaign took the form of widespread publicity to encourage vaccination at existing facilities. The availability of vaccinations was increased through their being offered at all times at clinics, mobile points and in hospital outpatient departments, which had not previously been the case. Few extra service points were introduced and defaulters and contacts were not followed up.

As one measure of the effectiveness of the campaign, it was deemed necessary to measure coverage rates in children before and after vaccination to see if a significant increase in coverage rates had occurred. The pre-campaign survey was undertaken in 1990. The survey reported here is the post-campaign survey, which aimed to ascertain the level of vaccination coverage of children aged from 9 months to 21 months in Natal and KwaZulu after the campaign, and to compare the levels with those recorded in the pre-campaign survey of February 1990. The detailed results of this survey have been reported elsewhere.

Department of Community Health, University of Natal, Durban

J. J. Dyer, M.B. CHB, D.T.M. & H., FFCH (SA), M.MED. (COMM. HEALTH)
K. N. Naidoo, M.B. CHB, M.MED. (COMM. HEALTH)
S. Knight, M.B. CHB, D.T.M. & H., FFCH (SA)
T. Mjekvu, M.B. CHB
G. Munro, M.B. CHB, D.HSM, FFCH (SA)
A. Robinson, M.B. CHB, D.HSM

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