A Pilot Study of Echinocandin Combination with Trimethoprim/Sulfamethoxazole and Clindamycin for the Treatment of AIDS Patients with Pneumocystis Pneumonia

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Background and Objectives. Pneumocystis pneumonia (PCP) is a common opportunistic infection in acquired immune deficiency syndrome (AIDS) patients that continues to result in a high mortality rate. To develop a better treatment strategy and improve PCP prognosis, a cohort study was conducted to evaluate the therapeutic potential of echinocandin treatment for AIDS patients with PCP (AIDS-PCP).

Methods. The AIDS-PCP patients were analyzed in our retrospective cohort study that were hospitalized in The First Affiliated Hospital of Zhejiang University during 2013–2018. The antifungal effects of echinocandins were evaluated in two subgroups that were classified by oxygenation as a proxy for the disease state: $\text{PaO}_2/\text{FiO}_2 > 200$ mmHg and $\text{PaO}_2/\text{FiO}_2 \leq 200$ mmHg. Intergroup comparisons and survival curves were used to evaluate the effectiveness of the two AIDS-PCP treatment regimens.

Results. During the follow-up, 182 AIDS-PCP patients were diagnosed and analyzed in the study. After excluding 55 patients with other superinfections and five patients that were treated with HAART, the remaining 122 patients were enrolled in the study. The group treated with echinocandins combined with trimethoprim-sulfamethoxazole (TMP-SMZ) and clindamycin exhibited a lower mortality rate (9.62%, 5/52) than did the group with TMP-SMZ and clindamycin treatment (20%, 14/70). For AIDS-PCP patients in the $\text{PaO}_2/\text{FiO}_2 > 200$ mmHg subgroup, treatment with echinocandins combined with TMP-SMZ significantly reduced their mortality rate (4.44% (2/45) vs. 18.18% (10/55), $P = 0.035$).

Conclusion. The results of this study indicate that treatment with echinocandins in combination with the standard TMP-SMZ and clindamycin regimen can improve the prognosis and reduce the mortality rate in patients with mild to moderate AIDS-PCP disease.

1. Introduction

Human pneumocystis pneumonia (PCP) is caused by Pneumocystis jirovecii. In patients with immunodeficiencies or that are undergoing immunosuppression, latent cells will rapidly multiply and destroy alveolar cells, thereby causing interstitial pneumonia [1]. PCP is a life-threatening opportunistic infection [2] that is the most common cause of AIDS-related deaths (20.3–47.7% of all deaths) [3, 4]. Although AIDS-related mortality within a year of initiating ART was 7.44 per 100 person-years which has declined owing to the routine use of highly active antiretroviral therapies (HAART), the risk of early death is still as high as 31.8% [4, 5]. TMP-SMX is the currently used first-line drug for the prevention and treatment of PCP. Alternative drugs include pentamidine, dapsone plus trimethoprim, primaquine plus clindamycin, and atovaquone. In addition, glucocorticosteroid adjuvant therapy can help mechanical ventilation and reduce the mortality rate within patients exhibiting moderate to severe PCP [6, 7]. Despite advances in the prevention and management of PCP, the serious side effects and drug resistance associated with existing treatment regimens require
consideration [8]. Increasing numbers of studies have indi-
cated that mutations in dihydropteroate synthase genes
may be associated with the emergence of TMP-SMX resistant
strains [9]. Alternative candidate drugs including echino-
candins like caspofungin have been investigated thoroughly for
therapeutic potential in treating PCP. Caspofungin is an
antifungal agent that acts on spore cysts by inhibiting the
synthesis of β-(1,3)-D-glucan [10]. Lee et al., Li et al., and
Lu et al. observed that echinocandins in combination with
TMP-SMX treatment can improve the prognosis of PCP
patients and decrease the associated mortality rate [11–13].
However, there has been little investigation of these effects
in AIDS-PCP patients. Consequently, the current study was
designed to evaluate the therapeutic potential of a combined
echinocandins/TMP-SMX treatment for AIDS-PCP patients.

2. Materials and Methods

2.1. Study Population. A total of 182 AIDS-PCP patients were
investigated that were hospitalized in The First Affiliated
Hospital of Zhejiang University between January 2013 and
June 2018. Inclusion criteria include (1) confirmed AIDS
diagnosis, (2) age ≥ 18 years, (3) naive adults with a first epi-
sode of AIDS-PCP, and (4) PCP diagnosis. Diagnosis for
PCP includes (1) insidious or subacute onset, dry cough,
shortness of breath, and increased postactivity; fever may have
fever, progressive dyspnea, and purpura; (2) chest computed
tomography suggests increased lung texture, coarse, strip-
like shadows, or scattered small patchy shadows or diffuse
reticular nodular interstitial infiltration or frosted glassy
shadows; (3) hypoxemia; (4) elevated level of blood lactate
dehydrogenase; and (5) TMP-SMX treatment responding
well. Exclusion criteria included: (1) patients that received
HAART at the onset of the disease; (2) the presence of other
immunocompromised diseases including tumors, congenital
diseases, and prior chemotherapy treatment; (3) immune
reconstitution inflammatory syndrome (IRIS)/patients; (4)
the presence of severe allergies or allergies to sulfa drugs;
(5) the presence of severe heart, brain, liver, kidney, or other
important organ diseases; and (6) the presence of severe
blood and endocrine system diseases or past medical history
of these diseases. All patients provided informed consent,
and this study was approved by the Ethics Committee of
The First Affiliated Hospital, College of Medicine, Zhejiang
University (reference number 2017471).

To specifically investigate the therapeutic effects of
echinocandins in AIDS-PCP patients, 55 patients with
other superinfections and five who had begun antiretrovi-
ral therapy were excluded. Of the remaining 122 patients,
52 were provided echinocandins/TMP-SMX/clindamycin
treatment and 70 patients were treated with TMP-SMX
and clindamycin treatment. And all these patients
accepted the treatment of glucocorticoid. Patients were
divided into two subgroups according to the patient’s
oxygenation index: PaO2/FiO2 > 200 mmHg (n = 100) and
PaO2/FiO2 ≤ 200 mmHg (n = 22). A schematic indicating
the work flow of patient inclusion and classification is
shown in Figure 1.

2.2. Clinical Information. Clinical data were collected for
each subject including demographic characteristics, treat-
ment, superinfections, clinical outcomes, and the results of
laboratory tests within 12 h of admission. The tests
comprised blood tests, biochemical assays, D-dimer, ferritin,
CRP, LDH, HBDH, CD4 cell counts, and blood gas analyses.

tests or Student’s t-tests were used for data analysis when
data were nonnormal or normal, respectively. Kolmogorov–
Smirnov tests were used for normal distribution. Chi-
squared tests, continuity corrections, or Fisher’s exact tests
were used to test statistical significance for categorical data.
Binary logistic regressions were used in multivariate analyses
to predict mortality. Kaplan-Meier and log-rank tests were
used to analyze and compare survival rates. All statistical
analyses were performed using SPSS version 19 (SPSS,
Armonk, New York, USA) using a statistical significance
threshold of P < 0.05.

3. Results

3.1. Demographic Characteristics and Mortality. A total of
182 AIDS-PCP patients were admitted to The First Affiliated
Hospital of Zhejiang University between January 2013 and
June 2018. Of the remaining 122 patients, 52 were provided
echinocandins/TMP-SMX/clindamycin treatment and 70
patients were treated with TMP-SMX and clindamycin
treatment. Clinical characteristics and baseline demographics of
the 122 patients between combined echinocandins and non-
combined echinocandins are shown in Table 1.

3.2. Intergroup Comparisons of Echinocandins/TMP-
SMX/Clindamycin and TMP-SMX/Clindamycin Treatments.
Among all 122 patients investigated in the study, those within
the echinocandins/TMP-SMX and clindamycin treatment
group exhibited a mortality rate of 9.62% (5/52), while those
within the TMP-SMX and clindamycin treatment group
exhibited a mortality rate of 20% (14/70). Despite the
difference in mortality outcomes, the difference was not
statistically significant (P = 0.118; Figure 2).

In the subgroup of patients with PaO2/FiO2 ≤ 200 mmHg
(n = 22), those with echinocandins/TMP-SMX and clinda-
mycin treatment exhibited a mortality rate of 26.67%
(4/15), while the rate was higher, 42.86% (3/7), for those
within the TMP-SMX and clindamycin treatment group.
However, the difference between the two treatment groups
was not statistically significant (P = 0.630).

In the subgroup of patients with PaO2/FiO2 > 200 mmHg
(n = 100), those within the echinocandins/TMP-SMX and
clindamycin treatment group exhibited a significantly lower
mortality rate (4.44%, 2/45) than did those in the TMP-
SMX and clindamycin group (18.18%, 10/55; P = 0.035).

3.3. Survival in Patients with Mild AIDS-PCP. Survival rates
were analyzed and compared between patients in the echino-
candins/TMP-SMX/clindamycin and TMP-SMX/clindamy-
cin treatment groups based on clinical outcomes within two
months for patients with PaO2/FiO2 > 200 mmHg. Patients
within the TMP-SMX/clindamycin treatment group exhibited
a significantly lower survival rate than did those in the echinocandins/TMP-SMX/clindamycin group ($P = 0.0384$; Figure 3).

4. Discussion

Most AIDS-PCP patients are in advanced stages and have high risks of contracting various opportunistic infections [14]. To adequately investigate the role of echinocandins and TMP-SMX treatments and reduce confounding factors caused by other superinfections and the corresponding treatments, we excluded patients with superinfections from the study cohort. These infections included tuberculosis, Cryptococcus, CMV, Epstein-Barr virus, hepatitis B virus, and syphilis. The glucocorticoid can improve clinical outcome in AIDS patients with PCP. All patients investigated in this study accepted treatment of glucocorticoid for reducing factors of the impacting clinical outcome.

Echinocandins inhibit the synthesis of $(1,3)$-β-D-glucan and block the formation of pneumocystis cysts, although they are less effective against trophozoite forms [15]. These observations suggest that echinocandins can reduce pathogen reservoirs. In addition, TMP-SMX inhibits trophozoite forms of Pneumocystis by interfering with their metabolism of folate. Therefore, the combination of echinocandins and TMP-SMX can inhibit the entire life cycle of Pneumocystis parasites [16]. TMP-SMX acts slowly, requiring five to eight days to achieve stable therapeutic effects [17], while echinocandins act rapidly. Consequently, the combination of TMP-SMX and echinocandins can exhibit synergistic effects in the treatment of PCP patients. Importantly, echinocandins induce less adverse events in PCP patients.
because they do not inhibit the CYP system or induce CYP3A4 drug metabolism [18].

The addition of echinocandins to a standard TMP-SMX regimen reduced the mortality rate among all 122 enrolled patients of this study (9.62% vs. 20%), although the difference was not statistically significant. Following this observation, patients were divided into two subgroups, \( \text{PaO}_2/\text{FiO}_2 > 200 \) mmHg (indicating mild disease) and \( \text{PaO}_2/\text{FiO}_2 \leq 200 \) mmHg (indicating severe disease). The early application of a combined echinocandins/TMP-SMX treatment for mild AIDS-PCP patients could significantly reduce the mortality rate compared to TMP-SMX treatment alone (4.44% vs. 18.18%, \( P < 0.05 \)). These findings are consistent with some case reports suggesting that echinocandins could improve the prognosis of patients with PCP [11–13]. In addition, the feasibility of combined echinocandins/TMP-SMX treatment for PCP was demonstrated in studies of PCP animal models and in vitro experiments [19–21]. A previous caspofungin salvage treatment trial indicated that caspofungin could improve the prognosis and reduce the mortality rate of AIDS-PCP patients [22]. However, there were two major limitations of this study: the lack of a control group and the small sample size (\( n = 12 \)). However, the results of the present study confirm the observations from the trial, while using a larger sample size (\( n = 122 \)) and an experimental design that featured a control group.

In our study, the subgroup of patients with \( \text{PaO}_2/\text{FiO}_2 \leq 200 \) mmHg (\( n = 22 \)) and those with echinocandins/TMP-SMX and clindamycin treatment exhibited a mortality rate of 42.86% (3/7), while the rate was higher, 26.67% (4/15), for those within the TMP-SMX and clindamycin treatment group. This results reported here indicate that adding echinocandins to the standard regimen could not reduce the mortality rate for critically ill patients in advanced stages. However, the sample size of patients with \( \text{PaO}_2/\text{FiO}_2 \leq 200 \) mmHg was small. Lung damage resulting from PCP is very rapid, and deaths often result from a rapid increase in proinflammatory cytokines [23]. Echinocandins can inhibit the inflammatory response induced by \( \beta \)-glucan by inhibiting \( \beta \)-glucan synthesis, thereby alleviating the symptoms of PCP [24]. Consequently, early application of a combined echinocandins/TMP-SMX treatment for PCP patients with mild to moderate disease states could inhibit the inflammatory response and cytokine production, thereby reducing their mortality rate.

Our study had some limitations: this study did not perform bronchoscopic examination to make a molecular test for PCP diagnosis. However, most patients were severe. Because of hypoxia and dyspnea symptoms, it was difficult to carry out bronchoscopic examination. And we had adopted a unified clinical diagnostic standard. Additionally, limited sample size, single-center analysis, and retrospective studies may cause some bias.

5. Conclusions

The results of this study demonstrate that early application of combined echinocandins/TMP-SMX treatment for AIDS-PCP patients can improve patient prognosis, increase their survival rate, and decrease their mortality rate.

Data Availability

The data statement support the findings of this study are available.

Conflicts of Interest

The authors declare that they have no competing interests.

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