Analysis of molecular mechanisms of drug resistance of *Mycobacterium tuberculosis* in patients with pulmonary tuberculosis and its pharmacoeconomics

Zeqing Bao¹, Yingyi Bao², Xiaocui Qin³, Weibin Wu⁴, Xia Zhang⁵*

¹Department of Basic Medicine, ²Department of Nursing, Foshan University Medical School, Foshan, Guangdong. ³Department of Physiology, Zhaoqing Medical College, ⁴The First Affiliated Hospital of Zhaoqing Medical College, Zhaoqing, ⁵Department of Pathology, Zhaoqing, China

*For correspondence: Email: xiazhangzhao558df@163.com; Tel: 86-13413830667

Sent for review: 24 June 2022

Revised accepted: 26 September 2022

**Abstract**

**Purpose:** To investigate the molecular mechanisms of drug resistance of *Mycobacterium tuberculosis* in patients with pulmonary tuberculosis and its pharmacoeconomics.

**Methods:** Data pertaining to patients with primary tuberculosis treated in the First Affiliated Hospital of Zhaoqing Medical College, Zhaoqing, China from January 2020 to June 2021 were retrospectively analyzed. Sputum specimens were collected from all eligible patients, and 151 uncontaminated specimens with good bacteriophage activity were screened.

**Results:** A total of 107 *Mycobacterium tuberculosis* strains were isolated from the 151 specimens, 31 of which strains were resistant to varying degrees to rifampicin, isoniazid, streptomycin, and ethambutol with an overall resistance of 28.97%. There were 16 strains with rpoB mutation, 22 strains with katG mutation, and 8 strains with inhA mutation. The difference in the sputum negative rate, lesion absorption rate, and tuberculosis cavity closure rate, and total medical cost between the two groups were not statistically significant (p > 0.05). The incidence of adverse reactions in the FDC group was significantly lower than that in the blister pack group (p < 0.05).

**Conclusion:** The total resistance of *Mycobacterium tuberculosis* in primary tuberculosis patients remains at a high level, and the development of resistance is associated with mutations in rpoB, katG, and inhA genes. FDC regimen provides more pharmacoeconomic and therapeutic benefits than blister pack regimen.

**Keywords:** Tuberculosis, Molecular mechanism of drug resistance, Fixed-dose combination, Cost-effectiveness analysis

This is an Open Access article that uses a funding model which does not charge readers or their institutions for access and distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0) and the Budapest Open Access Initiative (http://www.budapestopenaccessinitiative.org/read), which permit unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited.

Tropical Journal of Pharmaceutical Research is indexed by Science Citation Index (SciSearch), Scopus, Web of Science, Chemical Abstracts, Embase, Index Copernicus, EBSCO, African Index Medicus, JournalSeek, Journal Citation Reports/Science Edition, Directory of Open Access Journals (DOAJ), African Journal Online, Bioline International, Open-J-Gate and Pharmacy Abstracts

**INTRODUCTION**

China has a heavy clinical burden of tuberculosis, with the third-highest prevalence worldwide [1]. Pulmonary tuberculosis is managed using first-line anti-tuberculosis drugs, such as rifampicin, isoniazid, streptomycin, and ethambutol. However, clinical practice has revealed an increasing trend in drug resistance in pulmonary tuberculosis, due to factors such as...
age and improper anti-tuberculosis treatment [2]. Prior research has shown that drug resistance gene mutations are a significant molecular mechanism of drug resistance in pulmonary tuberculosis [3].

It has been reported that, compared with ordinary tuberculosis, the long course and treatment difficulties for multidrug-resistant tuberculosis impose a serious economic burden on patients and their families, which consequently impairs patient compliance and complicates the treatment [4]. Blister pack and fixed-dose combination (FDC) medications are the current treatment regimens for pulmonary tuberculosis with promising efficacy [5]. Accordingly, this study was designed to compare FDC and blister pack regimen as well as analyze the molecular mechanism of drug resistance of Mycobacterium tuberculosis and some pharmacoeconomics outcomes.

METHODS

Clinical data

The medical data of patients with primary tuberculosis treated in the First Affiliated Hospital of Zhaoqing Medical College, from January 2020 to June 2021 were retrospectively analyzed. Sputum specimens were collected from all patients, and a total of 151 specimens with no contamination and good bacteriophage activity were screened.

Inclusion criteria

Patients aged 18 - 60 years, with a confirmed diagnosis of pulmonary tuberculosis [6], with positive acid-fast bacilli smear or a positive mycobacterial culture, with complete clinical data, and who received FDC or blister pack medications (2HRZE/4HR protocol) were included.

Exclusion criteria

Patients with disseminated tuberculosis, tuberculous pleurisy, or extrapulmonary tuberculosis, with contaminated strains or a low survival of strains after culture, who were pregnant or lactating, with allergies to anti-tuberculosis drugs, or who failed to complete the prescribed course of treatment were excluded.

There were 92 males and 59 females, aged 20 to 58 years, with a mean age of 51.29 ± 5.73 years, and the duration of disease ranged from 1 to 24 months, with a mean duration of 7.79 ± 4.96 months. The study complied with the relevant regulations of hospital clinical research ethics and it was approved by the ethics committee of the First Affiliated Hospital of Zhaoqing Medical College (approval no. 2019-12-26). The study protocol was conducted in strict accordance with the guidelines of Helsinki Declaration [7].

Species identification

Non-tuberculous mycobacteria and Mycobacterium bovis were excluded using p-nitro benzoic acid (PNB) selective medium and 2-thiophenecarboxylic acid hydrazide (TCH) selective medium. The colonies of Mycobacterium tuberculosis cultured for 2 - 3 weeks were ground in a sterile glass grinder, diluted with 0.9 % saline containing 0.05 % Tween 80, and made into 1 mg/mL bacterial suspension using the McFarland standards to adjust the turbidity of the suspension. After diluting the concentration to 10 – 2 mg/mL using a 22SWG standard inoculation loop, 0.01 mL of the solution was inoculated into PNB and TCH medium and incubated at 37 °C with 5 % CO₂ for 4 weeks. In the case of Mycobacterium bovis, no colony growth was observed on PNB and TCH media. Colonies growing only on TCH medium were considered Mycobacterium tuberculosis, and those growing on both PNB and TCH media were considered non-tuberculous mycobacteria.

Drug susceptibility test

In accordance with the National Bacteriological Procedures for Tuberculosis (NBPT), drug-containing media were prepared by dissolving rifampicin (40 μg/mL), isoniazid (0.2 μg/mL), streptomycin (4 μg/mL), and ethambutol (2 μg/mL) in Roche media (Zhuhai Yinke Medical Engineering Co., Ltd.), solidified at 85 °C for 50 min and kept at 4 °C away from light after inspection to ensure no contamination. The bacterial solution was diluted to a concentration of 10 - 2 mg/mL and 10 – 4 mg/mL using a 22SWG standard inoculation loop, and inoculated evenly into the slant of drug-containing media and blank medium respectively by streaking, and incubated at 37 °C and 5 % CO₂ for 4 weeks. Drug resistance (DR) was calculated using Eq 1.

\[
DR \% = \frac{(CD – CM)}{CB} \times 100 \quad \ldots \ldots (1)
\]

where CD represent the colonies grown in drug, CM is the containing medium and CB are the colonies grown in blank medium

The percentage of drug resistance greater than 1 % was considered resistant to the drug. Mono-resistance cases refer to resistance to a single
first-line anti-tuberculosis drug, poly-resistance cases refer to resistance to two or more first-line drugs but not to both isoniazid and rifampicin, while multidrug resistance cases refer to resistance to first-line anti-tuberculosis drugs including at least isoniazid or rifampicin.

Drug-resistant gene determination

The DNA extraction fresh colonies were collected using the inoculation loop, transferred in a centrifuge tube containing 1.5 mL of sterile saline, and inactivated at 100 °C for 30 min. The solution was then centrifuged at 3000 rpm for 5 min, and the supernatant was discarded. A 400 μL volume of TE buffer (Beijing Solabao Biotechnology Co., Ltd., item No. T1120) was added to the solution and the cell pellet was suspended evenly, followed by the addition of lysozyme (Beijing Ita Biotechnology Co., Ltd., Item No. SY3854), and the solution was then incubated overnight at 37 °C. The DNA of Mycobacterium tuberculosis was extracted according to the instructions of cetyltrimethylammonium bromide (CTAB) kit (Shanghai JingAn Biological Engineering Co. Ltd., Item No. JK-EA02057), and stored at -20 °C, prior to the determination of DNA concentration using the ultra-micro UV-Vis spectrophotometer (METTLER TOLEDO, Switzerland, model UV5Nano) and 10-fold dilution. The primers for polymerase chain reaction (PCR) amplification were synthesized by Shanghai Bioengineering Co. Ltd and compared with the standard sequences of rpoB, katG, and inhA genes in the NCBI database.

Treatments

The blister pack group was treated with 0.3 g of bulk isoniazid tablets (NMPA approval no. H51020436) daily, 0.45 g of rifampin capsules (NMPA approval no. H51022410) daily, 0.5 g of pyrazinamide tablets (NMPA approval no. H51022733) daily, and 0.75 g of ethambutol hydrochloride tablets (NMPA approval no. H51020720) daily. After 2 months of treatment with the drugs, isoniazid tablets and rifampin capsules were administered for another 2 months. The FDC group was given an anti-tuberculosis fixed-dose combination manufactured by Shenyang Hongqi Pharmaceutical Co. Ethambutol hydrochloride + pyrazinamide + rifampin + isoniazid tablets (NMPA approval no. H20090219) were administered for 2 months, 4 tablets daily, and isoniazid tablets (NMPA approval no. H20103325) were administered for 4 months, 2 tablets daily.

Evaluation of therapeutic effect

Sputum negative rate

Negative sputum culture for 2 consecutive months and no re-positive cases observed were considered a successful conversion from positive to negative.

Lesion absorption

Chest CT showing lesion reduction > 70 % indicates significant absorption, a reduction of 50 to 70 % indicates partial absorption, a reduction of < 50 % indicates no absorption, and a significant enlargement of more than 50 % indicates deterioration. The total effectiveness (T) was calculated with the formula in equation 2.

\[ T = S + P \]  

Where S is significant absorption, and P is partial absorption.

| Table 1: PCR primer sequence used |
|----------------------------------|
| Primer | Upstream (5’-3’) | Downstream (5’-3’) |
| rpoB | GTTTAGTTGCGTGCGTGAG | CAATGGTCTCGTGAAATACA |
| katG | GGTCTATGTTCTGATTGTTCG | TTCTCCAGATCCGGTTCG |
| inhA | TCCGAGGATGCGAGCTATA | ACCTGGTTAGCCGACTCCAA |
**Tuberculosis cavity closure**

Closure of the tuberculosis cavity or disappearance of the cavity shown by chest CT is considered a tuberculosis cavity closure. The diameter of the cavity, if equal to 1/2 or less of the original diameter is considered a reduced tuberculosis cavity. Reduction or enlargement of the diameter of the cavity less than 1/2 of the original diameter is considered an unchanged cavity, while an enlargement of the diameter of the cavity by 1.5 times of the original diameter and above is considered increased cavity. The total effectiveness ($T_1$) was calculated as in Eq 3.

$$T_1 = C + R \quad \text{................. (3)}$$

where C is the cavity closure, and R is reduced cavity.

**Adverse reactions**

The occurrence of gastrointestinal reactions, liver damage, allergic reactions, hyperuricemia, and leukopenia in patients during treatment were recorded.

**Medical cost**

The total cost includes direct medical cost, direct non-medical cost, indirect cost, and hidden cost. The direct medical cost includes medication fee, examination fee, bed fee, nursing fee, hospitalization fee, and fee for adverse reaction management. The direct non-medical cost was the escort fee, which was calculated based on the hourly wage standard of part-time hourly workers (RMB 18.4 or USD 2.67), and the mean daily escort fee was about RMB 147.2 or USD 21.33 (8 h of work per day). The indirect cost was the loss of income caused by illness, and the cost of lost wages was calculated using the annual mean wage of employed persons in urban non-private entities in China in 2020 (97,379 Yuan (USD 14,110.44)/year in 2020), with 251 effective working days and an average wage of about 387.96 Yuan (USD 56.22) for working days in 2020. Hidden costs were not considered in this study given the complexity and difficulty of calculation.

**Statistical analysis**

The Statistical Packages for the Social sciences (SPSS) 20.0 software was used for statistical analyses. Normally distributed measurement data are expressed as mean ± standard deviation (SD), and independent samples t-test was used for comparison between the two groups. Count data are expressed as frequencies or composition ratios and analyzed using chi-square test. A difference was considered statistically significant at $p < 0.05$.

**RESULTS**

**Species identification**

After preliminary identification using PNB and TCH selective media, a total of 107 strains of *Mycobacterium tuberculosis*, 39 strains of *Mycobacterium bovis*, and 5 strains of non-tuberculous mycobacteria were isolated from the 151 sputum specimens, of which 16 strains with rpoB mutation (Table 2).

**Table 2**: Sequencing results of rpoB gene of drug-resistant *Mycobacterium tuberculosis*

| Mutation Loci | Codon change | n   | %    |
|---------------|--------------|-----|------|
| 511           | CTG→CCG     | 3   | 18.75|
| 531           | TCG→TTG     | 1   | 6.25 |
| 516           | GAC→GTC     | 3   | 18.75|
| 526           | CAC→CGC     | 9   | 56.25|

**Drug sensitivity**

In the present study, 31 strains were resistant to rifampicin, isoniazid, streptomycin, and ethambutol to varying degrees, with an overall resistance rate of 28.97 % (31/107). There were 19 strains (17.76 %) resistant to 1 drug, 6 strains (5.61 %) resistant to 2 drugs, 4 strains (3.74 %) resistant to 3 drugs, and 2 strains (1.87 %) resistant to 4 drugs. The percentage of mono-resistance, poly-resistance, and multi-drug resistance was 17.76 % (19/107), 11.21 % (12/107), and 3.8 % (4/107) of which 22 strains with katG mutation (Table 3).

**Table 3**: Sequencing results of katG gene of drug-resistant *Mycobacterium tuberculosis*

| Mutation Loci | Codon change | n   | %    |
|---------------|--------------|-----|------|
| 315           | AGC→ACC     | 14  | 63.64|
| 463           | CGG→CTG     | 6   | 27.27|
| 68            | GTC→GAC     | 2   | 9.09 |

**Gene sequencing**

A total of 16 strains (51.61 %) had rpoB gene mutations at 511 (CTG→CCG), 531 (TCG→TTG), 516 (GAC→GTC), and 526 (CAC→CGC) loci, respectively (Table 2). 22 strains (70.97 %) had katG gene mutations at 315 (AGC→ACC), 463 (CGG→CTG), and 68 (GTC→GAC) loci with katG gene mutations (Table 3); 8 strains (25.81 %) had inhA gene mutations at 145 (GTC→GKC), 268 (TTG→TGG), 175 (GTC→GKG) loci (Table 4).
Table 4: Sequencing results of inhA gene of drug-resistant Mycobacterium tuberculosis

| Mutation Loci Codon change | n | %   |
|----------------------------|---|-----|
| 145 GTC→GKC              | 62.50 |
| 268 TTG→TGG              | 7.81  |
| 175 GTG→GKG              | 25.00 |

Genetic mutations and drug resistance

The degrees of mutation % of rpoB, katG, and inhA genes were 63.16 % (12/19), 63.16 % (12/19) and 26.32 % (5/19) for 19 mono-resistant strains, 75.00 % (9/12), 58.33 % (7/12), 26.32 % (5/19) for 12 poly-resistant strains, and 33.33 % (4/12) and 75.00 % (3/4), 25.00 % (1/4) for 4 multidrug-resistant strains, respectively (Table 5).

Efficacy of treatment regimens

The difference in the sputum negative rate, lesion absorption rate, and tuberculosis cavity closure rate between the two groups did not come up to the statistical standard (P > 0.05) (Table 6).

Incidence of adverse reactions

The incidence of adverse reactions in the FDC group (7.89 %) was significantly lower than that in the blister pack group (18.67 %) (p < 0.05) (Table 7).

Costs treatment protocol

The total cost per capita in the blister pack and FDC groups was 9813.14 ± 249.28 Yuan and (9693.28 ± 236.37) yuan, respectively. The FDC group had a lower total cost per capita than the blister pack group, but the difference was not statistically significant (t = 135.27, p = 0.216).

Cost-effectiveness and sensitivity of the two treatment regimens

A cost-effectiveness analysis was performed on the two treatment regimens. The cost (C) / effective (E) ratio was 105.15 for the blister pack group and 100.92 for the FDC group, and the ΔC/ΔE for the blister pack group was 125.29 with the lowest cost FDC group as a parameter.

A univariate sensitivity analysis assuming a 15 % decrease in drug price and no change in treatment effect found that the C/E ratios for the blister pack and FDC groups were 89.33 and 85.70, respectively, and the ΔC/ΔE for the blister pack group was 113.87 using the lowest cost FDC group as a parameter (Table 8).

Table 5: Relationship between genetic mutations and drug resistance

| Resistance          | Strains | rpoB gene | katG gene | inhA gene |
|---------------------|---------|-----------|-----------|-----------|
| Mono resistance     | 19      | 12        | 7         | 12        | 7         | 5         | 14        |
| Poly resistance     | 12      | 9         | 3         | 7         | 5         | 4         | 8         |
| Multidrug resistance| 4       | 3         | 1         | 3         | 1         | 1         | 3         |

Table 6: Comparison of efficacy of treatment regimens (n, %)

| Group            | n | Sputum negative rate | Lesion absorption rate | Tuberculosis cavity closure rate |
|------------------|---|----------------------|------------------------|-------------------------------|
| Blister pack     | 75 | 70/93.33             | 71/94.67               | 75/100.00                     |
| FDC              | 76 | 73/96.05             | 73/96.05               | 76/100.00                     |

| χ² | P-value |
|----|---------|
| 0.556 | 0.164  |
| 0.456 | 0.685  |

Table 7: Comparison of the incidence of adverse reactions (n, %)

| Group          | n | Gastrointestinal reactions | Liver damage | Leukopenia | Hyperuricemia | Allergic reactions | Total incidence |
|----------------|---|---------------------------|--------------|------------|---------------|-------------------|-----------------|
| Blister pack   | 75 | 4                         | 3            | 2          | 4             | 1                 | 14/18.67        |
| FDC            | 76 | 2                         | 1            | 1          | 1             | 1                 | 6/7.89          |

| χ² | P-value |
|----|---------|
| 4.620 | 0.032  |
**DISCUSSION**

The global tuberculosis report released in October 2020 stated that TB remains the leading cause of negative health status of people and one of the top 10 causes of death worldwide [9]. *Mycobacterium tuberculosis* drug resistance or multidrug resistance is a major contributor to mortality in patients with tuberculosis [10]. In this study, an analysis of sputum specimens from patients with primary tuberculosis admitted to the hospital from January 2020 - June 2021 revealed that the overall drug resistance prevalence of pulmonary tuberculosis was 28.97 %, which was higher than that reported by Yuan Wei et al [11] and by Li et al [12]. The development of drug resistance in *Mycobacterium tuberculosis* is considered to be attributed to mutations in drug resistance genes, and drug resistance-related genes include rpoB, katG, and inhA [13]. Drug resistance gene testing of *Mycobacterium tuberculosis* is of great clinical value to provide guidance for proper clinical regulation of drug use [14]. In the present study, gene sequencing after PCR amplification of drug-resistant *Mycobacterium tuberculosis* DNA from 31 extracted strains revealed that the degree of mutation rates of rpoB, katG, and inhA genes were 51.61, 70.97, and 25.81 %, respectively, which were basically consistent with the results of the previous study [15]. The results suggest an association between the development of drug resistance in *Mycobacterium tuberculosis* patients with primary tuberculosis and mutations in the rpoB, katG, and inhA genes, with higher mutation rates in the rpoB and katG genes in mono- and multidrug-resistant strains and higher mutation % in the rpoB gene in polyresistant strains, in accordance with previous findings [16].

Research has demonstrated that blister pack medication significantly improves compliance and provides high overall clinical efficacy when compared to traditional dosage forms [17]. Fixed-dose combination (FDC) is a synthetic formulation with a fixed-dose based on compounded formulations. An application of FDC to the treatment of patients with pulmonary tuberculosis was found to be moderately effective and to reduce the economic burden of the disease by improving patient compliance [18]. The results of sputum negativity rate, lesion absorption rate, and cavity closure rate in the present study were consistent with the results of previous studies. The above indexes were slightly higher in the FDC group than in the blister pack group, suggesting that FDC may be a preferred treatment option for the patients. Furthermore, the FDC group showed a significantly lower incidence of adverse reactions than the blister pack group, which was attributed to the reduction of anti-tuberculosis drug doses and the improvement of drug safety by FDC. For tuberculosis patients, especially those with drug resistance, the economic burden is a major factor impacting their treatment efficacy and relapse [19-20]. In the present study, the total cost per capita in the FDC group was lower than that in the blister pack group, but no significant difference was detected, and cost-effectiveness analysis revealed a C/E ratio of 105.15 and 100.92 in the blister pack and FDC groups, respectively, indicating a better performance of FDC regimen versus the blister pack method.

**Limitations of this study**

The limitations of this study include the absence of pharmacoeconomic analysis of other treatment regimens for patients with primary tuberculosis and treatment regimens for patients with relapsed tuberculosis, which will be further analyzed in future studies.

**CONCLUSION**

The development of resistance is associated with mutations in the rpoB, katG, and inhA genes. The FDC regimen provides more pharmacoeconomic and therapeutic benefits when compared to the blister pack medication regimen. There will be need for further studies for a more detailed pharmacoeconomic analysis.

**DECLARATIONS**

**Acknowledgements**

None provided.

**Funding**

This study was supported by Guangdong Province Science and Technology Innovation
Strategy Special Fund (No. pdjh2022a1069) and Zhaoqing Special Projects for Scientific and Technological Innovation in Social Development and People’s Livelihood (No. 2021SN014).

Ethical approval

This study was approved by the Ethics Committee of the First Affiliated Hospital of Zhaoqing Medical College, China (approval no. 2019-12-26).

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Conflict of Interest

No conflict of interest associated with this work.

Contribution of Authors

We declare that this work was done by the authors named in this article and all liabilities pertaining to claims relating to the content of this article will be borne by the authors. Zeqing Bao and Yingyi Bao performed the majority of experiments. Xia Zhang analyzed the data. Xiaocui Qin drew the charts. Weibin Wu designed and coordinated the research while Zexing Bao wrote the paper. All authors reviewed and approved the manuscript for publication.

Open Access

This is an Open Access article that uses a funding model which does not charge readers or their institutions for access and distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0) and the Budapest Open Access Initiative (http://www.budapestopenaccessinitiative.org/read), which permit unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited.

REFERENCES

1. MacPherson P, Webb EL, Kamchedzera W, Joekes E, Mjoli G, Laloo DG, Divalia TH, Choko AT, Burke RM, Maheswaran H, et al. Computer-aided X-ray screening for tuberculosis and HIV testing among adults with cough in Malawi (the PROSPECT study): A randomised trial and cost-effectiveness analysis. PLoS Med 2021; 18(9): e1003752.

2. Bao Y, Wang C, Xu H, Lai Y, Yan Y, Ma Y, Wu T, Wu Y. Effects of an mHealth intervention for pulmonary tuberculosis self-management based on the integrated theory of health behavior change: randomized controlled trial. JMIR Public Health Surveill 2022; 8(7): e34277.

3. Li T, Shi T, Sun Y, Chen F, Jiang W, Chen Y. Molecular characteristics of drug-resistance Mycobacterium tuberculosis strains isolated from extra pulmonary tuberculosis sites. Enferm Infec Microbiol Clin (Engl Ed) 2021; 39(4): 168-173. English, Spanish.

4. Berry C, du Cros P, Fielding K, Gajewski S, Kazounis E, McHugh TD, Merle C, Motta I, Moore DAJ, Nyang’wa BT. TB-PRACTECAL: study protocol for a randomised, controlled, open-label, phase II-III trial to evaluate the safety and efficacy of regimens containing bedaquiline and pretomanid for the treatment of adult patients with pulmonary multidrug-resistant tuberculosis. Trials 2022; 23(1): 484.

5. Svensson EM, Yngman G, Denti P, McIlreron H, Kjellsson MC, Karlsson MO. Correction to: evidence-based design of fixed-dose combinations: principles and application to pediatric anti-tuberculosis therapy. Clin Pharmacokinet 2020; 59(1): 121.

6. Berry C, du Cros P, Fielding K, Gajewski S, Kazounis E, McHugh TD, Merle C, Motta I, Moore DAJ, Nyang’wa BT. TB-PRACTECAL: study protocol for a randomised, controlled, open-label, phase II-III trial to evaluate the safety and efficacy of regimens containing bedaquiline and pretomanid for the treatment of adult patients with pulmonary multidrug-resistant tuberculosis. Trials 2022; 23(1): 484.

7. World Medical Association (AMM). Helsinki Declaration. Ethical principles for medical research involving human subjects]. Assist Infenn Ric 2001; 20(2): 104-7.

8. Wu JT, Chiu CT, Wei YF, Lai YF. Comparison of the safety and efficacy of a fixed-dose combination regimen and separate formulations for pulmonary tuberculosis treatment. Clinics (Sao Paulo) 2015; 70(6): 429-34.

9. Chinese Medical Association. Guidelines for primary care treatment of pulmonary tuberculosis (2018). Chin J Gen Pract,2019; 18(8): 709-717.

10. Marais BJ, Sintchenko V. Epidemic spread of multidrug-resistant tuberculosis in China. Lancet Infect Dis 2017; 17(3): 238-239.

11. Warr AJ, Anterasian C, Shah JA, De Rosa SC, Nguyen FK, Maleche-Obimbo E, Cranmer LM, Matemo D, Mecha J, Kinuthia J, LaCourse SM, John-Stewart GC, Hawn TR. A CD4+ TNF+ monofunctional memory T-cell response to BCG vaccination is associated with Mycobacterium tuberculosis infection in infants exposed to HIV. EBioMedicine 2022; 80: 104023.

12. Li Q, Zhao G, Wu L, Lu M, Liu W, Wu Y, Wang L, Wang K, Qian HZ, Xie L. Prevalence and patterns of drug resistance among pulmonary tuberculosis patients in Hangzhou, China. Antimicrob Resist Infect Control 2018; 7: 61.

13. Ghosh A, N S, Saha S. Survey of drug resistance associated gene mutations in Mycobacterium tuberculosis self-management based on the integrated theory of health behavior change: randomized controlled trial. JMIR Public Health Surveill 2022; 8(7): e34277.

Trop J Pharm Res, October 2022; 21(10): 2217
14. Oudghiri A, Karimi H, Chetioui F, Zakham F, Bourkadi JE, Elmessaoudi MD, Laglaoui A, Chaoui I, El Mzibri M. Molecular characterization of mutations associated with resistance to second-line tuberculosis drug among multidrug-resistant tuberculosis patients from high prevalence tuberculosis city in Morocco. BMC Infect Dis 2018; 18(1): 98.

15. Gao M, Yang T, Li GL. Characterization of multidrug-resistant Mycobacterium tuberculosis drug resistance mutations in China based on whole-genome sequencing. Chin J Epidemiol 2020; 41(5): 770-775.

16. Muthaiah M, Shivekar SS, Cuppusamy Kapalamurthy VR, Alagappan C, Sakkaravarthy A, Brammachary U. Prevalence of mutations in genes associated with rifampicin and isoniazid resistance in Mycobacterium tuberculosis clinical isolates. J Clin Tuberc Other Mycobact Dis 2017; 8:19-25.

17. Semitala FC, Kadota JL, Musinguzi A, Nabunje J, Weishe F, Nakitende A, Akello L, Bishop O, Patel D, Sammann A, et al. Completion of isoniazid-rifapentine (3HP) for tuberculosis prevention among people living with HIV: Interim analysis of a hybrid type 3 effectiveness-implementation randomized trial. PLoS Med 2021; 18(12): e1003875.

18. Singh G, Patrikar S, Basarnar DR, Bhatti VK. Health technology assessment of fixed-dose combination regimen in treatment of newly diagnosed smear-positive pulmonary tuberculosis: A meta-analysis. Med J Armed Forces India 2020; 76(2): 192-200.

19. Sharma A, Hill A, Kurbatova E, van der Walt M, Kvasnovsky C, Tupasi TE, Caoli JC, Gler MT, Volchenkov GV, Kazennyy BY, et al. Global preserving effective TB treatment study investigators. Estimating the future burden of multidrug-resistant and extensively drug-resistant tuberculosis in India, the Philippines, Russia, and South Africa: a mathematical modelling study. Lancet Infect Dis 2017; 17(7): 707-715.

20. Atif M, Sulaiman SAS, Shafie AA, Muttilaf AR, Hassali MA, Saleem F. Health-related quality of life (HRQoL) in co-morbid tuberculosis relapse patient: a case report from Malaysia. Trop J Pharm Res 2012; 11(4): 651-655.