In Vitro Activity of Antifolate and Polymorphism in Dihydrofolate Reductase of Plasmodium falciparum Isolates from the Kenyan Coast: Emergence of Parasites with Ile-164-Leu Mutation

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Received 6 March 2009/Returned for modification 17 May 2009/Accepted 8 June 2009

The inhibition of dihydrofolate reductase (DHFR) remains an attractive drug target against Plasmodium falciparum. The combination of pyrimethamine (PM), a potent inhibitor of DHFR, and sulfadoxine (SD), an inhibitor of dihydropteroate synthase (DHPS), has been widely used for the treatment of malaria but is now abandoned for mass treatment due to the spread of drug resistance (39). However, this drug is still used for intermittent preventive treatment of pregnant women and children (55). Another combination, chlorproguanil-dapsone, known as Lapdap, has been developed (7). Chlorproguanil is converted to the active metabolite chlorcycloguanil (CCG), an inhibitor of DHFR; dapsone is an inhibitor of DHPS. An artemesinin-based combination, Lapdap with artesunate (known as CDA), has also been evaluated (11), but both drugs have recently been phased out because of the toxicity of dapsone.

Another antifolate, cotrimoxazole, is a combination of trimethoprim (TMP), a potent inhibitor of bacterial DHFR, and sulfamethoxazole (SMZ), an inhibitor of DHPS. TMP-SMZ is used as an antibacterial agent (30) and has been recommended by the World Health Organization (WHO) for the treatment of childhood febrile diseases and for prophylaxis against opportunistic infections in human immunodeficiency virus-infected patients in Africa (59). This use as a prophylactic agent has been associated with a reduction in malaria incidence in many parts of Africa (32, 53). This drug has also been shown to treat malaria infection (6, 10), and in some studies, it was reported to be as efficacious as PM-SD (20, 44). A recent study indicated that the combination of cotrimoxazole-artesunate was as effective as amodiaquine-artesunate in Nigeria (13).

Mutations in the dhfr gene lead to antifolate resistance. For instance, PM resistance is associated with the mutation of the amino acid Ser to Asn at codon 108 of DHFR (Ser-108-Asn). Ancillary mutations of Asn-51-Ile and Cys-59-Arg are associated with an increase in resistance, and the presence of the Ile-164-Leu mutation results in a higher level of PM resistance and decreased CCG activity (39). In vivo, PM-SD resistance is associated with the presence of triple mutant DHFR (Ser-108-Asn Asn-51-Ile Cys-59-Arg) with or without a mutation in DHPS (39). The presence of Ile-164-Leu (quadruple mutant parasites) is associated with a substantial increase in PM-SD resistance and a decrease in Lapdap efficacy in vivo (54, 57).

As part of our previous work, we provided evidence that the anticancer drugs methotrexate (MTX) and trimetrexate (TMX) are potent antimalarials, and these two drugs have a potential to be used as antimalarials (37). In this paper, we sought to (i) investigate the activities of PM, CCG, MTX, TMX, and TMP against recent P. falciparum field isolates from Kenya adapted in vitro for long-term culture and (ii) establish...
the relationship between polymorphism in the isolates’ dhfr genes and these drug activities.

MATERIALS AND METHODS

The antimalarial PM, MTX, and TMP were purchased from Sigma Chemical Co. (Poole, United Kingdom). CCG and WR99210 were a gift from Andre Rosowsky; Dana-Farber Cancer Institute, Boston, MA.

Parasite adaptation and drug assays. Samples infected with P. falciparum were collected as part of the malaria studies in Kilifi, Kenya, between 2006 and 2008 and were in vitro adapted for long-term culture as described elsewhere (46). Antimalarial activity was measured in the presence of varying concentrations of each compound using radioisotopic incorporation (49). Results were expressed as the drug concentration required for 50% inhibition of [3H]hypoxanthine incorporation into parasite nucleic acid (50% inhibitory concentration [IC50]), using nonlinear regression analysis of the dose-response curve. Two reference P. falciparum laboratory strains were tested: 3D7, a fully PM sensitive isolate with a wild-type dhfr genotype, and V1/S, a highly PM resistant strain with point mutations at codons 108, 51, 59, and 164 of dhfr (quadruple mutant strain). P. falciparum cultures were carried out in RPMI 1640 (Gibco BRL, United Kingdom) medium supplemented with 10% (vol/vol) normal human serum, 25 mM bicarbonate, 2 mM glutamine, 25 mM HEPES buffer, and physiological concentrations of para-aminobenzoic acid (5 mM) and folic acid (23 nM). Human blood used to culture the parasites in vitro was obtained from healthy subjects and was washed three times with RPMI culture medium not supplemented with serum.

Genotyping of dhfr. After in vitro adaptation of parasites, infected blood samples were spotted onto filter paper and stored. Parasite genomic material from these filter papers was prepared using the methanol procedure, and point mutations at codons 108, 51, 59, and 164 of dhfr were analyzed by PCR and restriction enzyme digestion (PCR-restriction fragment length polymorphism [RFLP]) as described elsewhere (41).

Sequencing of dhfr. To confirm the PCR-RFLP result, we sequenced a 651-bp dhfr coding region from selected parasites. We included 3D7 and V1/S as controls. Two overlapping templates, each containing codons 51, 59, 108, and 164, were amplified separately through 35 cycles by PCR using primers Dfa1 (5'-CT CTTTTTTATGATTG-GGACAGCTGCATTTGG-3', F2 (5'-AAATT CTTGATAAACACGGAACCCTTTA-3'), P51a (5'-AAATGAGCTTGTGAA TAACTACATTTGAGG-3'), and Dfa2 (5'-TCTATGACATGTAT-CT TGTCATATCTTTAGGC-3'). The resulting amplification products were purified using the QIAquick PCR purification kit (Qiagen, United Kingdom) and were sequenced using the amplification primers given above, BigDye Terminator (version 3.1; Applied Biosystems, United Kingdom), and an ABI 3130xl capillary sequencer (Applied Biosystems, United Kingdom). The raw sequence data from forward and reverse reactions on each sample were assembled into contigs, aligned to ensure sequence fidelity, and aligned using the Seqman and MegAlign programs (Lasergene, version 7.2; DNAStar, Madison, WI).

Analysis of MSP1 and MSP2. We used the dhfr quadruple mutant strain V1/S as our reference, which we cultured routinely in vitro. To rule out the possibility of contamination of our isolates with this strain, we have determined the mer-, dhfr, and allelic differences with MAD20, K1, and RO33 (7G8) for MSP1 and polymorphic, with differing numbers of tandem repeats, conferring size polymorphisms in the isolates (41).

RESULTS

We used V1/S and 3D7 as controls. The median IC50s of PM, TMP, CCG, MTX, TMX, and WR99210 against V1/S were 6,929.14, 101,754, 92.3, 40.0, 24.8, and 0.063 nM, respectively. As expected, use of the antifolate-sensitive strain 3D7 gave lower median IC50s of 3.9, 406.7, 0.011, 49.9, 1.9, and 0.015 nM for PM, TMP, CCG, MTX, TMX, and WR99210, respectively.

We have analyzed 33 fresh isolates collected in Kilifi, Kenya, in the period from 2006 to 2008. The data are summarized in Table 1. Among the drugs tested, WR99210, as expected, was the most potent. For 18 of the 33 isolates (55%), WR99210 IC50s were <0.01 nM and thus could not be estimated with accuracy according to our protocol. The remaining isolates (15/33) had a median IC50 of 0.072 nM (95% confidence interval [95% CI], 0.04 to 0.23 nM). Subsequent analyses were carried out using these 15 isolates.

TMX was the second most active drug, with a median IC50 of 30 nM (95% CI, 11.82 to 52.63 nM). The triazine CCG had a median IC50 of 37.80 nM (95% CI, 12.11 to 49.19 nM). The IC50 distribution of MTX showed a median IC50 of 83.60 nM (95% CI, 61.75 to 127.80 nM). PM and TMP were the least active drugs, with median IC50s of 733.26 nM (95% CI, 229 to 941 nM) and 29,656 nM (95% CI, 6,686 to 62,448 nM), respectively (Table 1). TMP was almost 40 times less active than PM.

We have analyzed the dhfr genotypes of the isolates. Of 33 isolates, none were wild type, and 8 were double mutants, of which 6 and 2 harbored the Ser-108-Asn and Cys-59-Arg mutations and the Ser-108-Asn and Asn-51-Ile mutations, respectively. The majority of isolates, 72.7% (24/33), were triple mutants (Ser-108-Asn Asn-51-Ile Cys-59-Arg). Interestingly, one isolate was a quadruple mutant, with an Ile-164-Leu mutation in addition to the mutations at the three codons (Ser-108-Asn Asn-51-Ile Cys-59-Arg Ile-164-Leu), and we named this isolate Kil-164. This is the first report of a parasite with Ile-164-Leu at codon 164. As expected, use of the antifolate-sensitive strain 3D7 gave lower median IC50s of 3,690.79 and 87.68 nM, respectively, values that were doubled in the upper 10th percentile (among the 10% of isolates that were most resistant) for the two drugs.

Since all of these drugs are known to target the parasite dhfr, we sought to investigate the relationship between mutations in dhfr and their chemosensitivity profiles. The data are summarized in Table 2. The median IC50 for PM was 370 nM in the double mutant group, and this value increased almost twofold in the triple mutant group. Likewise, IC50 for TMP increased from 9,308.6 nM in the double mutant group to 33,655 nM in the triple mutant group, a 3.6-fold increase; however, these differences were not significant. This may be due to the small number of double mutants compared to triple mutants or the small sample size. Interestingly, an increase in activity from double to triple mutants was noticed when TMX was used, with median IC50s changing from 40.92 to 20.91 nM, but this

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**TABLE 1. Summary of the in vitro activities of PM, TMP, TMX, CCG, and WR99210 against field isolates of Plasmodium falciparum from Kenya**

<table>
<thead>
<tr>
<th>Drug</th>
<th>No. of isolates</th>
<th>Median IC50 (nM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WR99210</td>
<td>15</td>
<td>0.072 (0.04-0.23)</td>
</tr>
<tr>
<td>TMX</td>
<td>23</td>
<td>30 (11.82-52.63)</td>
</tr>
<tr>
<td>CCG</td>
<td>33</td>
<td>37.80 (12.11-49.19)</td>
</tr>
<tr>
<td>MTX</td>
<td>33</td>
<td>83.60 (61.75-127.80)</td>
</tr>
<tr>
<td>PM</td>
<td>33</td>
<td>733.26 (229-941)</td>
</tr>
<tr>
<td>TMP</td>
<td>33</td>
<td>29,656 (6,686-62,448)</td>
</tr>
</tbody>
</table>

a WR99210 IC50 for 18 of 33 isolates were <0.01 nM and thus could not be estimated with accuracy according to our protocol. The data reported pertain to the remaining 15 isolates.
Table 2. Relationship between median IC_{50} of drugs and parasite dhfr genotypes

<table>
<thead>
<tr>
<th>DHFR genotypea</th>
<th>PM (nM)</th>
<th>TMP (nM)</th>
<th>CCG (nM)</th>
<th>MTX (nM)</th>
<th>TMX (nM)</th>
<th>WR99210b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double mutant</td>
<td>371 (8)</td>
<td>9,308.6 (7)</td>
<td>38.06 (8)</td>
<td>84.89 (8)</td>
<td>40.92 (8)</td>
<td>0.069 (4)</td>
</tr>
<tr>
<td>Triple mutant</td>
<td>778.28 (24)</td>
<td>33,655 (15)</td>
<td>39.99 (24)</td>
<td>83.59 (24)</td>
<td>29.91 (24)</td>
<td>0.11 (10)</td>
</tr>
<tr>
<td>Quadruple mutant</td>
<td>3,690.79 (1)</td>
<td>154,736 (1)</td>
<td>87,679 (1)</td>
<td>56.63 (1)</td>
<td>44.66 (1)</td>
<td>0.012 (1)</td>
</tr>
</tbody>
</table>

a No wild-type dhfr isolate was identified. None of the tested differences between double and triple mutants were significant at a P value of 0.05 by the Kruskal-Wallis test.
b WR99210 IC_{50} for 18 out of 33 isolates were <0.01 nM and thus could not be estimated with accuracy according to our protocol. The data reported pertain to the remaining 15 isolates.

Discussion

We have confirmed that a high proportion of parasites circulating in Kilifi, Kenya, are triple mutants (>70% of isolates), and we report for the first time the presence of a parasite carrying the Ile-164-Leu mutation in Kilifi, our study site. Experience in the use of PM-SD in Southeast Asia and South America indicates that PM-SD can select for Ile-164-Leu, and this mutation is associated with high resistance to PM-SD and decreased efficacy of Lapdap (54, 57). In Africa, this mutation was identified for the first time in Tanzania, using the yeast complementation approach, which is based on the expression of Plasmodium dhfr genes in Saccharomyces cerevisiae followed by the selection of cells expressing highly resistant alleles (22). When this discovery was made, it was anticipated that the rate of parasites carrying this mutation would rise in this population as a result of PM-SD pressure. Surprisingly, 5 years afterwards, we did not find this mutation by use of standard PCR-based methods (43). Recently, this mutation has been found in Malawi, in parasites from human immunodeficiency virus-positive pregnant women, by using a real-time PCR method and a heteroduplex tracking assay (1, 26); however, this has not been confirmed in a subsequent study in the same area (42). This Ile-164-Leu mutation has also been reported in Uganda and the Central African Republic (16, 35, 51), and a recent study showed prevalences of 4 to 14% at two sites in Uganda where P. falciparum is endemic (31). Interestingly, this mutation has been found in the western part of Kenya by using standard PCR methods and cloning; surprisingly, its presence was not associated with reduced PM-SD efficacy (21, 34), questioning its clinical relevance. There has been debate as to whether this mutation would be efficiently selected in Africa, and if so, whether it would be associated with reduced antifolate efficacy (23, 40). In this paper, we have provided evidence that the Ile-164-Leu mutation is present in Africa and that it is associated with a substantial increase in resistance to PM and TMP in vitro and with a decrease in CCG activity. Thus, in vivo, this mutation would be associated with increased PM-SD resistance and decreased Lapdap efficacy, though this mutation did not render PM-SD ineffective in the western part of Kenya (21).

Resistance to PM-SD started rising in Kilifi, Kenya, in the mid-1990s, even before the drug became the first line of treatment in the country (in 1998) (48). By the early 2000s, this drug was ineffective in most parts of Kenya, including Kilifi, and it was officially withdrawn in 2004 and replaced with the combination of lumefantrine and artemether (Coartem) (2). However, PM-SD is still available in the country for the management of malaria in pregnancy and for intermittent preventive treatment (8, 52). In addition, because it is cheap and affordable, this drug is likely to continue to be used for self-medication, thus maintaining drug pressure for the selection of resistance, explaining the emergence of the quadruple mutant. However, it remains puzzling that from the time PM-SD was widely used up to its official withdrawal, only limited numbers of quadruple mutant parasites were found in Africa, in spite of extensive investigations (43, 45, 56).

We focused our study on the dhfr gene only. The pressure for PM-SD is also exerted on the dhps gene. However, we and other groups have demonstrated that the dhfr gene is the critical marker associated with PM-SD (39); hence the focus on dhfr. Recently, a report has indicated that copy number variation in GTP-cyclohydrolase, the first enzyme in the folate pathway, was associated with reduced antifolate efficacy (23). The high prevalence of dhfr mutations in the Kilifi population is likely to affect the efficacy of alternative antifolate therapies, such as the combination of lumefantrine and artemether (Coartem). Therefore, monitoring the prevalence of dhfr mutations is crucial for the effective use of antifolate drugs in the region to avoid the development of resistance.
pathway, is likely to influence antifolate sensitivity in Southeast Asia, an area where Ile-164-Leu is dominant (36). Thus, it will be important to establish the role of this gene in the context of the emergence of Ile-164-Leu in Africa.

We have provided data on the in vitro activity of CCG against recent Kenyan isolates. Overall, this drug is potent, with IC_{50}s of <40 nM for more than 95% of parasites. However, the quadruple mutant isolate we have identified was among the 10% of isolates that were least susceptible, and experience with the use of Lapdap in Southeast Asia, an area with a high rate of the parasite with Ile-164-Leu, clearly indicates that this mutation would be associated with decreased Lapdap efficacy (57). Based on our in vitro data, this mutation would also compromise Lapdap efficacy in Africa. However, this drug has been phased out because of the toxicity of dapson.

We have investigated the activity of the antibacterial agent TMP, a component of cotrimoxazole. Since cotrimoxazole is commonly used in Africa, there had been debate as to whether the use of this drug could have selected for mutations in dhfr, which would eventually have brought about resistance to PM. Jelinek et al. reported the selection of an unusual dhfr genotype (wild type at codon 108 but mutant at codons 51 and 59) following the use of TMP-SMZ (25), yet experience with PM-SD indicates that a mutation at codon 108 of dhfr was among the 10% of isolates that were least susceptible, and with a high rate of the parasite with Ile-164-Leu, clearly indicates that this mutation would be associated with decreased TMP-SMZ treatment failure has been reported in an area of PM-SD resistance (29). Thus, TMP-SMZ is a good antimalarial in the context of the high efficacy of PM-SD, so this antibacterial agent does not offer any advantage over PM-SD, probably explaining why it was abandoned as an antimalarial (39).

We and other groups have shown the high potency of MTX against laboratory reference strains, with IC_{50}s for parasites ranging from 25 to 60 nM, and these values are not affected by polymorphism in the dhfr gene (9, 37). In the present work, we have provided data on the activity of MTX against field isolates. MTX is active, with a median IC_{50} of 83.5 nM and IC_{99} of around 250 to 350 nM (drug concentrations that kill 90 or 99% of parasites). MTX is used at high doses, as much as 5 to 12 g/m² per week (130 to 300 mg/kg) for several weeks for the treatment of cancer (4). This dose can yield concentrations of >1,000 μM MTX, which can have life-threatening toxicity (4).

On the other hand, a low dose of MTX (0.1 to 0.35 mg/kg [7.5 to 25 mg per adult]) is used for the treatment of rheumatoid arthritis and juvenile arthritis on a chronic basis, for as long as 5 years (18, 38). At this dose, MTX is safe and well tolerated and can yield MTX concentrations around 250 to 950 nM (15, 17). This information has led us to propose that a dose of <7.5 mg could be used to treat malaria. In support of this hypothesis, two small clinical trials in the 1970s demonstrated that doses as low as 2.5 mg/day (adult dose) for 3 to 5 days are safe and effective at treating malaria infection in humans (47, 58). We are currently reevaluating the antimalarial potential of this agent.

We have also studied the activity of TMX against field isolates. This drug has been used in the treatment of cancer (19, 33). It has been combined with the folate derivative folic acid (FNA) in the treatment of Pneumocystis jirovecii infection (an opportunistic infection commonly associated with human immunodeficiency virus infection). TMX is potent against P. jirovecii, and this microorganism cannot transport folate derivatives. As a result, the combination of TMX with FNA retains potency against P. jirovecii, and the use of FNA protects the host against TMX toxicity. This combination is now the mainstay of P. jirovecii treatment (3, 33). As part of our previous work, we have shown that the most dominant form of folate, 5-methyl-tetrahydrofolate, is not utilized by P. falciparum; thus, we proposed that a low dose of TMX combined with 5-methyl-tetrahydrofolate be developed as an antimalarial (37), as it is used in the treatment of P. jirovecii. Our current data showing high activity of TMX against field isolates, even against triple and quadruple mutant parasites, lend support to the development of this drug as an antimalarial.

In conclusion, we have, for the first time, culture-adapted a P. falciparum dhfr Ile-164-Leu mutant from Africa. This isolate has high resistance to PM and CCG, and it has the highest resistance to TMP, as evidenced by the IC_{50}s of these drugs. We have confirmed that MTX and TMX are potent against P. falciparum and that their activities are independent of the parasite dhfr genotype. Thus, studies evaluating these two antifolates for the treatment of malaria are warranted.

ACKNOWLEDGMENTS

We thank the director of the Kenya Medical Research Institute for permission to publish these data. This study was supported by a Pfizer-Royal Society (United Kingdom) award (to A.N.), by the EU Commission under Framework 6 as part of the AntiMal Integrated Project 018834, by the Wellcome Trust (grant WT077092 and 084538), and by the European and Developing Countries Clinical Trials Partnership (EDCPT). A.N. is an EDCTP
senior fellow, and L.M. is an EDCPT-funded Ph.D. student. S.B. is funded through a Junior Group grant (SFB544, A7) by the Deutsche Forschungsgemeinschaft (DFG).

REFERENCES


22. Hasting, M. D., S. J. Bates, E. A. Blackstone, S. M. Monks, T. K. Muta-