Protein Synthesis Inhibitors

- Macrolides - Lincosamides
- Aminoglycosides
- Tetracyclines
- Chloramphenicol
- Oxazolidinones
- Streptogramins

Overview of Translation (1)

Initiation:
- 30S binds RBS of mRNA
- AA binds tRNA using aminocyl-tRNA synthetase
- IF2 and fmet-tRNA binds 30S at P site
- 50S binds complex → 70S resulting in the formation of the initiation complex

Overview of Translation (2)

Initiation
- tRNA + AA binds translation elongation factor
- Enters ribosome and attaches at the A site

Overview of Translation (3)

Amino Acid Transfer
- Peptidyltransferase on 50S ribosome attaches the next AA to the polypeptide
- Met added to Leu at A site

Overview of Translation (4)

Elongation
- tRNA moved to P site by EF-G creating room at A site for next tRNA

Translation termination
- Occurs at nonsense codon sites e.g. UAA
- Release factors
- Ribosome dissociates

Overview Outline

- Description of protein synthesis - translation
- Antibiotics
  - Structure - function - classification
  - Mechanism(s) of action
  - Mechanism(s) of resistance
  - Spectrum of activity/Indications for use
  - Pharmacology
  - Toxicity
- Clinical examples
Mechanisms of Action - Protein Synthesis Inhibitors

Macrolides

- Broad spectrum antibiotics
- Original agent: erythromycin
- Azalides: azithromycin and clarithromycin
  - selected antimicrobial and pharmacokinetic advantages

Large 14 member macrolactone ring with one or more deoxy sugars attached.

Inhibits formation of 50S ribosome blocking transpeptidation or translocation.

Large 14 member lactone ring with modification of C6 to a methoxy group.
Azithromycin has a 15 membered lactone ring (azalide)

Macrolides - Mechanisms of Resistance

- Mechanisms differ for different bacterial species
- Decreased permeability of envelope (e.g., the enterobacteriaceae)
- Mutation of the 23S ribosomal RNA of the 50S ribosomal subunit (alters binding site)
  - Can be chromosomal, plasmid or on a transposon
  - Can confer resistance to macrolides, lincosamycins and streptogramins (mls)
- Active efflux of antibiotic (plasmid-mediated) - mostly with Gram positive bacteria

Macrolides - Spectrum of Activity

- Erythromycin:
  - Gram positives: pneumococci, viridans streptococci, Group A streptococci, methicillin sensitive staphylococci
  - Gram negatives: bordetella, neisseria, campylobacter, ± hemophilus
  - Miscellaneous: mycoplasma, legionella, chlamydia, treponemes

Azalides - Spectrum of Activity

- Spectrum similar to erythromycin
- Increased activity against hemophilus, E. coli, Campylobacter spp., Helicobacter pylori, Mycobacterium avium intracellulare, toxoplasma
- Azithromycin > Gram negative activity
- Clarithromycin > Gram positive activity
Macrolides - Pharmacology

- Can be administered orally or parenterally
  - Well absorbed - especially azalides
- t1/2  erythromycin - 1.4h
- Azalides have long t1/2
  - Clarithromycin 3-7h
  - Azithromycin 2-4 days
- Well distributed, CNS penetration limited except with inflammation

Macrolides - Indications for Use

- Novel indication for use
  - Potential antibacterial (vs. anti-inflammatory) effects in the treatment of *P. aeruginosa* infections in Cystic Fibrosis

Macrolides - Pharmacology

- High concentrations in alveolar cells and polymorphonuclear leukocytes, especially azalides
- Most of drug is concentrated in the liver and excreted in the bile. Some is inactivated in the liver by demethylation.

Macrolides - Toxicity

- Generally well tolerated
- Gastrointestinal symptoms - cramps, diarrhea secondary to motility stimulating effects of antibiotic. Motilin receptor agonist
- Prolonged QT syndrome - risk of sudden death
- Cholestatic hepatitis (rare)
- Drug interactions - erythromycin > clarithromycin interferes with the cytochrome P450 enzymes leading to increased levels of other drugs e.g. dilantin, warfarin, cyclosporine

Macrolides - Indications for Use

- Community acquired pneumonia: mycoplasma, legionella, chlamydia
- Pertussis
- *Campylobacter jejuni* gastroenteritis
- MAC (azalides)
- Alternative agents for: group A,C,G streptococcal infections, rheumatic fever prophylaxis, *C. trachomatis* urethritis, anthrax

Clindamycin (Lincosamide)

- MOA similar to macrolides
- Bacteriostatic activity against Gram positive bacteria and anaerobes - also toxoplasma
- Pharmacology - high bone concentrations
- Toxicity - diarrhea, allergy
- Indications - penicillin-resistant anaerobic infections
Aminoglycosides

- Complex sugars with glycosidic linkages
- Bactericidal antibiotics with activity primarily directed against aerobic Gram negative bacteria
- Narrow therapeutic window with significant toxicity
- Primarily used as a second therapeutic agent in the treatment of serious Gram negative or enterococcal infections

Aminoglycosides - Mechanism of Resistance

- *Enzymatic modification of the aminoglycoside by adenylation, phosphorylation or acetylation
  - Usually found on plasmids or transposons
- Anaerobes are resistant because they lack an O$_2$ dependent transport system
- Chromosomal mutations can also cause alterations in binding and uptake e.g. S. aureus

Aminoglycosides

- Polycationic molecule with at least 2 aminosugars linked by glycosidic bonds to an amino-cyclitol ring
- Removal of amino or hydroxyl groups correlates with loss of antibacterial activity and toxicity
- Water soluble - limited ability to cross lipid membranes

Antibacterial Spectrum

- Aerobic gram negative bacilli
- *Pseudomonas aeruginosa*
- Gram positive bacteria (used for synergy) *Staphylococcus spp., Enterococcal spp.*
- Selected aminoglycosides have activity against: *Mycobacteria spp., Yersinia pestis*
- No activity against: hemophilus, anaerobes, pneumococcus, neisseria

Aminoglycosides - Mechanism of Action

- Diffuses through porin channels in outer membrane of Gram negative bacteria
- Binds to and alters bacterial cell membrane causing leakage of the outer Gram negative membrane and disruption of the cell wall
- *Interferes with mRNA translational accuracy primarily at the 30S ribosome causing misreading and premature chain termination
- Bactericidal activity appears to be multifactorial

Aminoglycosides - Indications for Use

- Empiric therapy: life-threatening infections that require broad spectrum coverage
- Specific therapy: synergistic antimicrobial activity
  - Enterococcal endocarditis
  - Pseudomonas infections
- Monotherapy: rarely used, inhalational therapy for CF patients with pseudomonal pneumonia
Aminoglycosides - Pharmacology

• Minimal absorption after oral administration
• Limited tissue distribution due to polarity
• Not metabolized, excreted by the kidney
• Rapid absorption after IM administration

Aminoglycosides - Toxicity

• Nephrotoxicity: incidence 5-25%
  – Damages proximal tubular cells,
• Ototoxicity: Cochlear 3-14%, Vestibular 4-6%
  – Long otic fluid t1/2
  – Cochlear damage to the outer hair cells of the organ of Corti
  – Vestibular damage to type 1 hair cell of the summit of the ampullar cristae

Tetracyclines

Basic structure consists of 4 fused 6 carbon rings - hydronaphthacene nucleus with modifications at selected positions
Binds to the 30S portion of ribosome, prevents access of aminoacyl tRNA molecules to the mRNA ribosome-peptide complex

Tetracyclines - Mechanism of Resistance

• Common in both Gram positive and negative bacteria
• Generally, but not exclusively, plasmid-mediated
• *Decreased uptake and increased excretion of the drug (pump)
• Resistance is conferred to all tetracyclines
• Has been associated with the extensive use of tetracyclines in animal food

Tetracyclines - Antimicrobial Spectrum

• Gram positives: *S. pneumoniae, S. pyogenes, S. agalactiae, enterococci
• Gram negatives: *E. coli, Neisseria spp., Hemophilus spp., Shigella spp.
• Miscellaneous: Spirochetes - Borrelia, Rickettsiae, Chlamydiae, Mycoplasma, Legionella, Pasteurella, Ehrlichia (Anaplasma)
• Tigecycline: new broad spectrum glycylcycline with activity against resistant gram positives and negatives
Tetracyclines - Indications for Use

- Treatment of chlamydia, mycoplasma, brucella, vibrio, helicobacter, rickettsia, borrelia, ehrlichia (anaplasma) infections
- Mycobacterium marinum infections
- Acne
- Skin and soft tissue infections due to methicillin-resistant staphylococci
- Rarely the first drug of choice

Tetracyclines - Pharmacology

- Primarily oral agents
- Cations Ca^2+, Mg^2+ interfere with absorption by chelating tetracyclines, e.g., dairy products
- t1/2 varies with agent as does extent of excretion by the kidney.
  - Doxycycline excreted in the feces
  - Minocycline metabolized in the liver
- In general excellent tissue distribution
- Concentrated in the bile, achieves levels of 10-26% of serum in CSF

Tetracyclines - Toxicity

- Gastrointestinal symptoms: common
- Photosensitivity
- Discoloration of teeth due to binding to calcium - not reversible
- Hypersensitivity reactions: rash, urticaria, anaphylaxis (rare)
- Hepatotoxicity - especially during pregnancy

Chloramphenicol

Binds to peptidyl transferase, component of 50S ribosomal subunit. Resistance usually due to presence of above enzyme

Chloramphenicol

- Broad spectrum, mostly bacteriostatic, covers aerobic Gram positives and most Gram negatives, most anaerobes and rickettsia
  - May be bactericidal against pneumococcus, neisseria
- Higher levels achieved following oral rather than intravenous administration
- Well distributed throughout the body
- Metabolized to inactive metabolite in the liver

Chloramphenicol

- CSF levels 30-50% of serum without inflammation
- Rarely used because of concern about toxicity - bone marrow aplasia, Gray baby syndrome
- Indications include: not the drug of choice for any infection. Used to treat typhoid fever (S. typhi), meningitis in penicillin allergic, and rickettsial infections
- Has been used as a marker of bad medical practice!
Linezolid - Oxazolidinone

- Bactericidal (often) combination derived from pristinamycin: quinupristin (30%) and dalfopristin (70%)
- Both interfere with 50S ribosomal subunit: Quinupristin inhibits peptide chain elongation and dalfopristin interferes with peptidyl transferase
- Resistance primarily occurs by methylation of MLS binding site (plasmid-mediated) also drug modification or efflux (less common)

Clinical Scenario 1

A 25 year old female returns from a camping trip in Maine in late July. She develops fever, malaise and myalgias. Other than her obvious discomfort her physical examination is unrevealing, however her laboratory examination is of note. She is both thrombocytopenic and leukopenic. Her peripheral smear is shown on the next slide.

Streptogramins

- Limited spectrum of activity: Gram positive cocci - staphylococci, streptococci, enterococci (only E. faecium not E. faecalis)
- Only parenteral, well distributed, metabolized in the liver to inactive metabolites
- Used to treat vancomycin or methicillin-resistant infections Gram positive infections
- Toxicity: phlebitis, myalgias, arthralgias

Streptogramins

- Bacterial synthetic antibiotic: activity against Gram positive cocci - even those resistant to other agents
- Administered parenterally or orally
- Excellent distribution, metabolized by liver, excreted in urine
- Resistance by mutation of 23s RNA (50S subunit)
- Indication: primarily for treatment of drug-resistant enterococcal or staphylococcal infections
- Toxicity: myelosuppression, peripheral and optic neuropathy
Clinical Scenario 1 (cont’d)

She is placed on the antibiotic that you recommend but she fails to improve. Why?

It turns out that she is taking her medication with Calcium supplemented milk.

Clinical Scenario 2

You have decided to take an elective in tropical medicine and arrive in sub-Saharan Africa only to learn that this is the meningitis belt. There is an enormously high incidence of meningococcal meningitis in this area. Given all the limitations of therapy in this economically impoverished area which antimicrobial agent might be a reasonable choice to treat the children with meningitis in this region?

Clinical Scenario 3

A 78 year old man develops a urinary tract infection caused by a vancomycin-resistant enterococcus. He refuses hospitalization noting that his granddaughter is getting married this coming weekend. What to do?

Clinical Scenario 4

A 19-year old college student with a prosthetic mitral valve secondary to rheumatic fever as a child needs prophylaxis against Group A streptococcus. He has a documented history of an anaphylactic allergic reaction to penicillin. What should be used as an alternate? Hint - he is warned to reduce his dose of Coumadin.

Clinical Scenario 5

A 70-year-old man with a history of refractory leukemia is re-hospitalized with a pseudomonas pneumonia. He develops renal failure in his second week of combination antibiotic therapy. Which antibiotic is the likely cause of this complication?
What I Think You Should Know

• The mechanisms of action of the different families of antibiotics
• The major mechanisms of resistance
• The spectrum of activity
• Pharmacology of the antibiotic - *i.e.* distribution, toxicity, mode of excretion
• General indications for use
• *NB* - You will need to be able to integrate this information and apply to clinical scenarios