Drug Resistant Tuberculosis

Barbara J Seaworth, M.D.
Heartland National TB Center

TB Nurse Expert Meeting · November 6-7, 2025 · San Antonio, Texas

What you should learn:

- 1. What is a drug-resistant isolate?
- 2. How can an isolate be identified as drug resistant?
- 3. How can **YOU** prevent drug resistance?
- 4. When should you suspect drug resistance?
- 5. What are the key things you should do as soon as you learn your patient may have drug resistant TB?
- 6. What are the "red flags" that things may not go well?
- 7. When should you be concerned the patient is not responding well?
- 8. How should I follow patients during therapy?
- 10. When is treatment over?
- 11. How should I follow patients after completion of therapy?

When Does Lab Report Resistance?

- If **> 1%** of the mycobacterial population grows on a culture which contains a drug at a certain specified concentration.
  - In comparison to amount which grows on a plate without the drug
- If treatment is given with the drug eventually all the mycobacteria in that population will become resistant

XDR-TB

Extensively Drug Resistant Tuberculosis

Isoniazid
Ethambutol
Rifampin

Streptomycin
Ethionamide
Ofloxacin

Rifabutin
Kanamycin
Capreomycin

CDC Classification: Drug Resistant Tuberculosis

MDR$_{H&R}$
Resistant to…
Rifampin + Isoniazid

Pre-XDR
Resistant to…
Rifampin + Isoniazid + Fluoroquinolone OR Amikacin *OR* Kanamycin *OR* Capreomycin

XDR
Resistant to…
Rifampin + Isoniazid + Fluoroquinolone + Bedaquiline *OR* Linezolid *OR* Amikacin Kanamycin Capreomycin

No Mention of Rifampin Mono-Resistant TB

WHO Terminology to Classify Drug Resistant TB

- **XDR-TB:**

Group A Drugs
Levofloxacin/Moxifloxacin
Bedaquiline
Linezolid

Note: No mention of the injectable agents by WHO

January 2021

- **Pre-XDR-TB:** TB caused by M. tuberculosis strains that fulfill the definition of MDR/RR-TB and are also resistant to **any fluoroquinolone**
- **XDR-TB: TB** caused by M. tuberculosis strains that fulfill the definition of MDR/RR-TB and that are also resistant to any **fluoroquinolone and at least one additional Group A drug.**

WHO Overarching Principals for New Definition of XDR TB…should be:

- **Simple:**
- **Measurable:**
- **Relevant to programs:**
  - Should signal a very serious form of TB and the need for such patients to have a regimen that is different to the regimen for patients with MDR-TB, or other less serious forms of DR-TB.
- **Future-proof:**
  - Accomplished by use of "Group A" drugs instead of specific drugs; allows new Group A drugs in the future.
    - CDC definition includes linezolid and bedaquiline in place of Group A designation; ignores delamanid and pretomanid and all future drugs

Diagnosis of Drug-Resistant TB:

First step is to consider the possibility

WHEN Patient Notes:

- Prior TB treatment
- Inadequate prior treatment
  - Inadequate regimen
  - Drug shortage
  - Drug toxicity
  - DST not done to guide RX
  - EMB/PZA stopped without DST results and INH resistance noted later
  - Poor absorption
- Poor response to treatment

WHO?

- Those from areas where DR TB is common
- Those who relapse,
  - with history of poor adherence
- Those exposed to a person with possible DR TB

Molecular Diagnosis of Drug-Resistant TB

Initial specimen resistant status unknown:

- **Xpert**
  - Sputum specimen or culture
  - Gives **same day** information as to rifampin resistance
  - If positive for rifampin resistance further testing needed to **confirm**
- **Whole genome sequencing**
  - Initial culture
  - Many states preform on all isolates
    - But not a diagnostic tool rather an epidemiological tool for most states
    - In Texas the isolates are batched
  - Florida, New York
    - A diagnostic tool; results in one week

If Xpert is positive for MTB and rifampin resistant:

- Additional testing (CDC/other reference lab)
  - **Confirm** rifampin resistance with pyrosequencing or Sanger sequencing
- If rifampin resistance is confirmed
  - Molecular testing for other first line drugs, FQNs, linezolid, BDQ and Clofazamine
  - Hopefully will soon also be able to do molecular testing for pretomanid and DST for linezolid, BDQ and Pretomanid at CDC
    - If needed can be requested to go to the NY State Lab or Florida lab
  - **THEN:** Culture based drug susceptibility studies for all first- and second-line drugs

Xpert reports rifampin resistance Important considerations to quickly address:

Laboratory:

Confirmation of rifampin resistance and ID of additional mutations

Get the specimen to the CDC! Identify who will do this!

Patient Assessment:

Treatment Plan:

How ill is patient? Who is at patient's home?

Most patients will need to start a bridging regimen as it will be two weeks at least to get specimen to CDC and report back and MDR regimen started. That is too long to leave an individual with MDR TB untreated

Work with medical consultant on treatment plan

Infection Control:

Contact Investigation:

Also Consider asking for Molecular Testing when:

- There is clinical or epidemiological evidence of INH mono-resistant TB
  - **Treatment is different if isolate has resistance to ethambutol**
    - We see this in Texas, especially in isolates from border areas.
- To document FQN susceptibility ideally before it is added to a treatment regimen
- To identify drug resistance in Group A drugs not part of DST testing
  - Bedaquiline, linezolid, clofazimine, pretomanid

What about Discrepancies in Rifampin Susceptibility?

Molecular tests and Culture Based DST

- **Rifampin?**
  - **Molecular testing** done by whole genome sequencing pyrosequencing, Sanger or next genome sequencing (not Expert) is:

"Gold Standard"

- Culture may miss rifampin resistance
  - MGIT (liquid media) misses more than solid media testing
- Often may be due to lower level of rifampin resistance
  - But these are clinically significant – cannot be treated with standard regimen

Treatment of Drug Resistant TB

INH Resistant Tuberculosis

Treatment of Drug-Resistant TB
An Official Clinical Practice Guideline

ATS, CDC, ERS, IDSA Drug Resistant TB Guideline CID Dec 2019

- We *suggest adding a later generation FQN* to a 6 month regimen of daily rifampin, ethambutol and PZA for patients with INH resistant TB

- In patients with INH resistant TB treated with a daily regimen of later-generation FQN, rifampin, ethambutol and PZA, we *suggest that the duration of PZA can be shortened to 2 months* in selected situations (non-cavitary and lower-burden disease or toxicity)

INH Resistant TB

WHO Consolidated Guidelines Module 4

Guidelines Development Committee (GDC) recommended

2025

- In patients with confirmed ***rifampicin susceptible*** INH resistant TB, treatment with rifampin, EMB, PZA and ***levofloxacin is recommended*** for duration of 6 months.
  - PZA given for at least 3-4 months associated with better outcomes
- In patients with confirmed rifampin susceptible, INH resistant TB, it is *not recommended* to add streptomycin or other injectable agents to the treatment regimen.

Clinical Scenarios: Implementation

- When INH resistance and **rifampin susceptibility known and before treatment start**:
  - Treat with Rifampin/EMB/PZA/FQN
  - Confirm FQN susceptibility
  - Start timing of modified regimen with start of FQN
- INH resistance noted **after start of RIPE while still on RIPE**
  - **Confirm rifampin susceptibility before adding FQN**
  - **Confirm FQN susceptibility**
- INH resistance noted **after start of RIPE but patient switched to RI** only before confirming DST results:
  - **Confirm rifampin susceptibility on a new specimen before starting -- acquired rifampin resistance possible!**
  - **Confirm FQN susceptibility**

Treatment of MDR TB Prior to 2019

- 18-24 months of treatment
- 6-8 months of an injectable
- 4-6 less effective second line drugs
- 50% cure, 10% mortality

From this to ----

The medicine and syringes to treat one MDR-TB patient for one year. Patients need to undergo treatment from 18–24 months

IDSA fact sheet 2013

- **Staggering Medication Burden**

TAG PIPELINE REPORT 2012

Novel Compounds to Treat Active TB Disease

TABLE 3. Novel and Second-Generation Compounds in Late-Stage Clinical Studies for Active TB as of June 2012

Agent	Class	Sponsor	Status	Indication	New Combination Study
delamanid (OPC-67683)	nitroimidazole*	Otsuka	Phase III	DR-TB	—
AZD5847	oxazolidinone	AstraZeneca	Phase IIa	TBA	—
sutezolid (PNU-100480)	oxazolidinone	Pfizer	Phase IIa	DR-TB	—
bedaquiline (TMC207)	diarylquinoline*	TB Alliance/ Janssen	Phase II	DS-TB	NC001, NC003
		Janssen	Phase II	DR-TB	
PA-824	nitroimidazole*	TB Alliance	Phase II	DS-TB/ DR-TB	NC001, NC002, NC003
SQ109	diamine	Sequella/ PanACEA‡	Phase II	DS-TB/ DR-TB	—

*indicates new drug class
†DS-TB indicates drug-sensitive TB; DR-TB indicates drug-resistant TB; TBA indicates to be announced
‡The Pan-African Consortium for Evaluating Anti-tuberculosis agents

2012:Bedaquiline available for compassionate use
Pa-824 - Pretomanid

2022: Bedaquiline - Core Drug for MDR/XDR TB

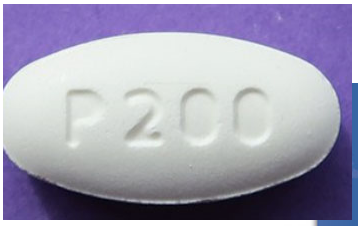
TB Alliance ABOUT WHY NEW TB DRUGS? R&D ACCESS NEWS DONATE

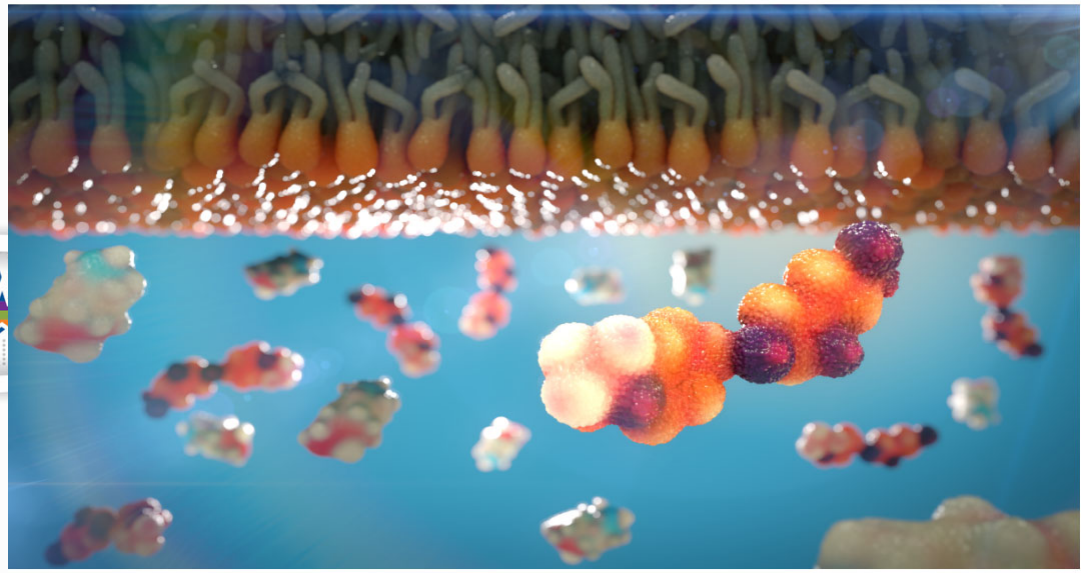
FDA Approves New Treatment for Highly Drug-Resistant Forms of Tuberculosis

Pretomanid, developed by the non-profit TB Alliance, has received U.S. approval in combination regimen with bedaquiline and linezolid for people with XDR-TB or treatment-intolerant/non-responsive MDR-TB

August 14, 2019

Combinations As "THE" Regimen
BPaL
BPaLM
? Coming…BPaMZ





Artist's rendering of the pretomanid compound.

ATS, CDC, ERS, IDSA Updates on the Treatment of Drug Susceptible and Drug-Resistant TB

Am J Respir Crit Care Med Jan 2025

Two 6 month regimens

Q3: Treatment of Rifampin-Resistant, Fluoroquinolone Resistant TB	
Recommended BPaL Regimen‖	
Bedaquiline	400 mg daily for 2 wk, then 200 mg three times/wk for subsequent 24 wk
Pretomanid	200 mg daily for 26 wk
Linezolid	600 mg daily for 26 wk
Q4: Treatment of Rifampin-Resistant, Fluoroquinolone-Susceptible TB	
Recommended BPaLM Regimen¶	
Bedaquiline	400 mg daily for 2 wk, then 200 mg three times/wk for subsequent 24 wk
Pretomanid	200 mg daily for 26 wk
Linezolid	600 mg daily for 26 wk
Moxifloxacin	400 mg daily for 26 wk

BPaLM (BPaL plus Moxifloxacin - 5 tablets)

BDQ/Pretomanid/Linezolid/Moxifloxacin

Treatment Options for RR/MDR TB
Six-month (26 weeks) regimens

WHO Consolidated TB Guidelines 2025

- **BPaLM:** BDQ/Pretomanid/Linezolid/Moxifloxacin 26 weeks
  - Recommended for **all unless FQN resistant or intolerant**
    - Linezolid dose 600 mg once daily
- **BPaL:** BDQ/Pretomanid/Linezolid 26 weeks x 6 months
  - Recommended if FQN resistant MTB
    - Linezolid dose 600 mg once daily as identified by ZeNix study
- **BDLLfxC (BEAT TB):**
  BDQ/Delamanid/Levofloxacin/Linezolid/Clofazimine
  - Stop clofazimine if FQN susceptible or
  - Stop Moxifloxacin is FQN resistant
  - Recommended when pretomanid cannot be used (children, pregnancy)
  - In U.S. Delamanid is compassionate use drug

BPaL Regimen (Nix Trial)

Bedaquiline-Pretomanid-Linezolid


The NEW ENGLAND JOURNAL of MEDICINE

MARCH 5, 2020

Treatment of Highly Drug-Resistant Pulmonary Tuberculosis

Bedaquiline 400 mg (14 days); 200 mg M/W/F
Pretomanid 200 mg daily
Linezolid 1200 mg daily

All Oral
Open Label – Observational
*109 patients
65% XDR
51% HIV +
84% cavitary on CXR
Unresponsive to treatment or intolerant

Favorable Treatment Outcomes
XDR TB 89%
MDR TB 92%
Relapse
XDR TB: 1/MDR TB: 1

Time to Culture Negative: MDR vs XDR TB

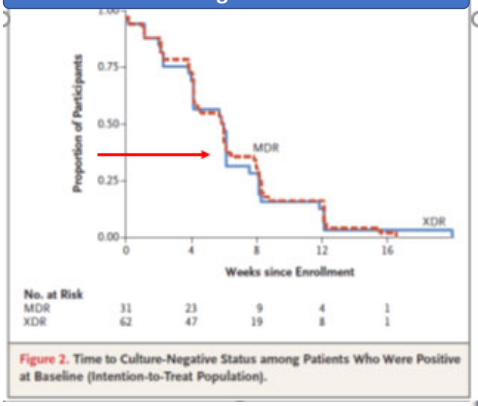


Figure 2. Time to Culture-Negative Status among Patients Who Were Positive at Baseline (Intention-to-Treat Population).

BUT …….. BPaL Adverse Events

- Adverse Effects:
  - HIV negative: 100%
  - HIV positive: 100%
- Adverse Effects by Linezolid dose
  - 1200 mg once daily: 100%
  - 600 mg twice daily: 100%

Myelosuppression 48%
Peripheral neuropathy 81%

ZeNix: Linezolid Optimization Trial

ZeNix

Patients with XDR-TB, Pre-XDR-TB or who have failed or are intolerant to MDR-TB treatment

NEJM September 2022

ORIGINAL ARTICLE

Bedaquiline–Pretomanid–Linezolid Regimens for Drug-Resistant Tuberculosis

F. Conradie, T.R. Bagdasaryan, S. Borisov, P. Howell, L. Mikiashvili, N. Ngubane, A. Samoilova, S. Skornykova, E. Tudor, E. Variava, P. Yablonskiy, D. Everitt, G.H. Wills, E. Sun, M. Olugbosi, E. Egizi, M. Li, A. Holsta, J. Timm, A. Bateson, A.M. Crook, S.M. Fabiane, R. Hunt, T.D. McHugh, C.D. Tweed, S. Foraida, C.M. Mendel, and M. Spigelman, for the ZeNix Trial Team*

Randomize

- B-Pa-L L=1200 mg/d x 6 mos
- B-Pa-L L=1200 mg/d x 2 mos
- B-Pa-L L=600 mg/d x 6 mos
- B-Pa-L L=600 mg/d x 2 mos

6 months of treatment

Additional 3 months if sputum culture positive at 4 months

1° follow up for relapse-free cure 6 months after end of treatment; Full f/u 24 mos after end of treatment

N=30 XDR-TB per group AND
up to 15 pre-XDR or intolerant/non-responsive MDR-TB per group

Pa dose = 200 mg daily; B Dose = 200 mg daily x 8 weeks, 100 mg x 18 weeks

ZeNIX: Linezolid Optimization Trial

MDR or XDR TB Treatment Failure or Intolerant

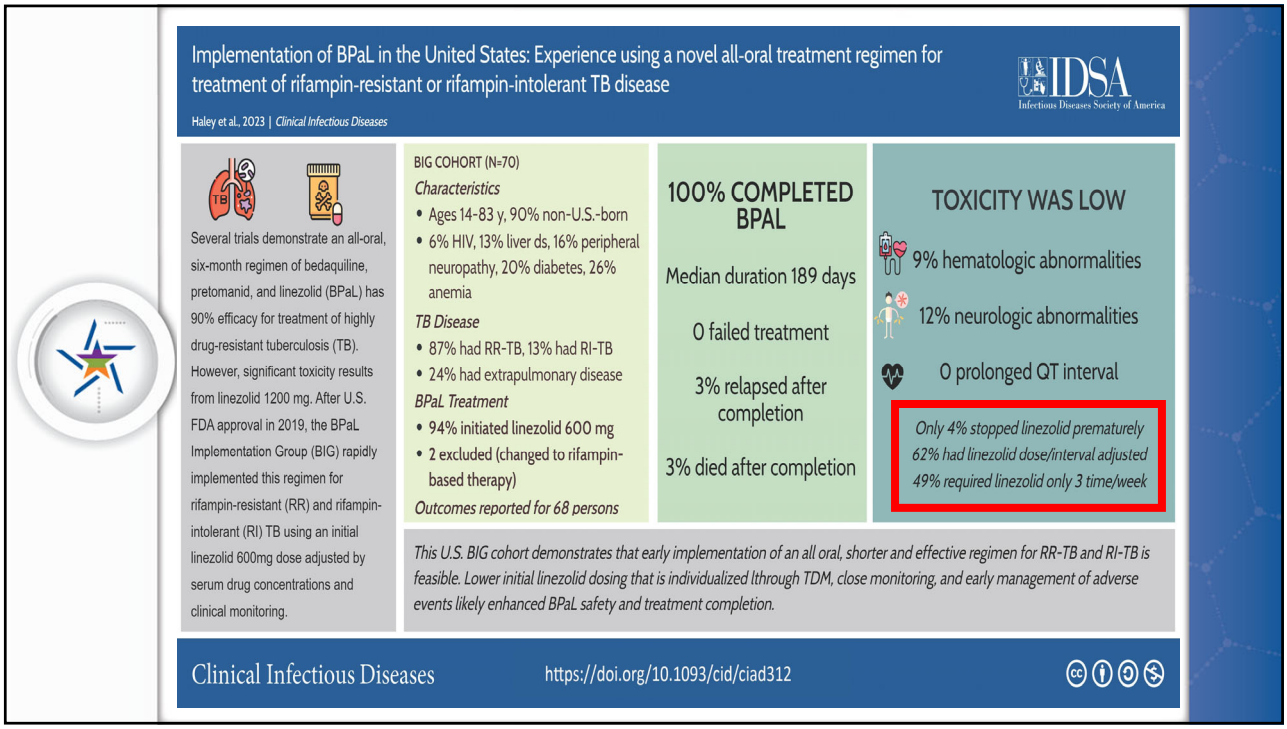
Safety

- Peripheral neuropathy **24%** (600 mg x26)
- Myelosuppression, **2%** (600 mg x 26)
- Only 13% required Linezolid dose modification at 600 mg/day dose

Efficacy

- LZD - 1200mg x 6 mo. - 93%
- LZD - 1200 mg x 9 wks. - 89%
- LZD - 600 mg x 6 mo. - 91%
- LZD - 600 mg x 9 wks. – 84%

Stopping linezolid early is associated with poorer outcomes with both high and low dose.



TB PRACTECAL –

- Regimen 1:
- bedaquiline + pretomanid + linezolid + **moxifloxacin** for 26 weeks (**BPaLM or BPaL plus Moxi)**

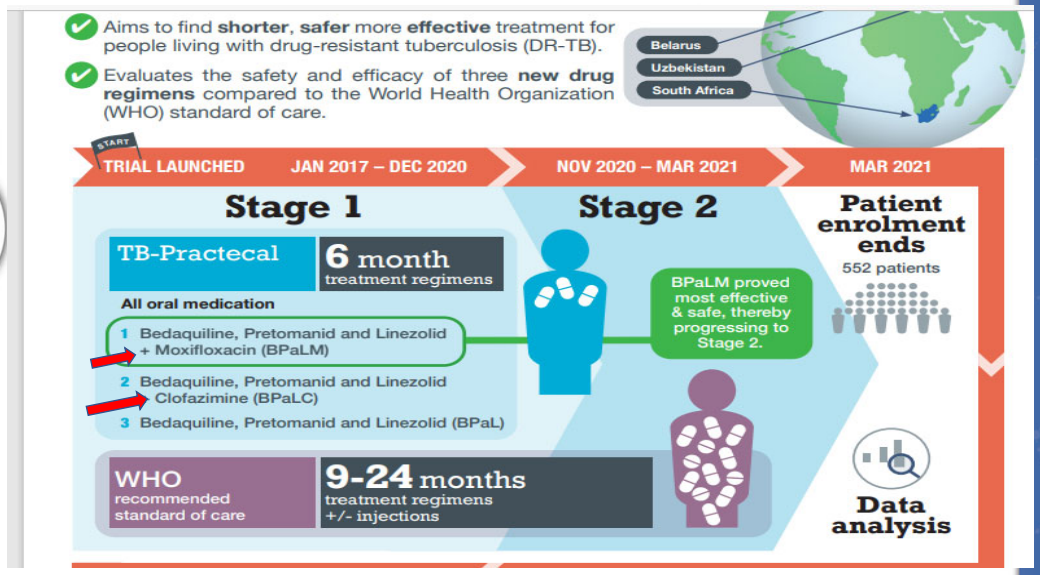
- Regimen 2:
- bedaquiline + pretomanid + linezolid + **clofazimine** for 26 weeks

- Regimen 3:
- bedaquiline + pretomanid + linezolid for 24 weeks

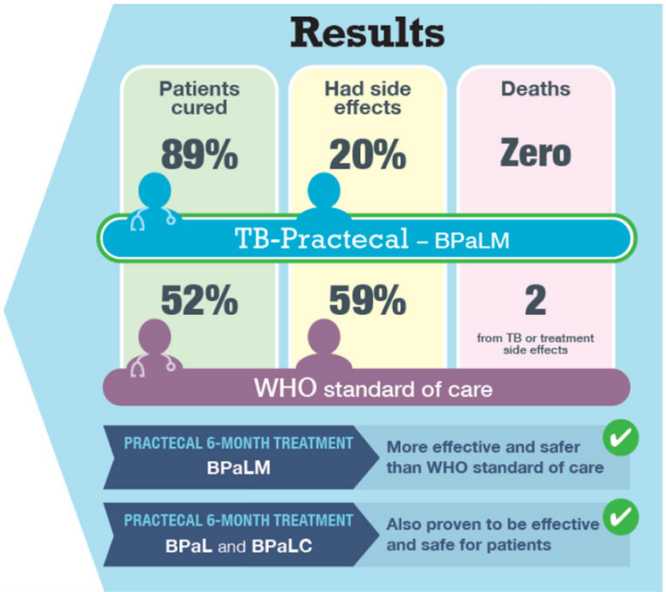
- Standard of Care in Country at the time

TB-Practecal Clinical Trial

randomized, controlled



TB PRACTECAL

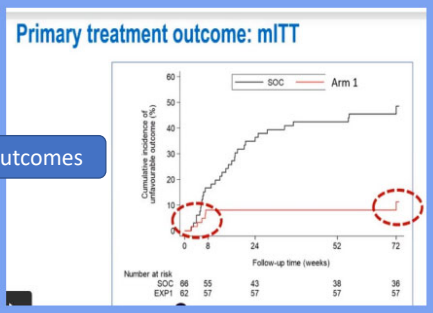


TB-PRACTECAL - Efficacy

- Arm 1: BPaLM: 89% favorable
- Arm 2: BPaLC: 81% favorable
- Arm 3: BPaL(modified): 77% favorable
- Arm 4: SOC: 52% favorable

26% FQN resistant

Cumulative incidence of unfavorable outcomes



2022 RESIST-TB Webinar

BPaL Regimen (Nix Trial)

Bedaquiline-Pretomanid-Linezolid


The NEW ENGLAND JOURNAL of MEDICINE

MARCH 5, 2020

Treatment of Highly Drug-Resistant Pulmonary Tuberculosis

Bedaquiline 400 mg (14 days); 200 mg M/W/F
Pretomanid 200 mg daily
Linezolid 1200 mg daily

All Oral
Open Label – Observational
*109 patients
65% XDR
51% HIV +
84% cavitary on CXR
Unresponsive to treatment or intolerant

Favorable Treatment Outcomes
XDR TB 89%
MDR TB 92%
Relapse
XDR TB: 1/MDR TB: 1

Time to Culture Negative: MDR vs XDR TB

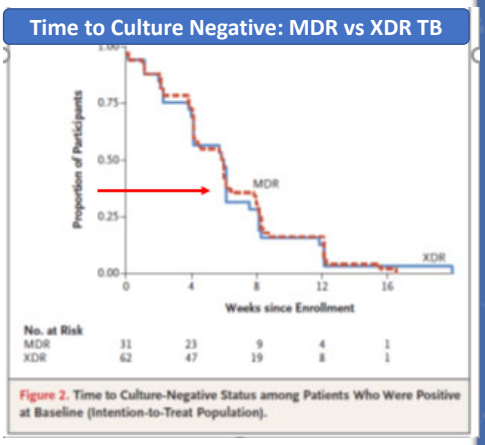


Figure 2. Time to Culture-Negative Status among Patients Who Were Positive at Baseline (Intention-to-Treat Population).

Short course treatment options for drug resistant TB

6 – 9 months
All oral
Core drugs:
Bedaquiline
Pretomanid
Linezolid
Moxifloxacin

- **BPaL** 6 months; may extend to 9
- **BPaLM** 6 months; may extend to 9
- **BDQ, LZD (2), Moxi core** 9 months
  - WHO includes in regimen:
    - BDQ, LZD (2), Moxi, high dose INH, EMB, PZA, Clofazimine x 4-6 months
    - moxifloxacin, clofazimine, EMB, PZA x 4 months
  - U.S. would likely include in regimen:
    - BDQ, LZD, Moxi throughout 9 – 12 months plus
    - Clofazimine or PZA
    - Cycloserine

(B)BDQ = bedaquiline, Pa = pretomanid, (L) LZD = linezolid, (M) Moxi = moxifloxacin

Key Considerations for Selecting a Regimen

- For MDR TB (not FQN resistant) **BPaLM preferred**
- Pre-XDR TB (FQN resistant) **BPaL** recommended.
- Extensive or Extrapulmonary disease **BPaLM or BPaL**
  - Most likely need to extend therapy and/or add other drugs
- BPaLM and BPaL-not recommended/contraindicated:
  - CNS disease (minimal data on CNS penetration)??
    - Increasing evidence of BPaLM plus cycloserine may be good choice
  - Pregnancy (current study underway)
  - Age < 15 (study underway but interrupted)

Case Management II

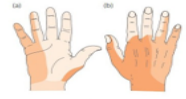
Critical Components of Monthly Nurse Assessment for 2nd-Line Drugs

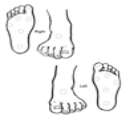
Additional information for selected nurse assessment (see complete toxicity assessment tool)

Peripheral Neuropathy

Peripheral neuropathy may be painful and is often non-reversible. Neuropathy usually manifests initially in the lower extremities, with sensory disturbances, but may also involve the upper extremities. Disturbances are often bilateral. Assess for:

- numbness (using a monofilament) or tingling
- burning, pain
- temperature sensation
- difficulty walking (unsteady gait/balance)
- decreased or absent deep tendon reflexes





Monthly assessment
Early Identification of Toxicity

Patient Education
Early report if symptoms occur

Behavior and Mood

Some TB medications may contribute to depression and in rare cases, suicidal ideation. Depressive symptoms may fluctuate during therapy. Although the risk may be increased in those with a history of depression, it is not an absolute contraindication to the use of cycloserine. Some patients with depression at baseline improve on cycloserine, as they respond to treatment.

- Use a mental health assessment tool at least monthly.
- Facilitate access to psychological support for patients and family, including antidepressant therapy at usual doses, if needed.
- Review drug-drug interactions with linezolid that may lead to serotonin syndrome.

Vision

Optic neuritis may exhibit as change in color vision or visual acuity. Loss of red-green color distinction may be detected first, however, a decrease in visual acuity is more common. Changes are usually reversible if detected early and medication is discontinued.

- Educate patients to report any vision changes.
- Screen patients using the Ishihara vision test and Snellen eye chart during monthly exams.

If either change is detected, hold linezolid and ethambutol, notify provider, and request referral to an ophthalmologist.

Ishihara Vision Test

Snellen Eye Chart

Monitoring for Adverse Effects

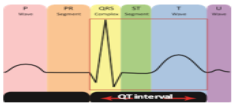
Monitoring for Adverse Effects

Cardiac Toxicity

QT interval prolongation: Fluoroquinolones, bedaquiline, pretomanid, clofazimine and delamanid may prolong the QT interval in the EKG(electrocardiogram) and may predispose patients to arrhythmias, torsade de pointes, and sudden death.

What is the QT Interval?

It is the portion of the EKG that begins at the start of the QRS complex and ends at the termination of the T wave. The QT is longer in women and those with lower heart rates. The QTc is a correction for extremes in heart rates.



What is the normal QTc value?

Normal QTc is < 450ms in men and < 470ms in women. It can vary by up to 75ms in the same individual at different times during the same day. Therefore, it is recommended that EKGs be done at approximately the same time of the day.

Risk Factors for QTc Prolongation

Presence of multiple factors may increase the risk of QT prolongation.

QTc > 450ms Asymptomatic
QTc > 470ms

- Draw blood for and correct if abnormal.
  - Electrolytes (Ca+, Mg+, K+)
  - TSH
  - Hgb
- Review other QTc prolonging drugs and stop these if possible.
- Get weekly EKG.

*Note: Many non-TB drugs may cause increased QTc prolongation. See www.challengetb.org/publications/tools/pmdt/Guidance_on_ECG_monitoring_in_NDR_v2.pdf

QTc > 500ms Asymptomatic

- Hospitalize patient, if possible.
- Draw blood for and correct if abnormal.
  - Electrolytes (Ca+, Mg+, K+)
  - TSH
  - Hgb (Blood transfusion if needed)

- Stop QTc prolongation drugs sequentially*
- Repeat EKG 24-48 hours
- Request cardiology consultation.
- Get weekly EKG until normal.

* Starting with ancillary drugs, then DR-TB drugs with moxifloxacin/levofloxacin, then pretomanid/clofazimine/delamanid, and then bedaquiline

QTc > 500ms
Symptoms: Palpitations, tachycardia, fainting, headache, chest pain, syncope

- Hospitalize patient (intensive or cardiac unit monitoring).
- Draw blood for and correct if abnormal.
  - Electrolytes (Ca+, Mg+, K+)
  - TSH
  - Hgb (Blood transfusion if needed)

- Stop ALL QTc prolongation drugs
- Repeat EKG 24-48 hours
- Request cardiology consultation
- Get weekly EKG until normal

Monitoring During Therapy

- Monitor sputum culture monthly during treatment
  - Unclear as to when failure is identified with shorter regimens
  - Recommendation to extend therapy for 6-month regimens when response delayed.
    - I often consider extending if positive at 3 months especially if clinical or radiographic response is delayed.
- Monitor weight monthly
- Monitor toxicity monthly (neuropathy, vision, lab)
- CXR at baseline, 2 months and 6 months
- Monitor EKG monthly

Monitor After Treatment for 24 months

- Monitor **RR or MDR TB patients** at 6-month intervals
  - Sputum culture
  - CXR
  - Medical assessment
  - Weight

Therapeutic Serum Drug Level Monitoring

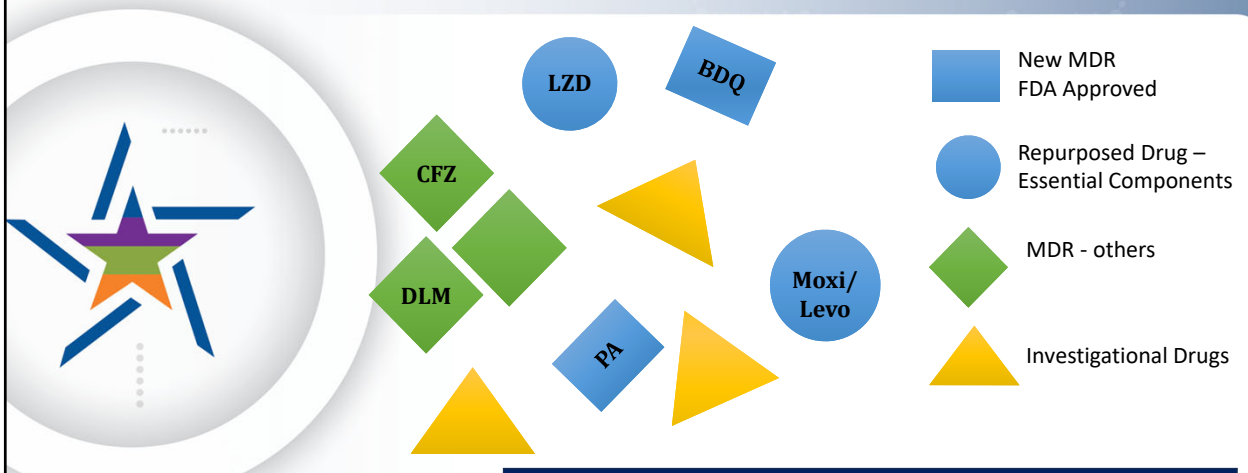
- No official absolute recommendation
- WHO and ATS/CDC/ERS/IDSA note may be helpful; especially a linezolid through
  - **Goal** is to keep linezolid trough < 2 as this seems to correlate, at least imperfectly with less toxicity
  - **Goal** also is to keep linezolid at 600 mg daily for initial 2 months if possible; WHO recommends this approach unless toxicity
  - Linezolid levels often not reproducible – be cautious with to change in dose

What else are we waiting for?

- **Expanded use of BPaLM or BPaL**
  - Children < 14 currently being studied
  - Pregnancy – currently being studied
  - CNS TB – no studies underway but some limited evidence that bedaquiline and pretomanid enter CNS
  - Other types of extra-pulmonary/ extensive TB disease
  - TB in special populations
    - Elderly
    - Transplants
    - Chemotherapy/Dialysis/Immunosuppressive medications
- **New drugs and regimens**
  - Reports of BDQ resistance and BPaL/BPaLM relapse

WHAT IS NEW?

TB Medication Soup Bowl



22 new or investigational compounds
11 from new class or new mechanism
11 potentially advantage alterations to existing drugs

BDQ – bedaquiline CFZ – Clofazimine DLM – delaminid Levo – levofloxacin LZD – linezolid Moxi – moxifloxacin PA – pretomanid

BEAT Tuberculosis (South Africa)

6BDLz (Lx, C or both) no pretomanid

Allows treatment during pregnancy and for children < 14

Study Name (Type of TB; Sample Size)	Study Arms Experimental Regimens [Control Regimen]	Key Findings
BEAT Tuberculosis NCT04062201 (RR-/MDR-TB, Pre-XDR; 374 enrolled, 199 included in interim analysis)	(a) 6BDLz (Lx, C, or both) (b) [9–12mo SOC]	**Primary Efficacy Outcome:** **The six-month bedaquiline- and delamanid-based regimen had similar efficacy to the standard-of-care regimen (ITT).** The NI margin was 10%.

87% favorable outcome

Unfavorable outcomes:		Risk difference, experimental-control (95% confidence interval)
(a)	13 (13%)	-1.4 (-10.9 to 8.1)
(b)	14 (14%)	NA

Primary Safety Outcome:
The six-month bedaquiline- and delamanid-based regimen had similar safety to the standard-of-care regimen.

	Any grade 3 or 4 AEs	Any serious AEs	Deaths
(a)	49 (25.7%)	33 (17.3%)	7 (3.7%)
(b)	51 (27.9%)	31 (16.9%)	6 (3.3%)

Similar safety and efficacy But compared to newer SOC

BDQ & Delamanid no increase cardiac toxicity

Conradie F, Phillips P, Badet T, et al. High rate of successful outcomes treating RR-TB with a delamanid-bedaquiline regimen in BEAT Tuberculosis: an interim analysis. Presented at the Union World Conference on Lung health during LBTB The Union/CDC late-breaker session on TB. 2022 November

endTB

PIPELINE REPORT 2023

BDQ or Delamanid – no pretomanid 9 months

Table 1. Key Findings from Recently Completed Treatment-Shortening Trials

Study Name (Type of TB; Sample Size)	Study Arms Experimental Regimens [Control Regimen]	Key Findings
endTB NCT02754765 (MDR-TB, N=754)	(a) 9BLzMZ (b) 9BLzLxCZ (c) 9BDLzLxZ (d) 9DLzLxCZ (e) 9DMCZ (f) [9–20mo local SOC]	**Primary Efficacy Outcome:** **Three of the five nine-month endTB regimens (a, b, c) demonstrated noninferiority to the SOC (mITT and PP analyses). Regimen b also demonstrated superiority.** The NI margin was 12%.

Met margin of non-inferiority

Favorable outcomes (mITT):			Risk difference, experimental - control (95% confidence interval)
(a)	105/118 (89.0%)	89	8.3 (-0.8 to 17.4)
(b)	104/115 (90.4%)	90.4	9.8 (0.9 to 18.7)
(c)	104/122 (85.2%)	85.2	4.6 (-4.9 to 14.1)
(d)	93/118 (78.8%)	78.8	-1.9 (-12.1 to 8.4)
(e)	89/104 (85.6%)		4.9 (-4.9 to 14.7)
(f)	96/119 (80.7%)		NA

Primary Safety Outcome:
The nine-month regimens had similar safety to the SOC regimen.

	Any grade 3 or 4 AEs	Any serious AEs	Deaths
(a)	69 (54.8%)	18 (14.3%)	3 (2.4%)
(b)	68 (55.7%)	16 (13.1%)	1 (0.8%)
(c)	78 (61.4%)	20 (15.8%)	3 (2.4%)
(d)	75 (60.5%)	18 (14.5%)	4 (3.2%)
(e)	72 (60.0%)	20 (16.7%)	2 (1.7%)
(f)	79 (62.7%)	21 (16.7%)	2 (1.6%)

Similar safety

Mitnick C, Khan U, Guglielmetti L, et al. SP01 Innovation to guide practice in MDR/RR-TB treatment: efficacy and safety results of the endTB trial. Presented at: Union World Conference on Lung Health. 2023 November 15. https://theunion.floq.live/event/worldconf2023/symposia?objectClass=timeslot&objectId=64ef5819e0400915b209e22f&type=detail.

81.5% of control regimen conformed to WHO guidance

end TB

Outcomes Non-inferior to SOC

Trial regimens		Bedaquiline	Delamanid	Clofazimine	Linezolid	Fluoroquinolone	Pyrazinamide
9BLMZ	89%	B			L	M	Z
9BCLLfxZ	90.4%	B		C	L	Lfx	Z
9BDLLfxZ	85.2%	B	D		L	Lfx	Z
9DCLLfxZ			D	C	L	Lfx	Z
9DCMZ			D	C		M	Z
Control	80.7%	Standard of care for the treatment of rifampicin-resistant and fluoroquinolone-susceptible tuberculosis. Composed according to latest World Health Organization guidelines, as they evolved during the trial. This group included mostly participants treated with the 18-month conventional regimen.					

Figure 1. Composition of endTB trial regimens

B denotes bedaquiline, L linezolid, M moxifloxacin, Z pyrazinamide, C clofazimine, Lfx levofloxacin, D delamanid

Modified 9 month all oral regimens for MDR/RR TB

WHO Consolidated TB Guidelines 2025

- **WHO suggests using** the 9-month all oral regimens (**B**LMZ, **B**LLfxCZ, and **B**DLLfxZ) over currently recommended longer (>18 months) regimens in patients with MDR/RR TB and in whom resistance to FQN has been excluded.
  - **BLMZ** > **BLLfxCZ** > **BDLLxZ**

Modified 9 month all oral regimens for MDR/RR TB

WHO Consolidated TB Guidelines 2025

- **Who suggests against** using 9-month DCLLfxZ or DCMZ regimens over currently recommended longer (>18 mo.) regimens in patients with FQN susceptible MDR/RR TB
  - Higher levels of failure or recurrence 11.2 % vs 2.5%
  - Higher levels of amplified resistance 6.7% vs 0%
  - Lower levels of death 2.8% vs 3.4%
  - Lower levels of adverse effects
- *Perhaps these regimens would be **helpful if longer?***

SimpliciTB - RIPE versus 4 months (drug susceptible) or 6 months BPaMZ(drug resistant)

Study Name (Type of TB; Sample Size)	Study Arms Experimental Regimens [Control Regimen]	Key Findings
Did not meet non-inferiority compared to HREZ **SimpliciTB** NCT03338621 (DS-TB; N=303) *Arm c was enrolled as an exploratory cohort (MDR-TB; N=152)	(a) 4BPaMZ (b) [2HRZE/4HR] (c) 6BPaMZ* Highly potent but unfavorable outcomes Hope when LZD not tolerated	**Efficacy Outcomes:** **The four-month BPaMZ regimen failed to demonstrate noninferiority to the six-month SOC for DS-TB (mITT).** The NI margin was 12%. **Favorable outcomes:** / **Risk difference, experimental - control (95% confidence interval)** (a) 118/144 (81.9%) **81.9** — 10.27 (3.06 to 17.48) (b) 134/144 (93.1%) **93.1** — NA (c) 111/133 (83.5%) **83.5** — NA **Primary Safety Outcome:** **The incidence of AEs was higher with 4BPaMZ compared to the 6-month standard of care regimen for DS-TB. A higher proportion of participants withdrew from treatment due to AEs (predominantly hepatotoxicity) in the 4BPaMZ arm.**

	Any grade 3 or 4 AEs	Any serious AEs	Deaths
(a)	68 (45.3%)	17 (11.3%)	3 (2.0%)
(b)	61 (39.9%)	7 (4.6%)	1 (0.6%)
(c)	47 (31.5%)	16 (10.7%)	2 (1.3%)

Eristavi M, Variava E, Haraka F, et al. SimpliciTB Results and Hepatic Safety of Pretomanid Regimens +/1 Pyrazinamide [OA-109]. Presented at: 2023 Conference on Retroviruses and Opportunistic Infections during Oral Abstracts Session-02 TB and Hepatitis. 2023 February 20; Seattle, Washington.

- AE = adverse event; DS-TB = drug-sensitive TB; mITT = modified intention to treat; MDR-TB = multidrug-resistant TB; N = sample size; NA = not applicable; NI = noninferiority; PP = per protocol; RR-TB = rifampicin-resistant TB; SOC = standard of care
- Numbers at the beginning of each regimen or after the forward slash (for regimens with intensive and continuation phases) represent the duration of treatment in months, unless otherwise specified
- Letters represent the individual drugs comprising each regimen: B = bedaquiline, C = clofazimine, D = delamanid, E = ethambutol, H = isoniazid, Lx = levofloxacin, Lz = linezolid, M = moxifloxacin, Pa = pretomanid, R = rifampicin, Z = pyrazinamide

SimpliciTB - RIPE versus 4 months (drug susceptible) or 6 months BPaMZ(drug resistant)

- Method was to study in drug susceptible TB to get initial information and to look for alternative 4-month regimen
  - Regimen **highly potent - 2.93 x more likely to reach culture conversion at 56 days but….**
  - Failed to meet non-inferiority due to unfavorable outcomes
    - 10% withdrew
    - Hepatotoxicity – likely due to combination of PZA and Pretomanid
      - **Stand Trial** Pretomanid/Moxifloxacin/PZA stopped due to safety. Restart allowed but TB Alliance decided to move forward with **NIX Trial** instead (BPaL).
- Drug resistant group added for safety analysis
  - Not powered for efficacy

Figure 1. Global Pipeline of Medicines in Clinical Development for TB

Phase 1	Phase 2	Phase 3	Regulatory Market Approvals
TBAJ-587	TBAJ-876	Sudapyridine (WX-081)	Bedaquiline
MK-7762 (TBD09)	TBI-223	Sitafloxacin	Delamanid
GSK-286	Delpazolid	Contezolid	Pretomanid
SPR720	Sutezolid		Linezolid
	Tedizolid		Clofazimine
	BTZ-043		Moxifloxacin
	Macozinone (PBTZ-169		Levofloxacin
	TBA-7371		
	Quabodepistat (OPC-167832)		
	Pyrifazimine (TBI-166)		
	Ganfeborole (GSK-656)		
	Telacebec (Q203)		
	Alpibectir (BVL-GSK098)		
	Sanfetrinem		
	SQ-109		

DprE1 inhibitors

Figure adapted from Stop TB Partnership Working Group on New Drugs.
Diarylquinoline; Oxazolidinone; DprE1 inhibitor; Riminophenazine Nitroimidazole; Fluroquinolone.
Drugs that appear in black font are from classes and/or with mechanisms of action not otherwise represented by the other colors.

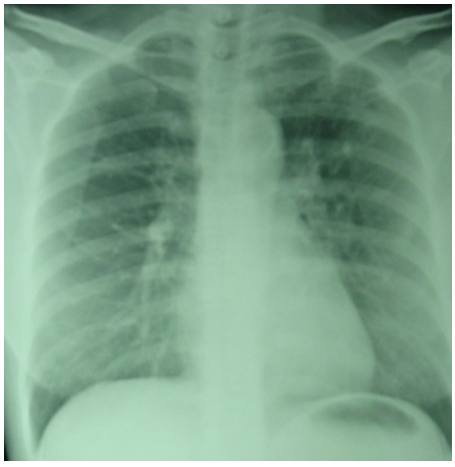
Pipeline Report 2023

Case study - new immigrant with abnormal CXR

- 62-year-old Asian male enters U.S. Sept 2022
  - Rx TB in Viet Nam 2004-2005
  - Screened overseas prior to entry
  - Evaluation in U.S.
    - Smear negative, **Xpert positive, rifampin resistance detected**
  - What additional information do we need?
  - What is the diagnosis?

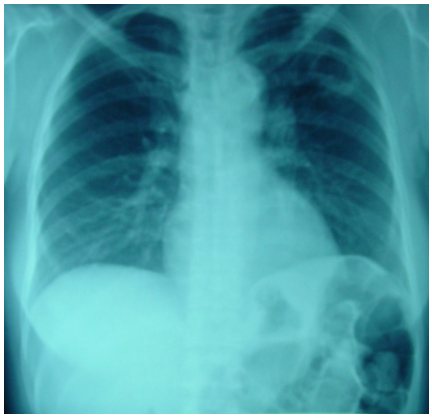
Case study new immigrant with abnormal CXR

- Overseas screen
  - CXR May 2022
    - Linear opacity LUL
  - Sputum x 3 smear and culture negative
  - Asymptomatic
- Plan: follow up in U.S. on arrival



Case study new immigrant with abnormal CXR

- CXR September 2022
  - Smear negative x 3
  - Xpert + MTB, + rifampin **R**
    - **Probe E dropout –**
    - **not sent for MDDR (Quest Lab)**
  - **New cavity LUL**



Case Study new immigrant with abnormal CXR

- 62-year-old Asian male enters U.S. Sept 2022
  - Rx TB in Viet Nam 2004-2005
    - **9 months including Injectable?**
    - **Possible FQN, linezolid or BDQ use?**
    - **DOT, ? Urine orange (rifampin) ? Adherence? Cured?**
  - What concerns are there?
    - **Non-standard regimen**
    - **Additional resistance?**
      - **Moxifloxacin – probably not but possible**
      - **Linezolid - very likely isolate is susceptible**
      - **Bedaquiline - likely isolate is susceptible**
      - **Pretomanid - likely isolate is susceptible**
  - Screened overseas prior to entry
    - **Results of CXR and sputum smears/cultures**
  - Evaluation in U.S.
    - **Smear negative, Xpert positive, rifampin resistance detected**

Case Study new immigrant with abnormal CXR

- 62-year-old Asian male enters U.S. Sept 2022
  - Rx TB in Viet Nam 2004-2005 - **9 months including Injectable**
  - What concerns are there?
    - **Non-standard regimen**
    - **INH, ethambutol and PZA compromised as well as streptomycin**
    - **Additional resistance?**
      - **Moxifloxacin – probably not but possible**
      - **Linezolid - very likely isolate is susceptible**
      - **Bedaquiline - very likely isolate is susceptible**
      - **Pretomanid - very likely isolate is susceptible**
  - Evaluation in U.S.: **Smear negative, Xpert positive, rifampin resistance detected**
    - **New CXR with cavity**
    - **Culture did not grow**
  - **What is diagnosis?**

Case Study new immigrant with abnormal CXR

- **What is diagnosis?**
  - Active TB disease
    - New radiographic change (cavity) and positive Xpert
    - With smears negative x 6 and only one of two + Xpert very likely low numbers of mycobacteria in sputum
    - Very possible that all cultures will be negative
    - Likely will diagnosis at least as culture negative TB
- **What should we treat with?**
  - Drugs unlikely that mycobacteria are resistant to
    - **Best option: BPaLM**
- **Follow for CXR improvement, clinical improvement (may be subtle), and to see if later cultures turn positive**

When do we worry about bedaquiline resistance?

Assessment of epidemiological and genetic characteristics and clinical outcomes of resistance to bedaquiline in patients treated for rifampicin-resistant tuberculosis: a cross-sectional and longitudinal study

Lancet Infect Dis 2022; 22: 496-506

Nazir Ahmed Ismail*, Shaheed Vally Omar*, Harry Moultrie*, Zaheda Bhyat, Francesca Conradie, M Enwerem, Hannetjie Ferreira, Jennifer Hughes, Lavania Joseph, Yulene Kock, Vancy Letsaolo, Gary Maartens, Graeme Meintjes, Dumisani Ngcamu, Nana Okozi, Xavier Padanilam, Anja Reuter, Rodolf Romero, Simon Schaaf, Julian te Riele, Ebrahim Variava, Minty van der Meulen, Farzana Ismail†, Norbert Ndjeka†

- 8041 patients starting BDQ-based treatment had samples collected at baseline, month 2, month 6
- Baseline BDQ resistance was 3.8%
  - BDQ naïve 72/2023, 3.6%
  - Prior BDQ or clofazimine, 4/19, 21.1%
- BDQ resistance associated with previous exposure to BDQ or clofazimine (OR 7.1)
- Rv0678 mutations were associated with resistance
- Resistance emerged in 12/695 (2.3%) of patients on treatment with median time to emergence of 90 days (range 21-654 days)
- Successful treatment outcomes were lower in patients with BDQ resistance

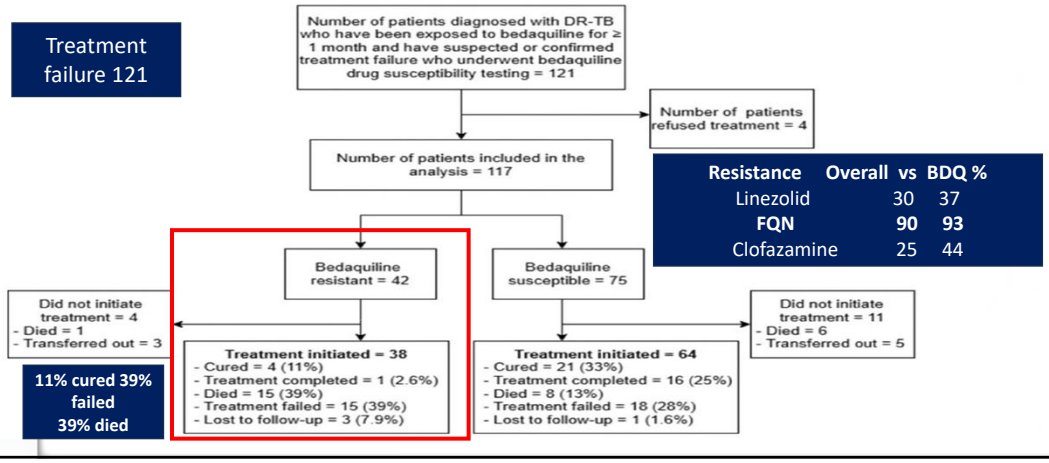
Clinical Infectious Diseases
MAJOR ARTICLE

Bedaquiline Resistance and Treatment Outcomes Among Patients With Tuberculosis Previously Exposed to Bedaquiline in India: A Multicentric Retrospective Cohort Study

July 2024

Rupak Singla,[1] Samsuddin Khan,[2,a,©] Arunima Silsarma,[2,a] Vijay Chavan,[2,a,©] Raman Mahajan,[2,a,©] Homa Mansoor,[2] Ravindra Kumar Devan,[1] Neeta Singla,[1,©] Manpreet Bhalla,[1] Gavish Kumar,[1] Pramila Singh,[2] Aparna Iyer,[2] Mabel Morales,[2,b] Satish Chandra Devkota,[2] Alpa Dalal,[3] Hannah Spencer,[4,a] and Petros Isaakidis[4,5,a,©]

Treatment failure 121



Resistance	Overall	vs BDQ %
Linezolid	30	37
FQN	**90**	**93**
Clofazamine	25	44

11% cured 39% failed 39% died

end TB (9 month regimens)

WHO now recommends #1-3 and if BDQ resistance #4

Non-inferior to SOC

Higher failure & acquired drug resistance

Superior

Trial regimens	Bedaquiline	Delamanid	Clofazimine	Linezolid	Fluoroquinolone	Pyrazinamide
9BLMZ	B			L	M	Z
9BCLLfxZ	B		C	L	Lfx	Z
9BDLLfxZ	B	D		L	Lfx	Z
9DCLLfxZ		D	C	L	Lfx	Z
9DCMZ		D	C		M	Z
Control	Standard of care for the treatment of rifampicin-resistant and fluoroquinolone-susceptible tuberculosis. Composed according to latest World Health Organization guidelines, as they evolved during the trial. This group included mostly participants treated with the 18-month conventional regimen.					

Figure 1. Composition of endTB trial regimens

B denotes bedaquiline, L linezolid, M moxifloxacin, Z pyrazinamide, C clofazimine, Lfx levofloxacin, D delamanid

9mo D-C-Lzd-Lfx-Z may give an option other than older individualized regimen when isolate is resistant to or patient is intolerant to Bedaquiline –

MDR-END 9 D-Lfx-Lzd-Z No BDQ or Pretomanid (Korea)

MDR-END
NCT02619994
(MDR-TB; 214; PLHIV not included)

(a) 9DLzLxZ
(b) [20mo IA-containing regimen]

Non – inferior to SOC but longer regimen with IA Had a better outcome 75% versus 70.6%

Primary Efficacy Outcome:
The nine-month delamanid-based regimen demonstrated non-inferiority to a 20-month injectable-containing regimen–the standard of care in 2014 (mITT). The NI margin was -10%.

Unfavorable outcomes:		**Risk difference, experimental-control (95% confidence interval)**
(a)	25 (29.4%)	4.4 (-9.5 to ∞)
(b)	18 (25%)	NA

Primary Safety Outcome:
No statistically significant differences in safety were detected between arms.

	Any grade 3 or 4 AEs	Any serious AEs	Deaths
(a)	29 (36.7%)	20 (25.3%)	5 (6%)
(b)	26 (29.2%)	19 (21.3%)	2 (2%)

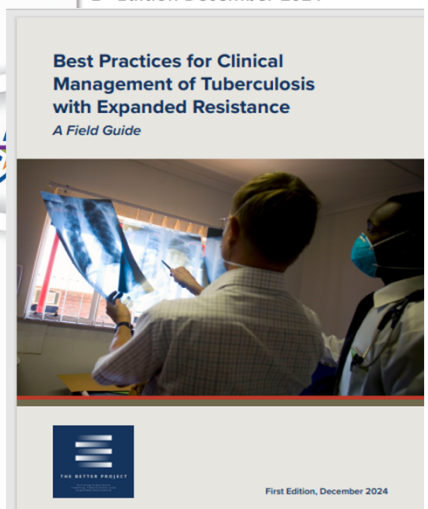
Mok J, Lee M, Kim DK, et al. 9 months of delamanid, linezolid, levofloxacin, and pyrazinamide versus conventional therapy for treatment of fluoroquinolone-sensitive multidrug-resistant tuberculosis (MDR-END): a multicentre, randomised, open-label phase 2/3 non-inferiority trial in South Korea. Lancet. 2022 Oct 29;400(10362):1522–1530. doi: 10.1016/S0140-6736(22)01883-9.

Back to Buidling Individualized Regimens

The Better Projec

Best Practices for Clinical Management of TB with Expanded Resistance

1st Edition December 2024



When designing an individualized regimen for a person with TB who has possible or known expanded resistance, consideration should be given to both the WHO groupings and the bactericidal/sterilizing activity. Regimens need to include a combination of drugs that are bactericidal and drugs that are sterilizing. We suggest the following steps below:

Step 1: Choose as many core drugs as you can

Core drugs are group A drugs that are both sterilizing and bactericidal and include Bdq, Lzd and the third-generation Flqs.

These drugs should be included if susceptibility is documented or uncertain. If low-level resistance has been demonstrated, the third-generation Flqs can be given at higher doses. High-dose Bdq could also be considered. Of note, for high-dose Bdq, there are no clinical studies that demonstrate the effectiveness of this approach. Rather, it is based on modeling data. If high-dose Bdq is given, it should be only done so when there are no other options and when there is close monitoring for toxicity.

Step 2: Choose as many oral agents as you can for their bactericidal activity, including a nitroimidazole (Pa or Dlm) and/or Cs. Depending on the resistance mutations detected, then either high-dose Inh could be given (if only an *inhA* mutation) or Eto (if only a *katG* mutation).

Step 3: Choose from the following oral agents for their sterilizing activity as you need to construct a 5-drug regimen:

Sterilizing: Pza (if susceptible), Cfz

Step 4: Choose as many injectable agents for their bactericidal activity as you need to construct a 5-drug regimen including Am and the carbapenems + clavulanic acid. It is essential that regimens have sufficient numbers of bactericidal agents, especially in the first weeks/months of treatment and thus many individualized regimens will need to have one of these injectable drugs. Of note, some experts would place step 4 above step 3 in the regimen design process to ensure there are adequate bactericidal drugs.

Step 5: Choose other drugs if more are needed to reach a total of at least 5 effective drugs in the regimen

Bactericidal: PAS, Emb (if susceptible), rifabutin (if there is susceptibility to rifabutin demonstrated, although in most settings, testing to this drug is not available nor is the drug).

Step 6: Consider pre-approval access/compassionate use drugs

Please see the section on pre-approval access for more details. Some possible agents that have already completed at least phase 2b include quabodepistat, ganfeborole, and telacebec.

Conclusions

- Treatment regimens for TB are shortening
- Fluoroquinolones are playing a larger role in TB treatments
- TB treatment regimens for drug resistant TB in the US and worldwide increasingly contain BDQ, FQNs and linezolid.
- Mechanisms for testing and surveillance need to grow in the direction the treatment regimens are taking us