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Antifungal susceptibility testing practices in mycology laboratories in France, 2018

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Abstract

A survey of mycology laboratories for antifungal susceptibility testing (AFST) was undertaken in France in 2018, to better understand the difference in practices between the participating centers and to identify the difficulties they may encounter as well as eventual gaps with published standards and guidelines. The survey captured information from 45 mycology laboratories in France on how they perform AFST (number of strains tested, preferred method, technical and quality aspects, interpretation of the MIC values, reading and interpretation difficulties). Results indicated that 86% of respondents used Etest as AFST method, with a combination of one to seven antifungal agents tested. Most of the participating laboratories used similar technical parameters to perform their AFST method and a large majority used, as recommended, internal and external quality assessments. Almost all the participating mycology laboratories (98%) reported difficulties to interpret the MIC values, especially when no clinical breakpoints are available. The survey highlighted that the current AFST practices in France need homogenization, particularly for MIC reading and interpretation.

Key words: antifungal susceptibility testing; Etest; MIC value interpretation; laboratory practice

1 **Introduction**

2 *In vitro* antifungal susceptibility testing (AFST) is required to determine the best treatment for
3 a specific fungal species [1-3] and to detect resistance. Two reference techniques (Clinical
4 Laboratory Standards Institute (CLSI) and European Committee on Antimicrobial
5 Susceptibility Testing (EUCAST)), that are both microdilution methods, are available [4-7] but
6 rarely incorporated in the routine hospital workflow because they are time-consuming and
7 laborious [8]. Commercial techniques (microdilution systems or strip test on solid media),
8 which are simple, rapid and cost effective, are generally the AFST methods applied in routine
9 daily practice by mycology laboratories.

10 The main difficulties encountered by the microbiologists while performing AFST are i) the
11 choice of the clinical breakpoints (CBs) which are validated for the reference techniques (CLSI
12 and EUCAST) but not for the commercial techniques; ii) the CBs availability only for a few
13 species, recognized as the most frequently isolated (such as *Candida albicans*, *C. glabrata*, *C.*
14 *krusei*, *C. parapsilosis*, *C. tropicalis*, and *Aspergillus fumigatus*) and only for a few antifungal
15 agents (fluconazole, posaconazole, itraconazole, voriconazole, and echinocandins, mostly); iii)
16 the possible confusion between CBs and epidemiological cut-off values (ECOFFs/ ECVs), and
17 thus interpretation difficulties.

18 In this context, a survey was undertaken in 2018 to clarify the current practices of the mycology
19 laboratories for AFST: type of method used, criteria to perform and interpret AFST, detailed
20 technical parameters and quality aspects. The preliminary results of this survey were presented
21 and discussed during a national meeting organized by the French Society of Medical Mycology
22 in Paris in November 2018.

23

24

25

26 **Methods**

27 In November 2018, a meeting dedicated to AFST was organized by the French Society of
28 Medical Mycology. Before the meeting, in September 2018, an online survey was performed
29 to assess the practices of AFST in mycology laboratories in France. All the mycology
30 laboratories within University Hospitals in France were contacted. Additionally, all
31 microbiologists registered to the meeting were also enrolled in the survey. The original
32 questionnaire was designed by the organizers of the meeting and first beta-tested by two
33 mycologists not involved in its set-up. After modifications, the final questionnaire was uploaded
34 in a web-based electronic platform. The electronic questionnaire consisted of 43 questions
35 divided into 16 sections (Suppl Material 1). Briefly, the survey included questions on i) the type
36 of center (type of hospital, number of hospital beds), ii) the mycology laboratory activity
37 (number of fungal isolates tested, type of method used for AFST, antifungal agents
38 systematically tested for yeast and filamentous fungi, way of interpreting the MIC value,
39 screening for emerging resistant species), iii) technical aspects such as method for inoculum
40 preparation, temperature of incubation, incubation time and rules used for reading MICs and
41 iv) quality aspects (internal and external quality assessments). Laboratories failing to respond
42 initially were contacted by personalized emails. All data were downloaded from the platform
43 and analyzed in Microsoft Excel (Office 365).

44

45 **Results**

46 *Study participants and AFST activity*

47 Among the 48 French mycology laboratories contacted, a total of 45 answered the e-
48 questionnaire (overall response rate of 94%). A majority (82%) of the participants were
49 University Hospital mycology laboratories. The size of the participating hospitals varied from
50 less than 500 beds (7%), between 500 and 1500 beds (41%), to more than 1500 beds (52%).

51 A majority (77%) of the participating mycology laboratories (PML) performed antifungal
52 susceptibility testing (AFST) on more than 150 fungal isolates per year. A ratio was calculated
53 to assess the number of fungal isolates tested according to the size of the hospital (number of
54 beds). Most of the PML (72%) tested annually 100 to 500 fungal isolates per 1000 beds, 14%
55 tested less than 100 fungal isolates per 1000 beds and 14% more than 500 fungal isolates per
56 1000 beds. All the PML performed AFST on both yeasts and filamentous fungi except five
57 centers which tested only yeasts, all of which but one, were non-university hospitals. AFST was
58 more often performed on yeasts than on filamentous fungi with 60% of the PML testing 100 to
59 500 yeasts per year and 58% testing at least 50 filamentous fungi. Among the PML that tested
60 both yeasts and filamentous fungi, the percentage of AFST performed against filamentous fungi
61 ranged from 1 to 39%.

62 The three situations mainly triggering AFST were “yeast isolates from deep sites” (86%),
63 “isolates from blood cultures” (91%) and “case-by-case decision of the microbiologist” (79%)
64 (Table 1).

65 ***Methods of AFST***

66 The Etest was the most frequently used method (86%) to perform AFST. The laboratories
67 performing AFST with Etest tested from one to seven antifungal drugs against yeasts, whereas
68 the five Sensititre YeastOne users tested nine drugs. For yeasts (Figure 1A), all centers using
69 Etest tested fluconazole, 97% at least one echinocandin and 41% tested 5-fluorocytosine (5FC).
70 Among the PML using Etest for AFST, 85% of them used routinely a combination of at least
71 four antifungal molecules to test yeasts (one echinocandin, fluconazole, voriconazole and
72 amphotericin B). Among the PML testing only one echinocandin (n=20), 50% chose
73 caspofungin, 15% micafungin, and 35% anidulafungin. Among the PML testing two
74 echinocandins (n=13), 85% associated caspofungin and micafungin. The four molecules more

75 often tested against filamentous fungi by Etest (Figure 1B) were voriconazole (100%),
76 amphotericin B (97%), posaconazole (86%) and itraconazole (71%).

77 ***Technical parameters of AFST***

78 Concerning the technical aspects of AFST, the PML generally used a spectrophotometrically
79 adjusted inoculum for yeasts (78%) and filamentous fungi (76%) (Table 2). A large majority of
80 the PML used an incubation at $35^{\circ}\text{C} \pm 2^{\circ}\text{C}$, both for yeasts (95%) and filamentous fungi (84%)
81 (Table 2). A majority of PML declared reading the MIC results first after 24h of incubation,
82 and reading them again after 48h, both for *Candida* spp. (67%) and *Aspergillus* spp. (58%)
83 (Table 2). Among the 39 PML using Etest on yeasts, 100% read amphotericin B (AMB) MIC
84 at complete inhibition, 97% read azole MIC at partial inhibition, 53% and 47% read
85 echinocandin MIC at complete or partial inhibition, respectively (Figure 2A). Concerning the
86 reading of the MIC against filamentous fungi, 97% of the PML using Etest read AMB MIC at
87 complete inhibition, 73% read azole MIC at complete inhibition, and 79% read echinocandin
88 MIC at partial inhibition (Figure 2B).

89 ***Internal quality assessment (IQA) and external quality assessment (EQA) (Table 3)***

90 A majority of the PML used an IQA (78%) made of an ATCC strain (76%), that was performed
91 either for each new batch delivery (42%) or at least monthly (52%) (Table 3). The two most
92 frequently used ATCC strains used were *Candida krusei* ATCC 6258 (76%) and *C. parapsilosis*
93 ATCC 22019 (67%). Seventy percent of the PML subscribed to at least one of the several EQA
94 available in France (UKNEQAS, ABP, Prospective biology, AGLAE, LABQUALITY and
95 RCPA QAP). Overall, 89% of the PML used either an IQA or an EQA and 62% used both IQA
96 and EQA.

97 ***MIC interpretation and reporting of results***

98 Forty-six percent of the PML used the EUCAST clinical breakpoints (CBs), when available, to
99 interpret the MIC values (as Susceptible/Intermediate/Resistant), and a large majority (89%)

100 declared reporting the interpretation of the MIC values on the medical report (Table 4). In the
101 absence of CBs for the species tested, 58% of the PML declared reporting the MIC values
102 without interpretation, while others interpret MIC values based either on CBs from other species
103 or based on ECOFF/ECVs (Figure 3). Most of those trying to interpret the MIC values in
104 absence of CBs discussed the case directly with the physician in charge (53%) (Figure 3).
105 Almost all the PML (98%) declared that the interpretation of MIC values was their main
106 problem encountered during AFST and 40% reported difficulties with MIC values reading
107 (Table 4).

108 *Screening of resistant strains*

109 Considering emerging antifungal resistant species, only a minority (11%) of the PML had
110 already incorporated into their routine work flow the screening for azole-resistant *Aspergillus*
111 *fumigatus* strains and even less of them (7%) used molecular techniques to detect antifungal
112 resistance in yeasts.

113

114 **Discussion**

115 This survey showed that AFST is performed by a majority of the PML both on yeasts and
116 filamentous fungi. The present survey highlighted some common practices: similar commercial
117 method used (Etest), similar AFST indication criteria (0% systematically, 86% yeast isolates
118 from deep sites, 91% isolates from blood culture, 79% case-by-case discussion), similar panels
119 of antifungal agents tested (a combination of four antifungals for more than 80% of the PML),
120 similar applied technical parameters (inoculum preparation and temperature of incubation).

121 This survey also showed that the mycologists face some difficulties while performing AFST.
122 The first issue is the reading of MIC values: the Etest manufacturer is unclear about the fact
123 that the reading should be made at 24h or at 48h. In the present survey, 67% of the PML declared
124 reading twice the MIC values for yeasts, 1st at 24h and a 2nd time at 48h. Considering that the

125 MIC value read at 48h may change the categorization (Susceptible / Intermediate / Resistant)
126 of the microorganism compared to the MIC value read at 24h, the optimal time for MIC reading
127 remains to be defined. This variation of the incubation time (e.g. 24h vs 48h) may explain some
128 low essential agreements between Etest and reference methods reported in the literature [9].
129 Therefore, new studies for determination of the optimal reading time are warranted. Moreover,
130 the time of reading probably differs according to the type of fungal microorganisms, depending
131 on their ability to grow more or less rapidly (yeasts vs molds for example). The manufacturer
132 and/or the French Society of Medical Mycology (or other international societies) should provide
133 clear recommendations on the optimal time of reading, detailed per group of fungal species. In
134 the same way, only 40% of the PML reported that the reading of the MIC value was a problem.
135 Nevertheless, they reported that MICs were read according to different criteria, especially for
136 the echinocandins against yeasts (about half/half of the PML read these MICs either at complete
137 inhibition or at partial inhibition). Reading at partial inhibition is more complex and more
138 subjective, as some parameters, such as the size of the colonies, may influence the MIC value.
139 It should be noted that there is clear guidance, supplied by the manufacturers of Etest, for
140 reading of micro- versus macro-colonies within the zone of inhibition to aid with result
141 interpretation [10]. Again, more detailed recommendations provided by both the manufacturer
142 and the French Society of Medical Mycology (or other international societies) would be helpful
143 to standardize MIC values determination.

144 The second issue is the choice of the drug to be tested for echinocandins. Caspofungin is the
145 most often tested molecule, while some PML are testing two molecules (mostly caspofungin
146 and micafungin). It has been clearly shown that caspofungin should not be tested with CLSI or
147 EUCAST methodology due to inter-laboratory variability [11]. Therefore, micafungin or
148 anidulafungin should be used as a marker of class for echinocandin susceptibility when using
149 these reference microbroth dilution techniques. Although, there are few evidences that this

150 problem also applied with Etest, a recent literature analysis showed that anidulafungin is
151 probably the best choice for testing echinocandins against *Candida* spp. by Etest [12].

152 The third main issue is that the interpretation of MICs is not always performed according to
153 recommendations: while about 86% of the PML use Etest as routine AFST method, only 38%
154 use the recommended CLSI CBs to interpret MIC values [10], while 46% use the EUCAST
155 CBs. This discrepancy may be explained by the fact that more data are available with EUCAST
156 in terms of species diversity and antifungal agents. It should be highlighted that CBs are
157 method-specific, and laboratories should not choose to use alternative CBs either due to better
158 availability or comfort. Applying non-CLSI breakpoints to MICs obtained by Etest may result
159 in some mis-interpretations of MICs (as the two sets of CBs are different), therefore, this
160 practice should be avoided. In contrast, when no CBs are available, about 31% of the PML
161 already use the ECOFFS/ECVs, showing that they are familiar with these criteria. Recently
162 published works proposing specific ECOFFS/ECVs, for Etest, for a large panel of species,
163 should be helpful to extend this attitude and help to categorize an isolate as wild-type or non-
164 wild-type [13-15].

165 Another point is that this survey, performed in 2018, showed that a large majority (89%) of the
166 PML used either an IQA or an EQA, many of them (62%) using both. This demonstrates that
167 quality assessment is a major preoccupation of mycologists performing AFST. In contrast, this
168 survey showed that systematic routine screening of resistance was performed by very few PML
169 ($\approx 10\%$) in 2018. As early detection of azole resistance in *Aspergillus fumigatus* is now
170 recommended [3] and may be important for management of patients with aspergillosis,
171 measures should be taken to improve a more widespread use of resistance screening.

172

173 **Conclusion**

174 A majority of French mycology laboratories are routinely using Etest as AFST method, both
175 for yeasts and filamentous fungi. If several parameters are similar between the 45 PML, the two
176 main issues that highlighted this survey were: the reading and the interpretation of MIC value.
177 Detailed guidelines and instructions are needed to standardize AFST practices, which could be
178 implemented by both the manufacturer and the French Society of Medical Mycology (or other
179 international societies).

180

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185

186 **Conflict of interest**

187 During the past 5 years:

188 Eric Dannaoui has received research grants from MSD and Gilead: travel grants from Gilead,
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208

References

- [1] Cuenca-Estrella M, Verweij PE, Arendrup MC, Arikan-Akdagli S, Bille J, Donnelly JP, et al. ESCMID* guideline for the diagnosis and management of *Candida* diseases 2012: diagnostic procedures. Clin Microbiol Infect 2012;18 Suppl 7:9-18.
- [2] Pappas PG, Kauffman CA, Andes DR, Clancy CJ, Marr KA, Ostrosky-Zeichner L, et al. Clinical practice guideline for the management of candidiasis: 2016 update by the Infectious Diseases Society of America. Clin Infect Dis 2016;62(4):e1-e50.
- [3] Ullmann AJ, Aguado JM, Arikan-Akdagli S, Denning DW, Groll AH, Lagrou K, et al. Diagnosis and management of *Aspergillus* diseases: executive summary of the 2017 ESCMID-ECMM-ERS guideline. Clin Microbiol Infect 2018;24 Suppl 1:e1-e38.
- [4] Arendrup MC, Meletiadis J, Mouton JW, Lagrou K, Hamal P, Guinea J, et al. Method for the determination of broth dilution minimum inhibitory concentrations of antifungal agents for yeasts. EUCAST definitive document E.Def 7.3.1. 2017.
- [5] Arendrup MC, Meletiadis J, Mouton JW, Lagrou K, Hamal P, Guinea J, et al. Method for the determination of broth dilution minimum inhibitory concentrations of antifungal agents for conidia forming moulds. EUCAST definitive document E.Def 9.3.1. 2017.
- [6] Clinical and laboratory Standards Institute (CLSI). Reference method for broth dilution antifungal susceptibility testing of filamentous fungi, 2nd ed. Approved standard. Document M-38A2. Clinical and Laboratory Standards Institute, Wayne, Pa; 2008.
- [7] Clinical and laboratory Standards Institute (CLSI). Reference method for broth dilution antifungal susceptibility testing of yeasts; Approved standard - third edition. CLSI document M27-A3. Clinical and Laboratory Standards Institute, Wayne, Pa; 2008.

- [8] Alastruey-Izquierdo A, Melhem MS, Bonfietti LX, Rodriguez-Tudela JL. Susceptibility test for fungi: clinical and laboratorial correlations in medical mycology. *Rev Inst Med Trop Sao Paulo* 2015;57 Suppl 19:57-64.
- [9] Dannaoui E, Espinel-Ingroff A. Antifungal susceptibility testing by concentration gradient strip Etest method for fungal isolates, a review. *J Fungi* 2019;5(4):108.
- [10] BioMérieux SA. Etest antifungal susceptibility testing package insert. BioMérieux SA, Marcy-l'Etoile, France. 2013.
- [11] Espinel-Ingroff A, Arendrup MC, Pfaller MA, Bonfietti LX, Bustamante B, Canton E, et al. Interlaboratory variability of caspofungin MICs for *Candida* spp. using CLSI and EUCAST methods: should the clinical laboratory be testing this agent? *Antimicrob Agents Chemother* 2013;57(12):5836-42.
- [12] Espinel-Ingroff A, Dannaoui E. Should Etest MICs for yeasts be categorized by reference (BPs/ECVs) or by Etest (ECVs) cutoffs as determinants of emerging resistance? *Current Fungal Infection Reports* 2020.
- [13] Espinel-Ingroff A, Arendrup M, Canton E, Cordoba S, Dannaoui E, Garcia-Rodriguez J, et al. Multicenter study of method-dependent epidemiological cutoff values for detection of resistance in *Candida* spp. and *Aspergillus* spp. to amphotericin B and echinocandins for the Etest agar diffusion method. *Antimicrob Agents Chemother* 2017;61(1):e01792-16.
- [14] Espinel-Ingroff A, Turnidge J, Alastruey-Izquierdo A, Botterel F, Canton E, Castro C, et al. Method-dependent epidemiological cutoff values for detection of triazole resistance in *Candida* and *Aspergillus* species for the Sensititre YeastOne colorimetric broth and Etest agar diffusion methods. *Antimicrob Agents Chemother* 2019;63(1):e01651-18.

- [15] Salse M, Gangneux JP, Cassaing S, Delhaes L, Fekkar A, Dupont D, et al. Multicentre study to determine the Etest epidemiological cut-off values of antifungal drugs in *Candida* spp. and *Aspergillus fumigatus* species complex. Clin Microbiol Infect 2019;May 11:DOI: 10.1016/j.cmi.2019.04.027.

Table 1. Responses to the questionnaire considering AFST strategy (several answers by PML were possible).

In which situation do you perform AFST?	%
For all isolates systematically	0
For all isolates from blood cultures	91
For all patients treated with ATF	20
For all yeast isolates from deep sites	86
Decided by the microbiologist, on a case-by-case basis	79

AFST: Antifungal susceptibility testing; ATF: antifungal; PML: participating mycology laboratories.

Table 2. Responses to the questionnaire considering technical parameters of AFST by Etest

How do you prepare your inoculum for AFST for yeasts?	%
Mc Farland spectrometer	78
Mc Farland by eye	15
Inoclic [®] (I2A)	2
Densitometer	5
How do you prepare your inoculum for AFST for filamentous fungi?	
Mc Farland spectrometer	76
Mc Farland by eye	19
Inoclic [®] (I2A)	3
Densitometer	2
At which temperature do you incubate your AFST method for yeasts?	
35 ± 2°C	95
30 ± 2°C	5
At which temperature do you incubate your AFST method for filamentous fungi?	
35 ± 2°C	84
27 ± 2°C	8
30 ± 2°C	5
27°C if non thermophilic species and 35°C if thermophilic species	3
When do you read the AFST results for yeasts?	
First reading at 24h, then second reading at 48h	67
A 24h reading only	20
A 48h reading only	13
When do you read the AFST results for filamentous fungi?	
First reading at 24h, then second reading at 48h	58
A 24h reading only	27
A 48h reading only	15

Table 3. Responses to the questionnaire considering quality aspect of AFST

Do you use an intern quality assessment (IQA)?	%
Yes	78
No	22
Do you use an ATCC strain as IQA?	
Yes	76
No	24
More specifically, which ATCC strain do you use as IQA?*	
<i>Candida krusei</i> ATCC 6258	76
<i>C. parapsilosis</i> ATCC 22019	67
<i>C. albicans</i> ATCC 90028	35
<i>C. krusei</i> ATCC 12243	3
<i>C. tropicalis</i> ATCC 1369	3
<i>Aspergillus fumigatus</i> ATCC 204305	44
<i>Aspergillus flavus</i> ATCC 204304	6
At which frequency do you test the IQA?	
At each change of reagent batch	42
Monthly (at least)	52
Less frequently than monthly	6
Do you use extern quality assessment (EQA)?	
Yes	70
No	30

*Several strains used per PML

Table 4. Responses to the questionnaire considering MIC interpretation

How do you interpret the MIC value to classify the strain S/I/R	
EUCAST clinical breakpoints (CB)	46
CLSI CB	27
CB recommended by the manufacturer (CLSI for Etest)	11
ECOFFs /ECVs	4
Other	16
Do you write the interpretation of the MIC values on the medical report?	
Yes	89
No	11
What is the main problem that you encounter while performing ATFS testing?	
Reading	40
MIC interpretation	98

Figure legends

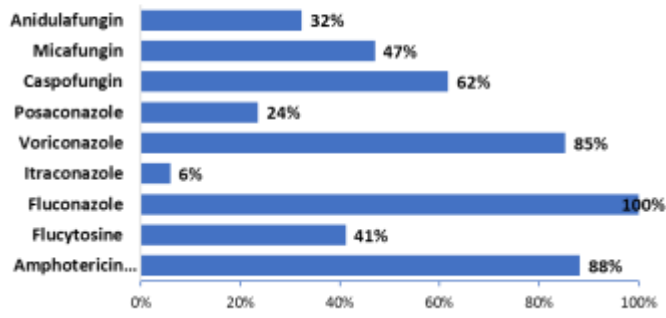
Figure 1: Antifungal tested against yeasts (1A) and filamentous fungi (1B) by laboratories using Etest for AFST

Figure 2: Type of reading of the MIC value for yeasts (2A) and fungi (2B) for azole, echinocandins and amphotericin B

Figure 3: Details of MIC interpretation in absence of clinical breakpoints available.

Figure 1

A



B

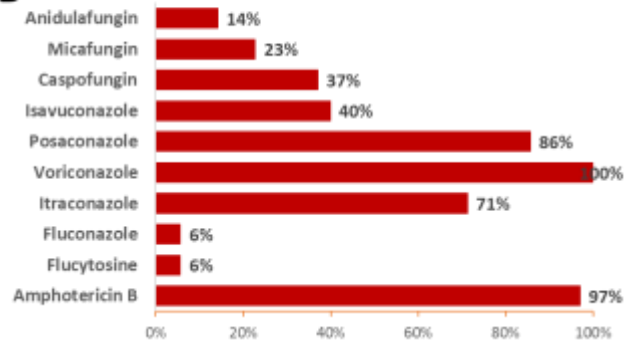


Figure 2

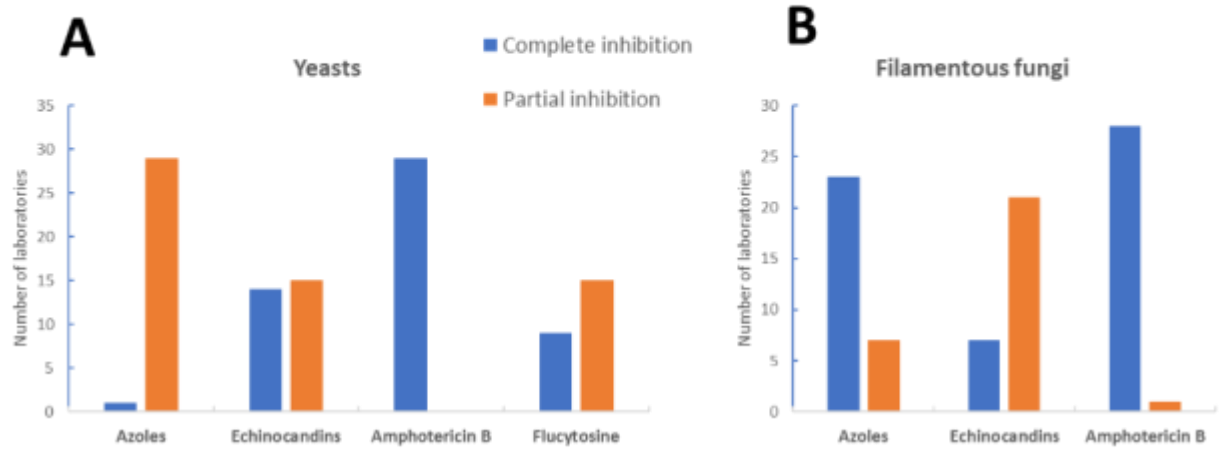
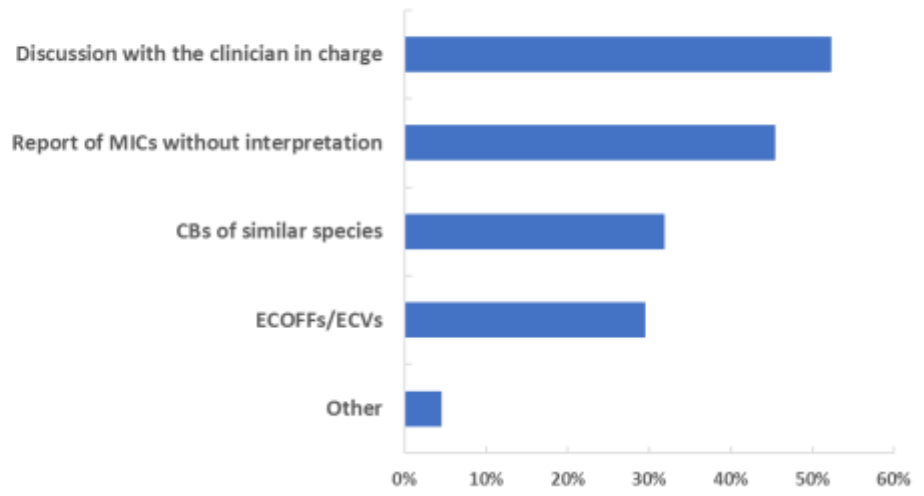


Figure 3



Supplementary Material 1

Questionnaire concernant vos pratiques des tests de sensibilité aux antifongiques

Ceci est une enquête des pratiques et pas une évaluation de la qualité des laboratoires. Nous souhaiterions donc des réponses reflétant les pratiques quotidiennes même si celles-ci ne sont pas en accord avec les recommandations des fournisseurs ou les recommandations de la littérature. Les réponses seront anonymisées et les résultats traités de façon confidentielle.

Informations - Hôpital - Laboratoire

Pour l'hôpital, ne pas compléter les lib de long séjour et de soins de suite

1. Hôpital Nom

2. Hôpital Type

Une seule réponse possible:

CHU

CHG

Autre : _____

3. Hôpital, Nombre de lits (hôpital/clinique conventionnelle et HDJ) (approximatif)

4. Laboratoire, Nom

5. Activité en D-BHM / an (approximatif)

6. Nom du biologiste ayant complété le questionnaire

7. Email du biologiste ayant complété le questionnaire
