AMPHOTERICIN-B: A DRUG APPROACH IN FUNGAL TREATMENT

MR. ASHOK KUMAR SHARMA¹, MR. MEHUL CHOUDHARY², DR. S.P GUPTA³

¹Asso. Professor, Arya College of Pharmacy, Kookas, Jaipur. Rajasthan ²Asso. Professor, Arya College of Pharmacy, Kookas, Jaipur. Rajasthan ³Professor, Department of Pharmaceutical Science and Technology, AKS University, Satna, MP

Abstract—Amphotericin B (AmB) is a polyene macrolide class of antifungal agent and it is the drug of choice for systemic fungal infection, but unfortunately, oral bioavailability of this drug is negligible due to its low aqueous solubility. Amphotericin-B is a potent and effective antifungal medication used for serious fungal infections. It is used to aspergillosis, treat blastomycosys, candidiasis and cryptococcosis and many other fungal infection. It is typically given by injection into a vein, now a day's it used topically like-cream and gel. Common side effects fever, chills, headaches and Naphrotoxicity (kidney problem). Amphotericin-B act as forming pores in cell membrane that causes leakage of monovalent ions and subsequent fungal cell death.

Keywords— Antifungal, Polyene Macrolide, Blastomycosys, Bioavailability, Leishmaniasis, Aspergillosis.

I. INTRODUCTION

We Fungi are large organisms that typically survive on dead rotting animal and plant matter. They are found mostly in soil, an object contaminated with soil, on plants and animals skin, and that they may additionally be airborne. Fungi may exist as yeasts or molds and will alternate between the 2 forms, looking on environmental conditions. Yeasts are simple cells, 3 to 5 micrometres (0.0001 to 0.0002 inch) in diameter. Molds include filamentous branching structures (called hyphae), 2 to 10 micrometres in diameter, that are formed of several cells lying end to finish.[1-6] Fungal diseases in humans are called mycoses; they include such disorders as histoplasmosis, coccidioidomycosis, blasto nmycosis, Mucormycosis.

A. Transmission

Fungi cells always reproduced by spreading single celled spores. The structure of a fungus is long and cylindrical, with small filaments branching from the body. Many fungal infections develop on the upper most layers of the skin, and some reached and spread in the deeper layers. Inhaled yeast or mold spores can sometimes lead to fungal infections, like pneumonia, or infections throughout the body. These also are called systemic infections. [7-12]

B. Antifungal Drugs

The most frequently used polyene macrolides are amphotericin-B and nystatin. These drugs act by binding to ergosterol in cell membranes increasing permeability, disrupting metabolism and causing death of cell. Amphotericin-B is a broad spectrum of activity against most species of Candida and Aspergillus. Amphotericin-B has been available since last four decade and exists in many type of formulations; however, because the oral bioavailability of amphotericin-B is less than 5%. So oral formulations are difficult to made. Intravenous formulations of amphotericin-B are used in the management of systemic fungal infections. [14-18]

C. Allylamines

The allylamine terbinafine inhibits squalene epoxidase, which acts in ergosterol depletion, membrane disruption and death of fungus cell.19 Terbinafine has activity against dermatophytes, low activity against Aspergillus spp. and other filamentous fungi but limited activity against Candida spp. The drug is registered for topical and oral treatment of cutaneous and nails dermatophyte infections, because terbinafine is lipophilic and keratinophilic, it accumulates in sebum, hair and nails. Terbinafine has been used alone or together with amphotericin-B or azoles for the treatment of invasive fungal infections. [19-22]

D. CHEMISTRY

Amphotericin-B is crystalline in bright yellow color having solid state. It show crystalline solid at room temperature that show physical characteristic of the drug. Amphotericin-B is water insoluble potent antifungal drug which belongs to the amino benzimidazole family drug. [24]

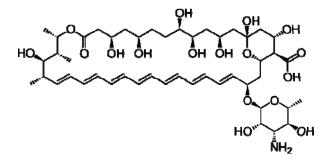
E. Amphotericin-B

Molecular weight: 924.09g/mol Molecular Formula: C47H73NO17 Melting point: 170°C Boiling point: 100°C Density: 0.9g/cm3 Flash Point: 163°C

Solubility: Amphotericin-B is bright yellow crystalline powder soluble in DMSO, Lipids and insoluble in water.

Storage: Store at well closed amber colored container.

II. CHEMICAL STRUCTURE & PROPERTIES



CHEMICAL PROPERTIES

Appearance- Amphotericin-B is solid crystalline powder in nature with bright yellow colour.

Solubility- Amphotericin-B is slightly soluble in DMSO (di-methyl-sulfoxide), but is insoluble in water.5-9

III.PHARMACODYNAMICS/MECHANISM OF ACTION

Amphotericin-B is an antifungal medication used for serious fungal infections and leishmaniasis. It accustomed treat aspergillosis, blastomycosys, candidiasis and cryptococcosis. It's typically given by injection into a vein. Common side effects fever, chills, headaches and kidney problem. 25-28

Mechanism of action:

polyene antifungals, amphotericin B associates with ergosterol, the main component of fungal cell membranes, forming a transmembrane channel that acts as monovalent ion (K+, Na+, H+ and Cl-) leakage, which is the primary effect resulting in fungal cell death. Recently, however, researchers found evidence that pore formation isn't necessarily linked to cell death. The particular mechanism of action is also more complex and multifaceted. 29-32

Pharmacokinetics:

Amphotericin B is very poorly absorbed when given orally, and this route is employed just for treating fungal infections of the upper alimentary canal. It is often used topically for local infection on skin. For systemic infections it's generally administered by slow injection complexed with liposomes or other lipid-containing preparations. This improves the pharmacokinetics and reduces the considerable burden of side effects. Amphotericin B is extremely highly protein bound. It penetrates tissues and membranes (such because the blood-brain barrier) poorly, although it's found in fairly high concentrations in inflammatory exudates and should cross the blood-brain barrier more readily when the inflamed, meninges are and intravenous Amphotericin-B is employed with flucytosine to treat cryptococcal meningitis. It's excreted very slowly via the kidney, traces being found within the urine for two months or more after administration has ceased.

Medicinal uses:-

Antifungal Activity-

Amphotericin B is an antifungal wont to treat fungal infections in neutropenic patients, cryptococcal meningitis in HIV infection, fungal infections, and leishmaniasis.

Black fungus treatment-

Amphotericin-B is widely used to treat postcovid symptoms black fungus (Mucormycosis) by inhibiting the synthesis of ergosterol, the most component of fungal cell membranes.18-21

Side effects

Amphotericin-B has some following common side effects.

• Fever and chills.

• increased or decreased urination.

• irregular heartbeat.

• muscle cramps or pain.

• nausea.

• pain at the place of injection.

• unusual tiredness or weakness.

• vomiting.

Adverse drug reactions:

The adverse reactions most ordinarily observed are:

General (body as a whole): fever, malaise, weight loss.

hypotension tachypnea, anorexia; nausea; vomiting; diarrhea

Hematologic: normochromic anemia, normocytic anemia, Local: pain at the injection site, generalized pain, including muscle and joint pains.

IV. ACKNOWLEDGEMENT

Many-Many thanks to all of the Faculty members and researchers who informed and feedback that made this chapter possible and especially for Dr. Vandana Sharma (Principal/ Professor, Arya College of Pharmacy) his assistance with the preparation. Special appreciation goes to Dr. Shiv Prakash Sharma (Faculty of Pharmacy, AKS University, Satna) for providing such academic environment and publication motivational environment.

V. REFERENCES

- [1] Sehgal, Mukul; Ladd, Hugh J.; Totapally, Balagangadhar (2020-12-01)
- [2] O'Brien, Deirdre J.; Gould, Ian M. (August 2013). "Maximizing the impact of antimicrobial stewardship". Current Opinion in Infectious Diseases. 26 (4): 352–58.
- [3] Alberti K.P., King L.A., Burny M.E., Ilunga B.K., Grais R.F. Reactive vaccination as an effective tool for measles outbreak control in measles mortality reduction settings, Democratic Republic of Congo, 2005–2006. International Health. 2010;2:65–68.
- [4] Anderson J.D., Bonner M., Scheifele D.W., Schneider B.C. Lack of nosocomial spread of Varicella in a pediatric hospital with negative pressure ventilated patient rooms. Infection Control. 1985;6:120–121.
- [5] Arvelo W., Sosa S.M., Juliao P., Lopez M.R., Estevez A., Lopez B., Morales-Betoulle M.E., Gonzalez M., Gregoricus N.A., Hall A.J., Vinje J., Parashar U., Lindblade K.A. Norovirus outbreak of probable waterborne transmission with high attack rate in a Guatemalan resort. Journal of Clinical Virology. 2012;55:8–11.
- [6] Asiedu-Bekoe F., Adu D.A., Offei A. Mass oseltamivir prophylaxis halts pandemic influenza A H1N1 2009 outbreak in a secondary school in Ashanti Region, Ghana. Ghana Medical Journal. 2012;46:219–224.
- [7] Bootsma M.C., Ferguson N.M. The effect of public health measures on the 1918 influenza pandemic in U.S. cities. Proceedings of the

National Academy of Sciences of the United States of America. 2007;104:7588–7593.

- [8] Bannister B.A., Begg N.T., Gillespie S.H., editors. Structure and classification of pathogens. 2nd edn. Blackwell Science Ltd; Oxford, UK: 1996. pp. 23–34.
- [9] Benenson A.S., editor. Control of Communicable Diseases Manual. 16th edn. American Public Health Association; Washington, DC: 1995.
- [10] Luby S.P. Effect of handwashing on child health: A randomised controlled trial. Lancet. 2005;366:225–233.
- [11] Engleberg N.C., DiRita V., Dermody T.S.Lippincott Williams and Wilkins; Baltimore, MD: 2007. Schaechter's Mechanisms of Microbial Disease.
- [12] Detels R., McEwen J., Beaglehole J., Tanaka
 H., editors. Oxford Textbook of Public
 Health. 4th edn. Oxford University Press;
 Oxford, UK: 2002.
- [13] S. M. Pimentel-Elardo, S. Kozytska, T. S. Bugni, C. M. Ireland, H. Moll, and U. Hentschel, "Anti-parasitic compounds from streptomyces sp. strains isolated from mediterranean sponges," Marine Drugs, vol. 8, no. 2, pp. 373–380, 2010.
- [14] R. H. Dahal, D. S. Shim, and J. Kim, "Development of actinobacterial resources for functional cosmetics," Journal of Cosmetic Dermatology, vol. 16, no. 2, pp. 243–252, 2017.
- [15] S. H. Gillespie, "Evolution of drug resistance in mycobacterium tuberculosis: clinical and molecular perspective," Antimicrobial Agents and Chemotherapy, vol. 46, no. 2, pp. 267– 274, 2002.

- [16] E. A. Eady, M. Gloor, and J. J. Leyden,
 "Propionibacterium acnes resistance: a worldwide problem," Dermatology, vol. 206, no. 1, pp. 54–56, 2003.
- [17] L. A. Dever and T. S. Dermody, "Mechanisms of bacterial resistance to antibiotics," Archives of internal medicine, vol. 151, no. 5, pp. 886–895, 1991.
- [18] Dignani MC. Epidemiology of invasive fungal diseases on the basis of autopsy reports. F1000Prime Rep. 2014;6.
- [19] Fisher MC, Henk DA, Briggs CJ, et al. Emerging fungal threats to animal, plant and ecosystem health. Nature. 2012;484:186–194.
- [20] Bitar D, Lortholary O, Le Strat Y, et al. Population-based analysis of invasive fungal infections, France, 2001-2010. Emerg Infect Dis. 2014;20:1149–1155.
- [21] Cornely OA, Bassetti M, Calandra T, et al. ESCMID* guideline for the diagnosis and management of Candida diseases 2012: nonneutropenic adult patients. Clin Microbiol Infect. 2012;18(Suppl 7):19–37.
- [22] Herbrecht R, Denning DW, Patterson TF, et al. Voriconazole versus amphotericin B for primary therapy of invasive aspergillosis. N Engl J Med. 2002;347:408–415.
- [23] Garber G. An overview of fungal infections.Drugs 2001; 61 Suppl. 1: 1-12.
- [24] Jantunen E, Ruutu P, Niskanen L, et al. Incidence and risk factors for invasive fungal infections in allogeneic BMT recipients. Bone Marrow Transplant 1997; 19: 801-8.
- [25] Tumbarello M, Tacconelli E, Pagano L, et al.Comparative analysis of prognostic indicators of aspergillosis in haematological

malignancies and HIV infection. J Infect 1997; 34: 55-60.

- [26] Groll AH, Shah PM, Mentzel C, et al. Trends in the postmortem epidemiology of invasive fungal infections at a university hospital. J Infect 1996; 33: 23-32.
- [27] Bolard J. How do the polyene macrolide antibiotics affect the cellular membrane properties? Biochim Biophys Acta 1986; 864: 257-304.
- [28] Gallis HA, Drew RH, Pickard WW. Amphotericin B: 30 years of clinical experience. Rev Infect Dis 1990; 12: 308-29.
- [29] Schafer-Korting M, Blechschmidt J, Korting HC. Clinical use of oral nystatin in the prevention of systemic candidosis in patients at particular risk. Mycoses 1996; 39: 329-39.
- [30] Ryder NS. The mechanism of action of terbinafine. Clin Exp Dermatol 1989; 14: 98-100.
- [31] Balfour JA, Faulds D. Terbinafine: a review of its pharmacodynamic and pharmacokinetic properties, and therapeutic potential in superficial mycoses. Drugs 1992; 43: 259-84.
- [32] Harari S, Schiraldi G, de Juli E, et al. Relapsing Aspergillus bronchitis in a double lung transplant patient, successfully treated with a new oral antimycotic agent [letter]. Chest 1997; 111: 835-6.