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**Original Article**

# *In vitro* antifungal susceptibility of *Malassezia* spp. to azole drugs

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## Abstract

***Objective*** To analyze *in vitro* the susceptibility of ketoconazole, fluconazole, and miconazole against *Malassezia* spp.

***Methods*** Antifungal susceptibilities were determined from isolates of pityriasis versicolor lesions using disc diffusion method. The minimum inhibitory concentrations (MICs), based on Clinical and Laboratory Standard Institute (CLSI) guide were recorded after 24-48 hour of incubation at 35ºC. *Malassezia* spp. showed different susceptibility profiles for the drug tested. The samples were tested for ketoconazole, fluconazole, and miconazole susceptibility. The susceptibility differences were analyzed using chi square test (x2).

***Results*** According to statistic, the susceptibility of ketoconazole, fluconazole and miconazole showed a significant difference ($p<0.05$) in which 16 samples were sensitive to ketoconazole and fluconazole, while 10 samples were resistant and 6 samples were intermediate to miconazole.

***Conclusion*** There was a significant difference in susceptibility of ketoconazole, fluconazole, and miconazole against *Malassezia* spp.

***Key words***
Pityriasis versicolor, susceptibility, disc diffusion, ketoconazole, fluconazole, miconazole, *Malassezia* spp.

## Introduction

Pityriasis versicolor is a superficial fungal infection of the skin caused by *Malassezia* spp. yeast which is a normal flora of human skin.[1] Pityriasis versicolor shows typical alteration of skin pigmentation resulting in macula, as the outcome of yeast colonization in stratum corneum that can often be found in sebaceous gland rich area such as chest, back, and head.[2,3]

Clinically suspected pityriasis versicolor can be confirmed by microscopic examination with KOH smear. Positive result under microscope shows pseudohyphae and yeast cell or usually called by spaghetti and meatballs.[1] Pityriasis versicolor is often found in tropical area because of its high temperature and humidity or people who have a lot of physical activity and excrete plenty of sweat.[1]

Topical antifungals are still considered the first-

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line treatment of pityriasis versicolor, while systemic antifungals are the second-line and only used for severe cases of pityriasis versicolor, recurrent infection, and if the first line fail to treat.[4]

The Clinical Laboratory and Standards Institute (CLSI) has issued 4 standard methods for antifungal susceptibility testing,[5] this study used disc diffusion method. Based on Esteban study, both disc diffusion and dilution method can be used for antifungal susceptibility testing measurement with no significant difference.[6]

Antifungal resistance cases in pityriasis versicolor are increasing due to many factors from host, drug, and the yeast itself.[7-9] Moreover, the research about antifungal susceptibility is rarely done in Indonesia. High recurrent rate of pityriasis versicolor still remains a problem. This condition leads to free antifungal drug use without any proper doctor prescription and eventually make higher antifungal resistance rate. Helou *et al*.[7] reported one of the antifungal resistance case in a 52-year-old male who had resistance to fluconazole, ketoconazole, itraconazole, fenticonazole cream, because of the recurrent infection and continuously drug use without any doctor prescription.[7] Thus, we intended to assess the *in vitro* susceptibility of ketoconazole, fluconazole, and miconazole against *Malassezia* spp.

## Methods

*Malassezia spp. and susceptibility testing* A total of 16 *Malassezia* spp. isolates were studied. All were isolated from clinical samples obtained from human patients with diagnosis of pityriasis versicolor. The yeasts were stored in the culture collection of Microbiology Department of Medical Faculty, Diponegoro University. Isolates were cultured using Sabouraud's dextrose agar (SDA) standardized onto a homogenous mixture using ($5x10^5$CFU/ mL/ 0,5) McFarland standard. Yeast colony inoculum was evenly cultured onto SDA media and after that ketoconazole, fluconazole, and miconazole disc placed on the media surface. After the incubation period in $35^0$C within 24-48 hours, we measured the inhibitory zone diameter, which then being interpreted using CLSI provision table (**Table 1**). Written informed concern from the patients were obtained according to Ethical Committee of Faculty of Medicine/ Dr. Kariadi Hospital, Diponegoro University, Semarang.

*Statistical analysis* The susceptibility differences were analyzed using chi square (x2) test after performing interpretation of MICs. SPSS software was used for statistical analysis.

## Results

Antifungal susceptibility test was performed using disc dilution method accordance to CLSI standard. MICs of each drug against *Malassezia* spp. could be recorded after 24-48 hours incubation at $35^0$C. Diameter inhibitory zone result showed in **Table 2**.

**Table 3** showed a significant *in vitro* susceptibility difference of ketoconazole, fluconazole, and miconazole against *Malassezia* sp. ($p$<0,05 ; $x^2$test).

Inhibitory zone measurement results are showed in **Figure 1.**

**Table 1** Inhibitory zone provision by Clinical Laboratory and Standards Institute.

| *Antifungal disc* | *Inhibitory zone (mm)* | | |
|---|---|---|---|
| | *Sensitive* | *Intermediate* | *Resistant* |
| Ketoconazole | ≥28 | 27-21 | ≤20 |
| Miconazole | >20 | 19-12 | <11 |
| Fluconazole | >19 | 18-15 | <11 |

**Table 2** Inhibitory zone interpretation by Clinical Laboratory and Standards Institute.

| *No* | *Ketoconazole* | | *Miconazole* | | *Fluconazole* | |
|---|---|---|---|---|---|---|
| | *Inhibitory zone (mm)* | *Interpretation* | *Inhibitory zone (mm)* | *Interpretation* | *Inhibitory zone (mm)* | *Interpretation* |
| 1 | 57 | Sensitive | 10 | Resistant | 50 | Sensitive |
| 2 | 53 | Sensitive | 8 | Resistant | 56 | Sensitive |
| 3 | 45 | Sensitive | 7 | Resistant | 45 | Sensitive |
| 4 | 47 | Sensitive | 7 | Resistant | 45 | Sensitive |
| 5 | 47 | Sensitive | 10 | Resistant | 45 | Sensitive |
| 6 | 49 | Sensitive | 17 | Intermediate | 47 | Sensitive |
| 7 | 50 | Sensitive | 17 | Intermediate | 47 | Sensitive |
| 8 | 45 | Sensitive | 12 | Intermediate | 43 | Sensitive |
| 9 | 42 | Sensitive | 14 | Intermediate | 40 | Sensitive |
| 10 | 46 | Sensitive | 16 | Intermediate | 40 | Sensitive |
| 11 | 45 | Sensitive | 13 | Intermediate | 40 | Sensitive |
| 12 | 50 | Sensitive | 7 | Resistant | 40 | Sensitive |
| 13 | 47 | Sensitive | 7 | Resistant | 48 | Sensitive |
| 14 | 45 | Sensitive | 7 | Resistant | 50 | Sensitive |
| 15 | 35 | Sensitive | 7 | Resistant | 40 | Sensitive |
| 16 | 50 | Sensitive | 8 | Resistant | 50 | Sensitive |

16 samples were sensitive to ketoconazole, while miconazole had 10 samples resistant and 6 samples intermediate.

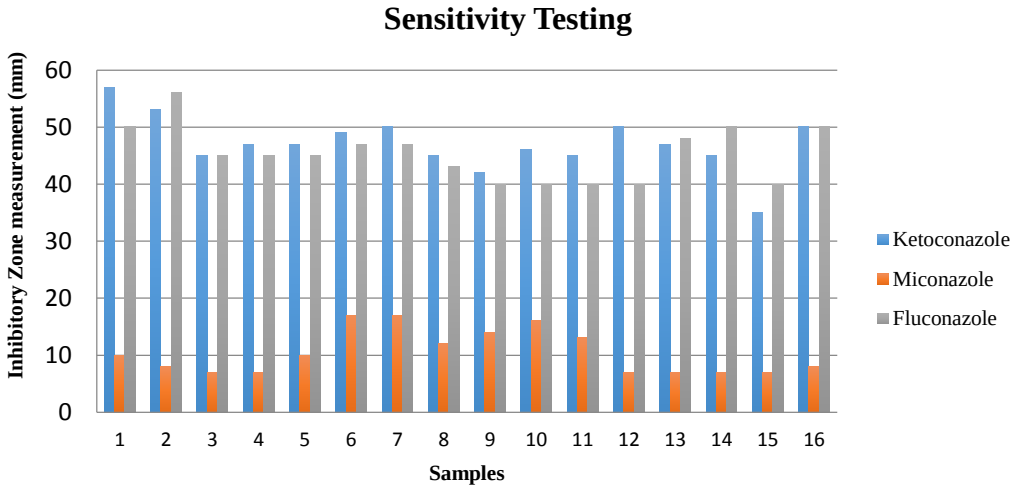


**Figure 1** Inhibitory zones of different antifungals.

**Table 3** Susceptibility difference of ketoconazole, fluconazole, and miconazole.

| *Antifungal* | *Interpretation* | | | *p* |
|---|---|---|---|---|
| | *Sensitive (%)* | *Intermediate (%)* | *Resistant(%)* | |
| Ketoconazole | 16 (100) | 0 (0) | 0 (0) | 0,001 |
| Miconazole | 0 (0) | 6 (37,5) | 10 (62,5) | |
| Fluconazole | 16 (100) | 0 (0) | 0 (0) | |

## Discussion

Based on statistical analysis, ketoconazole and miconazole showed a significant susceptibility difference. 16 samples were sensitive to ketoconazole while miconazole had 10 samples resistant and 6 samples intermediate. This study is in accordance with Alfonso *et al*.[10] who reported that ketoconazole had high sensitivity rate compared to other azoles including miconazole. Similar results were also reported by Rojas *et al*.[11] that ketoconazole had the best

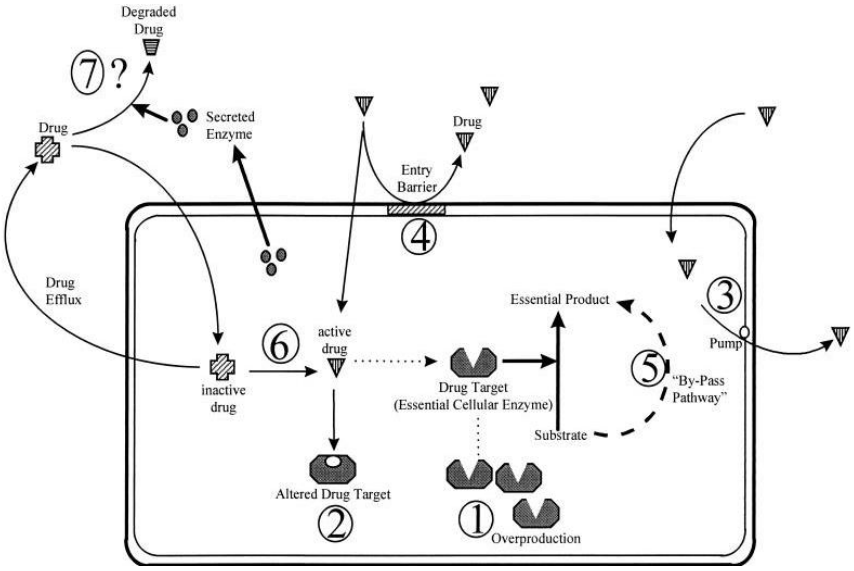


**Figure 2** Resistance mechanism azole group antifungal drug in *Malassezia* spp.[16]

antifungal drug activities and minimal variability compared to fluconazole, miconazole, and amphotericin B. Miconazole itself showed resistant results.[11] The latest study in 2017 by Leong *et al*.[12] showed that ketoconazole still had the best sensitivity although it showed resistant result in few samples, nevertheless ketoconazole still being the recommendation antifungal drug for treating *Malassezia* spp. infection.[12]

Regarding fluconazole, in the previous study conducted in Dr. Kariadi hospital in 2012 from 36 total samples, all the samples were sensitive to fluconazole.[13] A research by Dheghan in 2010 also reported high sensitivity rate of fluconazole with 82% from 50 total samples.[4] Another study held by Rojas *et al*.[14] in 2016 with 50 total samples of *Malassezia*, reported that sensitivity rate for fluconazole was 72%.

The high sensitivity of fluconazole against *Malassezia* spp. might be caused by the rare use of this drug to treat pityriasis versivolor.[13] One of the reason was that fluconazole preparation is only available for systemic use, prescribed in patients with widespread lesions, recurrent infection or if the first-line fail to treat. Besides, the side effects of fluconazole are gastrointestinal inconvenience like nausea, vomit, and diarrhea. AIDS patients could had urticaria, Stevens-Johnson syndrome, hidden liver failure, and thrombocytopenia, which is another reason why the drug infrequently use.[15] However, as noted above there was 0% *Malassezia* spp. sensitive to miconazole. The acquired data was 62.5% resistant and 37.5% intermediate to miconazole. This result was similar to the previous study, in which 50 samples of pityriasis versicolor were 58% intermediate sensitive and 18% resistant.[11]

Whereas ketoconazole and fluconazole had no significant difference because both of them had 100% same sensitivity, this result was similar in the previous study, reported that *Malassezia* spp. showed 100% sensitive to ketoconazole and fluconazole.[13]

Resistance mechanism of miconazole could be caused by several process including (**Figure 2**): 1. Excessive production of target enzyme, so the drug could not inhibit the whole process; 2. Drug target alteration, so that drug could not bind to the target site; 3. The drug being pumped

out by efflux pump; 4. Entrance of the drug was blocked in cell membrane or cell wall level; 5. Cell has bypass route which can compensate functional loss by the antifungal drug activities; 6. Some of the yeast enzymes that transformed the inactive drug into active drug were inhibited; and 7. Yeast cell secreted some enzyme into extracellular medium, which then degraded the drug.[14]

In the previous study,[10-12] microdilution method was used, yet in this study used disc diffusion method. Esteban said in his study that both disc diffusion and dilution method was able to measured sensitivity rate of antifungal drug with no significant difference.[6] Cordoba *et al*.[14] in their study about comparison of disc diffusion and dilution method, said that disc diffusion method could not estimate MIC value of the drug, but it can determined the sensitivity of *Malassezia* spp.[14]

## Conclusion

There was a significant in vitro susceptibility difference of ketoconazole, fluconazole and miconazole against *Malassezia* spp.

## References


1. Banerjee S. Clinical profile of pityriasis versicolor in a referral hospital of West Bengal. *J Pak Assoc Dermatol*. 2011;**21**:248-52.
2. Hidayani M, Amin S, Vitayani S, Ilyas F, Massi MN. Spesies Malassezia pada pasien pitiriasis versikolor di medium kultur (analisis makroskopik, mikroskopik dan biokimia). Fakultas Kedokteran Universitas Hasanuddin, Makassar. 2013:1-14.
3. Hayati I, Handayani ZP. Identifikasi jamur Malassezia furfur pada nelayan penderita penyakit kulit di RT 09 kelurahan Malabro kota Bengkulu. *Gradien*. 2014;**10**:972-5.
4. Gupta AK, Foley KA. Antifungal treatment for pityriasis versicolor. *J Fungi*. 2015;**1**:13-29.
5. Fothergill AW. Antifungal susceptibility testing: Clinical Laboratory and Standards institute (CLSI) Methods. In: Hall G (ed). *Interactions of Yeasts, Moulds, and Antifungal Agents*. Berlin: Springer Science Business Media LLC; 2012. P. 65-74.
6. Esteban A, Abarca ML, Cabanes FJ. Comparison of disc diffusion method and broth microdilution method for antifungal susceptibility testing of dermatophytes. *Med Mycol*. 2005;**43**:61-6.
7. Helou J, Obeid G, Moutran R, Maatouk I. Pityriasis versicolor: a case of resistance to treatment. *Int J Dermatol*. 2014;**53**:114-6.
8. Espinel-Ingroff A. Clinical relevance of antifungal resistance. *Infect Dis Clin North Am*. 1997;**11**:929-44.
9. Espinel-Ingroff A. Mechanisms of resistance to antifungal agents: Yeasts and filamentous fungi. *Rev Iberoam Micol*. 2008;**25**:101-6.
10. Carrillo-Muñoz AJ, Rojas F, Tur-Tur C, de Los Ángeles Sosa M, Diez GO, Espada CM *et al*. In vitro antifungal activity of topical and systemic antifungal drugs against Malassezia species. *Mycoses*. 2013;**56**:571-5.
11. Rojas FD, Sosa MA, Fernandez MS, Cattana ME, Córdoba SB, Giusiano GE. Antifungal susceptibility of Malassezia furfur, Malassezia sympodialis, and Malassezia globosa to azole drugs and amphotericin B evaluated using a broth microdilution method. *Med Mycol*. 2014;**52**:641-6.
12. Leong C, Buttafuoco A, Glatz M, Bosshard PP. Antifungal susceptibility testing of Malassezia sp. with an optimized colorimetric broth microdilution method. *J Clin Microbiol*. 2017;**55**:1883-93.
13. Hidayati N. Uji resistensi Malassezia sp. terhadap azol secara in vitro pada kasus pitiriasis versikolor [thesis]. Semarang: Fakultas Kedokteran Universitas Diponegoro; 2012.
14. Rojas FD, Córdoba SB, de Los Ángeles Sosa M, Zalazar LC, Fernández MS *et al*. Antifungal susceptibility testing of Malassezia yeast: comparison of two different methodologies. *Mycoses*. 2017;**60**:104-8
15. Setiabudy R, Bahroelim B. Obat Jamur. Dalam: Gunawan SG, Setiabudi R, Nafrialdi, Elysabeth. Farmakologi dan terapi. 5th ed. Jakarta: Departemen Farmokologi dan terapetik. Fakultas Kedokteran Universitas Indonesia; 2011. 571-83.
16. Apsari AS, Adiguna MS. Resistensi antijamur dan strategi untuk mengatasi. *MDVI*. 2013;**40**:89-95.