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Antibiotic efflux pumps in prokaryotic cells: occurrence, impact on resistance and strategies for the future of antimicrobial therapy

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Originally described in bacteria, drug transporters (or efflux pumps) are now recognized as major determinants in the modulation of the accumulation and efflux of antibacterials in virtually all cell types, from prokaryotes to superior eukaryotes. Transport proteins are in fact major cellular products. Based on sequence similarities with known transporters and with proteins possessing at least two transmembrane segments, it has been calculated that 15–20% of the genome of *Escherichia coli* or of *Saccharomyces cerevisiae* may code for this type of protein.¹ At least 300 gene products are proposed to transport known substrates effectively, out of which ~20–30 transport antibiotics and other drugs.² Figure 1, on this basis, identifies the main groups of transporters (also referred to as superfamilies) that have been shown so far to act effectively upon antibiotics. Two of these superfamilies [major facilitator superfamily (MFS) and ATP binding cassette superfamily (ABC)] span the prokaryote–eukaryote boundary, but with specific members in each kingdom. It must be remembered, however, that most transporters have been identified only very recently, so that the discovery of many more families, with both prokaryotic and eukaryotic members, would not be surprising in the near future. Efflux pumps usually consist of a monocomponent protein with several transmembrane spanning domains (most often 12 of them). However, in Gram-negative bacteria, which are protected by an outer membrane, efflux transporters can be organized as multicomponent systems, in which the efflux pump located in the inner membrane works in conjunction with a periplasmic fusion protein and an outer membrane protein (Figure 2).³ This first review focuses on the impact for antibiotic treatments of efflux pumps found in prokaryotes, while the companion paper⁴ examines those characterized in eukaryotes.

Why antibiotic transporters?

The first description of antibiotic transporters in bacteria resulted from the study of resistance to tetracyclines in the early 1980s.⁵ Soon after, several transporters were identified based on the same approach, i.e. through the unravelling of resistance mechanisms towards various classes of antibacterials, including successively the macrolides,⁶ the fluoroquinolones,⁷ the β -lactams⁸ and, more recently, the aminoglycosides.⁹ This led eventually to the concept that efflux must be considered as a common and basic mechanism of resistance, along the same lines as, and perhaps even more ubiquitous than, target modification or production of antibiotic-inactivating enzymes. The reason why antibiotics are subject to efflux may simply be that most of them share the necessary basic structural features for effective recognition. These determinants are most often the simple combination of an amphipathic character and the presence of an ionizable function. In this context, antibiotics appear as occasional substrates of transporters aimed at protecting cells from exogenous, diffusible molecules. Other examples of potentially harmful substrates include biocides¹⁰ or bile salts for Enterobacteriaceae.¹¹ But efflux pumps can also be viewed as machines developed by cells to extrude poorly diffusible or toxic endogenous molecules from the cytosol, and the latter may constitute some of the natural substrates of these transporters. Using *Pseudomonas aeruginosa* PAO1 wild-type and its efflux mutants, it was shown with a model of epithelial cells and of murine endogenous septicaemia, that most mutants demonstrated significantly reduced invasiveness and decreased capacity to kill mice. Invasiveness was restored by complementation of the mutants with the wild-type genes, or

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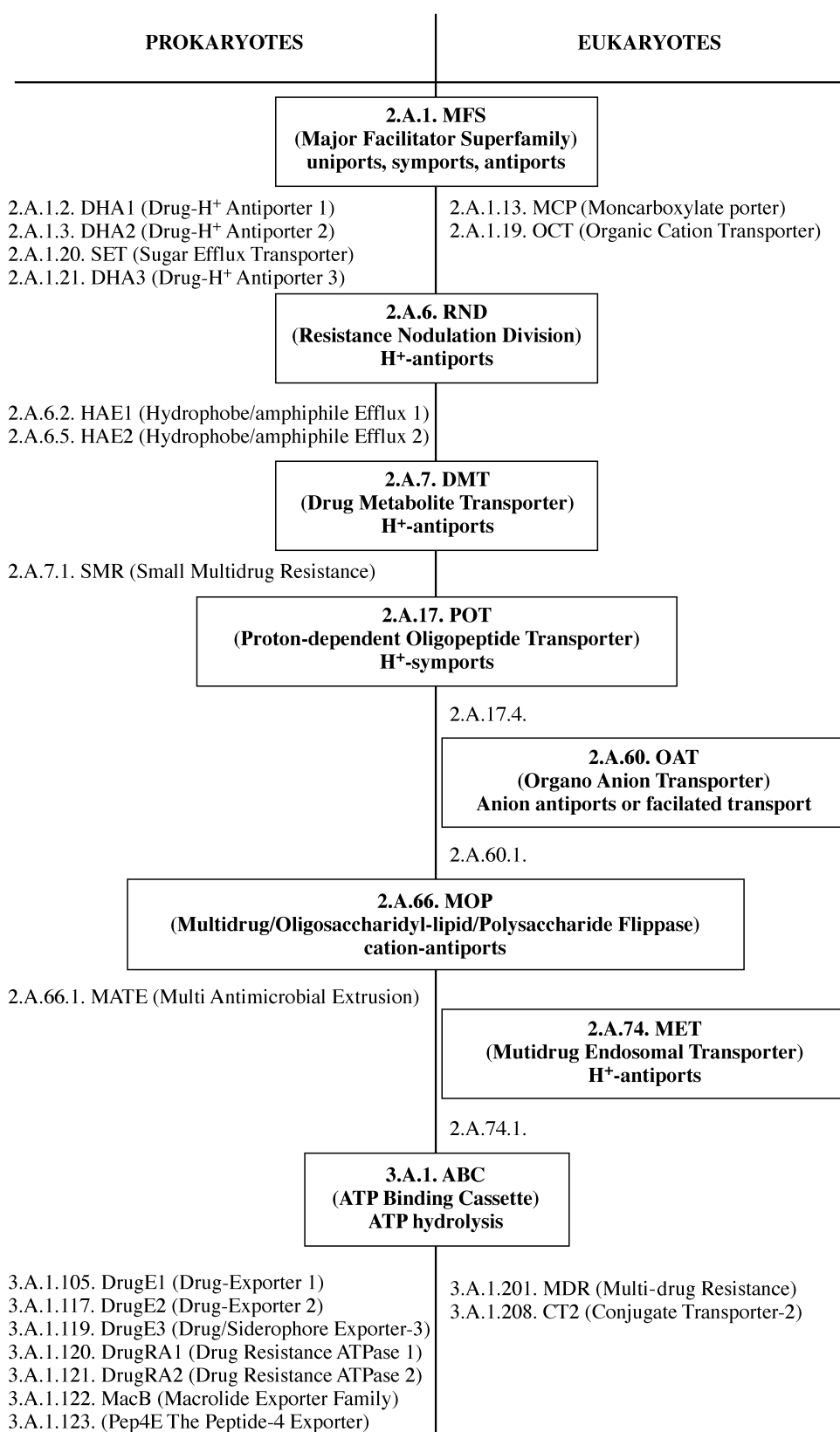


Figure 1. Occurrence and distribution of antibiotic transporters in prokaryotic and eukaryotic cells. The nomenclature is based on the classification of Saier.² The transporters are grouped in so-called superfamilies (three-component nomenclature; bold characters), six of which are found in prokaryotes and eukaryotes. Within each superfamily, only those families (four-component nomenclature; normal characters) transporting antibiotics are shown. OAT and MET are not found in prokaryotes.

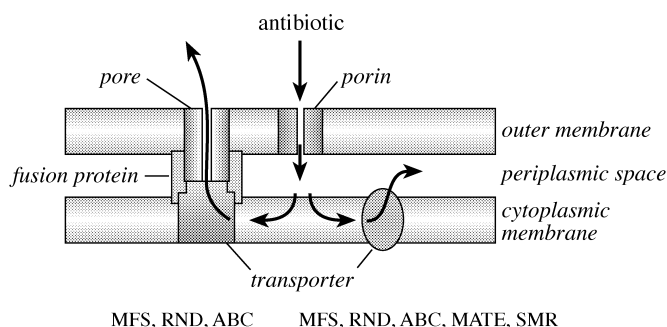


Figure 2. Topology of multicomponent (left) and monocomponent (right) efflux pumps as they can be found in the MFS, RND and ABC superfamilies and in the MFS, RND, ABC and MATE superfamilies, respectively. Multicomponent efflux pumps are specific to Gram-negative bacteria, since their particular organization allows extrusion of antibiotics directly into the extracellular medium. Arrows show directions of antibiotic transport. MFS, RND, SMR and MATE are energized by ion gradients and ABC by ATP hydrolysis.

by adding culture supernatants from epithelial cells infected with wild-type.¹² Along the same lines, the quorum-sensing auto-inducer 3-oxo-C12-homoserine lactone, which plays a key role in *P. aeruginosa* pathogenesis, is regulated by the MexAB–OprM efflux system.¹³ These effects can, however, be counterbalanced by the reduced fitness that may occur as a consequence of the extrusion of bacterial metabolites,¹⁴ or by a decreased intracellular concentration of auto-inducing virulence factors,¹⁵ as shown in MDR-overproducing mutants of *P. aeruginosa*. Finally, combining both self-protecting and physiological roles, transporters also export bacterial toxins¹⁶ as well as antibiotics from antibiotic producers.¹⁷

What are the main antibiotic transporters?

Table 1 shows, in a systematic fashion, the antibiotic transporters positively identified in some important human pathogens. For each of them, we present the necessary elements of identification and a non-exhaustive list of antibiotics transported. Many other efflux pumps are suspected to exist, based either on phylogenetic comparison with established transporters, or on phenotypical characterization (see 18 for a recent reference). Examination of Table 1 shows three major features. First, several transporters recognize very different classes of antibiotics. This holds especially true for resistance nodulation division (RND) superfamily transporters and is the basis for the cross-resistance of several bacteria to apparently structurally unrelated drugs (substituting one class of antibiotics by another will not be a satisfactory answer to resistance detected in these isolates). Secondly, a given species (typically *P. aeruginosa* and *E. coli*) may express quite different drug transporters, leading again to multiresistant phenotypes. Thirdly, a given antibiotic may be recognized by different pumps, and some classes such as tetracyclines,

macrolides, fluoroquinolones and chloramphenicol appear as quasi-universal substrates. However, individual drugs, within a given class, may show specific behaviour with respect to recognition by transporters (see Table 2). This has raised passionate debate concerning apparently closely related molecules, but may simply illustrate the critical impact of apparently minor chemical modifications in the recognition process of substrates by transporters.

Impact on resistance

Generally speaking, efflux mechanisms confer a low to moderate level of resistance only (1- to 64-fold increase in MIC),^{19,20} so that their clinical relevance has been questioned.²¹ The following points need, therefore, to be carefully taken into consideration. First, the intrinsic (or natural) resistance of many bacteria to antibiotics depends on the constitutive or inducible expression of active efflux systems. A typical example is *P. aeruginosa*, which was thought for a long time to be poorly susceptible to a large range of antibiotics of different classes because of the relative impermeability of its outer membrane to drugs. However, the simple disruption of the gene coding for the MexB pump dramatically increases the susceptibility of *P. aeruginosa* to β -lactams, tetracyclines, fluoroquinolones and chloramphenicol.²² Likewise, disruption of the gene coding for MdrL in *Listeria monocytogenes* causes a 10-fold decrease in the MIC of cefotaxime,²³ which suggests that the intrinsic resistance of *L. monocytogenes* to cephalosporins may be due to other mechanisms besides the existence of penicillin-binding proteins with low affinity towards this subclass of β -lactams. Finally, the poor susceptibility of *Haemophilus influenzae* to macrolides may result partly from the presence of an efflux mechanism²⁴ (in addition to the well known effect of acidity on the activity of macrolides, a CO₂-containing atmosphere is necessary to grow this bacteria). This suggests fresh avenues for the design of new macrolides with enhanced activity against *H. influenzae*.

Secondly, concomitant expression of several efflux pumps in a given bacterial species may lead to apparently ‘high level’ resistance phenotypes when considering the shared substrates. This has been observed in Gram-negative bacteria, in which the multicomponent efflux pumps of the RND superfamily transport antibiotics from the cytosolic leaflet of the inner membrane to the periplasmic space, and the single component efflux pumps of the MFS superfamily promote efflux from this space to the external medium.²⁵

Thirdly, efflux may also cooperate with other resistance mechanisms to confer not only high level but also broad-spectrum resistance. For example, the high intrinsic penem resistance of *P. aeruginosa* results from the interplay between the outer membrane barrier, the active efflux system MexAB–OprM and AmpC β -lactamase.²⁶ In *E. coli*, expression of

Table 1. Main efflux transporters as observed in clinically important human pathogens with their corresponding antibiotic substrates^a

Pathogen	Transporter	Super-family	TC number ^b	Antibiotics																			
				β-lactams								Q											
				peni	ceph	carb	m-bac	inhib		Tet	OX	ML	SG	LM	CHL	RIF	NAL	FQ	SM	TMP			
<i>S. aureus</i>	NorA ⁷	MFS	2.A.1.2.10															+ ⁵⁸	+ ⁵⁸				
	TetK-L ⁵⁹	MFS	2.A.1.3.6																				
	MdeA ⁶⁰	MFS																					
<i>S. pneumoniae</i>	MsrA ⁶	ABC	3.A.1.121.1																				
	MefE ⁶¹	MFS																					
	PmrA ⁶²	MFS																				+ ⁶²	
<i>Streptococcus pyogenes</i>	TetK-L	MFS																					
<i>Streptococcus pyogenes</i>	MefA ⁶³	MFS	2.A.1.21.2																				
<i>L. monocytogenes</i>	MdrL ²³	MFS		- ²³	+ ²³																		
	Lde ⁶⁴	MFS																					
	TetK-L	MFS																					
<i>Mycobacterium tuberculosis</i>	Mmr ⁶⁵	SMR	2.A.7.1.2.																				
	TetK-L	MFS																					
	DrrB ⁶⁶	ABC	3.A.1.105.1																			+ ⁶⁶	
<i>Enterococcus</i> spp.	Mef ⁶⁷	MFS																					
	TetK-L	MFS																					
	EmeA ⁶⁸	MFS																				+ ⁶⁸	
<i>H. influenzae</i>	Lsa ⁶⁹	ABC																					
	TetB, K	MFS																					
	AcrB-like	RND																					
<i>Neisseria gonorrhoeae</i>	MtrD ⁷¹	RND	2.A.6.2.5	+ ⁷²																			
<i>Salmonella</i> spp.	AcrB ⁷³	RND		+ ⁷⁴	+ ⁷⁴																		
	TetA-D	MFS																					
	FloR ⁷⁵	MFS																					
<i>Shigella dysenteriae</i>	TetA-D	MFS																					
	EmrE ⁷⁶	SMR	2.A.7.1.3																			+ ⁷⁷	
	YdhE ⁷⁸	MATE	2.A.66.1.3																			+ ⁷⁹	
<i>E. coli</i>	TetA-E ⁸⁰	MFS	2.A.1.2.4																				
	Bcr ⁸¹	MFS	2.A.1.2.7																			+ ⁸²	
	MdfA ⁸³	MFS	2.A.1.2.19																			+ ⁷⁹	
	YceL ⁸⁴	MFS	2.A.1.2.21																				
	YidY ⁸⁴	MFS	2.A.1.2.22																				
	EmrB ⁸⁵	MFS	2.A.1.3.2																				
	YebQ ⁸⁴	MFS	2.A.1.3.17																			+ ⁷⁹	

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Table 2. Relative affinities of antibiotics for efflux pumps

Antibiotic class	Affinity for efflux pumps			References
	high	variable ^a	low	
Penicillins ^b	nafcillin, cloxacillin, penicillin G		carbenicillin	74
Cephalosporins ^b	cefalotin, cefotaxime, ceftriaxone		cefazolin, cephaloridin	74
Carbapenems	meropenem	imipenem		98
Macrolides	14- and 15-membered		16-membered, ketolides	107–109
Tetracyclines	tetracycline	minocycline	glycylcyclines ^c	31,110,111
(Fluoro)quinolones	ciprofloxacin, norfloxacin	ofloxacin, levofloxacin	cinafloxacin, gatifloxacin, gemifloxacin, moxifloxacin, ^d garenoxacin	19,112–115

^aDepending on the efflux pump.

^bRanking corresponding to the degree of lipophilicity of the side chain.

^cLow affinity substrate of MexD in *P. aeruginosa* and AcrB and AcrF in *E. coli*.^{116,117}

^dLow affinity substrate of a still unidentified efflux transporter in *S. aureus*.¹¹⁸

Importantly, efflux-mediated resistance mechanisms can spread between phylogenically very distant species. This is exemplified by the macrolide-mediated efflux, which has moved not only among streptococci but also to Gram-negative bacteria.³⁷ Co-transfer with genes for other resistance mechanisms may also take place if these are present together on large mobile genetic elements.

Strategies for the future

Efflux mechanisms should now be taken fully into account in the evaluation of new antibiotics as well as for the future of chemotherapy in the long term. At the level of the clinical microbiology laboratory, suspicion of efflux as a cause of resistance ideally should be confirmed either phenotypically or genotypically so that cross-resistances during therapy can be anticipated. However, phenotypic characterization of efflux may prove difficult or impossible in multiresistant isolates that have several mechanisms. The clear-cut situation of macrolides and streptococci, in which efflux-based resistance is limited to 14- and 15-membered macrolides,³⁸ may be unique. Conversely, demonstrating resistance to a large variety of unrelated agents can suggest the presence of wide-spectrum transporters (see 39 for an example with clinical isolates). Unfortunately, several of the antibiotic substrates recognized by many efflux pump systems (such as chloramphenicol, tetracyclines or trimethoprim) are no longer tested in clinical laboratories because of lack of immediate therapeutic interest. More genotypic characterization could yield important information for surveillance studies. For instance, PCR has been used successfully to identify unambiguously efflux-based resistance mechanisms to macrolides,⁴⁰ tetracyclines⁴¹ and fluoroquinolones,²⁹ and fingerprinting has allowed the spread of the corresponding resistant clones to be

followed.³² Further development of new genotypic tests to improve the characterization of efflux mechanisms in clinical isolates would be welcome in this context (see 42 for first attempts in this direction).

Moving to the evaluation of new antibiotics, exploring their potential recognition by typical efflux transporters must now be in the forefront of their pre-clinical and clinical assessment. All other pharmacological and toxicological properties being equal, the aim here will be to favour the selection of derivatives that are poor substrates of the efflux pumps and that do not induce their overexpression. Table 2 illustrates the relative affinity of current and newly introduced antibiotics for efflux transporters, and reveals that most recent antibiotics in each class are less well recognized than those that are older. The development of pump inhibitors as adjuvant therapy also represents an interesting area for drug discovery, similar to how β -lactamase inhibitors brought new life to β -lactams.⁴³ This approach, however, appears very challenging because of potential effects on efflux transporters also present in eukaryotic cells. It must be emphasized that most inhibitors currently available display strong pharmacological activities in eukaryotic cell systems and are therefore unusable in clinical practice. Typical examples include reserpine,⁴⁴ omeprazole,⁴⁵ phenothiazines,⁴⁶ sertraline,⁴⁷ verapamil⁴⁸ and siderophores.⁴⁹ It is therefore essential to develop molecules not only designed specifically to inhibit prokaryotic transporters, but also with some distance from molecular structures close to those of drugs. Another difficulty is that the pharmacokinetic/dynamic properties of the pump inhibitors will need to match closely those of the companion antibiotic. Only three main categories of compound have been uncovered so far.⁵⁰ The first group comprises compounds specifically raised against the Tet transporters for tetracyclines (namely tetracycline derivatives substituted in position 13 and probably acting as

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competitive inhibitors,⁵¹ and a non-competitive inhibitor built on an indan nucleus).⁵² The second group is represented by a family of flavonolignans derived from a natural alkaloid from *Onopordon corymbosum*.⁵³ These molecules inhibit the NorA transporter of *Staphylococcus aureus*. As flavones are also known to inhibit the eukaryotic P-glycoprotein, considerable lead optimization studies will be needed to obtain safe compounds. The third category is represented by peptides acting upon the RND transporters of *P. aeruginosa*.⁵⁴ These inhibitors selectively improve the activity of antibiotics that are substrates of the MexB efflux pump (quinolones, macrolides, chloramphenicol, and to a lesser extent, tetracycline or carbenicillin),⁵⁵ which suggests a high level of specificity.⁵⁶ They do not interact with the eukaryotic P-glycoprotein. A desirable step forward would be to consider the design of wider spectrum inhibitors acting on pumps present in both Gram-positive and Gram-negative bacteria and belonging to different phylogenetic families. Prudent use of these inhibitors will, however, be essential, to avoid fast emergence of resistance to them, which will most probably also emerge. Laboratory mutants of *Bacillus subtilis* have already been isolated with resistance to the inhibitory activity of reserpine.⁵⁷

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