iJRASET
International Journal For Research in Applied Science and Engineering Technology



INTERNATIONAL JOURNAL FOR RESEARCH

IN APPLIED SCIENCE & ENGINEERING TECHNOLOGY

Volume: 13 **Issue:** XI **Month of publication:** November 2025

DOI: https://doi.org/10.22214/ijraset.2025.75347

www.ijraset.com

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International Journal for Research in Applied Science & Engineering Technology (IJRASET)
ISSN: 2321-9653; IC Value: 45.98; SJ Impact Factor: 7.538
Volume 13 Issue XI Nov 2025- Available at www.ijraset.com

Bedaquiline: A Breakthrough in Tuberculosis Treatment

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Abstract: ***Tuberculosis (TB) remains a leading cause of death from a single infectious agent, with its global control severely undermined by the proliferation of multidrug-resistant (MDR) and extensively drug-resistant (XDR) strains. For decades, the therapeutic landscape for these formidableformsof TB wasdefinedbyarchaic,prolonged,andhighly toxic treatmentregimens, which yielded cure rates of only 50–60%. The accelerated approval of bedaquiline in 2012, the first new anti-TB drug from a novel class in over 40 years, heralded a paradigm shift in the management of drug-resistant TB. Bedaquiline introduced a unique mechanism of action, the specific inhibition of the proton pump of mycobacterial ATP synthase, a critical enzyme in the bacterium's energy metabolism. This novel target confers potent bactericidal and sterilizing activity against both actively replicating and dormant, non-replicating bacilli, and crucially, exhibits no cross-resistance with existing anti-TB drug classes.Pivotal Phase II clinical trials (C208 and C209) provided the foundational evidence for its efficacy, demonstrating that the addition of bedaquiline to a background regimen significantly accelerated the time to sputum culture conversion and substantially improved final treatment success rates, even in patients with pre-XDR and XDR-TB. Its introduction has served as the cornerstone fora revolution in treatment strategy, enabling the development of all-oral, shorter- course regimens. Groundbreaking trials such as Nix-TB, ZeNix, and TB-PRACTECAL have validated 6-month, bedaquiline-based regimen that achieve cure rates approaching 90%, while being significantly safer and more tolerable than the older, injectable- based standards of care. While significant challenges related to its safety profile (notably QTc interval prolongation), the inevitable emergence of drug resistance, and the persistent struggle for equitable global access remain, bedaquiline has fundamentally transformed the prognosis for patients with drug-resistant TB. It has converted a debilitating, often fatal disease into a manageableand highlycurable conditionforthevastmajorityofpatients.Thisarticle providesa comprehensive review of the discovery, detailed pharmacology, clinical evidence, and the profound, paradigm-shifting impact of bedaquiline on the global fight against tuberculosis.***

I. INTRODUCTION

1) TheEscalatingCrisisofDrug-ResistantTuberculosis

Tuberculosis (TB), an ancient disease caused by the bacterium *Mycobacterium tuberculosis*, continuestobeoneof the world'smost significantpublichealth threats.While thedevelopment of effective chemotherapy in the mid-20th century offered the promise of control, this optimism has been severely eroded by the relentless emergence and global spread of drug-resistant forms of thedisease. Thishas createda complexand escalatingcrisis thatchallengesthe very foundations of global TB control efforts [1].

2) The Spectrum of Resistance and Its Drivers

The challengeofdrug resistance in TBisstratifiedintocategoriesofincreasing therapeutic difficulty. Multidrug-resistant TB (MDR-TB) is defined as disease caused by strains of *M. tuberculosis* that are resistant to at least isoniazid and rifampicin, the two most potent and essential first-line anti-TB drugs. The therapeutic challenge intensifies with pre-extensively drug-resistant TB (pre-XDR-TB), which is MDR-TB with additional resistance to any fluoroquinolone,and culminatesin extensivelydrug-resistantTB (XDR-TB),nowdefinedasMDR-TB with resistancetoafluoroquinolone andat leastoneothercore second-linedrug, such as linezolid.The genesis of this crisis is multifaceted. Drug resistance can be acquired within an individual patient during treatment (secondary resistance), often as a result of inadequate or poorly managed therapy, patient non-adherence, or the use of substandard drugs. However, a more alarming driver of the modern epidemic is primary resistance, where individuals are directly infected with already-resistant strains. In most high-burden countries, community transmission is nowthe dominantmodeof spreadforMDR-TB,indicatingthattheepidemic is self-sustaining and no longer merely a consequence of individual treatment failures [2]. This reality points to a profound systemicfailure, where weak medical systemsand a lackof universalaccess to rapid diagnostics have allowed resistant strains to flourish.

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A stark example is the "amplifier effect," were standardized treatment strategies, if implemented without universal drug susceptibility testing, can paradoxically worsen the problem by repeatedly treating resistant infections with ineffective drugs, thereby selecting for even more resistant strains [1][2].

3) ThePre-BedaquilineEra:ATherapeutic Wasteland

Prior to 2012, the standard of care for patients with MDR-TB was a relic of a bygone medical era. It was an arduous, toxic, and frequently futile undertaking. Patients were subjected to grueling treatment regimens lasting a minimum of 18 to 24 months, and often much longer. These regimenswerecomplex cocktails offive ormore second-linedrugs,many of which were repurposed agents with limited efficacy and substantial toxicity.A mandatoryandparticularly brutalcomponentof theseolderregimens was theinclusionof a second-line injectable agent, such as amikacin, kanamycin, or capreomycin[1]. These drugs required months of painful daily injections and were notorious for causing severe, often irreversible adverse effects. The most devastating of these were permanent hearing loss (ototoxicity) and kidney damage(nephrotoxicity), side effects that left many survivors with lifelong disabilities.Despite this immense burden on patients, the outcomes were deeply suboptimal. Global treatment success rates for MDR-TB hovered at a dismal 50–60%, with outcomes for XDR-TB beingeven worse.Patientsendured immensesuffering withonlya coin-flip's chanceof a cure, while mortality rates remained unacceptably high. This grim landscape created an urgent and profoundunmet medical needfor new therapeuticagentsthatcouldfundamentally change this bleak reality. It was into this context of therapeutic stagnation and escalating crisis that bedaquiline emerged,representing thefirsttruepharmacologicalbreakthrough in ageneration [1][2].

II. DISCOVERY AND DEVELOPMENT

1) ANewDawninTBTherapeutics

The journeyof bedaquilinefromlaboratorybenchtoglobalstandard of care isa landmarkstory in modern pharmacology, notable for its scientific innovation and for breaking a decades-long stasis in anti-TB drug development.Ending the 40-Year drought. Bedaquiline, initially known by its compound code TMC207, was discovered by a team of scientistsled byKoen Andriesat JanssenPharmaceutica,a subsidiaryof Johnson& Johnson. Its discovery was the result of a dedicated screening program, and the compound was first described at a scientific conference in 2004 after more than seven years of development. Its eventualapproval in 2012 marked the end of a more than 40-yearperiod in which no newclass of anti-TBdrug with anovelmechanismof actionhad been successfullybrought to market.This prolonged gap highlights a significant market failure in research and development for diseases thatprimarilyaffectimpoverishedpopulations,wherefinancialincentivesareofteninsufficientto drive private-sector investment.The development of bedaquiline was facilitated not only by scientific ingenuity but also by regulatory innovation. Recognizing thedireunmetneed,regulatorybodies like the U.S.Food andDrugAdministration(FDA) utilized"acceleratedapproval "pathways.Thesemechanisms allow for earlier marketing of drugs for serious conditions based on surrogate endpoints, creating a viable path to market that might not otherwise exist [3][4].

2) ANovelChemicalClassand Pre-clinicalPromise

Bedaquiline is the first member of a new chemical class of antimycobacterial known as the diarylquinolines.Itsuniquemolecularstructureisfundamentallydifferentfromallotherexisting classes of anti-TB agents. A critical consequence of this novelty is the absence ofcross-resistance; resistancetootherdrugs, includingthefluoroquinolones thatareoftenused in MDR-TB regimens, does not confer resistance to bedaquiline. This property made it an invaluable new toolfor constructing effective regimensagainst highly resistant bacterial strains. The promise of bedaquiline was evident from its early pre-clinical evaluation. In vitro studies demonstrated that the compound possessed potent activity against a wide range of *M. tuberculosis* isolates, including both drug-susceptible and multidrug-resistant strains. This potent activity was further validated in animal studies. In murine models of TB infection, bedaquiline exhibited strong bactericidal (ability to kill bacteria) and sterilizing (ability to kill persistent, slow-metabolizing bacteria) properties. Its activity in these models was shown to be superior to that of first-line drugs and key combination therapies, providing the foundational evidence needed to justify its progression into human clinical trials [5].

III. ANOVELMECHANISMOFACTION:

1) TargetingtheEngineof Mycobacteriumtuberculosis

The breakthrough status of bedaquiline isfundamentally rooted in its unique mechanism of action,whichtargetsapreviouslyunexploitedpathwayin *M.tuberculosis*physiology.Unlike other antitubercular agents that interfere with cell wall synthesis, protein synthesis, or DNA replication, bedaquiline strikes at the very heart of the bacterium's energy metabolism [4].

2) InhibitionofMycobacterialATPSynthase

Bedaquilinespecificallyinhibitstheproton pumpofmycobacterialadenosine triphosphate (ATP) synthase. This enzymeis anessential molecularmachine responsiblefor synthesizing ATP,the universal energy currency of the cell. By shutting down this "engine," bedaquiline effectively starvesthe bacteriumof the energy required for all vital cellular processes, ultimately leading to cell death [4][5].

3) ASophisticatedDual-TargetingMolecularMechanism

The molecularinteractionbetweenbedaquilineand itstargetisnowunderstoodin considerable detail. The drug functions through a sophisticated dual-targeting mechanism that ensures robust inhibition of the enzyme.**Stalling the c-Ring Rotor:** The primary mechanism involves the direct binding of bedaquiline to thec-subunit of the F-ATP synthase. The c-subunitsassemble intoa ring-like structure that rotates as protons pass through it, driving ATP synthesis.Bedaquilinelodgesitself withina specificcleftbetweentwoadjacentc-subunits,actingas a molecular wedge that physically stalls the rotation of the ring. Furthermore, its interaction with a critical amino acid residue (E61) in the binding site directly blocks the ion exchange necessary for proton translocation [5].**Disrupting the ε-Subunit Clutch:** More recent research has revealed a second, complementary mechanism of inhibition. Bedaquiline also binds to the ε-subunit of the ATP synthase. Theε-subunitactsasa clutch, transmittingthe rotationalenergyof thec- ring to the catalytic headpiece of the enzyme where ATP is actually synthesized. By binding to the ε-subunit, bedaquiline disrupts the necessary conformational changes, effectively uncoupling the engine's rotation from its synthetic output.This refined understanding of a dual-target mechanism was clarified by studies with a bedaquiline analogue, TBAJ-876,whichconfirmedthat thisdualinhibition isessentialforthe drug's potent bactericidal activity. A previously hypothesized mechanism—acting as an "uncoupler" that dissipates the proton gradient—was found to be non-essential for its killing effect. Thissophisticated blueprintprovidesa rationalbasisforthedesign ofnext-generation ATP synthase inhibitors [6][7].

4) HighSelectivityandPotentSterilizingActivity

A remarkable feature of bedaquiline is its high degree of selectivity for the mycobacterial enzyme.Theconcentrationofbedaquiline requiredtoinhibitthemycobacterialATPsynthaseis over20,000 times lower than that required to inhibit the homologoushuman mitochondrialATP synthase. This vast difference in affinity is the molecular basis for the drug's favorable therapeutic index.A key pharmacodynamic consequence of its mechanism is bedaquiline ability to kill both actively replicating and dormant, non-replicating mycobacteria. Dormant bacilli, which exist in a low-energy state,arenotoriouslydifficulttoeradicatewith conventionaldrugs andareaprimary cause of disease relapse. By targeting the fundamental process of energy generation, bedaquiline is effective even against these persistent cells. This potent sterilizing activity is crucial for achieving a durable cure and is a key prerequisite that enables the shortening of treatment duration [6][8][15].

IV. CLINICAL PHARMA COLOGY OF BEDAQUILINE

The clinicaluseof bedaquiline isdictatedbyitsuniquepharmacokineticandpharmacodynamic properties,which haveinformed as pecificdosingregimendesigned to maximize efficacywhile managing potential for toxicity and resistance [9] .

1) Pharmacokinetics(PK)

- Absorption: Bedaquiline isadministeredorally.Its absorptionis significantlyenhanced by the presence of food; administration with a meal increases its bioavailability by approximately two-fold. This makes co-administration with food a critical instruction for patients.Followinganoraldose,themaximumplasma concentration (Tmax)istypically reached in about 5 hours.Distribution: The drug is extensively distributed into body tissues, as indicated by its large apparent volume of distribution of approximately 164 liters. It is also highly bound to plasmaproteins(>99.9%),whichinfluencesitsdistributionandeliminationcharacteristics.Metabolism: Bedaquiline is primarily metabolized in the liver by the cytochrome P450 isoenzyme CYP3A4. This process forms a major metabolite, N-monodesmethyl bedaquiline (M2),which islessactive against *M.tuberculosis*thantheparentcompound. The reliance on CYP3A4 for metabolism creates a significant potential for drug-drug interactions. Co-administration with strong CYP3A4 inducers (such as rifampicin) can decrease bedaquiline exposure and reduce its efficacy, while co-administration with strong CYP3A4 inhibitors (such as certain antiretroviral drugs) can increase itsexposure and the risk of adverse events.

- Elimination:Adefiningfeatureofbedaquilinepharmacokineticsisitsexceptionallylong terminal elimination half-life, which is approximately 5.5 months for both the parent drug and its M2 metabolite. Thisprolonged half-life is attributed to the slowrelease of the drug from deep tissue compartments where it accumulates.Thisextremelylong half-life isapharmacological"double-edged sword."Onone hand,it allows for a convenient intermittent dosing schedule during the maintenance phase. On the other hand, it poses a significant risk for the development of drug resistance if treatment is interrupted. If apatientstopstakingtheirfull combination regimen, thecompanion drugs willbe cleared from the body relatively quickly, while bedaquiline will persist at declining, sub- therapeutic concentrations for many months. This extended period of functional monotherapy createstheidealselective pressureforanysurvivingbacillitodevelopresistance.Thisinherent risk underscores why programmatic use of bedaquiline must be coupled with robust patient support and adherence strategies, such as Directly Observed Therapy (DOT) [2][3][9][15].

2) Pharmacodynamics(PD)andDosing Regimen

Bedaquiline exhibits concentration-dependent bactericidal activity, where the ratio of the area under the concentration-time curve to the minimum inhibitory concentration (AUC/MIC) is the keyparameterdrivingitsefficacy. ThisPK/PDprofile directlyinformsitsuniquedosing strategy. The recommended regimen consists of a loading phase of 400 mg once daily for the first two weeks. This is designed to rapidly saturate tissue compartments and achieve therapeutic plasma concentrations. This is followed by a maintenance phase of 200 mg administered three times per week for the subsequent 22 weeks. This intermittent dosing maintains effective drug exposure while minimizing the potential for long-term accumulation and associated toxicity [17].

V. CLINICAL EFFICACY IN DRUG-RESISTANT TUBER CULOSIS

1) Evidencefrom Pivotal Trials

Theclinicalefficacyofbedaquilinewasestablishedthroughapairofpivotal PhaseIIbtrials,C208andC209.These studiesprovided the foundational evidenceof itspotent activityagainst MDR-TB, which ultimately led to its accelerated approval and integration into global treatment guidelines [21][35].

2) PhaseIIbPlacebo-ControlledTrial(TMC207-C208)

The C208 trial was a multinational, randomized, double-blind, placebo-controlled study that served as the cornerstone of bedaquiline clinical development program. The studyenrolled 160 patients with newly diagnosed, sputum smear-positive pulmonary MDR-TB. Participants were randomized to receive either bedaquiline (for 24 weeks) or a matching placebo,bothadded to astandardizedfive-drugbackground regimen of second-line anti-TB drugs [32]. The trial's primary endpoint was the time to sputum culture conversion, a key microbiological marker of treatment response. The results were striking:

- Accelerated Culture Conversion: The addition of bedaquiline to the background regimen significantly accelerated culture conversion. The median time to achieve two consecutive negative cultures was 83 days in the bedaquiline group, compared to 125 days in the placebo group. This corresponded to a hazard ratio of 2.44 (95% CI, 1.57– 3.80), indicatingthatpatientsonbedaquiline weremore than twice aslikelyto convertat any given time point.
- ImprovedConversionRates: Atthe 24-weekmark,the rateof culture conversionwas significantly higher in the bedaquiline arm (77.6–79%) compared to the placebo arm (57.6–58%) [37][61][63].

Feature	TrialC208	TrialC209
StudyDesign	Randomized,Double-Blind,Placebo-Controlled	Open-Label,Single-Arm
PatientPopulation	NewlydiagnosedpulmonaryMDR-TB	Newandpreviouslytreatedpulmonary MDR-TB, pre-XDR-TB, and XDR-TB
N(patients)	160(79Bedaquiline,81 Placebo)	233(205inefficacyanalysis)
Intervention	Bedaquiline(24weeks)+Background Regimen vs. Placebo+Background Regimen	Bedaquiline(24weeks)+ Investigator-Chosen BackgroundRegimen

PrimaryEndpoint	Timetosputumcultureconversion	Timetosputumcultureconversion
KeyResult(MedianTimetoCulture Conversion)	83days(vs.125daysforplacebo)	57days
KeyResult(CultureConversionRateat 24 weeks)	79%(vs.58%forplacebo)	79.5%
KeyResult(FavorableOutcomeat120 weeks)	62%(vs.44%forplacebo)	72.2%
Table1:Summaryof Pivotal PhaseIIClinicalTrials(C208&C209)		

- Sustained Favorable Outcomes: This microbiological advantage was sustained long afterbedaquilinetreatment was completed. At the120-weekfollow-up,62%of patients in the bedaquiline group had a favorable outcome (defined as cure or treatment completion), compared to only 44% in the placebo group [61][63].

3) PhaseIIOpen-LabelTrial(TMC207-C209)

The C209 trial was a single-arm, open-label study designed to provide further evidence of bedaquiline efficacy and safety in a broader and more diverse patient population. This trial enrolled233patients, includingnotonlynewlydiagnosed MDR-TB patients butalsothosewho had been previously treated, as well as patients with more advanced forms of resistance, including pre-XDR and XDR-TB.TheresultsofC209stronglycorroboratedthefindingsfromtheC208trial:

- Rapid Bacteriological Response: The study demonstrated a rapid and potent bacteriologicalresponse, withamediantimetocultureconversionofjust57days.
- HighOverallSuccess: Theoveralltreatmentsuccesswashigh,witha culture conversion rate of 72.2% at 120 weeks.
- EfficacyinHighlyResistantTB: Critically,thisefficacyextended to themostdifficult-to- treat patients. Success rates were 70.5% among those with pre-XDR-TB and 62.2% among those with XDR-TB, populations for whom previous treatment options were extremely limited.Together, theC208and C209 trialsprovided robust andconsistentevidence thatadding bedaquiline to a standard MDR-TB regimen significantly accelerates and improves microbiological outcomes, forming the basis for its accelerated regulatory approval [55][64][71].

VI. SAFETY AND TOLER ABILITY PROFILE

While the efficacy of bedaquiline was quickly established, its initial safety profile presented severalcomplexitiesthatrequiredcarefulevaluationandhave shaped its clinicaluse.The main concerns included its effect on cardiac repolarization, an observed mortality imbalance in the pivotal trial, and potential hepatotoxicity [62] .

1) TheBlackBoxWarning:QTIntervalProlongation

The most significant safety concern associated with bedaquiline is its potential to prolong the corrected QT (QTc) interval on an electrocardiogram (ECG). The QTc interval represents the time it takesfortheheart's ventricles to repolarizeaftera contraction [32][54].Aprolonged QTcinterval is a risk factorfora life-threatening cardiac arrhythmia known as Torsade de Pointes. This risk prompted the U.S. FDA to issue its most stringent caution, a "black box warning," in the drug's labeling.The mean increase in the QTc interval observed with bedaquiline is generally modest, on the order of 15 ms. While clinically significant prolongation (defined as a QTc interval >500 ms) is infrequent, the risk is additive and becomes a major clinical consideration when bedaquiline is co-administered withotherdrugsknowntoprolong theQTcinterval. Thisis particularly relevant in the context of MDR-TB treatment, as standard regimens frequently include other QT- prolonging agents such as fluoroquinolones (e.g., moxifloxacin) and clofazimine. Management of this risk requires a proactive monitoring strategy. Clinical guidelines recommend obtaining a baseline ECG before starting treatment, followed by regular follow-up ECGs, particularly at weeks 2, 12, and 24. Additionally, serum electrolytes—specifically potassium, calcium, and magnesium—should be monitored and corrected if abnormal, as imbalances can exacerbate therisk of arrhythmia.

If apatient'sQTcintervalpersistentlyexceeds500 msorif asignificant arrhythmia develops, discontinuation of bedaquiline and other offending agents is recommended [71][75].

2) TheMortalityImbalance

Afinding thatcaused considerableconcern duringthe drug'sinitialreviewwasanunexplained mortality imbalance observed in the pivotal C208 trial. By the 120-week follow-up point, there was a statistically significant increase in the number of deaths in the bedaquiline arm (9 of 79 patients, or 11.4%) compared to the placebo arm (2 of 81 patients, or 2.5%).Investigators were unable to identify a discernible pattern or a clear causal link between the deaths and bedaquiline administration. However, as bedaquiline was rolled out globally, subsequent large-scale observational studies and meta-analyses of real-world data have not substantiated this increased risk. On the contrary, these larger datasets have consistently shown thatthe inclusionofbedaquiline inan MDR-TBregimen isassociatedwitha significant *reduction* in mortality compared to older, injectable-based regimens. This accumulating evidence suggests that the initial finding in the relatively small C208 trial may have been a statistical anomaly rather than a true drug effect [55][62].

3) HepatotoxicityandOtherAdverseEvents

AdverseEvent	DetailsandSignificance	RecommendedManagement& Context
QTcProlongation	Mean increase of ~15 ms. Risk is additive with other QT-prolonging drugs (e.g., moxifloxacin, clofazimine). Infrequent but seriousriskofTorsadedePointes.Ledtoan FDA black box warning.	Baseline andfollow-up ECGs (weeks 2, 12, 24). Monitor and correct serum electrolytes (K+,Ca2+,Mg2+).DiscontinueifQTc>500 ms or significant arrhythmia develops.
MortalityImbalance	Anunexplainedincreaseindeathswasseen in the pivotal C208 trial (11.4% vs. 2.5% placebo).	Nospecificcausewasidentified.Subsequent large-scale observational data show a mortality *benefit* with bedaquiline-containing regimens, suggesting the initial finding may have been an anomaly.
Hepatotoxicity	Increasedincidenceofelevatedliver transaminases (ALT, AST).	Monitor liverfunctiontests at baseline and monthly.Avoidco-administrationwithother hepatotoxicdrugsandalcohol.Discontinue for evidence of significant liver injury.
CommonAEs	Nausea,arthralgia(jointpain),headache, hemoptysis, chest pain.	Symptomaticmanagement.Generallymild to moderate and do not require discontinuation of therapy.
Table2:BedaquilineSafety ProfileandManagementRecommendations		

An increased incidence of hepatic-related adverse events, primarily elevations in liver transaminases,hasbeenobservedinpatientstreatedwithbedaquiline.Therefore,monitoring of liverfunction tests is recommended at baselineand at least monthly throughout treatment. Discontinuation of the drug is recommended in cases of significant liver injury. The most frequently reported common adverse events include nausea, arthralgia (joint pain), and headache [77].

VII.REGULATORY PATHWAY AND GLOBAL POLICY INTEGRATION

The journeyof bedaquilinefroman investigationalcompoundtoaglobalstandardof care isa compelling case study in modern drug regulation and public health policy, characterized by innovative regulatory mechanisms and a dynamic evolution of global guidelines driven by accumulating real-world evidence [23][55].

1) LandmarkRegulatoryApprovals

U.S. Food and Drug Administration (FDA): On December 28, 2012, the FDA granted bedaquiline accelerated approval, a landmark decision that made it the first new anti-TB drug with a novel mechanism of action to be approved in over 40 years. This approval wasbasedonthe surrogateendpointof time to sputumculture conversion [42].In June 2024, following the review of additional data, the FDA converted this to a full, traditional approval.EuropeanMedicines Agency(EMA): Followingthe FDA's lead, theEMA granted bedaquilineaconditionalmarketingauthorizationinMarch2014.Thiswassimilarly converted to a standard authorization in 2024 [43][57][60].

2) EvolutionofWorldHealthOrganization(WHO) Guidelines

TheWHO'srecommendationsforbedaquilinehave undergone adramaticevolution,reflectinga shift from initial caution to widespread endorsement as the evidence base grew.Initial Caution (2013): The WHO first issued interim policy guidance in June 2013. Reflecting the limited data available, this guidance was highly restrictive, recommending bedaquiline onlywhenaneffectiveregimen couldnototherwisebe constructedandunder five strict conditions: proper patient selection, adherence to regimen design principles, informed consent, close safety monitoring, and active pharmacovigilance [67].Shift to Core Agent (2018): Over the next five years, a wealth of real-world evidence accumulated from compassionate use programs and observational cohorts. This data was pivotal, demonstrating not only manageable safety but also a significant mortality benefit. In response, theWHO madea landmarkupdatein2018, elevatingbedaquilineto a Group A drug, recommending it as a core component for nearly all patients with MDR- TB and recommending *against* the routine use of toxic injectable agents.Current Status (2022 onwards): Today, bedaquiline is the undisputed cornerstone of modern MDR-TB therapy.The latestWHO guidelines,updated in 2022, recommend a6- month, all-oral regimen known as BPaLM (bedaquiline, pretomanid, linezolid, and moxifloxacin) as the preferred treatment for most people with MDR/RR-TB [69][70].

3) ExpansiontoPediatricandAdolescentPopulations

Following its approval for adults, dedicated research established the safety and appropriate dosingof bedaquiline inyoungerpopulations.Thisledtotheexpansionof regulatory approvals to include adolescents (12-17 years) in 2019 and children (5-11 years) in 2020, for whom a new, more palatable 20 mg pediatric formulation was developed. The WHO now recommends the use of bedaquiline in children of all ages, ensuring that even the youngest patients can benefit from modern, all-oral treatment regimens [44][65].

VIII. THE PARADIGM SHIFT: BEDAQUILINE AS THE CORNER STONE OF ALL-ORAL, SHORTER REGIMENS

The introductionof bedaquilinewasnot merelyanincremental improvement; itwasa catalyst foracomplete paradigmshift in thetreatmentof drug-resistanttuberculosis.Its efficacyasan oral agent enabled the development of regimens that are dramatically shorter, safer, more tolerable, and more effective than the archaic standards they replaced [43].

1) MovingBeyondInjectables

The most immediate and transformative impact of bedaquiline was that it provided a potent oral drug that could replace the toxic second-line injectable agents. By enabling the construction of effective all-oral regimens, bedaquiline effectivelyrendered the use of drugslike kanamycin and amikacinobsoleteformostpatients.Thissingle change representeda monumentalleapforward in making MDR-TB treatment more humane[76][77].

2) TheBPaLandBPaLMRegimens: ANewGoldStandard

Bedaquilinebecame thebackboneupon whichanewgeneration of highlyeffective, short- course regimens were built. The results from several groundbreaking clinical trials fundamentally redefined the global standard of care:**The Nix-TB and ZeNix Trials:** These studies evaluated a three-drug, all-oral regimen consisting of Bedaquiline, Pretomanid, and Linezolid (BPaL) for patients with the most highlyresistantformsof TB, includingXDR-TB.Thetrialsdemonstrated unprecedented success, with treatment success rates of approximately 90% after just 6 months of therapy [47]. The ZeNix trial further optimized the regimen by showing that lower doses or shorter durations of linezolid could maintain high efficacy while significantly reducing toxicity.**The TB-PRACTECAL Trial:** This landmark randomized controlled trial compared a six- month, four-drugregimen—BPaL plusMoxifloxacin(BPaLM)—against the existing standard of care. The results were definitive: the BPaLM regimen was found to be statistically superior,withan89% cure ratecompared to52%forthe standard of care,and was associated with significantly fewer severe adverse events.

The collective evidence from these trials has cemented a new standard of care for drug-resistant TB, leading to drastic shortening of treatment, a marked increase in efficacy, and vastly improved safety and tolerability [65][32].

Characteristic	Pre-BedaquilineStandardofCare(Injectable-based)	Post-BedaquilineStandardofCare (BPaLM Regimen)
TypicalDuration	18–24monthsorlonger	6months
KeyDrugs	5-6drugsincludingafluoroquinolone,cycloserine, ethionamide, pyrazinamide, etc.	Bedaquiline,Pretomanid,Linezolid, Moxifloxacin
RouteofAdministration	Combinationoforalanddailypainfulinjections for≥6months	All-oral
CommonSevereToxicities	Irreversiblehearingloss,kidneydamage, psychosis, severe nausea	Peripheral neuropathy, myelosuppression(fromlinezolid), QTc prolongation
TypicalTreatmentSuccessRate	~55–60%	~90%
Table3:EvolutionofMDR-TB TreatmentRegimens:A Comparative Overview		

IX. CHALLENGES AND FUTURE PERSPECTIVES

Despite its transformative success, the story of bedaquiline is not over. Securing its long-term benefitsrequiresconfrontingongoing challengesrelatedtodrug resistance,globalaccess,and equity, while continuing to pursue research that can further optimize its use [33][51].

1) TheSpecterofBedaquilineResistance

The emergence of drug resistance is an inevitable consequence of antimicrobial use, andbedaquiline isnoexception.Casesof resistanceare being reported with increasingfrequency in settings where the drug is widely used. Resistance can occur through two primary genetic mechanisms:

- Low-levelresistance:This ismostcommonly caused bymutations in the *v0678* gene, which regulatesaneffluxpump. Thesemutationslead to thepumpbeingoverexpressed, actively pushing bedaquiline out of the bacterial cell.
- High-levelresistance:This iscaused by mutations inthe *atpE*gene,whichencodesthe c-subunit of the ATP synthase itself. These mutations alter the drug's binding site, preventing it from inhibiting the enzyme.The rise of resistance highlights the absolute necessity of antimicrobial stewardship. To preserve bedaquiline efficacy, it must only be used as part of an effective combination regimen,adherencemustbe rigorouslysupported,and robustsurveillancesystemswithaccess to rapid drug susceptibility testing must be implemented globally [66][68][71].

2) TheBattleforGlobalAccessandEquity

For years after its approval, the global rollout of bedaquiline was unacceptably slow. Numerous barriers prevented the drug from reaching the majority of patients who needed it. These included the high initial cost, a complex patent landscape where the manufacturer sought secondarypatentsinapractice known as"evergreening,"andslownationalregulatoryapproval processes in many high-burden countries [55].The battle for bedaquiline access has become a case study in the tension between intellectual property rights and the public health imperative for affordable access to life-saving medicines.

Years of persistent advocacy from civil society, TB survivors, and global health organizations successfully challenged these barriers. This pressure ultimately led to significant price reductions anda landmark licensingagreement in2023thatallowsfortheprocurementof more affordable generic versions of bedaquiline to the majority of low- and middle-income countries. This victory represents a major step towards achieving equitable access [76].

3) OngoingandFutureResearch

Thefieldof TBtherapeuticscontinuestoevolve,with ongoing research aimedatbuildingon the success of bedaquiline.

- Regimen Optimization: Clinical trials are underway to further optimize bedaquiline-containingregimens,withgoalsofpotentiallyshorteningtreatmentevenfurther,finding combinations with lower toxicity, and developing effective regimens for patients with bedaquiline-resistant TB.
- ExpandedUse: Thepotentsterilizingactivityofbedaquilinehasprompted research into its potential role in treating drug-sensitive TB, which could lead to a universal, shorter treatment regimen for all forms of TB.
- Next-Generation Drugs: Thevalidation of ATP synthase as a druggable target has reinvigorated the TB drug discovery pipeline. Research is now focused on developing next-generation diarylquinolinesandotherATP synthaseinhibitorsthatmaypossessan improved safety profile or enhanced activity against bedaquiline-resistant strains [64][67].

X. CONCLUSION: CEMENTING A PHARMA COLOGICAL BREAK THROUGH

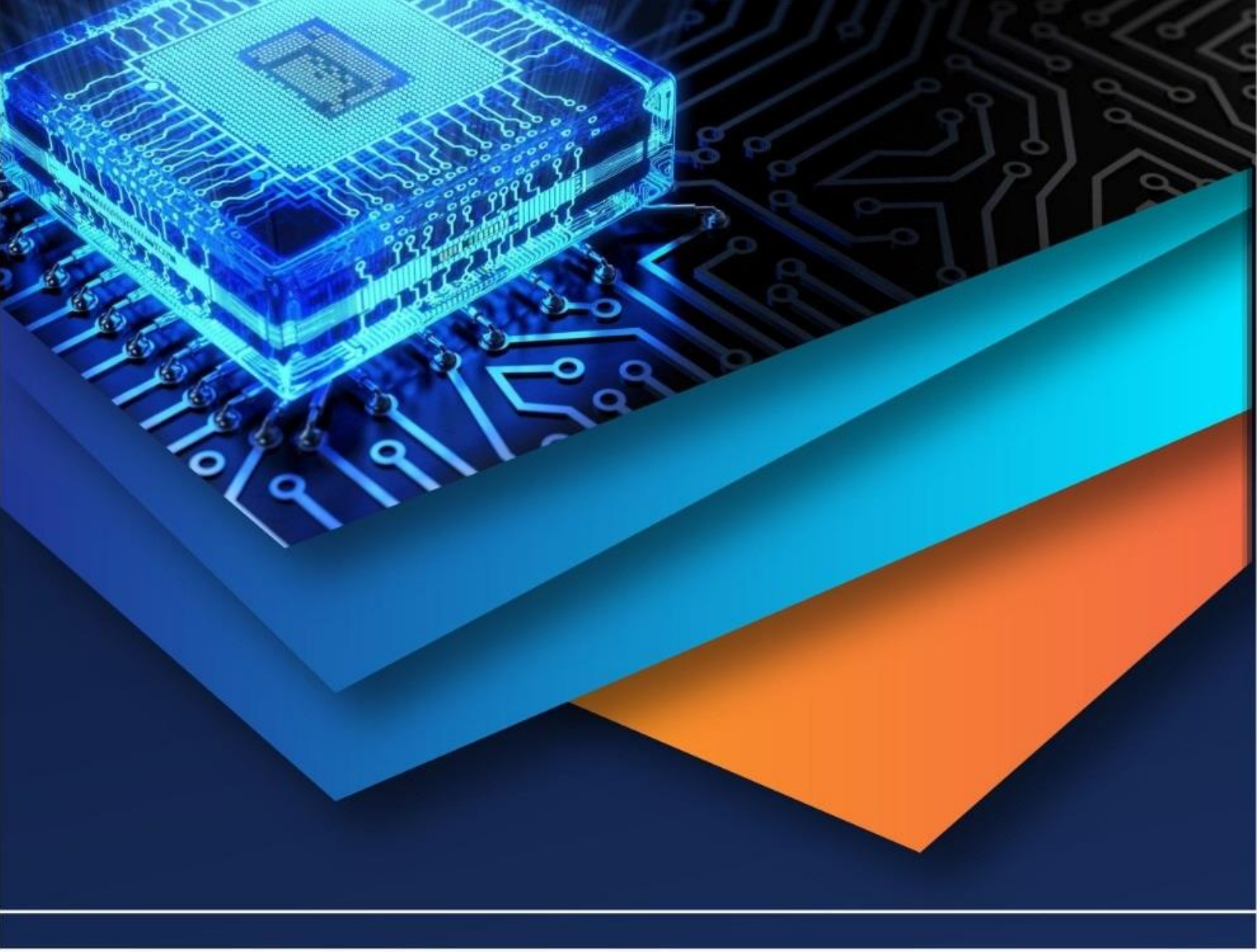
Bedaquiline represents a true and undeniable pharmacological breakthrough in the global fight againsttuberculosis.Its introductionendedafour-decade-longperiod of therapeuticstagnation and fundamentally reshaped the standard of care for the most dangerous and difficult-to-treat forms of the disease.Through its novel mechanism of action—the specific inhibition of mycobacterial ATP synthase— bedaquiline provided a powerful new weaponagainst strains of*M. tuberculosis* that hadevolved resistance to other drug classes. This efficacy, proven in pivotal clinical trials, enabled the development of all-oral treatment regimens that have transformed patient outcomes. The paradigm has shifted from grueling, two-year-long therapies reliant on toxic injections with a mere 50% chance of success, to a highly effective, six-month, all-oral regimen that cures approximately 90% of patients. This achievement has not only saved countless lives but has also drastically reduced patient suffering.However, the success of this breakthrough is not guaranteed to last. The future utility of bedaquiline hingesonourcollectiveabilitytonavigate thepersistentchallengesofemerging drug resistance.

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