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Antiretroviral treatment guidelines

Duncan Churchill

Conflicts of Interest

- Gilead sponsored me to go to CROI 2014
- I have been paid for attending an Advisory Board by MSD

Treatment guidelines

- When will they be ready?
- Will they be written by the same old people?

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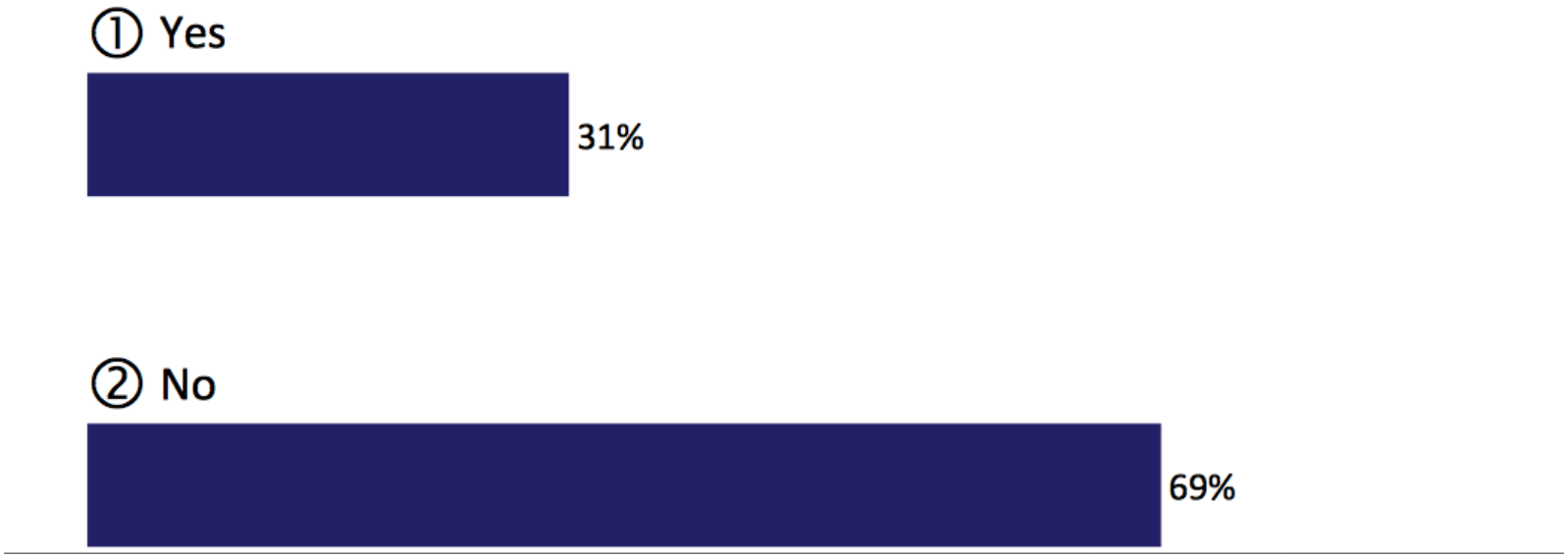
Question 3 (non-pharma, for those who have not previously been involved)

I would like to be involved with writing the treatment guidelines



Call for new members

- January 2014 – 19 applications
- 2 withdrew
- 6 added to guidelines writing group

- + Trainee representative (Nadia Ahmed)
- + New community representative (Chris Williams)

When will they be ready?

- Appointment of section leads
- Appointment of rest of panel
- Questions for literature search
- Completion of literature search
- Selection/sifting of abstracts
- Drafting of sections
- Production of GRADE tables/Grading of evidence
- Final draft
- Public consultation
- Final version

Other forthcoming guidelines

- Immunisation (Anna Maria Geretti)

- Monitoring (Brian Angus)
- Tuberculosis (Anton Pozniak)

- Testing (NICE plan to replace PH33 and PH34 with single set of guidelines, working with BHIVA, BIS, BASHH)

Adrian Palfreeman

COI

Sponsorship to attend CROI 2014
from Gilead

AVAILABLE GUIDELINES

- HIV in pregnancy
- Opportunistic infections in HIV
- Post-exposure prophylaxis
- TB Co-infection
- HIV associated malignancies
- Hepatitis co infection
- Investigation and monitoring of HIV
- Antiretroviral treatment

DRUGS

- A-Z List

WHEN TO GIVE PEP

- receptive anal sex
- insertive anal sex
- vaginal sex
- fellatio with ejaculation
- splash of semen into the eye
- sharing of injecting equipment
- other

Recommended combinations for PEP

Truvada one tablet once daily plus raltegravir 400mg twice daily

OR

Truvada one tablet once daily plus Kaletra two tablets twice daily or four tablets once daily for 28 days

(Raltegravir suggested as first line as per 2014 EAGA recommendations)

CRYPTOCOCCAL MENINGITIS

- Background
- Presentation
- Diagnosis
- Treatment
- Prophylaxis
- Pregnancy
- ART Issues

CLINICAL DIAGNOSIS

- Aspergillosis
- Bacterial Pneumonia
- Bartonellosis
- C.difficile diarrhoea
- Candidiasis
- CNS Toxoplasmosis
- Chagas Disease
- CMV Encephalitis
- CMV Colitis
- CMV Pneumonitis
- CMV Retinitis
- Cryptococcal meningitis
- Cryptococcal Pneumonia
- Cryptosporidiosis

Diagnosis

All HIV patients presenting with a CD4 count less than 200 cells/mL and symptoms compatible with cryptococcosis should have this disease excluded.

Diagnostic tests include

Serum cryptococcal antigen

This is the principle diagnostic test and most commonly uses the latex agglutination method. A negative test generally excludes disseminated cryptococcal disease although there are isolated reports of a negative cryptococcal antigen with disseminated disease. False positive cryptococcal antigen may occur in the presence of rheumatoid factor, heterophile antibodies, anti-idiotypic antibodies and *Trichosporon asahii* (*beigelii*) infection.

All patients with a positive serum cryptococcal antigen should undergo further evaluation by lumbar puncture after CT or MRI cerebral scanning.

Lumbar puncture

Manometry must always be performed to exclude a raised intracranial pressure. A positive CSF cryptococcal antigen, Indian ink stain of CSF, or CSF cryptococcus culture confirms meningitis. CSF should always be sent for fungal culture.

Blood culture

Blood culture should always be performed.

Fungal cultures

Where blood cultures or CSF cultures are positive, isolates may be sent for fungal susceptibility testing where facilities exist. Strains with increased azole minimum inhibitory concentrations (MICs) have been reported, in particular from sub-Saharan Africa. However, the correlation between clinical response and fluconazole MIC has been variable so the decision to switch requires supportive laboratory or clinical markers of an impaired response to therapy.

Poor prognostic factors are blood culture positivity, low white blood cell in CSF (<20 cells/mL), high CSF cryptococcal antigen (>1:1024), a confused state and a raised intracranial pressure.

Thanks to

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- Simon Edwards
- Sophie Flavell
- Helen Colver
- Ed Wallitt