Diagnosis of active TB

We recommend
• Microscopy for AFB
• Molecular testing for rapid identification of MTB and rifamycin resistance
• Mycobacterial culture and drug sensitivity testing

We recommend against
• The use of IGRA for the diagnosis of active TB
TB Treatment

We recommend

- Daily administration of standard TB therapy (2RHZE/4RH) in those with drug sensitive TB  
  (1A)
- Using fixed-dose combination tablets (RHZE, RHZ and RH) wherever possible  
  (GPP)
- That rifampicin is substituted with rifabutin if drug-drug interactions preclude the use of rifampicin  
  (1C)  
  (Unchanged)

We recommend

- That patients with TB meningitis receive corticosteroids  
  (1A)
- Against the use of corticosteroids in TB pericarditis  
  (1A)  
  (Updated)
TB Treatment

Management of treatment failure, relapse and MDR-TB

We recommend that

• Advice is sought from a centre with expertise in the management of such cases (GPP)

Directly observed therapy (DOT)

We recommend

• Individualised, patient-centred care plans for all patients; these may include DOT and video observed therapy (VOT) (GPP)
• Against the routine use of DOT (1A)

(Unchanged)
Patients who develop TB not on ART: When to start ART

Integration of Antiretroviral Therapy with Tuberculosis Treatment

Salim S. Abdool Karim, M.B., Ch.B., Ph.D., Kagieleum Naidoo, M.B., Ch.B.,...
Patients who develop TB not on ART: When to start ART

We recommend that

• Patients with TB start ART within 8-12 weeks of starting TB treatment (1A)

• Patients with CD4 cell count <50 cells/μL start ART within 2 weeks once they are stable and TB treatment is tolerated (1A)

We recommend against

• Early initiation (<8 weeks) of ART in patients with CNS TB (1A)

(Updated)
Patients who develop TB not on ART: What to start

CARINEMO trial: NVP not non-inferior in patients with HIV/TB

- 570 TB/HIV patients; CD4 89
- Rifampicin-based TB treatment
- AZT/3TC (or d4T/3TC) + NVP 400 or EFV 600 after 4-6 weeks of TB Rx
Patients who develop TB not on ART: What to start

REFLATE trial: similar rates of HIV suppression with RTG 400/800mg and EFV 600mg

- 155 TB/HIV patients (median CD4 140); RIF-based TB treatment
- TDF/3TC + RTG (400 or 800 bid) or EFV 600 after 2-8 weeks of TB Rx
Patients who develop TB not on ART: What to start

We recommend

- Efavirenz (standard dose) in combination with TDF/FTC as first-line ART (1A)
- Against the use of TAF in TB patients treated with rifampicin (1D)
- Against the use of nevirapine (1A) or rilpivirine (1D) in ART naive TB patients

We suggest that

- Raltegravir (standard or double dose) can be used for patients in whom efavirenz is contra-indicated (2B)

(Updated)
Patients who develop TB on ART

We recommend that

• Patients who develop TB on ART with undetectable HIV viral loads do not interrupt their ART (1A)

• Rifampicin-based TB treatment is used in patients whose established ART consists of efavirenz (1B), raltegravir (1C), or nevirapine (2C) plus 2NRTI (Updated)
Drug interactions and toxicities

- An updated table of (potential) drug-drug interactions between ART and (MDR) TB drugs is included

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Diagnosis of latent TB infection

• We suggest that IGRA rather than TST should be used when testing HIV-positive individuals for LTBI (2C)
• We recommend “test and treat” LTBI for all HIV-positive close contacts of people with infectious TB (1B)

(Unchanged)

• We recommend testing HIV-positive individuals from high and medium TB-incidence countries for LTBI, regardless of CD4 count and antiretroviral therapy, with particular attention to those newly diagnosed with HIV (1C)
• We recommend testing HIV-positive individuals from low-incidence countries for LTBI if they have additional TB risk factors (1C)

(Updated)
Treatment of latent TB infection

We recommend

• Treatment for LTBI for individuals with a positive IGRA, in whom active TB has been excluded by clinical assessment and chest X-ray with:
  – 6 months isoniazid plus pyridoxine, or
  – 3 months isoniazid plus rifampicin plus pyridoxine

(Unchanged)
In memoriam
Steve Lawn 1966-2016

• The committee would like to dedicate these guidelines to Professor Stephen Lawn who has made an exceptional contribution to the field of HIV/TB through his clinical studies in South Africa