35 – HIV Associated Opportunistic Infections I

Speaker: Henry Masur, MD

IDBR INFECTIOUS DISEASE BOARD REVIEW AUGUST 20-24 2022

Management of AIDS-Related Opportunistic Infections I

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7/24/2022

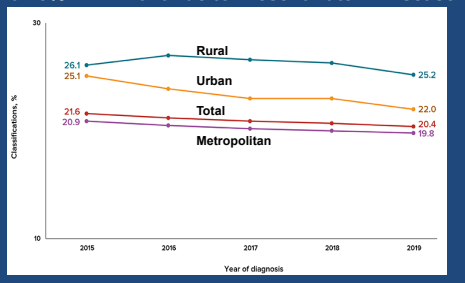
IDBR INFECTIOUS DISEASE BOARD REVIEW AUGUST 20-24 2022

Disclosures of Financial Relationships with Relevant Commercial Interests

- None

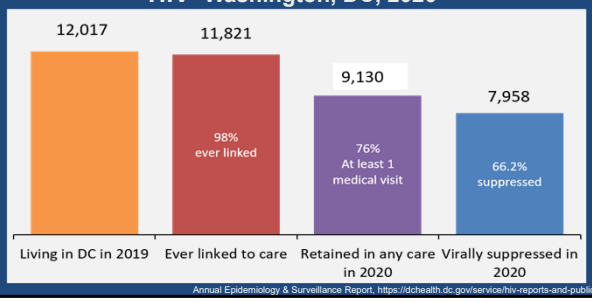
AIDS at Time of Diagnosis 2015-2019, United States

20-25% PWH Continue to Present Late in Disease



https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-26-no-2/index.html

HIV Care Continuum among People Living with HIV Washington, DC, 2020



Annual Epidemiology & Surveillance Report, https://dchealth.dc.gov/service/hiv-reports-and-publications

Causes of Death in Persons With HIV

	DAD Study (1999-2011) N=3909 deaths		London (2016) N=206 deaths	
AIDS-related	1123	(29%)	37	(32%)
Liver-related	515	(13%)	12	(6%)
CVD-related	436	(11%)	23	(20%)
Non-AIDS cancer	590	(15%)	40	(29%)
Drug related	109	(3%)	6	(3%)
Bacterial infection	259	(7%)	14	(7%)

Smith et al Lancet 2014; 384: 241–48
Croxford, HIV Medicine, 2019

Question #1

- An asymptomatic patient with a new diagnosis of HIV (CD4 = 10 cells/uL and HIV Viral Load 300,000 copies/uL is started on antiretroviral therapy (dolutegravir plus tenofovir alafenamide/emtricitabine)
- His labs are unremarkable as is his chest xray
- His serum toxoplasma IgG is positive
- He asks whether you want to add prophylaxis for pneumocystis pneumonia but warns you that twice when he has taken sulfonamides he has developed hives and laryngeal edema

What would you recommend regarding PCP and Toxo prophylaxis?

A. No chemoprophylaxis: his viral load should fall quickly, and his CD4 will rise quickly in response to this first exposure to antiretroviral therapy
B. Trimethoprim sulfamethoxazole plus solu-medrol dose pak
C. Dapsone
D. Aerosol pentamidine plus pyrimethamine
E. Atovaquone

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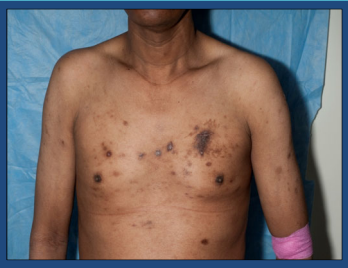
Question #2

The patient whose photo is shown is HIV positive (CD4=10 cells/uL, VL=2 mil copies) and has noted these lesions developing on his trunk, face and extremities over the past 8 months.

He has had low grade fevers for several months.

For your differential diagnosis, what besides Kaposi sarcoma would be the most likely cause of these lesions and their associated fever?

Question #2

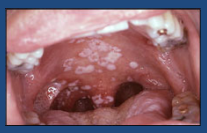


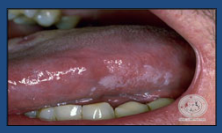
Question #2

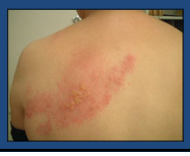
The most likely cause of these skin lesions, if they are not Kaposi sarcoma, is:

A. HHV-6
B. CMV
C. Cryptococcus neoformans
D. Bartonella
E. Rhodococcus

Clinical Indicators of Immunosuppression







Cardinal AIDS-Defining Illnesses

- **Pneumocystis pneumonia**
- **Toxoplasma encephalitis**
- **CMV Retinitis**
- **Disseminated Mycobacterium avium complex/Tuberculosis**
- **Chronic cryptosporidiosis/microsporidiosis**
- **Kaposi Sarcoma**

Is COVID-19 an HIV Related Opportunistic Infection?

- **Not testable**
  - Controversial whether excess morbidity/mortality is related to HIV or to co-morbidities such as obesity, hypertension, diabetes etc
  - Not relevant to prevention, diagnosis, therapy
  - Prudent to emphasize vaccine and other preventive measures

PS: Monkeypox could be presented in terms of prior US cases linked to travel or to the 2003 pet shop related outbreaks but…. the current outbreak in MSM will NOT show up on exam—too new and too many unresolved issues!!

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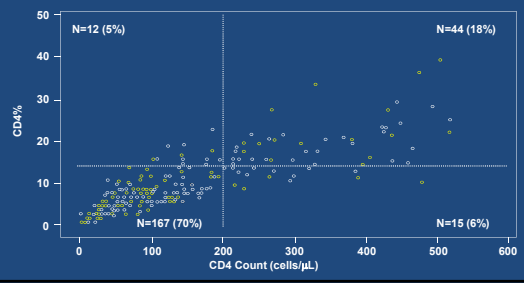
Susceptibility to Opportunistic Infections Patients with HIV

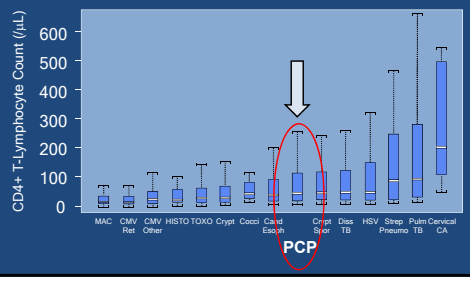
- **CD4 Count**
  - Current count is most important
  - Prior nadir count is much less important
- **Viral Load**
  - Independent risk factor for OIs

At What CD4 Counts Do Opportunistic Infections Occur?

Scatterplot of CD4 Number vs CD4 Percent Within 6 Months of HIV-Associated PCP



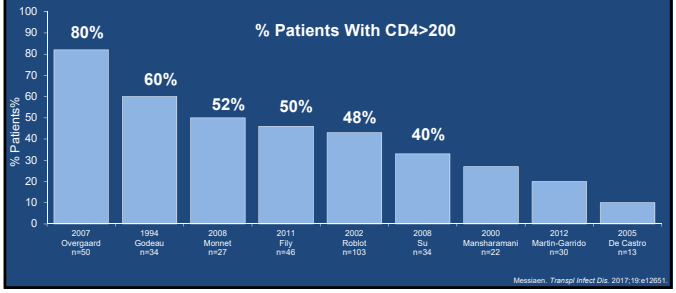
CD4+ Lymphocyte Counts Are Excellent Predictor of the Occurrence of Opportunistic Infections for HIV/AIDS



CD4 Counts in Non-HIV Patients

- **Low CD4 Count**
  - Susceptible to PCP
- **High CD4 Count**
  - Not necessarily protected from PCP

WARNING For Non-HIV Patients CD4 Count Are Not A Sensitive Indicator of PCP



Messiaen. *Transpl Infect Dis.* 2017;19:e12651.

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What is the Most Effective Intervention to Prevent Opportunistic Infections and Neoplasms Regardless of CD4 Count and Viral Load?

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Antiretroviral Therapy

When to Start ART Following Opportunistic Infection

You Have Seen This Question!!

A 52-year-old woman without known HIV is diagnosed with PCP

- **HIV Ab test positive**
- **CD4 103, HIV RNA 135,000 copies/ml**
- **She is still intubated on day 4 of IV trimethoprim-sulfa and corticosteroids**

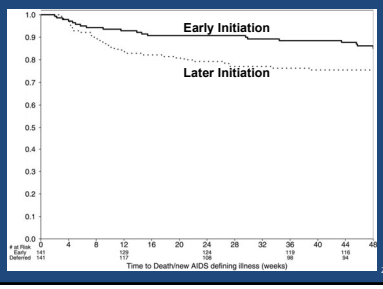
When should she start ART?

A. Immediately
B. In the next 2 weeks
C. After completing 21 days of trimethoprim-sulfa
D. At her first outpatient clinic visit

When to Start ART Following Opportunistic Infection

- **Most OIs**
  - **–Within 2 weeks of diagnosis**

ART Initiation Following HIV Related Opportunistic Infections
Early Favors Survival



Zolopa PLoS One 2009;4:e5575

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When to Start ART Following Opportunistic Infection

- **Tuberculosis: 2-8 weeks after initiation RX**
  - CD4<50 or Pregnant-within 2 weeks of diagnosis
  - CD4>50-within 8 weeks of diagnosis
- **Cryptococcal Meningitis: 4-6 weeks after initiation of RX**
  - Sooner if mild and if CD4<50
  - Later if severe
- **"Untreatable" OIs, i.e., PML, Cryptosporidiosis**
  - Start immediately

Primary and Secondary OI Prophylaxis

These Are Guidelines But They Are Based on 1980-1990 ART

- Primary Prophylaxis
  - PCP (CD4 <200, ~~oral candida, prior AIDS Defining~~)
  - Toxo (CD4 <100, old or new positive anti Toxo IgG)
  - Cocci (CD4<250, IgG or new positive cocci IgM
  - ~~MAC (CD4 < 50)~~ ----NIH/CDC/IDSA guideline has eliminated this for all practical purposes
  - *
- Secondary Prophylaxis /Chronic Suppression
  - PCP
  - Toxo
  - MAC
  - CMV
  - Cryptococcus
  - Histoplasma
  - Coccidio

*Some experts would give Histo primary prophylaxis with itraconazole in high risk situations if CD4<150

Prophylaxis NOT Routinely Recommended in US

Primary	Secondary
• Candida	Candida*
• Cryptococcus	
• HSV	HSV*
• VZV	VZV*
• CMV	
• MAC	

*Secondary Prophylaxis would be reasonable if recurrences were frequent or severe

Discontinue Prophylaxis/Chronic Maintenance

Board might consider this a "look up"

Primary Prophylaxis	CD4 Count Due to ART
– PCP or Toxo	>200 x 3 months
– PCP	(>100 and VL<50)

Secondary Prophylaxis/Chronic Maintenance	
– PCP	>200 x 3 months
– Toxo	>200 x 6 months
– Crypt	>200 x 6 months
– MAC	>100 x 6 months + 12 m Rx
– CMV	>100 x 3-6 months*

Primary Coccidiomycosis Prophylaxis 2022 OI Guideline

Testing

- Once or twice yearly testing for seronegative patients

Primary Prophylaxis

- Do not administer in endemic area if serology negative
- Within the endemic area
  - New positive IgM or IgG serology and
  - CD4 count is <250 cells (BIII) and
  - No Active Disease
- Regimen
  - Fluconazole 400mg qd until CD4>250 and fully suppressed viral load

OI Guidelines Vaccination Recommendations

Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV

VACCINE	All people	Where varies by age	Where varies by CD4 cell count (cells/mm³)	
			< 200	≥ 200
Hepatitis A	2-3 doses (varies by formulation)			
Hepatitis B	2-4 doses (varies by formulation and indication)			
Human papillomavirus (HPV)		3 doses ages 18-26*		
Influenza	1 dose annually			
Measles, mumps, rubella (MMR)			Contraindicated	2 doses if born after 1956 with no history of vaccination or positive antibody titer
Meningococcal A,C,W,Y conjugate (MenACWY)	2 doses, booster every 5 years			
Meningococcal B (MenB)	2-3 doses (varies by formulation)			
Pneumococcal conjugate (PCV15 or PCV20)	1 dose			
Pneumococcal polysaccharide (PPSV23)	1 dose (if conjugate vaccine was PCV<15)			
COVID 19	For current COVID-19 vaccination recommendations please visit CDC.gov		Recommendations differ with advanced or untreated HIV infection	
Tetanus, diphtheria, pertussis (Tdap/Td)	Tdap once, then Td or Tdap booster every 10 years			
Varicella (VAR)			Contraindicated	2 doses
Zoster recombinant (RZV)		2 doses for ages 18 and older		

Recommended for all adults and adolescents with HIV who meet the age requirement or lack documentation of vaccination or evidence of past infection.

Recommended for adults and adolescents with HIV with another risk factor (medical, occupational, or other indication) or in select circumstances.

Contraindicated

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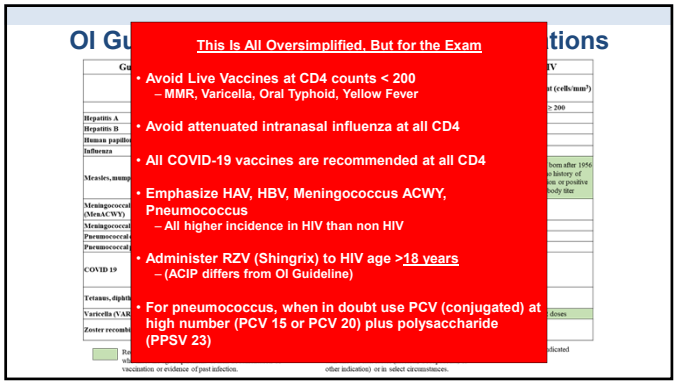

Pneumococcal Vaccine for Persons With HIV

Bottom Line: Give Polyvalent Pneumococcal Conjugate PCV15 or 20 and Then See Details

- Administer either 15-valent pneumococcal conjugate vaccine (PCV15) or 20-valent (PCV20)
- If PCV15 is used, a dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23) should be administered at least 8 weeks later.
- For PWH who previously started or completed a pneumococcal vaccination series, there is no need to restart the series.
  - PWH who previously received only the 13-valent pneumococcal conjugate vaccine (PCV13) should receive PPSV23 at least 8 weeks later
- PWH who have received PCV13 and PPSV23 should receive a booster PPSV23 at least 5 years after the first dose.
- If they were <65 at the time of the second dose, they should receive a third and final dose at or after age 65, at least 5 years after the second PPSV23 dose
- PWH who have only received PPSV23 may receive a PCV (either PCV20 or PCV15) ≥1 year after their last PPSV23 dose.
- When PCV15 is used in those with history of PPSV23 receipt, it need not be followed by another dose of PPSV23.

Who Should be Vaccinated for HBV

- **People without chronic HBV infection and without immunity to HBV infection (anti-HBs <10 mIU/mL)**
  - ACIP and NIH OI Guidelines Differ
    - Whether to Use Single or Double Dose for 3 dose series
  - The specific regimens are too granular and changing to likely be on exam
  - NIH/IDSA and CDC have different perspectives re rechecking antibody
    - 1-2 months post vaccine and then
    - Annually and boost responders if annual level <10mIU/ml

HBV Non-Responders

- **Definition**
  - Anti-HBs <10 international units/mL 1 month after vaccination series
- **Options: Not testable**
  - Switch to other recombinant vaccine, i.e., GSK to Merck or vice versa
  - Double dose of recombinant vaccine (if that was not the initial regimen)
  - Four dose regimen
  - Heplisav adjuvant vaccine

HBV Immunization for Persons with Isolated Anti HBc

- **Recommend one standard dose of HepB vaccine followed by checking anti-HBs level at 1–2 months.**
  - If the titer is >100 mIU/mL, no further vaccination is needed,
  - If the titer is <100 mIU/mL, a complete series of HepB vaccine should be completed, followed by anti-HBs testing
- **If the anti-HBs quantitative titer is not available**
  - Recommend complete HepB vaccine series
  - Follow-up quantitative anti-HBs testing

Post Exposure to HBV for PWH

- **Prior vaccine with documented response**
  - Nothing needed
- **Prior vaccine with NO response measured**
  - Administer single dose
- **No prior vaccine**
  - HBIG if within 7 days of percutaneous and 14 days of sexual exposure
    - Might not be necessary for patients on tenofovir or lamivudine
  - Full vaccine series simultaneously with HBIG
  - https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm

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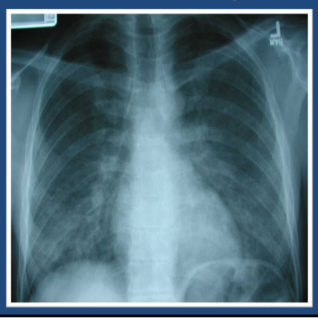
HIV Associated Pulmonary Disease



Etiology of HIV Associated Pulmonary Disorders

Common	Uncommon	Rare
• Pneumococcus	• Aspergillus	• CMV
• Hemophilus	• Histo/Cocci	• MAC
• Pneumocystis	• Staphylococci	• HSV
• Tuberculosis	• Toxoplasma	
• "Atypicals/viral"	• Lymphoma	
	• Kaposi sarcoma	

Respiratory Disease in Patients with HIV
Do Not Focus Only on OIs!

- **Non-Infectious**
  - **Congestive Heart Failure** (Age, cocaine, pulm hypertension)
  - **Pulmonary emboli** (Increased risk)
  - **Drug toxicity** (Abacavir, Lactic acidosis, dapsone)
  - **Neoplastic** (KS, Lymphoma, Lung CA)

Respiratory Disease in Patients with HIV
Do Not Focus Only on OIs!

- **Non-Infectious**
  - **Congest Heart Failure** (Age, cocaine, pulm hypert)
  - **Pulmonary emboli** (Increased risk)
  - **Drug toxicity** (Abacavir, Lactic acidosis, dapsone)
  - **Neoplastic** (Kaposi sarcoma, Lymphoma, Lung CA)
- **Non-Opportunistic Infections**
  - **Community acquired** (Influenza and MRSA)
  - **Aspiration** (Opioid related, nosocomial)
  - **Septic Emboli** (IV catheters, endocarditis)

Approach to Diagnosis and Therapy of Pneumonia in PWH

Parameter	Example
• Rapidity of Onset	> 3 days: PCP, TB, <3 days: Bacteria, viral
• Temperature	Afebrile: Neoplasm, PE, CHF
• Sputum	Scant: PCP, Virus, TB Purulent: Bacteria
• Physical Exam	Normal: PCP Consolidation: Bacteria
• Xray	Suggestive But Never Diagnostic

Pneumococcal Disease in Persons with HIV Infection

- **CD4<200**
  - Frequency enhanced
  - Severity/Extrapulmonary Complications Enhanced
- **CD4>350**
  - Frequency: Enhanced
  - **Severity: No difference**
- **Comorbidities Predisposing to Pneumococci Over-Represented in HIV**
  - Opioid Use Disorder, Etoh, Tobacco, Lack of Immunization
  - COPD, CHF, Obesity, MRSA colonization, Liver Disease

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Are There Strategies for Reducing Bacterial Pneumonias in Patients with HIV Infection?

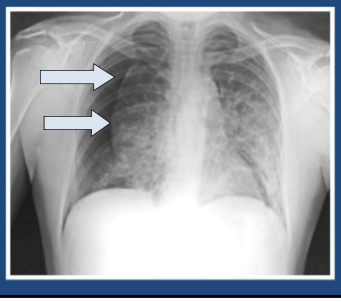
Strategies to Reduce Incidence of Pneumonia for Patients with HIV

- **Patient Focused Strategies**
  - Antiretroviral Therapy
  - Pneumococcal vaccine
  - Influenza vaccine
  - Tobacco cessation
- **Environmental Strategies**
  - Immunize contacts and community (esp children)
    - Pneumococcal and Hemophilus vaccines
    - Influenza vaccine

Question #3

- **A 28-year-old male with HIV (CD4 count = 10 cells) presents to the ER 4 weeks of malaise and mild cough, and now has bilateral interstitial infiltrates and a right sided pneumothorax.**
- **The patient lives in Chicago, works in an office and has never left the Midwest and no unusual exposures.**
- **The most likely INFECTIOUS cause of this pneumothorax is:**

HIV Patient with Shortness of Breath



Question #3

A 28-year-old male with HIV (CD4 count = 10 cells) presents to the ER 4 weeks of malaise and mild cough, and now has bilateral interstitial infiltrates and a right sided pneumothorax.

The patient lives in Chicago, works in an office and has never left the Midwest and no unusual exposures.

The most likely INFECTIOUS cause of this pneumothorax is:

A. Cryptococcosis
B. Blastomycosis
C. PCP
D. CMV
E. Aspergillosis

Pneumocystis Jirovecii (Formerly *P. carinii*)

- **Taxonomy**
  - Fungus (no longer Protozoan)
- **Epidemiology**
  - Environmental source unknown
- **Life Cycle**
  - Unknown
- **Transmission**
  - Respiratory

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Host Susceptibility to PCP

- CD4 < 200 cells/μL --(90% of cases)
- CD4% <14

Clinical Features of PJP in Pre-AIDS Era, (n=168)

No Feature is Present 100% of Initial Presentations

Symptom	% Patients
• Dyspnea	91%
• Fever	66%
• Cough	47%
Productive	7%
Non-productive	40%
• Signs	
– Cyanosis	39%
– Rales	33%

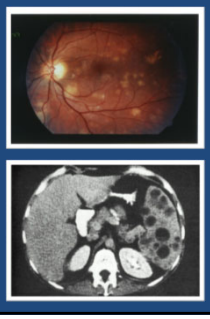
Walzer, Ann Intern Med 1974

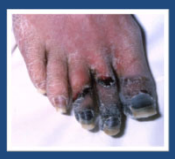
PCP is More Subacute in Persons With HIV Than Other Immunosuppressed Persons

Sign or Symptom	HIV (n=48)	Non-HIV (n=38)
Symptom		
Fever	81%	87%
Cough	81%	71%
Shortness of breath	68%	66%
Duration of symptoms,	28 days	5 days
Temp> 38°C	76%	92%
PaO_2	69 mm Hg	52 mm Hg
A-a gradient	41 mm Hg	59 mm Hg
% with normal ABG	5-20%	

Kovacs et al. Ann Intern Med 1984

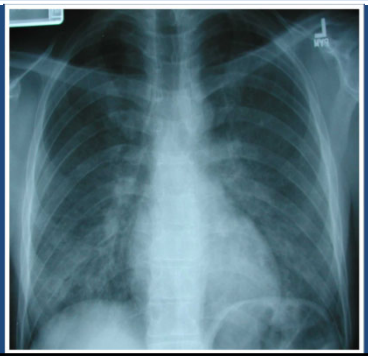
Uncommon Manifestations of PCP





Imaging of PCP

- **Early-CT is never normal!**
  - Reticular (interstitial)
  - Nodular (interstitial)
  - Ground Glass (sparing periphery)
- **Later-Progression from Interstitial**
  - Consolidation (late finding)
  - Upper Lobe Cysts (thin walled)
  - Pneumothorax
    - (cyst and bronchopleural fistula)



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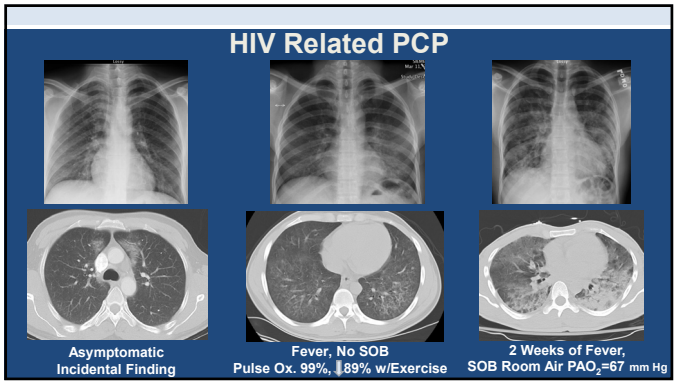
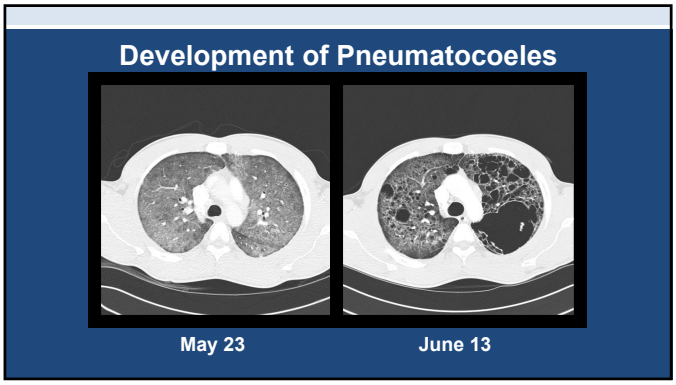




Radiologic Patterns Associated with Documented Pneumocystis Pneumonia

- Most Frequent
  - Diffuse symmetric interstitial infiltrates progressing to diffuse alveolar process
    - Butterfly pattern radiating from hilum

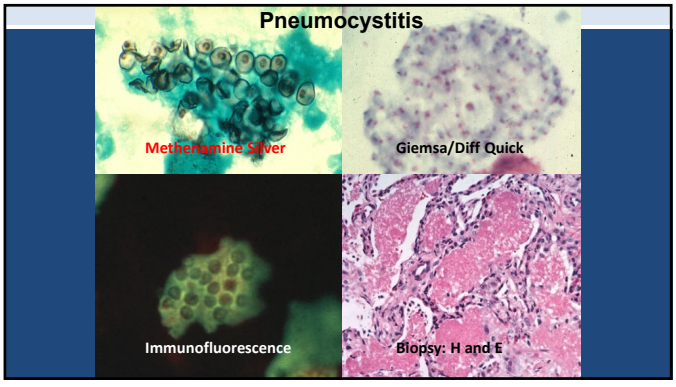
Radiologic Patterns Associated with Documented Pneumocystis Pneumonia

- Other Patterns Recognized
  - (Other concomitant infectious or neoplastic disease processes?)
  - Lobar infiltrates
  - Upper lobe infiltrates
  - Pneumothorax
  - Solitary nodules
  - Cavitating lesions
  - Infiltrates with effusions
  - Asymmetric or unilateral processes
  - Normal chest x-ray

Diagnosis of Pneumocystis Pneumonia

Specimen Acquisition	Organism Detection
Open lung biopsy	Methenamine silver
Transbronchial biopsy	Immunofluorescence
Bronchoalveolar lavage	Giemsa / Diff Quik
Induced sputum	PCR

1957 → 2022



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PCR
For Diagnosis of Pneumocystis in Bronchoalveolar Lavage

- **Highly sensitive in BAL**
  - Not useful in blood/serum/plasma
- **High biologic specificity**
  - Positive result might be infection or disease
  - Cycle number (copy number)helpful but not definitive

PCR
For Diagnosis of Pneumocystis in Bronchoalveolar Lavage

- **High**
  - No
- **High**
  - Po
  - Cy

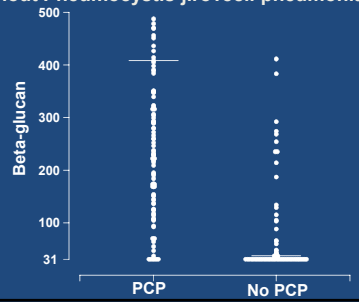
Negative BAL PCR rules out PCP

Positive BAL PCR *might* be PCP
- **Colonization vs Disease**

Is There A Serologic Test for PCP?
No!

- **Serum Antibody or PCR Test**
  - Not useful…yet
- **LDH**
  - Sensitivity depends on severity
  - Non-specific-elevated in many lung diseases
- **Beta Glucan**
  - Sensitive but not specific
  - Maybe useful for
    - Heightened suspicion of PCP if BAL or sputum not feasible
    - Following response to Rx

Distribution of β-glucan Results at Baseline in Those With and Without Pneumocystis jirovecii pneumonia (PCP)



Sax PE. *Clin Infect Dis* 2011

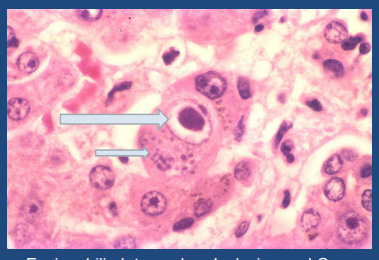
Question #4

- **A 45-year-old woman with HIV (CD4 = 50 cells/uL, HIV viral load = 500,000 copies/uL) presents with fever, shortness of breath, room air P02 =80mm Hg) and diffuse bilateral infiltrates and is started on TMP-SMX. The bronchoalveolar lavage is positive for pneumocystis by direct fluorescent antibody test.**
- **The cytology lab reports several CMV inclusion bodies in the BAL.**

The best course of action in addition to considering antiretroviral therapy would be:

A. To add ganciclovir to the TMP-SMX regimen
B. To add prednisone to the TMP-SMX regimen
C. To add ganciclovir plus prednisone to the TMP-SMX regimen
D. To add ganciclovir plus IVIG to the regimen
E. To add nothing, ie continue TMP-SMX alone

CMV Cytology



Eosinophilic Intranuclear Inclusion and Coarse Basophilic Cytoplasmic Inclusions

CMV Almost Never Causes Pneumonia In HIV Infected Pts

CMV is a marker of more severe immunosuppression but not usually the cause of pneumonia…in this population

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35 – HIV Associated Opportunistic Infections I

Speaker: Henry Masur, MD

Question #5

A patient with HIV infection newly diagnosed (CD4=10, VL= 200,000 copies/uL) was started on the following medications: efavirenz, emtricitabine, tenofovir, dapsone, fluconazole clarithromycin.

Ten days later the patient returns with headache, shortness of breath, a normal chest CT

Pulse oximetry shows an O2 saturation of 85%

A stat ABG is ordered which shows pH 7.40, pO2=96mmHg, pCO2 =39mm Hg, O2 Sat 96%.

The ABG lab reports methemoglobinemia = 25%

The most likely cause of this patient's syndrome is:

A. Pneumocystis pneumonia
B. Pulmonary Kaposi sarcoma
C. Fluconazole interaction with another drug
D. Dapsone
E. Clarithromycin

Answer #5

Methemoglobinemia = Methemoglobin>3%

Causes: Many: Dapsone and topical anesthetics notorious
Also chloroquine, primaquine, sulfa, nitrofurantoin

Therapy: Stop drug +/- methylene blue, ascorbic acid, transfusions

Answer #5

Methemoglobinemia = Methemoglobin>3%

Unlike normal hemoglobin, methemoglobin does not bind oxygen and as a result cannot deliver oxygen to the tissues

Symptoms: Headache to dyspnea to delirium and organ ischemia to death start occurring at methg >10%; >30% is life threatening

Detection
Too complicated for IDBR due to improving technology
Many systems measure methemoglobinemia directly
look for high P02, low O2 Sat and…report of methemoglobin

Causes: Many: Dapsone and topical anesthetics notorious
Also chloroquine, primaquine, sulfa, nitrofurantoin

Therapy: Stop drug +/- methylene blue, ascorbic acid, transfusions

Question #6

A 50-year-old male with HIV and PCP is receiving pentamidine 4 mg/kg IV over 1 hr qd.

On the ninth day of therapy, while awaiting transportation home, he has a syncopal episode.

An EKG done by the code team is normal.

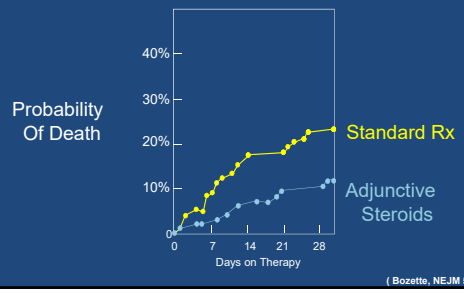
What Non cardiac toxicity of pentamidine would be most likely

A. Hyponatremia
B. Seizure
C. Hypoglycemia
D. Hypertensive crisis and stroke
E. Pulmonary embolus

Therapy for Pneumocystis Pneumonia

- **Specific Therapy**
  - **First Choice**
    - Trimethoprim-Sulfamethoxazole
  - **Alternatives**
    - Parenteral Pentamidine
    - Atovaquone
    - Clindamycin-Primaquine
- **Adjunctive Corticosteroid Therapy**
  - **Moderate to Severe PCP**
    - Room air p02 less than 70mmHg or A-a gradient >35mm Hg

Likelihood of Death in Patients with Moderate-Severe PCP Receiving Corticosteroids (n=251)



(Bozette, NEJM 5/90)

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35 – HIV Associated Opportunistic Infections I

Speaker: Henry Masur, MD

A Question That Could Be on Boards

- What drugs should only be given after screening for Glucose-6-Phosphate Dehydrogenase
- Drugs
  - Primaquine
  - Dapsone
  - And…..fluoroquinolones, Nitrofurantoin, Nalidixic acid, tafenoquine

A Question That Could Be on Boards

- What drugs should only be given after screening for Glucose-6-Phosphate Dehydrogenase
  - G6PD is common and nationality is increasingly difficult to define as a predictor
  - Males have more severe hemolysis since this is X linked
- Presentation
  - Hemolysis, jaundice, back and abdominal pain 2-4 days post drug exposure
  - Smear shows hemolytic pattern and "Heinz bodies"
  - Hemoglobinuria, high retic count
- Drugs
  - Primaquine
  - Dapsone
  - And…..fluoroquinolones, Nitrofurantoin, Nalidixic acid, tafenoquine
- Screening
  - Qualitative assay is used in urgent situations before drug administration
    - Testing after hemolysis can be misleading
  - Other management issues are too complicated for ID boards

How to Manage Patients Who Are Failing TMP-SMX

- Average Time to Clinical Improvement
  - 4-8 Days
- Radiologic Improvement
  - Lags clinical improvement

Reasons to Deteriorate During Treatment for PCP

- Fluid overload
  - Iatrogenic, cardiogenic, renal failure (Sulfa or Pentamidine related)
- Anemia
- Methemoglobinemia
  - Dapsone, primaquine
- Pneumothorax
- Unrecognized concurrent infection
- Immune Reconstitution Syndrome (IRIS)

Reasons to Deteriorate During Treatment for PCP

- Fluid overloa
  - Iatrogenic, ca… entamidine related)
- Anemia
- Methemoglob
  - Dapsone, prim
- Pneumothora
- Unrecognize
- Immune Rec

Patients Failing TMP-SMX Not Testable!

- Whether to Switch
- When to Switch
- What to Switch To
- How to Manage Steroid Dosing

Can *Pneumocystis Jiroveci* Become Resistant to TMP-SMX?

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35 – HIV Associated Opportunistic Infections I

Speaker: Henry Masur, MD

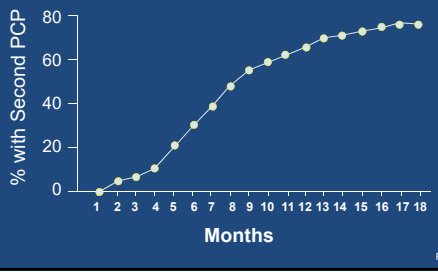
Toxicities of TMP-SMX and Pyrimethamine-Sulfadiazine

Drug	Toxicities
TMP-SMX	↓WBC, ↓plat, ↑LFT, ↑Creat, ↑Amylase, rash, fever, pruritus, "Sepsis" syndrome-distributive shock Hyperkalemia (TMP) Cross reactivity: dapsone (± 50%)
Pyrimethamine-Sulfadiazine	Similar to TMP-SMX Folinic acid necessary (not folate) to prevent cytopenias

Toxicity and Other Considerations Regarding Antipneumocystis Therapy

Drug	Issues
Pentamidine - IV	Hypotension-rate related ↑Creatinine, ↑Amylase, ↓WBC ↑ Early and then ↓Glucose Associated with↑Creatinine may occur days-wks post therapy Torsade de Pointes
Atovaquone	Poor absorption if low fat diet Rash, N + V, diarrhea, LFT

Without ART or Chemoprophylaxis Second Episodes of HIV Associated PCP Are Amazingly Common



Fischl/ACTG 002, 10/88

Indications for Primary and Secondary PCP Prophylaxis

Start	CD4 < 200 cells/uL (14%) ~~Oral candidiasis~~ ~~AIDS Defining Illness~~ ~~Prior PCP~~
Stop	CD4 >200 cells/µL x 3 M (Consider: CD4 100-200 and VL<50 x 3M)
Restart	CD4<200 cells/µL

Whether prophylaxis is needed at CD4 100-200 with suppressed viral load is too controversial for exam

Non HIV---When Is PCP Prophylaxis Indicated

Poor Data----------NOT TESTABLE

- **Corticosteroids**
  - ≥20mg prednisone x 1 month if also additional immunosuppressive condition
- **Renal transplant**
  - 6-12 months and longer if high doses of immunosuppressive
- **Human stem cell transplant**
  - Start after engraftment and for duration of immunosuppression, esp if Graft vs Host
- **Lung transplant**
  - Lifelong
- **Certain primary immunodeficiencies**
  - Lifelong
- **Certain drugs**
  - Fludarabine, Idelalisib, probably ibrutinib, probably TNP inhibitors, Temsirolimus
- **Some Biologics**
  - Rituximab-for 6 months after induction and during maintenance
  - TNF inhibitors
  - Alemtuzumab (Campath)
    - At least 2 months post therapy or CD4 > 200, whichever is later

Primary or Secondary Prophylaxis Agents for Pneumocystis Pneumonia

- **First Choice**
  - TMP-SMX
- **Other Options**
  - Aerosol pentamidine **OR**
  - Atovaquone **OR**
  - (Monthly IV pentamidine) **OR**
  - (Dapsone)

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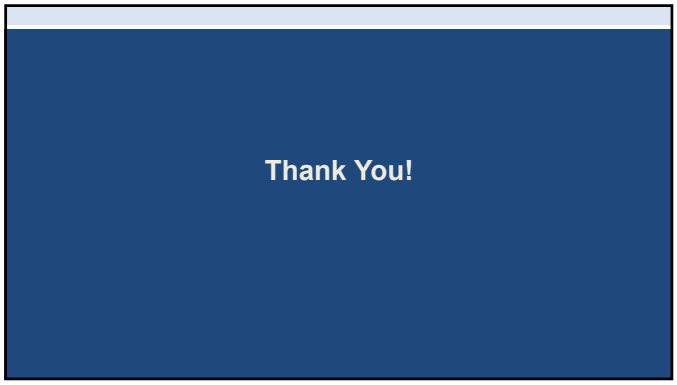

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