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a Cryptococcal disease screen-and-treat programme in the management of HIV

Cryptococcal disease screen-and-treat is recommended in the new national consolidated guidelines for the management of HIV

On 24 December 2014, the South African Department of Health published national consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults. These integrated guidelines harmonise recommendations across the continuum of HIV-related care for all age groups and populations.

Aspiring to fulfil the health department's 2020 targets of having 90% of the population tested for HIV, 90% of eligible HIV-infected persons on antiretroviral treatment (ART), and 90% of those on ART virally suppressed, these guidelines provide necessary clinical and programmatic guidance towards improved management of people living with HIV.

The 2014 guidelines reflect recent important advances in HIV management. Among these is the inclusion of new recommendations for routine screening and treatment of cryptococcal disease among ARV-naïve adults with CD4 counts <100 cells/µl. The recommendations are based on the World Health Organization 2011 guidelines as well as preliminary local data from the first phase of the cryptococcal disease screen-and-treat programme in South Africa (including sites in Western Cape, Gauteng and Free State provinces). Either clinician-initiated or reflex testing for cryptococcal antigenaemia (CrAg) is recommended, with testing performed in the laboratory. At the time of publication, reflex laboratory testing for CrAg was only available at three NHLS CD4 laboratories.

Clinical recommendations for CrAg-positive patients include further clinical investigation and management, antifungal treatment and optimal timing of ART (Figure 1):

- Patients with a positive cryptococcal antigen (CrAg) blood test have disseminated cryptococcal disease and should be **specifically** evaluated for symptoms/signs of meningitis.
- CrAg-positive patients with symptoms/signs should be referred for lumbar puncture (LP) to exclude cryptococcal meningitis. If cryptococcal meningitis is confirmed on LP, patients should be managed in hospital (for at least 2 weeks) and ART deferred for 4-6 weeks.
- CrAg-positive patients without symptoms/signs may be offered an LP, if this is immediately accessible, to exclude subclinical meningitis. For CrAg-positive patients without suspected meningitis, oral fluconazole (800mg daily for 2 weeks, followed by standard consolidation and maintenance treatment) is recommended, as well as for patients with an LP that is cryptococcal test-negative. For patients without signs or evidence of meningitis, ART is recommended to be started 2 weeks after anti-fungal therapy is initiated.

Of note are the following revised recommendations:

- Combination amphotericin B and fluconazole as induction treatment for patients with laboratory-confirmed cryptococcal meningitis.
- Timing of ART in cryptococcal disease. Defer ART for 4-6 weeks in patients with laboratory-confirmed cryptococcal meningitis, whilst ART can be commenced 2 weeks after antifungal therapy for CrAg-positive patients without signs or laboratory evidence of meningitis.

Further information can be accessed on the following websites:

- www.doh.gov.za
- http://www.nicd.ac.za/?page=communicable_diseases_surveillance_bulletin&id=45

Source: Centre for Opportunistic, Tropical and Hospital Infections, NICD-NHLS

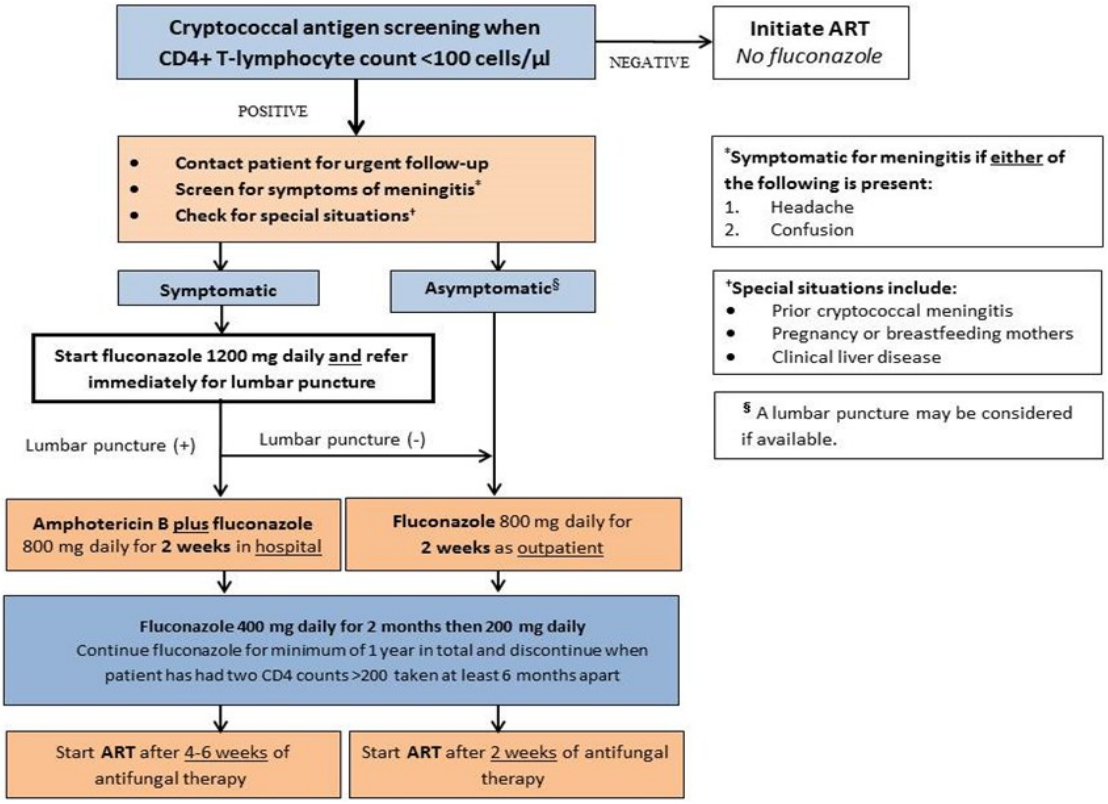

Figure 1. Algorithm for clinical management of disseminated cryptococcal disease