Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents

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### Table 1. Prophylaxis to Prevent First Episode of Opportunistic Disease

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<thead>
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<tr>
<td>Coccidioidomycosis</td>
<td>A new positive IgM or IgG serologic test in patients who live in a disease-endemic area and with CD4 count &lt;250 cells/µL (BIII)</td>
<td>Fluconazole 400 mg PO daily (BIII)</td>
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<td>Hepatitis A Virus (HAV) Infection</td>
<td>HAV-susceptible patients with chronic liver disease, or who are injection-drug users, or MSM (AII).</td>
<td>Hepatitis A vaccine 1 mL IM x 2 doses at 0 and 6–12 months (AII). IgG antibody response should be assessed 1 month after vaccination; non-responders should be revaccinated when CD4 count &gt;200 cells/µL. (BIII).</td>
<td>For patients susceptible to both HAV and hepatitis B virus (HBV) infection (see below): Combined HAV and HBV vaccine (Twinrix®), 1 mL IM as a 3-dose (0, 1, and 6 months) or 4-dose series (days 0, 7, 21 to 30, and 12 months) (AII).</td>
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| Hepatitis B Virus (HBV) Infection | • Patients without chronic HBV or without immunity to HBV (i.e., anti-HBs <10 international units/mL) (AII)  
  • Vaccination is recommended before CD4 count falls below 350 cells/µL (AII).  
  • In patients with CD4 counts 350 cells/µL, vaccination should not be deferred until CD4 count reaches >350 cells/µL, because some patients with CD4 counts <200 cells/µL do respond to vaccination (AII). | • HBV vaccine IM (Engerix-B 20 µg/mL or Recombivax HB 10 µg/mL), 0, 1, and 6 months (AII), or  
  • HBV vaccine IM (Engerix-B 40 µg/mL or Recombivax HB 20 µg/mL), 0, 1, 2 and 6 months (BII),  
  • Vaccine conjugated to CpG (Heplisav-B®) IM at 0 and 1 months (CIII) – a 2-dose series can only be used when both doses given are Heplisav-B®.  
  • Combined HAV and HBV vaccine (Twinrix®), 1 mL IM as a 3-dose (0, 1, and 6 months) or 4-dose series (days 0, 7, 21 to 30, and 12 months) (AII) | Some experts recommend vaccinating with 40-µg doses of either HBV vaccine (CIII). |
|                               | Anti-HBs should be obtained 1 month after completion of the vaccine series. Patients with anti-HBs <10 international units/mL at 1 month are considered non-responders (BII).  
  For patients with isolated anti-HBc  
  • One standard dose of HBV vaccine followed by anti-HBs at 1-2 months.  
  If the titer is >100 IU/mL, no further vaccination is needed, but if it is <100 IU/mL, a complete series of HBV vaccine should be completed followed by anti-HBs testing (BII). | Re-vaccinate with a second vaccine series (BIII) | • HBV vaccine IM (Engerix-B 40 µg/mL or Recombivax HB 20 µg/mL), 0, 1, 2 and 6 months (BII). |
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<td><strong>Histoplasmosis</strong></td>
<td>CD4 count ≤150 cells/µL and at high risk because of occupational exposure or live in a community with a hyperendemic rate of histoplasmosis (&gt;10 cases/100 patient-years) (<strong>BI</strong>)</td>
<td>Itraconazole 200 mg PO daily (<strong>BI</strong>)</td>
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<td><strong>Human Papillomavirus (HPV) Infection</strong></td>
<td>Females and males aged 13–26 years (<strong>AIII</strong>)</td>
<td>• HPV recombinant vaccine 9 valent (Types 6, 11, 16, 18, 31, 33, 45, 52, 58) 0.5 mL IM at 0, 1–2, and 6 months (<strong>AIII</strong>)</td>
<td>For patients who have completed a vaccination series with the recombinant bivalent or quadrivalent vaccine, many experts would give an additional full series of recombinant 9-valent vaccine, but there are no data to define who might benefit or how cost effective this approach might be (<strong>CIII</strong>).</td>
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<td><strong>Influenza A and B Virus Infection</strong></td>
<td>All HIV-infected patients (<strong>AIII</strong>)</td>
<td>Inactivated influenza vaccine annually (per recommendation for the season) (<strong>AIII</strong>)</td>
<td>Live-attenuated influenza vaccine is <strong>contraindicated</strong> in HIV-infected patients (<strong>AIII</strong>).</td>
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<td><strong>Malaria</strong></td>
<td>Travel to disease-endemic area</td>
<td>Recommendations are the same for HIV-infected and HIV-uninfected patients. Recommendations are based on region of travel, malaria risks, and drug susceptibility in the region. Refer to the following website for the most recent recommendations based on region and drug susceptibility: <a href="http://www.cdc.gov/malaria/">http://www.cdc.gov/malaria/</a>.</td>
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| **Mycobacterium avium Complex (MAC) Disease** | For CD4 Count <50 cells/mm³  
• **Not recommended** for those who immediately initiate ART (**AII**).  
• Recommended for those who are not on fully suppressive ART, after ruling out active disseminated MAC disease (**AI**). | • Azithromycin 1200 mg PO once weekly (**AI**), or  
• Clarithromycin 500 mg PO BID (**AI**), or  
• Azithromycin 600 mg PO twice weekly (**BIII**) | Rifabutin (dose adjusted based on concomitant ART) (**BI**); rule out active TB before starting rifabutin. |
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<td><strong>Mycobacterium tuberculosis (TB) Infection</strong></td>
<td>(+) screening test for LTBI, with no evidence of active TB, and no prior treatment for active TB or LTBI (AI), or Close contact with a person with infectious TB, with no evidence of active TB, regardless of screening test results (AII).</td>
<td>(INH 300 mg + pyridoxine 25–50 mg) PO daily x 9 months (AII), or INH 900 mg PO BIW (by DOT) + pyridoxine 25–50 mg PO daily x 9 months (BII).</td>
<td>Rifampin 600 mg PO daily x 4 months (BIII), or Rifabutin (dose adjusted based on concomitant ART) x 4 months (BIII), or [Rifapentine (see dose below) PO + INH 900 mg PO + pyridoxine 50 mg PO] once weekly x 12 weeks rifapentine dose: 32.1 to 49.9 kg: 750 mg &gt;50 mg: 900 mg Rifapentine only recommended for patients receiving raltegravir or efavirenz-based ART regimen For persons exposed to drug-resistant TB, select anti-TB drugs after consultation with experts or public health authorities (AII).</td>
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<td><strong>Pneumocystis Pneumonia (PCP)</strong></td>
<td>CD4 count &lt;200 cells/mm³ (AI), or CD4 &lt;14% (BII), or If ART initiation must be delayed, CD4 count ≥200, but &lt;250 cells/mm³ and if monitoring of CD4 cell count every 3 months is not possible (BII) Note: Patients who are receiving pyrimethamine/sulfadiazine for treatment or suppression of toxoplasmosis do not require additional PCP prophylaxis (AII).</td>
<td>TMP-SMX² 1 DS tablet PO daily (AI), or TMP-SMX² 1 SS tablet daily (AI)</td>
<td>TMP-SMX² 1 DS PO three times weekly (BII), or Dapsone¹ 100 mg PO daily or 50 mg PO BID (BII), or Dapsone² 50 mg PO daily with (pyrimethamine³ 50 mg plus leucovorin 25 mg) PO weekly (BII), or (Dapsone² 200 mg plus pyrimethamine³ 75 mg plus leucovorin 25 mg) PO weekly (BII); or Aerosolized pentamidine 300 mg via Respigard II™ nebulizer every month (BII), or Atovaquone 1500 mg PO daily (BII), or (Atovaquone 1500 mg plus pyrimethamine³ 25 mg plus leucovorin 10 mg) PO daily (CIII)</td>
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| *Streptococcus pneumoniae* Infection | For individuals who have not received any pneumococcal vaccine, regardless of CD4 count, followed by:  
• if CD4 count ≥200 cells/µL  
• if CD4 count <200 cells/µL | PCV13 0.5 mL IM x 1 *(AI)*.  
PPV23 0.5 mL IM at least 8 weeks after the PCV13 vaccine *(AII)*.  
PPV23 can be offered at least 8 weeks after receiving PCV13 *(CIII)* or can wait until CD4 count increased to ≥200 cells/µL *(BIII)*. | PPV23 0.5 mL IM x 1 *(BII)* |
|  | For individuals who have previously received PPV23 | One dose of PCV13 should be given at least 1 year after the last receipt of PPV23 *(AII)*. |  |
|  | Re-vaccination  
• If age 19–64 years and ≥5 years since the first PPV23 dose  
• If age ≥65 years, and if ≥5 years since the previous PPV23 dose | • PPV23 0.5 mL IM or SQ x 1 *(BIII)*  
• PPV23 0.5 mL IM or SQ x 1 *(BIII)* |  |
| Syphilis | • For individuals exposed to a sex partner with a diagnosis of primary, secondary, or early latent syphilis within past 90 days *(AII)*, or  
• For individuals exposed to a sex partner >90 days before syphilis diagnosis in the partner, if serologic test results are not available immediately and the opportunity for follow-up is uncertain *(AIII)* | Benzathine penicillin G 2.4 million units IM for 1 dose *(AII)* | For penicillin-allergic patients:  
• Doxycycline 100 mg PO BID for 14 days *(BII)*, or  
• Ceftriaxone 1 g IM or IV daily for 8–10 days *(BII)*, or  
• Azithromycin 2 g PO for 1 dose *(BII)* – not recommended for MSM or pregnant women *(AII)* |
| Talaromyces (Formerly Penicilliosis) | Patients with CD4 cell counts <100 cells/µL who live or stay for a long period in rural areas in northern Thailand, Vietnam, or Southern China *(B)* | Itraconazole 200 mg once daily *(BII)* | Fluconazole 400 mg PO once weekly *(BII)* |
| *Toxoplasma gondii* Encephalitis | • Toxoplasma IgG-positive patients with CD4 count <100 cells/µL *(AII)*  
**Note:** All regimens recommended for primary prophylaxis against toxoplasmosis are also effective as PCP prophylaxis. | TMP-SMX<sup>c</sup> 1 DS PO daily *(AII)* | • TMP-SMX<sup>c</sup> 1 DS PO three times weekly *(BII)*, or  
• TMP-SMX<sup>c</sup> 1 SS PO daily *(BIII)*, or  
• Dapsone<sup>e</sup> 50 mg PO daily + (pyrimethamine<sup>e</sup> 50 mg + leucovorin 25 mg) PO weekly *(BII)*, or  
• (Dapsone<sup>e</sup> 200 mg + pyrimethamine<sup>e</sup> 75 mg + leucovorin 25 mg) PO weekly *(BII)*; or  
• Atovaquone 1500 mg PO daily *(CIII)*; or  
• (Atovaquone 1500 mg + pyrimethamine<sup>e</sup> 25 mg + leucovorin 10 mg) PO daily *(CIII)* |
### Table 1. Prophylaxis to Prevent First Episode of Opportunistic Disease (page 6 of 6)

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| Varicella-Zoster Virus (VZV) Infection | Pre-exposure prevention: Patients with CD4 counts $\geq$ 200 cells/µL who have not been vaccinated, have no history of varicella or herpes zoster, or who are seronegative for VZV (CIII)  
**Note:** Routine VZV serologic testing in HIV-infected adults and adolescents is not recommended.  
Post-exposure prevention: (AIII) Close contact with a person with chickenpox or herpes zoster; and is susceptible (i.e., no history of vaccination or of either condition, or known to be VZV seronegative) | Pre-exposure prevention: Primary varicella vaccination (Varivax™), 2 doses (0.5 mL SQ each) administered 3 months apart (CIII).  
If vaccination results in disease because of vaccine virus, treatment with acyclovir is recommended (AIII).  
Post-exposure prevention: Varicella-zoster immune globulin (VariZIG™) 125 international units per 10 kg (maximum 625 international units) IM, administered as soon as possible and within 10 days after exposure (AIII)  
**Note:** VariZIG is exclusively distributed by FFF Enterprises at 800-843-7477.  
Individuals receiving monthly high-dose IVIG (>400 mg/kg) are likely to be protected if the last dose of IVIG was administered <3 weeks before exposure. | Pre-exposure prevention: VZV-susceptible household contacts of susceptible HIV-infected persons should be vaccinated to prevent potential transmission of VZV to their HIV-infected contacts (BIII).  
Alternative post-exposure prevention:  
- Acyclovir 800 mg PO 5 x/day for 5–7 days (BIII), or  
- Valacyclovir 1 g PO TID for 5–7 days (BIII)  
These alternatives have not been studied in the HIV population.  
If antiviral therapy is used, varicella vaccines should not be given until at least 72 hours after the last dose of the antiviral drug. |

### Evidence Rating:

**Strength of Recommendation:**
- A: Strong recommendation for the statement
- B: Moderate recommendation for the statement
- C: Optional recommendation for the statement

**Quality of Evidence for the Recommendation:**
- I: One or more randomized trials with clinical outcomes and/or validated laboratory endpoints
- II: One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes
- III: Expert opinion

In cases where there are no data for the prevention or treatment of an OI based on studies conducted in HIV-infected populations, but data derived from HIV-uninfected patients exist that can plausibly guide management decisions for patients with HIV/AIDS, the data will be rated as III but will be assigned recommendations of A, B, C depending on the strength of recommendation.