

**APPENDIX B: TREATMENT OF AIDS-ASSOCIATED OIS IN ADULTS**

OPPORTUNISTIC INFECTIONS	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ ISSUES
<p><i>Pneumocystis jiroveci</i> Pneumonia (PCP)</p>	<p><u>Acute Therapy:</u></p> <ul style="list-style-type: none"> <li>• TMP-SMX: [15-20mg TMP + 75-100mg SMX]/kg/day IV given q6h or q8h; or</li> <li>• Same daily dose of TMP/SMX po in 3 divided doses; or</li> <li>• TMP-SMX, DS 2 tablets t.i.d</li> </ul> <p>Total duration = 21 days</p> <p><u>Chronic Maintenance Therapy:</u> (Secondary prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• TMP-SMX, 1 DS tablet po q.d; or</li> <li>• TMP-SMX, 1 SS tablet po q.d</li> </ul> <p><i>Alternatives:</i></p> <ul style="list-style-type: none"> <li>• Dapsone, 50mg po b.i.d or 100mg po q.d; or</li> <li>• Dapsone, 50mg po q.d + pyrimethamine, 50mg po q.w + leucovorin, 25mg po q.w; or</li> <li>• Dapsone, 200mg po + pyrimethamine 75mg po + leucovorin 25mg po q.w; aerosolised pentamidine, 300mg every month via Respirgard II™ nebuliser*; or</li> <li>• Atovaquone, 1,500mg po q.d: or TMP-SMX, 1 DS po t.i.w</li> </ul>	<p><u>For Severe PCP:</u></p> <p>Pentamidine, 4mg/kg IV q.d infused over at least 60 minutes, some experts reduce dose to 3mg/kg IV q.d because of toxicities</p> <p><u>For Mild to Moderate PCP:</u></p> <ul style="list-style-type: none"> <li>• Dapsone, 100mg po q.d + TMP, 15mg/kg/day po (3 divided doses); or</li> <li>• Primaquine, 15-30mg (base) po q.d + clindamycin, 600-900mg IV q6h to q8h or clindamycin, 300-450mg po q6h to q8h; or</li> <li>• Atovaquone, 750mg po b.i.d with food; or</li> <li>• Trimetrexate, 45mg/m<sup>2</sup> or 1.2mg/kg IV q.d with leucovorin, 20mg/m<sup>2</sup> or 0.5mg/kg IV or po q6h (leucovorin must be continued for 3 days after the last trimetrexate dose); addition of dapsone or SMX or sulfadiazine may improve efficacy</li> </ul>	<p><u>Indications for Corticosteroids:</u></p> <p>PaO<sub>2</sub> &lt;70mmHg @ room air; or Alveolar-arterial O<sub>2</sub> gradient &gt;35mmHg</p> <p>Prednisone doses (beginning as early as possible and within 72 hours of PCP therapy): 40mg b.i.d days 1-5, 40mg q.d days 6-10, then 20mg q.d days 11-21</p> <p>IV methylprednisolone can be given as 75% of prednisone dose</p> <p>Chronic maintenance therapy (secondary prophylaxis) should be discontinued if CD4+ T cell count increases in response to HAART from &lt;200 to &gt;200 cells/mm<sup>3</sup> for &gt;3 months</p>

\*The Respirgard II™ nebuliser is manufactured by Marquest, Englewood, Colorado, USA.

OPPORTUNISTIC INFECTIONS	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ ISSUES
<p><b><i>T. gondii</i></b> <b>Encephalitis</b></p>	<p><u>Acute Therapy:</u> Pyrimethamine 200mg po x1, then 50mg (&lt;60kg) to 75mg (≥60kg) po q.d + sulfadiazine 1,000 (&lt;60kg) to 1,500mg (≥60kg) po q6h + Leucovorin 10-20mg po q.d (can increase up to 50mg or higher)</p> <p>Total duration for acute therapy = at least 6 weeks</p> <p><u>Chronic Maintenance Therapy:</u> (Secondary Prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• Sulfadiazine, 500-1,000mg po 4x q.d + pyrimethamine, 25-50mg po q.d + leucovorin, 10-25mg po q.d</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>• Clindamycin, 300-450mg po q6-8h + pyrimethamine, 25-50mg po q.d + leucovorin, 10-25 po q.d; or</li> <li>• Atovaquone, 750mg po q6-12h with or without pyrimethamine, 25mg po q.d + leucovorin, 10mg po q.d</li> <li>• Continue with 50% of acute dose for patients on pyrimethamine + sulfadiazine or clindamycin or those receiving TMP-SMX; or</li> <li>• [Pyrimethamine, 50mg q.d + leucovorin, 15mg q.d + sulfadiazine, 1g q12h] given t.i.w; or</li> <li>• Full dose of alternative regimens continued indefinitely</li> </ul>	<ul style="list-style-type: none"> <li>• Pyrimethamine (leucovorin)* + clindamycin, 600mg IV or po q6h; or</li> <li>• TMP-SMX (5mg/kg TMP + 25mg/kg SMX) IV or po b.i.d; or</li> <li>• Atovaquone, 1,500mg po b.i.d with meals (or nutritional supplement) + pyrimethamine (leucovorin)*; or</li> <li>• Atovaquone, 1,500mg po b.i.d with meals (or nutritional supplement) + sulfadiazine, 1,000–1,500mg po q6h; or</li> <li>• Atovaquone, 1,500mg po b.i.d with meals; or</li> <li>• Pyrimethamine (leucovorin)* + azithromycin, 900-1,200mg po q.d</li> </ul> <p><u>For Severely Ill Patients Who Cannot Take Oral Meds:</u> TMP-SMX IV + pyrimethamine po</p> <p>For other regimens with limited experience, see text.</p>	<p>Adjunctive corticosteroids (e.g. dexamethasone) should be given when clinically indicated for treatment of mass effect due to focal lesions or associated oedema and discontinued as soon as clinically feasible</p> <p>Anticonvulsants should be administered to patients with a history of seizures</p> <p><u>Secondary Prophylaxis May Be Discontinued If:</u></p> <p>Free of TE signs and symptoms; and sustained CD4+ T cell count of &gt;200 cells/mm<sup>3</sup> for ≥6 months of HAART</p>

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<b>Cryptosporidiosis</b>	Symptomatic treatment of diarrhoea Effective HAART (to increase CD4+ T cell count to >100 cells/mm <sup>3</sup> ) can result in complete, sustained clinical, microbiological, and histologic resolution of HIV-associated cryptosporidiosis	Nitazoxanide, 500mg po b.i.d Paromomycin, 25-35mg/kg po in 2-4 divided doses	Supportive care including hydration, nutritional support
<b>Microsporidiosis</b>	Initiate or optimise HAART with immune reconstitution to CD4+ T cell count >100 cells/mm <sup>3</sup>  <b><u>For Disseminated (Not Ocular) and Intestinal Infection Due to <i>Microsporidia</i> Other Than <i>E. bienuesi</i>:</u></b>  <ul style="list-style-type: none"> <li>• Albendazole, 400mg po b.i.d, continue until CD4+ T cell count is &gt;200 cells/mm<sup>3</sup></li> </ul> <b><u>For Ocular Infection:</u></b>  <ul style="list-style-type: none"> <li>• Fumidil B<sup>®</sup>, 3mg/mL in saline (final conc. = fumagillin, 70 µg/mL eye drops continued indefinitely (not available in U.S.) + albendazole, 400mg po b.i.d for management of systemic infection</li> </ul> <b><u>For Gastrointestinal Infections Due to <i>E. bienuesi</i>:</u></b>  <ul style="list-style-type: none"> <li>• Fumagillin, 60mg po q.d (not available in U.S.)</li> </ul>	<b><u>Disseminated Disease:</u></b>  Itraconazole, 400mg po q.d + albendazole for disseminated disease due to <i>Trachipleistophora</i> or <i>Brachiola</i>	Fluid support in patients with diarrhoea resulting in severe dehydration  Nutritional supplement for patients with severe malnutrition and wasting  Treatment for ocular infection should be continued indefinitely; with immune reconstitution, it is possible that this treatment can be discontinued  Chronic maintenance therapy may be discontinued if patients:  <ul style="list-style-type: none"> <li>• Remain asymptomatic with regards to signs and symptoms of microsporidiosis;</li> <li>• Have sustained CD4+ T cell count of &gt;200 cells/mm<sup>3</sup> for ≥6 months on HAART</li> </ul>

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<p><b><i>M. tuberculosis</i> (TB)</b></p>	<p><b><u>For Drug-Sensitive TB:</u></b></p> <p><u>Initial Phase (8 Weeks):</u></p> <ul style="list-style-type: none"> <li>• INH, 5mg/kg (max 300mg) po q.d + RIF, 10mg/kg (max 600mg) po q.d; or</li> <li>• Rifabutin, 300mg po q.d (or dose adjusted based on concomitant meds<sup>3</sup>) + PZA (dose based on wt<sup>6</sup>) po q.d + EMB (EMB) (dose based on wt<sup>6</sup>) po q.d</li> </ul> <p><u>Continuation Phase (18 Weeks):</u></p> <ul style="list-style-type: none"> <li>• INH, 5mg/kg (max 300mg) po q.d + RIF, 10mg/kg (max 600mg) or rifabutin, 300mg po q.d]; or</li> <li>• INH, 15mg/kg (max 900mg) po b.i.w or t.i.w + RIF, 10mg/kg (max 600mg) or rifabutin, 300mg po or t.i.w]</li> </ul> <p>In patients with delayed clinical or microbiological response to initial therapy (e.g. sputum culture (+) after 2 months or if cavitary pulmonary lesions are present), total duration up to 9 months</p>	<p><b><u>Treatment for Drug Resistant TB:</u></b></p> <p><u>Resistant to INH:</u></p> <ul style="list-style-type: none"> <li>• discontinue INH (and streptomycin, if used)</li> <li>• Rifamycin, PZA, and EMB x 6 months; or</li> <li>• Rifamycin + EMB x 12 months (preferably with PZA during at least first 2 months)</li> </ul> <p><u>Resistant to Rifamycin:</u></p> <ul style="list-style-type: none"> <li>• INH + PZA + EMB + a fluoroquinolone (e.g. levofloxacin 500mg q.d) for 2 months, followed by 10-16 additional months with INH + EMB + fluoroquinolone</li> </ul> <p><u>MDR-TB (e.g. Both INH- and Rifamycin-Resistant):</u></p> <ul style="list-style-type: none"> <li>• Therapy should be individualised based on resistance pattern and with close consultation with experienced specialist</li> </ul> <p><b><u>TB Treatment in Patients with Liver Disease:</u></b></p> <p><u>If AST &gt;3x Normal Prior to Treatment Initiation:</u></p> <ul style="list-style-type: none"> <li>• Standard therapy with frequent monitoring; or</li> <li>• Rifamycin + EMB + PZA x 6 months</li> <li>• INH + rifamycin + EMB x 2 months, then INH + rifamycin x 7 months</li> </ul> <p><b><u>For Patients with Severe Liver Disease:</u></b></p> <ul style="list-style-type: none"> <li>• Rifamycin + EMB x 12 months (preferably with another agent such as fluoroquinolone for first 2 months)</li> <li>•</li> </ul>	<p>Treatment by DOT is strongly recommended for all HIV patients</p> <p>Rifabutin has less drug interaction potential and can be used in place of RIF</p> <p>Rifapentine given q.w can result in development of resistance, it is <b>NOT RECOMMENDED</b> in HIV patients</p> <p>b.i.w intermittent regimen containing rifamycin may lead to rifamycin resistance, particularly in advanced HIV patients with CD4+ T cell counts of &lt;100 cells/mm<sup>3</sup>; in this situation, therapy must be given as q.d or t.i.w</p> <p>Paradoxical reactions that are not severe may be treated with NSAIDs without change in TB or HIV medications</p>

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<p><b>MAC</b></p>	<p><u>At Least 2 Drugs as Initial Therapy:</u></p> <p>Clarithromycin, 500mg po b.i.d + EMB, 15mg/kg po q.d</p> <p>Consider adding third drug for patients with advanced immunosuppression (CD4+ T cell count of &lt;50 cells/mm<sup>3</sup>), high mycobacterial loads, or in the absence of effective HAART:</p> <p>Rifabutin, 300mg po q.d (dosage may be adjusted based on drug-drug interactions)</p> <p><u>Duration (Chronic Maintenance Therapy):</u> Lifelong therapy unless in patients with sustained immune recovery on HAART.</p> <p><u>Chronic Maintenance Therapy:</u> (Secondary Prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• Clarithromycin, 500mg po b.i.d + EMB, 15mg/kg body weight po q.d; with or without rifabutin, 300mg po q.d</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>• Azithromycin, 500mg po q.d + EMB 15mg mg/kg body weight po q.d; with or without rifabutin, 300mg po q.d</li> </ul>	<p><u>Alternative to Clarithromycin:</u></p> <p>Azithromycin, 500-600mg po q.d</p> <p><u>Alternative Third or Fourth Drug for Patients with More Severe Symptoms or Disseminated Disease:</u></p> <p>Ciprofloxacin, 500-750mg po b.i.d; or</p> <p>Levofloxacin, 500mg po q.d; or</p> <p>Amikacin, 10-15mg/kg IV q.d</p>	<p>NSAIDs may be used for patients who experience moderate to severe symptoms due to HAART-associated IRS</p> <p>If symptoms persist, short term (4-8 weeks of systemic corticosteroid (20-40mg of prednisone)) can be used.</p> <p>Maintenance therapy can be discontinued in patients who:</p> <ul style="list-style-type: none"> <li>• completed <math>\geq 12</math> months therapy, and</li> <li>• remain asymptomatic, and</li> <li>• have sustained (&gt;6 months) CD4+ T cell counts of &gt;100 cells/mm<sup>3</sup></li> </ul>

OIS	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ ISSUES
<b>Bacterial Pneumonia</b>	<p><u>Empiric Therapy (Targeting towards <i>Streptococcus pneumoniae</i> and <i>Haemophilus Influenzae</i>):</u></p> <ul style="list-style-type: none"> <li>Extended spectrum cephalosporin (such as cefotaxime or ceftriaxone); or</li> <li>Fluoroquinolone with enhanced activity against pneumococcus (e.g. gatifloxacin, levofloxacin, or moxifloxacin)</li> </ul> <p><u>Empiric Therapy in Patients with Severe Illness:</u></p> <ul style="list-style-type: none"> <li>Extended-spectrum cephalosporin + a macrolide</li> </ul>	<p><u>For High-Level Penicillin Resistant Isolates (MIC <math>\geq 4.0\mu\text{g/mL}</math>):</u></p> <ul style="list-style-type: none"> <li>Consider adding vancomycin or a fluoroquinolone</li> </ul> <p><u>Empiric Therapy in Patients with Severe Immunodeficiency (CD4+ T cell counts of <math>&lt;100\text{ cell/mm}^3</math>), a Known History of Prior Pseudomonas Infection, Bronchiectasis, or Relative or Absolute Neutropaenia):</u></p> <ul style="list-style-type: none"> <li>Broaden empiric coverage to include antimicrobials with activities against <i>P. aeruginosa</i> and other gram-negative bacilli (e.g. ceftazidime, cefepime, piperacillin-tazobactam, a carbapenem, or high-dose ciprofloxacin or levofloxacin)</li> <li>If ceftazidime or ciprofloxacin is used, the addition of another antibacterial with optimal coverage for gram-positive infection is recommended</li> </ul>	<p>Patients with CD4+ T cell counts of <math>\geq 200\text{ cells/mm}^3</math> should receive a single dose of 23-valent polysaccharide pneumococcal vaccine (if not received in the past 5 years)</p> <p>Yearly influenza vaccine may be useful in preventing pneumococcal superinfection after influenza respiratory infection</p> <p>Antibiotic prophylaxis may be considered in patients with frequent recurrences; caution should be taken for the risks of development of drug resistance and drug toxicities</p>
<b>Salmonellosis</b>	<p><u><b>Salmonella Gastroenteritis:</b></u></p> <ul style="list-style-type: none"> <li>Ciprofloxacin, 500–750mg po b.i.d (or 400mg IV b.i.d)</li> </ul> <p><u>Duration:</u></p> <ul style="list-style-type: none"> <li>Mild gastroenteritis without bacteraemia: 7-14 days</li> <li>Advanced HIV (CD4+ T cell count of <math>&lt;200\text{ cells/mm}^3</math>) and/or bacteraemia: at least 4-6 weeks</li> </ul> <p><u>Chronic Suppressive Therapy:</u></p> <p>For patients who relapse after cessation of therapy: to be given for several months or until HAART-induced immune reconstitution</p> <p>For patients with <i>Salmonella</i> bacteraemia: ciprofloxacin, 500mg po b.i.d</p>	<ul style="list-style-type: none"> <li>TMP-SMX po or IV</li> <li>Third generation cephalosporin such as ceftriaxone (IV) or cefotaxime (IV)</li> </ul>	<p>Treatment is recommended in HIV patients due to high risk of bacteraemia in this population</p> <p>Newer fluoroquinolones (e.g. levofloxacin, gatifloxacin, or moxifloxacin) may also be effective</p>

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<b><i>C. jejuni</i> Infections</b>	<p><b><u>For Mild Disease:</u></b>            May withhold therapy unless symptoms persist for &gt;several days            Optimal therapy is not well-defined; options include:</p> <ul style="list-style-type: none"> <li>• Ciprofloxacin, 500mg po b.i.d; or</li> <li>• Azithromycin, 500mg po q.d</li> </ul> <p>*consider addition of an aminoglycoside in bacteraemic patients</p> <p><u>Duration:</u></p> <ul style="list-style-type: none"> <li>• Mild to moderate disease: 7 days</li> <li>• Bacteraemia: at least 2 weeks</li> </ul>		<p>There is an increasing rate of quinolone resistance</p> <p>Antimicrobial therapy should be modified based on susceptibility reports</p> <p>Role of aminoglycoside is unclear</p>
<b>Shigellosis</b>	<p>Fluoroquinolone IV or po x 3-7 days            Duration for bacteraemia: 14 days</p>	<ul style="list-style-type: none"> <li>• TMP-SMX DS 1 tab po b.i.d x 3-7 days; or</li> <li>• Azithromycin, 500mg po on day 1, then 250mg po q.d x 4 days</li> </ul> <p>Duration for bacteraemia: 14 days</p>	<p>Therapy is indicated both to shorten the duration of illness and to prevent spread of infection</p> <p><i>Shigella</i> infections acquired outside of U.S. have high rates of TMP-SMX resistance</p>
<b><i>Bartonella</i> Infections</b>	<p><b><u>Non-CNS Infections:</u></b></p> <ul style="list-style-type: none"> <li>• Erythromycin, 500mg po q.i.d (or IV at same dose if unable to take po); or</li> <li>• Doxycycline, 100mg po or IV q12h</li> </ul> <p><b><u>CNS Infections:</u></b></p> <ul style="list-style-type: none"> <li>• Doxycycline, 100mg po or IV q12h</li> </ul> <p><u>Duration:</u>            At least 3 months            Life-long therapy for patients with relapse</p>	<ul style="list-style-type: none"> <li>• Azithromycin, 600mg po q.d</li> <li>• Clarithromycin, 500mg po b.i.d</li> <li>• Fluoroquinolones have variable activity in case reports and <i>in vitro</i>; may be considered as alternative</li> </ul>	

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<b><i>T. pallidum</i> Infection (Syphilis)</b>	<p><b><u>Early Stage (Primary, Secondary, and Early Latent Syphilis):</u></b></p> <ul style="list-style-type: none"> <li>Benzathine penicillin, G 2.4 MIU IM x 1</li> </ul> <p><b><u>Late-Latent Disease (&gt;1 Year or of Unknown Duration, without CNS Involvement):</u></b></p> <ul style="list-style-type: none"> <li>Benzathine penicillin, G 2.4 MIU IM q.w x 3</li> </ul> <p><b><u>Late-Stage (Aortitis and Gummata):</u></b></p> <ul style="list-style-type: none"> <li>Infectious diseases consultation</li> </ul> <p><b><u>Neurosyphilis (CNS Involvement including Otic and Ocular Disease):</u></b></p> <ul style="list-style-type: none"> <li>Aqueous crystalline penicillin G, 3-4 MIU IV q4h or total dose by continuous IV infusion x 10-14 days +/- benzathine penicillin G, 2.4 MIU IM q.w x 3 after completion of IV therapy</li> </ul>	<p><b><u>Early Stage (Primary, Secondary, and Early Latent Syphilis):</u></b> <i>treatment with close clinical monitoring</i></p> <ul style="list-style-type: none"> <li>Doxycycline, 100mg po b.i.d x 14 days; or</li> <li>Ceftriaxone, 1g IM or IV q.d x 8-10 days; or</li> <li>Azithromycin, 2g po x 1 dose</li> </ul> <p><b><u>Late-Latent Disease (without CNS Involvement):</u></b></p> <ul style="list-style-type: none"> <li>Doxycycline, 100mg po b.i.d x 28 days</li> </ul> <p><b><u>Neurosyphilis:</u></b></p> <ul style="list-style-type: none"> <li>Procaine penicillin, 2.4 MIU IM q.d + probenecid, 500mg po q.i.d x 10-14 days +/- benzathine penicillin, G 2.4 MIU IM q.w x 3 after completion of above; or</li> <li><u>For penicillin allergic patients:</u> Ceftriaxone, 2g IM or IV q.d x 10-14 days</li> </ul>	<p>Desensitisation to penicillin may be a better option than ceftriaxone in penicillin-allergic patients with neurosyphilis</p> <p>Combination of procaine penicillin + probenecid is not recommended for patients with history of sulfa allergy as these patients may be at risk of hypersensitivity reactions to probenecid</p>
<b>Candidiasis (Mucosal)</b>	<p><b><u>Oropharyngeal Candidiasis:</u></b></p> <p><u>Initial Episodes (7-14-Day Treatment):</u></p> <ul style="list-style-type: none"> <li>Fluconazole, 100mg po q.d; or</li> <li>Itraconazole oral solution, 200mg po q.d; or</li> <li>Clotrimazole troches, 10mg po 5x daily ; or</li> <li>Nystatin suspension, 4-6mL q.i.d or 1-2 flavoured pastilles q4-5d</li> </ul> <p><b><u>Oesophageal Candidiasis (14-21 Days):</u></b></p> <p>Fluconazole, 100mg (up to 400mg) po or IV q.d; or Itraconazole oral solution, 200mg po q.d</p>	<p><b><u>Fluconazole-Refractory Oropharyngeal Candidiasis:</u></b></p> <ul style="list-style-type: none"> <li>Itraconazole oral solution, <math>\geq 200</math>mg po q.d; or</li> <li>Amphotericin B suspension, 100mg/mL (not available in U.S.) – 1 mL po q.i.d; or</li> <li>Amphotericin B deoxycholate, 0.3mg/kg IV q.d; or</li> <li>Caspofungin, 50mg q.d</li> <li>Voriconazole, 200mg po b.i.d</li> </ul>	<p><b>Suppressive Therapy – Generally Not Recommended Unless Patients Have Frequent or Severe Recurrences</b></p> <ul style="list-style-type: none"> <li><b><u>Oropharyngeal Candidiasis:</u></b> fluconazole or itraconazole oral solution may be considered.</li> <li><b><u>Vulvovaginal Candidiasis:</u></b> daily topical azole for recurrent cases</li> <li><b><u>Oesophageal Candidiasis:</u></b> fluconazole, 100-200mg q.d.</li> </ul> <p>Chronic or prolonged use of azoles may</p>

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	<p><b><u>Vulvovaginitis:</u></b></p> <ul style="list-style-type: none"> <li>• Topical azoles (clotrimazole, butoconazole, miconazole, tioconazole, or terconazole) x 3-7 days</li> <li>• Topical nystatin x 14 days</li> <li>• Oral itraconazole, 200mg b.i.d x 1 day or 200mg q.d x 3 days</li> <li>• Oral fluconazole, 150mg x 1 dose</li> </ul>	<p><b><u>Fluconazole-Refractory Oesophageal Candidiasis:</u></b></p> <ul style="list-style-type: none"> <li>• Caspofungin, 50mg q.d; or</li> <li>• Voriconazole, 200mg po or IV b.i.d</li> <li>• Amphotericin B, 0.3-0.7mg/kg IV q.d; or</li> <li>• Amphotericin liposomal or lipid complex, 3-5mg/kg IV q.d</li> </ul> <p><b><u>C. glabrata and Other Non-albicans Candida:</u></b></p> <ul style="list-style-type: none"> <li>• Caspofungin; or</li> <li>• Amphotericin B preparations</li> </ul>	<p>promote development of resistance</p>
<p><b><i>C. neoformans</i> Meningitis</b></p>	<p><b><u>Acute Infection:</u></b></p> <ul style="list-style-type: none"> <li>• Amphotericin B deoxycholate, 0.7mg/kg IV q.d ± flucytosine, 25mg/kg po q.i.d x 2 weeks; or</li> <li>• Liposomal amphotericin B, 4mg/kg IV q.d ± flucytosine, 25mg/kg po q.i.d x 2 weeks</li> </ul> <p><b><u>Consolidation Therapy:</u></b></p> <ul style="list-style-type: none"> <li>• Fluconazole, 400mg po q.d x 8 weeks or until CSF cultures are sterile</li> </ul> <p><b><u>Chronic Maintenance Therapy:</u></b> (Secondary Prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• Fluconazole, 200mg po q.d;</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>• Amphotericin B, 0.6-1.0mg/kg body weight IV q.w x 3; or</li> <li>• Itraconazole, 200mg capsule po q.d</li> </ul>	<p><b><u>Acute Infection (Alternative):</u></b></p> <ul style="list-style-type: none"> <li>• Amphotericin B, 0.7mg/kg/day IV x 2 weeks; or</li> <li>• Fluconazole, 400-800mg/day (po or IV) for less severe disease</li> <li>• Fluconazole, 400-800mg/day (po or IV) + flucytosine, 25mg/kg po q.i.d for 4-6 weeks</li> </ul> <p><b><u>Consolidation Therapy (Alternative):</u></b></p> <ul style="list-style-type: none"> <li>• Itraconazole, 200mg po b.i.d</li> </ul> <p><b><u>Maintenance Therapy (Alternative):</u></b></p> <ul style="list-style-type: none"> <li>• Amphotericin B, 1mg/kg IV per week for patients with multiple relapse on azole(s) or intolerant of azole(s); or</li> <li>• Itraconazole, 200mg po q.d for patients intolerant of or failed fluconazole</li> </ul>	<p>Repeated lumbar puncture may be indicated as adjunctive therapy for patients with increased intracranial pressure</p> <p>Discontinuation of antifungal therapy can be considered in patients who remain asymptomatic, with CD4+ T cell counts of &gt;100–200 cells/mm<sup>3</sup> for &gt;6 months</p> <p>Some may consider performing a lumbar puncture before discontinuation of maintenance therapy</p>

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<p><b><i>H. capsulatum</i></b> <b>Infections</b></p>	<p><b><u>Severe Disseminated:</u></b></p> <p><u>Acute Phase (3–10 Days or Until Clinically Improved):</u></p> <ul style="list-style-type: none"> <li>• Amphotericin B deoxycholate, 0.7mg/kg IV q.d; or</li> <li>• Liposomal amphotericin B, 4mg/kg IV q.d</li> </ul> <p><u>Continuation Phase (12 Weeks):</u></p> <ul style="list-style-type: none"> <li>• Itraconazole, 200mg cap po b.i.d</li> </ul> <p><b><u>Less Severe Disseminated:</u></b></p> <ul style="list-style-type: none"> <li>• Itraconazole, 200mg cap po t.i.d. x 3 days, then 200mg po b.i.d x 12 weeks</li> </ul> <p><b><u>Meningitis:</u></b></p> <ul style="list-style-type: none"> <li>• Amphotericin B deoxycholate or liposomal x 12–16 weeks</li> </ul> <p><u>Chronic Maintenance Therapy (Chronic Suppression):</u></p> <ul style="list-style-type: none"> <li>• Itraconazole, 200mg capsule po b.i.d</li> </ul> <p><u>Chronic Maintenance Therapy</u> (Secondary prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• Itraconazole capsule, 200 mg po b.i.d</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>• Amphotericin B, 1.0 mg/kg body weight IV q.w; or</li> <li>• Itraconazole, 200mg capsule po b.i.d</li> </ul>	<p><b><u>Severe Disseminated:</u></b></p> <p><u>Acute Phase (Alternative):</u></p> <p>Itraconazole, 400mg IV q.d</p> <p><u>Continuation Phase</u> <u>Alternatives:</u></p> <ul style="list-style-type: none"> <li>• Itraconazole oral solution</li> <li>• Fluconazole, 800mg q.d</li> </ul> <p><b><u>Mild Disseminated:</u></b></p> <ul style="list-style-type: none"> <li>• Fluconazole, 800mg po q.d</li> </ul>	<p>Acute pulmonary histoplasmosis in HIV-infected patients with CD4+ T cell counts of &gt;500 cells/mm<sup>3</sup> may require no therapy</p> <p>Some experts would consider discontinuation of antifungal therapy in patients who:</p> <ul style="list-style-type: none"> <li>• are in remission</li> <li>• have completed 1 year itraconazole</li> <li>• have CD4+ T cell counts of &gt;100 cells/mm<sup>3</sup></li> </ul>

OIs	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ISSUES
<b>Coccidioidomycosis</b>	<p><b><u>Non-Meningeal Infection:</u></b></p> <p><u>Acute Phase (Diffuse Pulmonary or Disseminated Disease):</u></p> <ul style="list-style-type: none"> <li>Amphotericin B deoxycholate, 0.5–1.0mg/kg IV q.d continue until clinical improvement, usually 500–1,000mg total dose</li> </ul> <p><u>Acute Phase (Milder Disease):</u></p> <ul style="list-style-type: none"> <li>Fluconazole, 400-800mg po q.d; or</li> <li>Itraconazole, 200mg po b.i.d</li> </ul> <p><b><u>Meningeal Infections:</u></b></p> <ul style="list-style-type: none"> <li>Fluconazole, 400-800mg IV or po q.d</li> </ul> <p><u>Chronic Maintenance Therapy:</u></p> <ul style="list-style-type: none"> <li>Fluconazole, 400mg po q.d; or</li> <li>Itraconazole, 200mg po b.i.d</li> </ul> <p><b><u>Chronic Maintenance Therapy:</u></b> (Secondary prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>Fluconazole, 400mg po q.d</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>Amphotericin B, 1.0mg/kg body weight IV q.w; or</li> <li>Itraconazole, 200mg capsule po b.i.d</li> </ul>	<p><b><u>Non-Meningeal Infection:</u></b></p> <p><u>Acute Phase (Diffuse Pulmonary or Disseminated Disease):</u></p> <ul style="list-style-type: none"> <li>Some experts add azole to amphotericin B therapy</li> </ul> <p><b><u>Meningeal Infections:</u></b></p> <ul style="list-style-type: none"> <li>Intrathecal amphoterin B</li> </ul>	Not enough data to recommend discontinuation of chronic suppressive therapy at this point
<b>Invasive Aspergillosis</b>	<p>Voriconazole, 400mg IV or po q12h x 2 days, then 200mg q12h</p> <p><u>Duration:</u> Based on clinical response</p>	<ul style="list-style-type: none"> <li>Amphotericin B deoxycholate, 1mg/kg/day IV; or</li> <li>Lipid formulations of amphotericin B, 5mg/kg/day IV</li> <li>Voriconazole + caspofungin</li> </ul>	Not enough data to recommend chronic suppression or maintenance therapy

OIS	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ISSUES
<b>CMV Disease</b>	<p><b><u>CMV Retinitis:</u></b></p> <p><u>For Immediate Sight-Threatening Lesions:</u></p> <p>Ganciclovir intraocular implant + valganciclovir, 900mg po q.d</p> <p><u>For Peripheral Lesions:</u></p> <p>Valganciclovir, 900mg po b.i.d x 14-21 days, then 900mg po q.d</p> <p><u>Duration of Chronic Maintenance Therapy:</u></p> <ul style="list-style-type: none"> <li>• Implant: replace q6-8m until immune recovery on HAART</li> <li>• Systemic therapy: continue for life or until immune recovery on HAART</li> </ul> <p><u>Chronic Maintenance Therapy:</u> (Secondary Prophylaxis)</p> <p><i>First choice:</i></p> <ul style="list-style-type: none"> <li>• Ganciclovir, 5-6mg/kg body weight/day IV for 5-7 days q.w or 1,000mg po t.i.d; or</li> <li>• Foscarnet, 90-120mg/kg body weight IV q.d; or</li> <li>• For retinitis, ganciclovir sustained-release implant, q6-9m + ganciclovir, 1.0-1.5g po t.i.d</li> </ul> <p><i>Second choice:</i></p> <ul style="list-style-type: none"> <li>• Cidofovir, 5mg/kg body weight IV q.o.w with probenecid, 2g po 3 hours before the dose followed by 1g po 2 hours after the dose, and 1g po 8 hours after the dose (total of 4g); or</li> <li>• Fomivirsen, 1 vial (330 µg) injected into</li> </ul>	<p><b><u>CMV Retinitis:</u></b></p> <ul style="list-style-type: none"> <li>• Valganciclovir, 900mg po b.i.d x 14-21 days, then 900mg po q.d; or</li> <li>• Ganciclovir intraocular implant + valganciclovir, 900mg po q.d; or</li> <li>• Ganciclovir, 5mg/kg IV q12h x 14-21 days, then 5mg/kg IV q.d; or</li> <li>• Ganciclovir, 5mg/kg IV q12h x 14-21 days, then valganciclovir, 900mg po q.d; or</li> <li>• Foscarnet, 60mg/kg IV q8h or 90 mg/kg IV q12h x 14-21 days, then 90-120mg/kg IV q24h; or</li> <li>• Cidofovir, 5mg/kg IV x 2 weeks, then 5mg/kg q.o.w; each dose should be given with IV saline hydration and oral probenecid; or</li> <li>• Repeated intravitreal injections with fomivirsen (for relapses only, not as initial therapy)</li> </ul>	<p>Choice of initial therapy for CMV retinitis should be individualised, based on location and severity of the lesion(s), level of immunosuppression, and other factors such as concomitant medications and ability to adhere to treatment</p> <p>Initial therapy in patients with CMV retinitis, oesophagitis, colitis, and pneumonitis should include optimisation of HAART</p> <p>Some experts suggest delaying HAART in patients with CMV neurological disease due to concerns of worsening of condition as a result of immune recovery inflammatory reaction</p> <p>Pre-emptive treatment of patients with CMV viraemia without evidence of organ involvement is generally not recommended</p> <p>Maintenance therapy for CMV retinitis can be safely discontinued in patients with inactive disease and sustained CD4+ T cell counts (&gt;100-150 cells/mm<sup>3</sup> for &gt;6 months); consultation with ophthalmologist is advised</p> <p>Patients with CMV retinitis who discontinued maintenance therapy should undergo regular eye examinations for early detection of relapse</p> <p>IRU may develop in the setting of immune reconstitution. <u>Treatment of IRU:</u> periocular corticosteroid or short courses of systemic steroid</p> <p>Due to its poor oral bioavailability and with the availability of valganciclovir, oral ganciclovir should no longer be used</p>

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	<p>the vitreous, then repeated q2-4w; or</p> <ul style="list-style-type: none"> <li>Valganciclovir, 900mg po q.d</li> </ul> <p><b><u>CMV Oesophagitis or Colitis:</u></b></p> <ul style="list-style-type: none"> <li>Ganciclovir IV or foscarnet IV x 21-28 days or until signs and symptoms have resolved; oral valganciclovir may be used if symptoms are not severe enough to interfere with oral absorption</li> <li>Maintenance therapy is generally not necessary, but should be considered after relapses</li> </ul> <p><b><u>CMV Pneumonitis:</u></b></p> <p>Treatment should be considered in patients with histologic evidence of CMV pneumonitis and who do not respond to treatment of other pathogens</p> <p>The role of maintenance therapy is not yet established.</p> <p><b><u>CMV Neurological Disease:</u></b></p> <ul style="list-style-type: none"> <li>GCV IV + foscarnet IV; continue until symptomatic improvement</li> <li>Maintenance therapy should be continued for life</li> </ul>		
<p><b>HSV Disease</b></p>	<p><b><u>Orolabial Lesions and Initial or Recurrent Genital HSV:</u></b></p> <ul style="list-style-type: none"> <li>Famciclovir, 500mg po b.i.d; or</li> <li>Valaciclovir, 1g po b.i.d; or</li> <li>Acyclovir, 400mg po t.i.d x 7 days</li> </ul> <p><b><u>Moderate to Severe Mucocoeaneous HSV Infections:</u></b></p> <ul style="list-style-type: none"> <li>Initial therapy acyclovir, 5mg/kg IV</li> </ul>	<p><b><u>Acyclovir-Resistant HSV:</u></b></p> <ul style="list-style-type: none"> <li>Foscarnet, 120-200mg/kg/day IV in 2-3 divided doses until clinical response</li> <li>Cidofovir, 5mg/kg IV q.w until clinical response</li> </ul> <p><b><u>Alternative for Acyclovir-Resistant HSV Infections:</u></b></p> <ul style="list-style-type: none"> <li>Topical trifluridine</li> </ul>	<p>Chronic suppressive therapy with oral acyclovir, famciclovir, or valacyclovir may be indicated in patients with frequent or severe recurrences</p>

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	<p>q8h</p> <ul style="list-style-type: none"> <li>After lesions began to regress, change to famciclovir, 500mg po b.i.d or valacyclovir, 1g po b.i.d or acyclovir, 400mg po t.i.d. Continue therapy until lesions have completely healed.</li> </ul> <p><b><u>HSV Keratitis:</u></b></p> <ul style="list-style-type: none"> <li>Trifluridine 1% ophthalmic solution, one drop onto the cornea q2h, not to exceed 9 drops per day for no longer than 21 days</li> </ul> <p><b><u>HSV Encephalitis:</u></b></p> <ul style="list-style-type: none"> <li>Acyclovir, 10mg/kg IV q8h x 14-21 days</li> </ul>	<ul style="list-style-type: none"> <li>Topical cidofovir</li> </ul> <p><u>Note:</u> Both of the above preparations are not commercially available. Extemporaneous compounding of these topical products can be prepared using trifluridine ophthalmic solution and cidofovir for IV administration</p>	
VZV Disease	<p><b><u>Primary VZV Infection (Chickenpox):</u></b></p> <ul style="list-style-type: none"> <li>Acyclovir, 10mg/kg IV q8h x 7-10 days</li> <li>Switch to oral therapy (acyclovir, 800mg po q.i.d; valacyclovir, 1g t.i.d; or famciclovir, 500mg t.i.d) after defervescent if there is no evidence of visceral involvement</li> </ul> <p><b><u>Local Dermatomal Herpes Zoster:</u></b></p> <ul style="list-style-type: none"> <li>Famciclovir, 500mg or valacyclovir, 1g po t.i.d x 7-10 days</li> </ul> <p><b><u>Extensive Coetaneous Lesion or Visceral Involvement:</u></b></p> <ul style="list-style-type: none"> <li>Acyclovir, 10mg/kg IV q8h, continue until coetaneous and visceral disease clearly resolved</li> </ul> <p><b><u>Progressive Outer Retinal Necrosis (poRN):</u></b></p> <ul style="list-style-type: none"> <li>Acyclovir, IV 10mg/kg q8h + foscarnet, 60mg/kg IV q8h</li> </ul>		

<b>HPV</b>	<b>Treatment of Condyloma Acuminata (Genital Warts)</b>		
	<u>Patient-Applied Treatment:</u>  Podofilox 0.5% solution or 0.5% gel – apply to all lesions b.i.d x 3 consecutive days, repeat q.w x up to 4 weeks; or  Imiquimod 5% cream – apply to lesion at bedtime and remove in the morning on 3 non-consecutive nights q.w x up to 16 weeks	<u>Provider-Applied Treatment:</u>  <ul style="list-style-type: none"> <li>• Liquid nitrogen cryotherapy – apply until each lesion is thoroughly frozen, repeat q1-2w for up to 3-4x</li> <li>• Trichloroacetic acid or bichloroacetic acid cauterisation – 80-95% aqueous solution, apply to each lesion, repeat q.w x 3-6 weeks</li> <li>• Surgical excision or laser surgery</li> <li>• Cidofovir topical – not commercially available</li> <li>• Podophyllin resin 10-25% suspension in tincture of benzoin – apply to area and wash off in a few hours, repeat q.w x up to 3-6 weeks</li> <li>• Intralesional interferon alpha is an option, but is generally not recommended</li> </ul>	
	<b>Treatment of Cervical Intraepithelial Neoplasia (CIN) or Anal Intraepithelial Neoplasia (AIN)</b>		
<u>CIN 1:</u>  <ul style="list-style-type: none"> <li>• Pap smears and/or colposcopy q4-6m</li> </ul> <u>CIN 2 or 3:</u>  <ul style="list-style-type: none"> <li>• LEEP</li> </ul> <u>AIN:</u> Insufficient data to recommend specific treatment. Treatment decision based on size, location of lesion, and grade of histology	<u>CIN 2 or 3:</u>  <ul style="list-style-type: none"> <li>• Cryotherapy</li> <li>• Laser therapy</li> <li>• Cone biopsy</li> </ul>	Low-dose intravaginal 5-fluorouracil (2g b.i.d x 6 months) for CIN may reduce short-term risk for recurrence  Efficacy of treatment of AIN 2 or 3 in preventing anal cancer is unknown	

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<b>HCV Disease</b>	<p><u>Combination therapy:</u>  [Peginterferon alfa-2b (1.5mcg/kg), sc q.w; or peginterferon alfa-2a (180mcg), sc q.w]  +  Ribavirin, po (weight-based dosing: if &lt;75kg, 400mg in A.M. + 600mg in P.M.; if &gt;75kg, 600mg b.i.d)</p> <p><u>Duration:</u>  <i>For genotype 1</i></p> <ul style="list-style-type: none"> <li>• 48 weeks: for patients who demonstrate an early virologic response (<math>\geq 2</math> log decrease in HCV viral load at 12 weeks)</li> <li>• 12 weeks: for patients who failed to achieve early virologic response at 12 weeks - therapy beyond 12 weeks is almost always futile for achieving virologic cure</li> </ul> <p><i>For genotype 2 or 3:</i></p> <ul style="list-style-type: none"> <li>• 24 weeks: based on data in non-HIV-1 infected patients</li> <li>• Some experts suggest 48 weeks</li> </ul>	<p><u>In patients where ribavirin is contra-indicated (e.g. unstable cardiopulmonary disease, pre-existing anaemia, or haemoglobinopathy):</u></p> <ul style="list-style-type: none"> <li>○ Peginterferon alfa-2b, 1.5 mcg/kg or</li> <li>○ Peginterferon alfa-2a, 180 mcg sc q.w</li> </ul>	<p>All patients should be counselled to avoid alcohol consumption due to increased risk of fibrosis progression</p> <p>Preliminary data suggest that responses to HCV therapy correlates to CD4+ T cell count</p> <ul style="list-style-type: none"> <li>• Some suggest treating HCV before CD4+ T cell count drops &lt;500 cells/mm<sup>3</sup>;</li> <li>• Conversely, if patient has CD4+ T of &lt;500 cells/mm<sup>3</sup>, some suggest initiating ARV before treatment of HCV</li> </ul>

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<p><b>HBV Disease</b></p>	<p>Due to the lack of controlled trial data on the use of antiviral agents against HBV in HIV/HBV-co-infected patients, none of the current therapy can be recommended as preferred regimen</p> <p>In patients with HIV/HBV/HCV co-infection, consideration for ARV therapy should be the first priority. If ARV therapy is not required, then treatment for HCV should be considered before HBV, as interferon treatment for HBV may also treat HBV infection</p>	<p><u>3TC-Naïve Patients Requiring HAART:</u></p> <ul style="list-style-type: none"> <li>• 3TC, 150mg po b.i.d, should be used as part of a HAART regimen for a minimum of one year or 6 months after seroconversion from HBeAg (+) to HbeAg (-) and anti-e positive;</li> <li>• <b>Adefovir, 10 mg per day in addition to HAART</b> for a minimum of one year or 6 months after seroconversion from HBeAg (+) to HbeAg (-) and anti-e positive;</li> <li>• Some experts advise adding adefovir, 10mg q.d or TDF, 300mg q.d to 3TC; or</li> <li>• Interferon alfa 2a or 2b, 5MU sc q.d or 10MU sc t.i.w; may be considered in patients who do not require ARV therapy^ or PEG IFN, 180mcg sc q.w</li> </ul> <p><u>Duration of Interferon Alfa Therapy:</u></p> <p>HBeAg (+) patients: 16-24 weeks HBeAg (-) patients: minimum of 12 months</p> <p><u>3TC-naïve patients where HAART is not indicated:</u></p> <ul style="list-style-type: none"> <li>○ Adefovir, 10mg po q.d or PEG IFN, 180mcg sc q.w</li> </ul> <p><u>Use for Treatment of Both HIV and HBV Infection:</u></p> <p>TDF, 300mg po q.d as part of a HAART regimen +/- 3TC</p>	<p>All patients should be advised to avoid or limit alcohol consumption</p> <p>Patients should receive 2 doses of hepatitis A vaccine, preferably before CD4+ T cell count drops to &lt;200 cells/mm<sup>3</sup></p> <p>Interferon should not be used in patients with decompensated liver disease</p> <p>Discontinuation of therapy for HBV infection risks flare of liver disease in ≈15% of patients and lost of anti-HBV benefit</p> <p>HAART should always include HBV treatment to minimise immune reconstitution flares</p>

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<b>Penicilliosis</b>	<p><u>Acute Infection in Severely Ill Patients:</u></p> <p>Amphotericin B, 0.6mg/kg/day IV x 2 weeks; followed by itraconazole oral solution 400mg q.d x 10 weeks</p> <p><u>Chronic Suppressive Therapy:</u></p> <p>Itraconazole, 200mg po q.d</p>		HAART should be administered according to standard of care in the community
<b>Leishmaniasis</b>	<p>Pentavalent antimony (or sodium stibogluconate) = 20mg/kg IV or IM q.d x 3-4 weeks depending on initial response</p> <p><u>Secondary Prophylaxis:</u></p> <p>Single dose of the initial therapy every 4 weeks, especially in patients with CD4+ T cell counts of &lt;200 cells/mm<sup>3</sup></p>	<ul style="list-style-type: none"> <li>Amphotericin B deoxycholate, 0.5-1.0 mg/kg IV q.d (maximum of 50mg q.d) for total dose of 1.5-2.0gm; or</li> <li>Amphotericin B lipid formulation, 3-5mg/kg IV q.d x 10 days; there is less experience with shorter regimens (see text); or</li> <li>Pentamidine isethionate, 3-4mg/kg IV t.i.w x 3-4 weeks followed by monthly maintenance therapy</li> </ul> <p><u>Secondary Prophylaxis:</u></p> <p>Single dose of the initial therapy every 4 weeks, especially in patients with CD4+ T cell counts &lt;200 cells/mm<sup>3</sup></p>	<p>Severely neutropaenic patients with visceral leishmaniasis may benefit from short course of granulocyte macrophage colony stimulating factor (GM-CSF), 5µg/kg/day sc x 5 days</p> <p><u>Other Regimens (Generally Not Recommended):</u></p> <ul style="list-style-type: none"> <li>Miltefosine, 100mg/day for 30 days. Schedule for secondary prophylaxis is unknown</li> </ul>
<b>Paracoccidioidomycosis</b>	<p>Amphotericin B for severely ill</p> <p>Itraconazole, 100-200mg po q.d for less ill</p>	<ul style="list-style-type: none"> <li>Ketoconazole, 200-400mg po q.d</li> <li>Sulfonamide</li> </ul>	HAART should be initiated in accordance with standards of care in the community.
<b><i>Isospora belli</i> Infection</b>	<p>TMP, 160mg + SMX, 800mg po (or IV) q.i.d x 10 days; or</p> <p>TMP, 320mg + SMX, 1,600mg po (or IV) b.i.d x 10-14 days</p> <p><u>Secondary Prophylaxis:</u></p> <p>In patients with CD4+ T cell counts of &lt;200 cells/mm<sup>3</sup>, TMP, 320mg + SMX, 1,600mg po q.d or t.i.w</p>	<ul style="list-style-type: none"> <li>Pyrimethamine, 50-75mg po q.d + leucovorin, 5-10mg po q.d; or</li> <li>Ciprofloxacin, 500mg po b.i.d</li> <li>Other fluoroquinolones</li> </ul> <p><u>Alternative Secondary Prophylaxis:</u></p> <p>Pyrimethamine, 25mg po q.d + leucovorin</p>	<p>Fluid management in patients with dehydration</p> <p>Nutritional supplementation for malnutrition and wasting</p> <p>Immune reconstitution with HAART may result in fewer relapses</p> <p>Discontinuation of secondary prophylaxis may be considered in patients with sustained CD4+ T cell counts of &gt;200 cells/mm<sup>3</sup> for &gt;3 months</p>

OIS	PREFERRED THERAPY AND DURATION	ALTERNATIVE THERAPY	OTHER OPTIONS/ISSUES
<b>Chagas Disease (American Trypanosomiasis)</b>	Benznidazol, 5-8 mg/kg/day in 2 divided doses x 30–60 days  Lifelong secondary prophylaxis probably indicated	Nifurtimox (currently not available), 10mg/kg/d	

\*Pyrimethamine and leucovorin doses are the same as in “preferred therapy” for toxoplasmosis.

%See *Table 6* for rifabutin doses based on concomitant ARV drug use.

%PZA dose: <55kg = 1,000mg; 56-75kg = 1,500mg; ≥76 kg = 2,000mg.

&EMB dose: <55kg = 800mg; 56-75kg = 1,200mg; ≥76kg = 1,600mg.

^In HIV-HBV-co-infected patients who do not need HIV therapy but who have HBeAg+ chronic hepatitis B and ALT >2x normal, some authorities would recommend treating HBV with interferon-alfa provided there is no evidence of hepatic decompensation. This strategy spares the patient from developing HIV and HBV resistance to 3TC therapy and from the toxicity of HAART.

=Available in the U.S. through the Centers for Disease Control and Prevention.