Thoughts on TB Prevention

• IPT durability
  – High incidence setting → Lifelong is necessary
    • (Thibela, BOTUSA, Novel TB)
  – Moderate incidence setting → 6 months enough?
  – What’s happening?
    • Not sterilizing? Re-infection? → Likely some of both
      – Better regimens needed for “cure” (consistent w mouse models)
        → increase Rifamyicin dose? ACTG Daily IPT/Rif one month?

• TST or not TST
  – What does a positive TST mean?
    • Spectrum of latent disease → Biomarker(s) needed
  – If IPT continues until TST implemented, than acceptable...
    • Otherwise, TB develops among TST unknowns while waiting
  – Anticipate implementation issues
    • Include qualitative work
    • Implementation issues
Thoughts on TB Prevention

• **IPT + HAART**
  – Evidence suggests beneficial in moderate and high incidence settings
  – TST role? Rangaka showed effective for TST -, IGRA-, AND IGRA+ (p=0.16), but not TST+ → Why?
  – Do IGRAs have a role? Expensive, reversion, lab resources needed, few longitudinal studies; but, MAY reduce numbers on IPT compared to TST alone...

• **HAART**
  – Reduces TB incidence in all settings
  – Need to start at higher CD4 counts?

• Advocacy for preventive therapy is needed
  – Care providers need to believe in it or implementation will fail
  – Cotrim implemented / IPT is not

• **Empowerment of patients**
  – ART was demanded by patients... IPT must be as well