

HIV IOI **Prevention of Opportunistic Infections.** *The following are recommended as standard of care.*

	RISK	PREFERRED PREVENTION	ALTERNATIVES
Pneumocystis carinii	CD4 count <200/ mm ³ , prior PCP or HIV-associated thrush or FUO x 2wks (A II)*	TMP-SMX 1 DS/day or 1 SS/day (A I)*	<ul style="list-style-type: none"> ■ TMP-SMX 1 DS 3x/wk (B I) ■ Dapsone 100mg qd or 50mg po bid (B I) ■ Dapsone 50mg qd plus pyrimethamine 50mg/wk plus leukovorin 25mg/wk (B I) ■ Dapsone 200mg/wk plus pyrimethamine 75 mg/wk plus leukovorin 25mg/wk (B I) ■ Aerosolized pentamidine 300mg q mo ■ Atovaquone 750mg po bid with meals (NEJM 1998;2\339:1889) (B I)
M. Tuberculosis	Positive PPD (≥5 mm induration) with prior treatment (A I), recent TB contact (A II) or history of inadequately treated TB that healed (A II)	<ul style="list-style-type: none"> ■ INH 300 mg/day + pyridoxine 50mg/day ≥ 270 doses, 9 mos. or up to 12 mos. with interruptions. (A II) ■ INH 900mg + pyridoxine 100mg 2x/wk with directly observed therapy, ≥ 76 doses, 9 mos. or up to 12 mos. with interruptions (B I) ■ Patient not receiving PI or NNRTI: Rifampin 600mg/day + pyrazinamide 20mg/kg/day with ≥ 60 doses x 2 mos. or up to 3 mos. with interruptions (A I) 	<p>Patients receiving a PI or NNRTI need rifabutin in place of rifampin/pyrazinamide 20mg/kg and dose adjustment of the antiretroviral agent (B III).</p> <ul style="list-style-type: none"> ■ Amprenavir-standard; rifabutin-150 mg/d ■ Efavirenz-standard; rifabutin-450mg/d ■ Indinavir -- 1200mg q8h; rifabutin -- 150mg/d ■ Nelfinavir -- 1000mg tid; rifabutin -- 150mg/d ■ Ritonavir -- standard dose; rifabutin -- 150mg qod <p>Note: Rifabutin should not be combined with delavirdine and dose schedules are not available for Fortovase. Rifabutin should be combined with pyrazinamide 20mg/kg/day with ≥ 60 doses x 2 mos. or up to 3 mos. with interruptions (B III)</p> <p>Rifampin 600mg qd x 4mos. (B III)</p> <p>Contact with INH resistant strain: Rifampin plus pyrazinamide x 2 mos. (Above doses) (A I)</p> <p>Alternative: Rifabutin/pyrazinamide (above doses x 2 mo.) (B III); Rifabutin 300mg po qd x 4 mo. (C III)</p> <p>Contact with strain resistant to INH and rifamycin: use 2 agent with anticipated activity-ethambutol/pyrazinamide or levofloxacin/pyrazinamide</p> <p>Pregnancy: INH regimens</p>
Toxoplasma gondii	CD4 count <100/ mm ³ plus positive IgG serology for <i>T. gondii</i>	TMP-SMX 1 DS/day (A II)*	<p>TMP-SMX 1 SS/day (B III)</p> <ul style="list-style-type: none"> ■ Dapsone 50 mg po qd plus pyrimethamine 50mg/wk plus leukovorin 25 mg po/wk (B I) ■ Dapsone 200mg po/wk plus pyrimethamine 75 mg po/wk plus leukovorin 25 mg po/wk ■ Atovaquone 1500mg qd ± pyrimethamine 25mg qd + leukovorin 10mg qd (C III).
M. avium complex	CD4 count <50 mm ³	Clarithromycin 500mg or bid (A I) or azithromycin 1200mg po weekly (A I)	Rifabutin 300 mg po qd (B I) or azithromycin 1200 mg/wk plus rifabutin 300mg qd (C I) (check rifabutin dose adjustment for use with PIs or NNRTIs)
Varicella	Significant exposure to chickenpox or shingles who are either seronegative for VAV or have no history of primary or secondary VZV	VZIG 5 vials (6.25mL) IM within 96 hours of exposure, preferably within 48 hours (A III)	Prophylactic acyclovir was included in the 1995 USPHS/IDSA Guidelines, but was deleted from the 1999 version due to lack of supporting clinical evidence of efficacy.

Adapted from Bartlett JG and Gallant JE. 2000-2001 Medical Management of HIV Infection. Johns Hopkins University, Baltimore, MD. 2000.

*Bactrim is preferable because it prevents two illnesses: Pneumocystis carinii and Toxoplasma gondi.

Rating systems for strength of recommendation

- A:** Both strong evidence for efficacy and substantial clinical benefit support recommendation for use. Should always be offered.
- B:** Moderate evidence for efficacy-or strong evidence for efficacy, but only limited clinical benefit-supports recommendation for use. Should generally be offered.
- C:** Evidence for efficacy is insufficient to support a recommendation for or against use, or evidence for efficacy may not outweigh adverse consequences (e.g. toxicity, drug interactions, or cost of the chemoprophylaxis or alternative approaches). Optional.

Categories Reflecting Quality of Evidence Supporting the Recommendation

- I:** Evidence from at least one properly randomized, controlled trial.
- II:** Evidence from at least one well-designed clinical trials without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time series studies or dramatic results from uncontrolled experiments.
- III:** Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees.