Alternative Primary Prophylaxis

PCP (Alternatives):
- TMP/SMX 1 DS po 3/4xw (BI)
- Dapsone 100 mg po once daily or 50 mg po bid (BI)
- Dapsone 50 mg po once daily or 25 mg po bid (BI)
- Azithromycin 300 mg po once daily monthly with risperidone (BI)
- Pyrimethamine 25 mg po once daily or (BI)
- Atovaquone 1500 mg po once daily (BI)

Toxoplasmosis (Alternatives):
- TMP/SMX 1 DS po 3/4xw (BI)
- Dapsone 50 mg po once daily (BI)
- Pyrimethamine 25 mg po once daily or (BI)
- Atovaquone 1500 mg po once daily (BI)

Disseminated MAC (Alternatives):
- Rifabutin 300 mg po once daily (AI)
- Azithromycin 500 mg po once daily (AI)
- Isoniazid 300 mg po once daily (AI)

Secondary Prophylaxis:
- Prophylaxis not routinely indicated. If recurrences are frequent or severe, consider suppressive therapy.
- Pts with fluconazole-refractory esophageal candidiasis should be referred to entoclinicians, voriconazol or posaconazole, should continue tx as ART results in antireconstitution illness.

CANDIDIASIS (Continued)

Treatment of OIs and Chronic Medicine Therapy/Secondary Prevention

Cryptococcal Meninigitis

Induction/Consolidation Therapy:
- Amphotericin B deoxycholate (AmB) 0.7 to 1 mg/kg IV qIV daily or
- Fluconazole 250 mg od po given 4x/weekly x 2 weeks followed by fluconazole 400 mg po once daily $8 wks (AI)
- 500 mg normal saline preinfusion may nphrotoxicity risk
- Fluconazole $65 mg/dose po given 4x/weekly x 2 weeks followed by fluconazole 400 mg po once daily $8 wks (AI)
- Dapsone 100 mg IV x 1 dose, then 50 mg IV once daily (AI)

NOTE: See the Cryptococcal guidelines referenced above for nosocomial, disseminated candidal fungal infection and/or management of antimycotic

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CANDIDIASIS (Continued)

Discontinuation of Primary Prophylaxis:
- PCP: CD4 ≥ 200 for ≥ 3 mos in response to ART (AI), reintiate if CD4 falls to ≤ 200 (AI)
- Toxoplasmosis: CD4 ≥ 200 for ≥ 3 mos in response to ART (AI), reintiate if CD4 falls to ≤ 200 (AI)
- MAC: CD4 ≥ 200 for ≥ 3 mos in response to ART (AI), reintiate if CD4 falls to ≤ 200 (AI)

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www.aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf#page=141
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Cryptococcal meningitis Induction/Consolidation Therapy: (Continued)

CYPHOSUMINOSIS (Continued)

Prepared by: Maximo M. Lora, BA
Managing Editor: Maximo M. Lora, BA
AIDS Therapy in Pediatrics

For more information on AIDS-related laboratory tests, visit www.cdc.gov/hiv/topics/labservices/index.htm

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Cryptosporidium infection in AIDS patients

Cryptosporidium infection in AIDS patients
Treatment of OIs and Chronic Maintenance Therapy/Secondary Prevention

**CRYPTOCOCCAL MENINGITIS (Continued)**

Discontinuation of Maintenance/Suppressive Therapy: After 12 mos of antifungal tx, consider stopping suppressive tx in pts virally controlled on ART with CD4 ≥ 200 for ≥ 3 mos (BII). Restart if CD4 ≤ 100 (BII).

**CRYPTOSPORIDIOSIS**

Prefered: History or optimize ART (AII), anti-diarrheal agents as needed as well as adequate fluid replacement (AII)

Alternative: No specific treatment required. In complicated cases, parenteral fluid therapy (BII).

**CYTOMEGALOVIRUS DISEASE (CMV)**

Prefered: Due to CMV viremia and associated disease severity, consider nucleoside analogs for 6 mos. If severe disease is present, consider nucleoside analogs for 12 mos (AII)

Note: Antiviral therapy should be delayed to avoid serious CMV disease in pts who are CMV seronegative (BII). CMV viremia in pts who are CMV seronegative and CMV-seropositive should be treated with ganciclovir (AII)

Consultation and Referral service

Clinical resources for health care professionals throughout the region.

MYCOBACTERIUM TUBERCULOSIS

See Table of Tuberculosis (TB) in HIV/AIDS, March 2012

www.fcaetc.org/Treatment

**PNEUMOCYSTIS JIROVECI PNEUMONIA (PCP) Moderate/Severe**

Prefered: Trimethoprim-sulfamethoxazole (TMP/SMX) 160 mg/800 mg 1 DS tab po once daily (AI)

or

Dapsone 100 mg po bid for ≥ 12 mos (AI)

or

Intermittent trimethoprim-sulfamethoxazole (TMP/SMX) 160 mg/800 mg 1 DS tab po once daily for 14 days. Repeat every 28 days or until resolution of symptoms (AII)

or

Intermittent dapsone 100 mg po bid for ≥ 12 mos (AII)

or

Intermittent pyrimethamine 200 mg po x 1 dose then 50 mg (< 60 kg) or 75 mg (≥ 60 kg) po once daily + leucovorin 25-30 mg po once daily (AI)

or

Pyrimethamine 200 mg po x 1 dose then 50 mg (< 60 kg) or 75 mg (≥ 60 kg) po once daily + sulfadiazine 1000-1500 mg po once daily + dapsone 100 mg po bid or 25 mg po 3 times daily (AI)

or

Pyrimethamine 150 mg po x 1 dose then 50-75 mg po once daily + dapsone 100 mg po bid for ≥ 12 mos (AI)

or

Sulfadiazine 1000 mg po once daily + dapsone 100 mg po bid for ≥ 12 mos (AI)

Diaphragm infections

**HERPES SIMPLEX VIRUS (HSV)**

Hsv Oropharyngeal Lesions, Initial or Recurrent Genital:

Acyclovir 10 mg/kg IV q8h (AII) until pt clinically improving

or

Foscarnet 80-120 mg/kg IV q 2-3 divided doses until clinical response (21-28 days or longer) (AI)

Famciclovir 500 mg po bid x 5 days (AII)

Dapsone 100 mg po once daily + pyrimethamine 25 mg + leucovorin 20-25 mg po once daily (AI)

Pyrimethamine 200 mg po x 1 dose then 50 mg (< 60 kg) or 75 mg (≥ 60 kg) po once daily + sulfadiazine 1000-1500 mg po once daily + dapsone 100 mg po bid or 25 mg po 3 times daily (AI)

or

Pyrimethamine 150 mg po x 1 dose then 50-75 mg po once daily + dapsone 100 mg po bid for ≥ 12 mos (AI)

or

Sulfadiazine 1000 mg po once daily + dapsone 100 mg po bid for ≥ 12 mos (AI)

**HERPES ZOSTER (VARIELLA ZOSTER VIRUS, VZV)**

HERPES ZOSTER-ACUTE LOCALIZED DERMATOMAL:

Acyclovir 800 mg po 5 times daily (AI)

or

Famciclovir 500 mg po 3 times daily (AI)

or

Valacyclovir 1 g po bid

Duration of tx: 7-10 days or if lesions slowly resolve

Discontinuation of Secondary Prophylaxis: If successful, complete tx, asymptomatic, and CD4 ≥ 200 in response to ART (BII).

Some recommended MFR for proof of brain lesion resolution before stopping secondary prophylaxis

Restart if CD4 ≤ 200 (AII).

**SYPHILIS**


Primary, Secondary, Early-Latent (≤ 1 year): 15. Benzathine penicillin G 2.4 million units IM 1 dose (AII)

Late-Latent (≥ 1 year or unknown duration) or Late-Stage (tertiary-cardiovascular or gummatous disease):

CSP examination (BII).

or

Benzathine penicillin G 2.4 million units IM every 3 x doses (AII)

Neurosyphilis (including otic and ocular):

or

Benzathine penicillin G 2.4 million units IM every 3 x doses (AII)

**TOXOPLASMA**

Acute Treatment:

Prefered: Pyrimethamine 25-50 mg po once daily + sulfadiazine 2000–4000 mg po daily (in 2-4 divided doses) + leucovorin 10-25 mg po once daily (BII)

or

Pyrimethamine 25-50 mg po once daily + sulfadiazine 2000-4000 mg po daily (in 2-4 divided doses) + leucovorin 10-25 mg po once daily (BII)

or

Pyrimethamine 25-50 mg po once daily + sulfadiazine 2000-4000 mg po daily (in 2-4 divided doses) + leucovorin 10-25 mg po once daily (BII)

with itraconazole (soln preferred) 200 mg po tid x 3 days, then amphotericin B 3 mg/kg IV once daily (AI), then maintenance tx as above (BII)

or

With leucovorin 200 mg po once daily + itraconazole (soln preferred) 200 mg po tid x 3 days, then amphotericin B 3 mg/kg IV once daily (AI) and itraconazole as above (BII)

Preferred:

Pyrimethamine 600 mg po x 1 dose + pyrimethamine 25-50 mg po once daily + leucovorin 10-25 mg po once daily (BII). Should add additional agents for appropriate OIs (BII).

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BIII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

or

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

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Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)

or

Itraconazole 200 mg po bid for ≥ 12 mos + leucovorin 25-30 mg po once daily + amphotericin B lipid complex 5 mg/kg IV once daily (BII)

or

Pyrimethamine 750 mg po x 1 dose + pyrimethamine 25 mg po once daily + leucovorin 10-25 mg po once daily (BII)