Management of suspected drug-induced rash, kidney injury and liver injury in adult patients on TB treatment and/or antiretroviral treatment

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This booklet has been compiled to improve the management of rash, renal injury and drug-induced liver injury in ADULT patients on TB treatment and/or antiretroviral therapy. If you need further assistance please call the National HIV and TB HCW Hotline, 0800 212 506 / 021 406 6782 / send an SMS or “Please call me” to 071 840 1572.

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WHEN USING THIS BOOKLET PLEASE NOTE:

1. The algorithms are intended for management of rashes, kidney injuries and liver injuries in adult patients only.
2. If a recommended laboratory test is not available at your facility, refer the patient.
3. If treatment is recommended in hospital, patients should be admitted to hospital urgently.
4. Always attempt to get the contact details of the patient as part of the history. This is necessary if the patient needs to be recalled.
5. If uncertain about the management of any of the adverse drug reactions, kindly seek expert advice or call the HIV hotline on 0800 212 506.
Rash

1.1 Rash in patient on efavirenz/nevirapine
1.2 Abacavir hypersensitivity reaction
1.3 Rash in a patient on TB treatment
1.4 TB drug rechallenge after skin reaction
1.5 TB treatment duration after a severe skin reaction
1.6 Co-trimoxazole rechallenge or replacement
1.1 RASH IN PATIENT ON EFAVIRENZ OR NEVIRAPINE

Patient who is taking efavirenz or nevirapine develops a rash*

Did the rash appear after starting antiretroviral therapy (ART)?

- Take an accurate drug history
- STOP any other non-essential drugs
- Assess rash severity. Does the patient have any one of the following:
  - Systemic illness/feeling unwell
  - Fever
  - Hepatitis (check ALT if on nevirapine)
  - Skin blistering
  - Mucosal involvement (eyes, mouth, genitalia)

Consider a differential diagnosis e.g. immune reconstitution inflammatory syndrome (IRIS), pruritic papular eruption (PPE), seborrheic dermatitis, folliculitis, Kaposi sarcoma, herpes zoster, eczema.

Discuss patient with an expert or call the hotline (0800 212 506) for further assistance.

Continue ART and treat rash symptomatically with oral antihistamines. Advise the patient to return if rash worsens, develops other symptoms or no improvement.

This is a severe skin reaction!

- STOP ALL drugs including ART and co-trimoxazole immediately
- If on nevirapine, do ALT
- Wait for rash and other symptoms/signs to settle

NEVER rechallenge co-trimoxazole if patient had a life-threatening skin reaction. For such cases, discuss with an expert or call the hotline (0800 212 506).

If patient was on co-trimoxazole, consider co-trimoxazole rechallenge as follows:

- For primary prophylaxis
  Do not rechallenge co-trimoxazole. Dapsone may be used unless skin reaction was life-threatening [Stevens-Johnson Syndrome, toxic epidermal necrolysis (TEN), erythema multiforme, drug reaction with eosinophilia and systemic symptoms (DRESS)].

- For secondary prophylaxis
  Once rash settles, consider co-trimoxazole desensitisation if:
  1. Patient is being treated for pneumocystis pneumonia or toxoplasmosis
  2. Patient has prior history of pneumocystis pneumonia (secondary prophylaxis) and current CD4 count < 200 cells/µL.

Discuss with an expert or call the hotline if considering co-trimoxazole desensitisation.

* Please note: The above algorithm does not include guidance for patients who are also on abacavir. Patients on abacavir who present with a rash and other symptoms (e.g. fever, GIT symptoms, general malaise or respiratory symptoms) may have an abacavir hypersensitivity reaction. Please consult with the hotline (0800 212 506) or see section on abacavir hypersensitivity (1.2) for diagnosis and management.
RASH IN PATIENT TAKING EFAVIRENZ OR NEVIRAPINE

Incidence and presentation of efavirenz/nevirapine drug-induced rash

The non-nucleoside reverse transcriptase inhibitors (NNRTIs) efavirenz and nevirapine are the most common drug cause of rashes in patients taking first-line antiretroviral therapy (ART). NNRTI-associated rash occurs in 10-17% of patients within 3 to 18 weeks of starting the NNRTI1,2 and most are mild. Severe reactions such as Stevens-Johnson syndrome, toxic epidermal necrolysis and erythema multiforme occur more frequently with nevirapine (0.3-1%) than efavirenz (0.1%)¹.

The presentation of an NNRTI-induced rash ranges from a mild macular, maculopapular or erythematos rash to a severe rash with blistering, moist desquamation and ulceration¹. Efavirenz-induced rash is often maculopapular, photodistributed and has non-tender palmar erythema.

Nevirapine hypersensitivity reaction

Nevirapine-associated hypersensitivity reaction is an immune-mediated reaction with rash and hepatotoxicity. It typically occurs within the first six weeks of therapy. Approximately half of patients presenting with hepatitis on nevirapine have an accompanying rash³. Therefore, all patients presenting with a rash on nevirapine need to have their ALT checked.

References

1.2 ABACAVIR HYPERSENSITIVITY REACTION

Incidence and presentation of abacavir hypersensitivity reaction

The incidence of the abacavir hypersensitivity reaction is approximately 4.3%\(^1\). It usually occurs within the first six weeks of therapy\(^2\). However, it may also occur at any time during abacavir therapy\(^3\). It is a multi-organ syndrome and consists of two or more of the following symptoms\(^4\):

- Rash (approximately 70%)
- Fever (70 to 80%)
- Respiratory symptoms: cough, dyspnoea, pharyngitis (approximately 18 to 30%)
- GIT symptoms: nausea, vomiting, diarrhoea, abdominal pain (approximately 50%)
- Constitutional symptoms: generalised malaise, achiness, fatigue (approximately 40 to 60%)

The majority (98%) of patients have fever and/or rash as part of the hypersensitivity reaction\(^3,4\). The rash generally presents as maculopapular or urticarial, but erythema multiforme has also been reported\(^4\). The symptoms worsen with continued therapy and may be life-threatening\(^4\).

Other less common symptoms and signs of abacavir hypersensitivity reaction include: lethargy, oedema, abnormal chest x-ray, and paraesthesia\(^4\).

Outcomes associated with abacavir hypersensitivity reaction include: anaphylaxis, liver failure, renal failure, hypotension, adult respiratory distress syndrome, respiratory failure, and death\(^4\).

Risk factors for abacavir hypersensitivity reaction

Risk factors for abacavir hypersensitivity include female sex, non-African ethnicity and the presence of the HLA-B*5701 gene\(^2\). Genetic testing may be used to confirm the risk of abacavir hypersensitivity.

Management of abacavir hypersensitivity reaction

It is a severe life-threatening reaction that requires immediate cessation of abacavir. Abacavir should be discontinued even if other diagnoses (respiratory illness, flu-like illness, gastroenteritis or other drugs) are possible and a hypersensitivity reaction cannot be ruled out\(^3\). Where feasible, screening for the presence of the HLA-B*5701 gene may be done to confirm the diagnosis of abacavir hypersensitivity.

The symptoms start resolving within 1-2 days upon cessation of the drug\(^2\). Once rash and other symptoms/signs have settled, substitute with an alternative antiretroviral drug, e.g. tenofovir or zidovudine.

Abacavir should never be rechallenged in a patient who has had a known or suspected hypersensitivity reaction as it may lead to anaphylaxis. If no improvement occurs after stopping abacavir, refer to an expert or call the HIV hotline.

References

1.3 RASH IN A PATIENT ON TB TREATMENT

Patient presents with rash while taking first-line TB treatment, with or without ART

Did the rash appear after starting TB treatment?

- Take an accurate drug history
- STOP any other non-essential drugs
- Assess rash severity. Does the patient have any one of the following:
  - Systemic illness/feeling unwell
  - Fever
  - Hepatitis
  - Skin blistering
  - Eosinophilia (raised eosinophil count)
  - Mucosal involvement (eyes, mouth, genitalia)

This is a severe skin reaction!

- Stop ALL TB treatment, ART and co-trimoxazole IMMEDIATELY
- Wait for rash and other symptoms/signs to settle

Continue TB treatment and ART and treat rash symptomatically with oral antihistamines. Advise the patient to return if rash worsens or no improvement.

- Take an accurate drug history
- STOP any other non-essential drugs
- Assess rash severity. Does the patient have any one of the following:
  - Systemic illness/feeling unwell
  - Fever
  - Hepatitis
  - Skin blistering
  - Eosinophilia (raised eosinophil count)
  - Mucosal involvement (eyes, mouth, genitalia)

Has rash and other symptoms settled?

- Stop ALL TB treatment, ART and co-trimoxazole IMMEDIATELY
- Wait for rash and other symptoms/signs to settle

Start TB background regimen:

- Moxifloxacin 400 mg daily
- Ethionamide 15-20 mg/kg/day as a single daily dose (maximum 1 g/day)
- Terizidone 10-20 mg/kg/day (maximum 1 g/day) as a single daily dose

Monitor patient for at least 1 week.

Did the patient develop rash on TB background therapy?

- Moxifloxacin 400 mg daily
- Ethionamide 15-20 mg/kg/day as a single daily dose (maximum 1 g/day)
- Terizidone 10-20 mg/kg/day (maximum 1 g/day) as a single daily dose

Monitor patient for at least 1 week.

CO-TRIMOXAZOLE RECHALLENGE

(see section 1.6)

NEVER rechallenge co-trimoxazole if patient had a life-threatening skin reaction. For such cases, discuss with an expert or call the hotline (0800 212 506).

If patient was on co-trimoxazole, consider co-trimoxazole rechallenge as follows:

For primary prophylaxis
Do not rechallenge co-trimoxazole. Dapsone may be used unless skin reaction was life-threatening (Stevens-Johnson Syndrome, toxic epidermal necrolysis (TEN), erythema multiforme, drug reaction with eosinophilia and systemic symptoms (DRESS)).

For secondary prophylaxis
Once rash settles, consider co-trimoxazole desensitisation if:
1. Patient is being treated for pneumocystis pneumonia or toxoplasmosis
2. Patient has prior history of pneumocystis pneumonia (secondary prophylaxis) and current CD4 count < 200 cells/µL

Discuss with an expert or call the hotline if considering co-trimoxazole desensitisation.

Consider rechallenge of TB treatment (see algorithm 1.4) after confirming TB diagnosis and checking that TB is drug susceptible.

Consider restarting ART once TB treatment has been successfully rechallenged. See flowchart 1.1
RASH IN A PATIENT TAKING TB-TREATMENT

Prevalence of rash in patients taking first-line TB treatment

The prevalence of rash in patients taking TB treatment ranges between 4.7% and 23%1-3. All the first-line TB drugs (rifampicin, isoniazid, pyrazinamide and ethambutol) are associated with rash.

Onset and presentation of TB treatment-induced rash

The onset of rash is typically within the first 2 months of TB treatment3. The types of rash that occur with TB treatment vary from less severe morbiliform/maculopapular skin eruptions to severe life threatening reactions such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) and drug rash with eosinophilia and systemic symptoms (DRESS)1. Morbiliform/maculopapular skin reactions are the most common types of skin reactions that occur with TB drugs, accounting for 95% of cases1.

Other less common skin reactions include fixed drug eruptions, lichenoid drug eruption and cutaneous vasculitis1.

General management of TB treatment-induced rash

The assessment of severity of the rash is vital as it influences the overall management, including treatment interruption and referral to higher levels of care.

Morbiliform/maculopapular skin reaction

Generally the majority of morbiliform/maculopapular skin reaction cases are self-limiting and can be managed symptomatically with oral antihistamines. However, a small percentage may progress into SJS/TEN. Thus, close monitoring of the patient for signs of worsening rash, systemic involvement and mucosal involvement is recommended.

SJS/TEN/DRESS

Life-threatening skin reactions such as SJS, DRESS or TEN require admission to hospital for management. Stop TB treatment and other drugs that may be implicated (e.g. antiretroviral therapy, co-trimoxazole). Always rechallenge TB treatment with close monitoring and as an inpatient.

References


1.4 TB DRUG RECHALLENGE AFTER SKIN REACTION

Once the rash has settled and the patient is clinically well, consider rechallenge of the TB treatment. Has the TB diagnosis been confirmed by either microbiological means or convincing clinical and/or radiological features?

- **Yes**
  - Is the TB drug susceptible?
    - **Yes**
      - Is the patient on intensive phase of TB treatment?
        - **Yes**
          - Intensive phase
            Continue TB background regimen - moxifloxacin 400 mg daily, ethionamide 15-20 mg/kg/day as a single daily dose (maximum 1 g/day) and terizidone 10-20 mg/kg/day as a single daily dose (maximum 1 g/day) - for at least 2 weeks before rechallenging TB treatment.

            **Rechallenge TB treatment in hospital.** During rechallenge, evaluate the patient for rash, fever and symptoms and signs of anaphylaxis daily. Discontinue the drug(s) immediately if the patient starts to develop a new rash, even if the rash is mild. Monitor ALT and creatinine 3 times a week. If baseline creatinine abnormal, monitor creatinine more frequently. Monitor eosinophil count frequently if raised.

            **Rechallenge Schedule**
            - Day 1: Rifampicin 75 mg daily
            - Day 2: Rifampicin 300 mg daily
            - Day 3: Rifampicin 600 mg daily, if < 60 kg, rifampicin 450 mg daily
            - Day 5: Isoniazid 50 mg daily
            - Day 6: Isoniazid 100 mg daily
            - Day 7: Isoniazid 300 mg daily
            - Day 9: Pyrazinamide 250 mg daily
            - Day 10: Pyrazinamide 1 g daily
            - Day 11: Pyrazinamide 25 mg/kg/day (max 2 g)

            Rechallenge with ethambutol, if intolerant to any of the above 3 drugs:
            - Day 12: Ethambutol 100 mg daily
            - Day 13: Ethambutol 400 mg daily
            - Day 14: Ethambutol 15 mg/kg/day (max 1200 mg)

            If patient tolerates rechallenged TB drugs, stop TB background regimen

            **Continuation phase**
            Continue TB background regimen - moxifloxacin 400 mg daily, ethionamide 15-20 mg/kg/day as a single dose (maximum 1 g/day) and terizidone 10-20 mg/kg/day as a single dose (maximum 1 g/day) - for at least 2 weeks before rechallenging TB treatment.

            **Rechallenge TB treatment in hospital.** During rechallenge, evaluate the patient for rash, fever and symptoms and signs of anaphylaxis daily. Discontinue the drug(s) immediately if the patient starts to develop a new rash, even if the rash is mild. Monitor ALT and creatinine 3 times a week. If baseline creatinine is abnormal, monitor creatinine more frequently. Monitor eosinophil count frequently if raised.

            **Rechallenge Schedule**
            - Day 1: Rifampicin 75 mg daily
            - Day 2: Rifampicin 300 mg daily
            - Day 3: Rifampicin 600 mg daily. If < 60 kg, rifampicin 450 mg daily
            - Day 5: Isoniazid 50 mg daily
            - Day 6: Isoniazid 100 mg daily
            - Day 7: Isoniazid 300 mg daily

            If patient tolerates both drugs, stop the TB background regimen and the individual TB drugs. Start the patient on a fixed dose combination of rifampicin and isoniazid (Rifinah®). Continue for 4 months.

- **No**
  - Do not rechallenge TB treatment. Discuss the patient with an expert or call the hotline (0800 212 506)

- **No**
  - Is the patient on intensive phase of TB treatment?
    - **Yes**
      - Intensive phase
        Continue TB background regimen - moxifloxacin 400 mg daily, ethionamide 15-20 mg/kg/day as a single daily dose (maximum 1 g/day) and terizidone 10-20 mg/kg/day as a single daily dose (maximum 1 g/day) - for at least 2 weeks before rechallenging TB treatment.

        **Rechallenge TB treatment in hospital.** During rechallenge, evaluate the patient for rash, fever and symptoms and signs of anaphylaxis daily. Discontinue the drug(s) immediately if the patient starts to develop a new rash, even if the rash is mild. Monitor ALT and creatinine 3 times a week. If baseline creatinine abnormal, monitor creatinine more frequently. Monitor eosinophil count frequently if raised.

        **Rechallenge Schedule**
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        - Day 3: Rifampicin 600 mg daily, if < 60 kg, rifampicin 450 mg daily
        - Day 5: Isoniazid 50 mg daily
        - Day 6: Isoniazid 100 mg daily
        - Day 7: Isoniazid 300 mg daily

        If patient tolerates rechallenged TB drugs, stop TB background regimen

        **Continuation phase**
        Continue TB background regimen - moxifloxacin 400 mg daily, ethionamide 15-20 mg/kg/day as a single dose (maximum 1 g/day) and terizidone 10-20 mg/kg/day as a single dose (maximum 1 g/day) - for at least 2 weeks before rechallenging TB treatment.

        **Rechallenge TB treatment in hospital.** During rechallenge, evaluate the patient for rash, fever and symptoms and signs of anaphylaxis daily. Discontinue the drug(s) immediately if the patient starts to develop a new rash, even if the rash is mild. Monitor ALT and creatinine 3 times a week. If baseline creatinine abnormal, monitor creatinine more frequently. Monitor eosinophil count frequently if raised.

        **Rechallenge Schedule**
        - Day 1: Rifampicin 75 mg daily
        - Day 2: Rifampicin 300 mg daily
        - Day 3: Rifampicin 600 mg daily. If < 60 kg, rifampicin 450 mg daily
        - Day 5: Isoniazid 50 mg daily
        - Day 6: Isoniazid 100 mg daily
        - Day 7: Isoniazid 300 mg daily

        If patient tolerates both drugs, stop the TB background regimen and the individual TB drugs. Start the patient on a fixed dose combination of rifampicin and isoniazid (Rifinah®). Continue for 4 months.
TB TREATMENT-INDUCED RASH RECHALLENGE

**Do not** rechallenge pyrazinamide if the patient presented with a rash with life-threatening hepatitis (transaminitis with total bilirubin > 34 µmol/L and/or coagulopathy and/or encephalopathy).

**Note:** Sometimes excipients (inactive ingredients in a drug formulation) may cause skin reactions. If the patient tolerates individual drugs during rechallenge but does not tolerate the fixed dose combination of RHZE (rifampicin, isoniazid, pyrazinamide, ethambutol) or RH (rifampicin, isoniazid), discuss with an expert or call the HIV hotline.

If TB drug rechallenge is tolerated, complete TB therapy with duration as per standard treatment guidelines. In determining the length of treatment required, take into account the period completed before the reaction occurred.

If rechallenge is not tolerated, discuss with an expert or call the HIV/TB hotline (0800 212 506).
1.5 TB TREATMENT DURATION AFTER A SEVERE SKIN REACTION
What drugs to use if not tolerating one of the TB drugs in the INTENSIVE PHASE

**RIFAMPICIN** not tolerated
- STOP rifampicin and substitute with rifabutin
- Continue rifabutin, isoniazid, pyrazinamide, ethambutol for **2 months**, then rifabutin and isoniazid for **4 months**

**ISONIAZID** not tolerated
- STOP isoniazid
- Continue rifampicin, pyrazinamide, ethambutol and levofloxacin (preferred)/ moxifloxacin for **6 - 9 months**

**PYRAZINAMIDE** not tolerated
- STOP pyrazinamide
- Continue rifampicin, isoniazid* and ethambutol for **9 months**
  *Try to confirm isoniazid susceptibility. If not susceptible, refer to expert or call the hotline

Refer to an expert or call the hotline (0800 212 506) if more than one TB drug is not tolerated during rechallenge, or in the continuation phase, or if unsure about the duration of TB treatment after rechallenge

**References**
1.6 CO-TRIMOXAZOLE RECHALLENGE OR REPLACEMENT

**Primary prophylaxis**

The aim of primary prophylaxis is to prevent opportunistic infections. If the skin reaction was not severe, patients receiving co-trimoxazole for primary prophylaxis with CD4 count < 200 cells/μL, should be switched to dapsone 100 mg po daily as an alternative.

Do not start dapsone for primary prophylaxis if the CD4 count is > 200 cells/μL.

If the skin reaction was life-threatening (e.g. Stevens-Johnson syndrome, erythema multiforme, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms), do not substitute with dapsone. There is a risk of cross-reactivity between co-trimoxazole and dapsone.

**Secondary prophylaxis/maintenance treatment after pneumocystis pneumonia**

If the patient was taking co-trimoxazole as secondary prophylaxis (maintenance therapy) after pneumocystis pneumonia, commence dapsone in place of co-trimoxazole.

Consider co-trimoxazole rechallenge for the following indications:

1. Previous history of pneumocystis pneumonia with current CD4 count < 200 cells/μL.
2. Use of co-trimoxazole to treat severe acute infections such as pneumocystis pneumonia or toxoplasmosis.

If the reaction was life-threatening, discuss with an expert or call the HIV hotline.

**Secondary prophylaxis/maintenance treatment after toxoplasmosis**

If the patient was taking co-trimoxazole as secondary prophylaxis (maintenance therapy) after toxoplasmosis infection, dapsone cannot be used as it is not effective against toxoplasmosis. There are 2 options:

1. Clindamycin plus pyrimethamine plus folinic acid
2. Co-trimoxazole desensitization using the slow desensitization protocol

If the reaction was life-threatening, discuss with an expert or call the HIV hotline.

**Acute treatment of pneumocystis pneumonia or toxoplasmosis**

Patients who developed a skin reaction while taking co-trimoxazole for treatment of pneumocystis pneumonia or toxoplasmosis will require in-hospital rapid desensitization. See protocol below.

If the reaction was life-threatening, discuss with an expert or call the HIV hotline.

**Rapid co-trimoxazole desensitisation protocol**

This should always be done as an in-patient without steroid or antihistamine cover. Stop the desensitization if a rash, pruritus, fever or
any other symptoms (e.g. burning of the skin) develop. Use diluted co-
trimoxazole suspension for the desensitisation.

Dilution is as follows:

**Mixture A - Trimethoprim 0.04 mg / sulfamethoxazole 0.2 mg / 5 mL:** Take 1 mL co-trimoxazole suspension (trimethoprim 40 mg/sulfamethoxazole 200 mg/5mL) and dilute to 1 litre with distilled water and shake well\(^5\).

**Mixture B - Trimethoprim 0.004 mg / sulfamethoxazole 0.02 mg / 5 mL:** Take 1 mL of mixture A and dilute to 10 mL with distilled water\(^5\).

<table>
<thead>
<tr>
<th>Time</th>
<th>Dose of diluted co-trimoxazole suspension</th>
<th>Dose in mLs of undiluted co-trimoxazole suspension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 0</td>
<td>Administer 5 mL orally of mixture B. (Discard balance of mixture B)</td>
<td>0.0005 (trimethoprim 0.004 mg/sulfamethoxazole 0.02 mg)</td>
</tr>
<tr>
<td>Time 1 hour</td>
<td>Administer 5 mL orally of mixture A (after shaking well)</td>
<td>0.005 (trimethoprim 0.04 mg/sulfamethoxazole 0.2 mg)</td>
</tr>
<tr>
<td>Time 2 hours</td>
<td>Administer 50 mL orally of mixture A (after shaking well and discard balance of mixture A)</td>
<td>0.05 (trimethoprim 0.4 mg/sulfamethoxazole 2 mg)</td>
</tr>
<tr>
<td>Time 3 hours</td>
<td>Administer 0.5 mL orally of co-trimoxazole suspension diluted to 5 mL with distilled water</td>
<td>0.5 (trimethoprim 4 mg/sulfamethoxazole 20 mg)</td>
</tr>
<tr>
<td>Time 4 hours</td>
<td>Administer 5 mL orally of undiluted co-trimoxazole suspension</td>
<td>5 (trimethoprim 40 mg/sulfamethoxazole 200 mg)</td>
</tr>
<tr>
<td>Time 5 hours</td>
<td>Administer 2 single strength co-trimoxazole tablets orally (trimethoprim 160 mg/sulfamethoxazole 800 mg)</td>
<td></td>
</tr>
<tr>
<td>Time 6 hours</td>
<td>Start full dose co-trimoxazole</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If there is any uncertainty regarding co-trimoxazole rechallenge, discuss with an expert or call the HIV hotline.

**References**

[2] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available online: 
Kidney injury

2.1 Kidney injury in a patient taking tenofovir

2.2 Renal adjustment of antiretroviral doses
2.1 KIDNEY INJURY IN A PATIENT TAKING TENOFOVIR

Patient presents with eGFR < 50 mL/min on tenofovir-based antiretroviral therapy (ART) regimen

**STOP** tenofovir immediately and switch to abacavir. If abacavir is contraindicated, then switch to zidovudine if haemoglobin > 8 g/dL.

Check if any drugs need renal dose adjustment. For dose adjustment of ART see Renal Adjustment of Antiretroviral Doses Table. If unsure about dose adjustment of other drugs, discuss with an expert or call the hotline at 0800 212 506.

Stop all nephrotoxic drugs (e.g. amphotericin B, NSAIDs, aminoglycosides, co-trimoxazole) if possible.

Is there a concomitant cause for the kidney injury e.g. acute/chronic gastroenteritis, dehydration, sepsis?

- Continue abacavir/zidovudine
- Do a blood gas to check for acidosis and electrolyte abnormalities
- Rehydrate (obtain IV access if required) and monitor urine output
- Do urine dipstick to check for proteinuria. If proteinuria 1+ or more, discuss with an expert or call the hotline (0800 212 506) for further assistance
- Treat the underlying condition
- Monitor renal function regularly according to clinical condition

Has underlying condition resolved and eGFR > 50 mL/min?

- Stop abacavir/zidovudine. Recomence tenofovir. Repeat eGFR at 1 month. If eGFR at 1 month > 50 mL/min, continue routine eGFR monitoring.

Has renal function improved?

- Yes
  - Continue abacavir/zidovudine.
  - Do urine protein:creatinine ratio
  - If proteinuria > 0.1, discuss with an expert or call the hotline (0800 212 506) for further assistance
  - Consider other causes of kidney injury e.g. HIVAN, opportunistic infections, malignancies, Hepatitis B
  - Consider non-HIV related causes e.g. diabetes, hypertension, atherosclerosis

- No
  - Continue abacavir/zidovudine.
  - Do monthly eGFR monitoring and urine dipstick
  - Do urine protein:creatinine ratio
  - If 1+ proteinuria or urine protein:creatinine ratio > 0.1, discuss with an expert or call the hotline (0800 212 506) for further assistance
  - Consider other causes of kidney injury e.g. HIVAN, opportunistic infections, malignancies, Hepatitis B
  - Consider non-HIV related causes e.g. diabetes, hypertension, atherosclerosis

- Yes
  - Continue abacavir/zidovudine.
  - Discuss with an expert or call 0800 212 506 for further assistance.

- No
  - Continue abacavir/zidovudine.
  - Discuss with an expert or call 0800 212 506 for further assistance.
KIDNEY INJURY ON TENOFOVIR

Presentation of tenofovir-induced kidney injury

Tenofovir may cause:

• Subclinical renal tubular dysfunction, characterised by increased concentration of glucose and/or low molecular protein in the urine and reduced reabsorption of phosphate
• Accelerated decline in eGFR ( > 3mL/min per 1.73m² per year)
• Proteinuria
• Fanconi syndrome - characterised by glycosuria, hypophosphataemia, proteinuria, hypouricaemia, hypokalemia and tubular acidosis
• Chronic kidney disease
• Acute kidney injury
• Tubulointerstitial nephritis

Incidence of tenofovir-induced kidney injury

Treatment-limiting renal disease due to tenofovir is rare. Fanconi syndrome requiring treatment discontinuation occurred in 0.5-1% of patients in clinical trials and has been reported in 1 to 1.5% of patients in cohort studies.

The incidence of tenofovir-associated kidney injury, defined as a decline in renal function below 50 mL/min/1.73 m² in a South African adult cohort was 3% over 12 months. In a Zambian cohort, the reported incidence of moderate (eGFR 30-59 mL/min) or severe (eGFR ≤ 29 mL/min) renal dysfunction associated with tenofovir was 1.84% over 12 months.

Risk factors for tenofovir-induced kidney injury:

- Pre-existing renal impairment
- Older age
- Advanced HIV disease
- Low body weight
- Concomitant protease inhibitors
- Concomitant use of nephrotoxic drugs
- Diabetes mellitus
- Hypertension

Monitoring for tenofovir-induced kidney injury

Kidney injury can occur any time during tenofovir therapy. Therefore, monitoring of eGFR is recommended at baseline, 3 months, 6 months and yearly thereafter.

To minimise kidney injury, tenofovir should not be initiated in patients with an eGFR < 50 mL/min. Monitor eGFR weekly if concomitant use of other nephrotoxic drugs (e.g. amphotericin B, aminoglycosides) cannot be avoided.

Management of acute kidney injury in a patient taking tenofovir

If eGFR drops to below 50 mL/min, stop tenofovir and switch to abacavir. If abacavir is contraindicated, use zidovudine, provided that haemoglobin is > 8 g/dL. Renally excreted drugs e.g. lamivudine will require dose adjustment. If uncertain about dose adjustment of other renally excreted drugs, seek expert advice or call the HIV hotline. Stop all other nephrotoxic drugs. Rule out other causes of renal dysfunction, e.g. diarrhoea, HIV-associated nephropathy (HIVAN), opportunistic infections and sepsis. Patients should always be referred to a higher level of care if renal function does not improve within 1 month or worsens despite stopping tenofovir.
References


## 2.2 RENAL ADJUSTMENT OF ANTIRETROVIRAL DOSES

<table>
<thead>
<tr>
<th>Drug</th>
<th>Standard adult dose</th>
<th>eGFR 10-49 mL/min</th>
<th>eGFR &lt; 10 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abacavir</td>
<td>600 mg daily OR 300 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Atazanavir/ritonavir</td>
<td>300 mg/100 mg daily</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Darunavir/ritonavir</td>
<td>600 mg/100 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Efavirenz</td>
<td>600 mg nocte</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Etravirine</td>
<td>200 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Lamivudine</td>
<td>300 mg daily OR 150 mg 12 hourly</td>
<td>150 mg daily</td>
<td>50 mg daily</td>
</tr>
<tr>
<td>Lopinavir/ritonavir</td>
<td>400 mg/100 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>200 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Raltegravir</td>
<td>400 mg 12 hourly</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Rilpivirine</td>
<td>25 mg daily</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Stavudine</td>
<td>30 mg 12 hourly</td>
<td>15 mg 12 hourly</td>
<td>15 mg daily</td>
</tr>
<tr>
<td>Tenofovir</td>
<td>300 mg daily</td>
<td>Avoid</td>
<td>Avoid</td>
</tr>
<tr>
<td>Zidovudine</td>
<td>300 mg 12 hourly</td>
<td>Unchanged</td>
<td>300 mg daily</td>
</tr>
</tbody>
</table>

Table: ART dose adjustment in renal impairment (Doses obtained from Aid for AIDS Clinical Guideline. 2016. 11th ed. p.99)
Liver injury

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3.3 TB treatment
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3.4 Liver injury in a patient on efavirenz/ nevirapine 36
3.1 PATTERNS OF DRUG-INDUCED LIVER INJURY (DILI)

Hepatic adaptation

Exposure to drugs may induce a physiologic, adaptive response in the liver, known as hepatic adaptation\(^1\). Adaptation causes low-grade, transient, asymptomatic transaminase elevation\(^1\). Hepatic adaptation should be distinguished from a symptomatic drug-induced liver injury (DILI) which frequently has more marked transaminitis and requires drug cessation.

Hepatocellular DILI

- In hepatocellular DILI, ALT is disproportionately elevated compared to the elevation of ALP:
  - ALT ≥ 3 times ULN with Ratio ≥ 5
  - Hepatocellular DILI may either be asymptomatic or symptomatic. Symptoms and signs may include fatigue, anorexia, nausea, vomiting, abdominal pain or right upper quadrant tenderness

Examples of drugs that may cause hepatocellular-pattern liver injury: isoniazid, pyrazinamide, nevirapine, efavirenz, paracetamol (chronic use/overdose)
- Other causes of hepatocellular-pattern liver injury include acute viral hepatitis, chronic hepatitis B and C, IRIS (immune reconstitution inflammatory syndrome)
- Hepatocellular DILI usually occurs within the first 2 to 12 weeks of drug exposure but may occur at any time of drug exposure\(^2\)
- Efavirenz-associated and INH-associated DILI may occur up to a year after drug initiation
- Generally, hepatocellular DILI resolves within 2 to 4 weeks of stopping the causative drug\(^2\)

Cholestatic DILI

- In cholestatic DILI, ALP is disproportionately elevated compared to ALT:
  - ALP ≥ 2 times ULN with Ratio ≤ 2
- Cholestatic DILI may result in a conjugated hyperbilirubinemia
- Typical symptoms and signs of cholestatic DILI include nausea, fatigue, pruritus, dark urine and jaundice
- Examples of drugs that may cause cholestatic-pattern liver injury: rifampicin, amoxicillin-clavulanic acid, cephalosporins, sulfonylureas

<table>
<thead>
<tr>
<th>ALT</th>
<th>ULN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALP</td>
<td>ULN</td>
</tr>
</tbody>
</table>

\[ \text{Ratio} = \left( \frac{\text{ALT}}{\text{ULN}} \right) / \left( \frac{\text{ALP}}{\text{ULN}} \right) \]

ALT = serum alanine aminotransferase
ALP = serum alkaline phosphatase
ULN = upper limit of normal

To determine the pattern of DILI, calculate the following ratio:
• Cholestatic DILI generally occurs within 2 to 12 weeks of drug initiation but may sometimes occur a year or more after drug initiation
• Cholestatic DILI resolves more slowly than hepatocellular DILI. Elevated enzyme concentrations should drop by 50% within 4 to 12 weeks
• Purely cholestatic DILI is rarely caused by TB treatment or antiretrovirals

**Mixed DILI**

• Moderate to marked elevations in both ALT and ALP\(^2\):
  - ALT ≥ 3 times ULN and ALP ≥ 2 times ULN with Ratio > 2 to < 5
• In mixed DILI, there are features of both hepatocellular and cholestatic DILI

• Onset of mixed DILI is typically within 2 to 12 weeks of drug initiation but may occur at any time during drug exposure\(^2\)
• The presenting symptoms and signs may include fatigue, anorexia and nausea followed by jaundice and often pruritus\(^2\)
• Examples of drugs that cause mixed-pattern liver injury: rifampicin, efavirenz, anti-convulsants (phenytoin, carbamazepine, and lamotrigine), non-steroidal anti-inflammatory drugs (NSAIDs), co-trimoxazole, amoxicillin-clavulanic acid, flucloxacillin, fluconazole
• Mixed DILI resolves more slowly than a purely hepatocellular DILI
• Elevated enzyme concentrations should drop by 50% within 4 to 12 weeks\(^2\)
• IRIS may present with mixed-pattern liver injury

**References**

3.2.1 LIVER INJURY IN A PATIENT ON TB TREATMENT AND ART

Asymptomatic patient with ALT > 200 IU/L

- Patient presents with symptoms/signs of hepatitis (e.g. nausea, vomiting, abdominal pain, malaise, anorexia, right upper quadrant tenderness, jaundice) on antiretroviral therapy (ART) and first-line TB drugs

- Do ALT and total bilirubin. If jaundiced and/or ALT and total bilirubin cannot be obtained within 24 hours, STOP ALL TREATMENT and refer to higher level of care immediately

- Does the patient have any of the following in addition to symptoms/signs of hepatitis: ALT > 100 IU/L OR total serum bilirubin > 34 µmol/L

THIS IS A LIVER INJURY THAT REQUIRES CESSIONATION OF DRUGS

- Admit patient to hospital
- STOP TB treatment, ART and other hepatotoxic drugs e.g. co-trimoxazole, fluconazole, amoxicillin-clavulanic acid
- Do full liver function test to identify liver enzyme pattern
- Calculate ratio (R): ALT/upper limit of normal (ULN) divided by ALP/ULN

Hepatocellular liver enzyme pattern: ALT ≥ 3 times ULN, R ≥ 5

Cholestatic liver enzyme pattern: ALP ≥ 2 times ULN, R ≤ 2

Mixed liver enzyme pattern: ALT ≥ 3 times ULN, ALP ≥ 2 times ULN, R > 2 but < 5

IN HOSPITAL

- Do INR and blood glucose
- Start TB background regimen as follows:
  - Moxifloxacin, oral, 400 mg daily; ethambutol, oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily
  - If eGFR < 60 mL/min or raised INR, substitute amikacin/kanamycin with ethionamide or linezolid.

EXCLUDE OTHER CAUSES OF LIVER DYSFUNCTION

Hepatocellular:
1. Hepatitis A IgM, hepatitis B surface antigen, hepatitis B core IgM antibody, hepatitis C antibody
2. Herpes simplex virus PCR
3. Immune reconstitution inflammatory syndrome (IRIS)

Cholestatic and Mixed:
1. Perform an abdominal ultrasound to exclude obstructive causes of liver dysfunction e.g. lymphoma, disseminated TB with obstruction, extra-hepatic obstruction
2. Sepsis as a contributing factor
3. HIV cholangiopathy
4. IRIS

- For mixed pattern also exclude alcohol abuse

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Follow-up monitoring: Is ALT improving?

- Stop laboratory monitoring
- Review the patient in 1 month
- Advise the patient to return to the clinic if any symptoms/signs of hepatitis develop

If ALT continues to increase or is unchanged: Monitor ALT and bilirubin weekly for 4 consecutive weeks

If ALT increases to > 200 IU/L or bilirubin increases to > 34 µmol/L or patient becomes symptomatic, manage as a DILI

Re-ID Liver Injuries

- Consider rechallenge of TB drugs after excluding other causes of liver dysfunction and confirmation of TB diagnosis (Algorithm 3.2.2)
- DO NOT rechallenge TB treatment if patient had acute liver failure (jaundice with encephalopathy and/or coagulopathy)

Discuss the patient with an expert or call the hotline (0800 212 506)
LIVER INJURY IN PATIENT ON TB TREATMENT AND ANTIRETROVIRAL THERAPY (ART)

DILI complicates first-line TB treatment in 1% of patients. The first-line antituberculosis drugs isoniazid, rifampicin and pyrazinamide can cause drug-induced liver injury (DILI). Ethambutol does not cause DILI.

Efavirenz, nevirapine and lopinavir + ritonavir can cause DILI. Tenofovir (TDF), emtricitabine (FTC) and lamivudine (3TC) do not cause DILI.

Risk factors for DILI in patients taking TB treatment and ART:

- Age > 35 years
- Female sex
- Pregnancy
- Hepatitis B/C co-infection
- Slow acetylator status (isoniazid-induced DILI)
- Malnutrition

Management of DILI in patients taking TB treatment and ART

Stop TB treatment and other hepatotoxic drugs immediately if:

1. ALT > 100 IU/L and patient symptomatic OR
2. ALT > 200 IU/L OR
3. Total bilirubin > 34 µmol/L

Jaundice in a patient with hepatocellular injury indicates severe liver injury, with a 10% chance of developing fulminant liver failure (jaundice with encephalopathy and/or coagulopathy).

Initiate a TB background regimen consisting of amikacin/kanamycin, moxifloxacin and ethambutol to prevent development of resistance. Consider ethionamide or linezolid in place of amikacin/kanamycin if an aminoglycoside is contraindicated due to renal impairment (eGFR < 60 mL/min) or if INR > 1.5. Discuss substitution with an expert or call the HIV hotline.

Take note: complete TB drug rechallenge before restarting ART.

References

Intensive phase, rechallenge as follows:

Continue background regimen (moxifloxacin, oral, 400 mg daily; and ethambutol, oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily).

If eGFR < 60 mL/min or INR is raised, substitute amikacin/kanamycin with ethionamide or linezolid.

Day 1: Rifampicin 10mg/kg/day (max 600 mg daily)
Day 3: Check ALT
Day 4-6: If ALT < 100 IU/l, add isoniazid 5mg/kg/day (max 300 mg daily)
Day 7: Check ALT
Day 8: If ALT < 100 IU/l, consider pyrazinamide 25 mg/kg/day

Note: Consider pyrazinamide rechallenge in cases of severe forms of TB e.g. miliary TB or TB meningitis, resistance or intolerance to rifampicin and isoniazid.

Day 10: Check ALT. If ALT < 100 IU/l and pyrazinamide successfully rechallenged, re-start TB fixed dose combination (RHZE). If pyrazinamide not rechallenged, continue RHE

Stop TB background regimen.
Monitor ALT weekly for 4 weeks after rechallenge.

Restart ART once TB treatment has been successfully rechallenged – refer to ART algorithm (Algorithm 3.2.4)

Continuation phase, rechallenge as follows:

Continue background regimen (moxifloxacin, oral, 400 mg daily; and ethambutol, oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily).

If eGFR < 60 mL/min or INR is raised, substitute amikacin/kanamycin with ethionamide or linezolid.

Day 1: Rifampicin 10mg/kg/day (max 600 mg daily)
Day 3: Check ALT
Day 4-6: If ALT < 100 IU/l, add isoniazid 5mg/kg/day (max 300 mg daily)
Day 7: Check ALT
Day 8: If ALT < 100 IU/l, consider rifampicin and isoniazid to complete the continuation phase

Stop TB background regimen.
Monitor ALT weekly for 4 weeks after rechallenge.
TB TREATMENT RECHALLENGE AFTER DRUG-INDUCED LIVER INJURY (DILI)

Rechallenge of TB drugs should only be attempted once ALT is < 100 IU/L and jaundice has resolved\(^1\)\(^3\). Do not rechallenge TB drugs if drug-induced liver injury (DILI) resulted in acute liver failure (jaundice with encephalopathy and/or coagulopathy)\(^2\)\(^3\). These cases need discussion with an expert or call the HIV hotline (0800 212 506).

Rechallenge of TB drugs has been found to be safe and effective in 60-90% of patients, provided frequent ALT monitoring is conducted\(^2\). Frequent ALT monitoring during rechallenge is essential. Monitor ALT at least 3 times weekly during rechallenge and weekly for 1 month following successful rechallenge\(^2\).

Pyrazinamide can cause severe DILI on rechallenge and should not be routinely rechallenged. Consider pyrazinamide rechallenge in patients who developed DILI during the intensive phase of TB treatment if:

1. TB meningitis OR
2. Miliary TB OR
3. Rifampicin or isoniazid rechallenge fails\(^2\)

If uncertain whether or not to attempt rechallenge with pyrazinamide, discuss with an expert or call the HIV hotline.

The length of TB treatment required after rechallenge, depends on how far into TB therapy the DILI occurred and on the outcome of rechallenge. If uncertain, discuss with an expert or call the HIV hotline (0800 212 506).

References

3.2.3 MODIFYING TB TREATMENT REGIMEN

(If one of the TB drugs are not tolerated during rechallenge in the INTENSIVE PHASE)

- **RIFAMPICIN** not tolerated
  - **STOP** rifampicin
  - Short course MDR-TB treatment regimen for **9 months**.
  - If uncertain discuss with an expert or call the hotline (0800 212 506).

- **ISONIAZID** not tolerated
  - **STOP** isoniazid
  - Pyrazinamide rechallenged successfully (if required for severe forms of TB):
    - Continue rifampicin, ethambutol, levofloxacin (preferred) / moxifloxacin and pyrazinamide for **6 - 9 months**
    - **OR**
    - Pyrazinamide not rechallenged:
      - Continue rifampicin, ethambutol and levofloxacin (preferred) / moxifloxacin for **9 - 12 months**
      - Monitor ALT weekly for 4 weeks after rechallenge.

- **PYRAZINAMIDE** not tolerated
  - **STOP** pyrazinamide
  - Continue rifampicin, isoniazid* and ethambutol for **9 months**.
  - Monitor ALT weekly for 4 weeks after rechallenge.
  - *Try to confirm isoniazid susceptibility.
  - If not susceptible, refer to expert or call the hotline.

- **PYRAZINAMIDE** not rechallenged
  - Continue rifampicin, isoniazid* and ethambutol for **9 months**.
  - Monitor ALT weekly for 4 weeks after rechallenge.
  - *Try to confirm isoniazid susceptibility.
  - If not susceptible, refer to expert or call the hotline.

Refer to an expert or call the hotline (0800 212 506) if more than one TB drug is not tolerated during rechallenge, or in the continuation phase, or if unsure about the duration of TB treatment after rechallenge.
3.2.4 RESTARTING ART AFTER DILI ON TB TREATMENT AND ART

Patient presents with DILI on TB treatment and ART.

DO NOT rechallenge first-line TB treatment or ART if patient presented with acute liver failure (jaundice with encephalopathy and/or coagulopathy).

Patients with acute liver failure should be discussed with an expert or the hotline (0800 212 506).

After successful rechallenge of TB treatment, restart ART.

**DILI developed on a nevirapine-based regimen**

DO NOT rechallenge the patient with nevirapine.

If previously on nevirapine and life threatening DILI (transaminitis with bilirubin > 34 µmol/L with encephalopathy and/or coagulopathy) commence a protease inhibitor or integrase inhibitor.

In less severe cases that were previously on nevirapine, commence efavirenz.

Monitor ALT every 2 weeks for 2 months.

**DILI developed on efavirenz-based regimen**

DO NOT rechallenge efavirenz, even with an asymptomatic DILI.

If previously on efavirenz, switch to a protease inhibitor or an integrase inhibitor.

Monitor ALT every 2 weeks for 2 months.

**DILI developed on protease-inhibitor based regimen with double dose lopinavir/ritonavir**

Discuss with an expert or call the hotline (0800 212 506).
Follow-up monitoring: Is ALT improving?

- If patient is asymptomatic, ALT < 100 IU/L but > 40 IU/L and total bilirubin < 34 µmol/L – Continue TB treatment (if TB confirmed)
- If ALT is > 100 IU/L but < 200 IU/L, monitor weekly
- Monitor for jaundice and other symptoms/signs of DILI

If ALT continues to increase or is unchanged: Monitor ALT and bilirubin weekly for 4 consecutive weeks

If ALT increases to > 200 IU/L or bilirubin increases to > 34 µmol/L or patient becomes symptomatic, manage as a DILI

Asymptomatic patient with ALT > 200 IU/L

- Admit patient to hospital
- STOP TB treatment and other hepatotoxic drugs e.g. co-trimoxazole, fluconazole, amoxicillin-clavulanic acid
- Do full liver function test to identify liver enzyme pattern
- Calculate ratio (R): ALT/upper limit of normal (ULN) divided by ALP/ULN

Hepatocellular liver enzyme pattern: ALT ≥ 3 times ULN, R ≥ 5

- Do INR and blood glucose
- Start TB background regimen as follows:
  - Moxifloxacin, oral, 400 mg daily; ethambutol, oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily
  - Note: If eGFR < 60 mL/min or raised INR, substitute amikacin/kanamycin with ethionamide or linezolid.
- If patient has TB meningitis, please call the hotline (0800 212 506) for assistance as the normal background regimen penetrates the CNS poorly.

IN HOSPITAL

Exclude other causes of liver dysfunction

- Hepatocellular:
  1. Hepatitis A IgM, hepatitis B surface antigen, hepatitis B core IgM antibody, hepatitis C antibody
  2. Herpes simplex virus PCR
  3. Immune reconstitution inflammatory syndrome (IRIS)

- Cholestatic and Mixed:
  1. Perform an abdominal ultrasound to exclude obstructive causes of liver dysfunction e.g. lymphoma, disseminated TB with obstruction, extra-hepatic obstruction
  2. Sepsis as a contributing factor
  3. HIV cholangiopathy
  4. IRIS

For mixed pattern also exclude alcohol abuse

If unsure about findings discuss with an expert or call the hotline (0800 212 506)

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Has ALT decreased to < 100 IU/L, bilirubin and INR normalised?

- Consider rechallenge of TB drugs after excluding other causes of liver dysfunction and confirmation of TB diagnosis (Algorithm 3.3.2)
- DO NOT rechallenge TB treatment if patient had acute liver failure (jaundice with encephalopathy and/or coagulopathy).

Discuss the patient with an expert or call the hotline (0800 212 506)
**TB DRUG-INDUCED LIVER INJURY (DILI)**

The first-line anti-tuberculosis drugs isoniazid, rifampicin and pyrazinamide can cause drug-induced liver injury (DILI). Ethambutol does not cause DILI. DILI complicates first-line TB treatment in 1% of patients.

**Risk factors for TB DILI**

- Age > 35 years
- Female sex
- Pregnancy
- Hepatitis B/C co-infection
- Slow acetylator status (isoniazid-induced DILI)
- Malnutrition
- HIV co-infection

**Management of TB DILI**

Stop TB treatment and other hepatotoxic drugs immediately if:

1. ALT > 100 and patient symptomatic OR
2. ALT > 200 OR
3. Total bilirubin > 34 µmol/L

Jaundice in a patient with hepatocellular injury indicates severe liver injury, with a 10% chance of developing fulminant liver failure (jaundice with encephalopathy and/or coagulopathy).

Initiate a TB background regimen consisting of amikacin/kanamycin, moxifloxacin and ethambutol to prevent development of resistance. Consider ethionamide or linezolid in place of amikacin/kanamycin if an aminoglycoside is contraindicated due to renal impairment (eGFR < 60 mL/min) or if INR > 1.5. Substitution should be discussed with an expert or the HIV hotline (0800 212 506).

**References**

3.3.2 TB DRUG RECHALLENGE AFTER DRUG-INDUCED LIVER INJURY ON TB TREATMENT

Before rechallenge, consider the following clinical question: Has the TB diagnosis been confirmed by either microbiological means or convincing clinical and/or radiological features? If patient has TB meningitis, please call the hotline (0800 212 506) for assistance as the normal background regimen penetrates the central nervous system poorly.

Is the TB drug susceptible?

Yes

Do not rechallenge with first-line TB treatment. Discuss the patient with an expert or call the hotline (0800 212 506)

No

On the ALT is < 100 IU/l, bilirubin is normal and patient is asymptomatic, consider rechallenge of TB drugs. DO NOT rechallenge first-line TB treatment if the patient presented with acute liver failure (jaundice with encephalopathy and/or coagulopathy). Patients with acute liver failure should be discussed with an expert or the hotline.

Once the ALT is < 100 IU/l, bilirubin is normal and patient is asymptomatic, consider rechallenge of TB drugs. DO NOT rechallenge first-line TB treatment if the patient presented with acute liver failure (jaundice with encephalopathy and/or coagulopathy). Patients with acute liver failure should be discussed with an expert or the hotline.

Is the patient on intensive phase of TB treatment?

Yes

Intensive phase, rechallenge as follows:

Continue background regimen (moxifloxacin, oral, 400 mg daily; and ethambutol, oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily).
If eGFR < 60 mL/min or INR is raised, substitute amikacin/kanamycin with ethionamide or linezolid.

Day 1: Rifampicin 10mg/kg/day (max 600 mg daily)
Day 3: Check ALT
Day 4-6: If ALT < 100 IU/L, add isoniazid 5mg/kg/day (max 300 mg daily)
Day 7: Check ALT
Day 8: If ALT < 100 IU/L, consider pyrazinamide 25 mg/kg/day
Note: Consider pyrazinamide rechallenge in cases of severe forms of TB e.g. miliary TB or TB meningitis, resistance or intolerance to rifampicin and isoniazid
Day 10: Check ALT. If ALT < 100 IU/L and pyrazinamide successfully rechallenged, restart TB fixed dose combination (RHZE). If pyrazinamide not rechallenged, continue RHE
Stop TB background regimen.
Monitor ALT weekly for 4 weeks after rechallenge.

No

Continuation phase, rechallenge as follows:

Continue background regimen (moxifloxacin, oral, 400 mg daily; and ethambutol; oral, 800-1200 mg daily; and either amikacin, IV/IM or kanamycin, IV/IM, 15 mg/kg daily).
If eGFR < 60 mL/min or INR is raised, substitute amikacin/kanamycin with ethionamide or linezolid.

Day 1: Rifampicin 10mg/kg/day (max 600 mg daily)
Day 3: Check ALT
Day 4-6: If ALT < 100 IU/L, add isoniazid 5mg/kg/day (max 300 mg daily)
Day 7: Check ALT
Day 8: If ALT < 100 IU/L, continue rifampicin and isoniazid to complete the continuation phase
Stop TB background regimen. Monitor ALT weekly for 4 weeks after rechallenge.
**TB TREATMENT RECHALLENGE AFTER DRUG-INDUCED LIVER INJURY (DILI)**

Rechallenge of TB drugs should only be attempted once ALT is < 100 IU/L and jaundice has resolved\(^1\,^3\). Do not rechallenge TB drugs if drug-induced liver injury (DILI) resulted in acute liver failure (jaundice with either encephalopathy and/or coagulopathy)\(^2\,^3\). These cases need discussion with an expert or call the HIV hotline.

Rechallenge of TB drugs has been found to be safe and effective in 60-90% of patients provided frequent ALT monitoring is conducted\(^2\). Frequent ALT monitoring during rechallenge is essential. Monitor ALT at least 3 times weekly during rechallenge and weekly for 1 month following successful rechallenge\(^2\).

Pyrazinamide can cause severe DILI on rechallenge and should not be routinely rechallenged. Consider pyrazinamide rechallenge in patients who developed a DILI during the intensive phase of TB treatment if:

1. TB meningitis OR
2. Miliary TB OR
3. Rifampicin or isoniazid rechallenge fails\(^2\)

If uncertain whether or not to attempt rechallenge with pyrazinamide, discuss with an expert or call the HIV hotline.

The length of TB treatment required after rechallenge, depends on how far into TB therapy the DILI occurred and on the outcome of rechallenge. If uncertain, discuss with an expert or call the HIV hotline.

**References**


3.3.3 MODIFYING TB TREATMENT REGIMEN

(If one of the TB drugs are not tolerated during rechallenge in the INTENSIVE PHASE)

- **RIFAMPICIN** not tolerated
  - STOP rifampicin
  - Short course MDR-TB treatment regimen for **9 months**.
  - If uncertain discuss with an expert or call the hotline (0800 212 506).

- **ISONIAZID** not tolerated
  - STOP isoniazid
  - Pyrazinamide rechallenged successfully (if required for severe forms of TB):
    - Continue rifampicin, ethambutol levofloxacin (preferred) / moxifloxacin and pyrazinamide for **6 - 9 months**
    - OR
    - Pyrazinamide not rechallenged:
      - Continue rifampicin, ethambutol and levofloxacin (preferred) / moxifloxacin for **9 - 12 months**
      - Monitor ALT weekly for 4 weeks after rechallenge.

- **PYRAZINAMIDE** not tolerated
  - STOP pyrazinamide
  - Continue rifampicin, isoniazid* and ethambutol for **9 months**.
  - Monitor ALT weekly for 4 weeks after rechallenge.
  - *Try to confirm isoniazid susceptibility.
  - If not susceptible, refer to expert or call the hotline.

- **PYRAZINAMIDE** not rechallenged
  - Continue rifampicin, isoniazid* and ethambutol for **9 months**.
  - Monitor ALT weekly for 4 weeks after rechallenge.
  - *Try to confirm isoniazid susceptibility.
  - If not susceptible, refer to expert or call the hotline.

Refer to an expert or call the hotline (0800 212 506) if more than one TB drug is not tolerated during rechallenge, or in the continuation phase, or if unsure about the duration of TB treatment after rechallenge.
3.4 LIVER INJURY IN A PATIENT ON EFAVIRENZ/NEVIRAPINE

Asymptomatic patient with ALT > 200 IU/L

Yes

Patient presents with symptoms/signs of hepatitis (e.g. nausea, vomiting, abdominal pain, malaise, anorexia, right upper quadrant tenderness, jaundice) on first-line ART

Do ALT and total bilirubin. If jaundiced and/or ALT and total bilirubin cannot be obtained within 24 hours, STOP ALL TREATMENT and refer to higher level of care immediately

Does the patient have any of the following in addition to symptoms/signs of hepatitis: ALT > 100 IU/L or total serum bilirubin > 34 µmol/L

No

- Admit patient to hospital
- STOP ART and other hepatotoxic drugs e.g. co-trimoxazole, fluconazole, amoxicillin-clavulanic acid
- Do full liver function tests to identify liver enzyme pattern
- Calculate ratio (R): ALT/upper limit of normal (ULN) divided by ALP/ULN

In Hospital

INR

Follow-up monitoring: Is ALT improving?

Yes

- Stop laboratory monitoring
- Review the patient in 1 month
- Advise the patient to return to the clinic if any symptoms/signs of hepatitis develop

No

- If unsure about findings discuss with an expert or call the hotline (0800 212 506)

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Hepatocellular liver enzyme pattern: ALT ≥ 3 times ULN, R ≥ 5

Yes

- Hepatitis A IgM, hepatitis B surface antigen, hepatitis B core IgM antibody, hepatitis C antibody
- Herpes simplex virus PCR
- Immune reconstitution inflammatory syndrome (IRIS)

If unsure about findings discuss with an expert or call the hotline (0800 212 506)

No

Cholestatic liver enzyme pattern: ALP ≥ 2 times ULN, R ≤ 2

Mixed liver enzyme pattern: ALT ≥ 3 times ULN, ALP ≥ 2 times ULN, R > 2 but < 5

Exclude other causes of liver dysfunction

Hepatocellular:
1. Hepatitis A IgM, hepatitis B surface antigen, hepatitis B core IgM antibody, hepatitis C antibody
2. Herpes simplex virus PCR
3. Immune reconstitution inflammatory syndrome (IRIS)

Cholestatic and Mixed:
1. Perform an abdominal ultrasound to exclude obstructive causes of liver dysfunction e.g. lymphoma, disseminated TB with obstruction, extra-hepatic obstruction
2. Sepsis as a contributing factor
3. HIV cholangiopathy
4. IRIS

For mixed pattern also exclude alcohol abuse

IN HOSPITAL

Do INR and blood glucose

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Has ALT decreased to < 100 IU/L, bilirubin and INR normalised?

Yes

Start new ART regimen
1. If previously on nevirapine and life threatening DILI (transaminitis with bilirubin > 34 µmol/L with encephalopathy and/or coagulopathy) commence a protease inhibitor or integrase inhibitor. In less severe cases that were previously on nevirapine, commence efavirenz
2. If previously on efavirenz, switch to a protease inhibitor or an integrase inhibitor

No

Discuss the patient with an expert or call the hotline (0800 212 506)

Note: Patients who presented with acute liver failure (jaundice with encephalopathy and/or coagulopathy) should be discussed with an expert or HIV hotline (0800 212 506) before re-starting ART

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Has ALT decreased to < 100 IU/L, bilirubin and INR normalised?

No

Discuss the patient with an expert or call the hotline (0800 212 506)

If on treatment for opportunistic infections e.g. fluconazole for cryptococcus or TB treatment, rechallenge fluconazole or TB treatment before rechallenging ART

If ALT continues to increase or is unchanged: Monitor ALT and bilirubin weekly for 4 consecutive weeks

Follow-up monitoring: Repeat ALT and bilirubin every 2-3 days, monitor INR if baseline > 1.5

Has ALT decreased to < 100 IU/L, bilirubin and INR normalised?

Yes

Start new ART regimen
1. If previously on nevirapine and life threatening DILI (transaminitis with bilirubin > 34 µmol/L with encephalopathy and/or coagulopathy) commence a protease inhibitor or integrase inhibitor. In less severe cases that were previously on nevirapine, commence efavirenz
2. If previously on efavirenz, switch to a protease inhibitor or an integrase inhibitor

No

Discuss the patient with an expert or call the hotline (0800 212 506)

If on treatment for opportunistic infections e.g. fluconazole for cryptococcus or TB treatment, rechallenge fluconazole or TB treatment before rechallenging ART
EFAVIRENZ/NEVIRAPINE DRUG-INDUCED LIVER INJURY (DILI)

Frequency of efavirenz/nevirapine DILI

The non-nucleoside reverse transcriptase inhibitors (NNRTIs) efavirenz and nevirapine, can both cause DILI\(^1,2\). DILI occurs more commonly with nevirapine than efavirenz\(^1,2\). The nucleoside reverse transcriptase inhibitors (NRTIs) used in the South African public sector’s 1\(^{st}\) line ART regimen (TDF, FTC, 3TC) do not cause DILI.

Onset of efavirenz/nevirapine DILI

Most cases of DILI due to nevirapine, occur within the first 6-8 weeks of therapy\(^3\). DILI due to nevirapine may present as part of a hypersensitivity reaction characterised by rash, fever and raised liver enzymes\(^4\).

Nevirapine-related DILI cases present with associated rash 50% of the time\(^4\). In patients with a rash due to nevirapine, DILI may develop up to 2 weeks after onset of the rash\(^5\).

Efavirenz may cause DILI any time during the course of ART and is not associated with rash.

Risk factors for efavirenz/nevirapine DILI

Risk factors for DILI in patients on ART include:

- Female sex
- Hepatitis B and hepatitis C co-infection
- Concomitant hepatotoxic drugs used to treat opportunistic infections (e.g. co-trimoxazole, fluconazole, TB drugs)
- Abnormal baseline liver function tests\(^1,3\)

In addition, higher CD4 counts (CD4 count > 250 cells/µL in females and CD4 > 400 cells/µL in males) are associated with an increased risk of nevirapine hypersensitivity reaction\(^2\). Therefore, nevirapine should not be started in patients with baseline CD4 counts above these thresholds.

Prognosis of DILI

Jaundice in a patient with hepatocellular injury indicates severe liver injury, with a 10% chance of developing fulminant liver failure (jaundice with encephalopathy and/or coagulopathy)\(^6\).

References

What questions can you ask?

The National HIV & TB Health Care Worker Hotline provides information on queries relating to:

- Pre-exposure prophylaxis (PrEP)
- Post exposure prophylaxis (PEP)
- HIV testing
- Management of HIV in pregnancy & PMTCT
- Drug interactions
- Treatment/prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of tuberculosis
- Antiretroviral Therapy (ART)
  ~ When to initiate
  ~ Treatment selection
  ~ Recommendations for laboratory and clinical monitoring
  ~ How to interpret and respond to laboratory results
  ~ Management of adverse events

Who answers the questions?

The centre is staffed by specially-trained pharmacists. They have direct access to the latest information databases, reference sources and a team of clinical consultants.

When is this service available?

The hotline operates from Mondays to Fridays 8:30am - 4:30pm.