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## INTRODUCING A PROTOCOL FOR DIAGNOSING AND TREATING LATENT TUBERCULOSIS IN NEWLY DIAGNOSED HIV PATIENTS: FEASIBILITY AND COST-EFFECTIVENESS

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**BACKGROUND:** Due to the synergy between tuberculosis and HIV infection and the increased risk of progression from latent to active TB in coinfecting patients, there is some evidence that we should screen and treat our HIV patients for latent TB. Thus far, interferon gamma release assays have not been routinely used in our HIV service. We aimed to assess the potential impact of introducing latent TB screening for newly diagnosed HIV patients.

**METHODS:** We audited TB screening in all 101 newly diagnosed HIV patients in 2007. The data were cross-referenced with the TB Clinic. Costs for introducing a screening programme using Quantiferon TB Gold were estimated.

**RESULTS:** Seventy (70%) patients with newly diagnosed HIV were born in Africa, 18 (18%) were UK born. Eighty-three (83%) patients had chest X-rays at diagnosis. Three patients were screened for latent TB at the time of their HIV diagnosis. A further 21 were screened as part of other screening programmes. Of the 24 patients screened, four tests were found to be abnormal and three patients received treatment for latent TB infection. Introducing a new screening and treatment programme would cost between  $\leq 12,760$  and  $\leq 23,720$  per year (latent TB rate 20–40%). This compares with costs of treating the cases of active TB of  $\leq 14,776$  to  $\leq 53,194$  (progression rate latent to active TB 20%–40%).

**CONCLUSIONS:** A minority of newly diagnosed HIV patients are currently being screened for latent TB infection. The majority of patients (70%) are eligible for screening as part of the new entrant screening programme reflecting the fact that our cohort is at high background risk of TB infection. In

consultation with Microbiology, Public Health and the TB Clinic we propose a protocol for screening newly diagnosed HIV patients. We are cognizant of the limitations of Quantiferon TB Gold in those with low CD4 counts, the importance of excluding 'atypical' active TB in those who test positive and the need to avoid both delay in the initiation of antiretrovirals and burdensome polypharmacy.

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