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FACTORS ASSOCIATED WITH MULTIDRUG-RESISTANT TUBERCULOSIS IN HIV-INFECTED PATIENTS, PERU

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BACKGROUND: To evaluate factors associated with multidrug resistant tuberculosis (MDR-TB) in patients with HIV infection.

METHODS: A longitudinal observational study was undertaken at the Dos de Mayo Hospital (Lima) between May 1999 and December 2004. All patients were HIV positive adults and had tuberculosis cultured from sputum. Tuberculosis susceptibility to isoniazid and rifampicin was determined by testing the diagnostic, pre-treatment sample. The factors associated with MDR-TB at the time of diagnosis were calculated using logistic regression analysis.

RESULTS: A total of 209 subjects were enrolled, 165 (79%) were males and the mean age was 32 years (standard deviation 8.0). CD4 was measured for 166 (79%) and the median was 44 cells/ μ l (inter-quartile range 15-118). The MDR-TB prevalence in these patients was 34% and an additional 20 (9.6%) of patients had tuberculosis resistant only to isoniazid. 180 (81%) were sputum microscopy positive but this was not associated with MDR-TB ($P=0.8$). In the multivariate analysis, the risk factors significantly associated with MDR-TB were: previous anti-tuberculosis chemoprophylaxis, odds ratio (OR)= 4.8 (95% confidence intervals (CI), 2.2 - 11), hospital admissions during the two years prior to this episode, OR= 2.9 (95% CI, 1.2 - 6.9) and known close contact with another tuberculosis patient, OR= 3.9 (95% CI, 1.6 - 9.9). MDR-TB was not significantly associated with the presence of a BCG scar, OR= 0.65 (95% CI, 0.30 - 1.4), past tuberculosis therapy, OR= 1.8 (95% CI, 0.91 - 3.4) or CD4 count, OR= 1.9 (95% CI, 0.77 - 4.6).

CONCLUSIONS: Amongst this population of HIV-positive subjects, the risk factors associated with MDR-TB were previous antituberculosis chemoprophylaxis with isoniazid, recent hospital admission and the close contact with another tuberculosis patient. These results emphasize the importance of ruling-out active tuberculosis before administering isoniazid preventive therapy and optimizing infection control practices to prevent nosocomial and domiciliary dissemination of MDR-TB.

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