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PO-08

Stopping secondary TE prophylaxis in suppressed patients with CD4 100-200 is not safe

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Background

Discontinuation of Maintenance Anti-*Toxoplasma* Therapy in Patients who Completed an initial Course of Therapy and had a CD4+ T Lymphocyte >200 Cells/mm^3 During More than 3 Months Due to Effective HAART

Study	No.	Relapses	Incidence/100 Patient-years (95% CI)
Denmark[159]	8	0	0 (0–47)
Madrid[161]	9	0	0 (ND)
France[162]	19	0	0 (ND)
Switzerland[162a]	22	1	4.5 (0.1–2.3)
Seven European Cohorts[163]	75	1	0.84 (0.02–4.68)
GESIDA[164]			
Stop	28	0	0 (0–4.78)
Continue	29	0	0 (0–5.19)

HAART, highly active antiretroviral therapy; ND, not done.

Miro JM et al. Toxoplasmosis. Dolin R, Masur H, Saag M (Eds). AIDS Therapy. 3rd Edition. Chruchill Livingstone. Phiadelphia. 2008: 659-681; 2016 GESIDA Guidelines, Enferm Infecc Microbiol Clin. 2016;34:516.e1-516.e18. 2017 EACS Guidelines, October 2017;

Objective

To know if secondary *Toxoplasma gondii* prophylaxis can be safely discontinued in HIV-infected patients with suppressed viremia on antiretroviral therapy (ART) and a CD4 cell counts between 101-200 cells/mm^3.

Methods

- The Collaboration of Observational HIV Epidemiological Research in Europe (COHERE) included data from 10 European cohorts on 1151 HIV-infected patients who developed a toxoplasmic encephalitis (TE) and started ART after 1997.
- TE was diagnosed on the basis of the 1993 CDC case definition. A relapse was defined as a new TE episode after 4 months of the initial TE.
- Patient follow-up began at the date of the first TE and ended at the time of first TE relapse, last visit, or death,whichever occurred first.
- Incidence rates of TE relapses were calculated after stratification by current use of prophylaxis, current CD4 cell count, and current viral load (VL).
- Multivariate Poisson regression models were used to model incidence rate ratios (IRRs) of TE.

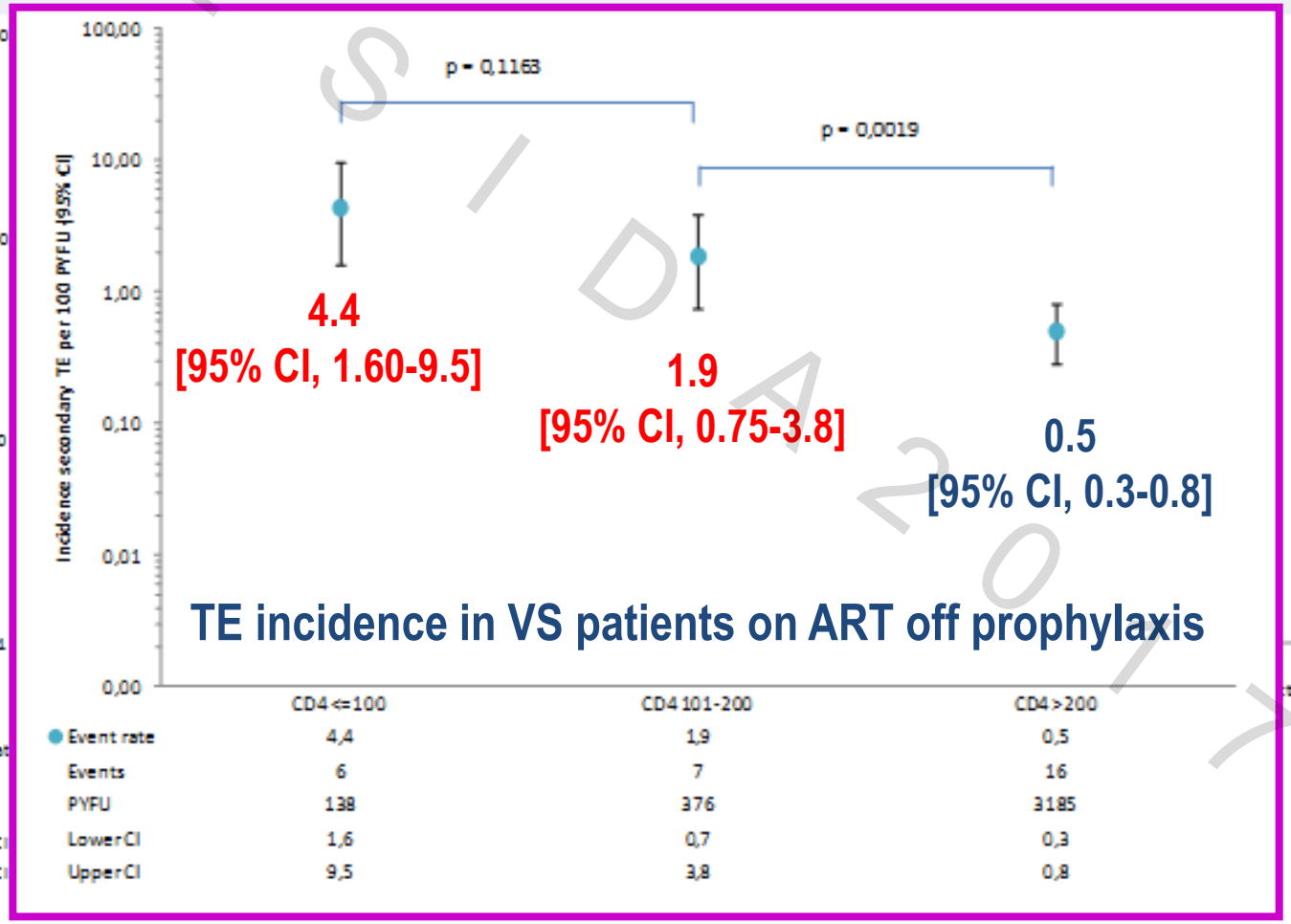
Results:

- 79 TE relapses during 6,030 person-years of follow-up (PYFU).

Table 1: Characteristics of patients at the time of the first TE episode.

		Overall		No relapse		Relapse		
		N	%	N	%	N	%	p
All patients		1151	100	1072	100,0	79	100	
Gender	Male	836	72.6	779	72.7	57	72.2	0.9209
HIV exposure group	MSM	324	28.1	301	28.1	23	29.1	0.5259
	IDU	201	17.5	182	17.0	19	24.1	
	Heterosexual	424	36.8	399	37.2	25	31.6	
	Other	199	17.3	187	17.4	12	15.2	
	Unknown	3	0.3	3	0.3	0	0.0	
Ethnic	White/Caucasian	384	33.4	363	33.9	21	26.6	0.0583
	Other	64	5.6	63	5.9	1	1.3	
	Unknown	703	61.1	646	60.3	57	72.2	
Viral load <400		139	12.1	130	12.1	9	11.4	0.8467
ART	Naive	613	53.3	582	54.3	31	39.2	0.0158
	Before TE	112	9.7	99	9.2	13	16.5	
	at TE episode	426	37.0	391	36.5	35	44.3	
		Median	IQR	Median	IQR	Median	IQR	p
Age	Years	38.4	32.9-45.8	38.8	33.0-45.9	36.0	30.7-43.5	0.0159
CD4	cells/µL	46	18-109	46	18-109	43.0	14-112	0.8257
Viral load	log10 copies/ml	5.1	3.9-5.6	5.1	3.9-5.6	4.9	4,0-5,5	0.3890

Figure 1: Incidence rate of TE relapses according to current CD4 cell count, viral load (VL) and use of anti-*T. gondii* prophylaxis.



Results

- To be on ART (IRR, 0.33; 95% CI, 0.12–0.94; P=.038) was the only TE relapse predictor in patients with CD4 cell count between 100 and 200 cells/mm3; whereas detectable VL, CD4 T cell count and prophylaxis were not predictors

Limitations

- The TE episodes and relapses are not validated and we do not know their clinical characteristics.
- No longitudinal data.

Conclusions

- In virologically suppressed HIV-infected adult patients on ART, secondary TE prophylaxis can be safely discontinued in patients with CD4 cell counts >200 cells/mm3.
- However, in patients with detectable HIV RNA the risk of relapse may be substantial, even if the CD4 cell count is >200 cells/mm3 and prophylaxis should be maintained.
- Secondary TE prophylaxis should not be stopped in virologically suppressed patients on ART with CD4 cell counts of 101-200 cells/mm3.

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