Questions not addressed during the webinar

Question 1: How long do we have to wait before we can initiate ipt after a patient have completed their TB treatment?

Answer: Guidance for Post-TB IPT is not provided in the EML, however, it is listed as an indication in the 2023 National Guidelines on the Treatment of Tuberculosis Infection. There is no specified timeframe to initiate treatment, so it can be started once the patient has been confirmed to have completed TB therapy and is not suspected to have active TB.

Question 2: what can you do if the pt have EGFR of 52 while he/she taking tld is it possible to change this pt to abc600+dtg50+3tc 300mg , because this pt did get the chance to drink lot of water but no change to his/her EGFR?

Answer: TDF is only contraindicated at eGFR below 50 ml/min, so they are still able to continue on their current therapy, perhaps with close monitoring of the GFR. If a patient in this circumstance has been assessed to have chronic kidney disease and there is a consistent pattern of declining renal function, then it may be reasonable to change to an abacavir based regimen if there are pragmatic and logistical benefits when compared with waiting for the eGFR to fall below 50 ml/min. It is also important to ensure that such a patient gets assessed for chronic kidney disease and managed appropriately.

Question 3: All patients on ART in Corrections are out on INH as long as they are incarcerated, and they normally stop outside when they get released and drink it again when they come back to us, MY CONCERN IS DOESN'T THIS SOMEHOW PRE-DISPOSE THIS PATIENTS TO INH RESISTANCY, especially the awaiting trial one, they are the one who are in and out prison repeatedly.

Answer: Various studies have shown that tuberculosis preventive therapy with isoniazid is not associated with an increased risk of resistance. The benefits of treating inmates in correctional services would outweigh any theoretical risks for resistance. This high-risk group should therefore be offered TPT when indicated, provided there are no contraindications.

Question 4: My first question was about a client taking second line regimen, when will they be able to be switched to what regimen?

Note: Unclear question, unable to answer.

Question 5: What happens to a patient with renal failure who has a positive RPR/TPHA result

Answer: If the syphilis serology (RPR & TPHA) is indicative of current infection, they should receive treatment according to the STI guidelines provided in the Primary Healthcare STG & EML, Section 12.8: Syphilis serology and treatment. Dose adjustment for benzathine penicillin may be required depending on the degree of renal failure (Refer to SAMF for dose adjustment guidelines). Confirm that there are no other reversible causes of the renal impairment, including co-morbidities, other medications, alternative/herbal medication, etc.

Question 6: Outpatient LAM, which CD4 count

Answer: Urine LAM is advised for outpatients who are symptomatic if CD4 <200, if they have advanced HIV disease, or other current serious illness.

Question 7: Dr we have client who doesn't want to be switched to TLD but want TEE ,we tried all avenues but failed, what can we do ?

Answer: TLD is recommended as first line therapy for a few reasons including the higher genetic barrier for resistance and improved side effect profile compared to efavirenz. One of the most common reasons why clients may be hesitant to be switched to a TLD regimen is the perceived side effects related to dolutegravir, mainly weight gain. Others may not want to change therapy simply because their current regimen seems to work well for them, they are virally suppressed, and don’t want to change therapy that is working. It is important to discuss the benefits of TLD and assess their understanding, and to dispel misconceptions as well. There is significant evidence mounting that dolutegravir does not cause weight gain, but rather that it is associated with improvements in patient health and the removal/absence of antiretroviral therapy agents such as TDF or efavirenz that impair weight gain. It is therefore important to counsel clients of these differences, explore fears and concerns they may have, and formulate a management plan that optimizes the likelihood of adherence to their ART.