British HIV Association guidelines on the management of opportunistic infection in people living with HIV: The clinical investigation and management of pyrexia of unknown origin 2023

Public consultation comments

Compilation of all comments received via the BHIVA website. The writing group thanks everyone who responded to the consultation. The guidelines have been revised based on the comments unless otherwise stated.
12 May 2023

BHIVA guidelines on the management of opportunistic infections: pyrexia of unknown origin

Consultation comments

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	Name	Affiliation	Comments	Writing group response
1.	Alan Winston	Imperial College Healthcare NHS Trust	Well done to the team on updating these guidelines which are very helpful and sensible. A few comments from me: 1 RE Box 2 - in general HIV encephalopathy isn't a cause of PUO. It would be the late stage untreated systemic HIV which is cause of PUO. Also, reference 51 does not justify the this being stated here. Please can this be reviewed. 2 SARS-Cov2 - should this be included in the investigations as PUO in late presenters. Have certainly seen a few patients with very low CD4 counts and PUO in whom persistent SARS-Cov2 was the underlying cause of PUO.	Thank you for raising this. HIV encephalopathy was included as it is listed as cause of one case of PUO in this series. We acknowledge the point that it is systemic, not the encephalopathy per se and have removed 'HIV encephalopathy' and replaced with 'untreated HIV'. Thank you again, a reasonable point. We have added exclusion of SARS-CoV2 along with flu as appropriate depending on season and respiratory PCR panel as appropriate (symptoms) in essential investigations box.
2.	Tristan Barber	Royal Free London NHS Foundation Trust	This is excellent. Congratulations to all authors.	Many thanks
3.	Emily Cheserem	North Middlesex Hospital	Thank you for this guideline, which I have found very helpful and which will be of great value to clinicians. My comments are for consideration only. - Page 3: From Section 9.2 Would fungal cultures be considered as well? - Page 9: Flowchart A timeline might be useful, particularly for trainees, e.g. baseline inv within 24-48 hrs (apart from blood cultures), and second line within the first 1 or 2 weeks. Finally, is there any value in urinary LAM? We have previously requested it for a patient with a high protein count in CSF and no mycobacteria	Yes it is reasonable to culture for fungi as standard (most will grow in standard and/or mycobacterial culture media, but added here). Thank you, we think 2 weeks appropriate for outpatients (with samples still in mycobacterial culture potentially at that time), depending on turnaround time and wait for imaging. The time should be shorter for inpatients and we have added a comment to this effect. LAM is largely unavailable in the UK and evidence supports use for unwell, hospitalised people with

			identified from other samples - however it was negative (toxoplasmosis felt to be sufficient sole cause for high CSF protein).	advanced HIV. For diagnostics in TB meningitis including molecular testing please see BHIVA tuberculosis guideline (to be updated 2024).