British HIV Association guidelines on the management of opportunistic infection in people living with HIV: The clinical management of pulmonary opportunistic infections 2024

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 February 2024

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	Name	Affiliation	Comments	Writing group response
1.	David Lawrence	King's College Hospital / London School of Hygiene & Tropical Medicine	Congratulations on this incredible work to update these guidelines. With regards to the recommendations for cryptococcal disease: There are no randomised controlled data to guide the management of pulmonary cryptococcosis but the current dose of 400mg for mild pulmonary disease is consistent across guidelines e.g. IDSA. However the draft guideline also recommends this dose for those with positive serum cryptococcal antigen and negative CSF. This is consistent with the BHIVA OI Guidelines 2011 however is extremely dated. In the case of positive serum cryptococcal antigen and negative CSF the WHO guidelines recommend 800-1200mg and the South African HIV Clinicians Society as well as many high-incidence countries recommend 1200mg for pre-emptive therapy. In addition, the upcoming ECMM and ISHAM guidelines for cryptococcosis (Lancet ID in press) also recommend this dose of 1200mg. I understand the challenge in updating guidelines for an OI that features in multiple systems and perhaps is more prominent in one than the other (e.g. CNS, pulmonary) but that recommendation of 400mg is too low for antigenaemia in any modern guideline. Ongoing prospective trials of fluconazole monotherapy versus fluconazole combined with a single, high-dose of AmBisome (ACACIA) and fluconazole and flucytosine dual therapy (EFFECT) are using this 1200mg dose.	Thank you for highlighting this important point. As discussed, in many cases pulmonary cryptococcal disease would be treated as per cryptococcal meningitis. In cases where there is localised pulmonary cryptococcal disease without disseminated disease with a positive antigen result and negative CSF examination, we agree that in line with recent guidance we should suggest fluconazole be dosed at 1200 mg. We agree this is an important point to highlight. We also believe however that where the antigen level is moderate–high, liposomal amphotericin B should still be used as the first-line option and would only recommend the high fluconazole dose when the antigen level is lower (i.e. <1:160 by enzyme immunoassay). We have amended the text to reflect these points.
2.	Melinda Tenant-Flowers	BHIVA member	6.5 Prophylaxis for bacterial pneumonia Suggest reinforce prophylaxis against H influenzae more as such a common infection. Add at the end of the first paragraph: Hib-containing vaccines are recommended in certain circumstances in HIV-positive adults, as is antibiotic prophylaxis for household contacts. Thank you for your consideration	Thank you for this comment. This topic will be covered in the updated BHIVA immunisation guidelines which are expected to be published later this year.
3.	Sally Welham	British Thoracic Society	The British Thoracic Society is grateful for the opportunity to respond to this document. It is clear around the scoping process, comprehensive and detailed sufficiently to provide confidence to the reader in the following aspects of care which	We thank the British Thoracic Society for their supportive comments.

			were nicely appraised: 1. Diagnosis looking at the best and alternative options for key conditions covered including PCP, CMV and aspergillosis. 2. Treatment regimes according to severity with relevant doses and durations including side effects 3. Clear differentiation of the regimes for prophylaxis 4. Research papers and studies evaluated have been referenced carefully 5. Easy to read and follow and logically laid out. This will prove to be a very useful tool and reference guide.	
4.	Nadia Ahmed	CNWL / UCLH	Thank you to all the authors for yet another excellent guideline on pulmonary OIs. It is very clearly written, easy to follow and understand, with clear expertise that is easy to follow and understand. Some minor comments: 1. Under the recommendations for 6.3 treatment of bacteria pneumonia - it states to refer to community pneumonia guidelines, which I assume are local guidelines to the readers location? 2. 5.8.5 PCP prophylaxis - are the authors able to comment on CD4 percentage? 3. Under the section on influenza, COVID-19 is mentioned as a recommendation to test. Would it be worth adding in a paragraph just on COVID-19? Or reference to other guidance on COVOD-19 in the context of HIV? 4. Each section either has when should ART be started or the impact of ART. With those that have the impact of ART, would it be worth adding a statement on when to start ART? 5. Under the CMV section, a high CMV viral load is mentioned. I appreciate this is a controversial area, but are the authors able to comment on the level?	Thank you. 1. Yes, that is correct. 2. 5.8.5. Unfortunately, we are not able to comment on the use of % CD4 count to guide a decision to discontinue prophylaxis as the studies on which we based our recommendations are based on absolute CD4 count (and not % CD4 count). 3. Thank you. We specify in the Introduction section of the guidelines that COVID-19 is not included. 4. We do not believe guidance on when to start ART in people living with HIV with influenza or bacterial pneumonia is needed as these are short-term infections and should not usually delay ART initiation where this is the first presentation of HIV. 5. Thank you for raising this point. Because of lack of HIV-specific data, we are not able to provide a specific level at which CMV viral load (copy number) by PCR is suggestive of end-organ disease; this is likely to represent a continuum, and the key point as already mentioned is that viral load alone lacks sufficient sensitivity and specificity to diagnose CMV pneumonitis.