

# Xpert MTB/RIF use in people at risk of MDR-TB

## **Group 1**

9h-12h30 discussion

1 December 2010

# Issues discussed (1)

- Important tool for expansion (increasing diagnosis and reducing delay in start of Rx)
- The algorithm to be directed by likelihood of getting treatment
- Confirmatory test for GeneXpert, esp. in low prevalence areas (due to low PPV concerns)
- Residual value of LPA, esp in SS+

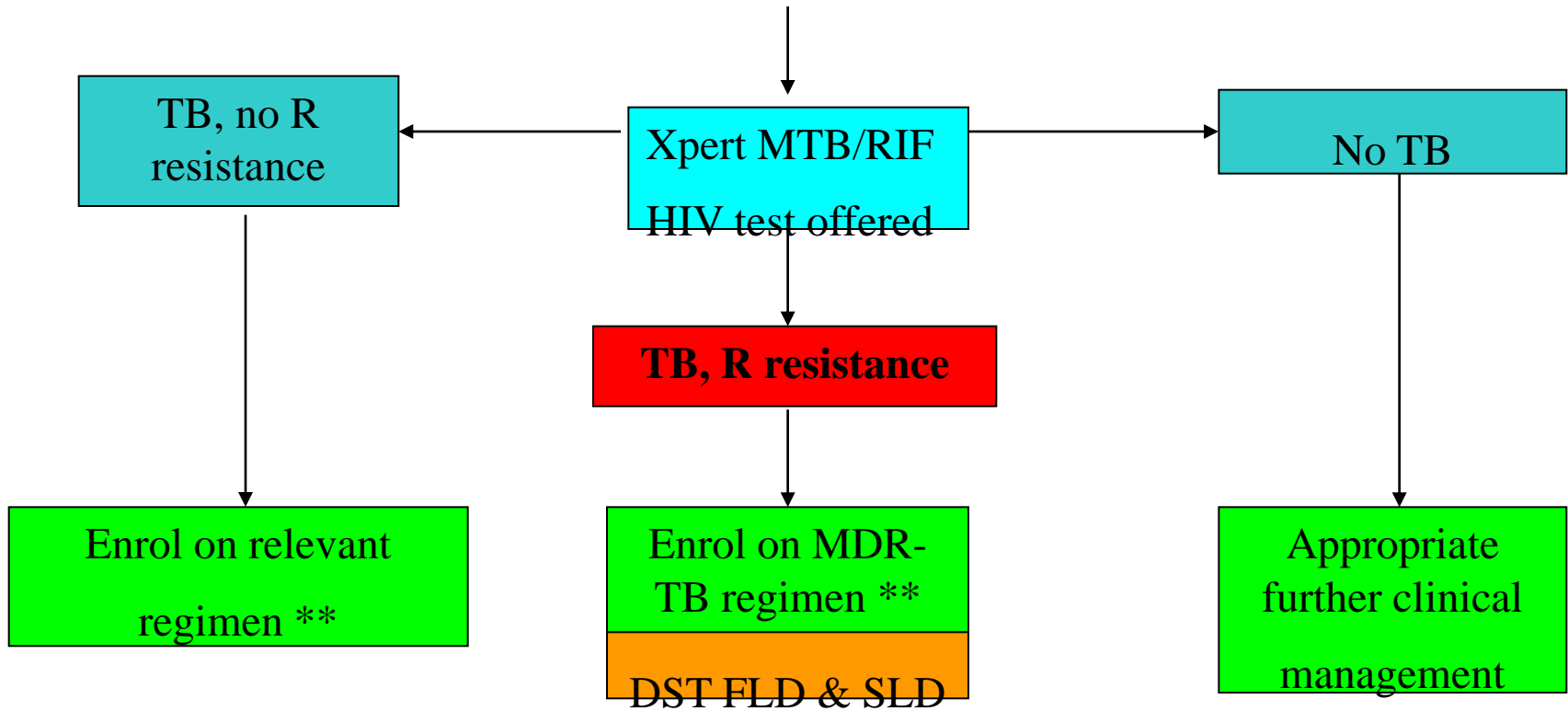
## **Issues discussed (2)**

- Discussion on risk categories
- Consider population level risk vs. individual risk (pre-test probability) for MDR
- HIV background prevalence

## Issues discussed (3)

- Testing in children, limited to sputum (eg shall we exclude CSF)
- Given that ...
  - Universal access for diagnosis and treatment by 2015 (WHA)
  - WHO recommends use of empirical treatment even if undiagnosed but suspected

## Person with high risk of MDR-TB (\*)



(\*)

1. All retreatment categories;
2. MDR-TB risk groups as defined in WHO guidelines for PMDT;
3. any person at higher risk of MDR-TB as per national policy

\*\* for HIV positive patients to use ARV and CPT

# Persons requiring Xpert MTB/RIF

- Person who have been treated with anti-TB drugs and in whom pulmonary TB is suspected, all retreatment categories (failure, default, relapse)
- Person suspected of having pulmonary TB at risk of harbouring MDR-TB bacilli (risk groups as defined in current WHO guidelines for DR-TB management)
- Any other person suspected of having pulmonary TB and considered at higher risk of MDR-TB as per national policy/guidelines t

# Where will it be placed ?

- Administrative level for implementation will be determined by the rationale for its use
  - Decisions of treatment/standardised therapy
  - Decision for infection control /interrupt transmission
  - Its utility for other diseases than TB (efficiency/scale)
- Should not be implemented only in the reference laboratory
- Use at a lower level of the laboratory network (eg microscopy centres in S.Africa)
- As close to the patient as practical
- Provincial TB/MDR services (Benin, Indonesia)
- District/Sub-district levels (trials in China and India; Moldova Rep., S.Africa)
- No plans (Peru)

# Gap and scale up

- Decentralisation of treatment to follow the one of diagnostics so long as infection control measures should be ensured
- Second line drugs should be available
- Surveillance guiding the expansion
- Potential of the private sector
- Documenting case studies of places where implementation has already happened [200 units in S.Africa at sub-district level (500-2million)]



## **Issues discussed (4)**

[DST may still be needed for other FLD for non Rif-resistant in populations with high MDR]

(subject for Grp III DOTS)

NTM

Replacement for smear microscopy

Baseline smear will not be available for monitoring purposes if GeneXpert is used for diagnostic

Is "No TB" determined by GeneXpert an exclusion or should other TB testing be done given that sensitivity for SS- is only 70% compared to culture

If nothing is in place it is better to put in place GeneXpert