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

Group 1

(9h-12h30 discussion; 1 December 2010

Issues discussed (1)

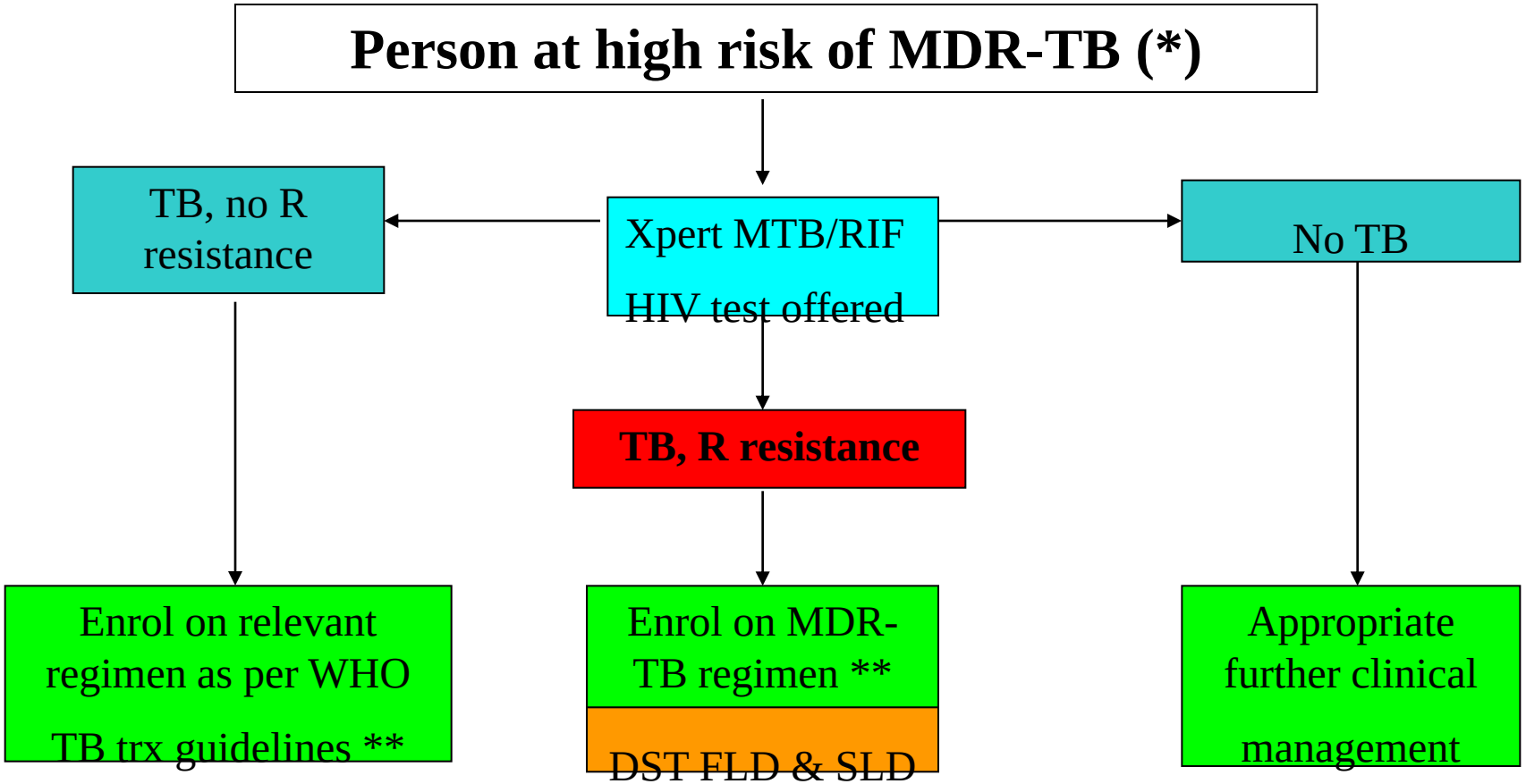
- Important tool for expansion (increasing diagnosis and reducing delay in start of Rx)
- The algorithm to be directed by likelihood of getting treatment
- Confirmatory test for GeneXpert, esp. in low prevalence areas (due to low PPV concerns)
- CXR not considered of use to increase PPV for Rif resistance
- 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
- OR : reliability of Xpert in smear negative culture positive patients

Issues discussed (3)

- Testing in children, limited to sputum (eg shall we exclude CSF)
- We cannot tell if a second GeneXpert test would increase test reliability. In low prevalence areas suggest to use other technology for confirmation (if this is not available then repeat GeneXpert on a different sample). The additional test would be applied to a very small proportion of patients. Space for OR.
- A table showing test PPV at different levels of R-resistance may help countries decide the cutoffs to use
- Given that …
  - Universal access for diagnosis and treatment by 2015 (WHA)
  - WHO recommends use of empirical treatment even if undiagnosed but suspected



(*)

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

Person at high risk of MDR-TB

- 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

Where will Xpert 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 (?mobile units)
- 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
- Price for testing (free of charge)
- Documenting case studies of places where implementation has already happened [200 units in S.Africa at sub-district level (500-2million)]

Parking space

- DST may still be needed for other FLD for non Rif-resistant in populations with high MDR
- NTM
- Replacement for smear microscopy
- Baseline smear will not be available for monitoring purposes if GeneXpert is used for diagnostic
- If "No TB" is determined by GeneXpert should other TB testing be done given that sensitivity for SS- is only 73% compared to culture
- If nothing is in place it is better to put in place GeneXpert
- Qualifying better that the treatment for cases with Xpert MTB/RIF negative does not require Streptomycin