

HIV Urgent Care Scenarios

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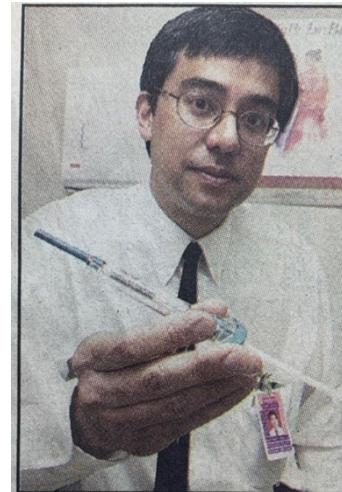
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Indian Health Service



Disclosures

*I really hate
syphilis!*



DOUGLAS TESNER
THE ASSOCIATED PRESS

DISEASE FIGHTER: Dr. Jonathan Iralu, of the Gallup Indian Medical Center, holds a syringe of penicillin used to treat syphilis, a disease that is sharply increasing on the Navajo Reservation.



ABQ Journal
June 2003

Four acute clinical scenarios...



- Is it just another viral syndrome?
- It's only a little cough!
- The fever that won't go away
- A confusing case of confusion

Presentation



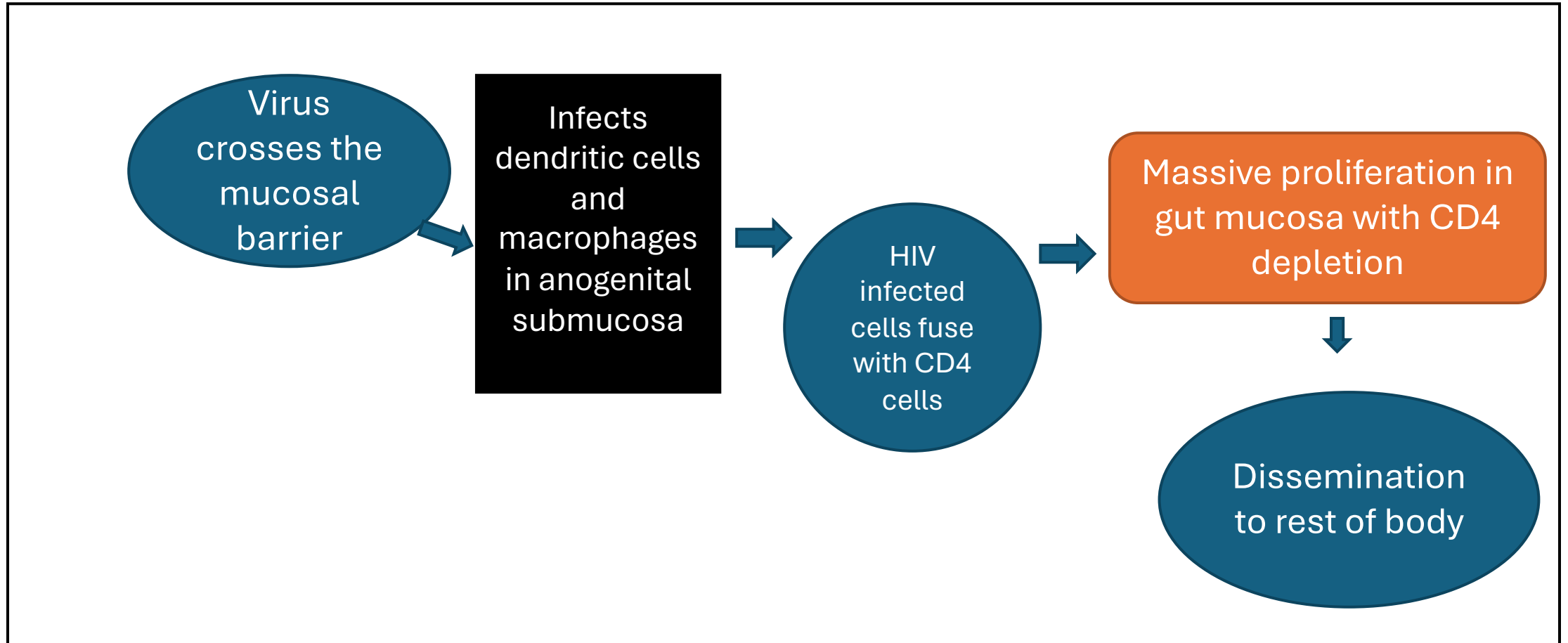
- A 29-year-old man experiencing homelessness comes to the mobile street clinic complaining of one week of fever, myalgias and sore throat. On review of systems, he denies cough but notes watery diarrhea. He drinks alcohol socially, does not inject drugs and is married with 2 children. On exam he has a temperature of 100.7 degrees F. Exam is notable for pharyngeal erythema, posterior cervical lymphadenopathy and a faint macular rash on the chest. Routine laboratory tests are notable for WBC 4.1K, platelets 135, Creatinine 0.7 and ALT 167/AST159.

Acute HIV Infection



- Background
 - Acute febrile illness occurring 2-4 weeks after HIV exposure
 - 40-90% of persons acquiring HIV experience this syndrome
 - 80% of transmissions occur via mucosal surfaces
 - 20% of transmissions are percutaneous or intravenous
- Definition of Early HIV infection
 - Acute HIV: positive antigen and PCR but negative antibody
 - Recent: Infection occurred in the last 6 months

Acute HIV Infection Pathogenesis



Acute HIV Infection

Differential Diagnosis



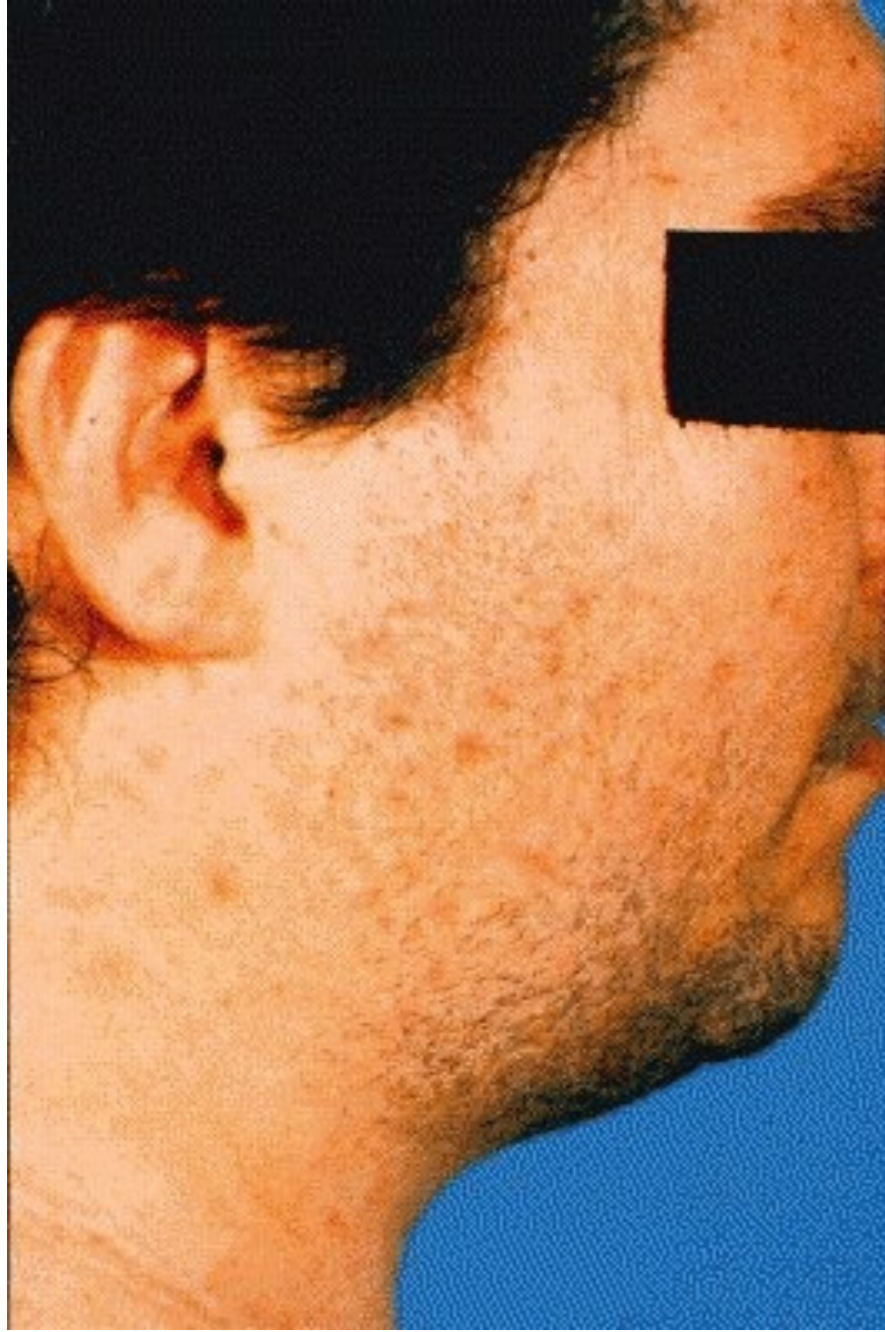
- HIV
- COVID-19
- Influenza
- Secondary Syphilis
- EBV
- RMSF
- Measles
- Drug rash
- Lupus

Acute HIV infection

Clinical Presentation



- Symptoms
 - Fever
 - Fatigue
 - Myalgia
 - Rash
 - Headache
 - Pharyngitis
 - Cervical adenopathy
 - Arthralgia
 - Night Sweats
 - Diarrhea

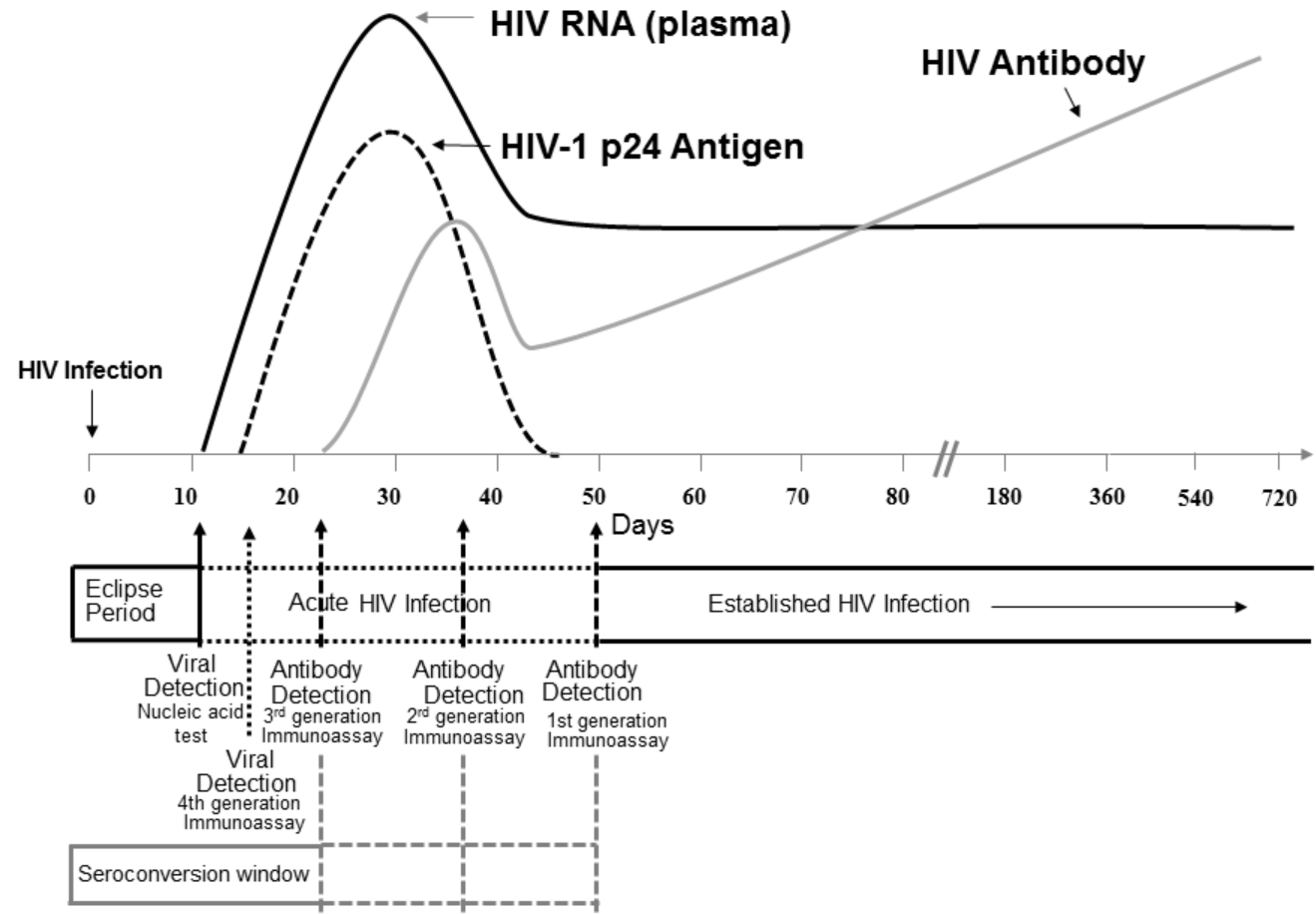




Acute HIV Infection: Diagnosis

- You have to think of it to make the diagnosis!
- What to order:
 - **Fourth Generation HIV Antigen/Antibody** test
 - Screen for Ag and Ab
 - **Reflex to**
 - Differentiation assay for HIV 1 vs HIV 2
 - HIV viral load
 - **HIV Viral load**

Order Both!



Acute HIV Infection: Treatment



- Treat immediately!
 - Improves symptoms especially if there is meningoencephalitis or neuropathy
 - Makes the biomarkers look good
 - Stops CD4 cell depletion during the initial phase of infection
 - Enhances immune reconstitution
 - Decreases risk of transmission
 - Risk of infection increased 2.5-fold for every 10-fold elevation in viral load



Acute HIV Infection: Treatment

- **When to treat**
 - Immediately
 - Don't wait for resistance testing results
- **What to treat with**
 - Tenofovir/Emtricitabine/Bictegravir
 - Tenofovir/Emtricitabine + Cobicistat boosted Darunavir
- **How long to treat**
 - Forever!

Modify Rx
when
resistance
test is
back

How about the patient on HIV PrEP?



- **Diagnosis**

- Obtain Genotypic antiretroviral resistance test (**GART**)
 - Standard test for Oral PrEP
 - Nucleoside/protease inhibitor/Integrase inhibitor for injectable cabotegravir
- If the Viral load is ≥ 200 , start ART immediately
- If the viral load is < 200
 - Get a confirmatory antibody test and repeat HIV Viral load
 - Start ART if confirmed

- **Treatment**

- Based on GART test result
 - TDF/FTC PrEP → typically switch to TAF/FTC/BIC
 - Cabotegravir PrEP → Start TAF/FTC and boosted Darunavir while waiting for GART

References



- <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/20/acute-and-recent--early--hiv-infection>

Case Presentation

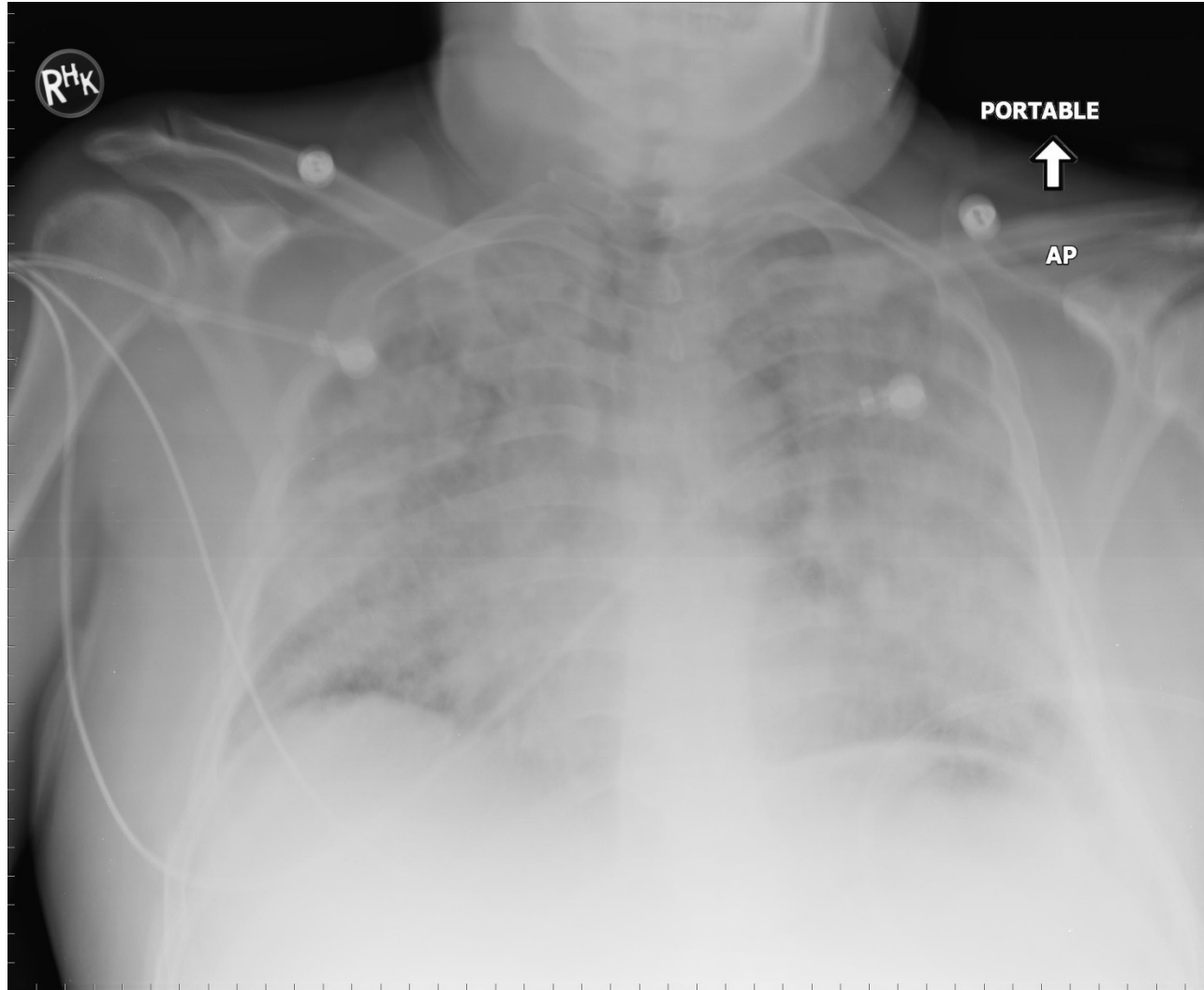


- A 42 year-old man is referred to ID clinic with a positive PPD at 10 mm after being exposed to a case of active pulmonary TB. He has a history of reactive arthritis but is not on immunosuppressive therapy. Review of symptoms is completely negative and physical exam is unremarkable. A CXR is normal. He is offered Isoniazid/Rifapentine therapy weekly for twelve weeks but declines.

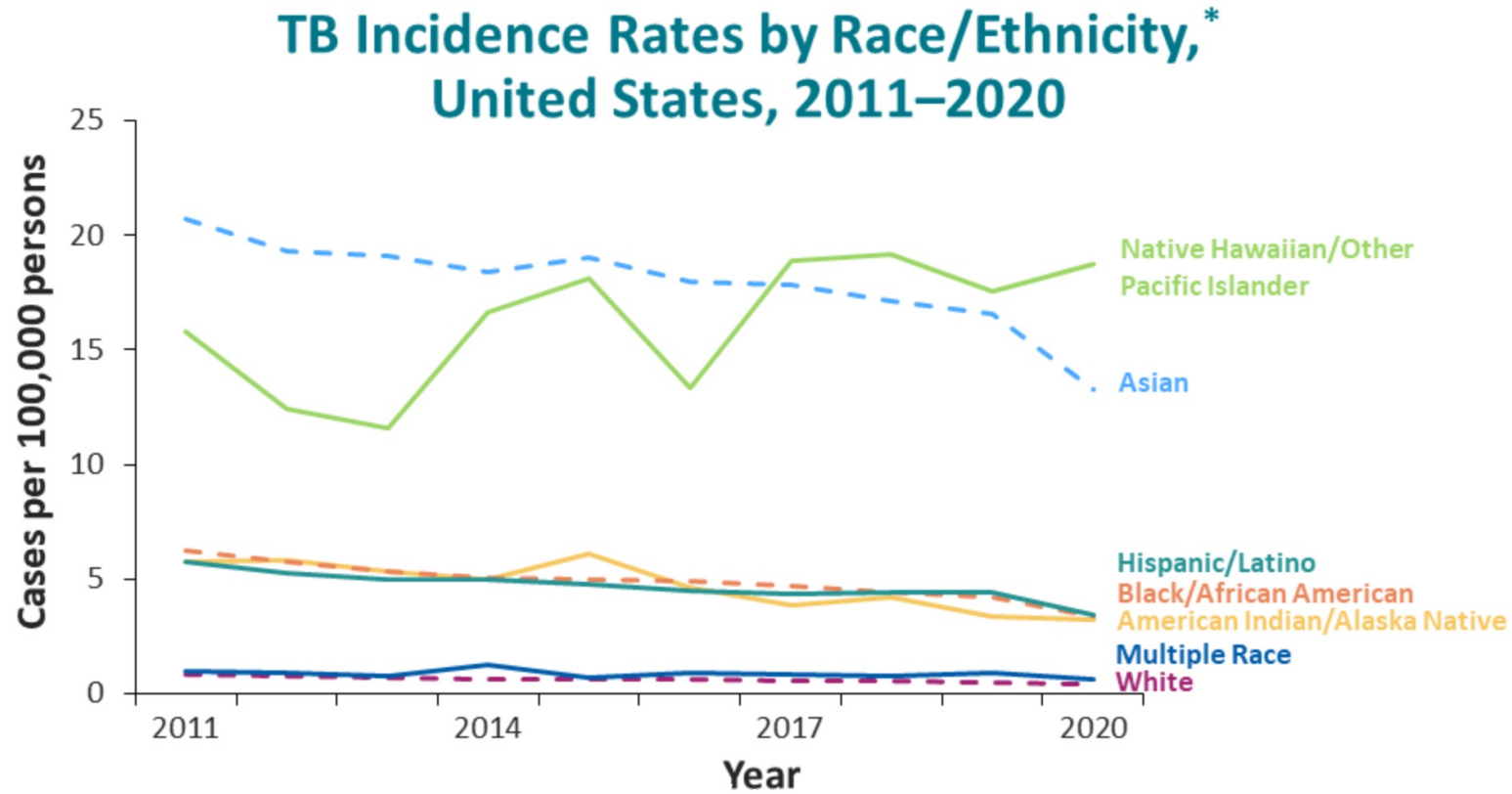
Case Presentation



- Nine months later the patient presents with chronic cough and fever. On exam he is tachycardic and has diffuse rales. A CXR is obtained...



Tuberculosis incidence



*All races are non-Hispanic; multiple race indicates two or more races reported for a person but does not include persons of Hispanic or Latino origin.

Tuberculosis incidence and risk factors: 2003-2008:



- 1.1% of all US TB patients were American Indian/Alaskan Natives (AI/AN)
- TB Incidence was 5.9 per 100,000 population, **5 x greater than non-Hispanic white persons**
- AI/ANs had the largest percentage decline in incidence of all groups
- **AI/AN were more likely to**
 - Be homeless
 - Excessively use alcohol
 - Have no health insurance
 - Live in poverty
 - Receive Directly Observed Therapy (DOT)

Tuberculosis incidence and risk factors: 2009-2019



- **TB incidence was 10 x higher** in AI/AN & NHPI than whites

- Risk ratio for

• Renal disease	1.33
• Diabetes mellitus	1.63
• HIV	0.66
• Alcohol Use	1.84
• Homelessness	1.48

Springer, Y.P., Kammerer, J.S., Silk, B.J. *et al.* Tuberculosis in Indigenous Persons — United States, 2009–2019. *J. Racial and Ethnic Health Disparities* (2021). <https://doi.org/10.1007/s40615-021-01112-6>

Tuberculosis Mortality



- TB Death rates for AI/AN significantly higher compared with Whites
 - 1990-1998: 3.3 vs 0.3. deaths per 100,000 per year (RR 11.37)
 - 1999-2009 1.5 vs 0.1 deaths per 100,000 per year (RR 11.5)
- Death rate for persons > 85 in 1990-1998 for AI vs White: RR 14.7

Reilley B, Bloss E, Byrd K, Iralu J, Neel L, Cheek J. Death Rates from HIV and TB Among American Indian/Alaska Native in the United States, 1990-2009. Am J Pub Health, Supplement 3, 2014(104)S253-S459.

TB/HIV Clinical Presentation



- TB in HIV with CD4 count > 200 behaves like HIV (-) disease
 - Cough
 - Hemoptysis
 - Fever
 - Night sweats
 - Weight loss
 - Upper lobe pulmonary disease with or without cavitation

TB/HIV Clinical Presentation



- TB in late HIV disease with CD4 < 200 cells is different
 - Looks like primary TB
 - Lymphadenopathy present on exam and CXR
 - Miliary pattern
 - Cavitation is less frequent and there is no predilection for the upper lobes
 - High Fever
 - Sepsis
 - Extrapulmonary sites involved in 40-80%:
 - Lymph nodes, brain, pleura, meninges, pericardium, abdomen

TB/HIV Clinical Presentation



- Subclinical TB disease is common in HIV
- Smear negative disease is more common in HIV
- 22% of patients with HIV and TB have a normal CXR

Diagnosing TB in HIV infected patients



- Chest imaging
 - CXR
 - Consider CT scan if CD4 <200
- Cultures:
 - Sputum, induction may be needed
 - Bronchoalveolar lavage
 - Blood
 - CSF
 - Tissue biopsy → send to CDC via state department of health
→ pathology@cdc.gov

Diagnosis of TB



- Sputum AFB x 3 in 24 hours including one early AM
- Culture
 - BACTEC and MGIT technology
- Nucleic Acid Amplification (at least one specimen)
 - Positive in 50-80% of smear-negative, culture-positive patients
 - Xpert MTB/RIF assay is preferred (88% sensitive, 98% specific)
 - Xpert can be used on extrapulmonary specimens (nodes, CSF, gastric aspirate, pleural)
 - IS6110 probe PCR performed in NM lab on all specimens

Diagnosis of TB



- **Drug Sensitivity Testing**
 - Required for all HIV patients
 - INH, RIF, PZA, EMB
 - **Rapid Molecular DST** for INH and Rifampin should be done up front
 - Xpert or line probe assay → require confirmation by sequencing
 - CDC offers Molecular Detection of Drug Resistance service (MDDR)
 - **Repeat DST should be done at four months** of treatment if cultures remain positive or revert to positive 1 month after conversion to negative



Treatment of TB and HIV

- Identical to treatment of HIV negative persons (**almost**)
- Use four drugs:
 - Rifampin, Isoniazid, Pyrazinamide, Ethambutol
- Treat two months of INH/RIF/PZA then 4 months INH/RIF
- **Daily therapy throughout is mandatory** (no intermittent Rx for HIV)

Treatment of TB and HIV



- **Extend to 9 months** for:
 - Positive cultures at 2 months
 - Severe cavitory disease
 - Severe disseminated extrapulmonary disease
- Most extrapulmonary TB is treated 6 months
- Treat meningeal and bone disease for 9-12 months
- Give **Steroids for TB Meningitis (A2)** but not Pericarditis (A1)

Drug Resistant TB

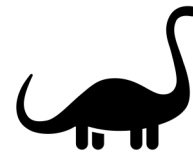


- INH resistance
 - Rx with Quinolone + RIF/PZA/EMB for 6 months
- Rifampin Resistance
 - INH + PZA + ethambutol + quinolone + (linezolid or amikacin):12-24 mo
- Multidrug resistance
 - Bedaquiline, linezolid, levo/moxifloxacin, clofazimine and cycloserine/terizidone for 14-20 months after culture conversion
 - BPaLM not yet recommended for HIV positive patients

Treatment of HIV infection in TB patients



- Nucleosides RT inhibitors (NRTIs):
 - **Tenofovir disoproxil fumarate (TDF) preferred** over Tenofovir alafenamide (TAF) when used with Rifampin
 - Abacavir, lamivudine, emtricitabine all OK with Rifampin
- Non-nucleoside RT inhibitors (NNRTIs)
 - **Only Efavirenz is safe** with Rifampin (no dose adjustment)



Treatment of HIV infection in TB patients



- Integrase Inhibitors (INSTIs)

- **Double dose** raltegravir to 800 mg po bid with Rifampin
- **Double dose** dolutegravir to 50 mg po bid with Rifampin (A1) ←
- **Don't use** Bictegravir, Elvitegravir-cobicistat or Cabotegravir with Rifampin

- **Protease Inhibitors (PIs)**

- Substitute Rifabutin 150 mg po daily for Rifampin with boosted PIs
- Double dose Lopinavir/ritonavir can be used with Rifampin
- Boosted darunavir should not be used

Immune Reconstitution Inflammatory Syndrome



- **Re-awakening immune syndrome** unmasks or causes paradoxical disease:
 - Cryptococcal meningitis
 - PML (JC virus)
 - PCP
 - CMV retinitis/gastroenteritis
 - Tb and MAC
- **Risk Factors:** low CD4 <100, high VL, dissemination, ART < 1-2 months after TB diagnosis

Immune Reconstitution Inflammatory Syndrome



- Two TB syndromes:
 - Unmasking TB-IRIS: TB is unmasked after anti HIV therapy is started
 - Fever, adenopathy, pulmonary, neurologic symptoms in the first week of ART
 - **Common presentation**: bacteria pneumonia with high fever, ARDS, sepsis
 - Paradoxical TB-IRIS: worsening of pre-existing TB after starting ARVs
 - New cavitation, new lymphadenopathy, pericardial tamponade, airway obstruction
 - **Hypercalcemia** is a hallmark.
 - Can occur even in HIV negative patients with anti TB therapy

Immune Reconstitution Inflammatory Syndrome



- Prevention

- Start TB therapy right away
- Delay start of HIV Therapy
 - CD4 count < 50 \rightarrow Start anti-retrovirals by ≤ 2 weeks
 - CD4 count ≥ 50 \rightarrow Start anti-retrovirals by 8-12 weeks

Treatment of TB-IRIS



- **Steroids:**
 - Established TB-IRIS:
 - Prednisone 1.5 mg/kg daily 2 week then 0.75 mg/kg for 2 weeks (offer longer 2 to 3-month taper for CNS TB)
 - Preemptive steroids for high risk (patients with CD4 <100 who are starting ART within 30 days of anti TB Rx) excluding patients with Rifampin resistance, Kaposi sarcoma or Hepatitis B)
 - Prednisone 40 mg po daily for 2 weeks then 20 mg po daily for 2 weeks
- **NSAIDS**
- Needle drainage of effusions, abscess, adenitis

References



- <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/mycobacterium-0?view=full>

Case



- A 47-year-old patient with advanced HIV disease (CD4 37, HIV V.L. 90,000) presents to your clinic with fever of 103 daily for 4 weeks. He has had watery diarrhea for 6 weeks. Physical exam shows muscle wasting and splenomegaly. A CXR is normal.
 - What is the differential diagnosis?
 - What should you do now?

HIV associated Fever: Differential Diagnosis



- ***Mycobacterium avium* complex Bacteremia**
- **Miliary Tuberculosis**
- **Disseminated Pneumocystis**
- **Cryptococcosis**
- **Disseminated Coccidioidomycosis**
- **Bacillary Angiomatosis**
- **CMV**
- **Non-Hodgkin's Lymphoma**

Fever Physical Exam



- **Adenopathy** may suggest MAC or TB
- **Retinal lesions** may suggest CMV
- **Umbilicated skin lesions** suggest cryptococcosis
- **Purple-red raised nodules** suggest bacillary angiomatosis

Tuberculous adenitis



Cutaneous Cryptococcosis



Bacillary Angiomatosis



HIV associated fever

Initial Evaluation



- CMP, CBC, CXR, Blood Cultures
- Bactec Blood Culture for AFB
- Cryptococcal Antigen
- Tuberculosis skin test or IGRA
- Lumbar Puncture
- Sputum induction for AFB and PCP
- Dilated fundoscopic exam

HIV associated Fever Evaluation continued

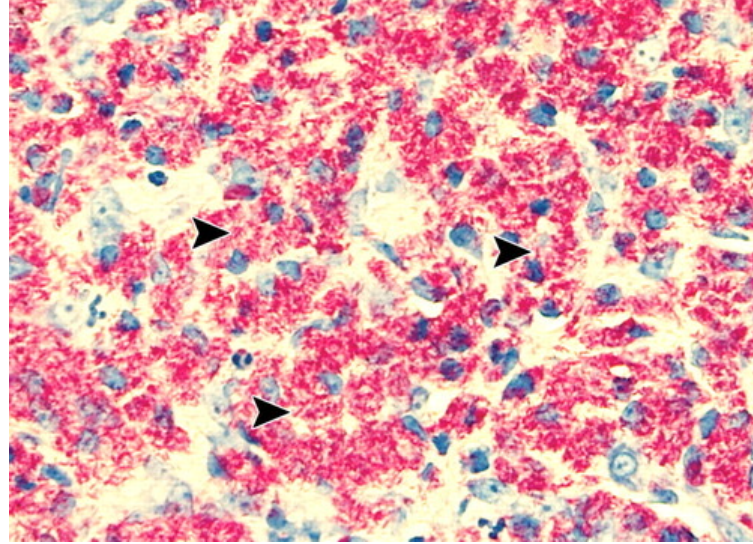
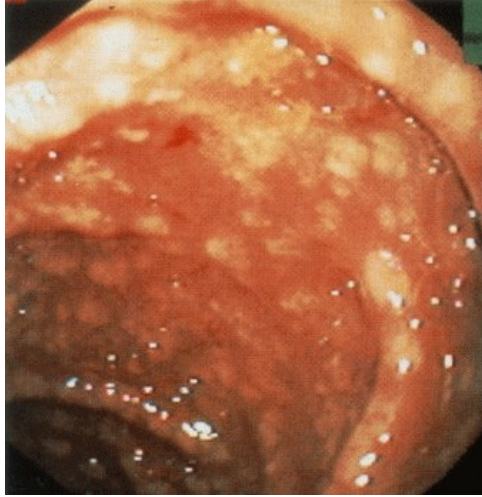


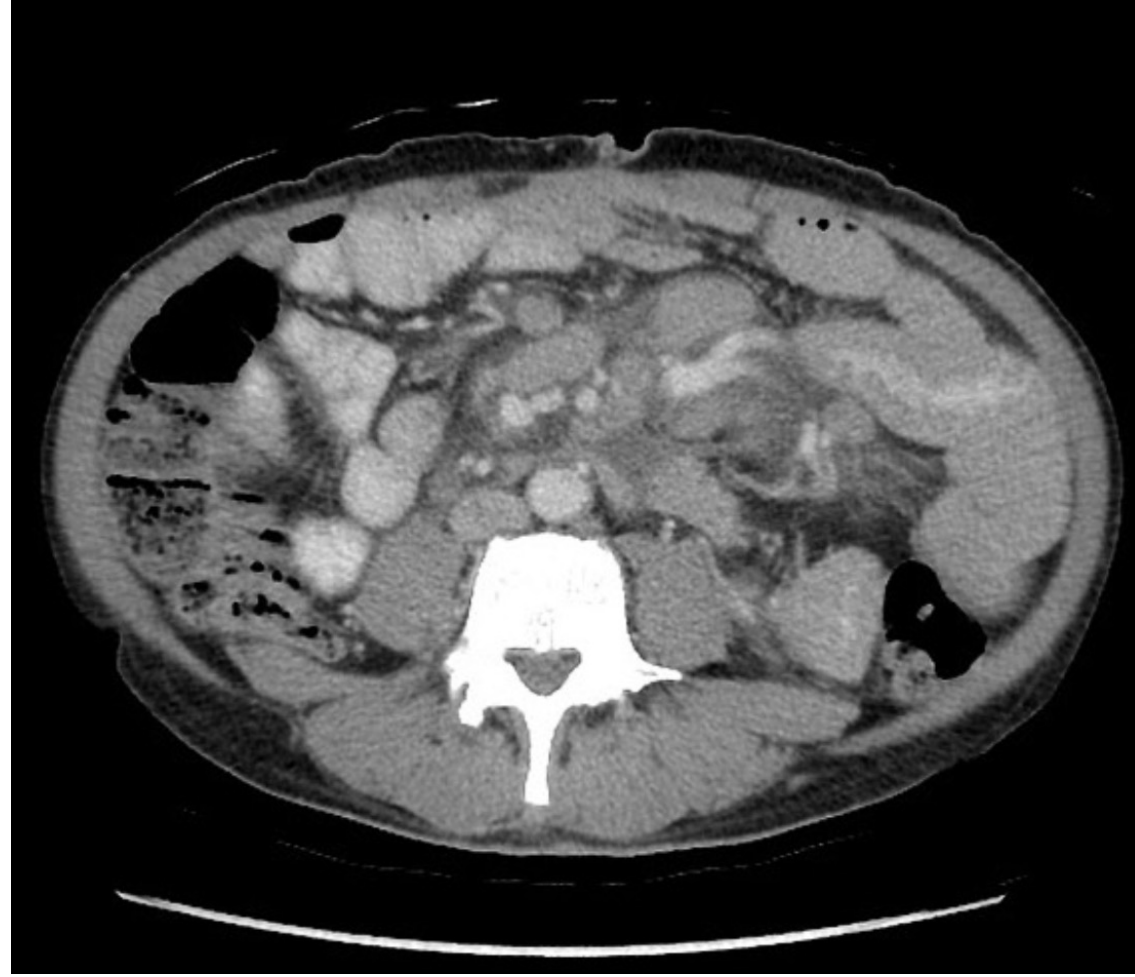
- **Abdominal/Pelvic CT**
- **Bone Marrow Biopsy**
- **Consider:**
 - **Liver biopsy**
 - **Skin biopsy**
 - **Endoscopy**

Mycobacterium avium Complex



- Slow growing Acid-Fast Bacillus seen when **CD4 <50**
- Patients present with **fever, night sweats** and **chronic diarrhea**.
- Cachexia, **hepatosplenomegaly** and **lymphadenopathy** are often seen on physical exam.
- **Pancytopenia** and **elevated alkaline phosphatase** are common





MAC Diagnostics



- **Bactec Blood cultures** are the test of choice.
 - Positive in 7-10 days
- Other cultures helpful but invasive:
 - **Bone Marrow** : Positive in 17 of 30 blood culture positive cases
 - **Gut biopsy** useful to document mucosal invasion
 - **Liver**
- Sputum and stool culture are not reliable.
- **CT Abdomen** : Adenopathy seen in 42% of cases

MAC Therapeutics



- Basic Therapy

Clarithromycin 500 mg po BID or Azithromycin 500 mg po QDay

Plus

Ethambutol 15-20 mg/kg po QD

MAC Therapeutics



- Add Rifabutin 300 to 450 mg po QD for more severe disease
- **Add a fourth drug** (quinolone, aminoglycoside, Bedaquiline, Linezolid, Tidezolid, or Omadacycline) **if**
 - Treatment failure and risk of resistance suspected
 - CD4 < 50
 - > 100 organisms per ml
 - ART ineffective.
- **Treat for 12 months** and until CD4 > 100 for 6 months of ART and asymptomatic

MAC Immune Reconstitution Syndrome



- **Unmasking IRIS**

- Previously undiagnosed MAC infection unmasked by viral suppression and CD4 count rise

- **Paradoxical IRIS**

- Worsening of previously diagnosed MAC
 - Fever, adenopathy, worsening infiltrate
 - Hypercalcemia is reported

- **Treatment**

- NSAIDS
- Steroids

MAC Prevention



- Start Azithromycin 1200 mg po weekly **if**
 - **CD4 < 50** **and**
 - Patient has not yet been started on ART
- Stop Prophylaxis after ART has been started
- Restart if CD4 < 50 and not fully suppressed on ART

References



- <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/disseminated?view=full>

Presentation



- A 37-year-old woman with a history of HIV infection returns after missing appointments for a year. She says she doesn't feel well. Her sister who brought her in says "She isn't quite right". She has been forgetting things for about a month and is having trouble with cooking and driving a vehicle. On physical exam she looks chronically ill. She can't recall the name of the US President. Her neck is slightly stiff. Her speech is slow but gait is normal. There are no focal motor abnormalities

Differential diagnosis



- Neurosyphilis → **DON'T MISS THIS DIAGNOSIS!!**
- Cryptococcal meningitis
- Tuberculous meningitis
- Coccidioidal meningitis
- CNS toxoplasmosis
- HIV associated neurocognitive disorder

Diagnostic approach



- CT or MRI with gadolinium to rule out mass lesion
- Lumbar Puncture
 - Cell counts, protein and glucose
 - Routine, AFB, fungal Cx
 - VDRL
 - Cryptococcal Antigen (rapid: lateral flow assay)
 - Coccidioides CSF complement fixation Ab
 - MTb PCR
 - EBV, Toxoplasma, JC virus PCR if mass lesion present

Cryptococcal Meningitis: History and Epidemiology



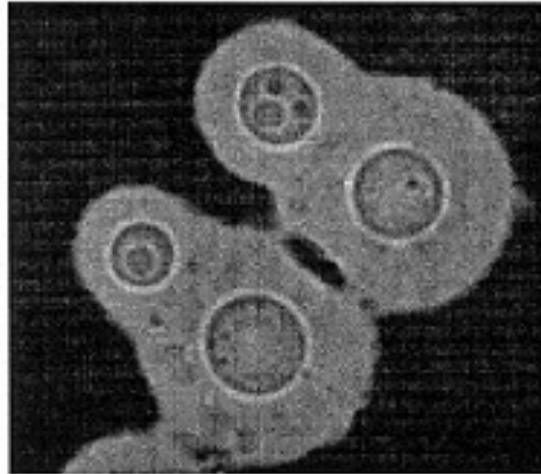
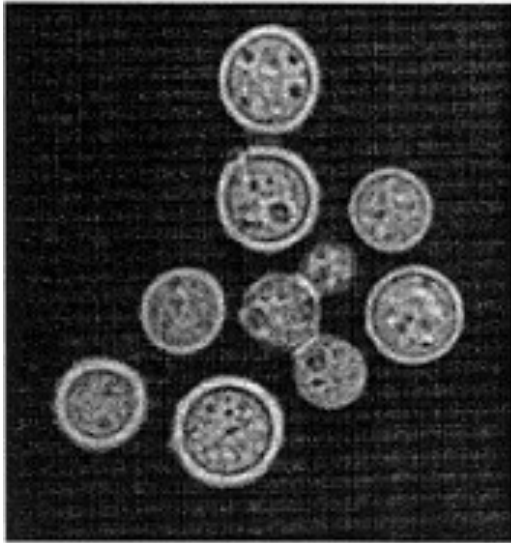
- First isolated in 1894 from the tibia of a 31 year old woman with osteomyelitis
- First described case of **meningoencephalitis was 1905**
- Now infects 280,000 new people per year, mostly in sub Saharan Africa, and is responsible for 15% of AIDS-related deaths

Mycology/Pathophysiology



- *Cryptococcus neoformans*: GLOBAL
 - Ubiquitous in soil, decaying vegetation, pigeon droppings
- *Cryptococcus gattii*: TROPICAL/SUBTROPICAL
 - Eucalyptus trees
- **Most people are infected early in life**
 - Active disease represents reactivation due to immunodeficiency with loss of TH1 cellular immunity and a predominant TH2 cellular response
 - HIV Infection
 - Malignancy
 - DM
 - Steroid therapy
 - Transplant
 - CKD/Chronic liver disease

Cryptococcus on india ink staining



Clinical Presentation



- Headache (most common in **US**)
- Cough
- NV
- Focal neurologic defects (most common in **Sub Saharan Africa**)
- Seizures
- Altered mental status

Physical exam findings

- Altered mentation
- Meningismus
- Papilledema
- Molluscum-like skin lesions



Cutaneous Cryptococcosis



Serologic diagnosis



- Send a Serum Crypto Antigen for patients with neurologic symptoms
- Send serum Crypto antigen for patient with $CD4 < 100$ at the time of HIV diagnosis

CSF Diagnosis



- **CSF Analysis:**

- | | Frequency |
|--------------------------|-----------|
| • Opening pressure > 200 | 66% |
| • Low Glucose | 24% |
| • Protein > 45 | 55% |
| • WBC >20 | 21% |
| • India Ink positive | 74% |
- Cryptococcal Antigen (CrAg)
 - Lateral Flow Assay
 - Biofire has low sensitivity (50%)
 - Fungal Culture
 - Pathology: GMS or mucicarmine

Treatment of Cryptococcal meningitis



- **Induction (14 days)**
 - Amphotericin B 0.7-1 mg/kg IV daily plus Flucytosine 100 mg/d
- **Consolidation (≥ 8 weeks)** → Fluconazole **800 mg** po daily until Cx (-) then 400 mg
- **Maintenance**
 - Fluconazole 200 mg po daily for at least one year with CD4 > 100 and HIV viral load is undetectable
- **Alternate regimen:** Fluconazole 1200 mg po daily + Flucytosine QID

Treatment of Cryptococcal Meningitis



- **Increased intracranial pressure (opening pressure > 250)**
 - Lumbar puncture (20-25 ml) REPEATED DAILY until pressure normalizes
 - Goal is opening pressure < 200 or cut in half
 - CSF shunting performed if pressure does not fall
- **Monitoring**
 - Lumbar puncture performed after 2 weeks for culture to prove CSF sterilization and repeat opening pressure



Immune Reconstitution Inflammatory Syndrome

- **Paradoxical worsening** of symptoms after starting HIV ART
- Difficult to distinguish from relapse during maintenance phase
- **What to do:**
 - Resume amphotericin B or increase fluconazole to 1200 mg
 - LP to reduce ICP
 - Consider Steroid taper (Prednisone 1 mg/kg/d)
- **Prevention** → Start ART 4-6 weeks after starting antifungal Rx

Cryptococcal Meningitis Prevention



- Send **serum Cryptococcal antigen** for HIV patients with CD4 < 100
- **Offer LP** if the antigen is positive
- **If the LP is negative and LFA titer is < 1:160**, treat with Fluconazole 800-1200 mg po daily for 10 weeks followed by 200 mg po daily for 6 months. If LFA \geq 1:160, treat as for meningitis

References



1. DHHS Opportunistic infection guidelines:
<https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/cryptococcosis?view=full>
2. A Makadzange, G McHugh. New Approaches to the diagnosis and Treatment of Cryptococcal Meningitis. *Seminars in Neurology*. 2014; 23(1):47-57.
3. M Abassi, D Boulware, J Rhein. Cryptococcal Meningitis: Diagnosis and Management Update. *Curr Trop Med Rep*. 2015 June 1;2(2):90-99





Presentation

- A 29-year-old-male with HIV infection on TAF/FTC/BIC with CD4 679 and HIV VL <20 now has a positive QFT assay after volunteering in a homeless shelter. He is completely asymptomatic. There is no travel history or family history of tuberculosis.
 - Does anything need to be done?
 - If so, what should you do?

TB screening in the HIV Clinic

- Screen for TB at HIV diagnosis and annually in Indian Country
 - Elsewhere: incarcerated, foreign travel, without home, congregate setting
- If test is negative and $CD4 < 200$, retest when $CD4 \geq 200$
- IGRA testing is preferred over TB Skin Test (TST)
 - Quantiferon (QFT-TB Gold Plus)
 - T-Spot.TB
- TST diameter of ≥ 5 is a positive test

Diagnosing Latent TB Infection in HIV

- Diagnose with PPD or IGRA (not both)
- Rule out active TB first before treating
 - No symptoms (no cough of any duration)
 - Clear CXR
 - Sputum culture is low yield in the absence of symptoms and CXR findings

TB/HIV Clinical Presentation

- TB in early HIV behaves like HIV (-) disease
 - Cough
 - Hemoptysis
 - Fever
 - Night sweats
 - Weight loss
 - Upper lobe pulmonary disease with cavitation

TB/HIV Clinical Presentation

- TB in late HIV disease is different
 - Looks like primary TB
 - Lymphadenopathy present on exam and CXR
 - Miliary pattern
 - Cavitation is less frequent
 - High Fever
 - Sepsis
 - Extrapulmonary sites involved in 40-80%:
 - Lymph nodes, brain, meninges, pericardium, abdomen

Treating LTBI

- **Priorities after you have ruled out TB disease:**
 - **Adjust the HIV meds first** to avoid drug interactions
 - Treat the latent TB infection with preferred regimens
 - **Directly Observed Therapy (DOT)** is always preferred

Regimens for LTBI in HIV infected persons

- Preferred regimens
 - 3HP (INH/Rifapentine **weekly** for 12 weeks) plus pyridoxine
 - 3HR (INH/Rifampin **daily** for 3 months) plus pyridoxine
- Alternate Regimens:
 - 9H (INH for 9 months) plus pyridoxine
 - 4R (Rifampin for 4 months)
 - Consider sputum collection
 - Avoid Rifabutin substitution

HIV -TB Drug interactions

- The Nucleosides backbone
 - Tenofovir disoproxil fumarate (TDF) preferred over Tenofovir alafenamide (TAF) when used with Rifamycins
 - Abacavir, lamivudine, emtricitabine all OK with Rifampin and Rifapentine
- The Third Drug
 - Efavirenz, raltegravir and dolutegravir are all OK with 3HP

HIV -TB Drug interactions

- **Switch** TAF/FTC to TDF/FTC
- **Switch** Bictegravir to Dolutegravir 50 mg
 - Daily dosing if using 3HP
 - Twice daily dosing if using 3HR or 4 R
- **Don't use Bictegravir/TAF/FTC with 3HP!**

After treatment...

- Resume single tablet regimen **2 weeks after stopping Rifamycin**
- **Check a viral load** to make sure there is no new HIV drug resistance after LTBI treatment
- Document treatment for all posterity

References

- <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/mycobacterium-0?view=full>