15ème ICASA

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Clinical considerations for care, focusing cotrimoxazole prophylaxis

Patricia Fassinou Ekouévi, MD
STA for PMTCT and pediatric care
EGPAF Côte d'Ivoire

Dakar, Sénégal

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Background

- 2007: 2.5 million children infected by HIV, over 90% of them acquired infection from their mother
- 370.000 newly infection per year (17% of new cases of HIV infection)
- HIV pediatric infection : represent 10% of global infection
- Disease is more aggressive in children : 30% mortality at year 1, 50% at Year 2 and 60% at year 5 (Newell Lancet 2004)
- Estimated deaths: 290.000

package for HIV care: Keys components

- Diagnosis and follow up
- Life saving interventions
  (Cotrimoxazole, Malaria, immunization, safe drinking water…)
- Care and treatment including access to Antiretroviral therapy
- Patient Education
- Nutritional, Community, social and psychological support
- Palliative care

WHO recommendations (1)

- Diagnosis

«All HIV exposed infants should have early virological testing around 6 weeks.

If virological testing is not available then HIV antibody testing schould be provided »

→ Early diagnosis of HIV is crucial to early initiation of life saving care

- Care and treatment

« There is a critical need to provide antiretroviral therapy (ART) for infants and children infected by HIV »

WHO recommendations (2)

- Prevention

« The most efficient and cost-effective way to tackle paediatric HIV globally is to reduce mother-to-child transmission (MTCT) »

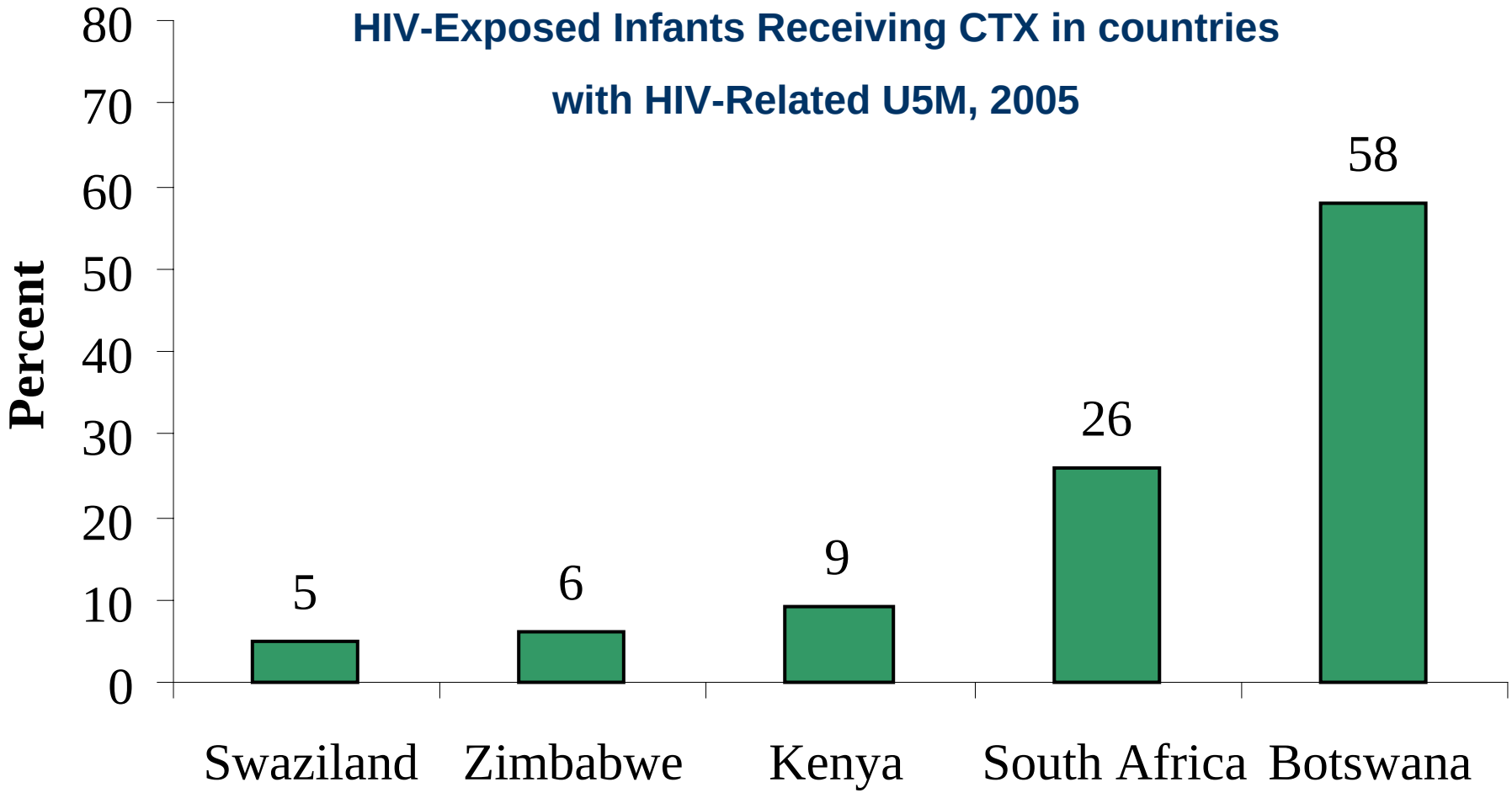
« Cotrimoxazole preventive therapy reduce morbidity and mortality in infected infants and children »

Target by 2010

Target: By 2010, provide either antiretroviral treatment or cotrimoxazole, or both, to 80 per cent of children in need

Does this challenge is Feasible ?

Few HIV-Exposed Infants are Receiving CTX



UNICEF, 2006

WHO recommendations for CMX

- HIV-exposed infants starting at 4– 6 weeks of age and continued until HIV infection is excluded

- HIV+ children < 1 year of age

- HIV+ children ≥ 1 year of age if symptomatic

(WHO clinical stages 2, 3 or 4 for HIV disease) or CD4 <25%

Co-trimoxazole prophylaxis

- *Simple*
- *Well tolerated*
- *Cost-effective intervention for people living with HIV*

  ➡ *Should be implemented as an integral component of the HIV chronic care package and as a key element of pre antiretroviral therapy care.*

  ➡ *Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery*

Co-trimoxazole prophylaxis effectiveness

- PCP pneumonia
- Diarrhoa
- Malaria
  - CHAMP trial in Uganda evaluated efficacy of CTX in preventing malaria in HIV-infected children
  - **CTX alone decreased malaria risk by 35%**
- Reduce mortality in case of co infection TB and HIV
- Reduce the morbidity, hospital admission and mortality

CTX decreases mortality and hospitalizations : The CHAP Trial

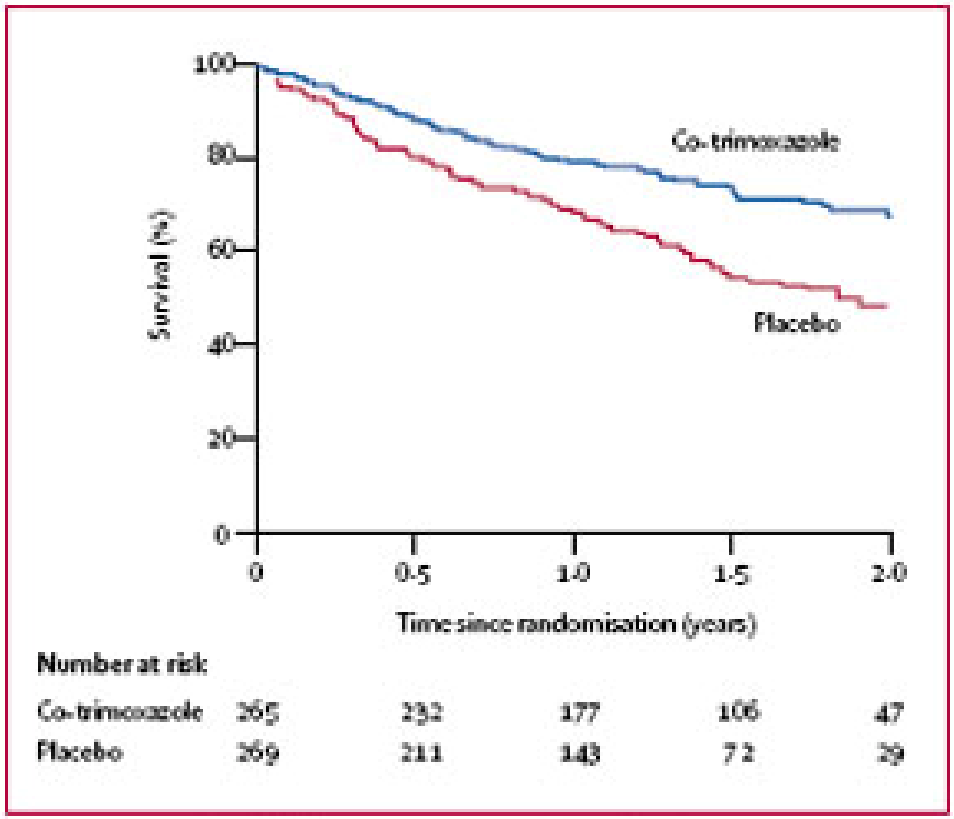


Figure 3: Survival in children on co-trimoxazole or placebo

At a median follow-up of 19 months:

- mortality in the CTX group (28% vs 42% in the placebo group)
- Decreased mortality by 43 %
- Decreased hospitalizations by 23 %
- Did not increase adverse drug effects

Co-trimoxazole prophylaxis: why a low uptake?

- Awareness of care givers
- Accessibility: cost, geographic, EID…
- Lake of follow up
- Lake of data collected and monitoring

Co-trimoxazole prophylaxis: (Côte d'Ivoire)

- CMX available and free of charge in infants exposed to HIV and in HIV-infected children
- Lack of monitoring to know the coverage
- Side effects reported are limited

Conclusions

- ✓ Safe and well tolerated
- ✓ Inexpensive
- ✓ Relatively simple
- ✓ Extremely effective
- ✓ Strongly recommended
- ✓ Decreases mortality and hospitalizations (Chap

Saves Lives!