Declines in Lung Function After Antiretroviral Therapy Initiation in Adults With Human Immunodeficiency Virus and Tuberculosis: A Potential Manifestation of Respiratory Immune Reconstitution Inflammatory Syndrome

Sara C. Auld
Emory University

Let us know how access to this document benefits you.

Follow this and additional works at: https://escholarship.umassmed.edu/oapubs

Part of the Bacterial Infections and Mycoses Commons, Infectious Disease Commons, Pulmonology Commons, Respiratory Tract Diseases Commons, Virus Diseases Commons, and the Viruses Commons

Repository Citation

Creative Commons License
This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License. This material is brought to you by eScholarship@UMassChan. It has been accepted for inclusion in Open Access Publications by UMMS Authors by an authorized administrator of eScholarship@UMassChan. For more information, please contact Lisa.Palmer@umassmed.edu.
Declines in Lung Function After Antiretroviral Therapy Initiation in Adults With Human Immunodeficiency Virus and Tuberculosis: A Potential Manifestation of Respiratory Immune Reconstitution Inflammatory Syndrome

Sara C. Auld,1 Photo Maenene,3 Shuthi Ravimohan,3,5 Drew Weissman,3 Itai Ncube,2 Mandla Mlotshwa,2 Nelly Ratsela,2 William Chase,3 Mboyo-Di-Tamba Vangu,4 Robert Wallis,2 Gavin Churchyard,2,5,6 Hardy Kornfeld,7 and Gregory P. Bisson3,8

1School of Medicine and Rollins School of Public Health, Emory University, Atlanta, Georgia; 2Aurum Institute, Johannesburg, South Africa; 3Department of Medicine, Division of Infectious Diseases, Perelman School of Medicine, University of Pennsylvania, Philadelphia; 4Nuclear Medicine, CM Johannesburg Academic Hospital, University of the Witwatersrand; 5Advancing Care and Treatment for TB/HIV, a Collaborating Centre of the South African Medical Research Council, and 6School of Public Health, University of the Witwatersrand, Johannesburg, South Africa; 7Department of Medicine, University of Massachusetts Medical School, Worcester, and 8Department of Biostatistics, Epidemiology, and Informatics, Center for Clinical Epidemiology and Biostatistics, Perelman School of Medicine, University of Pennsylvania, Philadelphia

End-organ impairment has received relatively little research attention as a possible manifestation of tuberculosis immune reconstitution inflammatory syndrome (TB-IRIS). In this prospective cohort study, one-half of adults with human immunodeficiency virus and pulmonary tuberculosis experienced meaningful declines in lung function on antiretroviral therapy, suggesting a role for lung function in TB-IRIS definitions.

Keywords. tuberculosis; HIV; immune reconstitution inflammatory syndrome; pulmonary function.

Tuberculosis (TB) remains the number one cause of death of people with human immunodeficiency virus (HIV) [1]. Initiating antiretroviral therapy (ART) during TB treatment decreases mortality in adults with HIV and TB, but can trigger the immune reconstitution inflammatory syndrome (IRIS) [2]. Using standard clinical definitions, TB-IRIS is reported to occur in approximately 20% of those initiating ART during TB treatment, often involves the lungs, and is driven in part by immune restoration to mycobacterial antigens [2].

Received 12 April 2019; editorial decision 24 July 2019; accepted 27 August 2019; published online September 25, 2019. Correspondence: S. C. Auld, Emory University, 615 Michael St NE, Suite 205, Atlanta, GA 30322 (sauld@emory.edu).

Clinical Infectious Diseases® 2020;70(8):1750–3
© The Author(s) 2019. Published by Oxford University Press for the Infectious Diseases Society of America. This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs licence (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial reproduction and distribution of the work, in any medium, provided the original work is not altered or transformed in any way, and that the work is properly cited. For commercial re-use, please contact journals.permissions@oup.com. DOI: 10.1093/cid/ciz733

1750 • CID 2020;70 (15 April) • BRIEF REPORT

Approximately one-half of HIV-negative adults cured of pulmonary TB have chronic lung impairment, and there is growing recognition of the global burden of respiratory disability following TB cure [3]. In people with HIV and TB coinfection, pulmonary inflammation from ART-mediated immune restoration may provoke additional lung damage, but there are limited data on lung function trajectories following ART initiation. Thus, we sought to determine the incidence of, risk factors for, and long-term impact of clinically meaningful lung function declines in adults initiating ART during TB treatment.

METHODS

We conducted a prospective cohort study enrolling ART-naive adults living with HIV with CD4 counts ≤500 cells/μL and GeneXpert-positive, rifampicin-susceptible pulmonary TB in Gauteng, South Africa, during 2016–2019. All participants initiated efavirenz, emtricitabine, and tenofovir during the intensive phase of short-course TB therapy. Lung function tests were conducted prior to (baseline) and at 4, 12, 24, and 48 weeks after ART initiation; participants completed at least 2 lung function tests in the first 12 weeks. Forced expiratory volume in 1 second (FEV1) and forced vital capacity were measured with an EasyOne Pro Spirometer (ndd Medical Technologies, Andover, Massachusetts) as absolute volumes (mL) and percentage of predicted values (ie, referenced to age, sex, height, and race). Respiratory symptoms were assessed using the Chronic Obstructive Pulmonary Disease Assessment Test (CAT), and the 6-minute walk test (6MWT) was administered as a submaximal exercise test of pulmonary disability [4, 5].

CD4 count and HIV viral load were measured at baseline and week 4 of ART. Paradoxical TB-IRIS was identified at monthly visits using the MeIntjes et al criteria [2].

We identified participants with an FEV1 decline of ≥100 mL, the minimum clinically important difference in other pulmonary diseases [6], during the first 12 weeks after ART initiation. Those with a ≥100 mL decline were then divided into tertiles according to the amount of decline. We compared sociodemographic and clinical characteristics of participants with and without lung function declines using the χ2 or Kruskal-Wallis test. Multivariate logistic regression was used to determine the association between an FEV1 decline ≥100 mL in the first 12 weeks and impaired lung function at the end of TB treatment, which we defined as an FEV1 <80% predicted at the latter available of the 24- or 48-week visit (ie, the “final” lung function measurement). We examined the following variables for effect modification or confounding: age, sex, smoking status, time to ART initiation, baseline CD4 count and viral load, and baseline FEV1. Covariates were included in the final model based on a
priori knowledge or a bivariate association with final FEV\textsubscript{1} with a \( P \) value < .2. Analyses were conducted in SAS version 9.4 software (SAS Institute, Cary, North Carolina).

**RESULTS**

Participant sociodemographic and clinical characteristics are shown in Table 1. Among 101 participants with at least 2 lung function measurements in the first 12 weeks of ART, half (50 [50%]) had a clinically significant FEV\textsubscript{1} decline of at least 100 mL after ART initiation. After dividing those 50 participants into tertiles, 16 (16%) participants had a mild FEV\textsubscript{1} drop of 100–299 mL, 16 (16%) had a moderate drop of 300–599 mL, and 18 (18%) had a severe drop of ≥600 mL, with a median FEV\textsubscript{1} drop of 955 mL (interquartile range, 840–1240 mL) in these individuals. No participants had evidence of HIV treatment failure, and all successfully completed TB treatment.

An FEV\textsubscript{1} drop of at least 100 mL on ART was significantly associated with a longer 6MWT distance and higher FEV\textsubscript{1} at baseline, but not with other characteristics either at baseline or after ART initiation, including sputum culture status and time to culture positivity in liquid media (Table 1 and Figure 1). Although there was no significant difference in the final FEV\textsubscript{1} for those with and without lung function declines, a significantly greater proportion of those with severe declines (ie, FEV\textsubscript{1} drop ≥600 mL) had a final FEV\textsubscript{1} <80% predicted, compared with

<table>
<thead>
<tr>
<th>Characteristica</th>
<th>No Lung Function Decline</th>
<th>Lung Function Decline</th>
<th>PValueb</th>
<th>Mild Lung Function Decline</th>
<th>Moderate Lung Function Decline</th>
<th>Severe Lung Function Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baselinecharacteristics</td>
<td>(n = 51)</td>
<td>(n = 50)</td>
<td>(n = 16)</td>
<td>(n = 16)</td>
<td>(n = 18)</td>
<td>(n = 18)</td>
</tr>
<tr>
<td>Age, y, mean (range)</td>
<td>36 (31–41)</td>
<td>36 (31–45)</td>
<td>&gt; .5</td>
<td>36 (29–44)</td>
<td>36 (30–45)</td>
<td>36 (32–47)</td>
</tr>
<tr>
<td>Female sex</td>
<td>25 (49)</td>
<td>19 (38)</td>
<td>.26</td>
<td>8 (50)</td>
<td>7 (44)</td>
<td>4 (22)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>5 (10)</td>
<td>10 (20)</td>
<td>.15</td>
<td>3 (19)</td>
<td>4 (25)</td>
<td>3 (17)</td>
</tr>
<tr>
<td>Time to ART initiation after TB treatment initiation, d</td>
<td>22 (16–38)</td>
<td>27 (15–47)</td>
<td>&gt; .5</td>
<td>24 (16–32)</td>
<td>20 (14–47)</td>
<td>31 (23–49)</td>
</tr>
<tr>
<td>CD4 count, cells/μL</td>
<td>106 (48–204)</td>
<td>110 (51–182)</td>
<td>&gt; .5</td>
<td>160 (66–274)</td>
<td>87 (20–133)</td>
<td>108 (51–180)</td>
</tr>
<tr>
<td>Log\textsubscript{10} plasma HIV-1, copies/mL</td>
<td>5.1 (4.7–5.7)</td>
<td>5.3 (4.9–5.8)</td>
<td>.30</td>
<td>5.2 (4.8–5.5)</td>
<td>5.3 (5.0–5.7)</td>
<td>5.4 (5.0–5.8)</td>
</tr>
<tr>
<td>Sputum culture positive at baseline visit</td>
<td>24 (47)</td>
<td>21 (42)</td>
<td>&gt; .5</td>
<td>7 (44)</td>
<td>7 (44)</td>
<td>7 (39)</td>
</tr>
<tr>
<td>Time to sputum culture positivity in liquid media among culture-positive samples, d</td>
<td>13 (9–15)</td>
<td>14 (12–18)</td>
<td>&gt; .5</td>
<td>14 (12–16)</td>
<td>18 (13–18)</td>
<td>12 (9–17)</td>
</tr>
<tr>
<td>CAT score</td>
<td>5 (3–12)</td>
<td>5.5 (2–11)</td>
<td>&gt; .5</td>
<td>3 (1–11)</td>
<td>6.5 (1.5–9)</td>
<td>8 (4–12)</td>
</tr>
<tr>
<td>6MWT, m</td>
<td>368 (328–430)</td>
<td>408 (361–456)</td>
<td>.05</td>
<td>432 (362–479)</td>
<td>403 (312–456)</td>
<td>406 (368–449)</td>
</tr>
<tr>
<td>FEV\textsubscript{1} % predicted</td>
<td>71 (58–84)</td>
<td>82 (75–95)</td>
<td>&lt; .001</td>
<td>81 (76–94)</td>
<td>86 (76–102)</td>
<td>82 (67–95)</td>
</tr>
<tr>
<td>FEV\textsubscript{1} &lt;80% predicted</td>
<td>34 (67)</td>
<td>19 (38)</td>
<td>.004</td>
<td>6 (38)</td>
<td>5 (31)</td>
<td>8 (44)</td>
</tr>
<tr>
<td>Increase from baseline to 4 wk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in CD4 count, cells/μL</td>
<td>65 (26–106)</td>
<td>69 (25–172)</td>
<td>.36</td>
<td>51 (24–169)</td>
<td>79 (32–172)</td>
<td>64 (34–170)</td>
</tr>
<tr>
<td>Decrease in log VL</td>
<td>5.1 (4.7–5.6)</td>
<td>5.2 (4.7–5.6)</td>
<td>&gt; .5</td>
<td>5.2 (4.6–5.5)</td>
<td>5.2 (4.6–5.5)</td>
<td>5.2 (4.9–5.7)</td>
</tr>
<tr>
<td>Change in CAT score</td>
<td>0 (−2 to 1)</td>
<td>0 (−1 to 2)</td>
<td>.44</td>
<td>0 (−1 to 1)</td>
<td>0.5 (−2.5 to 3.5)</td>
<td>−1 (−3 to 3)</td>
</tr>
<tr>
<td>Change in 6MWT, m</td>
<td>−12 (−48 to 22)</td>
<td>−27 (−60 to 7)</td>
<td>.19</td>
<td>−37 (−79 to 4)</td>
<td>−43 (−72 to −12)</td>
<td>−10 (−34 to 12)</td>
</tr>
<tr>
<td>Change in FEV\textsubscript{1}, mL</td>
<td>−100 (−20 to 270)</td>
<td>−500 (−870 to −210)</td>
<td>&lt; .001</td>
<td>−155 (−205 to −130)</td>
<td>−495 (−530 to −375)</td>
<td>−955 (−1240 to −850)</td>
</tr>
<tr>
<td>Final FEV\textsubscript{1} % predictedd</td>
<td>83 (68–90)</td>
<td>82 (73–93)</td>
<td>&gt; .5</td>
<td>86 (77–92)</td>
<td>86 (77–100)</td>
<td>73 (67–83)</td>
</tr>
<tr>
<td>Final FEV\textsubscript{1} &lt;80% predicted</td>
<td>15 (39)</td>
<td>20 (47)</td>
<td>&gt; .5</td>
<td>5 (36)</td>
<td>5 (33)</td>
<td>10 (71)</td>
</tr>
<tr>
<td>Change in FEV\textsubscript{1}, mL, baseline to final</td>
<td>400 (60–660)</td>
<td>−10 (−350 to 310)</td>
<td>.01</td>
<td>170 (−110 to 310)</td>
<td>0 (−190 to 230)</td>
<td>−375 (−540 to 580)</td>
</tr>
</tbody>
</table>

Mild pulmonary TB immune reconstitution inflammatory syndrome (IRIS) is defined as initial FEV\textsubscript{1} decline of 100–299 mL; moderate pulmonary TB-IRIS is defined as initial FEV\textsubscript{1} decline of 300–599 mL; and severe pulmonary TB-IRIS is defined as initial FEV\textsubscript{1} decline of ≥600 mL. \( P \) values ≤ .05 are in bold.

Abbreviations: 6MWT, 6-minute walk test; ART, antiretroviral therapy; CAT, Chronic Obstructive Pulmonary Disease Assessment Test; FEV\textsubscript{1}, forced expiratory volume in 1 second; HIV-1, human immunodeficiency virus type 1; TB, tuberculosis; VL, viral load.

\*Unless otherwise indicated, continuous variables are expressed as median (interquartile range) and categorical variables are expressed as No. (%).

\*\*\*P values compare those with and without pulmonary IRIS, using \( \chi^2 \) test for categorical variables and Kruskal-Wallis test for continuous variables.

\*\*\*\*Change in FEV\textsubscript{1}, included change during baseline to 12 weeks, as explained in the Methods.

\*\*\*\*\*Final values were available for 81 participants (38 no IRIS; 43 IRIS [14 mild, 15 moderate, 14 severe]) based on week 24 values for 30 participants and week 48 values for 51 participants.
those without a decline (71% vs 39%; \( P = .04 \)). Furthermore, after adjustment for age, sex, time from TB treatment to ART initiation, baseline CD4 count, and baseline FEV\(_1\), those with FEV\(_1\) drops of any severity had >7 times the odds of having a final FEV\(_1\) <80% predicted compared with those without an early FEV\(_1\) drop (odds ratio, 7.59 [95% confidence interval, 1.67–34.63]). This significantly increased risk of a final FEV\(_1\) <80% predicted seen after adjustment for baseline factors, notably the baseline FEV\(_1\), parallels the trends in Figure 1A and 1B, whereby those who developed lung function declines typically started with higher lung function but had less recovery of lung function during treatment. All participants had improvements in their symptom scores, and most had accompanying improvements in their 6MWT.

Six participants met standard definitions for TB-IRIS [2], 5 of whom had qualifying spirometry. One had respiratory symptoms but did not experience a decline in lung function (Supplementary Table).

**DISCUSSION**

In this prospective cohort study, approximately half of those with pulmonary TB initiating ART experienced FEV\(_1\) declines of a magnitude considered clinically significant in other pulmonary diseases [6], and 18% had severe FEV\(_1\) drops associated with lung function that remained depressed at TB treatment completion, when impairment may be permanent [7]. These findings are important because decreased lung function is associated with increased mortality in people with and without overt pulmonary disease [8].

Patients whose lung function declined on ART experienced these declines within the first 3 months of ART initiation, completed TB treatment without evidence of microbiological failure, had no newly diagnosed pulmonary infections, and had substantial virologic decreases and CD4 increases on ART, consistent with standard definitions of paradoxical TB-IRIS [2, 9, 10]. Furthermore, the finding that less lung involvement at baseline was associated with an increased risk of lung function decline after starting ART is consistent with findings from a subset of this cohort, indicating that less pulmonary radiographic inflammation at baseline is associated with greater increases in lung inflammation during the initial weeks of ART [11]. Nonetheless, the lack of association between both bacterial burden and timing of ART initiation with declines in lung function contrasts with the concept that greater antigen burden drives TB-IRIS risk. Furthermore, TB progression despite TB treatment and ART initiation, drug toxicity, and undiagnosed pulmonary opportunistic infections.
illnesses cannot be excluded as possible contributors to the lung function declines we identified. Additional research is needed.

Lung function declines were not always symptomatic and may not be detected by routine TB-IRIS surveillance unless spirometry is performed. Our findings require validation, but suggest that otherwise unexplained drops in pulmonary function on ART warrant consideration as an additional criteria for a TB-IRIS diagnosis. In the definition used in this study, if lung function declines were considered “focal tissue involvement” (as per the Meintjes et al [2] definition), the incidence of IRIS would have increased considerably. Major lung function declines on ART could also be considered a manifestation of a “clinical course not consistent with the expected course of TB” to fulfill the definition of French et al [10], or could have spirometry added to radiography as a sign of worsening disease in the TB-IRIS–specific definition of Colebunders et al [9]. This functional definition of pulmonary TB-IRIS could help identify those experiencing incident pulmonary damage on ART [2]. Lung function declines of a magnitude associated with greater longer-term pulmonary impairment (eg, in this study, ≥600 mL) may merit a TB-IRIS diagnosis. Failure to improve from baseline, when acute TB-associated inflammation is present, to end of therapy was also common in this study and merits consideration as an IRIS criterion.

We were unable to conduct prediagnosis pulmonary function testing, nor did we have baseline and follow-up chest radiography. Our sample size also limits our ability to examine all risk factors of interest. Nevertheless, our data suggest that people with HIV and TB are at risk of incident lung damage following ART initiation. A recent randomized clinical trial demonstrated that corticosteroid use at the time of ART initiation decreased TB-IRIS risk in adults and that these or other anti-inflammatory therapies may improve pulmonary outcomes in this population [12]. Inhaled corticosteroids, which specifically target inflammation in the lungs, present another potential intervention. Preclinical data also indicate that novel agents, such as phosphodiesterase-4 and matrix metalloproteinase inhibitors, reduce lung involvement in small-animal models of TB [13, 14]. The majority of TB-related disease burden, as measured in disability-adjusted life-years, is due to pulmonary impairment after treatment completion [15]. Therefore, patients with HIV/TB may benefit from research on interventions to preserve lung function and prevent chronic pulmonary impairment on ART.

Supplementary Data
Supplementary materials are available at Clinical Infectious Diseases online. Consisting of data provided by the authors to benefit the reader, the posted materials are not copyedited and are the sole responsibility of the authors, so questions or comments should be addressed to the corresponding author.

Notes
Acknowledgments. The authors are grateful to the study team at the Aurum Institute for their tireless efforts in data collection, participant recruitment, and interviews, and to the participants who consented to participate in this study.
Financial support. This work was supported by the National Institute of Allergy and Infectious Diseases (grant numbers K23AI134182 to S. C. A. and R01AI120821 to G. P. B.); the National Center for Advancing Translational Sciences (grant number KL2TR001879 to S. R.); and the Emory University and University of Pennsylvania Centers for AIDS Research (grant numbers P30AI045008 and P30AI050409). Grants from Advancing Care and Treatment for TB/HIV (ACT4TB/HIV) (http://act4tbhiv.org/) were awarded to R. W. and G. C.
Potential conflicts of interest. The authors report no potential conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References