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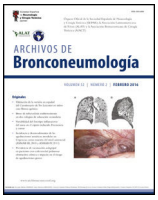

Letters to the Editor

Comments on the Treatment of Resistant Tuberculosis☆

Comentarios al tratamiento de la tuberculosis con resistencia

To the Editor,

I read with interest the guidelines published by Caminero et al.[1] on the diagnosis and treatment of drug-resistant tuberculosis. I agree that according to the published evidence, bedaquiline and delamanid should be considered essential components in the design of multidrug-resistant (MDR) tuberculosis treatment regimens, as the authors set out in their rational classification and sequential use of anti-TB drugs for the design of a treatment regimen (Caminero et al., Table 3[1]). Indeed, the 2016 WHO classification[2] should have included them in group C (other core second-line drugs) along with linezolid, rather than in group D (add-on agents, not part of the core regimen). Caminero et al., however, seem to give a greater theoretical than practical value to bedaquiline and delamanid, as treatment regimens with these drugs are not recommended from the outset, probably for the same reason that WHO included them in group D2: these drugs are very costly. Nevertheless, it is important to bear in mind that some studies have shown that the inclusion of these expensive drugs in multi-resistant tuberculosis treatment is a cost-effective measure.[3,4]

These guidelines recommend that priority be given to the shorter 9–12 month regimen proposed by the WHO in 2016, known as the "9-month Bangladesh regimen",[2] for all patients with rifampicin or multiresistant tuberculosis who have not previously received fluoroquinolones (FQ) or second-line injectable drugs (SLID) or who can demonstrate sensitivity in vitro to these 2 classes of antibiotics. The WHO also recommends that this regimen should not be used in patients with suspected or confirmed resistance to 1 or more drugs in a shorter regimen (e.g., pyrazinamide), apart from FQs and SLIDs. Some studies have raised serious questions about the suitability of shorter regimens in certain regions of the world (including some European countries), due to the prevalent resistance patterns in those areas.[5] Moreover, the shorter regimen should be avoided in patients with extrapulmonary disease and in pregnancy.[2]

References

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