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SUPPLEMENT 1

A B S T R A C T B O O K

**45th World Conference
on Lung Health of the
International Union Against
Tuberculosis and Lung Disease (The Union)**

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on Lung Health of the
International Union Against
Tuberculosis and Lung Disease
(The Union)**

**BARCELONA · SPAIN
28 OCTOBER–1 NOVEMBER 2014**

S1 PLENARY SESSIONS

SYMPOSIA

THURSDAY 30 OCTOBER 2014

- S2 01. Progress in clinical trials for drug-susceptible TB: 2014
- S3 02. Preparing frontline health workers for community-led change
- S4 03. How multi-sectoral approach and community engagement may strengthen programmatic management of TB in prisons
- S5 04. Tuberculosis and diabetes: from evidence to action
- S7 05. Next generation of Ehealth for TB: systems that communicate
- S9 06. Empirical treatment for TB among HIV-positive people: who, when, how? Update on trials in progress
- S10 07. Community engagement and relief of suffering in palliative care
- S12 08. Child pneumonia: innovative solutions for the next generation
- S13 09. Integrating community-based tobacco control activities in TB programmes: experience from multiple countries
- S15 10. Shortened treatment regimens for MDR-TB: results from the field and future direction
- S16 12. Exploring the intersection between TB and maternal and neonatal health: from research to implementation
- S18 14. Outstanding issues in HIV/AIDS
- S19 15. Systematic screening for active TB: from guideline to implementation
- S19 16. Community as partner: creating successful collaborations in TB control
- S20 17. Community-based approaches to address lung health
- S20 18. Non-tuberculous mycobacterial infections: diagnosis and management

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- S22 20. Community-driven psychosocial support: don't forget medication counselling!
- S25 21. Practical considerations for successful contact tracing and linkage to care in low- and middle-income countries
- S26 22. Countries' experience in decentralising PMDT: community-based MDR-/XDR-TB care
- S28 23. QMS implementation and accreditation of TB laboratories
- S30 24. Mathematical approaches to better understand and tackle tuberculosis
- S31 25. Tobacco control, trade and international treaties

- S32 26. Know your epidemic: fundamental to solutions for child TB
- S33 27. What practical steps are needed to achieve a patient-centered continuum of care in TB control?
- S34 28. Adolescent TB, TB-HIV and MDR-TB: addressing a vulnerable population with unique needs using innovative solutions
- S34 29. Management of latent tuberculosis infection: from evidence to policy
- S35 30. TB in Europe: MDR-/XDR-TB control and challenges of high risk groups
- S36 31. Implementing "FAST": a refocused approach to institutional TB transmission control
- S38 32. Changing the status quo in TB drug and regimen R&D
- S38 33. TB patients: learning from the experience of those personally affected
- S39 34. Supervision or support? A debate panel on challenges around DOT and patient-centered care
- S41 36. Tobacco, poverty and possible solutions: health promotion funding models

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- S43 38. Progress and lessons learnt from national TB prevalence surveys
- S44 39. Engaging communities of special risk groups in conflict affected communities
- S46 40. Tuberculosis infection control and occupational TB among health care workers: a time for action
- S47 41. Moving the next generation of TB diagnostics for drug resistance closer to patients: data sharing
- S49 42. Emerging perspectives in the treatment of paediatric MDR-TB
- S51 43. Magic bullet? Data-driven insights on the impact of community workers on case detection and treatment outcomes
- S51 44. Zoonotic tuberculosis: a global socio-economic problem
- S54 45. Partnerships: working for community-driven impact to ensure quality care for persons affected by TB
- S55 46. Innovative solutions in surveillance of drug-resistant TB: from phenotypic to molecular testing
- S57 47. Engaging communities in the fight against TB and HIV
- S59 48. Multi-faceted regional response to tuberculosis in the mining sector in southern Africa
- S61 50. Enhancing TB control with structural interventions: from incentives and enablers to social protection
- S63 51. COPD: diagnostic and therapeutic challenges in developing countries
- S64 53. Non-communicable diseases and tobacco control

ABSTRACT PRESENTATIONS
THURSDAY 30 OCTOBER 2014

- e-poster session
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- Poster discussion sessions
- S71. 01. TB in children: latent TB and IPT
- S78 02. Lung cancer, occupational exposure and air pollution
- S84 03. TB in children: diagnosis
- S89 04. Xpert MTB/RIF: diagnosis of pulmonary and extrapulmonary TB
- S96 05. Gene polymorphisms and immunology
- S100 06. Immune Responses in TB
- S106 07. Molecular detection of TB and drug resistance – 1
- S112 08. Opening the door to community engagement in TB
- S118 09. HIV/TB programme links: hand in hand screening for TB and HIV
- S125 10. Community commitments to improving TB treatment adherence
- S130 11. Retrospective TB data analysis: case identification, treatment and control
- S136 12. TB and diabetes: the rising burden
- S141 13. TB public private mix: India
- S147 14. Diagnostic evaluation of TB: what does and doesn't work
- S154 15. Molecular epidemiology: from Beijing to Brazil and points in between
- S159 16. TB public private mix in countries other than India
- S166 17. TB infection control
- S171 18. MDR-TB management
- S177 19. Epidemiology: tuberculosis management and control
- S184 20. MDR-TB: treatment and adverse reactions
- S190 21. TB in vulnerable populations
- S196 22. Tobacco use in women and children: a worrying trend
- Oral abstract presentation sessions
- S202 01. Paediatric and adolescent TB: epidemiology, outcomes and MDR
- S207 02. Screening / testing / diagnostics in TB-HIV
- S212 03. M-health: expanding the frontiers of TB control
- S216 04. TB in health care workers
- S220 05. Tuberculosis epidemiology: predicting the future
- S224 06. Developing new regimen for MDR-TB treatment
- S229 07. Clearing the smoke: the synergistic role of the FCTC and MPOWER
- S233 08. Evaluation of diagnostics, drugs and vaccines
- S237 09. TB and diabetes: the new deadly duo
- S241 10. All hands on deck: communication engagement and TB programmes

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- e-poster session
- S246 02. Multi-disciplinary approach to TB control
- Poster discussion sessions
- S252 23. TB in children: outcomes, extra pulmonary TB, BCG and other
- S259 24. COPD and outcomes post-TB
- S262 25. Asthma, spirometry and ARIs
- S268 26. Xpert MTB/RIF: implementation and performance
- S274 27. External quality assurance for TB: getting better all the time!
- S280 28. Culture and phenotypic drug susceptibility testing
- S286 29. AFB smear microscopy
- S292 30. What do singers, football and maps have in common: new horizons in TB community engagement
- S298 31. Inextricably linked: integrating TB and HIV care
- S303 32. Best practices in supporting clients to complete TB treatment
- S308 33. Tuberculosis and diabetes: look out for both
- S312 34. TB in special populations
- S316 35. Social determinants and quality of TB care
- S323 36. Comorbidity and deadly TB**
- S329 37. TB active case finding
- S335 38. Tuberculosis: a contact sport
- S342 39. MDR-TB: outcomes of treatment
- S347 40. MDR-TB management
- S353 41. Case-finding: special interventions
- S359 42. A potpourri of TB issues
- S364 43. Bidis, Bloomberg, Bali and behaviour: frontiers in tobacco control
- S369 44. David vs. Goliath: fighting the media war against the tobacco industry
- Oral abstract presentation sessions
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- S379 12. Finding cases: how good are our notification systems?
- S383 13. Epidemiology: where is TB? Hotspots, hospitals and the highlands of Mexico
- S388 14. TB control strategies: what is effective?
- S391 15. Lessons learnt from implementing Xpert MTB/ RIF
- S395 16. The depths of drinking, drugs and depression in TB
- S399 17. Prophylactic therapies
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- S407 19. TB drug treatment regimens/trials
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- S416 03. TB in children: MDR and training

Poster discussion sessions

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S425 46. Clinical trials: drugs and vaccines
S431 47. TB molecular epidemiology: from laboratory diversity to outbreak
S436 48. Molecular detection of TB and drug resistance – II
S441 49. Factors affecting access and health seeking behaviour
S447 50. Treatment, management and diagnosis: a potpourri of TB and HIV issues
S453 51. The gamut of training: from patients to professionals
S458 52. TB case finding: if you look for it, you will find it
S464 53. Case finding/LTBI: adults and children
S470 54. TB in the elderly: effects and outcome
S475 55. TB spatial epidemiology in high-burden settings
S480 56. TB relapses, recurrence and retreatment
S485 57. TB control
S490 58. MDR-/XDR-TB management: new approaches
S495 59. MDR-TB: epidemiology
S499 60. MDR-TB: special locations

- S506 61. TB information systems: evaluating treatment outcomes
S513 62. TB in special populations: risky places and occupations
S519 63. All smoke free: from government to community
S524 64. Tobacco control laws: the force is still with us!
S530 65. TB prevalence estimations
S536 66. TB in prisons

Oral poster presentations

- S543 01. The promise of life: initiating treatment in coinfecting patients
S548 02. Community engagement in TB control
S553 03. Tuberculosis programmes: from lab to bedside
S558 04. Paediatric TB, pneumonia and asthma
S564 05. High and low: the search for TB cases
S569 06. Managing MDR-TB: problems and solutions
S574 07. Developing new regimens for treating MDR-TB
S579 08. Non tuberculosis mycobacteria and identification
S584 09. Drug resistance and drug-resistance surveys
S589 10. Tobacco, TB and cancer: triple threat

PD-905-31 Antibiotic prescriptions in tuberculous pneumonia associated with hemodynamic instability and toxicity to first-line drugs

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Background: TB pneumonia may be associated with hemodynamic instability in 10% of cases being needed urgently initiate TB therapy once the diagnosis is made, however the situation can be complicated by the presence of drug-induced liver toxicity, unable to establish which of the drugs of first line is the cause of the situation. The aim of this study is to describe in these patients, the clinical behavior and smear findings after the first month of treatment with pharmacological unconventional schemes.

Design/Methods: Information of 36 patients admitted to intensive care in western Colombia between January 2003 and December 2013 due TB pneumonia and drug toxicity to first-line drugs is collected.

Results: Following the initiation of conventional therapy 90% of patients presented elevation of more than 5 times the normal value in the level of liver enzymes, the remaining 10% the value was between 3 and 5 times, hyperbilirubinemia document in all cases; the time to onset of toxicity was 8 days on average and in all cases the tests normalized after the withdrawal of the scheme ; the combination of moxifloxacin, aminoglycoside and ethambutol was used in 32 cases, in the remaining 2 ethambutol was excluded ; the average prescription time while hemodynamic stability was achieved and the cause of drug toxicity was established replacement was 28 days ; toxicity was secondary to pyrazinamide in 55%, whereas isoniazid and rifampicin in 30 and 15% respectively ; the time of mechanical ventilation had a mean of 9 days; 2 patients died ;the smear was positive in 4 patients after the term of unconventional scheme;in all patients conventional scheme is restart once were in hemodynamic stability and removing the causative drug toxicity.

Conclusion: The severity of hemodynamic and respiratory compromise in patients following TB pneumonia requires drug alternatives in situations in which drug toxicity appears to conventional antituberculosis drugs , this is based on the impact may cause the delay of antibiotic therapy in patients with critical condition. The combination of moxifloxacin, aminoglycoside, ethambutol is presented as a therapeutic alternative in patients whose condition can not tolerate delays in initiation of treatment.

PD-906-31 The causes of death among patients with tuberculosis in institute for lung diseases and tuberculosis, Skopje, Macedonia

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Introduction Tuberculosis is one of the main causes of morbidity and mortality in different societies. In 2010,

there were an estimated 12 million people living with active TB, including 8.8 million new cases and there were an estimated 1.4 million deaths. Identifying causes for death following diagnosis of TB is important for planning effective interventions to reduce death rates. The aim of this study was to assess and determine main causes of death in TB patients in our Institute.

Materials and methods It is a retrospective descriptive study conducted in Institute for lung diseases and tuberculosis, Skopje, Macedonia, from 2010 to 2013. Medical records of died tuberculosis patients over 4 – year period were reviewed and death data were analyzed. Results Twenty two deaths (15% from all hospitalized patients) with mean age of 58p/- 10.3 years were detected, 69.6% were male and 30.4% were female. The frequency rate for cigarette smoking, alcoholism, diabetes, intravenous drug usage, as risk factors were 54.5%, 22.7%, 4.5% and 4.5% respectively. 12 deaths (54,5%) were directly attributed to tuberculosis, among them overwhelming TB disease with respiratory failure, massive hemoptysis and MDR-TB accounted as the cause of death in 75%, 8.3% and 16.6% respectively. 10 deaths (45,5%) were due to other medical problems, which included, COPD, cardiovascular diseases, high blood pressure, cirrhosis, dementia i.e. 18.2%, 31.8%, 18.2%, 4.5% and 4.5% respectively. The median time of survival was 28 days. 77.2% of patients died during the initial-2- month intensive phase of anti - TB treatment. 36.4% died in the first 10 days of treatment. Those who died of tuberculosis had statistically significant (p, 0.001) a shorter median survival (14,9) days in comparison with group who had other medical problems (27days).

Conclusion This study showed that overwhelming TB disease, with respiratory failure, haemoptysis, cardiovascular diseases, COPD, cirrhosis are main causes of death. Smoking, alcoholisms, diabetes, intravenous drug usage are frequent risk factors for TB mortality.

PD-907-31 Increased mortality risk in HIV-infected patients is limited to those with low CD4 counts in the stride study

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Background: Tuberculosis (TB) control is complicated by the interaction of the TB and human immunodeficiency virus (HIV) epidemics, yet participation of HIV-infected patients in TB treatment trials is often limited. Reasons for this include drug-drug interactions amongst antiretroviral and antituberculous agents, overlapping drug toxicities, and concerns about increased morbidity and mortality from the HIV disease, all of which may

