Timing of Antiretroviral Therapy for HIV-1 Infection and Tuberculosis


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ABSTRACT

Background
Antiretroviral therapy (ART) is indicated during tuberculosis treatment in patients infected with human immunodeficiency virus type 1 (HIV-1), but the timing for the initiation of ART when tuberculosis is diagnosed in patients with various levels of immune compromise is not known.

Methods
We conducted an open-label, randomized study comparing earlier ART (within 2 weeks after the initiation of treatment for tuberculosis) with later ART (between 8 and 12 weeks after the initiation of treatment for tuberculosis) in HIV-1 infected patients with CD4+ T-cell counts of less than 250 per cubic millimeter and suspected tuberculosis. The primary end point was the proportion of patients who survived and did not have a new (previously undiagnosed) acquired immunodeficiency syndrome (AIDS)–defining illness at 48 weeks.

Results
A total of 809 patients with a median baseline CD4+ T-cell count of 77 per cubic millimeter and an HIV-1 RNA level of 5.43 log$_{10}$ copies per milliliter were enrolled. In the earlier-ART group, 12.9% of patients had a new AIDS-defining illness or died by 48 weeks, as compared with 16.1% in the later-ART group (95% confidence interval [CI], −1.8 to 8.1; P = 0.45). Among patients with screening CD4+ T-cell counts of less than 50 per cubic millimeter, 15.5% of patients in the earlier-ART group versus 26.6% in the later-ART group had a new AIDS-defining illness or died (95% CI, 1.5 to 20.5; P = 0.02). Tuberculosis-associated immune reconstitution inflammatory syndrome was more common with earlier ART than with later ART (11% vs. 5%, P = 0.002). The rate of viral suppression at 48 weeks was 74% and did not differ between the groups (P = 0.38).

Conclusions
Overall, earlier ART did not reduce the rate of new AIDS-defining illness and death, as compared with later ART. In persons with CD4+ T-cell counts of less than 50 per cubic millimeter, earlier ART was associated with a lower rate of new AIDS-defining illnesses and death. (Funded by the National Institutes of Health and others; ACTG A5221 ClinicalTrials.gov number, NCT00108862.)
The treatment of patients with tuberculosis and newly identified infection with human immunodeficiency virus type 1 (HIV-1) is one of the most challenging aspects of HIV medicine. Antiretroviral therapy (ART) must be started during treatment for tuberculosis, yet starting ART very early in the course of tuberculosis therapy increases the pill burden, the potential drug toxicity, and the risk of tuberculosis-associated immune reconstitution inflammatory syndrome (IRIS). For these reasons, programs, providers, and patients are reluctant to initiate ART during the intensive 8-week induction phase of tuberculosis therapy, when the pill burden and toxicity of tuberculosis medications are greatest. Conversely, delaying ART until after the completion of tuberculosis therapy increases morbidity and mortality associated with the acquired immunodeficiency syndrome (AIDS). The timing of ART in patients who are receiving tuberculosis therapy is thus a critical question to address because more than a half-million persons die annually from HIV-associated tuberculosis.

We designed a strategy trial to evaluate the timing of ART during tuberculosis therapy. Our trial included both patients with confirmed tuberculosis and those with suspected tuberculosis, since in clinical practice, the decision to start or delay ART must often be made before there is a definitive diagnosis of tuberculosis (a reflection of the current limitations of and access to tuberculosis diagnostics). We sought to include patients from a wide geographic spectrum to maximize the generalizability of the findings and to inform policy.

METHODS

STUDY POPULATION

Patients were eligible for the study if they were 13 years of age or older, had HIV-1 infection with a CD4+ T-cell count of less than 250 per cubic millimeter, had not previously received ART, and had confirmed or probable tuberculosis. Confirmed tuberculosis was defined by the detection of acid-fast bacilli in a sputum smear or lymph-node specimen or a positive culture for Mycobacterium tuberculosis from sputum, a lymph node, or another sterile site. Probable tuberculosis required a clinician’s assessment that signs and symptoms warranted empirical tuberculosis therapy. Patients were required to have received 1 to 14 days of a rifamycin-based treatment for tuberculosis. Entry criteria also included an absolute neutrophil count of 500 per cubic millimeter or more; a hemoglobin level of 7 g per deciliter or more; a platelet count of 50,000 per cubic millimeter or more; aspartate aminotransferase, alanine aminotransferase, and bilirubin levels that were no more than 5 times the upper limit of the normal range; a score of 20 or more on the Karnofsky performance scale (which ranges from 0 to 100, with higher scores indicating better performance); and no known or suspected multidrug-resistant or extensively drug-resistant tuberculosis. All participants provided written informed consent.

STUDY DESIGN

Our randomized, open-label, 48-week study compared earlier with later ART in persons with HIV-1 infection who were beginning to receive therapy for tuberculosis. Earlier ART was initiated within 2 weeks and later ART between 8 and 12 weeks after the start of tuberculosis treatment. Randomization was stratified according to screening CD4+ T-cell count (<50 or ≥50 per cubic millimeter) and was balanced according to site.

The ART regimen consisted of efavirenz at a dose of 600 mg daily (Stocrin, donated by Merck) and a fixed-dose combination of emtricitabine, at a dose of 200 mg daily, and tenofovir disoproxil fumarate, at a dose of 300 mg daily (Truvada, donated by Gilead Sciences). Substitutions of antiretroviral drugs were permitted for the management of toxic effects. Tuberculosis therapy was provided to the patients by the study sites according to the country’s national tuberculosis guidelines. The protocol, available with the full text of this article at NEJM.org, was approved by the institutional review board or ethics committee at each site. Companies donating drugs for this study did have the opportunity to review the manuscript, but they had no other role in study design, data accrual, or data analysis. The authors vouch for the accuracy and completeness of the data reported as well as the fidelity of the report to the study protocol. Full details of the study design are provided in the protocol.

Clinical and laboratory evaluations were conducted at entry; at weeks 4, 8, 12, and 16; and every 8 weeks thereafter for a total of 48 weeks. Plasma HIV-1 RNA (Roche Amplicor assay) and CD4+ T-cell counts were measured at Division of AIDS (DAIDS)–certified laboratories. Adverse events were graded with the use of the DAIDS Table for Grading the Severity of Adult and Pediatric...
Out of the study-stratum assignments confirmed tuberculosis-associated IRIS cases on the basis of at least one major or two minor clinical criteria. Concurrent ART was not required for a patient to be classified as having tuberculosis-associated IRIS.

STATISTICAL ANALYSIS

The National Institutes of Health funded the study and provided study oversight. Since this was a strategy study, all participants who met clinical eligibility criteria were included in the analyses. Participants were followed for up to 48 weeks, regardless of whether or not they started ART as scheduled. We determined that a sample of 400 patients per group would provide 90% power (at a two-sided alpha level of 0.05) to detect a 40% reduction in the rate of treatment failure with later ART versus earlier ART (from 25% to 15%), with adjustment for a 10% rate of loss to follow-up and interim analyses. Treatment assignments were generated by a central computer with the use of permuted blocks within strata.

Estimated proportions of patients who survived without a new AIDS event at 48 weeks and failure-time plots were calculated with the use of the Kaplan–Meier method. Failure was defined at the first qualifying event. Tests and confidence intervals that were stratified according to the screening CD4+ T-cell count category, as well as interactions with respect to the primary end point, were calculated by weighting by the inverse of the Greenwood’s variance in each CD4+ T-cell count stratum.

Two prespecified subgroup analyses of the primary end point according to CD4+ T-cell count strata and level of diagnostic certainty with regard to tuberculosis (probable or confirmed) were performed and are reported here. A post hoc subgroup analysis of the primary end point according to body-mass index (BMI) and a post hoc analysis of mortality were performed; the BMI results are reported here. These analyses were tested in the same manner as that described above. Unstratified log-rank, Fisher’s exact, Pearson chi-square, and Wilcoxon tests were used to assess between-group differences in secondary end points.

An NIAID data and safety monitoring board monitored the trial annually. Prespecified interim reviews of efficacy were performed by means of the O’Brien–Fleming method with a Lan–DeMets spending function. Two efficacy analyses were presented to the data and safety monitoring board. With adjustment for these analyses, a P value of less than 0.05 for the primary end point was considered to indicate statistical significance. Confidence intervals for the primary end point were similarly adjusted.

RESULTS

Patients

From September 2006 through August 2009, a total of 809 patients were enrolled (Fig. 1) at 26 clinical-research sites in four continents (Table 1). Three patients who were medically ineligible were removed from the study and excluded from the analysis. The median baseline CD4+ T-cell count was 77 per cubic millimeter (interquartile range, 36 to 145); 46% of patients had confirmed tuberculosis. Among 120 patients who underwent baseline testing for susceptibility to tuberculosis drugs, 8 had isoniazid resistance, 5 had multidrug-resistant tuberculosis, and 3 had single-drug resistance to rifampin, pyrazinamide, or ethambutol. A total of 94% of the patients received trimethoprim–sulfamethoxazole prophylaxis.

Primary End Point

There were 26 new AIDS-defining illnesses and 26 deaths in the earlier-ART group and 37 new AIDS-defining illnesses and 27 deaths in the later-ART group (Table 2), with no significant difference between the groups with respect to the rates of this combined outcome (12.9% vs. 16.1%; 95% confidence interval [CI], –1.8 to 8.1; P = 0.45, stratified according to the screening CD4+ T-cell count). In a prespecified subgroup analysis of the primary end point, among patients with CD4+ T-cell counts of less than 50 per cubic millimeter, the rate of new AIDS-defining illness or death was significantly lower in the earlier-ART...
group than in the later-ART group (15.5% vs.
26.6%; 95% CI, 1.5 to 20.5; P = 0.02); there was
no significant difference between the groups
among patients with CD4+ T-cell counts of 50 or
more per cubic millimeter (P = 0.67). There was
no interaction between the CD4+ T-cell count
stratum and treatment group (P = 0.13). When
the analysis was performed within subgroups
defined according to confirmed or probable tu-
berculosis, there were no significant differences
between the treatment groups (P = 0.21 and 0.35,
respectively, stratified according to the screening
CD4+ T-cell count stratum); results according to each
CD4+ T-cell count stratum within these sub-
groups were consistent with the primary result.
In patients with a baseline BMI (the weight in
kilograms divided by the square of the height in
meters) of 18.5 or less, there were fewer events
in the earlier-ART group than in the later-ART
group (P = 0.06, stratified according to the CD4+
T-cell count). This result was largely driven by
the significant reduction in the primary end
point among patients in the lower stratum of
the CD4+ T-cell count who received earlier ART
(15.2%, vs. 38.2% among patients in the same
stratum who received later ART; 95% CI, 8.0 to
37.8; P = 0.003).

The most common AIDS-defining illnesses
were extrapulmonary cryptococcal disease, esopha-
geal candidiasis, and Kaposi’s sarcoma (see Ta-
ble 7 in the Supplementary Appendix, available
at NEJM.org). Overall, there were 31 deaths in
the earlier-ART group and 37 deaths in the later-
ART group. A total of 21 of 31 deaths (68%) in
the earlier-ART group and 21 of 37 deaths (57%) in the later-ART group were attributed to HIV-related disease, including progression of tuberculosis. Of these 42 deaths, 21 were attributed to HIV-related diseases other than tuberculosis, including bacterial infection or sepsis (in 10 patients), cryptococcal meningitis (in 5 patients), cytomegalovirus disease (in 2 patients), M. avium complex (in 2 patients), toxoplasmosis (in 1 patient), and lymphoma (in 1 patient). Among the 21 deaths attributed to tuberculosis, there were 14 in the earlier-ART group and 7 in the later-ART group (P = 0.18). Thirteen of these deaths were ascribed to pulmonary tuberculosis, and 8 deaths were ascribed to extrapulmonary tuberculosis, including 4 cases of reported tuberculosis affecting the central nervous system.

In a sensitivity analysis that also included 23 patients with a single episode of bacterial pneumonia as the primary end point, the between-group difference in the rate of the primary end point remained nonsignificant (14.6% in the earlier-ART group and 19.7% in the later-ART group; 95% CI, −0.2 to 10.4; P = 0.14, stratified...
according to the CD4+ T-cell count). However, the between-group difference among patients with a CD4+ T-cell count of less than 50 per cubic millimeter was significant (16.2% vs. 31.0%; 95% CI, 4.9 to 24.6; P = 0.003).

HIV RNA and Immune Response to ART
Suppression of plasma HIV RNA to less than 400 copies per milliliter was achieved in 95% of the 663 patients for whom data were available at the end of 48 weeks (Table 3). Overall, the rate of viral suppression at the end of 48 weeks was 74% (596 of 806 patients), with no significant difference between the treatment groups (P = 0.38). In 35 patients, the definition of virologic failure was met, with no significant between-group difference. The median change in the CD4+ T-cell count at the end of 48 weeks was 156 per cubic millimeter in 666 patients and did not differ significantly between the groups (P = 0.46).

Tuberculosis-Associated IRIS
A total of 62 of the 806 patients (8%) met the criteria for tuberculosis-associated IRIS: 43 patients in the earlier-ART group (11%) and 19 in the later-ART group (5%) (P = 0.002) at a median of 4.6 and 11.7 weeks from the start of tuberculosis treatment, respectively (P < 0.001). The median time from the start of antiretroviral therapy to the development of tuberculosis-associated IRIS was 21 days (interquartile range, 10 to 59) in the earlier-ART group and 15 days (interquartile range, 7 to 23) in the later-ART group. Four of the IRIS cases in the later-ART group developed before the initiation of antiretroviral therapy. The proportion of patients with grade 3 or 4 adverse events attributed to tuberculosis-associated IRIS was 40% in the earlier-ART group and 47% in the later-ART group (P = 0.80). The median time to resolution of symptoms was 75 days in the earlier-ART group versus 69 days in the later-ART group. Prednisone was used in 29 of the 62 patients for a median duration of 15 days. There were no deaths attributed to tuberculosis-associated IRIS among the patients who were classified as having tuberculosis-associated IRIS.

Adverse Events
Grade 3 or 4 toxic effects were reported in 18% of patients and were similar in the two study groups (Table 4). Constitutional symptoms, including fever and weight loss, were the most common grade 3 or 4 events, occurring in 8% of patients. Grade 3 or 4 laboratory abnormalities were reported in 46% of patients and were similar in the two study groups; the notable exceptions were neutropenia (in 36 patients in the earlier-ART group vs. 69 patients in the later-ART group, P = 0.001) and thrombocytopenia (3 vs. 13 patients, P = 0.01). Twenty-one of 783 patients (14

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Table 2. Rates of New AIDS-Defining Illness or Death at 48 Weeks, According to CD4+ T-Cell Count.

<table>
<thead>
<tr>
<th>Study Population and CD4+ T-Cell Count</th>
<th>No. of Patients</th>
<th>AIDS or Death</th>
<th>95% CI for Difference in Proportions</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>806</td>
<td>12.9</td>
<td>16.1</td>
<td>0.45*</td>
</tr>
<tr>
<td>&lt;50 cells/mm³</td>
<td>285</td>
<td>15.5</td>
<td>26.6</td>
<td>0.02</td>
</tr>
<tr>
<td>≥50 cells/mm³</td>
<td>521</td>
<td>11.5</td>
<td>10.3</td>
<td>0.67</td>
</tr>
<tr>
<td>Confirmed tuberculosis at study entry</td>
<td>374</td>
<td>13.8</td>
<td>19.7</td>
<td>0.21*</td>
</tr>
<tr>
<td>&lt;50 cells/mm³</td>
<td>151</td>
<td>17.9</td>
<td>31.4</td>
<td>0.06</td>
</tr>
<tr>
<td>≥50 cells/mm³</td>
<td>223</td>
<td>10.8</td>
<td>12.1</td>
<td>0.77</td>
</tr>
<tr>
<td>Suspected tuberculosis at study entry</td>
<td>432</td>
<td>15.4</td>
<td>19.7</td>
<td>0.35*</td>
</tr>
<tr>
<td>&lt;50 cells/mm³</td>
<td>134</td>
<td>14.1</td>
<td>30.5</td>
<td>0.02</td>
</tr>
<tr>
<td>≥50 cells/mm³</td>
<td>298</td>
<td>15.9</td>
<td>14.5</td>
<td>0.75</td>
</tr>
<tr>
<td>Low BMI (≤18.5) at study entry</td>
<td>332</td>
<td>16.3</td>
<td>26.5</td>
<td>0.06*</td>
</tr>
<tr>
<td>&lt;50 cells/mm³</td>
<td>130</td>
<td>15.2</td>
<td>38.2</td>
<td>0.003</td>
</tr>
<tr>
<td>≥50 cells/mm³</td>
<td>202</td>
<td>16.9</td>
<td>17.8</td>
<td>0.88</td>
</tr>
</tbody>
</table>

* This P value was stratified according to the screening CD4+ T-cell count (<50 or ≥50 per cubic millimeter).
in the earlier-ART group and 7 in the later-ART group) who started ART switched regimens. A total of 56% of patients completed tuberculosis treatment without a modification or an interruption in the regimen, with no significant difference between the groups.

**DISCUSSION**

Our study showed that ART can be safely administered soon after the initiation of tuberculosis treatment and that the urgency of starting ART earlier after the initiation of tuberculosis therapy depends on the immune status of the patient. Among patients with CD4+ T-cell counts below 50 per cubic millimeter, new AIDS-defining illnesses and deaths were reduced by 11.1 percentage points, from 26.6% to 15.5%, in the group of patients who started ART 2 weeks after the initiation of tuberculosis treatment, a 41.7% reduction as compared with those who started 8 to 12 weeks after the initiation of tuberculosis therapy. That this short delay in the initiation of ART in patients with low CD4+ T-cell counts would have such an effect on the rate of new AIDS-defining illnesses and death highlights the vulnerability of immunosuppressed patients with tuberculosis to these complications and the remarkable capacity of ART to abrogate them rapidly.

Our study showed that among patients with CD4+ T-cell counts of 50 per cubic millimeter or higher, waiting 8 to 12 weeks after the initiation of tuberculosis therapy to start ART did not confer any increase in the risk of a new AIDS-defining illness or death and was associated with fewer cases of IRIS. For several reasons, including the risk of tuberculosis-associated IRIS, this brief delay in starting ART may simplify the management of tuberculosis, although there were cases of IRIS in the later-ART group. Our findings should not be interpreted as indicating that there is no urgency in starting ART in this group of patients; indeed, delaying ART until after completion of tuberculosis therapy was associated with increased mortality in an earlier randomized study.²

The results of this trial complement and extend findings from concurrent randomized studies of ART involving HIV-1-infected persons with tuberculosis. Elsewhere in this issue of the Journal, Blanc et al.¹³ report on the results of the Cambodian Early versus Late Introduction of Antiretrovirals (CAMELIA) study (ClinicalTrials.gov number, NCT00226434). The rate of death in the CAMELIA study (median baseline CD4+ T-cell count, 25 per cubic millimeter [interquartile range, 10 to 56]) and the rates of death or AIDS-defining illness among patients with a low CD4+ T-cell count (<50 per cubic millimeter) in our study and in the Starting Antiretroviral Therapy at Three Points in Tuberculosis (ClinicalTrials.gov number, NCT00398996) study, reported on by Abdool Karim et al.¹⁴ in this issue of the Journal, were all significantly reduced with earlier versus later ART. Our inclusion of patients from four continents and cases of either confirmed or probable tuberculosis also extends the generalizability of prior studies.
Clinicians are often hesitant to initiate ART because of potential drug toxicity and laboratory abnormalities that may occur when ART and tuberculosis therapy are started at approximately the same time. Overall, there was no significant difference in these events between the strategies of earlier and later ART. The frequency of neutropenia and of thrombocytopenia was higher in the later-ART group than in the earlier-ART group. Although the explanation for this difference is probably multifactorial, earlier ART may have had a more rapid effect in reversing the bone marrow suppression that is characteristic of untreated HIV disease.

The rate of tuberculosis-associated IRIS was higher in the earlier-ART group than in the later-ART group. Although the explanation for this difference is probably multifactorial, earlier ART may have had a more rapid effect in reversing the bone marrow suppression that is characteristic of untreated HIV disease. The frequency of neutropenia and of thrombocytopenia was higher in the later-ART group than in the earlier-ART group. Although the explanation for this difference is probably multifactorial, earlier ART may have had a more rapid effect in reversing the bone marrow suppression that is characteristic of untreated HIV disease.

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strategy study involving patients with AIDS conditions other than tuberculosis.\textsuperscript{16}

Patients with known drug-resistant tuberculosis were ineligible for our study; thus, our results may not be applicable to this population.\textsuperscript{17} In addition, our study does not provide definitive guidance for the care of patients with tuberculosis-associated meningitis, in whom IRIS can lead to inflammation in the central nervous system. A recent randomized study of adults with tuberculosis-associated meningitis in Vietnam showed very high mortality in both treatment groups and no benefit of earlier versus later ART.\textsuperscript{18} These exceptions notwithstanding, our study shows that it is feasible and safe to start ART within 2 weeks after the initiation of tuberculosis treatment and that for patients with CD4+ T-cell counts of less than 50 per cubic millimeter, this timing of treatment significantly reduces morbidity and mortality.

Applying the findings of this study to the clinical setting will require a concerted and coordinated effort on the part of tuberculosis and HIV programs worldwide. Prompt HIV testing in patients with tuberculosis is critical for the application of our findings.\textsuperscript{19} Although progress is visible on this front, less than half of patients in sub-Saharan Africa who presented to tuberculosis-control programs in 2008 underwent HIV testing.\textsuperscript{5} Implementation of these findings also means that ART must be available at the tuberculosis clinic or there must be a seamless and prompt referral of patients from the tuberculosis clinic to an HIV clinic for rapid initiation of ART.\textsuperscript{20,21} The time requirements for counseling regarding adherence to HIV and ART before the initiation of ART will need to be balanced with the substantial risk of illness and death associated with delayed treatment. Training for identification and treatment of tuberculosis-associated IRIS may need to be increased. Implementation studies that identify barriers to adaptation of the clinical practice of earlier ART for patients with low CD4+ T-cell counts and newly diagnosed tuberculosis are warranted.

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Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

Table 4. Grade 3 or 4 Clinical Events or Laboratory Abnormalities.\textsuperscript{5}

<table>
<thead>
<tr>
<th>Event</th>
<th>Earlier ART (N = 405)</th>
<th>Later ART (N = 401)</th>
<th>Total (N = 806)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>31 (8)</td>
<td>31 (8)</td>
<td>62 (8)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>17 (4)</td>
<td>16 (4)</td>
<td>33 (4)</td>
</tr>
<tr>
<td>Cardiac or circulatory</td>
<td>11 (3)</td>
<td>7 (2)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>17 (4)</td>
<td>20 (5)</td>
<td>37 (5)</td>
</tr>
<tr>
<td>Cutaneous</td>
<td>11 (3)</td>
<td>11 (3)</td>
<td>22 (3)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>22 (5)</td>
<td>28 (7)</td>
<td>50 (6)</td>
</tr>
<tr>
<td>Laboratory abnormality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolute neutrophil count &lt;750/mm\textsuperscript{3}†</td>
<td>36 (9)</td>
<td>69 (17)</td>
<td>105 (13)</td>
</tr>
<tr>
<td>Hemoglobin &lt;7.5 g/dl</td>
<td>28 (7)</td>
<td>22 (5)</td>
<td>50 (6)</td>
</tr>
<tr>
<td>Platelet count &lt;50,000/mm\textsuperscript{3}‡</td>
<td>3 (1)</td>
<td>13 (3)</td>
<td>16 (2)</td>
</tr>
<tr>
<td>Aminotransferase &gt;5× ULN§</td>
<td>26 (6)</td>
<td>41 (10)</td>
<td>67 (8)</td>
</tr>
<tr>
<td>Creatinine &gt;1.9× ULN‡</td>
<td>12 (3)</td>
<td>7 (2)</td>
<td>19 (2)</td>
</tr>
<tr>
<td>Any laboratory abnormality</td>
<td>65 (16)</td>
<td>55 (14)</td>
<td>120 (15)</td>
</tr>
<tr>
<td>Any grade 3 or 4 adverse event</td>
<td>177 (44)</td>
<td>190 (47)</td>
<td>367 (46)</td>
</tr>
</tbody>
</table>

\begin{itemize}
\item ULN denotes upper limit of the normal range.
\item † P = 0.001.
\item ‡ P = 0.01.
\item § Patients with elevations of aspartate aminotransferase, alanine aminotransferase, or both were included in this category.
\end{itemize}
We thank the study participants; the site principal investigators and staff for their exceptional efforts to conduct the study, to coordinate efforts with the in-country tuberculosis-control programs, and to help build the capacity of integrated HIV-tuberculosis services; Constance Benson, M.D., for her pivotal contributions and ACTG leadership; the data managers, Carol Suckow, B.S.N., and Lynne Jones, B.S., D.A.I.D.S.; the protocol pharmacist, Ana Martinez, R.Ph.; the protocol pharmacist, Francesca Awecka, Pharm.D.; the field representatives, Janet Nicotera, R.N., B.S.N.; the laboratory technologist, Patty Anthony, B.S., C.L.S.; the laboratory-data coordinator, Travis Behm, B.S.; and the community representative, Marthe Tholanah Mensah-King.

APPENDIX

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