



Tuberculosis

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Tuberculosis remains the leading cause of death from an infectious disease among adults worldwide, with more than 10 million people becoming newly sick from tuberculosis each year. Advances in diagnosis, including the use of rapid molecular testing and whole-genome sequencing in both sputum and non-sputum samples, could change this situation. Although little has changed in the treatment of drug-susceptible tuberculosis, data on increased efficacy with new and repurposed drugs have led WHO to recommend all-oral therapy for drug-resistant tuberculosis for the first time ever in 2018. Studies have shown that shorter latent tuberculosis prevention regimens containing rifampicin or rifapentine are as effective as longer, isoniazid-based regimens, and there is a promising vaccine candidate to prevent the progression of infection to the disease. But new tools alone are not sufficient. Advances must be made in providing high-quality, people-centred care for tuberculosis. Renewed political will, coupled with improved access to quality care, could relegate the morbidity, mortality, and stigma long associated with tuberculosis, to the past.

Introduction

Tuberculosis—the leading cause of death worldwide from an infectious disease among adults—has been considered a global public health emergency for the past 25 years.¹ Although public health approaches to tuberculosis have saved tens of millions of lives, modest progress has been made to control (let alone to end) tuberculosis. Drug-resistant forms of tuberculosis are currently on course to be the world's deadliest pathogens, responsible for a quarter of deaths due to antimicrobial resistance.² Great ambition and radical action are needed to tackle this completely curable pathogen, which remains one of the greatest health problems in the world.

The global tuberculosis situation is dire, but now is also a time of great promise and discovery for the disease. Numerous advances have been made in our understanding of the epidemiology, risk factors, and pathophysiology of tuberculosis, and new diagnostics and treatment for all forms of tuberculosis infection and disease are appearing on the horizon. Access to these innovations remains a substantial challenge for the majority of people living with the disease, but if the political will that seems to be building in the tuberculosis community and beyond³ is put into action, with a focus on the rights of people affected by the disease, the next decade might finally see the devastation caused by this age-old disease start to abate.

Search strategy and selection criteria

We searched the Cochrane library, PubMed, and Ovid for items published between Jan 1, 1946, and Nov 21, 2018. We used the search terms “tuberculosis” in combination with “epidemiology”, “pathophysiology”, “risks”, “diagnosis”, “test”, “treatment”, “prevention”, “vaccine”, “infection”, “quality”, “political will”, “patient-centered”, “person-centered”, “drug-resistant”, “drugs”, “access”, and “prognosis”. We prioritised research published since 2014, but we also included other papers of substantial clinical impact.

Epidemiology, pathogenesis, and risk factors

Tuberculosis continues to cause considerable morbidity and mortality globally. According to WHO,⁴ an estimated 10 million people became newly sick with tuberculosis in 2017; 8·7 million (87%) of these individuals reside in 30 high-burden countries. Among these 10 million individuals, only 6·4 million were diagnosed and officially notified. 1·3 million people are estimated to die from tuberculosis each year.

Tuberculosis is a disease of poverty. Although most high-income countries have estimated tuberculosis incidences of less than ten per 100 000 population per year, the 30 high tuberculosis burden countries (which are predominantly low-income and middle-income countries) have an estimated collective tuberculosis incidence of 183 per 100 000 population per year, with the incidence being above 400 per 100 000 population per year in eight countries.⁴ Within countries, the tuberculosis burden is also primarily borne by the poorest people.⁵

Global tuberculosis incidence is estimated to be slowly declining by 1·6% per year, far from the 4–5% estimated to be required to reach WHO's End TB Strategy targets⁶ By contrast, mortality is declining more rapidly at 4·1% per year. Global Burden of Diseases, Injuries, and Risk Factors⁷ data for tuberculosis (1990–2016) show that if current trends in incidence continue, few countries are likely to meet the UN Sustainable Development Goals' target to end the epidemic by 2030.

In many settings, drug-resistant tuberculosis is also a major threat to tuberculosis control efforts. Each year, more than half a million people become sick with rifampicin-resistant forms of tuberculosis, but in 2017, only 160 684 people were diagnosed or notified, and only 139 114 were started on treatment.⁴ Modelling suggests that, in the absence of rapid diagnosis and specific treatment for rifampicin-resistant tuberculosis, tuberculosis incidence will continue to increase.^{8–10} Currently, prevalence of rifampicin-resistant tuberculosis is increasing in several key countries including Russia, Myanmar, China, and South Africa.¹¹

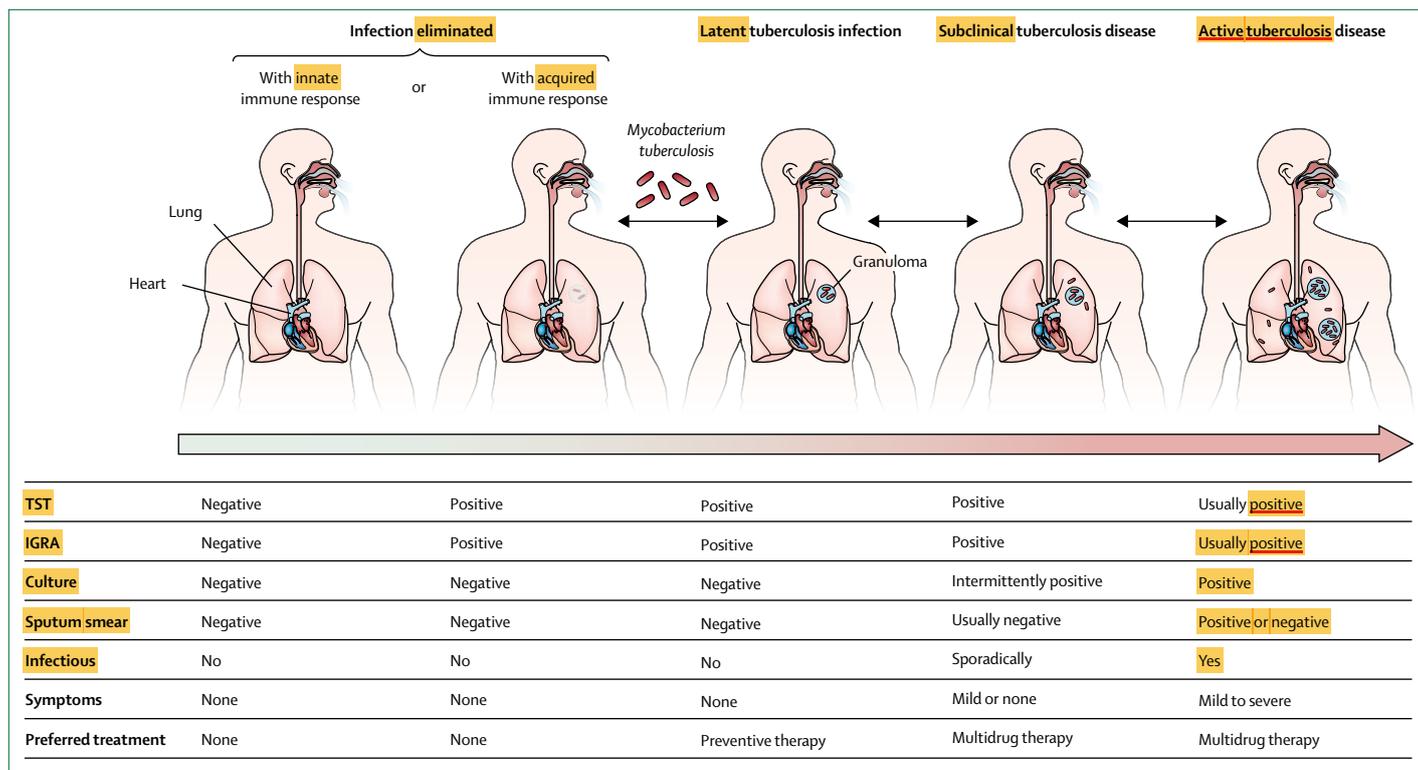


Figure 1: Spectrum of tuberculosis infection and disease.

Reproduced from Pai et al,¹⁴ by permission of Springer Nature. IGRA=interferon- γ release assay. TST=tuberculin skin test.

Mycobacterium tuberculosis and humans have coexisted for thousands of years.¹² Although 1.7 billion people globally are estimated to be infected with *M tuberculosis*, only some of these people will go on to develop active tuberculosis.¹³ Our understanding of the pathophysiology of tuberculosis continues to evolve, and there is growing acceptance that, beyond the classical model of distinct latent and active forms of tuberculosis disease, the complex bacterial and host dynamics result in the pathology of tuberculosis disease falling on a spectrum (figure 1).¹⁵

On an individual basis, immunity to tuberculosis also appears to fluctuate over time, even within a single human host.¹⁶ In a recent study, immune responses found within individual granulomas suggest that local immune responses at the site of infection are as important in controlling tuberculosis infection as systemic immunity.¹⁷ Data also show that some individuals exposed to tuberculosis do not become infected, whereas others rapidly succumb to infection and disease even, with minimal exposure.¹⁸

In terms of tuberculosis drug resistance, data suggest that many people who present with drug-resistant tuberculosis are infected with drug-resistant strains.¹⁹ Other data show that non-adherence to the prescribed antibiotic drug regimen might have a lesser role in the development of drug resistance than other causes of acquired drug resistance, including inefficient serum drug

concentrations, drug gradients in pulmonary tissue, and the presence of drug efflux pumps at the surface of bacteria.²⁰ Additionally, new analyses of older data also show the time course of progression from infection to disease. Although there has long been a shared belief within the scientific community that people newly infected with *M tuberculosis* have the highest risk of progression to disease within the first several years after infection, analysis of historical data has confirmed that the incubation of *M tuberculosis* is probably shorter than previously thought: around 24 months.²¹ This finding suggests that identifying recently exposed individuals (eg, close contacts) at high risk of progression, and offering them preventive therapy, might be an effective strategy to prevent progression to disease. Some biomarkers show promise for identifying individuals at highest risk of progression.²²

A substantial amount of work has looked at how pathogen and host factors, including local immune responses and disease tolerance, can explain the pathogenesis and risk factors for developing tuberculosis disease, but important work has also been done on socioeconomic risk factors that might be just as predictive of who becomes infected with, and sick from, tuberculosis. People from low socioeconomic-status populations are known to be at high risk of becoming sick from tuberculosis,²³ and in low-burden tuberculosis countries, substantial declines in tuberculosis morbidity

and mortality have occurred as a result of improvement in overall living conditions.²⁴ A seminal study done in Peruvian shanty towns found that some modifiable socioeconomic risk factors, including indoor air pollution, living in a house with a low number of windows per room, and socioeconomic position of the household, can be powerful predictors of tuberculosis infection and disease.²⁵ Furthermore, people who have had one episode of tuberculosis are at increased risk of developing tuberculosis again, further exacerbating the vicious cycle of poverty and tuberculosis.²⁶ Addressing socioeconomic factors, including smoking and indoor air pollution, could be just as important as addressing host and pathogen factors in easing the global burden of tuberculosis. A controlled human infection model to improve the understanding tuberculosis infection is an unmet need in the field.

Diagnosis

Although multiple advances have been made in the diagnosis of tuberculosis, no reliable, simple, point-of-care test exists to definitively diagnose the disease. Clinicians often seek bacteriological diagnosis, but this evidence is also supplemented by clinical findings, radiological evidence, and tests for bacterial products that indicate the presence of *M tuberculosis*. WHO currently endorses a range of diagnostic and drug susceptibility tests (appendix).

New developments exist for the use of radiological screening for and diagnosis of tuberculosis, and interest in this area is increasing. Digital chest x-rays with computer-aided detection of tuberculosis have been increasingly used in various settings, including prisons, among household contacts, and for people who have worked in the mining sector.²⁷ Although research is required to refine the use of computer-aided detection, chest x-ray appears to be making a comeback as a triage test, and this assessment method is now recommended by WHO for screening and diagnosis of tuberculosis in some populations.²⁸

Tuberculosis bacteria shed multiple proteins and byproducts when they replicate in the human host, and one of these substances, lipoarabinomannan (LAM), forms the basis of the urinary LAM test, the use of which has been associated with a mortality reduction for tuberculosis.²⁹ The test has the advantages of being administered at the point of care and making use of an easily obtained specimen type (urine). Although initial evidence for the clinical utility of urinary LAM testing was disappointing (showing a low degree of sensitivity),³⁰ a clear mortality benefit is shown when used in hospitalised people with HIV and a CD4 count of less than 200 cells per μL .³¹ In 2018, a study found the test not only to be associated with a higher rate of case detection and a lower rate of mortality, but also to be cost-effective.³² The existing urinary LAM test is currently recommended for all patients who have HIV and a CD4 count of less than

100 cells per μL , are seriously ill, and are hospitalised.³³ Higher sensitivity LAM assays have been developed and show great promise for rapid tuberculosis diagnosis, even among people without HIV, including children and those in the outpatient setting.^{34,35}

Developments continue in the field of tuberculosis biomarkers, with multiple promising candidates identified for risk of infection, risk of disease, likelihood of cure, and disease protection.³⁶ Most of these biomarkers are associated with host immunity and include proteins, metabolites, cell markers, and signals of transcription.³⁷ Although numerous reports of correlation with different phases of tuberculosis have been reported, most notably in children,³⁸ to date, no predictive biomarker signatures are close to commercialisation and no clinically useful biomarker tests are available on the market.

In terms of bacteriological testing, our understanding of the bacterium itself also needs to be improved, including understanding factors that affect its growth and virulence.³⁹ Most advances have been in the area of molecular testing both for the presence of *M tuberculosis* and for drug resistance. The Xpert MTB/RIF test (Cepheid, CA, USA), which can detect genetic material from *M tuberculosis* along with mutations that cause resistance to rifampicin, remains the genotypic diagnostic test of choice. Although access to this form of testing remains restricted, time-trend analyses show increasing market penetration in many high-burden countries.^{40,41} A more sensitive version of the assay, called Xpert MTB/RIF Ultra, has been developed. The new test, which has a sensitivity for *M tuberculosis* detection similar to culture assays (which are known to be highly sensitive), but the advantages of requiring fewer resources and yielding faster results, has been endorsed by WHO and is being used in South Africa; however, this test does have a lower specificity for detection of *M tuberculosis*, and so interpretation of so-called trace-positive results remains a challenge. An expanded version of the Xpert cartridge, called Xpert XDR, which allows for detection of resistance to isoniazid, injectable agents, and fluoroquinolones was also shown to be effective in a large validation study,⁴² and is expected to become commercially available in 2019. There have been some breakthroughs in sample collection and processing to allow for broader use of these Xpert MTB/RIF tests in paediatric populations, including the use of stool samples.⁴³ In terms of hardware used for these tests, in 2015, Cepheid had announced a novel, portable, battery-operated, point-of-care version of their GeneXpert system. However, the release of this technology, called GeneXpert Omni, has been repeatedly pushed back because of technical challenges. Meanwhile, in July, 2018, Cepheid announced the launch of the GeneXpert Edge, a portable, single-module, near-patient technology that can be used in decentralised settings. Cartridges available for use on the Edge include Xpert MTB/RIF, Xpert MTB/RIF Ultra, and Xpert HIV-1 Qual assays.

See Online for appendix

Other genotypic tests based on nucleic acid amplification are being developed, and some are commercially available for centralised laboratories, including RealTime MTB (Abbott, IL, USA), FluoroType MTBDR (Hain Lifescience, Nehren, Germany), and BD MAX MDR-TB (Beckton, Dickinson and Company, NJ, USA), whereas the chip-based Truenat MTB (Molbio Diagnostics, Goa, India) is designed for microscopy centres.⁴⁴ Line probe assays, which can detect drug resistance to isoniazid, rifampicin, injectable agents, and fluoroquinolones, are also available and WHO-endorsed, but require additional laboratory capacity.⁴⁵

Whole-genome sequencing is becoming an increasingly appealing option for detection of drug resistance in *M tuberculosis* and can also be used to improve the understanding of tuberculosis transmission.⁴⁶ This technology relies on identifying mutations in the *M tuberculosis* genome that are associated with phenotypic drug resistance, and data show a correlation between the genetic mutations and culture-based drug susceptibility results, at least for the four first-line drugs (isoniazid, rifampicin, ethambutol, and pyrazinamide).⁴⁷ As technology enables sequencing directly from specimens and more genotypic or phenotypic correlations are confirmed, whole-genome sequencing is likely to become the preferred method for tuberculosis drug-resistance testing in the next decade,⁴⁸ especially given its potential use in outbreak investigations.⁴⁹

For the diagnosis of latent tuberculosis infection, two main immune-based approaches are currently used and included in WHO guidelines:⁵⁰ the tuberculin skin test (TST) and the interferon- γ release assay (IGRA). Although the IGRA has higher specificity than the TST, neither test can accurately differentiate between latent tuberculosis infection and active tuberculosis. Both tests have low sensitivity in a variety of immunocompromised populations. Cohort studies have shown that both TST and IGRA tests have low predictive value for progression from infection to active tuberculosis.⁵¹ Therefore, testing only people at risk of progression and use of all clinical data, in addition to test results, is important. User-friendly calculators, such as the Online TST/IGRA Interpreter, are available to assist with evaluation of results. C-Tb (Statens Serum Institut, Copenhagen, Denmark), a skin test that is based on the more *M tuberculosis*-specific ESAT-6 and CFP10 antigens, has a similar safety profile to the TST, and accuracy similar to IGRAs in phase 3 clinical trials in adults and children.^{52,53}

Whatever sampling and testing techniques are used, a more active approach to finding people with tuberculosis is essential. Active case finding (as opposed to waiting for people to present to the health system with signs and symptoms of tuberculosis) involves systematic efforts to seek out people who might have the disease.⁵⁴ Although a detailed review of active case finding is beyond the scope of this Seminar, multiple strategies are involved, usually focused on high-risk groups, such as household

contacts, people living with HIV, and people living in congregate settings. Strategies include systematic screening, community-based activities, and deployment of novel screening and diagnostic technologies.⁵⁵ A 2017 randomised controlled trial of different tuberculosis diagnostic tools used during intensified case finding, for example, found that when coupled with active mobile van screening services, the Xpert MTB/RIF resulted in an increased proportion of people being started on treatment for tuberculosis.⁵⁶

Treatment

The treatment landscape for tuberculosis has changed dramatically over the past 5 years, with the introduction of two new drugs, bedaquiline and delamanid, and multiple clinical trials whose results are being used to radically alter the care of people with all forms of tuberculosis.⁵⁷ More tuberculosis treatment studies are happening than ever before in the history of the disease, and not only will these studies help improve the care of people living with tuberculosis, but they should also help show aspects of tuberculosis pathophysiology that can be used to develop better, targeted therapies for people with tuberculosis.

To date, no major changes in treatment of drug-susceptible tuberculosis have been made. For pan-susceptible tuberculosis, treatment still consists of four drugs (isoniazid, rifampicin, pyrazinamide, and ethambutol) given for a total of 2 months followed by two drugs (isoniazid and rifampicin) given for an additional 4 months. Data from a 2014 study show that a so-called hard-to-treat phenotype, defined by high smear grades and cavitation, can require durations of more than 6 months to achieve cure.⁵⁸ Studies have shown that daily administration of therapy results in improved treatment outcomes compared with thrice-weekly treatment, and WHO recommends all people diagnosed with tuberculosis be offered daily treatment with fixed-dose combinations.⁵⁹ Of note, studies show that some combination tablets can result in subtherapeutic concentrations of certain key drugs (especially rifampicin)⁶⁰ but the clinical implications of this occurrence are not entirely clear.

Therapeutic advances in the treatment of drug-susceptible tuberculosis have focused on two areas: high-dose rifampicin and the addition or substitution of fluoroquinolones in the regimen. Although high-dose rifampicin shows early promise for treatment-shortening,^{61–65} randomised controlled trials with the fluoroquinolones did not show a treatment-shortening benefit.^{66–69} Multiple studies to assess shorter tuberculosis treatment regimens are ongoing, including regimens containing rifapentine, clofazimine, and the novel drugs bedaquiline and PA-824, also known as pretomanid (an experimental nitroimidazole agent for drug-resistant tuberculosis).⁷⁰

Isoniazid-resistant forms of tuberculosis are the most common forms of drug-resistant tuberculosis in the

For more on the Online TST/IGRA Interpreter see <http://www.tstin3d.com>

	Class and mechanism of action	Phase completed and regulatory approval	Summary of findings	Adverse events	Drug–drug interactions and overlapping toxicities	Access and pricing ⁷⁵	Ongoing trials ⁷⁶
Bedaquiline ^{77–79}	Diarylquinoline; inhibits mycobacterial ATP synthase	Phase 2b US FDA, EMA, SAHPRA, multiple other countries	Significantly faster time to culture conversion; significantly higher culture conversion; significantly improved treatment outcomes when compared with placebo	QTc prolongation (moderate), hepatitis	Cannot use with efavirenz; use with protease inhibitors results in increased bedaquiline concentration but clinical significance not clear; cannot use with rifampicin; caution when used with other QTc prolonging agents	Available to <20% of individuals that need it; US\$400 for a 6-month course via GDF	endTB (NCT02754765), TB PRACTECAL (NCT02589782), NiX-TB (NCT02333799), STREAM 2 (NCT02409290), NeXT (NCT02454205), ZeNix (NCT03086486), Janssen C211 (NCT02354014), ACTG 5343 (NCT02583048), Janssen Japan Trial (NCT02365623), SimpliciTB (NCT03338621), P11018 (NCT02906007)
Delamanid ^{80–85}	Nitroimidazole; inhibits mycolic acid synthesis	Phase 3 EMA, Japanese Regulatory Authority	Faster time to culture conversion compared with placebo; no differences in final outcomes but study did not have statistical power for detection	QTc prolongation (mild), generally well tolerated	No clinically significant drug–drug interactions	Available to <5% of individuals that need it; \$1700 for a 6-month course from GDF	endTB, MDR-END (NCT02619994), ACTG 5453, Otsuka 213 (NCT01424670), Otsuka 233 (NCT01859923), Otsuka 232 (NCT01856634), IMPAACT 2005 (NCT03141060)
Pretomanid ^{86–88}	Nitroimidazole; inhibits mycolic acid synthesis, generates mycobacterial nitrogen oxide	Phase 2b; currently undergoing regulatory review	Has only been tested in combination regimens and not as a single agent	Hepatitis, animal studies show ocular and reproductive toxic events	No clinically significant drug–drug interactions	Not available	SimpliciTB, NiX-TB, TB PRACTECAL, ZeNix
Linezolid ^{89–111}	Oxazolidinone; inhibits mycobacterial protein synthesis	Phase 2b, phase 3 (non-placebo controlled); no registered indication for tuberculosis	Improved outcomes (in delayed-start trial and non-placebo controlled trials), significantly higher rates of culture conversion, and faster times to culture conversion in people who received linezolid at the start of treatment compared with those who had a delayed start	Toxic effects on bone marrow, peripheral neuritis, optic neuritis	Caution when used in patients on zidovudine due to overlapping toxic effects on bone marrow; caution when given with other drugs that are associated with peripheral neuropathy (eg, isoniazid); use with caution when given with other drugs associated with optic neuritis or neuropathy (eg, ethambutol)	\$1.30 per tablet from GDF	endTB, NiX-TB, TB PRACTECAL, ZeNix, NeXT, MDR-END, MDR-PK2 (NCT02619994)
Sutezolid ^{93–94}	Oxazolidinone; inhibits mycobacterial protein synthesis	Phase 2a	Significant 14-day early bactericidal activity	No severe adverse events reported in 14-day early bactericidal activity trial	Not available	Not available	Obtained by the Medicines Patent Pool for further testing
Clofazimine ^{95–96}	Inhibits mycobacterial DNA synthesis, increases activity of mycobacterial phospholipase A2	Phase 3 (non-placebo controlled)	Improved treatment outcomes, significantly faster time to culture conversion, and higher rates of culture conversion compared with people that did not receive clofazimine	Skin discoloration, QTc prolongation	Caution when used with other QTc prolonging agents	\$1.00 per tablet from GDF	endTB, STREAM 2, TB PRACTECAL
Carbapenems (imipenem-cilastatin, meropenem) ⁹⁷	β-lactams; inhibit mycobacterial cell wall synthesis	Phase 2a	Significant 14-day early bactericidal activity	Seizures, rash, hepatitis	Cannot use with penicillin allergy; must be given with clavulanic acid to be effective in tuberculosis; must be given intravenously	\$3.10 for one 500 mg vial of imipenem; \$0.14 for one 125 mg tablet of clavulanic acid (only available in combination with 875 mg amoxicillin)	None known

FDA=Food and Drug Administration. EMA=European Medicines Agency. SAHPRA=South African Health Products Regulatory Authority. GDF=Global Drug Facility.

Table 1: Summary of new and repurposed drugs for treating rifampicin-resistant tuberculosis

world,⁷¹ although no data-driven guidelines exist on when to systematically test people for isoniazid-resistant tuberculosis. With the roll-out of molecular tests, isoniazid-resistant tuberculosis is likely to be more commonly diagnosed in the coming years. No formal trials have been done to guide therapy, but a 2017 meta-analysis found that although there was great heterogeneity in treatment practice, with more than 55 regimens used, regimens containing fluoroquinolones resulted in improved outcomes.⁷² WHO has recommended that fluoroquinolones be given to people with isoniazid-resistant tuberculosis, but also note the need for formal clinical studies to assess the optimal therapy for this form of tuberculosis.⁷³ Rifampicin monoresistant tuberculosis (with retained susceptibility to isoniazid) is increasingly documented, and this strain might constitute an important population of patients with monoresistant tuberculosis in the future.⁷⁴ Since treatment recommendations are the same as for those with multidrug-resistant tuberculosis (although this situation could change in the future), the treatment of these two entities will be considered together in this Seminar.

The treatment of rifampicin-resistant tuberculosis has substantially changed with the introduction of bedaquiline and delamanid, and with increasing use of repurposed agents such as linezolid and clofazimine. For the first time, WHO has recommended all-oral therapy for a majority of people with rifampicin-resistant tuberculosis, and regimens of 9–12 months' duration (compared with the standard 18–24 months of therapy) are also being rolled out for the treatment of rifampicin-resistant tuberculosis. These therapeutic advances have already been shown to greatly improve the treatment of rifampicin-resistant tuberculosis. Ongoing trials aim to assess new and repurposed drugs for the treatment of rifampicin-resistant tuberculosis (table 1).

Bedaquiline was first recommended by WHO in 2013,⁹⁸ and was recommended again in 2017.⁹⁹ While phase 3 studies of bedaquiline are pending, widespread experience with the drug has accumulated via compassionate use and observational cohort studies.^{101–103} A majority of these have shown treatment success exceeding 75%, notable since most people who received bedaquiline early in the course of its use were patients with highly resistant tuberculosis and few therapeutic treatment options.¹⁰⁴ The largest cohorts of patients to receive bedaquiline are from South Africa, where high treatment success and reduced mortality have been reported among people receiving the drug.¹⁰⁵ Although QTc prolongation was seen in patients receiving bedaquiline, few patients required discontinuation of the medication.¹⁰⁶ These results led the South African Government to commit to providing bedaquiline for all people with rifampicin-resistant tuberculosis in the country.¹⁰⁷ A 2018 case-control study done in South Africa compared the treatment outcomes of people who received bedaquiline instead of injectable agents and

found that the patients who received bedaquiline had higher treatment success compared with those who received injectable agents, and a delay in bedaquiline initiation was significantly associated with mortality.¹⁰⁸ Use of bedaquiline was also found to be cost-effective when compared with injectable drug-based therapy.¹⁰⁹

Although bedaquiline was only administered for 24 weeks in these clinical trials (in part to reach trial endpoints more quickly), many patients on bedaquiline will have few therapeutic options and will require bedaquiline for longer periods.¹¹⁰ A study done in France found that people who received bedaquiline for prolonged periods had no additional safety problems.¹¹¹

Bedaquiline is now recommended by WHO as a core drug in the treatment of rifampicin-resistant tuberculosis and it is part of the newly recommended all-oral regimens.¹¹² Bedaquiline is also a component of most regimens being tested in rifampicin-resistant tuberculosis clinical trials and is likely to remain part of the rifampicin-resistant tuberculosis treatment option for some time. The drug is also being tested in drug-susceptible tuberculosis as part of the SimpliciTB trial (NCT03338621) being run by Tuberculosis Alliance (known as TB Alliance).

Access to bedaquiline has remained a major global problem with fewer than 20% of those in need of the drug being able to access it.¹¹³ A joint donation programme funded by Janssen Pharmaceutica (Beerse, Belgium) and the US Agency for International Development has allowed for 60 000 courses of bedaquiline to be provided free of charge, but current pricing of bedaquiline (US\$400 for a 6-month course of treatment) means it will be unobtainable by most people and programmes.¹¹⁴ Global advocates are calling for a price no higher than \$1 per day for bedaquiline treatment, given that most of the drug's development was through tax-payer funded studies.¹¹⁵ Given the prominent role of bedaquiline in the treatment of rifampicin-resistant tuberculosis access, ensuring access through affordability will be an important step in fighting this strain.¹¹⁶

The second novel drug to be both conditionally approved by stringent regulatory authorities and recommended by WHO in 2014 for the treatment of tuberculosis is delamanid.¹¹⁷ A phase 3 trial done with delamanid when the drug was added to a multidrug backbone regimen for 24 weeks compared with the addition of placebo found that the reduction in median time to sputum culture conversion over 6 months was not significant in the primary analysis (although significance was achieved when alternative methods for handling missing cultures were used).¹¹⁸ Delamanid has been shown to be safe and effective in short-term pharmacokinetic studies in children aged 2 years and older,^{119,120} and the treatment is recommended by WHO as the drug of choice for treating children younger than 6 years with rifampicin-resistant tuberculosis.¹²¹ Thus, few observational cohort studies exist that include people who have been treated with delamanid. Those studies that have been done support the

efficacy and safety of delamanid,^{122,123} and data increasingly show that delamanid can be safely given in combination with bedaquiline. This combination had been discouraged in the early days of delamanid's approval, given a potential concern about additive or synergistic QTc prolongation if the two drugs were combined. In a cohort study of individuals requiring both bedaquiline and delamanid for the treatment of highly resistant forms of rifampicin-resistant tuberculosis, no individuals had an absolute QTc interval (corrected by use of the Fridericia formula) greater than 500 msec.¹²⁴

Another medication in the nitroimidazole class that has been developed further in the past 5 years is pretomanid.¹²⁵ This chemical entity has been in development for more than a decade and has been advanced as a component of treatment regimens in several clinical trials.⁸⁶ Concerns were raised about the safety of pretomanid after a study using the medication in combination with moxifloxacin and pyrazinamide resulted in fulminant hepatitis in a series of participants with pan-susceptible disease.⁸⁷ The drug continues to be assessed in trials in both drug-susceptible and drug-resistant tuberculosis; these include the SimpliciTb trial and, perhaps the most promising, the NiX-Tb trial (NCT02333799),⁸⁸ which is sponsored by TB Alliance. In this single arm study, people with extensively drug-resistant tuberculosis were given a 6-month to 9-month regimen of high-dose linezolid (1200 mg daily), bedaquiline, and pretomanid. Of the 75 participants with results, 89% achieved cure and have been followed for at least 12 months for relapse.⁶⁹ High rates of linezolid toxicity have been reported with this regimen, and ongoing studies (eg, clinical trial NCT03086486) are assessing dose optimisation of this drug. If confirmed, the results of this trial could substantially transform the treatment of rifampicin-resistant tuberculosis. Pretomanid has not been used outside of clinical trials and TB Alliance has submitted a new drug application to the US Food and Drug Administration for regulatory approval. No head-to-head comparisons between delamanid and pretomanid have been made.

Various other novel chemical entities are in development for tuberculosis,¹²⁶ including benzothiazone agents, decaprenylphosphoryl-beta-D-ribose oxidase (also known as DprE1) inhibitors and mycobacterial respiratory chain inhibitors such as telacebec (previously Q203; Qurient, Seongnam, South Korea), and imidazopyridines.¹²⁷ Although in the early stages of development, these drugs could offer additional treatment options in a field where few therapeutics exist. The process for drug development in tuberculosis, however, is anaemic and hampered by a dearth of funding, a long trialling process, regulatory delays, and a seeming difficulty for countries to roll out new drugs even when their efficacies have been established.¹²⁸

In addition to new medications for the treatment of tuberculosis, interest in repurposed drugs is increasing.

Chief among these drugs is linezolid, an oxazolidinone antibiotic that has been shown to be effective in two randomised trials among people with tuberculosis,^{89,90} and which is a regimen component of multiple ongoing and planned clinical trials.⁹¹ The safety of linezolid is a concern as the drug has been associated with bone marrow suppression, optic neuritis, and peripheral neuropathy;⁹² however, studies are ongoing to find strategies to reduce these toxic effects, including alternate-day dosing and discontinuation of the medication after 2–3 months of therapy. Other oxazolidinones have been tested for use in tuberculosis treatment with sutezolid (Sequella; Rockville, MD, USA) showing some promise in an early study.⁹³ Testing of this drug has been delayed but it has now been acquired by the Medicines Patent Pool and might proceed into phase 2b trials.⁹⁴

Another repurposed agent, clofazimine, has been shown to be effective against rifampicin-resistant tuberculosis in a randomised, non-placebo controlled trial done in China.⁹⁵ The study suggested that the drug might be especially effective against mycobacteria that are not actively replicating. Clofazimine is currently being studied in clinical trials for both treatment of rifampicin-resistant tuberculosis and for shortening of treatment for drug-susceptible tuberculosis, however QTc prolongation and skin pigmentation are primary safety concerns.⁹⁶

In 2018, a large meta-analysis, which included patient data from more than 12 500 individuals, was done to assess the role of individual drugs in the treatment of rifampicin-resistant tuberculosis.²⁹ Although the limitations of meta-analyses (eg, population heterogeneity, absence of formal control groups, and incomplete data sets) should be kept in mind when interpreting their findings, this study had multiple unexpected outcomes. Commonly used agents, such as kanamycin, capreomycin, pyrazinamide, ethionamide, and para-aminosalicylic acid, were found to be associated with worse treatment outcomes, even when used in people with susceptibility to these medications, suggesting that the toxicity of these agents might be worse than previously thought. Capreomycin was associated with higher mortality. Regimens containing bedaquiline, linezolid, or the third generation fluoroquinolones were associated with improved treatment outcomes and lower mortality than regimens that did not contain one or more of these medications. In addition, the drugs clofazimine and cycloserine were found to be associated with improved treatment outcomes. The data also showed no benefit to administering drugs to which the individual had documented resistance and thus called into question the common practice of treating rifampicin-resistant tuberculosis with multiple agents without a strong evidence-base.

This individual patient data meta-analysis formed the basis of evidence that was used by WHO in July, 2018, to issue new treatment recommendations for rifampicin-resistant tuberculosis.¹³⁰ WHO recommends that the majority of individuals are treated with all oral regimens

that include the drugs bedaquiline, linezolid, a third generation fluoroquinolone, clofazimine, and cycloserine (table 2).¹³⁰ In essence, these recommendations challenged the therapeutic hierarchy at the time, and called for the up-front use of medications such as bedaquiline, linezolid, and clofazimine (which had previously been relegated for use only in salvage situations) and called for the commonly used agents (such as the injectables, ethionamide, and pyrazinamide) to be used only in cases when other therapeutic options were not available. For the first time ever, all-oral regimens are now recommended for the majority of people living with rifampicin-resistant tuberculosis. Even the definitions that were previously used to define the highly resistant forms of tuberculosis, known as extensively drug-resistant and pre-extensively drug-resistant, are irrelevant given that the injectable drugs are no longer core agents in the treatment of drug-resistant tuberculosis.¹³¹

In addition to regimens including more effective drugs, a substantial amount of clinical research has found that shorter regimens can be used for the treatment of rifampicin-resistant tuberculosis. A 9–12 month regimen, often known as the Bangladesh regimen (since its effectiveness was first shown in the country)¹³² has been shown to be effective among carefully selected patients in numerous observational cohort studies.^{133,134} A phase 3 trial (STREAM 1; ISRCTN78372190) of the Bangladesh regimen, which contains kanamycin, isoniazid (high dose), pyrazinamide, ethambutol, moxifloxacin (high dose), clofazimine, and ethionamide, found that overall outcomes were non-inferior to a longer 18–24 month regimen.^{135,136} However, although the shorter treatment course had lower loss to follow-up, this regimen also had a higher prevalence of failed treatment, relapse, and death. WHO recommended this regimen in 2016,¹³⁷ and has maintained the recommendation in their 2018 guidance, although the organisation now notes that the shorter regimen should not be given to people with resistance to any drug in the regimen (except isoniazid) and that outcomes might be worse than with administration of bedaquiline, linezolid, or both. The continued use of the injectable agents in the shorter regimen is problematic given the high amounts of hearing loss reported with this class of drugs.¹³⁸ An ongoing trial called STREAM 2 (NCT02409290) is assessing a regimen with bedaquiline replacing the injectable agents, and results are expected in 2022.

Multiple ongoing trials exist that look at shorter, all oral regimens for the treatment of rifampicin-resistant tuberculosis (appendix). Given the long time period it takes to recruit, enrol, treat, and follow-up people in this type of trial, it could be years before these results are available.¹³⁹

Although treatment for tuberculosis is currently selected on the basis of drug susceptibility alone, growing evidence suggests that disease severity should be more broadly considered in therapeutic determinations. This situation is

	Drugs	Comments
Group A	Levofloxacin or moxifloxacin; bedaquiline; linezolid	Include all three medicines (unless they cannot be used)
Group B	Clofazimine; cycloserine or terizidone	Add both medicines (unless they cannot be used)
Group C	Ethambutol; delamanid; pyrazinamide; imipenem-cilastatin or meropenem (both must be given with clavulanic acid); amikacin or streptomycin; ethionamide or prothionamide; para-aminosalicylic acid	Add to complete a four-drug to five-drug regimen and when medicines from groups A and B cannot be used

Table 2: 2018 WHO grouping of medications for second-line drug-resistant tuberculosis¹³⁰

already the standard in the management of paediatric rifampicin-resistant tuberculosis, where children with non-severe disease are treated for 9–12 months,¹⁴⁰ and forms drug-susceptible extrapulmonary tuberculosis (including meningitis and osteoarticular disease), which are treated for prolonged 12-month durations. Multiple components of tuberculosis treatment regimens that are considered fixed, including the number of drugs used and the duration of therapy, could possibly be altered on the basis of the extent of disease. Data show that cavitory disease and smear-positivity at 2 months predict relapse,¹⁴¹ and similar results have been found in people with drug-resistant tuberculosis.¹⁴² Patients with these indicators will probably require longer treatment than those without such clinical features. Treatment choice should take into account considerations for special populations (including children, adolescents, and people living with HIV, diabetes, or other comorbidities), the use of adjunctive therapies, and long-term effects (appendix).

Support for successful outcomes

Adherence support aimed at ensuring successful tuberculosis treatment has historically relied on the use of directly observed therapy (DOT). The use of DOT has shown mixed results in multiple studies and meta-analyses, largely because the term appears to be a catch-all phrase for radically different treatment support approaches. When coupled with emotional support, nutritional supplementation, and other types of enablers, DOT can be a way to ensure daily contact with vulnerable individuals and close monitoring for the development of adverse events.¹⁴³ At the other end of the spectrum, DOT can add a substantial burden to the lives of people living with tuberculosis (eg, patients are required to collect their treatment from a facility each day),^{144,145} which could increase the loss to follow-up. Data show that self-administered treatment, even among people with rifampicin-resistant tuberculosis results in similar outcomes.¹⁴⁶ Nowadays self-administered treatment can be enhanced by digital tools that could improve adherence (eg, phone-based and smartphone-based technologies or digital pillboxes). Although published data are scarce, several studies are ongoing.¹⁴⁷

The first pillar of WHO's End TB Strategy is patient-centred care;¹⁴⁸ however, although the term is often used,

	Description	Examples
Holistic care	Care that sees the patient as a whole and addresses multiple individual needs	Effective and integrated care of comorbidities such as diabetes, HIV, and harmful substance use ¹⁵²
Individualised care	Care that reflects each patient's needs, preferences, and concerns	The provision of individualised treatment for rifampicin-resistant tuberculosis based on detailed drug susceptibility testing ¹⁵³
Empowering care	Care that recognises patients as active consumers	Mechanisms for supporting self-administration of treatment ¹⁵⁴
Respectful care	Care that encourages informed decision making and self-determination	Patient choice in regimen composition is based on understanding of efficacy and adverse events ¹⁵⁵

Table 3: Key attributes of patient-centred care for tuberculosis¹⁵⁶

little information is available to define what this means and advise how to deliver it. Ideally, this term should mean that services and support for individuals affected by tuberculosis should be focused on them and their needs as opposed to the needs of the health system.¹⁴⁹ Such care would include socioeconomic support, and new data now show that conditional cash transfer programmes (where people are given a monthly spend during their treatment) for people with tuberculosis are associated with a decreased risk of mortality.¹⁵⁰ This finding is not surprising given that people living with tuberculosis often face catastrophic costs, and providing tuberculosis services as part of universal health coverage is likely to be the best way to decrease the cost and impact of this disease on people's lives.¹⁵¹ To truly provide patient-centred care (table 3), or what some advocates refer to as person-centred care, the tuberculosis community needs to embrace a human rights framework in the treatment of tuberculosis.¹⁵⁷ Patient-centred care should also focus on mental health care, pain relief, and the principles of palliative care for tuberculosis (appendix).

All services provided to people with tuberculosis, from the time of presentation with initial symptoms to the time of discharge with non-relapsing cure, must be of the highest quality possible. Unfortunately, much work is to be done in terms of quality of care. Studies from India and South Africa published in the past 2 years show large gaps in the cascade of care for tuberculosis and multidrug-resistant tuberculosis.^{158,159} Simulated patient studies among tuberculosis care providers in India, Kenya, China, and South Africa show that a wide spectrum exists in the quality of services offered to people with tuberculosis, with many receiving suboptimal services.^{160–162} Thus, improving quality of tuberculosis care must be a key consideration for achieving better outcomes and will require system-wide action to develop high-quality health systems.¹⁶³

Prevention

Prevention efforts have focused on tuberculosis vaccination and the treatment of latent tuberculosis or tuberculosis infection. Immunisation with the BCG vaccine is known to protect children from severe and disseminated forms of disease, decrease infection by 30%, and potentially offer some protection to adult

populations.¹⁶⁴ In general, the vaccine is not thought to be immunogenic enough to induce long-term immunity, although some studies show that intrapulmonary administration might be more immunogenic and development of an inhaled BCG vaccine could be an important strategy to pursue.¹⁶⁵ A 2018 phase 2b study of a novel vaccine candidate known as M72/AS01_E (GlaxoSmithKline, London, UK) was found to provide more than 50% protection from progression to active tuberculosis among adults with tuberculosis infection and could be a candidate to advance into larger studies.¹⁶⁶

In the past few years, major advances in the treatment of tuberculosis infection have occurred. Substantially shorter tuberculosis prevention regimens have been developed, and have been shown to be effective in both adults and children, including those living with HIV. Such regimens, including a 4-month regimen of rifampicin was tested in both adults and children and found to be as effective as 9 months of daily isoniazid.¹⁶⁷ This regimen has the added benefit of using a drug with well established dosing and safety data available from populations of all ages,¹⁶⁸ and which can be used with almost all forms of antiretroviral therapy within known dose-adjustment parameters. However, concerns about the development of drug resistance when using a single drug in patients with undiagnosed active tuberculosis disease remain.

Other shorter regimens for the treatment of tuberculosis infection have focused on the use of rifapentine. The 12-week regimen of high-dose isoniazid given with high-dose rifapentine once a week has now been shown to be safe, and dosing has been established in children as young as 2 years.¹⁶⁹ Preliminary data suggest that a 1-month regimen of daily isoniazid and rifapentine might be as effective as 9 months of daily isoniazid in the treatment of tuberculosis infection among adults living with HIV.¹⁷⁰ Both of these regimens include the drug rifapentine, and although there were initial concerns about using this drug with the antiretroviral agent dolutegravir,¹⁷¹ data presented on the combination of dolutegravir and rifapentine co-administration in people living with HIV (NCT03435146)¹⁷² found no grade 3–4 events, suggesting that the combination is safe in people with HIV. Additionally, there is concern that these shorter, rifapentine-based regimens might not confer sufficient protection among people with HIV living in high-tuberculosis settings, and studies on annual cycled courses are now underway.¹⁷³ Both of these rifapentine-based regimens could substantially shorten treatment for people who have been infected with tuberculosis. WHO recommends that one of four regimens be used for the treatment of tuberculosis infection: daily isoniazid for 6 to 9 months, daily rifampicin for 4 months, daily isoniazid and rifampicin for 3 months, or weekly isoniazid and rifapentine for 12 weeks (appendix).

People who have been exposed to rifampicin-resistant tuberculosis previously had few options to treat

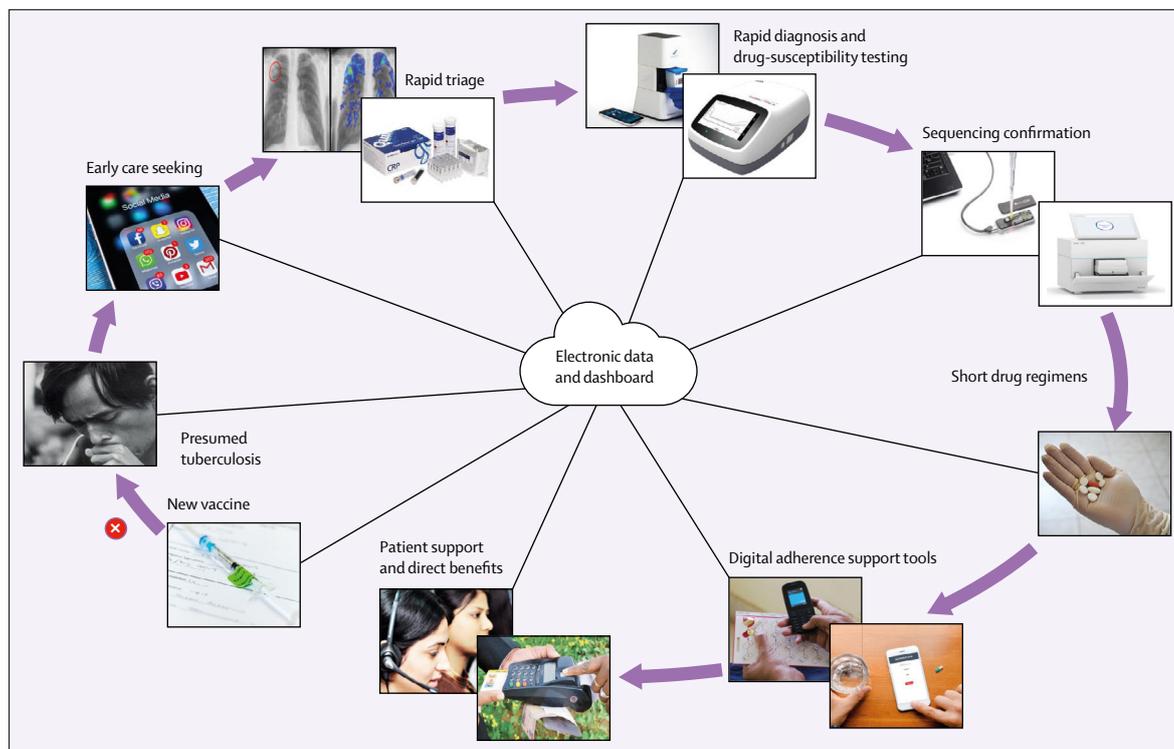


Figure 2: Schematic for a modern tuberculosis care delivery system
Reproduced from Pai.¹⁷⁶

their infection. Individualised regimens with multiple drugs based largely on fluoroquinolone were only available in selected settings. However, a meta-analysis of such preventive therapy found a 90% reduction in the risk of development of tuberculosis among contacts that were provided with such treatment. Furthermore, use of fluoroquinolone-based preventive therapy was also found to be cost-effective.³⁰ These findings led to WHO recommending the treatment of drug-resistant forms of tuberculosis infection with regimens selected on the basis of the drug-susceptibility pattern of the known contact.¹⁷⁴ Three studies (V-QUIN [ACTRN12616000215426], TB CHAMP [NCT02365623], and PHOENIX [NCT03568383]) are either ongoing or planned to formally assess treatment of drug-resistant tuberculosis infection with treatment regimens including either levofloxacin or delamanid. The results of these studies are expected in 3–5 years. In the meantime, however, given the poor outcomes of people who become sick with drug-resistant forms of tuberculosis, the benefit of such treatment is likely to outweigh the risks in most situations.

How to modernise tuberculosis care

For too long, tuberculosis care has relied on antiquated tools that are no longer fit for purpose. This can and must change.¹⁷⁵ As described in this Seminar, many new tools and solutions already exist in some form (figure 2); however, these developments have not come

together to serve those who need them the most. For some improvements to be made, such as the development of a better vaccine or a shorter drug therapy, new investments are urgently needed. High-quality systems for data management need to be established and maintained for national and international monitoring, resource allocation, and accurate problem solving.¹⁷⁷

Political will to end tuberculosis

On Sept 26, 2018, a UN meeting focused on tuberculosis was held in New York, NY, USA.¹⁷⁸ The pledges made by multiple, high-level delegations, including heads of state from high burden tuberculosis countries, such as South Africa, could herald a new level of political commitment in the fight against tuberculosis. Although similar meetings held to discuss HIV and Ebola led to substantial increases in funding for research and treatment, the effects of the UN tuberculosis meeting are not yet apparent. New global accountability systems are badly needed to ensure that “ending tuberculosis” does not become yet another slogan tied to limited action of little benefit for those most affected by tuberculosis.¹⁷⁸

Conclusions

Although tuberculosis continues to be one of the most important public health problems of the 21st century, clinical and scientific advances exist that stand to

revolutionise the diagnosis, treatment, and prevention of all forms of this disease. Access to these diagnostic and therapeutic advances must be guaranteed for all as part of a human rights-based approach to tuberculosis. The political will to eliminate tuberculosis is stronger than ever; this intention must be matched with unparalleled implementation efforts to spare millions of men, women, and children from the unnecessary burden of this disease.

Contributors

JF led the conception of this Seminar. All authors contributed to literature review and writing.

Declaration of interests

HC reports grants from the Wellcome Trust, the National Research Foundation, and the UK Medical Research Council, outside of the submitted work. MP serves on the Access Advisory Committee of TB Alliance, New York, NY, USA, and on the Scientific Advisory Committee of the Foundation for Innovative New Diagnostics, Geneva, Switzerland; these non-profit agencies were not involved in the preparation of this manuscript. JF declares no competing interests.

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