Adult meningitis in areas of high HIV prevalence in southern Africa is most commonly caused by Cryptococcus neoformans.1 Short-term mortality in the antiretroviral therapy (ART) era varies widely, depending on treatment modalities and resources.2 Little is known about the longer-term prognosis in Africa, which would probably be an indicator of general effectiveness of the health system in managing complex HIV-associated conditions. Optimal management of cryptococcal meningitis (CM) involves induction therapy with amphotericin B ± flucytosine, acute management of elevated cerebrospinal fluid (CSF) pressure, consolidation therapy with fluconazole, initiation of ART, and linkage to long-term outpatient care.2 We explored outcomes 2 years after an episode of cryptococcal meningitis in a rural area of South Africa.

Methods
Hlabisa Hospital is a 296-bed district hospital that, with 17 primary health care (PHC) clinics, serves 228 000 people in northern KwaZulu-Natal. The Hlabisa HIV Treatment & Care Programme delivers ART at the hospital and all PHC clinics. This retrospective case series included all adult individuals (≥16 years) with a laboratory diagnosis of CM from January - December 2007 at Hlabisa Hospital – a district hospital in northern KwaZulu-Natal. From 104 individuals, 140 positive CSF CRAG tests were identified; 74 (71.2%) with complete hospital records were included. Median age was 35 years (IQR 16 - 86). The 74 patients most commonly presented with: headache (82.4%), fever (37.8%), vomiting (35.1%), and reduced conscious level (33.8%). Sixty-seven (90.5%) of the 74 samples were positive on India ink examination; median CSF white blood cell (WBC) count was 49 cells/μl (IQR 4 - 56), and 22 (29.7%) had a WBC count <5/ml. Only 26 patients (35.1%) received amphotericin B, and only 6 received at least 14 days. Repeat therapeutic lumbar puncture was uncommon, documented in only 11 patients (14.9%).

Inpatient mortality was 40.5% (30/74), all deaths occurring within 30 days of admission. The inpatient mortality rate was 2.99 per 100 person-days (95% CI 2.09 - 4.28). Allowing for age, sex, CSF WBC count, amphotericin B treatment, CD4 cell count and ART, inpatient mortality was significantly associated with reduced conscious level at presentation (aHR 3.09, 95% CI 1.30 - 7.33) and with the presence of headache (aHR 0.33, 95% CI 0.13 - 0.87).

Conclusions
Long-term outcomes of CM are poor in routine practice. Interventions to strengthen linkage to HIV treatment and care and continuation of secondary fluconazole prophylaxis are critical.

Results
From 104 individuals, 140 positive CSF CRAG tests were identified; 74 (71.2%) with complete hospital records were included. Median age was 35 years (IQR 16 - 86). The 74 patients most commonly presented with: headache (82.4%), fever (37.8%), vomiting (35.1%), and reduced conscious level (33.8%). Sixty-seven (90.5%) of the 74 samples were positive on India ink examination; median CSF white blood cell (WBC) count was 20 cells/ml (IQR 4 - 56), and 22 (29.7%) had a WBC count <5/ml. Only 26 patients (35.1%) received amphotericin B, and only 6 received at least 14 days. Repeat therapeutic lumbar puncture was uncommon, documented in only 11 patients (14.9%).

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Forty-four patients survived to hospital discharge. Thirty-five of these (35/44) (79.5%) were confirmed HIV-infected by time of discharge (2 were counselled but refused testing; for 7 there was no documentation of counselling and testing). On discharge, all 44 were prescribed fluconazole, of whom 12 (27.3%) also received ART (5 on ART at admission; 7 initiated ART during admission). Fig. 1 illustrates events following hospital discharge; 6 patients were re-admitted with cryptococcal meningitis, of whom 3 died in hospital. Only 9/44 (20.5%) collected further fluconazole after the consolidation phase, and 9/32 (28.1%) discharged on fluconazole episode and follow-up to 31 December 2009. Kaplan-Meier survival analysis and Cox regression were used to analyse inpatient mortality and associations with baseline clinical and laboratory features. To assess bias introduced by exclusion of individuals without hospital case records, characteristics of included and excluded patients were compared using the chi-squared (categorical variables) and Wilcoxon rank-sum tests (continuous variables). Ethical approval was received from the Hlabisa Hospital Ethics Committee.
alone subsequently initiated ART. Only 8 (10.8% of all subjects, 95% CI 8.7 - 12.8) were alive and receiving ART 2 years after the CM episode. For the 10 confirmed deaths post-discharge, the median time to death was 133 days (IQR 43 - 230).

There was no evidence that included patients (N=74) differed from those excluded (N=30) in terms of sex (p=0.73), age (p=0.13), CSF protein (p=0.35), CSF glucose (p=0.31) or CSF lymphocyte count (p=0.26).

Discussion:

These data from routine practice in a rural health district show poor long-term outcomes and highlight the challenges faced by overburdened health services in delivering comprehensive HIV care in high-prevalence settings. The short-term mortality is comparable with data from similar settings, but higher than reports from clinical trials or tertiary hospitals. About 1 in 10 of our patients were known to be alive on ART at 2 years, compared with: 60% at 12 months in a clinical trial in Cape Town; 40.9% at 12 months in a cohort in Uganda; 36.7% at 6 months in a Ugandan clinical trial, and 27% at 3 years in a trial in Zimbabwe. Inpatient mortality was associated with more severe disease (reduced conscious level and absence of headache), as also suggested in a neighbouring hospital associated with more severe disease (reduced conscious level and 27% at 3 years in a trial in Zimbabwe. Inpatient mortality was uncommon, mainly owing to drug supply problems, in accordance with national-level data showing short-term mortality, although we could not confirm this. Amphotericin B treatment was uncommon, possibly owing to patient refusals, health care worker uncertainty about consent for confused or unconscious patients, or inadequate provision of counselling and testing services. The most striking finding was the high rate of loss to follow-up after hospital discharge; almost half were not seen again, which suggests poor linkage between hospital inpatient services and PHC clinics providing ongoing HIV care and treatment. Continuation of fluconazole after the consolidation phase was also uncommon, similar to other findings in South Africa.14,15 While some patients might have accessed fluconazole and ART elsewhere, the majority probably died.

There are limitations to this analysis, including those inherent in retrospective investigations. Retrieval of hospital records was incomplete, although we found no evidence that bias was introduced by excluding those without case records. Our numbers were too small to explore factors associated with long-term survival. Since this study, aspects of care have been improved: improved supply of amphotericin B, clear protocols for managing CSF pressure, enhanced HIV counselling and testing service for inpatients, and better linkage systems between hospital and PHC clinics. However, numerous challenges remain with the increasing numbers of CM cases in South Africa. Practical, implementable local care pathways, that encompass acute management and early post-discharge community support and enhanced clinical follow-up, must be developed and evaluated. By strengthening health systems, we can realise the full benefits from the scale-up of comprehensive HIV treatment and care.

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