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Clinical epidemiology of infections in immunocompromised hosts

Prevention of toxoplasmosis in transplant patients: a European survey

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Background: Toxoplasmosis is a life-threatening disease in immunocompromised patients. Its prevention is well-codified in HIV-infected patients, but guidelines in transplant patients differ according to regulations and health care policies of countries. This study aimed to review prevention practices in Europe for hematopoietic stem cell (HSC) or solid organ transplant (SOT) patients.

Material/methods: A survey was conducted through the ESGCP and the ESGICH study groups. Participants were asked to answer a questionnaire collecting the following items: annual number of transplantations, implementation of a national prevention program with serologic screening of donors and recipients (HSC, heart, kidney, liver transplant recipients), chemoprophylaxis and scheme, if any, special guidelines in case of mismatch (organ from *Toxoplasma*-seropositive donor to seronegative recipient).

Results: Overall, 37 centres from 11 countries (France, Germany, Greece, Italy, Romania, Serbia, Slovakia, Spain, Switzerland, Turkey, United Kingdom) participated to the survey. The mean annual number of allo-HSCT and auto-HSCT patients were 1016 (extreme 13-1900) and 1524 (extreme 14-3078), respectively. Regarding SOT patients, the mean annual number of heart, kidney and liver transplant patients were 198 (10-420), 1071 (55-3074) and 609 (35-1241), respectively. Five countries declared to benefit from a national reporting system of toxoplasmosis cases. Serologic screening of organ and allo-HSC donors or recipients was declared to be the rule in 100% and 80% of countries, respectively. Virtually, 20/22 and 14/22 responding centres screened allo-HSCT and auto-HSCT patients for *Toxoplasma* prior engraftment, respectively. There was no specific recommendations regarding anti-*Toxoplasma* chemoprophylaxis in HSCT patients, but allo-HSCT patients benefited from anti-*Pneumocystis* cotrimoxazole prophylaxis for at least 6 months in 68% of centres (preferred regimen 980 mgx3/week, in 60% of centres). Similarly, auto-HSCT patients received cotrimoxazole in 15/22 centres. Special attention was given to toxoplasmosis in 7/9 countries for heart transplant patients, particularly in case of mismatch, as 19/20 centres declared to give cotrimoxazole prophylaxis and 10/20 centres implemented a regular serologic follow-up. Only two countries declared to have specific recommendations regarding toxoplasmosis chemoprophylaxis in kidney or liver transplant mismatched patients, but indirect protection was again warranted in most patients, by anti-*Pneumocystis* prophylaxis which was the rule in 21/26 kidney and 14/22 liver transplant centres for 3 to 12 months (at least 6 months in 71% and 64% of centres, respectively). Cotrimoxazole regimens differed greatly among countries and centres.

Conclusions: All centres appear to perform serologic screening of organ donors and recipient, in agreement with Scientific Societies guidelines, whatever official screening policies. As a result of consensual anti-*Pneumocystis* prophylaxis, most patients receive cotrimoxazole, thus are protected against toxoplasmosis, except in case of intolerance when pentamidin aerosols are used. European guidelines could be proposed to homogenize prophylactic regimens and simplify patient management.