Treatment of nontuberculous mycobacterial pulmonary disease: an official ATS/ERS/ESCMID/IDSA clinical practice guideline

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The official ATS/ERS/ESCMID/IDSA clinical practice guidelines provide 31 evidence-based recommendations for the treatment of nontuberculous mycobacterial (NTM) pulmonary disease https://bit.ly/3fOEwlc

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ABSTRACT Nontuberculous mycobacteria (NTM) represent over 190 species and subspecies, some of which can produce disease in humans of all ages and can affect both pulmonary and extrapulmonary sites. This guideline focuses on pulmonary disease in adults (without cystic fibrosis or human immunodeficiency virus infection) caused by the most common NTM pathogens such as *Mycobacterium avium* complex, *Mycobacterium kansasii*, and *Mycobacterium xenopi* among the slowly growing NTM and *Mycobacterium abscessus* among the rapidly growing NTM. A panel of experts was carefully selected by leading international respiratory medicine and infectious diseases societies (ATS, ERS, ESCMID, IDSA) and included specialists in pulmonary medicine, infectious diseases and clinical microbiology, laboratory medicine, and patient advocacy. Systematic reviews were conducted around each of 22 PICO (Population, Intervention, Comparator, Outcome) questions and the recommendations were formulated, written, and graded using the GRADE (Grading of Recommendations Assessment, Development, and Evaluation) approach. Thirty-one evidence-based recommendations about treatment of NTM pulmonary disease are provided. This guideline is intended for use by healthcare professionals who care for patients with NTM pulmonary disease, including specialists in infectious diseases and pulmonary diseases.

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Executive summary

The American Thoracic Society (ATS), European Respiratory Society (ERS), European Society of Clinical Microbiology and Infectious Diseases (ESCMID), and Infectious Diseases Society of America (IDSA) jointly sponsored the development of this Guideline to update the treatment recommendations for nontuberculous mycobacterial (NTM) pulmonary disease in adults. NTM represent over 190 species and subspecies (http://www.bacterio.net/mycobacterium.html), many of which can produce disease in humans of all ages and can affect both pulmonary and extrapulmonary sites. Attempting to cover such a broad array of species and disease in a guideline using current guideline development methods is impossible. Therefore, this guideline focuses on pulmonary disease in adults (without cystic fibrosis or human immunodeficiency virus [HIV] infection) caused by the most common NTM pathogens comprising *Mycobacterium avium* complex (MAC), *Mycobacterium kansasii,* and *Mycobacterium xenopi* among the slowly growing NTM and *Mycobacterium abscessus* among the rapidly growing NTM. Twenty-two PICO (Population, Intervention, Comparators, Outcomes) questions and associated recommendations are included in the Guideline. A panel of experts was carefully selected and screened for conflicts of interest and included specialists in pulmonary medicine, infectious diseases and clinical microbiology, laboratory medicine, and patient advocacy. The recommendations were developed based on the evidence that was appraised using GRADE (Grading of Recommendations Assessment, Development, and Evaluation) and are summarized below [1, 2]. Recommendations were either "strong" or "conditional" (table 1), and as suggested by GRADE, the phrase "we recommend" was used for strong recommendations and "we suggest" for conditional recommendations [3].

This executive summary is a condensed version of the panel's recommendations for the 22 PICO questions. A detailed description of background, methods, evidence summary, and rationale that support each recommendation can be found online in the full text and accompanying supplementary material.

Diagnostic criteria for NTM pulmonary disease

The 2007 guideline included clinical, radiographic, and microbiologic criteria for diagnosing NTM pulmonary disease [4]. The current guideline also recommends use of these criteria to classify patients as having NTM pulmonary disease (table 2). The significance of NTM isolated from the sputum of individuals who meet the clinical and radiographic criteria in table 2 must be interpreted in the context of the number of positive cultures and specific species isolated. Because NTM can be isolated from respiratory specimens due to environmental contamination and because some patients who have an NTM isolated from their respiratory tract do not show evidence of progressive disease, >1 positive sputum culture is recommended for diagnostic purposes, and the same NTM species (or subspecies in the case of *M. abscessus*) should be isolated in ⩾2 sputum cultures. Clinically significant MAC pulmonary disease is

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TABLE 1 Interpretation of strong and conditional (weak) recommendations

	Recommendations	
	Strong	**Conditional**
Patients	• Most individuals in this situation would want the recommended course of action, and only a small proportion would not.	• The majority of individuals in this situation would want the suggested course of action, but many would not.
Clinicians	• Most individuals should receive the intervention. • Adherence to the recommendation according to the guideline could be used as a quality criterion or performance indicator. • Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.	• Recognize that different choices will be appropriate for individual patients and that you must help each patient arrive at a management decision consistent with his or her values and preferences. Decision aids may be useful in helping individuals to make decisions consistent with their values and preferences.
Policy makers	• The recommendation can be adopted as policy in most situations.	• Policy making will require substantial debate and involvement of various stakeholders.

Source: Grading of Recommendations Assessment, Development and Evaluation Working Group [1, 2].

unlikely in patients who have a single positive sputum culture during the initial evaluation [5–7] but can be as high as 98% in those with ⩾2 positive cultures [5].

The pathogenicity of NTM varies significantly from organisms like *M. gordonae*, which rarely cause disease in humans, to *M. kansasii,* which should usually be considered pathogenic [8]. For species of low pathogenicity such as *M. gordonae*, several repeated positive cultures over months, along with strong clinical and radiological evidence of disease, would be required to determine if it was causing disease, whereas a single positive culture for *M. kansasii* in the proper context may be enough evidence to initiate treatment [9]. The pathogenicity of NTM species may differ between geographic areas [9, 10].

Importantly, just because a patient meets diagnostic criteria for NTM pulmonary disease does not necessarily mean antibiotic treatment is required. A careful assessment of the pathogenicity of the organism, risks and benefits of therapy, the patient's wish and ability to receive treatment as well as the goals of therapy should be discussed with patients prior to initiating treatment. In some instances, "watchful waiting" may be the preferred course of action.

Recommendations for specific PICO questions

Twenty-two PICO questions are addressed in this Guideline resulting in 31 recommendations. For each NTM covered, the recommendations are organized by the drugs to be included in the regimen, frequency of administration, and duration of therapy.

TABLE 2 Clinical and microbiologic criteria for diagnosis of nontuberculous mycobacterial pulmonary disease[#]

Clinical	Pulmonary or systemic symptoms	***Both clinical and radiologic criteria required***
Radiologic	Nodular or cavitary opacities on chest radiograph, or a high-resolution computed tomography scan that shows bronchiectasis with multiple small nodules	
And	Appropriate exclusion of other diagnoses	
Microbiologic[¶]	1) Positive culture results from at least two separate expectorated sputum samples. If the results are nondiagnostic, consider repeat sputum AFB smears and cultures *or* 2) Positive culture results from at least one bronchial wash or lavage *or* 3) Transbronchial or other lung biopsy with mycobacterial histologic features (granulomatous inflammation or AFB) and positive culture for NTM or biopsy showing mycobacterial histologic features (granulomatous inflammation or AFB) and one or more sputum or bronchial washings that are culture positive for NTM	

Source: Official ATS/IDSA statement [4]. AFB: acid-fast bacilli; NTM: nontuberculous mycobacteria. [#]: expert consultation should be obtained when NTM are recovered that are either infrequently encountered or that usually represent environmental contamination. Patients who are suspected of having NTM pulmonary disease but do not meet the diagnostic criteria should be followed until the diagnosis is firmly established or excluded. Making the diagnosis of NTM pulmonary disease does not *per se*, necessitate the institution of therapy, which is a decision based on the potential risks and benefits of therapy for individual patients. [¶]: when 2 positive cultures are obtained, the isolates should be the same NTM species (or subspecies in the case of *M. abscessus*) in order to meet disease criteria.

Treatment of NTM pulmonary disease (Questions I–II)

Question I. Should patients with NTM pulmonary disease be treated with antimicrobial therapy or followed for evidence of progression ("watchful waiting")?

Recommendation

1) In patients who meet the diagnostic criteria for NTM pulmonary disease (table 2), we suggest initiation of treatment rather than watchful waiting, especially in the context of positive acid-fast bacilli sputum smears and/or cavitary lung disease (conditional recommendation, very low certainty in estimates of effect).

Remarks: The decision to initiate antimicrobial therapy for NTM pulmonary disease should be individualized based on a combination of clinical factors, the infecting species, and individual patient priorities. Any treatment decision should include a discussion with the patient that outlines the potential side effects of antimicrobial therapy, the uncertainties surrounding the benefits of antimicrobial therapy, and the potential for recurrence including reinfection (particularly in the setting of nodular/bronchiectatic disease) [11–13].

Question II: Should patients with NTM pulmonary disease be treated empirically or based on *in vitro* drug susceptibility test results?

Recommendations

1) In patients with MAC pulmonary disease, we suggest susceptibility-based treatment for macrolides and amikacin over empiric therapy (conditional recommendation, very low certainty in estimates of effect).
2) In patients with *M. kansasii* pulmonary disease, we suggest susceptibility-based treatment for rifampicin over empiric therapy (conditional recommendation, very low certainty in estimates of effect).
3) In patients with *M. xenopi* pulmonary disease, the panel members felt there is insufficient evidence to make a recommendation for or against susceptibility-based treatment.
4) In patients with *M. abscessus* pulmonary disease we suggest susceptibility-based treatment for macrolides and amikacin over empiric therapy (conditional recommendation, very low certainty in estimates of effect). For macrolides, a 14-day incubation and/or sequencing of the *erm*(41) gene is required in order to evaluate for potential inducible macrolide resistance.

Remark: Although *in vitro-in vivo* correlations have not yet been proven for all major antimycobacterial drugs, baseline susceptibility testing to specific drugs is recommended according to the Clinical and Laboratory Standards Institute (CLSI) guidelines [14, 15] for NTM isolates from patients with definite disease. Testing of other drugs may be useful, but there is insufficient data to make specific recommendations.

Mycobacterium avium *complex (Questions III–IX)*

Question III: Should patients with macrolide-susceptible MAC pulmonary disease be treated with a 3-drug regimen with a macrolide or without a macrolide?

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease, we recommend a 3-drug regimen that includes a macrolide over a 3-drug regimen without a macrolide (strong recommendation, very low certainty in estimates of effect).

Remarks: Although no well-designed randomized trials of macrolide therapy have been performed, macrolide susceptibility has been a consistent predictor of treatment success for pulmonary MAC [16–18]. Loss of the macrolide from the treatment regimen is associated with a markedly reduced rate of conversion of sputum cultures to negative and higher mortality [16–18]. Therefore, the panel members felt strongly that a macrolide should be included in the regimen.

Question IV: In patients with newly diagnosed macrolide-susceptible MAC pulmonary disease, should an azithromycin-based regimen or a clarithromycin-based regimen be used?

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease we suggest azithromycin-based treatment regimens rather than clarithromycin-based regimens (conditional recommendation, very low certainty in estimates of effect).

Remarks: The panel felt that azithromycin was preferred over clarithromycin because of better tolerance, less drug interactions, lower pill burden, single daily dosing, and equal efficacy. However, when azithromycin is not available or not tolerated, clarithromycin is an acceptable alternative.

Question V: Should patients with MAC pulmonary disease be treated with a parenteral amikacin or streptomycin-containing regimen or without a parenteral amikacin or streptomycin-containing regimen?

Recommendation

1) For patients with cavitary or advanced/severe bronchiectatic or macrolide-resistant MAC pulmonary disease, we suggest that parenteral amikacin or streptomycin be included in the initial treatment regimen (conditional recommendation, moderate certainty in estimates of effect).

Remarks: In the absence of comparably effective oral medications there are few options other than parenteral aminoglycosides for "intensifying" standard oral MAC therapy. The committee thought that the benefits outweighed risks in those patients with cavitary or advanced/severe bronchiectatic or macrolide-resistant MAC pulmonary disease and that administration of at least 2–3 months of an aminoglycoside was the best balance between risks and benefits.

Question VI: In patients with macrolide-susceptible MAC pulmonary disease, should a regimen with inhaled amikacin or a regimen without inhaled amikacin be used for treatment?

Recommendations

1) In patients with newly diagnosed MAC pulmonary disease, we suggest neither inhaled amikacin (parenteral formulation) nor amikacin liposome inhalation suspension (ALIS) be used as part of the initial treatment regimen (conditional recommendation, very low certainty in estimates of effect).
2) In patients with MAC pulmonary disease who have failed therapy after at least 6 months of guideline-based therapy, we recommend addition of ALIS to the treatment regimen rather than a standard oral regimen, only (strong recommendation, moderate certainty in estimates of effect).

Remarks: Randomized controlled trials have demonstrated the efficacy and safety of ALIS when added to guideline-based therapy for treatment refractory MAC pulmonary disease [19, 20]. ALIS is currently approved by the United States Federal Drug Administration for treatment of refractory MAC pulmonary disease. As noted in question 5, we suggest that parenteral amikacin or streptomycin be included in the initial treatment regimen in patients with cavitary or advanced/severe bronchiectatic or macrolide-resistant MAC pulmonary disease.

Question VII: In patients with macrolide-susceptible MAC pulmonary disease, should a 3-drug or a 2-drug macrolide-containing regimen be used for treatment?

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease, we suggest a treatment regimen with at least 3 drugs (including a macrolide and ethambutol) over a regimen with 2 drugs (a macrolide and ethambutol alone) (conditional recommendation, very low certainty in estimates of effect).

Remarks: A priority in MAC pulmonary disease therapy is preventing the development of macrolide resistance. The panel members were concerned that the currently available data [21] were insufficient to determine the risk of acquired macrolide resistance with a 2-drug regimen and therefore suggest a 3 drug macrolide-containing regimen.

Question VIII: In patients with macrolide susceptible MAC pulmonary disease, should a daily or a 3-times weekly macrolide-based regimen be used for treatment?

Recommendations

1) In patients with noncavitary nodular/bronchiectatic macrolide-susceptible MAC pulmonary disease, we suggest a 3 times per week macrolide-based regimen rather than a daily macrolide-based regimen (conditional recommendation, very low certainty in estimates of effect).
2) In patients with cavitary or severe/advanced nondular bronchiectatic macrolide-susceptible MAC pulmonary disease we suggest a daily macrolide-based regimen rather than 3 times per week macrolide-based regimen (conditional recommendation, very low certainty in estimates of effect).

Remarks: Intermittent therapy has similar sputum conversion rates as daily therapy for nodular/bronchiectatic MAC pulmonary disease and is also better tolerated than daily therapy [22, 23]. A critically important finding from the available studies is the lack of development of macrolide resistance with intermittent therapy. There is not similar evidence to justify or support intermittent therapy for cavitary MAC pulmonary disease and it is not recommended.

Question IX: In patients with macrolide-susceptible MAC pulmonary disease, should patients be treated with <12 months of treatment after culture negativity or ⩾12 months of treatment after culture negativity?

Recommendation

1) We suggest that patients with macrolide-susceptible MAC pulmonary disease receive treatment for at least 12 months after culture conversion (conditional recommendation, very low certainty in estimates of effect).

Remarks: The optimal duration of therapy for pulmonary MAC disease is not currently known. The panel felt that in the absence of evidence identifying an optimal treatment duration that the recommendation from the 2007 Guideline should be followed [4].

Mycobacterium kansasii *(Questions X–XIV)*

Question X: In patients with rifampcin-susceptible *M. kansasii* pulmonary disease, should an isoniazid-containing regimen or a macrolide-containing regimen be used for treatment?

Recommendation

1) In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, we suggest a regimen of rifampicin, ethambutol, and either isoniazid or macrolide (conditional recommendation, very low certainty in estimates of effect).

Remarks: Isoniazid is widely used at present for treatment of *M. kansasii* pulmonary disease, and in the experience of the panel members, there have been good outcomes when using a regimen consisting of rifampicin, ethambutol, and isoniazid irrespective of the result of minimal inhibitory concentrations (MICs) for isoniazid and ethambutol [24]. Based on the *in vitro* activity of macrolides against *M. kansasii*, and 2 studies that demonstrated good treatment outcomes when clarithromycin was substituted for isoniazid [25, 26], the panel suggests that either isoniazid or a macrolide can be used in combination with rifampicin and ethambutol.

Question XI: In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should parenteral amikacin or streptomycin be included in the treatment regimen?

Recommendation

1) We suggest that neither parenteral amikacin nor streptomycin be used routinely for treating patients with *M. kansasii* pulmonary disease (strong recommendation, very low certainty in estimates of effect).

Remarks: Regimens of 3 oral agents, rifampicin and ethambutol, and either isoniazid or a macrolide, achieve high rates of sustained culture conversion and treatment success in the treatment of *M. kansasii* pulmonary disease. Therefore, given the good outcomes observed with oral regimens and the high risk of adverse effects associated with parenteral amikacin or streptomycin, the committee felt strongly that the use of these parenteral agents is not warranted, unless it is impossible to use a rifampicin-based regimen or severe disease is present.

Question XII: In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

Recommendations

1) In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, we suggest using a regimen of rifampicin, ethambutol, and either isoniazid or macrolide instead of a fluoroquinolone (conditional recommendation, very low certainty in estimates of effect).
2) In patients with rifampicin-resistant *M. kansasii* or intolerance to one of the first-line antibiotics we suggest a fluoroquinolone (*e.g.* moxifloxacin) be used as part of a second-line regimen (conditional recommendation, very low certainty in estimates of effect).

Remarks: Treatment success of *M. kansasii* pulmonary disease with a rifamycin-based drug regimen is usually excellent but the optimal choice of companion drugs is not clear. While ethambutol is usually the preferred companion drug, the choice of an additional companion drug may be isoniazid, a macrolide or a fluoroquinolone. As there is more experience and better evidence for treatment regimens that include isoniazid or a macrolide as a companion drug, these drugs are preferred [25–28]. For rifampicin-resistant disease, a regimen such as ethambutol, azithromycin, and a fluoroquinolone would be likely to lead to successful treatment.

Question XIII: In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should a 3 times per week or daily treatment regimen be used?

Recommendations

1) In patients with noncavitary nodular/bronchiectatic *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol, and macrolide regimen, we suggest either daily or 3 times weekly treatment (conditional recommendation, very low certainty in estimates of effect)
2) In patients with cavitary *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol, and macrolide-based regimen, we suggest daily treatment instead of 3 times weekly treatment (conditional recommendation, very low certainty in estimates of effect).
3) In all patients with *M. kansasii* pulmonary disease treated with an isoniazid, ethambutol, and rifampicin regimen, we suggest treatment be given daily instead of 3 times weekly (conditional recommendation, very low certainty in estimates of effect).

Remarks: Because there are no randomized trials available and the small size of the single study that evaluated 3 times weekly therapy [26], the committee did not feel that they could recommend intermittent therapy in the setting of cavitary disease until more evidence was available. Similarly, there are no data to support the use of isoniazid on a 3 times weekly basis in patients with *M. kansasii* pulmonary disease.

Question XIV: In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should treatment be continued for <12 months or ⩾12 months?

Recommendation

1) We suggest that patients with rifampin susceptible *M. kansasii* pulmonary disease be treated for at least 12 months (conditional recommendation, very low certainty in estimates of effect).

Remarks: Current rifampicin-based treatment regimens are associated with a high rate of success if used for at least 12 months [27, 29]. Randomized controlled trials comparing shorter treatment regimens are currently lacking. Although some experts would favour 12 months of treatment after culture conversion, there is no evidence that relapses could be prevented with treatment courses longer than 12 months. Therefore, the panel members felt that *M. kansasii* could be treated for a fixed duration of 12 months instead of 12 months beyond culture conversion. Because sputum conversion at 4 months of rifampicin-based regimens is usually observed [29–31], expert consultation should be obtained if cultures fail to convert to negative by that time.

Mycobacterium xenopi *(Questions XV–XVIII)*

Question XV: In patients with *M. xenopi* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

Recommendation

1) In patients with *M. xenopi* pulmonary disease, we suggest using a multidrug treatment regimen that includes moxifloxacin or macrolide (conditional recommendation, low certainty in estimates of effect).

Remarks: There is *in vitro* evidence that macrolides and fluoroquinolones are active against *M. xenopi*, whereas rifampicin and ethambutol are inactive *in vitro* alone and in combinations [32]. Preliminary data from a study in France that randomized patients to receive either moxifloxacin or clarithromycin plus ethambutol and rifampicin reported no difference in the treatment success between the study arms [33].

Question XVI: In patients with *M. xenopi* pulmonary disease, should a 2-, 3-, or 4-drug regimen be used for treatment?

Recommendation

1) In patients with *M. xenopi* pulmonary disease, we suggest a daily regimen that includes at least 3 drugs: rifampicin, ethambutol, and either a macrolide and/or a fluoroquinolone (*e.g.* moxifloxacin) (conditional recommendation, very low certainty in estimates of effect).

Remarks: Given the high mortality associated with *M. xenopi* disease, the panel members felt the large risk of treatment failure with a 2-drug regimen warranted at least a 3-drug treatment regimen. However, the absence of universal access to moxifloxacin and the small amount of data for other fluoroquinolones has to be considered when choosing a regimen.

Question XVII: In patients with *M. xenopi* pulmonary disease, should parenteral amikacin or streptomycin be included in the treatment regimen?

Recommendation

1) In patients with cavitary or advanced/severe bronchiectatic *M. xenopi* pulmonary disease, we suggest adding parenteral amikacin to the treatment regimen and obtaining expert consultation (conditional recommendation, very low certainty in estimates of effect).

Remarks: Barring compelling evidence to the contrary, *M. xenopi* patients should be treated aggressively given the high mortality of the disease [34–36]. In addition to the high mortality, the committee considered the general acceptability and feasibility of parenteral therapy, and potential costs and toxicities, all based on clinical experience.

Question XVIII: In patients with *M. xenopi* pulmonary disease, should treatment be continued for <12 months or ⩾12 months after culture conversion?

Recommendation

1) In patients with *M. xenopi* pulmonary disease, we suggest that treatment be continued for at least 12 months beyond culture conversion (conditional recommendation, very low certainty in estimates of effect).

Remarks: Data suggest that treatment outcomes improve if the duration of treatment increases [35, 37]. The panel felt that this outweighs the risk of adverse events associated with longer treatment and agrees with previous recommendations [4].

Mycobacterium abscessus *(Questions XIX–XXI)*

Question XIX: In patients with *M. abscessus* pulmonary disease, should a macrolide-based regimen or a regimen without a macrolide be used for treatment?

Recommendations

1) In patients with *M. abscessus* pulmonary disease caused by strains *without* inducible or mutational resistance, we recommend a macrolide-containing multidrug treatment regimen (strong recommendation, very low certainty in estimates of effect).
2) In patients with *M. abscessus* pulmonary disease caused by strains *with* inducible or mutational macrolide resistance, we suggest a macrolide-containing regimen if the drug is being used for its immunomodulatory properties although the macrolide is not counted as an active drug in the multidrug regimen (conditional recommendation, very low certainty in estimates of effect).

Remarks: *M. abscessus* infections can be life-threatening, and the use of macrolides is potentially of great benefit. Macrolides are very active *in vitro* against *M. abscessus* strains without a functional *erm*(41) gene, and evidence supports use of macrolides in patients with disease caused by macrolide-susceptible *M. abscessus* [38, 39]. It is important to perform *in vitro* macrolide susceptibility testing including detection of a functional or nonfunctional *erm*(41) gene [40–42].

Question XX: In patients with *M. abscessus* complex pulmonary disease, how many antibiotics should be included within multidrug regimens?

Recommendation

1) In patients with *M. abscessus* pulmonary disease, we suggest a multidrug regimen that includes at least 3 active drugs (guided by *in vitro* susceptibility) in the initial phase of treatment (conditional recommendation, very low certainty in estimates of effect).

Remarks: Given the usual disease severity of *M. abscessus* pulmonary disease, the variable and limited *in vitro* drug susceptibility of these organisms, the potential for the emergence of drug resistance, and the potential for more rapid progression of *M. abscessus* pulmonary disease, the panel members suggest using a regimen consisting of three or more active drugs. The panel members felt strongly that treatment regimens should be designed in collaboration with experts in the management of these complicated infections.

Question XXI: In patients with *M. abscessus* pulmonary disease, should shorter or longer duration therapy be used for treatment?

Recommendation

1) In patients with *M. abscessus* pulmonary disease, we suggest that either a shorter or longer treatment regimen be used and expert consultation obtained (conditional recommendation for either the intervention or the comparison, very low certainty in estimates of effect).

Remarks: The lack of studies, the variation in drug availability, resources, and practice settings made it difficult to come to a consensus on the optimum duration of therapy. In addition, the panel members felt that some subgroups of patients should be considered separately in determining the length of therapy such as: patients with nodular/bronchiectatic *versus* cavitary disease, patients affected by lung disease caused by different *M. abscessus* subspecies and importantly, depending on susceptibility to macrolides and amikacin. The panel members suggest that an expert in the management of patients with *M. abscessus* pulmonary disease be consulted.

Surgical resection (Question XXII)

Question XXII: Should surgery plus medical therapy or medical therapy alone be used to treat NTM pulmonary disease?

Recommendation

1) In selected patients with NTM pulmonary disease, we suggest surgical resection as an adjuvant to medical therapy after expert consultation (conditional recommendation, very low certainty in estimates of effect).

Remarks: Selected patients with failure of medical management, cavitary disease, drug resistant isolates, or complications such as hemoptysis or severe bronchiectasis may undergo surgical resection of the diseased lung. The decision to proceed with surgical resection must be weighed against the risks and benefits of surgery. The panel suggests that surgery be performed by a surgeon experienced in mycobacterial surgery [43].

Background

The genus *Mycobacterium* consists of a diverse group of species and subspecies (http://www.bacterio.net/mycobacterium.html). With the exception of *Mycobacterium tuberculosis* complex, *Mycobacterium leprae* complex, and *Mycobacterium ulcerans* the rest of the species are referred to as NTM, and they can be found throughout our environment. The most common clinical presentation is that of pulmonary disease, often occurring in the setting of underlying structural airway disease such as bronchiectasis or chronic obstructive pulmonary disease [4]. The incidence and prevalence of NTM pulmonary disease are increasing in many areas of the world with rates particularly high in older individuals and those with underlying bronchiectasis [44–48]. The reasons for the increases in prevalence are not fully understood but are likely multifactorial including environmental, host, and microbial factors. Regardless of the reasons for the increase, it is clear that healthcare providers will be encountering these patients increasingly frequently in the coming years.

The availability of gene sequencing has improved taxonomy of mycobacteria, with an extraordinary increase in the number of validly published NTM species. Of the many known NTM species, only a small number appear to cause pulmonary disease in humans. The most common slowly growing NTM to do so are members of *Mycobacterium avium* complex which now consists of 12 separate species [49]. The most common to cause pulmonary disease are *M. avium, M. intracellulare,* and *M. chimaera*. Other important NTM causing pulmonary disease are *M. kansasii* and *M. xenopi*. *M. abscessus* and its subspecies *abscessus, bolletii*, and *massiliense* are by far the most common causative agents of pulmonary disease due to rapidly growing mycobacteria.

Diagnosis of NTM pulmonary disease requires the synthesis of clinical, radiographic, and microbiology data. The ATS and IDSA developed a set of criteria to help guide clinicians in determining which patients are likely to have progressive disease [4]. Unfortunately, the predictive values of these criteria are not well studied, and thus they serve primarily as a guide to clinicians. The laboratory remains a critical component in the diagnosis of NTM pulmonary disease given the many species and variable pathogenicity. Identification of NTM to the species level and in the case of *M. abscessus*, to the subspecies level, can provide important clinical and epidemiologic information.

Treatment of NTM pulmonary disease varies depending on the species (in some cases subspecies), extent of disease, drug susceptibility results (with limitations), and underlying comorbidities. Regimens require the use of multiple antimicrobial agents that are often associated with clinically significant adverse reactions and must be administered for prolonged periods. Even so, treatment outcomes are often suboptimal, and reinfection with another strain or species is common. In many settings, expert consultation is helpful.

Methods

Committee composition

This guideline was developed by a multidisciplinary committee consisting of physicians and researchers with recognized NTM expertise (C. Andrejak, E.C. Böttger, E. Cambau, C.L. Daley, D.E. Griffith,

L. Guglielmetti, G.A. Huitt, Jakko van Ingen, C. Lange, T.K. Marras, K.N. Olivier, J.E. Stout, M. Santin, E. Tortoli, D. Wagner, K.L. Winthrop, R.J. Wallace Jr), methodologists (J. Brozek and J.M. Iaccarino), and a representative from an NTM nonprofit organization the goal of which is patient support, education, and research in NTM (P. Leitman). The patient representative was a full participant in each step of the development process but did not vote on specific recommendations. The committee was chaired by C.L. Daley (ATS) and cochaired by C. Lange (ERS), E. Cambau (ESCMID), and R.J. Wallace Jr (IDSA), representing their respective societies. The committee worked with a medical librarian (S.L. Knight) who had expertise in evidence synthesis and the guideline development process. All of the members who had potential financial and/or intellectual conflicts recused themselves or were excused by the chairs from discussions related to the recommendation formulation and grading, and voting on recommendations related to the potential conflict. The methodology team conducted systematic reviews and prepared evidence summaries following the GRADE approach [1, 2].

Formulating clinical questions

The committee developed potential questions to be addressed in the guideline using the 2007 guideline document [4] and their own clinical experience and expertise. Committee members were asked to rank questions in order of importance and priority with all questions deemed important and high priority included for the guideline. Twenty-two questions were chosen based on committee ranking pertinent to the treatment of NTM pulmonary disease. Some of these questions had been previously addressed in 2007 but required updating based on new evidence, whereas others were new questions that the committee felt were critical topics for NTM management. Outcomes of interest were selected a priori by the panel based on their experience and clinical expertise, using the approach suggested by the GRADE working group [1, 2, 50].

Literature search and review of evidence

A medical librarian (S.L. Knight) designed a search strategy using medical subject heading keywords and text words (see online supplement) limited to human studies and articles with English abstracts. Databases searched included MEDLINE, EMBASE, Cochrane Registry of Controlled Trials, Health Technology Assessment, and the Database of Abstracts of Reviews of Effects from 1946 through July 2015. An update was performed in May 2016 prior to the final meeting at the ATS International Conference and a final update was performed in June 2018 prior to manuscript submission.

Development of clinical recommendations

The committee developed recommendations that considered the certainty of the evidence from the GRADE evidence profiles, as well as other domains that inform decision-making. The GRADE evidence-to-decision framework was used to organize and document discussion for each recommendation [2, 50]. The committee considered each of the following in recommendation development: the quality of the evidence, the balance of desirable and undesirable consequences of compared management options, the values and preferences associated with the decision, the implications for resource use and health equity, the acceptability of the intervention to stakeholders, and the feasibility of implementation (see online supplement). The committee developed recommendations based on the GRADE evidence profiles for each question, with recommendations and their strength decided by committee consensus during face-to-face meetings.

Recommendations were either "strong" or "conditional," according to the GRADE approach (table 1) [3]. Strength of the recommendations was based upon the confidence in the estimates of effect, the outcomes studied and associated importance to patients, the desirable and undesirable consequences of treatment, the cost of treatment, the implications of treatment on health equity, the feasibility of treatment, and the acceptability of treatment to important stakeholders. In instances where there was low certainty in the estimates of effect, the committee determined whether a strong recommendation was warranted based on paradigmatic situations outlined by Andrews *et al.* [3]. As suggested by GRADE, the phrase "we recommend" was used for strong recommendations and "we suggest" for conditional recommendations [3]. The guideline, which was funded by ATS, ERS, ESCMID, and IDSA, will be re-evaluated in 4 years to determine if an update is necessary.

Diagnostic criteria for NTM pulmonary disease

The 2007 guideline included clinical, radiographic and microbiologic criteria for diagnosing NTM pulmonary disease [4]. The current guideline also recommends use of these criteria to classify patients as having NTM pulmonary disease (table 2). The significance of NTM isolated from the sputum of individuals who meet the clinical and radiographic criteria in table 2 must be interpreted in the context of the number of positive cultures and specific species isolated. Because NTM can be isolated from

respiratory specimens due to environmental contamination and because some patients who have an NTM isolated from their respiratory tract do not show evidence of progressive disease, >1 positive sputum culture is recommended for diagnostic purposes and the same NTM species (or subspecies in the case of *M. abscessus*) should be isolated in ⩾2 sputum cultures collected over an interval of a week or more. Clinically significant MAC pulmonary disease is unlikely in patients who have a single positive sputum culture during the initial evaluation [5–7] but can be as high as 98% in those with ⩾2 positive cultures [5].

The pathogenicity of NTM varies significantly from organisms like *M. gordonae*, which rarely cause disease in humans, to *M. kansasii,* which should usually be considered pathogenic [8]. For species of low pathogenicity such as *M. gordonae*, several repeated positive cultures over months, along with strong clinical and radiological evidence of disease, would be required to determine if it was causing disease whereas a single positive culture for *M. kansasii* in the proper context may be enough evidence to initiate treatment [9]. The pathogenicity of NTM species may differ between geographic areas [9, 10].

Importantly, just because a patient meets diagnostic criteria for NTM pulmonary disease does not necessarily mean antibiotic treatment is required. A careful assessment of the pathogenicity of the organism, patient's symptoms, risks and benefits of therapy, the patient's wish and ability to receive treatment as well as the goals of therapy should be discussed with patients prior to initiating treatment. In some instances, "watchful waiting" may be the preferred course of action.

Laboratory diagnosis of nontuberculous mycobacterial pulmonary disease

The clinical laboratory plays a critical role in the diagnosis of NTM pulmonary disease. A detailed review of the subject is beyond the scope of the guideline but a brief review of clinically relevant laboratory issues is below.

Obtaining respiratory samples

Given the slow course of NTM pulmonary disease, a prolonged interval ensures that repeat positive cultures are unlikely to reflect a transient contamination of the tracheobronchial system after a single environmental exposure. To distinguish NTM pulmonary disease from occasional presence of NTM in the tracheobronchial tract, at least 3 respiratory samples are investigated, over an interval of at least a week. For cavitary NTM pulmonary disease, sputum samples often suffice for diagnosis [4]. Bronchoalveolar lavage fluid and bronchial washing cultures have been reported in several small studies to be more sensitive than spontaneously expectorated sputum culture to diagnose nodular/bronchiectatic NTM disease [51–54]. However, in the largest study, the yield of sputum culture and bronchial washing culture were equivalent [55]. Bronchoscopy is performed only in patients suspected of having NTM pulmonary disease from whom sputum specimens cannot be obtained spontaneously or through induction.

Sample processing and culture

Decontamination by 0.25% N-acetyl-L-cysteine and 1% NaOH (NALC-NaOH) is the preferred method. An increase of NaOH concentrations lowers contamination rates but decreases sensitivity of culture [56].

Culture of respiratory samples is performed on both liquid and solid media, to improve sensitivity. A meta-analysis [57] of 9 studies [58–65] showed an increase in the sensitivity of culture for NTM of 15% if a solid medium was incubated alongside a liquid culture system. In the few studies that applied multiple solid media and reported results per medium, the Löwenstein-Jensen medium was found to be most sensitive for the detection of NTM [59, 64]. However, the Clinical and Laboratory Standards Institute (CLSI) currently recommends use of 7H10 and 7H11 solid media [66]. CLSI has suggested incubations temperatures of 36±1°C for slow growers and 28±2°C for rapid growers [66]: higher temperatures (*i.e.* 42°C) might accelerate growth of *M. xenopi* but lower incubation temperatures have not proven useful in diagnosing NTM pulmonary disease [67].

In patients with a high suspicion of NTM pulmonary disease but negative cultures, review of decontamination procedures and use of supplemented media and molecular detection may be helpful although supplemental media are rarely necessary to diagnose NTM pulmonary disease. For molecular detection, most use a *Mycobacterium* genus specific assay used in conjunction with nucleic acid sequencing, to distinguish *M. tuberculosis* complex from NTM [68, 69].

Species identification

Correct identification of NTM is important, as it can predict the clinical relevance of an isolate [8] as well as aid in the selection of a treatment regimen. Both molecular and mass spectrometry-based methods can be applied. Molecular identification is the preferred method and can be achieved using probes or gene sequencing. Probe-based assays are easier to perform and implement but lack discriminatory power, leading to misidentification and an oversimplified view of NTM phylogeny and epidemiology [70, 71].

Gene sequencing allows a higher level of discrimination, often up to subspecies level but is only feasible for laboratories with access to sequencing facilities. Several target genes have been described, *e.g.* 16S rRNA, *hsp65, rpoB,* and the 16S–23S internal transcribed spacer (ITS) [72–75]. 16S rRNA gene sequencing alone offers limited discriminatory power, particularly for the *M. abscessus-M. chelonae* group [70]. The *hsp65* and *rpoB* genes and ITS are more discriminative [76]. Complementing 16S rRNA sequencing with additional targets where required yields the best discriminatory power, allowing identifications up to subspecies level (*e.g.* for *M. abscessus*) [77, 78].

The discriminatory power of the matrix-assisted laser desorption ionization-time of flight (MALDI-TOF) mass spectrometry method for NTM has increased with recent improvements in protein extraction protocols and databases but not all species and subspecies can be differentiated with this approach [79, 80]. These procedures work well for pure cultures [80, 81]; however, if applied to newly positive liquid cultures, only 50% of isolates can be immediately identified [82]. For the remainder, subculture on solid media until the occurrence of visual growth is needed to obtain good MALDI-TOF results [79].

All clinically relevant isolates of NTM should be identified by molecular methods, including follow-up isolates of patients undergoing NTM pulmonary disease treatment. Where possible, isolates from patients who are being treated for NTM pulmonary disease are frozen and saved in order to distinguish reinfection from relapse when recurrence occurs.

Drug susceptibility testing

In general, drug susceptibility testing is performed for drugs used in treatment regimens and for which there are clear correlations between *in vitro* activity and the *in vivo* outcomes of treatment. Such correlations have become increasingly clear for NTM, especially for macrolides and amikacin. CLSI provides guidelines for test procedures [14, 15].

For *M. avium* complex, there is a clear correlation between baseline macrolide susceptibility of the causative strain and the outcome of treatment with macrolide-ethambutol-rifampicin regimens [83, 84]. Acquired macrolide resistance in *M. avium* complex is due to point mutations in the 23S rRNA (*rrl*) gene [85, 86]. For amikacin, acquired resistance is due to resistance conferring mutations in the 16S rRNA (*rrs*) gene and are mostly isolated from patients with extensive exposure to amikacin and/or related aminoglycosides [55, 87]. The breakpoint for resistance is a MIC $\geqslant$64 $\mu g \cdot mL^{-1}$ for parenteral amikacin and $\geqslant$128 $\mu g \cdot mL^{-1}$ for amikacin liposome inhalation suspension (ALIS) [15], and finding such MICs would lead to cessation of intravenous or nebulized amikacin therapy [20]. Tentative breakpoints for linezolid and moxifloxacin are also provided by CLSI but for these, *in vitro-in vivo* correlations have not been established [15].

For *M. kansasii*, rifampicin and clarithromycin are the key drugs to test. Rifampicin resistance (MIC >2 $\mu g \cdot mL^{-1}$) is rare but can occur in isolates from patients with significant rifamycin exposures and failure of treatment with a rifamycin containing regimen [15]. Resistance to clarithromycin is defined as an MIC $\geqslant$32 $\mu g \cdot mL^{-1}$ [15]. When rifampicin resistance has been identified, susceptibilities to amikacin, ciprofloxacin, doxycycline, linezolid, minocycline, moxifloxacin, rifabutin, and trimethoprim-sulfamethoxazole are tested [88].

In *M. abscessus* pulmonary disease the association between *in vitro* drug susceptibility and *in vivo* outcome of treatment is evident for macrolides and amikacin [39, 89, 90]. Parenteral drugs with *in vitro* activity include amikacin, imipenem, cefoxitin, and tigecycline. Oral drugs with some activity are the macrolides, oxazolidinones (linezolid) and clofazimine. Clofazimine shows *in vitro* activity, acts synergistically with amikacin and macrolides [91, 92], and prevents the emergence of amikacin-resistant *M. abscessus in vitro* [92].

Strains of *M. abscessus* subsp. *abscessus* and *M. abscessus* subsp. *bolletii* have an erythromycin resistance methylase (*erm*) gene, named *erm*(41), that results in inducible resistance to macrolides [93]. This inducible resistance can be measured *in vitro* by prolonged (*i.e.* up to 14 days) incubation of microdilution trays [40, 93] or can be investigated by molecular detection and characterization of the *erm*(41) gene. In *M. abscessus* subsp *massiliense*, the *erm*(41) gene is nonfunctional owing to a large deletion, thus rendering the strains macrolide susceptible. A nonfunctional gene also occurs in some *M. abscessus* subsp *abscessus* as a result of a C instead of a T at the nucleotide 28 position (Arg10 instead of Trp10) in the *erm*(41) gene [40, 94]. All of the 3 *M. abscessus* subspecies can develop constitutive macrolide resistance owing to 23S RNA (*rrl*) gene mutations [94]. Susceptibility testing panels for *M. abscessus* include at least amikacin, cefoxitin, imipenem, clarithromycin, linezolid, doxycycline, tigecycline, ciprofloxacin, and moxifloxacin.

CLSI recommends that drug susceptibility testing be performed by broth microdilution [88]. For patients whose NTM isolate is deemed to be clinically significant, drug susceptibility testing is performed for primary isolates as well as relapse/failure isolates.

Recommendations for specific PICO questions

Twenty-two PICO questions are addressed in this guideline. For additional details please see the online supplement, which includes supporting supplemental evidence profiles for each question (tables E3.1–22) and evidence to decision tables (tables E4.1–22) for each recommendation. For specific pathogens (*M. avium* complex, *M. kansasii*, *M. xenopi*, and *M. abscessus*), the PICO questions are organized by the drugs to be included in the regimen, frequency of administration, and duration of therapy.

Treatment of NTM pulmonary disease (Questions I–II)

Question I. Should patients with NTM pulmonary disease be treated with antimicrobial therapy or followed for evidence of progression ("watchful waiting")?

Background: Treatment of NTM pulmonary disease with antimicrobial agents offers the possibility of cure of the disease. However, the potential benefits of antimicrobial treatment must be weighed against the potential adverse effects of treatment, low cure rates for some forms of infection, uncertain effect of treatment on quality and quantity of life, high costs of treatment, and the potential for reinfection.

Recommendation

1) In patients who meet the diagnostic criteria for NTM pulmonary disease (table 2), we suggest initiation of treatment rather than watchful waiting, especially in the context of positive acid-fast bacilli sputum smears and/or cavitary lung disease (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: No randomized, controlled trials have been conducted to examine the impact of treatment on either survival or quality of life. Limited retrospective observational data have failed to demonstrate that treatment of NTM pulmonary disease prolongs survival over watchful waiting [95, 96]. The relative and absolute effect estimates and 95% confidence intervals (CIs) for each outcome (table E3. 1) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.1) can be found in the supplement.

Not all patients who have NTM isolated from a respiratory specimen or who meet ATS/IDSA diagnostic criteria will develop progressive NTM pulmonary disease. For example, among 488 patients with MAC pulmonary disease in Taiwan who met ATS/IDSA disease criteria and were followed for at least 1 year, 305 (62.5%) demonstrated progression of disease [97]. Progression was more likely to occur in patients who were acid-fast bacilli smear positive, had fibrocavitary disease or more extensive radiographic disease. Among those patients who met the 2007 ATS/IDSA criteria for MAC pulmonary disease and in whom treatment was not initiated, 51.6% underwent spontaneous sputum conversion during a median follow-up of 5.6 years [97]. Predictors of spontaneous sputum culture conversion included younger age, higher body mass index, and negative sputum acid-fast bacilli smears at initial diagnosis.

Observational cohorts have noted wide variability in the proportion of patients with NTM pulmonary disease who are offered treatment (20–81%) likely contributing to selection bias [95, 98–105]. NTM pulmonary disease has been associated with diminished quality of life that correlates with the severity of lung impairment [106, 107]. A single study using standardized methods for quality of life assessment demonstrated improvement of quality of life associated with treatment of *M. abscessus* infection [108].

Justification and implementation considerations: The decision to initiate antimicrobial therapy for NTM pulmonary disease should be individualized based on a combination of clinical factors, the infecting species, and individual patient priorities. Factors associated with relatively poor prognosis (*e.g.* cavitary disease, low body mass index, low albumin, and/or elevated inflammatory markers) [97, 99, 102, 104, 109], isolation of an organism that is more virulent and/or more responsive to antimicrobial therapy (*e. g. M. kansasii*), and underlying immune suppression were felt to move the balance toward antimicrobial treatment. Major symptoms such as severe fatigue with marked decrease in quality of life can also be major factors in starting therapy. Conversely, mild signs and symptoms of disease, higher potential for medication intolerance/toxicity and organisms less responsive to treatment (*e.g. M. abscessus*) were felt to move the balance toward watchful waiting. Any treatment decision should include a discussion with the patient that outlines the potential adverse effects of antimicrobial therapy, the uncertainties surrounding the benefits of antimicrobial therapy, and the potential for recurrence including reinfection (particularly in the setting of nodular-bronchiectatic disease) [11–13].

Question II. Should patients with NTM pulmonary disease be treated empirically or based on in vitro *drug susceptibility test results?*

Background: Drug susceptibility testing for NTM is useful but only for antibiotics for which correlations between *in vitro* activity and microbiological response to treatment have been well documented [110, 111].

These include the macrolides (clarithromycin and azithromycin) [112] and amikacin [19, 20, 87] with MAC and *M. abscessus* [19, 113], and rifampicin with *M. kansasii* [114, 115].

Recommendations

1) In patients with MAC pulmonary disease, we suggest susceptibility-based treatment for macrolides and amikacin over empiric therapy (conditional recommendation, very low certainty in estimates of effect).
2) In patients with *M. kansasii* pulmonary disease, we suggest susceptibility-based treatment for rifampicin over empiric therapy (conditional recommendation, very low certainty in estimates of effect).
3) In patients with *M. xenopi* pulmonary disease, the committee members feel there is insufficient evidence to make a recommendation for or against susceptibility-based treatment.
4) In patients with *M. abscessus* pulmonary disease we suggest susceptibility-based treatment for macrolides and amikacin over empiric therapy (conditional recommendation, very low certainty in estimates of effect). For macrolides, a 14-day incubation and/or sequencing of the *erm*(41) gene should be performed to evaluate for potential inducible macrolide resistance.

Summary of the evidence: Only one study was identified that reported treatment outcomes based on empiric treatment *versus* the results of drug susceptibility results [101]. The study was a retrospective observational study of 31 patients with various species causing NTM pulmonary disease who met the 1997 ATS case definition. Patients were treated with a variety of treatment regimens (13 different combinations were used). Adjusting treatment according to the results of drug susceptibility tests was not associated with any difference in median survival (75% with adjustment and 80% without). However, the study suffers from serious methodological flaws including lack of randomization, use of the 1997 ATS diagnostic criteria, and methods of determining and interpreting drug susceptibility that are no longer recommended. Discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.2) can be found in the supplement.

Although only 1 study was identified that attempted to evaluate the outcomes of treatment based on drug susceptibility results there are other studies that have correlated outcomes with *in vitro* activity. Trials of monotherapy with clarithromycin, rifampicin, ethambutol, or clofazimine for HIV-associated disseminated MAC demonstrated that only clarithromycin susceptibility results correlated with treatment outcomes [113, 116]. In MAC pulmonary disease, retrospective case series [83, 84, 112, 117, 118] have also shown that *in vitro* resistance to clarithromycin was associated with worse outcomes than susceptibility to clarithromycin, and a randomized trial found no association between *in vitro* susceptibility to either rifampicin or ethambutol and failure/relapse [119]. However, the latter study applied a drug susceptibility method not recommended for NTM and presented and analysed only aggregate resistance data for all groups (MAC, *M. xenopi*, and *M. malmoense*) utilizing uniform discrete thresholds rather than considering MICs as a continuous variable to be explored for an association across species.

Amikacin is an important drug used for treatment of *M. abscessus* pulmonary disease. Resistance to amikacin is caused by a specific mutation (A1408G) in the 16S rRNA (*rrs*) gene that has been associated with a high MIC (>64 $\mu g \cdot mL^{-1}$) and previous exposure to amikacin [87, 120].

Recent phase II and III clinical trials evaluating the efficacy and safety of ALIS in patients with refractory pulmonary disease due to MAC (or *M. abscessus*) reported that when there was an A1408G mutation in the 16S rRNA gene and/or the MIC was >64 $\mu g \cdot mL^{-1}$ in MAC isolates, no patients achieved culture conversion on ALIS; responses were seen with MIC values up to and including 64 $\mu g \cdot mL^{-1}$ [19, 20]. Treatment failure occurred in 2 patients whose isolates had become resistant by mutation to amikacin [19]. In a randomized trial comparing intravenous streptomycin with placebo added to a standard 3-drug regimen, there was no association of treatment outcome with MIC to streptomycin; however, exact MIC values were not determined if above 4 $\mu g \cdot mL^{-1}$ [121].

For *M. kansasii* pulmonary disease, resistance to rifampicin has been associated with treatment failure [114, 115], although no randomized trials have been conducted that associate baseline MICs to clinical outcome. For *M. xenopi* lung disease, few studies have correlated *in vitro* activity of specific antimycobacterial drugs with treatment outcomes [36, 101, 122, 123]. No association could be found between *in vitro* activity and treatment failure/relapse in a randomized trial comparing rifampicin plus ethambutol with or without isoniazid. The study had important limitations including a small sample size and the use of discrete thresholds (based on *M. tuberculosis*) rather than considering MIC values as a continuous variable [36].

Recent studies have reported poor treatment outcomes associated with macrolide resistance due to either mutational or inducible resistance related to the presence of a functional *erm*(41) gene in *M. abscessus*

subsp. *abscessus* and *bolletii*. In a retrospective cohort treated with a standard regimen, the presence of *in vitro* resistance to clarithromycin was associated with worse outcomes [39]. In a follow-up study, patients with *M. abscessus* subsp. *massiliense* were more likely to convert cultures to negative compared with patients infected with *M. abscessus* subsp. *abscessus* (85% *versus* 25%, p<0.001), presumably because of the presence of a nonfunctional *erm*(41) gene in the former (gene with major deletions) and inducible macrolide resistance due to a functional *erm*(41) gene in the latter [38, 40–42]. In addition, culture conversion rates were significantly higher in patients infected with an *M. abscessus* subsp. *abscessus* C28 sequevar isolate that does not exhibit inducible resistance to macrolides [12]. Alternatively, when *M. abscessus* subsp. *massiliense* develops mutational macrolide resistance with a mutation in the 23S rRNA gene, culture conversion is similar to that seen with subsp. *abscessus* and functional *erm*(41) gene [40, 124, 125].

Justification and implementation considerations: Although *in vitro-in vivo* correlations have been proven only for macrolides, amikacin and rifampicin (the latter only for *M. kansasii*), baseline susceptibility testing is recommended by CLSI guidelines for NTM isolates from patients with definite disease [14, 15]. Based on studies reviewed above, there is evidence of poor outcomes in cases of macrolide-resistant MAC [16, 112] and *M. abscessus* [38, 39] and poor outcomes in rifampicin-resistant *M. kansasii* [114, 115]. Similarly, recent data from randomized clinical trials evaluating ALIS have demonstrated that high MICs of amikacin are associated with poor microbiological response as reported in a previous retrospective analysis of patients treated with parenteral amikacin [19, 20, 87]. Based on the studies and recommendations above, laboratories should provide drug susceptibility test results for the macrolides and amikacin for MAC and *M. abscessus* and rifampicin for *M. kansasii*. Precise subspeciation is helpful for *M. abscessus* as identification of subsp. *massiliense* is associated with a nonfunctional*erm*(41) gene and *in vitro* susceptibility (MIC below 4 $\mu g \cdot mL^{-1}$) [42], and thus the macrolides are active if constitutive resistance is not present. Alternatively, sequence analysis of the *erm*(41) gene can provide information (*e.g.*, truncated or C28 sequevar) that can exclude inducible macrolide resistance. Although other drugs are sometimes tested in order to guide *M. abscessus* therapy, there are insufficient data to make specific recommendations in this regard.

Because no studies could be identified that adequately addressed *M. xenopi* pulmonary disease and in the absence of drug susceptibility testing guidelines and breakpoints for *M. xenopi*, the panel was unable to provide recommendation for or against susceptibility-based treatment.

Treatment of MAC pulmonary disease (Questions III–IX)

Question III. Should patients with macrolide-susceptible MAC pulmonary disease be treated with a 3-drug regimen with a macrolide or without a macrolide?

Background: Macrolides (clarithromycin and azithromycin) have been the basis of therapy against MAC pulmonary disease because they were demonstrated in multiple trials to be effective in prophylaxis and multidrug treatment of disseminated MAC infection [126–130].

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease, we recommend a 3-drug regimen that includes a macrolide over a 3-drug regimen without a macrolide (strong recommendation, very low certainty in estimates of effect).

Summary of the evidence: In spite of the widespread use of macrolides for treating MAC disease, there have been only two randomized controlled trials comparing a macrolide-containing regimen with a nonmacrolide-containing regimen [131, 132]. A British Thoracic Society trial randomized 170 patients with primarily cavitary MAC pulmonary disease to receive standard doses of rifampicin and ethambutol with either clarithromycin or ciprofloxacin [131]. The results showed that the clarithromycin group had a lower failure/relapse rate than the ciprofloxacin group (13% *versus* 23%) and was tolerated better. However, all-cause mortality was higher in the clarithromycin group for unclear reasons (48% *versus* 30%). At 5 years only 30% of the clarithromycin group and 21% of the ciprofloxacin group were known to have completed therapy and been alive.

In a second small prospective trial from Japan [132], 27 patients with MAC pulmonary disease were treated for 1 year with rifampicin and ethambutol plus either gatifloxacin or low dose (600 mg) clarithromycin. The treatment outcomes were not significantly different between study arms: 11/13 (84.6%) in the gatifloxacin group and 9/14 (64%) patients in the clarithromycin group achieved sputum culture conversion to negative. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.3) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.3) can be found in the supplement.

The committee was concerned about several aspects of these 2 studies including, a) small sample size, b) underdosing of the macrolide, c) populations not representative of nodular bronchiectatic MAC pulmonary disease patients encountered frequently in clinical practice, d) the use of gatifloxacin which is not approved for use or no longer marketed in many countries worldwide, and e) the high overall mortality seen in one study [131], which raised questions about the validity of the study.

There have been other noncomparator trials of macrolide-containing regimens that have reported varying culture conversion rates. A recent systematic review reported a sustained sputum culture conversion incidence rate ratio of 0.54 (95% CI 0.45–0.63) for macrolide-containing regimens *versus* 0.38 (0.25–0.52) for macrolide-free regimens [133]. Sputum conversion increased in the macrolide-containing regimens compared with macrolide-free regimens as study quality improved. Another systematic review reported overall treatment success using macrolide-containing regimens was 52.3% (95% CI 44.7%–59.9%) and success increased to 61.4% if treated with an ATS/IDSA 3-drug regimen, and to 65.7% if further treated for at least 12 months [134]. The companion drugs and length of treatment are important factors in treatment success. Only regimens using rifamycin and ethambutol or clofazimine and ethambutol have been shown to prevent the emergence of macrolide resistance during treatment [22, 135].

Perhaps the strongest available evidence for the importance of the macrolide in the treatment regimen is demonstrated by its loss from the regimen. In the setting of macrolide-resistant disease, the sputum culture conversion rate falls from approximately 80% [22, 23] to only 5–36% [16–18, 136].

Justification and implementation considerations: Case series have demonstrated that macrolide-containing regimens are associated with higher culture conversion rates than nonmacrolide-containing regimens [137]. Macrolide susceptibility has been a consistent predictor of treatment success for MAC pulmonary disease, whereas susceptibility to most other drugs has not been a predictor [112]. In a postmarketing study from Japan, among 271 patients with macrolide-susceptible MAC pulmonary disease who received a clarithromycin-based regimen, sputum culture conversion to negative occurred in 95% [136]. Although no well-designed randomized trials of macrolide therapy have been performed, the panel felt that macrolides are a critical component of MAC treatment based on poor patient outcomes if macrolides are not included in the treatment regimen. As such the panel members voted unanimously to make a strong recommendation despite the very low certainty of estimates of effect.

Question IV. In patients with newly diagnosed macrolide-susceptible MAC pulmonary disease, should an azithromycin-based regimen or a clarithromycin-based regimen be used?

Background: The macrolides are considered to be key components in treatment regimens against MAC pulmonary disease. The 2007 guideline expressed a preference for azithromycin over clarithromycin in initial treatment regimens [4].

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease we suggest azithromycin-based treatment regimens rather than clarithromycin-based regimens (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: Both clarithromycin and azithromycin have demonstrated activity in MAC pulmonary disease, with early studies demonstrating some efficacy for monotherapy [117, 138], and subsequent studies demonstrating efficacy as part of multi-drug regimens administered both daily [83] and 3 times weekly [22, 139, 140]. Limited data are available from comparisons of treatment outcomes in patients treated with clarithromycin *versus* azithromycin [22, 141], and no significant difference was found in either microbiologic efficacy or tolerability, although there was a nonsignificant trend toward lower tolerability for clarithromycin in 1 study [141]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.4) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.4) can be found in the supplement.

A recent systematic review reported no clinically significant differences between azithromycin and clarithromycin in sputum culture conversion at 6 months, end of therapy, or on sustained conversion after treatment nor was there a difference in the acquisition of macrolide resistance [133]. However, azithromycin has less potential for drug-drug interactions than clarithromycin [142]. The drug-drug interactions are particularly relevant when a rifamycin (rifampicin or rifabutin) is given concurrently; azithromycin serum concentrations are affected less by concurrent rifampicin or rifabutin administration than clarithromycin, but the interaction is bidirectional for clarithromycin and rifabutin, leading to increased concentration of rifabutin (but not rifampicin), which has been associated with uveitis [111, 143–145]. Other considerations that would favour azithromycin over clarithromycin include a lower pill burden, once daily dosing, and possibly lower costs.

Justification and implementation considerations: The preference for azithromycin is primarily based on the expert panel's perception of better tolerability of azithromycin and fewer drug-drug interactions mediated by the cytochrome P450 system [146] than with clarithromycin. Both azithromycin and clarithromycin have been reported to be associated with severe adverse effects, including sudden death presumably mediated by QTc prolongation [147, 148]. However, a systematic review that evaluated adverse events in people taking macrolides *versus* placebo for any indication reported no increase in cardiac disorders or mortality when compared with placebo [149]. Electrocardiographic monitoring may be considered for patients when concurrent medications that prolong the QTc interval are being used. In the same systematic review noted above [149], hearing loss was reported more frequently in patients taking macrolides than placebo; however, the differences were not statistically significant, and there were no studies of clarithromycin to address differences between macrolides. In older patients, hearing loss and gastrointestinal symptoms have been associated with higher doses (600 mg daily) and serum concentrations of azithromycin [150], whereas bitter taste, nausea, and elevated hepatic enzymes have been associated with higher doses (1000 mg twice daily) of clarithromycin [151]. Of note, all studies included some patients who did not tolerate azithromycin and were successfully switched to clarithromycin and *vice versa*. Switching from one agent to the other is a strategy that may be considered in case of intolerance. The panel felt that azithromycin was preferred over clarithromycin because of likely better tolerance, less drug interactions, lower pill burden, single daily dosing, and equal efficacy. In places where azithromycin is not available, clarithromycin is an acceptable alternative although more drug interactions are possible.

Question V. Should patients with MAC pulmonary disease be treated with a parenteral amikacin or streptomycin-containing regimen or without a parenteral amikacin or streptomycin-containing regimen?

Background: MAC isolates are usually susceptible *in vitro* to amikacin. Streptomycin was used in early noncomparative treatment trials during the initial months of treatment for both cavitary and nodular/bronchiectatic MAC pulmonary disease [83, 138]. Parenteral aminoglycoside therapy was recommended in some previous NTM guidelines during the initial months of MAC therapy [152]. In the 2007 guideline [4], parenteral aminoglycosides were recommended for initial therapy of fibrocavitary MAC pulmonary disease and severe or previously treated MAC pulmonary disease [4]. Amikacin or streptomycin administration have been viewed as an intensification of oral therapy although that assumption has not been rigorously tested.

Recommendation

1) For patients with cavitary or advanced/severe bronchiectatic or macrolide-resistant MAC pulmonary disease, we suggest that parenteral amikacin or streptomycin be included in the initial treatment regimen (conditional recommendation, moderate certainty in estimates of effect).

Summary of the evidence: One randomized controlled trial was performed evaluating the impact of streptomycin addition to macrolide-based oral therapy for the initial three months of therapy [121]. One hundred forty-six patients with MAC pulmonary disease (both nodular/bronchiectatic and cavitary disease) were randomized to receive clarithromycin, ethambutol, and a rifamycin daily with (73) or without (73) streptomycin (15 $mg \cdot kg^{-1}$ 3 times per week during the initial 3 months of therapy). The sputum culture conversion rate was significantly higher for patients who received streptomycin than for those who received oral therapy only (71.2% *versus* 50.7%). There were, however, no significant differences in microbiologic recurrence rates or clinical improvement (which included both clinical symptoms and radiological findings). There were also no significant differences in adverse reactions and abnormal laboratory findings between the 2 groups. Two additional retrospective studies have suggested that the inclusion of a parenteral aminoglycoside administered for $\geqslant$6 months in addition to adjunctive surgery improves outcome for patients with macrolide-resistant MAC pulmonary disease [16, 18]. There are no published data examining the relative efficacy of streptomycin *versus* amikacin for treating MAC pulmonary disease; streptomycin is no longer available in several countries. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.5) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.5) can be found in the supplement.

Justification and implementation considerations: In the absence of comparably effective oral medications there are few options other than parenteral aminoglycosides for "intensifying" standard oral MAC therapy. Although the evidence is limited, it appears that there is some improvement in microbiologic response with the addition of three months of streptomycin to macrolide-based oral MAC therapy [121] and when administered for a longer duration in the setting of macrolide resistant MAC pulmonary disease [16, 18]. Amikacin must be paired with adequate companion medications, such as a macrolide, ethambutol and possibly rifampicin and clofazimine, to prevent the emergence of acquired mutational resistance and predictable treatment failure [153]. Based on the results of one randomized trial [121] and the experiences

of the panel members, the benefits were felt to outweigh risks in those patients with cavitary or advanced/severe bronchiectatic disease or those with macrolide-resistant MAC pulmonary disease. Administration of at least 2–3 months of an aminoglycoside was considered the best balance between risks and benefits.

Question VI. In patients with macrolide-susceptible MAC pulmonary disease, should a regimen with inhaled amikacin or a regimen without inhaled amikacin be used for treatment?

Background: Amikacin is active against MAC and has been recommended for intravenous treatment of cavitary or severe bronchiectatic MAC pulmonary disease [4]. However, systemic use of parenteral amikacin has been associated with a high frequency of renal, auditory, and vestibular toxicity [154]. Delivery of amikacin by hand-held nebulization may be a potential way to improve efficacy and decrease drug-related toxicity.

Recommendations

1) In patients with newly diagnosed MAC pulmonary disease, we suggest neither inhaled amikacin (parenteral formulation) nor ALIS be used as part of the initial treatment regimen (conditional recommendation, very low certainty in estimates of effect).
2) In patients with MAC pulmonary disease who have failed therapy after at least 6 months of guideline-based therapy, we recommend addition of ALIS to the treatment regimen instead of a standard oral regimen, only (strong recommendation, moderate certainty in estimates of effect).

Summary of the evidence: Reports evaluating the use of inhaled amikacin as part of a multidrug regimen for NTM pulmonary disease, including patients with MAC pulmonary disease, have primarily targeted patients with treatment refractory disease. Five retrospective case series (N=138 patients, 55 with MAC) with no comparator arm most commonly used inhaled doses of commercially available amikacin (parenteral formulation) ranging from 250 to 500 mg once daily up to 15 $mg \cdot kg^{-1}$ once daily added to their oral antibiotic regimen [155–159]. Clinical responses were reported in 20–100% and sputum conversion was reported in 18–67% of treatment refractory MAC pulmonary disease. Reported side effects in these series ranged from 8 to 38% and included hoarseness, throat irritation, bitter taste, and thrush. Ototoxicity occurred in 0 to 19% of patients with nephrotoxicity reported in only 1 patient and vertigo in 2 patients [155–159]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.6) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.6) can be found in the supplement.

A Phase II controlled trial randomized treatment refractory patients (*e.g.* with culture positivity after at least 6 months of guideline-based treatment that included a macrolide) with predominantly MAC (n=57) or *M. abscessus* (n=32) pulmonary disease to investigational ALIS (n=44) *versus* placebo (empty liposomes, n=45) [19]. Although the primary endpoint of reduction in semiquantitative mycobacterial culture growth from baseline was not achieved, significantly more patients who received ALIS achieved culture conversion by day 84 and had greater improvement in distance achieved on 6-minute walk test. Adverse events were common (~90%) in both groups, but patients receiving ALIS had more dysphonia and oropharyngeal discomfort, cough, wheezing, chest discomfort, acute exacerbations of bronchiectasis, and fatigue [19].

A randomized controlled phase III trial recently reported that ALIS, when added to guideline-based regimen for treatment refractory MAC pulmonary disease, was associated with a higher proportion of patients with negative cultures at 6 months compared to those who continued to take the standard regimen only [20]: Culture conversion was achieved by 65 of 224 patients (29.0%) with ALIS + guideline-based therapy (GBT) compared with 10 of 112 (8.9%) with GBT alone (odds ratio, 4.22; 95% CI 2.08, 8.57; p<0.001). Adverse reactions were very common in both treatment arms: treatment-emergent adverse events (TEAE) were reported in 98.2% and 91.1% of patients in the ALIS+GBT and GBT-alone arms, respectively. The most common TEAEs overall were respiratory events reported by 87.4% and 50.0% of patients in the ALIS+GBT and GBT alone arms, respectively. TEAEs reported in ⩾10% of patients in the ALIS+GBT arm included dysphonia, cough, hemoptysis, dyspnea, fatigue, diarrhea, nausea, and oropharyngeal pain. These events infrequently led to early discontinuation of ALIS (dyspnea, 3.1%; dysphonia, 2.2%; all others <1%) or withdrawal from the study. Audiological TEAEs were generally similar in both arms although tinnitus was reported in 17 patients (7.6%; 20 events) in the ALIS+GBT arm compared with one event (0.9%) in those receiving GBT alone. Vestibular TEAEs (dizziness, balance disorder, vertigo), although infrequent, were also more common in the ALIS+GBT arm than in the GBT alone arm. Serious TEAEs were reported in 45 patients (20.2%) and 20 patients (17.9%) in the ALIS+GBT and GBT-alone arms, respectively. During the study, more patients in the ALIS+GBT arm had MAC isolates with post-baseline amikacin MIC >64 $\mu g \cdot mL^{-1}$ than those receiving GBT alone (10.3% *versus* 2.7%). Of these 26.9% subsequently had MAC isolates with an MIC less than 64 $mg \cdot mL^{-1}$. Based on the

phase II and III trial results, ALIS was approved by the US Food and Drug Administration for treatment of MAC pulmonary disease in patients who have failed therapy after at least 6 months of GBT.

Justification and implementation considerations: There are insufficient data to support the use of inhaled antibiotics as an initial treatment option. There may be a risk of developing acquired mutational amikacin resistance with either inadequate companion medications or poor and irregular antibiotic deposition in the lung with areas of low amikacin concentration. In patients who fail treatment with an initial MAC regimen, inhaled therapy should be used as part of a salvage regimen to aggressively treat MAC pulmonary disease in those whose isolates retain *in vitro* susceptibility to amikacin. The results of phase II and phase III randomized trials [19, 20] of ALIS show that addition of ALIS to patients with MAC pulmonary disease that failed to convert sputum cultures after 6 months of GBT leads to culture conversion in 29% of patients in comparison to 9% in patients who continue GBT only. Because 10% of patients in the ALIS-arm developed amikacin resistance, the addition of another companion drug to prevent resistance development needs to be considered in these patients, although the preventive effect of an additional medication has not been determined in this situation. Where ALIS is not yet available, addition of inhaled parenteral amikacin is a reasonable alternative.

Question VII. In patients with macrolide-susceptible MAC pulmonary disease, should a 3-drug or a 2-drug macrolide-containing regimen be used for treatment?

Background: The poor response to treatment in AIDS patients with disseminated MAC in the premacrolide era and the rapid development of resistance with clarithromycin monotherapy reinforced the need for multiple drugs for treatment success. In contrast to the need for multidrug therapy, there is an opposing pressure to reduce the number of agents in MAC regimens to minimize drug-related adverse effects, the cost of the drug regimen, and the pill burden seen with 12–18 months of therapy.

Recommendation

1) In patients with macrolide-susceptible MAC pulmonary disease, we suggest a treatment regimen with at least 3 drugs (including a macrolide and ethambutol) over a regimen with 2 drugs (a macrolide and ethambutol alone) (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: There are 2 randomized studies that compared a 2-drug regimen with a 3-drug regimen [21, 119], but only 1 of these studies included a macrolide-containing regimen [21]. In this single centre open label study from Japan, patients with previously untreated nodular/bronchiectatic or fibrocavitary MAC pulmonary disease were randomly assigned to either a daily 3-drug (clarithromycin/ethambutol/rifampicin) or a daily 2-drug (clarithromycin/ethambutol) regimen for 12 months [21]. The drug doses (especially clarithromycin at 200 mg 3 times daily or twice daily based on body weight) were all lower than ATS/IDSA recommended dosing. The primary endpoint was sputum conversion (*i.e.* 3 consecutive negative cultures). Fifty-nine patients were assigned to a 3-drug regimen and 60 to a 2-drug regimen with lung cavitation present in approximately 50% of patients in both arms. In the intent to treat analysis, the sputum culture conversion rate was 40.6% with the 3-drug regimen and 55.0% with the 2-drug regimen. The incidence of adverse events leading to the discontinuation of treatment was 37.2% and 26.6% for the 3-drug and the 2-drug regimens, respectively. In the per protocol analysis (those who completed therapy) 24/32 (75%) converted on 3 drugs, and 33/40 (82.5%) converted on 2 drugs. No isolates in either group developed macrolide resistance, although the study was underpowered to detect a difference. This study has significant limitations making interpretation difficult. The study was unblinded with a small sample size, had significant drop out during the course of the study, and used low doses of clarithromycin administered in a nonstandard frequency of dosing [160]. When combined with rifampicin in the 3-drug regimen, this would have led to low and potentially ineffective clarithromycin levels. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.7) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.7) can be found in the supplement.

Justification and implementation considerations: A priority in MAC pulmonary disease therapy is preventing the development of macrolide resistance. Ethambutol is the best companion drug for preventing the emergence of macrolide resistance [16, 18, 161]. A 2-drug regimen including a macrolide and ethambutol is the regimen with the fewest possible drugs for treating MAC. The role of a rifamycin, or another third drug, is unclear. One possibility is that a third drug provides additional protection to that provided by ethambutol for preventing the emergence of macrolide resistance. In a randomized controlled trial of rifabutin added to clarithromycin and ethambutol for treatment of disseminated MAC infection, response rates, with or without rifabutin, were equivalent but development of macrolide resistance was lower ($p=0.055$) in patients on the 3-drug regimen [161]. Until additional evidence is provided showing that acquired macrolide resistance is equally common among macrolide containing 3-drug and 2 drug

regimens, the panel prefers a 3-drug regimen. A PCORI-funded randomized controlled trial to evaluate the safety and efficacy of a 2 *versus* 3 drug regimen is currently underway (https://www.pcori.org).

Question VIII. In patients with macrolide-susceptible MAC pulmonary disease, should a daily or 3-times weekly regimen be used for treatment?

Background: The intermittent administration of antimycobacterial drugs has been a standard approach to drug susceptible tuberculosis therapy in North America for more than 2 decades [162]; therefore, it seems reasonable that macrolide susceptible MAC pulmonary disease might also be effectively treated with intermittent antibiotic administration. In the prior guideline [4], 3 times weekly therapy was recommended for patients with nodular/bronchiectatic MAC pulmonary disease but was not recommended for patients with cavitary disease, patients previously treated, or patients with moderate or severe disease [4, 163].

Recommendations

1) In patients with noncavitary nodular/bronchiectatic macrolide-susceptible MAC pulmonary disease, we suggest a 3 times per week macrolide-based regimen rather than a daily macrolide-based regimen (conditional recommendation, very low certainty in estimates of effect).
2) In patients with cavitary macrolide-susceptible MAC pulmonary disease we suggest a daily macrolide-based regimen rather than 3 times per week macrolide-based regimen (conditional recommendation, very low certainty in estimates of effect)

Summary of the evidence: No randomized trials have been performed that address this question; however, there are several cohort studies that have reported treatment outcomes with intermittent therapy. The first prospective noncomparative case series of patients receiving intermittent azithromycin-containing therapy for MAC pulmonary disease was reported in 1998 [164]. These preliminary results were followed by the results of 3 prospective noncomparative studies of azithromycin-containing regimens (including rifabutin or rifampicin, and ethambutol) for MAC pulmonary disease [140]. Patients received either intermittent azithromycin with daily companion medications, intermittent azithromycin with intermittent companion medications, or daily azithromycin with daily companion medicines. Conversion of sputum cultures to negative was observed in 17/29 (59%), 11/20 (55%), and 28/43 (65%) of patients, respectively. The microbiologic outcomes for the 3 regimens were not significantly different. In a subsequent study, 41 patients completed 6 months of therapy with clarithromycin 1000 mg, rifabutin 300–600 mg, and ethambutol 25 $mg \cdot kg^{-1}$ administered 3 times per week [139]. Thirty-two (78%) of these patients converted sputum cultures to negative. Adverse events associated with this regimen were primarily due to rifabutin, and in 41% of patients the dosage was decreased or the drug discontinued. These initial 3 studies included both cavitary and nodular bronchiectatic MAC pulmonary disease patients [139, 140, 164].

A large retrospective case series that included 180 patients with nodular/bronchiectatic MAC pulmonary disease reported outcomes with either daily or intermittent macrolide-containing (either azithromycin or clarithromycin) regimens (with rifampicin and ethambutol) for a minimum of 12 months [22]. Conversion of sputum cultures to negative occurred in 147/172 (85%) of patients treated with the intermittent regimen compared to 7 of 8 (88%) patients who completed therapy with daily medication. A significantly greater number of patients treated with daily medications experienced medication intolerance and required a switch in regimen to intermittent therapy. None of the NTM strains from patients in the study developed macrolide resistance. Another retrospective study compared daily (earlier temporal period, 99 patients) with intermittent (later temporal period, 118 patients) administration of clarithromycin, rifampicin, and ethambutol for nodular/bronchiectatic MAC pulmonary disease [23]. Significantly more patients on daily therapy required regimen modification because of medication intolerance than patients on intermittent therapy (46% *versus* 21%). Seventy-six percent of patients receiving daily therapy, and 67% of patients receiving intermittent therapy converted cultures to negative. Acquired macrolide resistance was not reported in the study.

In addition to the 2 recent studies showing that intermittent macrolide-containing regimens are better tolerated than daily regimens, there may be other benefits to intermittent regimens. A case series suggested that intermittent ethambutol administration was less often associated with ethambutol-related ocular toxicity than daily ethambutol administration [165]. A recent systematic review reported that the default rate was 12.0% (95% CI 8.9%–15.0%) in patients receiving 3 times weekly therapy compared to 16.0% (95% CI 12.3–19.7%) with daily administration [166]. A small study from South Korea on patients who were failing an intermittent regimen after 12 months of treatment reported that sputum culture conversion to negative was observed in approximately 30% of patients after switching to daily therapy [167].

Treatment outcomes with intermittent therapy are not as favourable in patients with cavitary pulmonary disease. A prospective open label multicentre trial reported a low culture conversion rate in patients with

MAC pulmonary disease treated with 3 times weekly therapy [163]. Sputum culture conversion occurred in only 4% of patients with cavitary disease. Patients with noncavitary disease were approximately 4 times more likely than patients with cavitary disease to demonstrate sputum culture conversion and high-resolution computed tomography (CT), or symptom improvement. A recent case series from South Korea reported a high sputum culture conversion rate in patients with recurrent nodular/bronchiectatic disease who received an intermittent macrolide-based regimen [168]. In this case series, 86% of the recurrences were likely due to reinfection which would possibly explain the good outcomes. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.8) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.8) can be found in the supplement.

Justification and implementation considerations: These recommendations are based on several noncomparative case series with consistent microbiologic results showing that intermittent therapy is similar to daily therapy for nodular/bronchiectatic MAC pulmonary disease and also better tolerated than daily therapy. A critically important finding from the available studies is the lack of development of macrolide resistance with intermittent therapy [22, 23]. There is not similar evidence to justify or support intermittent therapy for cavitary MAC pulmonary disease and it is not recommended.

Question IX. In patients with macrolide-susceptible MAC pulmonary disease, should patients be treated with <12 months of treatment after culture negativity or ⩾12 months of treatment after culture negativity?

Background: Although MAC species are the most common organisms causing NTM pulmonary disease, the optimal treatment duration for MAC pulmonary disease has not been evaluated in a prospective randomized clinical trial. Although the duration of treatment of MAC pulmonary disease that is needed to achieve relapse-free cure is likely highly variable among individual patients, clinical guidance is needed for the recommendation of a general treatment duration.

Recommendation

1) We suggest that patients with macrolide-susceptible MAC pulmonary disease should receive treatment for at least 12 months after culture conversion (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: There are no randomized studies or case series that address this question although there is one study that reported outcomes based on whether the patient received <12 months of treatment [22]. In a single centre retrospective observational cohort study that evaluated and reported treatment outcomes of patients with nodular/bronchiectatic MAC pulmonary disease, 27 patients received treatment for <12 months and 180 patients for ⩾12 months of a clarithromycin or azithromycin-based combination therapy, either daily or 3 times a week. Sputum culture conversion to negative was observed in 6 of the 27 patients (22%) who received treatment for <12 months, compared with 154 of 180 (86%) of patients who completed at least 12 months of therapy ($p<0.001$). The relative and absolute effect estimates and 95% CIs for each outcome (table E3.9) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.9) can be found in the supplement.

A recent systematic review reported that treatment success was higher in persons who received at least 12 months of macrolide-based therapy compared with <12 months [134]. Neither the aforementioned study nor the systematic review evaluated treatment outcomes by duration of treatment after culture conversion [134]. In a postmarketing study from Japan, bacteriologic relapse was noted in 5% of patients when treatment was continued for <15 months after sputum culture conversion and in zero patients who continued treatment for >15 months [136]. Given the lack of data on the optimal duration of therapy, the panel voted unanimously to continue to follow the recommendations from the 2007 guideline.

Justification and implementation considerations: The optimal duration of therapy for MAC pulmonary disease is currently not known. Semiquantitative sputum culture scores from the third month of treatment onwards are predictive of sustained sputum conversion at 12 months of treatment, so regular (*e.g.* monthly) sputum cultures are recommended during the treatment of MAC pulmonary disease [169]. There is currently not sufficient evidence to support bronchoscopy to obtain specimens for mycobacterial culture to determine the duration of therapy. Treatment outcome definitions have now been published to promote uniform outcome reporting in studies and gather more reliable data on optimal duration of therapy in MAC pulmonary disease [170]. In patients who fail to convert sputum cultures to negative after 6 months of treatment or who have extensive disease, expert consultation should be obtained.

Treatment of MAC pulmonary disease: summary

We recommend a 3-drug, macrolide-based regimen for patients with macrolide-susceptible MAC pulmonary disease (tables 3 and 4). For patients with cavitary or advanced/severe bronchiectatic or macrolide-resistant MAC pulmonary disease, we suggest that parenteral amikacin or streptomycin be included in the initial treatment regimen. The parenteral agent is typically administered for at least 2–3 months. We suggest a 3 times per week regimen in patients with nodular/bronchiectatic disease but a daily macrolide-based regimen in those with cavitary disease. We suggest that treatment be administered for at least 12 months after culture conversion. If sputum cultures have not converted to negative after 6 months of guideline-based treatment, we recommend the use of ALIS as part of the continuation treatment regimen. In the setting of disease caused by macrolide-resistant MAC, the expert panel suggests seeking expert consultation.

Treatment of M. kansasii *pulmonary disease (Questions X–XIV)*

Question X. In patients with rifampicin-susceptible M. kansasii *pulmonary disease, should an isoniazid-containing regimen or a macrolide-containing regimen be used for treatment?*

Background: *M. kansasii* was one of the first NTM to be recognized to cause pulmonary disease [171]. Initially, a *M. tuberculosis*-like regimen including isoniazid was used, but treatment success was unsatisfactory [30, 172] until the introduction of rifampicin [29, 31]. Once rifampicin was included in the regimen, treatment outcomes improved dramatically, and thus a rifampicin-based regimen is recommended [4]. Because of the uncertain value of isoniazid [173] and excellent *in vitro* activity of the macrolides [174–177], some clinicians have begun to substitute a macrolide for isoniazid in rifampicin-containing regimens [178].

Recommendation

1) In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, we suggest a regimen of rifampicin, ethambutol, and either isoniazid or macrolide (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: No randomized clinical trials have directly compared an isoniazid-containing regimen with a macrolide-containing regimen, but there are case series that reported treatment outcomes of these regimens for treating *M. kansasii* pulmonary disease. A 3-drug regimen that includes isoniazid, rifampicin, and ethambutol was recommended in the 2007 guideline [4]. Treatment outcomes with the 3-drug regimen when administered for 9–18 months have been excellent with cure rates of 80–100% and low relapse rates of 2.5–6.6% when administered for at least 12 months [27–29].

Untreated strains of *M. kansasii* are susceptible to macrolides, as minimal inhibitory concentrations of clarithromycin for *M. kansasii* range from 0.125 to 0.25 $\mu g \cdot mL^{-1}$ [176]. Two small retrospective cohort studies evaluated treatment outcomes of regimens that substituted clarithromycin for isoniazid and reported similar cure rates of 80–100% [25, 26]. Among subjects who completed the treatment regimen, cure was 100%. Discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.10) can be found in the supplement.

Justification and implementation considerations: Isoniazid is widely used at present for treatment of *M. kansasii* pulmonary disease, and in the experience of the expert panel, there have been good outcomes when using a regimen consisting of rifampicin, ethambutol, and isoniazid irrespective of the result of MICs for isoniazid and ethambutol [24]. Based on the *in vitro* activity of macrolides against *M. kansasii*, and 2 studies that demonstrated good treatment outcomes when clarithromycin was substituted for isoniazid [25, 26], the panel suggests that either isoniazid or a macrolide can be used in combination with rifampin and ethambutol.

Question XI: In patients with rifampicin-susceptible M. kansasii *pulmonary disease, should parenteral amikacin or streptomycin be included in the treatment regimen?*

Background: Amikacin or streptomycin is sometimes used for treating NTM pulmonary disease. Studies that included 2–3 months of streptomycin added to a multidrug oral regimen demonstrated high rates of culture conversion and cure in patients with *M. kansasii* pulmonary disease [28, 29, 179]. However, their use in *M. kansasii* disease has not been recommended since the introduction of highly effective rifampicin-based regimens [4, 152, 173].

Recommendation

1) We suggest that neither parenteral amikacin nor streptomycin be used routinely for treating patients with *M. kansasii* pulmonary disease (strong recommendation, very low certainty in estimates of effect).

TABLE 3 Dosing guidelines for drugs used in the management of nontuberculous mycobacterial pulmonary disease

Drug	Daily dosing	Thrice weekly dosing	Hepatic impairment	Renal impairment
Oral				
Azithromycin	250–500 mg per day	500 mg per day	N/A	N/A
Ciprofloxacin	500–750 mg twice per day	N/A	N/A	250–500 mg dosed at intervals according to CrCl
Clarithromycin	500 mg twice per day	500 mg twice per day	N/A	Reduce dose by 50% if CrCl <30 mL·min^{-1}
Clofazimine[#]	100–200 mg per day	N/A	Caution in severe hepatic impairment	N/A
Doxycycline	100 mg once to twice a day	N/A	N/A	N/A
Ethambutol	15 mg·kg^{-1} per day	25 mg·kg^{-1} per day	N/A	Increase dosing interval (*e.g.* 15–25 mg·kg^{-1}, 3 times per week)
Isoniazid	5 mg·kg^{-1} up to 300 mg per day	N/A	Caution	N/A
Linezolid	600 mg once or twice per day[¶]	N/A	N/A	N/A
Moxifloxacin	400 mg per day	N/A	N/A	N/A
Rifabutin	150–300 mg per day (150 mg per day with clarithromycin)	300 mg per day	Caution	Reduce dose by 50% if CrCl <30 mL·min^{-1}
Rifampicin (rifampin)	10 mg·kg^{-1} (450 mg or 600 mg) per day	600 mg per day	Caution	N/A
Trimethoprim/ sulfamethoxazole	800 mg/160 mg tab twice daily	N/A	Caution	Reduce dose by 50% if CrCl 15–30 mL·min^{-1}
Parenteral				
Amikacin (IV)	10–15 mg·kg^{-1} per day[+], adjusted according to drug level monitoring[§]	15–25 mg·kg^{-1} per day[+], adjusted according to drug level monitoring[§]	N/A	Reduce dose or increase dosing interval (*e.g.* 15 mg·kg^{-1}, 2–3 times per week)
Cefoxitin (IV)	2–4 g 2–3 times daily (maximum daily dose is 12 g per day)	N/A	N/A	Reduce dose or increase dosing interval
Imipenem (IV)	500–1000 mg, 2–3 times per day	N/A	N/A	Reduce dose or increase dosing interval
Streptomycin (IV or IM)	10–15 mg·kg^{-1} per day, adjusted according to drug level monitoring	15–25 mg·kg^{-1} per day, adjusted according to drug level monitoring	N/A	Reduce dose or increase dosing interval (*e.g.* 15 mg·kg^{-1}, 2–3 times per week)
Tigecycline (IV)	25–50 mg once or twice per day[¶]	N/A	25 mg once or twice daily per day in severe hepatic impairment	N/A
Inhalation				
Amikacin liposome inhalation suspension	590 mg per day	N/A	N/A	N/A
Amikacin, parenteral formulation	250–500 mg per day	N/A	N/A	N/A

CrCL: creatinine clearance; IM: intramuscular; IV: intravenous; N/A: not applicable. [#]: clofazimine availability varies by country. In the United States, an investigational new drug application is required. [¶]: most experts recommend once daily dosing of linezolid and tigecycline due to the high rate of drug-related adverse reactions associated with twice daily dosing. [+]: the use of the described regimens for 15 weeks was associated with permanent ototoxicity in approximately one third of patients, and the risk was associated with age and cumulative dose [154]. Given the high rates of ototoxicity, risks and benefits should be carefully considered in light of the goals of therapy. Clinicians should consider lower dose ranges and probably rely on intermittent dosing when more prolonged therapy is employed. [§]: drug level monitoring: trough <5 mg·L^{-1}; peak with daily dosing 35–45 µg·mL^{-1}; peak with intermittent dosing 65–80 µg·mL^{-1} [154].

Summary of the evidence: There have been no randomized clinical trials addressing the use of amikacin or streptomycin for treating *M. kansasii* pulmonary disease, however three case series reported results with parenteral-containing regimens [28, 29, 179]. In one retrospective study including a mixture of NTM species, 16 patients with *M. kansasii* pulmonary disease were treated for 6 months to 2.5 years with regimens including streptomycin (n=14) or capreomycin (n=2) [179]. In the other 2 studies, 115 patients were treated with a rifampicin-based regimen that included isoniazid and ethambutol for 12 months,

TABLE 4 Recommended treatment regimens for *Mycobacterium avium* complex, *M. kansasii*, and *M. xenopi* pulmonary disease

Organism	Number of drugs	Preferred drug regimen[#]	Dosing frequency
M. avium complex			
Nodular-bronchiectatic	3	Azithromycin (clarithromycin) Rifampicin (rifabutin) Ethambutol	3 times weekly
Cavitary	⩾3	Azithromycin (clarithromycin) Rifampicin (rifabutin) Ethambutol Amikacin IV (streptomycin)[¶]	Daily (3 times weekly may be used with aminoglycosides)
Refractory[+]	⩾4	Azithromycin (clarithromycin) Rifampicin (rifabutin) Ethambutol Amikacin liposome inhalation suspension or amikacin IV (streptomycin)[¶]	Daily (3 times weekly may be used with aminoglycosides)
M. kansasii			
	3	Azithromycin (clarithromycin) Rifampicin (rifabutin) Ethambutol	Daily
	3	Azithromycin (clarithromycin) Rifampicin (rifabutin) Ethambutol	3 times weekly
	3	Isoniazid Rifampicin (rifabutin) Ethambutol	Daily
M. xenopi			
	⩾3	Azithromycin (clarithromycin) and/or moxifloxacin Rifampicin (rifabutin) Ethambutol Amikacin[¶]	Daily (3 times weekly may be used with aminoglycosides)

[#]: see table 3 for recommended dosages. Alternative drugs for patients who are intolerant of or whose isolate is resistant to first-line drugs include clofazimine, moxifloxacin, and linezolid. Some experts would consider bedaquiline or tedizolid. [¶]: consider for cavitary, extensive nodular/bronchiectatic disease or macrolide-resistant MAC. Amikacin or streptomycin may be given 3 times a week. [+]: refractory disease is defined as remaining sputum culture positive after 6 months of guideline-based therapy. Amikacin liposome inhalation suspension (ALIS) has been shown to improve culture conversion when added to guideline-based therapy in treatment refractory patients with MAC pulmonary disease.

supplemented with streptomycin 3 days a week for the first 2 months [29]. The pooled culture conversion rate was 95.5% (42 of 44 patients in 2 studies) [29, 179], and recurrences were observed in 4.7% (6 of 127 patients in 3 studies) [28, 29, 179]. Significant adverse events were reported in one study (14.7%), leading to discontinuation of the parenteral agent in 9.5% [28]. Studies that have used oral regimens without inclusion of aminoglycosides have also demonstrated high culture conversion rates and cure with low relapse rates [25–27]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3. 11) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.11) can be found in the supplement.

Justification and implementation considerations: In general, regimens of 3 oral agents, rifampicin and ethambutol, and either isoniazid or a macrolide, achieve high rates of sustained culture conversion and treatment success in the treatment of *M. kansasii* pulmonary disease. Therefore, given the good outcomes observed with oral regimens, the lack of data supporting the benefit of amikacin or streptomycin, and the potential risk of adverse effects associated with amikacin or streptomycin, the panel members felt strongly that the use of these parenteral agents is not warranted, unless it is impossible to use a rifampicin-based regimen or severe disease is present.

Question XII. In patients with rifampicin-susceptible M. kansasii *pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?*

Background: *In vitro* testing shows susceptibility of clinical *M. kansasii* isolates to fluoroquinolones [175, 177, 180, 181], and fluoroquinolones are currently recommended as part of a multidrug regimen to treat

rifampicin-resistant *M. kansasii* pulmonary disease [4]. It is not known whether the *in vitro* activity translates into treatment success that would lead to a change in the current treatment recommendation.

Recommendations

1) In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, we suggest using a regimen of rifampicin, ethambutol, and either isoniazid or macrolide instead of a fluoroquinolone (conditional recommendation, very low certainty in estimates of effect).
2) In patients with rifampicin-resistant *M. kansasii* or intolerance to 1 of the first-line antibiotics we suggest a fluoroquinolone (*e.g.* moxifloxacin) be used as part of a second-line regimen (conditional recommendation, very low certainty in estimates of effect).

Summary of evidence: Although there is good *in vitro* activity of the fluoroquinolones against *M. kansasii*, no randomized clinical trial or case series have been published in which a fluoroquinolone was used for the treatment of *M. kansasii* pulmonary disease. Discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.12) can be found in the supplement.

Justification and implementation considerations: Treatment success of *M. kansasii* pulmonary disease with a rifamycin-based drug regimen is usually excellent but the optimal choice of companion drugs is not clear. Although ethambutol is usually the preferred companion drug, the choice of an additional companion drug may be isoniazid, a macrolide, or a fluoroquinolone. As there is more experience and better evidence for treatment regimens that include isoniazid or a macrolide as a companion drug, these drugs are preferred. For rifampicin-resistant disease, a regimen such as ethambutol, azithromycin, and a fluoroquinolone would be likely to lead to successful treatment.

Question XIII. In patients with rifampicin-susceptible M. kansasii *pulmonary disease, should a 3 times per week or daily treatment regimen be used?*

Background: A rifamycin-based multidrug regimen for treatment of *M. kansasii* pulmonary disease is associated with a high cure rate when administered daily for at least 12 months [25, 27, 182]. Three times weekly treatment has been used successfully in the treatment of noncavitary MAC pulmonary disease [22, 23] and may decrease side effects and increase tolerability without impacting treatment success in patients with *M. kansasii* pulmonary disease [26].

Recommendations

1) In patients with noncavitary nodular/bronchiectatic *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol, and macrolide regimen, we suggest either daily or 3 times weekly treatment (conditional recommendation, very low certainty in estimates of effect).
2) In patients with cavitary *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol, and macrolide-based regimen, we suggest daily treatment rather than 3 times weekly treatment (conditional recommendation, very low certainty in estimates of effect).
3) In all patients with *M. kansasii* pulmonary disease treated with an isoniazid, ethambutol, and rifampicin regimen, we suggest treatment be given daily rather than 3 times weekly (conditional recommendation, very low certainty in estimates of effect).

Summary of evidence: Treatment regimens using daily administration of rifampicin, isoniazid, and ethambutol are associated with high treatment success and low relapse rates [27–29]. There are no studies that have evaluated treatment outcomes of this regimen when given intermittently. In contrast, clarithromycin-based treatment regimens have been demonstrated to have similarly good success rates [25, 26], even when given 3 times per week (14/14 evaluable patients converted sputum cultures and remained relapse free after 46±8.0 months); 9 of the 14 patients had cavitary disease [26]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.13) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.13) can be found in the supplement.

Justification and implementation considerations: Cavitary NTM pulmonary disease has higher morbidity and mortality and warrants a more aggressive treatment approach than noncavitary disease [163, 183]. It is unclear to what extent this principle applies to patients with *M. kansasii* pulmonary disease given that 3 times weekly treatment can be effective in patients with nodular/bronchiectatic or cavitary disease [26]. However, because there are no randomized trials available and the small size of the single study that evaluated 3 times weekly therapy, the panel did not feel that they could recommend intermittent therapy in the setting of cavitary disease until more evidence was available. Similarly, there are no data to support the use of isoniazid on a 3 times weekly basis in patients with *M. kansasii* pulmonary disease.

Question XIV: In patients with rifampicin-susceptible M. kansasii *pulmonary disease, should treatment be continued for <12 months or ⩾12 months?*

Background: Treatment for *M. kansasii* pulmonary disease with a rifampicin-based regimen for at least 12 months after negative sputum cultures was recommended by the 2007 ATS treatment guideline [4]. However, data from several studies suggest that a 12-month fixed duration may be enough to cure most patients [27–29].

Recommendation

1) We suggest that patients with rifampicin-susceptible *M. kansasii* pulmonary disease be treated for at least 12 months (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: There have been no randomized clinical trials comparing <12 months with ⩾12 months of treatment after culture conversion, but a 12-month fixed duration regimen was evaluated in 3 studies [27–29], and a 9-month regimen in one [173]. A clinical trial randomized 28 patients into 2 groups of 14: one group received rifampicin, isoniazid and ethambutol daily for 6 months, followed by rifampicin and isoniazid to complete 12 months (14 patients), and the other group completed 18 months (14 patients) [27]. After 12–30 months of follow-up, one patient in the 12-month arm (7%) and none in the 18-month arm recurred after completing treatment. In a prospective study [29], 40 patients were treated with 1 g of streptomycin (twice weekly for the first 3 months) plus rifampicin, isoniazid, and ethambutol for 12 months. One patient (2.5%) recurred 6 months after completing treatment. Using the same regimen in a series of 75 patients [28], 5 (6.6%) recurred after a median follow-up of 41.5 months. The pooled recurrence rate from these 3 studies was 5.4% (7 of 129 patients) [27–29]. The British Thoracic Society evaluated a 9-month regimen with rifampicin and ethambutol in 115 patients in a prospective study [173]. Although conversion of sputum to negative was achieved in 99.4% of patients, 10% experienced disease recurrence. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.14) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.14) can be found in the supplement.

Justification and implementation considerations: Current rifampicin-based treatment regimens are associated with a high rate of success if used for at least 12 months [27, 29]. Randomized controlled trials comparing shorter treatment regimens are currently lacking. Although some experts would favour 12 months of treatment after culture conversion, there is no evidence that relapses could be prevented with treatment courses longer than 12 months. Some of the reported relapses may actually be exogenous reinfections, as suggested by the long periods between treatment completion and recurrence [27, 173]. Therefore, the panel members felt that *M. kansasii* could be treated for a fixed duration of 12 months instead of 12 months beyond culture conversion. Because sputum conversion at 4 months of rifampicin-based regimens is usually observed [29–31], expert consultation should be obtained if cultures fail to convert to negative by that time.

Treatment of M. kansasii *pulmonary disease: summary*

We suggest a regimen of rifampicin, ethambutol, and either isoniazid or macrolide for patients with rifampicin-susceptible *M. kansasii* pulmonary disease (tables 3 and 4). Neither parenteral amikacin nor streptomycin are recommended for routine use in these patients. We suggest that patients with nodular/bronchiectatic *M. kansasii* pulmonary disease receive either daily or 3 times weekly treatment when receiving a macrolide, rifampicin, and ethambutol. However, in patients with cavitary disease, the regimen should be administered daily. In addition, when patients are treated with a regimen that includes isoniazid, rifampicin, and ethambutol, we suggest treatment be given daily. In patients with rifampicin-resistant *M. kansasii* or intolerance to one of the first-line antibiotics we suggest a fluoroquinolone (*e.g.* moxifloxacin) be used as part of a second-line regimen. We suggest that all patients be treated for at least 12 months.

Treatment of M. xenopi *pulmonary disease (Questions XV–XVIII)*

Question XV. In patients with M. xenopi *pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?*

Background: *M. xenopi* pulmonary disease is difficult to treat and associated with high all-cause mortality [35, 36, 131, 184, 185] that is higher than other NTM species, with a 5-year mortality of 51% and 43% in population-based studies from Denmark and Canada, respectively [34, 186]. The elevated mortality may be due to the underlying lung disease, frequent concomitant chronic pulmonary aspergillosis [187, 188], as well as frequent cavitation among patients with *M. xenopi* disease [189]. *In vitro* data suggest that MIC values of fluoroquinolones are low for *M. xenopi*: *in vitro* activity of moxifloxacin is equal to that of clarithromycin [190]. In murine models, adding either moxifloxacin or clarithromycin to a rifampicin-ethambutol combination leads to drug regimens of equal efficacy [191].

Recommendation

1) In patients with *M. xenopi* pulmonary disease, we suggest using a multidrug treatment regimen that includes moxifloxacin or a macrolide (conditional recommendation, low certainty in estimates of effect).

Summary of the evidence: There are 2 systematic reviews that have reported treatment outcomes of *M. xenopi* pulmonary disease, and both noted a wide range of drugs and regimens used [184, 185]. Only 1 randomized clinical trial has been published that compared ciprofloxacin with clarithromycin when added to rifampicin and ethambutol in patients with *M. xenopi* pulmonary disease [131]. In this study, 34 patients were treated with either ciprofloxacin (n=17) or clarithromycin (n=17) in addition to rifampicin and ethambutol. No significant differences were found between the 2 regimens in term of death, cure, recurrence or adverse effects. However, the power of the study was too low to conclude which regimen was best (only 34 patients and 2 events). Moreover, in this study that also included patients with *M. avium* or *M. malmoense*, adverse events were not reported separately for *M. xenopi*. Preliminary data from a study in France in which randomized patients received either moxifloxacin or clarithromycin plus ethambutol and rifampicin reported no difference in the treatment success between the study arms [33]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.15) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.15) can be found in the supplement.

Justification and implementation considerations: There is *in vitro* evidence that macrolides and fluoroquinolones are active against *M. xenopi*, whereas rifampicin and ethambutol are inactive *in vitro* alone and in combinations [32]. From this perspective, a multidrug regimen that utilizes a macrolide or fluoroquinolone would be likely more active.

Question XVI. In patients with M. xenopi *pulmonary disease, should a 2-, 3-, or 4-drug regimen be used for treatment?*

Background: Despite the poor prognosis of *M. xenopi* pulmonary disease, there are few studies available on optimal treatment [35]. Like in other NTM infections, a multidrug therapy is used to avoid selecting for drug resistance, but the optimal number and combination of drugs are not known.

Recommendation

1) In patients with *M xenopi* pulmonary disease, we suggest a daily regimen that includes at least 3 drugs: rifampicin, ethambutol, and either a macrolide and/or a fluoroquinolone (*e.g.* moxifloxacin) (conditional recommendation, very low certainty in estimates of effect).

Summary of evidence: There are 2 systematic reviews that have reviewed treatment outcomes of *M. xenopi* pulmonary disease, and both noted a wide range of drugs and regimens used [184, 185]. The authors of these reviews were unable to recommend the optimal number of drugs to be used in the regimen, although in 1 review, fluoroquinolone-containing regimens were associated with a greater proportion of relapse-free success [185]. Two randomized controlled studies in patients with *M. xenopi* pulmonary disease were conducted by the British Thoracic Society [36, 119, 131]. The first study compared efficacy of a regimen containing rifampicin, ethambutol with or without isoniazid in 42 patients (20 *versus* 22) [36, 119]. No significant differences were found in terms of death, cure or recurrence between the 2 groups. Nevertheless, the power is probably insufficient, with few patients included and few events occurred. The main result of this study was the poor prognosis of these patients (5-year mortality of 57% with *M. xenopi versus* 31% in MAC disease and 25% in *M. malmoense* disease). In the second study, 34 patients with *M. xenopi* pulmonary disease were randomized to receive rifampicin, ethambutol, and either ciprofloxacin or clarithromycin. Treatment failure/relapse occurred in 24% of the clarithromycin group *versus* 6% in the ciprofloxacin group [131]. In a murine model of *M. xenopi* infection, a 4-drug regimen (rifampicin, ethambutol, amikacin, and clarithromycin or moxifloxacin) demonstrated better efficacy than a 3-drug regimen (rifampicin, ethambutol, and moxifloxacin or clarithromycin) [191]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.16) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.16) can be found in the supplement.

Justification and implementation considerations: In animal and *in vitro* models, regimens of rifampicin, ethambutol, and either clarithromycin or moxifloxacin are efficacious and those that included amikacin (see Question 17) even more so. Given the very high mortality associated with *M. xenopi*, the committee felt the large risk of treatment failure with a 2-drug regimen warranted a strong recommendation for at least a 3-drug treatment regimen. However, the lack of confidence in the estimates of effect from the available studies tempered the recommendation. Additionally, the absence of universal access to

moxifloxacin and the small amount of data for other fluoroquinolones has to be considered when choosing a regimen.

Question XVII. In patients with M. xenopi *pulmonary disease, should parenteral amikacin or streptomycin be included in the treatment regimen?*

Background: Patients with *M. xenopi* pulmonary disease frequently present with cavitary disease [189], often respond poorly to treatment [35, 36, 184, 185], and suffer a higher all-cause mortality than other NTM species [34, 186]. Based on expert opinion, the 2007 guideline suggested that adding streptomycin to a multidrug oral regimen is reasonable [4]. However, there is substantial uncertainty regarding best treatment regimens for *M. xenopi*.

Recommendation

1) In patients with cavitary or advanced/severe bronchiectatic *M. xenopi* pulmonary disease, we suggest adding parenteral amikacin to the treatment regimen and obtaining expert consultation (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: For the current guideline, no high-quality studies addressing the question were identified. In a systematic review of *M. xenopi* pulmonary disease, data regarding parenteral therapy were found exclusively in retrospective series, and the data synthesis identified evidence against aminoglycosides [185]. Compared with patients who did not receive aminoglycosides, patients who received aminoglycosides had lower success rates both in the short term (56% *versus* 82%, p=0.019) and long term (38% *versus* 68%, p=0.029). However, the comparison was undoubtedly biased strongly by disease severity. Two studies in mice infected with *M. xenopi* have shown reduced colony forming units among mice treated with amikacin in addition to comparator regimens [191, 192]. One study used intravenously infected mice treated with clarithromycin, ofloxacin plus/minus amikacin [192], and the other study used an inhalational infection model and treatment with either clarithromycin/ethambutol/rifampicin or moxifloxacin/ethambutol/rifampicin plus/minus amikacin [191], and both studies identified microbiologic benefit of the addition of amikacin. Discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.17) can be found in the supplement.

Justification and implementation considerations: This recommendation is based on expert opinion and data from murine models of *M. xenopi* infection, wherein microbiologic benefit was observed in mice treated with amikacin [191, 192]. Barring compelling evidence to the contrary, *M xenopi* patients should be treated aggressively given the high mortality of the disease [34–36]. In addition to the high mortality, the panel considered the general acceptability and feasibility of parenteral therapy, and potential costs and toxicities, all based on clinical experience.

Question XVIII. In patients with M. xenopi *pulmonary disease, should treatment be continued for <12 months or ⩾12 months after culture conversion?*

Background: The optimal duration of treatment for *M. xenopi* pulmonary disease is not known, neither is the effect of treatment duration on the frequency of disease recurrence. The 2007 guideline suggested a treatment duration of 12 months beyond culture conversion, acknowledging that the optimal duration was unknown [4].

Recommendation

1) In patients with *M. xenopi* pulmonary disease, we suggest that treatment be continued for at least 12 months beyond culture conversion (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: No studies have specifically addressed this question. Two studies in the 1980s found that treatment durations had an effect on outcomes (typically with isoniazid-rifampicin-ethambutol regimens). Treatment duration over 18 months lead to relapse-free cure in 8/11 patients [122]; treatment regimens over 9 months of duration cured more patients (11/23) than shorter regimens (1/11) [37]. A 2009 systematic review concluded that the data available at the time of the review did not permit comment on the impact of treatment duration on treatment outcomes [185]. Subsequent case series could not address the specific question but found that treatment duration of <6 months was associated with higher mortality and with recurrence [35]. One clinical trial has examined 24-month long regimens for *M. xenopi* pulmonary disease; 12 of 34 (35%) patients treated showed a favourable response that could be sustained for 3 years after treatment; however, 18 patients (54%) deviated from the treatment protocol, for which no further details are available [131]. Three retrospective case series have reported on outcomes and mean or median treatment duration, but regimens varied and none of these studies specifically correlated treatment duration with outcomes. A study in France recorded 27% clinical and/ or microbiological conversion with

a median duration of treatment of 5 months in 122 patients [35]. In Croatia, 6 months of first-line antituberculosis treatment led to favourable outcomes in 10 of 20 patients (50%) [193]. In the Netherlands, 11 of 19 patients (58%) treated for a mean of 9 months achieved culture conversion sustained until end of treatment [123]. Mortality rates varying from 21% [123] to 41% [131] and even 69% [35] suggest that long-term treatment and follow-up are a significant challenge in this specific disease. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.18) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.18) can be found in the supplement.

Justification and implementation considerations: The data reviewed above suggest that treatment outcomes improve if the duration of treatment increases. The panel members felt that this outweighs the risk of adverse events associated with longer treatment and agrees with previous recommendations [4].

Treatment of M. xenopi *pulmonary disease: summary*

In patients with *M. xenopi* pulmonary disease, we suggest a daily regimen that includes at least 3 drugs: rifampicin, ethambutol, and either a macrolide and/or a fluoroquinolone (*e.g.* moxifloxacin) (tables 3 and 4). In patients with severe *M. xenopi* pulmonary disease, we suggest adding parenteral amikacin to the treatment regimen and obtaining expert consultation given the poor treatment outcomes. We suggest treatment be continued for ⩾12 months after culture conversion.

Treatment of M. abscessus *pulmonary disease (Questions XIX–XXI)*

Question XIX. In patients with M. abscessus *pulmonary disease, should a macrolide-based regimen or a regimen without a macrolide be used for treatment?*

Background: Macrolides possess potent activity against *M. abscessus* as well as immunomodulatory effects. Macrolide resistance can develop through chromosomal mutations in the 23S rDNA (*rrl*) gene resulting in high level mutational resistance as well as through induction of the *erm*(41) gene that causes inducible resistance in the presence of a macrolide [125]. *M. abscessus* subsp. (*abscessus*, *bolletii*, and *massiliense*) are rapidly growing mycobacteria that differ in *in vitro* susceptibility to macrolides based on the functionality of the *erm*(41) gene [194]. The different mechanisms leading to macrolide resistance have made it difficult for clinicians to determine when to use a macrolide in the treatment of *M. abscessus* pulmonary disease.

Recommendations

1) In patients with *M. abscessus* pulmonary disease caused by strains *without* inducible or mutational resistance, we recommend a macrolide-containing multidrug treatment regimen (strong recommendation, very low certainty in estimates of effect).
2) In patients with *M. abscessus* pulmonary disease caused by strains *with* inducible or mutational macrolide resistance, we suggest a macrolide-containing regimen if the drug is being used for its immunomodulatory properties although the macrolide is not counted as an active drug in the multidrug regimen (conditional recommendation, very low certainty in estimates of effect).

Summary of evidence: There were no studies identified that compared macrolide-containing regimens with nonmacrolide-containing regimens. A recent systematic review [195] reported that a single study reported the use of macrolide-free regimens in 120 patients of whom 8% experienced culture conversion [196]. This review included an additional 13 studies that used macrolide-containing regimens of which 10 were retrospective [38, 39, 89, 197–203] and 3 prospective cohort designs [12, 108, 204]. A second systematic review [184] included 10 studies including 2 [90, 205] that were not assessed in the other systematic review. Evidence from these studies has demonstrated the importance of macrolide susceptibility and treatment outcomes. Compared with the macrolide-free regimen, the macrolide-containing regimens had a pooled sustained sputum culture conversion of 34% with *M. abscessus* subsp. *abscessus* and 54% with subsp. *massiliense* [195]. Overall, good treatment outcomes were noted in 84% of those with *M. abscessus* subsp. *massiliense* compared with 23% with subsp. *abscessus*.

Four studies compared treatment outcomes in patients with infections due to *M. abscessus* subsp. *abscessus* or *massiliense* [38, 198, 199, 203, 206, 207]. Among the over 200 patients included in the studies, culture conversion ranged between 25–42% and 50–96% among those with subsp. *abscessus* and *massiliense*, respectively. The very large differences in culture conversion between the 2 subspecies were likely related to the nonfunctional *erm*(41) gene (no inducible resistance) in subsp. *massiliense* and a functional gene in most isolates of subsp. *abscessus*. This strongly suggests that macrolides provide a very large benefit in the treatment of macrolide-suspectible *M. abscessus*. Additional data demonstrating the importance of the macrolide in treatment is a study that reported that only 1 (7%) patient with macrolide resistant *M. abscessus* subsp. *massiliense* had a favourable outcome with treatment [124]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.19) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.19) can be found in the supplement.

Justification and implementation considerations: *M. abscessus* infections can be life-threatening, and the use of macrolides is potentially of great benefit. Macrolides are very active *in vitro* against *M. abscessus* strains without a functional *erm*(41) gene [208]. The far better treatment outcomes in studies of *M. abscessus* subsp. *massiliense versus* subsp. *abscessus* (inactive *versus* active *erm*(41) gene), where treatment differences appear to depend on the activity of the macrolide, strongly suggest a major benefit from this drug class [38, 39, 203, 206, 207]. Despite the very low certainty in the estimates of effect, the committee felt a strong recommendation was appropriate given the high morbidity and mortality of *M. abscessus* infections and significant potential clinical impact of macrolides given their *in vitro* activity.

It is important to consider identification of the *M. abscessus* subsp. in addition to *in vitro* macrolide susceptibility testing, because of the difference in response to macrolide therapy based on the presence of a functional or nonfunctional *erm*(41) gene. The acquisition of treatment associated mutational macrolide resistance in patients with *M. abscessus,* with or without inducible macrolide resistance, suggests that mutations in 23S rRNA are responsible for high level macrolide resistance [125]. In this setting, macrolides are unlikely to be contributing to the antimicrobial effect of the treatment regimen.

Macrolides have been demonstrated to prevent exacerbations of bronchiectasis in patients with chronic *Pseudomonas* infection, despite the lack of antimicrobial activity against *Pseudomonas* [209, 210], which is a common copathogen in patients with bronchiectasis [211]. However, the risk of acquiring resistance to other coinfecting pathogens must be considered when macrolides are used for immunomodulatory purposes in patients whose isolate has documented inducible or mutational macrolide resistance [209, 210]. As with all patients receiving treatment, frequent sputum cultures should be obtained during the course of therapy to monitor for treatment response and survey for the appearance of other organisms such as *M. avium* complex. In this setting, the treatment regimen should be adjusted to cover the new isolates in order to avoid development of macrolide resistance in the new NTM.

Question XX. In patients with M. abscessus *pulmonary disease, how many antibiotics should be included within multidrug regimens?*

Background: *M. abscessus* isolates display *in vitro* resistance to most oral antibiotics and are generally susceptible to a limited number of parenteral agents including tigecycline, imipenem, cefoxitin, and amikacin. Previous guidelines recommend using a multidrug regimen including ⩾2 of these antibiotics to which the organism is susceptible *in vitro*. Recent work suggests a lack of consensus among treating physicians, with a variety of regimens employed against this organism ranging from 2 to 5 drugs in the initial phases of therapy [212].

Recommendation

1) In patients with *M. abscessus* pulmonary disease, we suggest a multidrug regimen that includes at least three active drugs (guided by *in vitro* susceptibility) (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: There are 2 systematic reviews [184, 195] that have reported treatment outcomes in patients with *M. abscessus* pulmonary disease, but there are no studies that have directly compared the efficacy or safety of different multidrug regimens. Based on the systematic reviews, the overall sputum culture conversion in patients with *M. abscessus* (not further subspeciated) treated with a multidrug, macrolide-containing regimen was 59%: culture conversion occurred in 34–41% in those with *M. abscessus* subsp. *abscessus* and 54–69.8% in those with *M. abscessus* subsp. *massiliense* [184, 195]. One observational retrospective study attempted to compare a macrolide plus amikacin regimen *versus* a 3-drug regimen consisting of a macrolide, amikacin, and either imipenem or cefoxitin [198]. However, they did not distinguish patients with *M. abscessus* isolates with and without functional *erm* genes. Accordingly, the interpretation of outcomes associated with these regimens was not possible. One additional observational retrospective study suggested that multidrug therapy is associated with improved quality of life in *M. abscessus* patients, but this study did not compare outcomes according to different drug regimens [108]. Importantly, the few cases series that have described treatment outcomes all used multidrug regimens with ⩾3 drugs [184, 195]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.20) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.20) can be found in the supplement.

Justification and implementation considerations: Given the usual disease severity of *M. abscessus* pulmonary disease, the variable and limited *in vitro* drug susceptibility of these organisms, the potential for the emergence of drug resistance, and the potential for more rapid progression of *M. abscessus* pulmonary disease, the expert panel suggests using a regimen consisting of ⩾3 active drugs in macrolide susceptible disease and at least 4 drugs, when possible, in macrolide resistant disease. This is particularly true in the initial months of therapy when bacterial burdens are greater. Design of regimens beyond the

initial intravenous phase is difficult given the lack of oral antimicrobials with activity against *M. abscessus*. Although macrolides might still be useful for immunomodulatory effects or antimicrobial effects against other coinfecting organisms, they are not counted as an active drug against *M. abscessus* when inducible or mutational resistance is noted. The committee members feel strongly that treatment regimens should be designed in collaboration with experts in the management of these complicated infections.

Question XXI. In patients with M. abscessus *pulmonary disease, should shorter or longer duration therapy be used for treatment?*

Background: The 2007 guideline noted that no medication strategy could reliably achieve the goal of 12 months of negative sputum cultures while on therapy [4]. It was therefore suggested that periodic treatment courses, or aggressive treatment regimens including multiple parenteral agents for a few months, could be effective strategies. However, the optimum treatment duration of pulmonary disease caused by *M. abscessus* complex is currently unknown.

Recommendation

1) In patients with *M. abscessus* pulmonary disease, we suggest that either a shorter or longer treatment regimen be used and expert consultation obtained (conditional recommendation for either the intervention or comparator, very low certainty in estimates of effect).

Summary of the evidence: Only 1 study addressing this specific question was identified by the systematic review [213]. This observational, retrospective study included 30 patients with *M. abscessus* pulmonary disease who met the diagnostic criteria defined in the 2007 guideline. Overall, 17 of the patients were treated for >1 month and had follow-up available for at least 1 year: 13 were treated for less than 12 months, and 4 were treated for ⩾12 months. No significant difference was found in the cure rate between the 2 groups. No additional information was available with regard to lung involvement, nor to the subsp. of *M. abscessus*. The study methodology, notably no control for confounding, indirect comparisons with different regimens of various duration, and a wide confidence interval, indicate high risk of bias. Two recent systematic reviews did not address the optimum duration of therapy but noted that most patients with *M. abscessus* were treated for over 12 months with multidrug regimens including a minimum of 4 weeks of ⩾1 parenteral antimicrobials [184, 195]. The relative and absolute effect estimates and 95% CIs for each outcome (table E3.21) and discussion of value preferences, feasibility, cost, acceptability, and health inequality (table E4.21) can be found in the supplement.

Given the better treatment outcomes with disease due to *M. abscessus* subsp. *massiliense*, a shorter or less intensive course of therapy may be possible. In a retrospective study of 128 patients with *M. abscessus*, patients with *M. abscessus* subsp. *massiliense* had better treatment outomes than patients with subsp. *abscessus* despite receiving shorter durations of parenteral and total treatment: patients with *M. abscessus* subsp. *massiliense* received a median of 4.7 months of parenteral therapy and 12.1 months of total treatment compared with 7.4 and 16.3 months in patients with *M. abscessus* subsp. *abscessus*, respectively [207]. In another study, 71 patients with *M. abscessus* subsp. *massiliense* were treated with either 2 or 4 weeks of intravenous amikacin and cefoxitin (or imipenem) along with an oral macrolide [204]. Those treated with a 2-week course of parenteral therapy followed by at least 12 months of an oral macrolide post conversion had a culture conversion rate of 91% compared with 100% in those who received a 4-week course and oral macrolide for 24 months. Two patients who received the shorter course of therapy developed acquired macrolide resistance. Although the expert panel does not recommend macrolide monotherapy for treatment of NTM pulmonary disease, the study demonstrated that similar treatment outcomes could be obtained using shorter and less intensive treatment than used for *M. abscessus* subsp. *abscessus*.

Justification and implementation considerations: The 1 study identified had a very small sample size, only indirectly addressed this question, and was felt to be of too low quality to form the basis of a recommendation. The lack of studies evaluating treatment durations, the variation in drug and resource availability, as well as the diverse practice settings, made it difficult to come to a consensus on the optimum duration of therapy. In addition, the panel members felt that some subgroups of patients should be considered separately in determining the length of therapy such as: patients with nodular/bronchiectatic *versus* cavitary disease, patients affected by lung disease caused by different *M. abscessus* subspecies and, importantly, depending on susceptibility to macrolides and amikacin. Although the optimal duration of therapy is not known, most patients reported in the literature with *M. abscessus* were treated for >12 months, and the treatment was divided into an initial phase usually including parenteral drugs followed by a longer phase using oral and sometimes inhaled antibiotics [184, 195]. The panel members suggest that an expert in the management of patients with *M. abscessus* pulmonary disease be consulted prior to initiation of therapy in order to assist with determination of the duration of therapy.

Treatment of M. abscessus *pulmonary disease: summary*

The optimal drugs, regimens, and duration of therapy are not known. Patients with *M. abscessus* pulmonary disease caused by strains *without* inducible (typically *M. massiliense*) or mutational macrolide resistance should be treated with a macrolide-containing multidrug regimen that includes at least 3 active drugs (guided by *in vitro* susceptibility) in the initial phase of treatment (the phase including intravenous agents) (tables 3 and 5). In patients with *M. abscessus* pulmonary disease caused by strains *with* inducible (typically *M. abscessus* or *M. bolettii*) or mutational macrolide resistance, we suggest a regimen that includes at least 4 active drugs, when possible. We suggest a macrolide-containing regimen if the drug is being used for its immunomodulatory properties although the macrolide is not counted as an active drug in the multidrug regimen. For the continuation phase of therapy (after the parenteral component), we suggest that at least 2–3 active drugs be given. Some experts would use intermittent courses of multidrug therapy instead of transitioning to a longer continuation phase, although almost all published studies treated patients for >12 months. In the absence of data to support a shorter or longer treatment course for *M. abscessus* pulmonary disease, the panel members suggest that expert consultation be obtained prior to initiation of therapy in order to assist with design of the regimen and determine whether a shorter or longer treatment regimen should be used.

Surgical resection for treatment of NTM pulmonary disease (Question XXII)

Question XXII. Should surgery plus medical therapy or medical therapy alone be used to treat NTM pulmonary disease?

Background: NTM pulmonary disease is often difficult to cure with antimicrobial therapy alone. Selected patients with failure of medical management, cavitary disease, drug-resistant isolates, or complications such as hemoptysis or severe bronchiectasis may undergo surgical resection of the diseased lung. The decision to proceed with surgical resection must be weighed against the risks and benefits of surgery.

Recommendation

1) In selected patients with NTM pulmonary disease, we suggest surgical resection as an adjuvant to medical therapy after expert consultation (conditional recommendation, very low certainty in estimates of effect).

Summary of the evidence: We identified 15 observational studies [30, 39, 43, 89, 214–223] including approximately 700 patients who underwent various surgical resections including segmentectomies, lobectomies, and pneumonectomies. Most patients included in the studies had MAC pulmonary disease, with 1 study including only patients with *M. xenopi* pulmonary disease [221], 1 with *M. kansasii* only [30], and 2 including patients with *M. abscessus* pulmonary disease [39, 89]. Almost all of the patients who underwent surgery had received antimicrobial treatment before and after surgery. Three studies reported results for patients treated with combined antibiotic and surgical therapy, compared with antibiotic therapy alone [30, 39, 89].

Cure rate of the NTM disease, death, and recurrences were not significantly different between medical and surgical therapy in the 3 comparative studies that included a total of 296 patients with follow-up data (95 surgical plus medical and 201 medical only). Although there was more culture conversion observed in the patients who underwent surgery, the quality of evidence was very low, due to the small number of patients treated, inherent selection bias by treatment group, lack of adjustment for other clinical variables, and the fact that all patients were treated by medical therapy. The desirable anticipated effects were estimated to be moderate. Surgical complications (such as bronchopleural fistula, prolonged air leak, pneumonia) were observed in 7–35% of participants. There was no operative mortality and postoperative mortality was reported in 0–9% of patients. In 1 study that reported outcomes of patients who underwent video assisted thoracoscopic surgery (VATS), culture conversion occurred in 84% of the patients, postoperative complications occurred in 7% of patients, and there were no operative or postoperative deaths reported [216]. Undesirable effects were estimated as small, and the balance between desirable and undesirable probably favours the intervention. There was no evidence identified for costs, which were estimated as moderate with regard to the duration of the disease. Therefore, surgery was estimated as acceptable to key stakeholders and feasible.

Justification and implementation considerations: The studies differed by location, the age and gender of patients, and the mycobacterial species involved (*M. avium* [214, 218, 220, 222], *M. kansasii* [30], *M. abscessus* [39, 89], *M. xenopi* [221] or a mix of species [89, 215–217, 219, 220, 223]). Moreover, the studies suffer from multiple potential biases including different reasons for performing surgery, patient selection, and subjective assessment of postsurgical outcomes. Even so, surgical resection was associated with improved treatment outcomes and for most of the patients (85–100%), conversion of sputum cultures to negative was observed after surgery. Therapy with antimicrobial agents continued during and after the

TABLE 5 Treatment regimens for *Mycobacterium abscessus* by macrolide susceptibility (mutational and inducible resistance)

Macrolide susceptibility pattern		Number of drugs[+]	Preferred drugs	Frequency of dosing
Mutational[#]	Inducible[¶]			
Susceptible	Susceptible	Initial phase ⩾3	*Parenteral (choose 1–2)* Amikacin Imipenem (or Cefoxitin) Tigecycline *Oral (choose 2)* Azithromycin (clarithromycin)[§] Clofazimine Linezolid	Daily (3 times weekly may be used for aminoglycosides)
		Continuation phase ⩾2	*Oral/inhaled (choose 2–3)* Azithromycin (clarithromycin)[§] Clofazimine Linezolid Inhaled amikacin	
Susceptible	Resistant	Initial phase ⩾4	*Parenteral (choose 2–3)* Amikacin Imipenem (or Cefoxitin) Tigecycline *Oral (choose 2–3)* Azithromycin (clarithromycin)[f] Clofazimine Linezolid	Daily (3 times weekly may be used for aminoglycosides)
		Continuation phase ⩾2	*Oral/inhaled (choose 2–3)* Azithromycin (clarithromycin)[f] Clofazimine Linezolid Inhaled amikacin	
Resistant	Susceptible or resistant	Initial phase ⩾4	*Parenteral (choose 2–3)* Amikacin Imipenem (or Cefoxitin) Tigecycline *Oral (choose 2–3)* Azithromycin (clarithromycin)[f] Clofazimine Linezolid	Daily (3 times weekly may be used for aminoglycosides)
		Continuation phase ⩾2	*Oral/inhaled (choose 2–3)* Azithromycin (clarithromycin)[f] Clofazimine Linezolid Inhaled amikacin	

[#]: mutational resistance: none present: isolate determined to be phenotypically susceptible at 3–5 days of incubation in culture. Present: isolate determined to be phenotypically resistant at 3–5 days of incubation or sequencing identifies *rrl* mutation know to confer resistance. [¶]: inducible resistance: functional *erm*(41) gene: isolate determined to be resistant after 14 days of incubation or sequencing identifies functional gene sequence. Nonfunctional *erm*(41) gene: isolate determined to be susceptible after 14 days of incubation or sequencing identifies truncated sequence or C28 mutation (in subspecies *abscessus*). [+]: initial phase refers to the time that the parenteral agents are being given. Continuation phase refers to the subsequent phase of therapy that typically includes oral antimicrobial agents sometimes paired with inhaled agents. [§]: azithromycin (clarithromycin) is active in this setting and should be used whenever possible. [f]: azithromycin (clarithromycin) activity is unlikely but can be added for its immunomodulatory effects but should not be counted as active against *M. abscessus* with a functional *erm*(41) gene. In this setting, frequent sputum cultures should be obtained to detect potentially new organisms like *M. avium* complex.

surgery, and the activity of these agents varied with regard to the study and the species involved (*e.g.* clarithromycin was given in recent studies but not in the older ones). Many experts feel it is desirable to achieve at least smear conversion prior to surgical resection, and the panel suggests that surgery be performed by a surgeon experienced in performing surgery on patients with mycobacterial disease [43].

Monitoring for response to therapy

Clinical, radiographic, and microbiologic data should be collected in order to assess whether or not a patient is responding to therapy. Chest radiographs or chest CT imaging may be beneficial for defining a

TABLE 6 Common adverse drug reactions and monitoring recommendations[#]

Drug	Adverse reactions	Monitoring
Azithromycin	Gastrointestinal Tinnitus/hearing loss Hepatotoxicity Prolonged QTc	Clinical monitoring Audiogram Liver function tests ECG (QTc)
Clarithromycin	Gastrointestinal Tinnitus/hearing loss Hepatotoxicity Prolonged QTc	Clinical monitoring Audiogram Liver function tests ECG (QTc)
Clofazimine	Tanning of skin and dry-ness Hepatotoxicity Prolonged QTc	Clinical monitoring Liver function tests ECG (QTc)
Doxycycline	GI upset Photosensitivity Tinnitus/vertigo	Clinical monitoring Clinical monitoring Clinical monitoring
Ethambutol	Ocular toxicity Neuropathy	Visual acuity and colour discrimination Clinical monitoring
Isoniazid	Hepatitis Peripheral neuropathy	Liver function tests Clinical monitoring
Linezolid	Peripheral neuropathy Optic neuritis Cytopenias	Clinical monitoring Visual acuity and colour discrimination Complete blood count
Moxifloxacin	Prolonged QTc Hepatotoxicity Tendinopathy	ECG (QTc) Liver function tests Clinical monitoring
Trimethoprim/sulfamethoxazole	GI upset Cytopenias Hypersensitivity Photosensitivity	Clinical monitoring Complete blood count Clinical monitoring Clinical monitoring
Rifabutin	Hepatotoxicity Cytopenias Uveitis Hypersensitivity Orange discolouration of secretions	Liver function test Complete blood count Visual acuity Clinical monitoring
Rifampicin (rifampin)	Hepatotoxicity Cytopenias Hypersensitivity Orange discolouration of secretions	Liver function test Complete blood count Clinical monitoring
Amikacin, streptomycin, tobramycin	Vestibular toxicity Ototoxicity Nephrotoxicity Electrolyte disturbances	Clinical monitoring Audiograms BUN, creatinine Calcium, magnesium, potassium
Amikacin liposome inhalation suspension	Dysphonia Vestibular toxicity Ototoxicity Nephrotoxicity Cough Dyspnea	Clinical monitoring Clinical monitoring Audiograms BUN, creatinine Clinical monitoring Clinical monitoring
Cefoxitin	Cytopenias Hypersensitivity	Complete blood count Clinical monitoring
Imipenem	Rashes Cytopenias Nephrotoxicity	Clinical monitoring Complete blood count BUN/Creatinine

Continued

TABLE 6 Continued

Drug	Adverse reactions	Monitoring
Tigecycline	Nausea/vomiting Hepatitis/pancreatitis	Clinical monitoring Liver function tests, amylase/lipase

Monitoring frequency should be individualized based on treatment regimen, age, comorbidities, concurrent drugs, overlapping drug toxicities, and resources. BUN: blood, urea, nitrogen; ECG: electrocardiogram; GI: gastrointestinal; QTc: corrected QT. #: the expert panel recommends that patients have a complete blood count, liver function tests, and metabolic panel every 1–3 months in patients on oral therapy and weekly when on intravenous therapy.

radiographic response to therapy, although there can be wide variability in findings given the common occurrence of underlying lung disease. Because the duration of therapy is based on the time of culture conversion, frequent collection of sputum specimens is required in order to determine the recommended treatment duration. The expert panel would consider obtaining sputum specimens for culture every 1–2 months in order to document when sputum cultures become negative. Sputum should be induced with hypertonic saline if spontaneous sputum specimens cannot be collected. Bronchoscopy should only be considered in exceptional circumstances to determine whether culture conversion has occurred. In addition to microbiologic assessments, clinical and radiographic response to therapy should be used to determine if the patient is responding to therapy.

Monitoring for adverse reactions

The drugs used to treat NTM pulmonary disease are frequently associated with adverse reactions. A recent randomized clinical trial reported that >90% of subjects in each arm reported a treatment emergent adverse reaction [20]. Therefore, educating patients regarding potential reactions and monitoring for them is an important component of management. Rapid identification and management of an adverse reaction is likely to decrease the risk of treatment for the patient and possibly improve the chances of treatment completion. Table 6 lists common adverse reactions associated with the drugs used to treat NTM pulmonary disease and an approach to monitoring. Unfortunately, there are no studies that have identified the optimum frequency or most cost-effective approach to monitoring for drug-related adverse reactions. Monitoring frequency should be individualized based on age, comorbidities, concurrent drugs, overlapping drug toxicities, and resources.

Therapeutic drug monitoring

Therapeutic drug monitoring (TDM) refers to the measurement of drug concentrations in serum specimens at some point after dosing to determine whether or not a specific target concentration has been obtained (table 3). There are no randomized trials that have determined the clinical utility of performing TDM. However, studies have documented significant reductions in serum drug concentrations of clarithromycin with concurrent use of rifampicin and to a lesser extent with rifabutin [145, 224, 225]. Two studies described the association of serum concentrations of macrolides and treatment outcomes. The first study reported no association between the serum concentration of clarithromycin and treatment outcomes [224], whereas the second study noted a correlation between the peak serum concentration (Cmax) of azithromycin and favourable treatment outcomes when administered daily (250 mg) but not intermittently (500 mg) [226]. Experts would consider performing TDM in situations in which drug malabsorption, drug underdosing, or clinically important drug-drug interactions are suspected [227]. Examples of situations in which TDM may be useful include patients with delayed sputum culture conversion or treatment failure not explained by nonadherence or drug resistance, patients receiving amikacin or streptomycin therapy and thus at risk of ototoxicity and nephrotoxicity, and patients with medical conditions (*e.g.* reduced renal function) that are suspected of leading to subtherapeutic or toxic drug concentrations.

Research priorities

During the development of this guideline, research gaps were identified for each of the PICO questions. Not surprisingly, there were many gaps and needs identified related to the treatment of NTM pulmonary disease. Many of the research priorities relate to the need for new drugs, treatment regimens, shorter regimens, and better tolerated regimens. Evaluation of new drugs will require standardized case definitions, outcome measures, and comparator regimens, as well as the ability to conduct multicentre trials [228]. A recent publication produced consensus definitions of microbiologic and functional endpoints [170]. In addition, a recent report of patient research priorities highlighted the importance of including quality of

life outcomes in addition to microbiologic assessments in clinical trials [229]. The interested reader is referred to a separate publication that will follow highlighting these research gaps and priorities.

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Treatment of Nontuberculous Mycobacterial Pulmonary Disease:

An Official ATS/ERS/ESCMID/IDSA Clinical Practice Guideline

Online Supplement

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Table E1. EXPERT PANEL MEMBERS

Name	Role	Society	Expertise	Location
Charles L. Daley, MD	Lead chair	ATS	Pulmonologist	Denver, CO, USA
Emmanuelle Cambau, PhD	Co-chair	ESCMID	Microbiologist	Paris, France
Christoph Lange, MD, PhD	Co-chair	ERS	Pulmonologist	Borstel, Germany
Richard J. Wallace Jr, MD	Co-chair	IDSA	Infectious diseases, microbiologist	Tyler, TX, USA
Jonathan M. Iaccario, MD	Methodologist	ATS	Methodology	Boston, MA, USA
Jan Brozek, MD, PhD	Methodologist	ATS	Methodology	Hamilton, Canada
Claire Andrejak, MD	Member	ERS	Pulmonologist	Amiens, France
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David E. Griffith, MD	Member	ATS	Pulmonologist	Tyler, TX, USA
Lorenzo Guglielmetti, MD, PhD	Member	ESCMID	Infectious Diseases	Paris, France
Gwen A. Huitt, MD	Member	Ad hoc	Infectious Diseases	Denver, CO, USA
Shandra L. Knight	Medical Librarian	Ad hoc	Systematic reviews	Denver, CO, USA
Philip Leitman	Patient advocate	Ad hoc	Patient advocacy	Miami, FL, USA

Theodore K. Marras, MD	Member	ATS	Pulmonologist	Toronto, Canada
Kenneth N. Olivier, MD	Member	ATS	Pulmonologist	Bethesda, MD, USA
Miguel Santin, MD	Member	ESCMID	Infectious Diseases	Barcelona, Spain
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Enrico Tortoli, MD	Member	Ad hoc	Microbiologist	Milan, Italy
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ATS – American Thoracic Society, ERS – European Respiratory Society, ESCMID - European Society of Clinical Microbiology and Infectious Diseases, IDSA - Infectious Diseases Society of America

Table E2. Search Strategy

The Medline search was adapted for execution on the Ovid Platform for Embase, Cochrane Central Register of Controlled Trials (CCTR), Database of Abstracts of Reviews of Effects (DARE), Health Technology Assessment (HTA), and NHS Economic Evaluation Database (NHSEED). Searches for all years were limited to human studies or studies indexed with neither human nor animal; and those published in English or containing an English abstract. A final update was run through July 2018. To supplement the electronic search, reviewers contacted experts and hand searched journals, conference proceedings, reference lists, and regulatory agency Web sites for relevant articles.

MEDLINE 1946 to Present with Daily Update

#	**Searches**
1	mycobacterium infections, nontuberculous/ or mycobacterium infections, atypical/ or mycobacterium avium-intracellulare infection/
2	nontuberculous mycobacteria/ or mycobacterium avium complex/ or mycobacterium kansasii/ or mycobacterium xenopi/
3	(mycobacter$ adj3 (atypical or kansasi$ or malmoense or xenopi$ or ab?cessus or massiliense or bolleti$ or avium or intracellulare or chim?era)).tw.
4	2 or 3 [mycobacterium terms]
5	(exp Mycobacterium/ or Mycobacterium Infections/) and (MOTT or NTM or MAC or MAIC).tw.
6	(nontubercul$ or non-tubercul$).tw.
7	(Lady adj Windermere$ Syndrome).tw.
8	5 or 6 or 7 [additional concepts]
9	1 or 4 or 8 [Total]
10	..l/ 9 lg=en or ab=y [English or English abstract]
11	animals/ not humans/
12	10 not 11
13	(th or tu).xs.
14	12 and 13

MEDLINE In-Process & Other Non-Indexed Citations

#	Searches
1	(mycobacter$ adj3 (atypical or kansasi$ or malmoense or xenop$ or ab?cessus or massiliense or bolleti$ or avium or intracellulare or chim?era)).tw.
2	(Mycobacter$ and (MOTT or NTM or MAC or MAIC)).tw.
3	(nontubercul$ or non-tubercul$).tw.
4	1 or 2 or 3

Embase 1974 to Present

#	Searches
1	atypical mycobacteriosis/ or Mycobacterium avium complex lung disease/
2	atypical Mycobacterium/ or mycobacterium avium complex/ or mycobacterium kansasii/ or mycobacterium xenopi/ or mycobacterium abscessus/ or "mycobacterium abscessus subsp. bolletii"/
3	(mycobacter$ adj3 (atypical or kansasi$ or malmoense xenopi$ or ab?cessus or massiliense or bolleti$ or avium or intracellulare or chim?era)).tw.
4	2 or 3 [mycobacterium terms]
5	(exp Mycobacterium/ or mycobacteriosis/) and (MOTT or NTM or MAC or MAIC).tw.
6	(nontubercul$ or non-tubercul$).tw.
7	(Lady adj Windermere$ Syndrome).tw.
8	5 or 6 or 7 [additional concepts]
9	1 or 4 or 8 [Total]
10	..l/ 9 lg=en or ab=y [English or English abstract]
11	animal/ not human/
12	10 not 11
13	exp respiratory system/
14	exp thorax/

15	exp respiratory tract disease/
16	exp lung surgery/
17	exp respiratory tract agent/
18	exp respiratory function/
19	or/13-18
20	(lung$ or pulmon$ or respirat$).tw.
21	19 or 20
22	12 and 21
23	random.tw. or clinical trial.mp. or exp health care quality/
24	double-blind.mp. or placebo.tw. or blind.tw.
25	(treat$ or therap$).ti.
26	(ad or ae or br or ca or cb or cm or co or ct or dm or dr or dt or ih or im or it or iv or pa or pc or pd or pe or pl or po or sc or si or su or th or to).fs.
27	or/23-26
28	22 and 27

CCTR, DARE, CLHTA, CLEED

#	**Searches**
1	(mycobacter$ adj3 (atypical or kansasi$ or malmoense or xenop$ or ab?cessus or massiliense or bolleti$ or avium or intracellulare or chim?era)).tw.
2	(Mycobacter$ and (MOTT or NTM or MAC or MAIC)).tw.
3	(nontubercul$ or non-tubercul$).tw.
4	1 or 2 or 3
5	remove duplicates from 4

MEDLINE – Medical Literature Analysis and Retrieval System Online

EMBASE – Excerpta Medica Database

CCTR – Cochrane Central Register of Controlled Trials

DARE – Database of Abstracts of Reviews of Effects

CLHTA – Health Technology Assessment

CLEED – National Health Services Economic Evaluation Database

Figure E1. PRISMA diagram of studies included and excluded for pulmonary NTM treatment guideline.

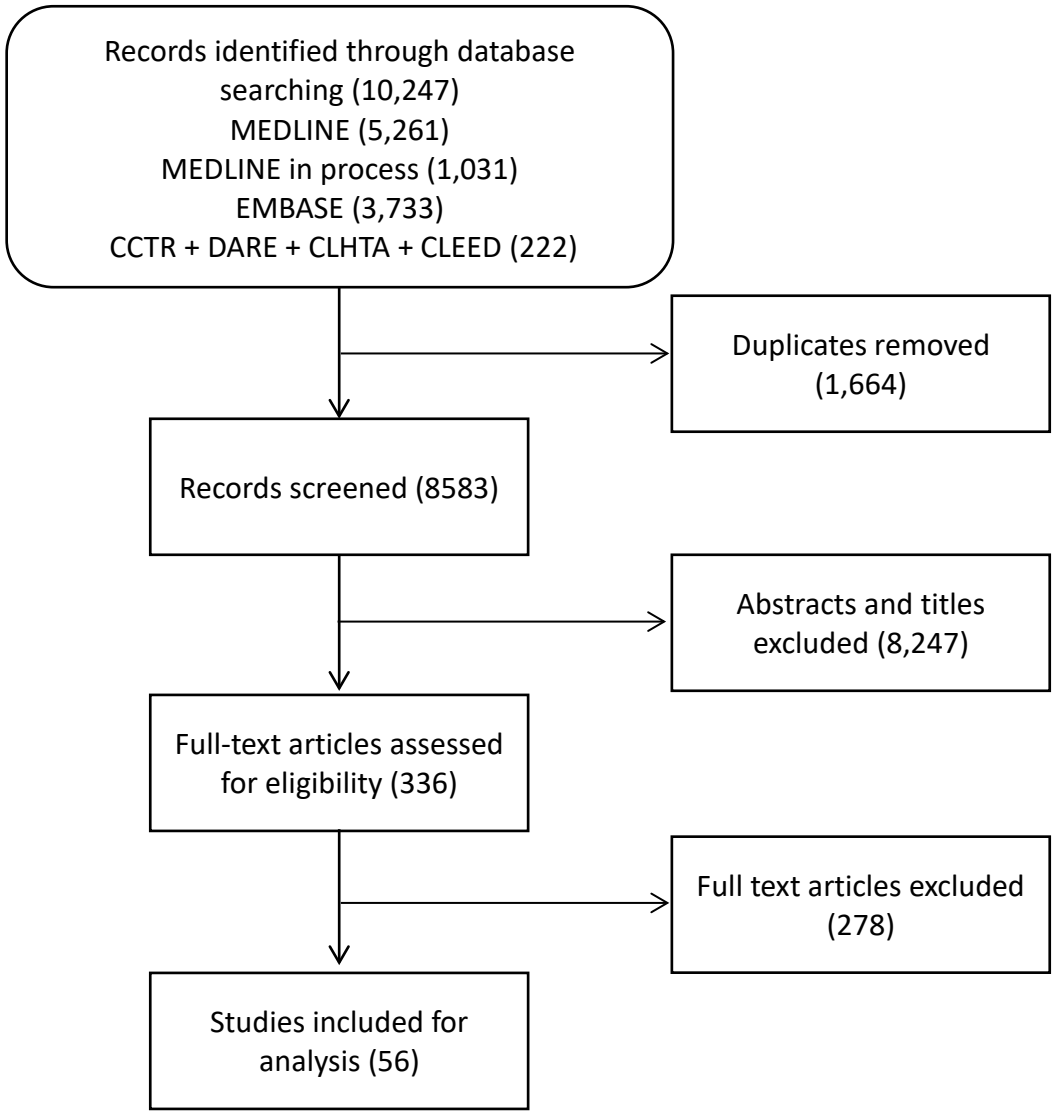

Figure E2: Inclusion and exclusion criteria for full text articles reviewed for pulmonary NTM treatment guideline.

Criteria for exclusion	
Type of publication	ANY of the following ☐ **Review** (if systematic review – exclude but keep record of any that you find) ☐ **Editorial** ☐ **Letter to editor** with no original data ☐ **Case series** ☐ **Case report** ☐ **Other** type of publication (i.e. not a clinical study in humans)
Population	ANY of the following ☐ Patients **without NTM** ☐ Patients **with tuberculosis** ☐ Patients **with HIV** ☐ Patients **with cystic fibrosis** ☐ Pediatric patients
	ANY of the following ☐ **No pharmacological treatment** (i.e. no drug used) ☐ **NTM prevention or prophylaxis**

Criteria for inclusion (at least one criterion in each category has to be met)	
Study design	☐ **Randomized trial** ☐ **Observational study** with a control group (e.g. cohort, before-after, etc.) ☐ **Retrospective review**
Population	☐ Adult patients **with NTM**

Intervention	ANY of the following ☐ **pharmacological treatment** (drug regimen) being the only treatment in ≥1 group ☐ **surgical treatment** in ≥1 group

DECISION

☐ **TO BE INCLUDED**

NOTE: ALL INCLUDED STUDIES WILL NEED TO BE FURTHER SCREENED IF THE REGIMENS USED WERE THE SAME AS THOSE SPECIFIED AS OF INTEREST FOR THESE GUIDELINES.

☐ FURTHER ACTION REQUIRED

What action:

☐ **TO BE EXCLUDED**

Additional comments:

EVIDENCE TABLES (Tables E3.1-22)

Table E3.1. Question 1: Should patients with NTM pulmonary disease be treated with antimicrobial therapy or followed for evidence of progression ("watchful waiting")?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	any treatment	watchful waiting	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
2	observational studies	serious [1]	not serious	not serious	serious [2]	none	43/71 (60.6%)	8/23 (34.8%)	RR 2.03 (0.44 to 9.30)	358 more per 1,000 (from 195 fewer to 1,000 more)	⊕◯◯◯ VERY LOW	CRITICAL
Death												
5	observational studies	serious [1]	not serious	not serious	not serious	none	90/252 (35.7%)	85/186 (45.7%)	RR 0.77 (0.64 to 0.92)	105 fewer per 1,000 (from 37 fewer to 165 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Culture Conversion												
2	observational studies	serious [1]	serious [3]	not serious	serious [2]	none	43/75 (57.3%)	47/93 (50.5%)	RR 1.41 (0.50 to 4.02)	207 more per 1,000 (from 253 fewer to 1,000 more)	⊕◯◯◯ VERY LOW	CRITICAL
Any adverse effect												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	any treatment	watchful waiting	Relative (95% CI)	Absolute (95% CI)		
2	observational studies	serious [1]	not serious	not serious	not serious	none	A total of 43 out of 100 patients in the treatment group had adverse effects. In neither study was it specified if there were any adverse effects in the watchful waiting group (of 67 patients), but presumedly there were none.				⊕◯◯◯ VERY LOW	IMPORTANT
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. Observational studies, risk treatment group had more serious disease
2. wide range in confidence interval
3. Non overlapping confidence intervals between studies

Table E3.2. Question II: Should patients with NTM pulmonary disease be treated empirically or based on in-vitro drug susceptibility results?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	empiric treatment	susceptibility-based treatment	Relative (95% CI)	Absolute (95% CI)		
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Cure of NTM Disease - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death												
1	observational studies	serious [1]	not serious	serious [2]	not serious	none	Authors report no significant difference between empiric vs culture-based regimens (80 vs 75%)				⨁◯◯◯ VERY LOW	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture Conversion - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval

1. No randomization, no concealment
2. Study used old 1997 ATS criteria

Table E3.3. Question III: Should macrolide-susceptible MAC pulmonary disease be treated with a three-drug regimen with a macrolide or without a macrolide?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	three drugs with a macrolide	three drugs without a macrolide	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
2	observational studies	not serious	not serious	not serious	serious [a]	none	31/94 (33.0%)	34/96 (35.4%)	RR 0.93 (0.62 to 1.37)	25 fewer per 1,000 (from 131 more to 135 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Death												
1	observational studies	not serious	not serious	not serious	serious [a]	none	40/83 (48.2%)	26/87 (29.9%)	RR 1.61 (1.09 to 2.39)	182 more per 1,000 (from 27 more to 415 more)	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse)												
2	observational studies	not serious	not serious	not serious	serious [a]	none	9/94 (9.6%)	10/96 (10.4%)	RR 0.87 (0.37 to 2.01)	14 fewer per 1,000 (from 66 fewer to 105 more)	⊕◯◯◯ VERY LOW	CRITICAL
Culture conversion												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	three drugs with a macrolide	three drugs without a macrolide	Relative (95% CI)	Absolute (95% CI)		
2	observational studies	not serious	serious [b]	not serious	serious [a]	none	88/97 (90.7%)	85/100 (85.0%)	RR 0.98 (0.67 to 1.43)	17 fewer per 1,000 (from 281 fewer to 365 more)	⊕◯◯◯ VERY LOW	CRITICAL
Any adverse effect												
1	randomised trials	not serious	not serious	not serious	serious [a]	none	1/14 (7.1%)	4/13 (30.8%)	RR 0.23 (0.03 to 1.82)	237 fewer per 1,000 (from 252 more to 298 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious advere effect												
1	randomised trials	not serious	not serious	not serious	serious [a]	none	0/14 (0.0%)	0/13 (0.0%)	not estimable		⊕⊕◯◯ LOW	CRITICAL
Withdrawal owing to adverse effect												
1	randomised trials	not serious	not serious	not serious	not serious	none	1/14 (7.1%)	2/13 (15.4%)	RR 0.46 (0.05 to 4.53)	83 fewer per 1,000 (from 146 fewer to 543 more)	⊕⊕◯◯ LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

a. Wide confidence interval

b. One study favors w/ macrolide and one favors w/o

Table E3.4. Question IV: In patients with newly diagnosed macrolide susceptible MAC pulmonary disease, should an azithromycin-based regimen or a clarithromycin-based regimen be used?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	azithromycin-based regimen	clarithromycin-based regimen	Relative (95% CI)	Absolute (95% CI)		
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture Conversion (follow up: range 4 to 12 months)												
4	observational studies	serious [1]	not serious	not serious	serious [2]	none	131/178 (73.6%)	156/190 (82.1%)	RR 0.88 (0.73 to 1.05)	10 fewer per 100 (from 4 more to 22 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse) - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance (follow up: range 4 to 12 months)												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	azithromycin-based regimen	clarithromycin-based regimen	Relative (95% CI)	Absolute (95% CI)		
3	observational studies	serious [1]	not serious	not serious	serious [3]	none	4/92 (4.3%)	9/97 (9.3%)	RR 0.51 (0.07 to 2.79) [4]	5 fewer per 100 (from 9 fewer to 17 more)	⊕◯◯◯ VERY LOW	CRITICAL
Serious adverse effects (follow up: 4 months)												
1	observational studies	serious [1]	not serious	not serious	serious [5]	none	0/29 (0.0%)	0/30 (0.0%)	not estimable	0 fewer per 100 (from 60 fewer to 60 more)	⊕◯◯◯ VERY LOW	CRITICAL
Withdrawal from study due to AEs (follow up: range 4 to 6 months)												
3	observational studies	serious [1]	not serious	not serious	serious [6]	none	12/87 (13.8%)	15/104 (14.4%)	RR 1.02 (0.45 to 2.07)	0 fewer per 100 (from 8 fewer to 15 more)	⊕◯◯◯ VERY LOW	CRITICAL
Any Adverse Effect (follow up: range 4 to 12 months)												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	azithromycin-based regimen	clarithromycin-based regimen	Relative (95% CI)	Absolute (95% CI)		
6	observational studies	serious [1]	not serious [7]	not serious	serious [8]	none	64/215 (29.8%)	109/268 (40.7%)	RR 0.75 (0.44 to 1.28)	10 **fewer per 100** (from 11 more to 23 fewer)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; RR: Risk ratio; OR: Odds ratio

1. Studies did not adjust for confounders in the analysis
2. Confidence interval does not exclude an appreciable benefit with azithromycin or no difference
3. Only 14 events
4. Based on unadjusted OR of 0.44 (0.06 to 3.41)
5. Only 59 patients
6. Only 27 events; Confidence interval does not exclude an appreciable benefit with ether intervention
7. There was statistical heterogeneity and CIs of some studies did not overlap; however, if one study hat was an outlier was excluded from analysis it did not change the results (RR 0.94; 95% CI: 0.68 to 1.29)
8. Confidence interval does not exclude an appreciable benefit with either intervention

Table E3.5. Question V: Should patients with macrolide susceptible MAC pulmonary disease be treated with a parenteral amikacin or streptomycin-containing regimen or without a parenteral amikacin or streptomycin-containing regimen?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a treatment regimen with a parenteral agent	a treatment regimen without a parenteral agent	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death												
1	randomised trials	not serious	not serious	not serious	serious [3]	none	2/73 (2.7%)	2/73 (2.7%)	RR 1.00 (0.14 to 6.91)	0 fewer per 1,000 (from 24 fewer to 162 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Recurrence (relapse)												
1	randomised trials	not serious	not serious	not serious	serious	none	16/52 (30.8%)	13/37 (35.1%)	RR 0.88 (0.48 to 1.59)	42 fewer per 1,000 (from 183 fewer to 207 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Culture Conversion												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a treatment regimen with a parenteral agent	a treatment regimen without a parenteral agent	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	serious [3]	none	52/73 (71.2%)	37/73 (50.7%)	RR 1.41 (1.07 to 1.84)	208 more per 1,000 (from 35 more to 426 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Any adverse reaction												
1	randomised trials	not serious	not serious	not serious	serious [3]	none	18/73 (24.7%)	15/73 (20.5%)	RR 1.20 (0.66 to 2.19)	41 more per 1,000 (from 70 fewer to 245 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events												
1	randomised trials	not serious	not serious	not serious	not serious	none	0/73 (0.0%)	0/73 (0.0%)	not estimable		⊕⊕⊕⊕ HIGH	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a treatment regimen with a parenteral agent	a treatment regimen without a parenteral agent	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounders
2. Drug regimens among patients varied widely, both with/without macrolide
3. Wide confidence interval

Table E3.6. Question VI: In patients with macrolide-susceptible MAC pulmonary disease, should a regimen with inhaled amikacin or a regimen without inhaled amikacin be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a regimen with inhaled antibiotics	a regimen without inhaled antibiotics	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
1	observational studies	serious [a]	not serious	not serious	not serious	none	3/3 (100.0%)	-	-	-	⊕◯◯◯ VERY LOW	CRITICAL
Death												
2	observational studies	serious [a]	not serious	not serious	not serious	none	2/9 (22.2%)	not pooled	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse)												
3	randomised trials	serious	not serious	not serious	not serious	none	9/21 (42.9%)	0/0	not pooled	see comment	⊕⊕⊕◯ MODERATE	CRITICAL
Culture Conversion												
3	randomised trials	serious [b]	serious [c]	not serious	not serious	none	16/40 (40.0%)	1/28 (3.6%)	not pooled	see comment	⊕⊕◯◯ LOW	CRITICAL
Any Adverse Effect												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a regimen with inhaled antibiotics	a regimen without inhaled antibiotics	Relative (95% CI)	Absolute (95% CI)		
3	randomised trials	serious [b]	serious [d]	not serious	not serious	none	46/59 (78.0%)	40/45 (88.9%)	not pooled	see comment	⨁⨁◯◯ LOW	CRITICAL
Serious Adverse Effect												
3	randomised trials	serious [b]	serious [e]	not serious	not serious	none	8/59 (13.6%)	4/45 (8.9%)	not pooled	see comment	⨁⨁◯◯ LOW	CRITICAL
Withdrawal owing to adverse effects												
4	randomised trials	serious [b]	serious [f]	not serious	not serious	none	15/79 (19.0%)	0/45 (0.0%)	not pooled	see comment	⨁⨁◯◯ LOW	CRITICAL
Quality of Life												
1	randomised trials	not serious	not serious	serious [g]	not serious	none	Study used Quality of Life - Bronchiectasis - Nontuberculous Mycobacteria Module scores with no significant difference (p-0.204) between the inhaled antibiotic group (-7.9 [14.2], n=36) and placebo group (-2.8 [13.7], n=36).				⨁⨁⨁◯ MODERATE	CRITICAL
Development of Antibiotic Resistance												
1	randomised trials	not serious	not serious	serious [g]	not serious	none	3/44 (6.8%)	2/45 (4.4%)	not estimable		⨁⨁⨁◯ MODERATE	CRITICAL

CI: Confidence interval; RR: Risk ratio; OR: Odds ratio

a. Studies were case series without a control group

b. Included 2 case series without a control group

c. Conversion with inhaled antibiotics ranged from 30% to 80%

d. Adverse effects ranged from 30% in case series to over 90% in RCT

e. Ranged from 0% in case series to nearly 20% in RCT

f. Ranged from 0% to 35% in inhaled group.

g. Included both MAC and M abscessus

Table E3.7. Question VII: In patients with macrolide-susceptible MAC pulmonary disease, should a three drug regimen or a two drug regimen be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three drug regimen	a two trug regimen	Relative (95% CI)	Absolute (95% CI)		
Culture Conversion												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	24/59 (40.7%)	33/60 (55.0%)	RR 0.74 (0.50 to 1.09)	143 fewer per 1,000 (from 50 more to 275 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious Adverse Effects												
1	randomised trials	serious [1]	not serious	not serious	not serious	none	0/59 (0.0%)	0/60 (0.0%)	not estimable		⊕⊕⊕◯ MODERATE	CRITICAL
Withdrawal owing to adverse effect												
1	randomised trials	serious [1]	not serious	not serious	serious [2]		22/59 (37.3%)	16/60 (26.7%)	RR 1.40 (0.80 to 2.12)	107 more per 1,000 (from 53 fewer to 299 more)	-	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Cure of NTM Disease - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three drug regimen	a two trug regimen	Relative (95% CI)	Absolute (95% CI)		
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence (relapse) - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. not blinded, no concealment
2. wide confidence interval

Table E3.8. Question VIII: In patients with macrolide susceptible MAC pulmonary disease, should a daily or an intermittent macrolide-based regimen be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week macrolide-based regimen	daily macrolide-based regimen	Relative (95% CI)	Absolute (95% CI)		
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Cure of NTM Disease (follow up: 12 months)												
1	observational studies	serious [1]	not serious	not serious [2]	not serious	none	79/118 (66.9%)	75/99 (75.8%)	RR 0.97 (0.72 to 1.14) [3]	2 fewer per 100 (from 11 more to 21 fewer)	⨁◯◯◯ VERY LOW	CRITICAL
Culture Conversion (follow up: range 6 to 12 months)												
5	observational studies	serious [1]	not serious	not serious [4]	not serious	none	328/413 (79.4%)	136/184 (73.9%)	RR 1.03 (0.93 to 1.14)	2 more per 100 (from 5 fewer to 10 more)	⨁◯◯◯ VERY LOW	CRITICAL

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week macrolide-based regimen	daily macrolide-based regimen	Relative (95% CI)	Absolute (95% CI)		
Recurrence (follow up: 12 months; assessed with: microbiological recurrence of two or more positive cultures after an initial negative conversion during antibiotic therapy)												
1	observational studies	serious [1]	not serious	not serious [2]	serious [5]	none	3/82 (3.7%)	1/76 (1.3%)	RR 2.78 (0.30 to 26.16)	2 more per 100 (from 1 fewer to 33 more)	⨁◯◯◯ VERY LOW	CRITICAL
Development of Antibiotic Resistance (follow up: range 6 to 12 months)												
4	observational studies	serious [1]	not serious	not serious [4]	serious [6]	none	3/146 (2.1%)	10/86 (11.6%)	RR 0.23 (0.07 to 0.74)	9 fewer per 100 (from 3 fewer to 11 fewer)	⨁◯◯◯ VERY LOW	CRITICAL
Serious adverse effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Discontinuation of the initial treatment due to adverse effects (follow up: range 6 to 12 months)												
4	observational studies	not serious [1]	not serious [7]	not serious	serious [8]	none	28/362 (7.7%)	45/202 (22.3%)	RR 0.44 (0.09 to 2.16)	12 fewer per 100 (from 20 fewer to 26 more)	⨁◯◯◯ VERY LOW	IMPORTANT

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week macrolide-based regimen	daily macrolide-based regimen	Relative (95% CI)	Absolute (95% CI)		
Adverse Effects (follow up: range 6 to 12 months)												
4	observational studies	not serious [1]	not serious	not serious	serious [8]	none	66/259 (25.5%)	72/186 (38.7%)	RR 0.63 (0.25 to 1.55)	14 fewer per 100 (from 21 more to 29 fewer)	⨁◯◯◯ VERY LOW	IMPORTANT

CI: Confidence interval; RR: Risk ratio

1. Studies did not adjust for confounders in analysis
2. None of the patients had cavitary disease which would make the information indirect for that population.
3. Based on adjusted OR of 0.891 (0.387 to 2.050)
4. Some studies included only patients without cavitary disease and some included both cavitary and non-cavitary but did not report the results separately
5. Only 4 events; confidence interval does not exclude an appreciable benefit from either regimen
6. Only 13 events
7. Im one study a large proportion of patients did not tolerate daily regimen; if this study was excluded from analysis the result would be 0.85 (0.48 to 1.49)
8. confidence interval does not exclude an appreciable harm from either regimen

Table E3.9. Question IX: In patients with macrolide susceptible MAC pulmonary disease, should patients be treated with less than 12 months of treatment after culture negativity or 12 or more months of treatment after culture negativity?

Quality assessment							**№ of** patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
Culture conversion												
1	observational studies	serious [1]	not serious	serious [2]	not serious	none	6/27 (22.2%)	154/180 (85.6%)	RR 0.26 (0.13 to 0.53)	633 fewer per 1,000 (from 402 fewer to 744 fewer)	⨁◯◯◯ VERY LOW	CRITICAL
Cure of NTM disease - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence (relapse) - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Adverse drug effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounding
2. Study compares TID vs daily regimens and this is a secondary analysis of patients unable to tolerate 12 months of therapy for various reasons

Table E3.10. Question X: In patients with *M. kansasii* pulmonary disease, should an isoniazid-containing regimen or a macrolide-containing regimen be used for treatment?

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a INH-containing regimen	a macrolide-contaning regimen	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance – not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture conversion - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Adverse drug effects - not measured												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a INH-containing regimen	a macrolide-contaning regimen	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence (relapse) - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

Table E3.11. Question XI: In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a treatment regimen with a parenteral agent	a treatment regimen without a parenteral agent	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
1	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [2]	8/10 (80.0%)	-	-	-	⊕◯◯◯ VERY LOW	CRITICAL
Death												
2	observational studies	serious [1]	not serious	not serious	not serious [2]	publication bias strongly suspected [2]	30/121 (24.8%)	not pooled	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse)												
2	observational studies	serious [1]	not serious	not serious	< not serious	publication bias strongly suspected [2]	6/115 (5.2%)	not pooled	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Culture Conversion												
2	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [2]	42/44 (95.5%)	not pooled	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a treatment regimen with a parenteral agent	a treatment regimen without a parenteral agent	Relative (95% CI)	Absolute (95% CI)		
Any adverse effect												
1	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [2]	11/75 (14.7%)	-	-	-	⨁◯◯◯ VERY LOW	CRITICAL
Serious Adverse Effect												
1	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [2]	0/75 (0.0%)	-	-	-	⨁◯◯◯ VERY LOW	CRITICAL
Withdrawal owing to adverse effects												
1	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [2]	7/75 (9.3%)	-	-	-	⨁◯◯◯ VERY LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of Antibiotic Resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio; OR: Odds ratio

1. Case series, no control group
2. Based on case series data. There are likely unpublished case series not included in the analysis.

Table E3.12. Question XII: In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a regimen with a fluoroquinolone	a regimen without a fluoroquinolone	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM Disease - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Recurrence (relapse) - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture Conversion - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a regimen with a fluoroquinolone	a regimen without a fluoroquinolone	Relative (95% CI)	Absolute (95% CI)		
Adverse drug effects - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; OR: Odds ratio

Table E3.13. Question XIII: In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should a three times per week or daily treatment regimen be used?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week treatment regimen	a daily treatment regimen	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
2	observational studies	serious [1]	serious [2]	not serious	not serious	publication bias strongly suspected [3]	0/0	115/182 (63.2%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Death												
3	observational studies	serious [3]	serious [2]	not serious	not serious	publication bias strongly suspected [3]	0/18 (0.0%)	39/229 (17.0%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse)												
3	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [3]	0/14 (0.0%)	16/178 (9.0%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Culture Conversion												
4	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [3]	17/18 (94.4%)	238/257 (92.6%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week treatment regimen	a daily treatment regimen	Relative (95% CI)	Absolute (95% CI)		
Any Adverse Effect												
1	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [3]	0/18 (0.0%)	0/0	not estimable		⊕◯◯◯ VERY LOW	CRITICAL
Serious adverse effects												
2	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [3]	0/18 (0.0%)	0/28 (0.0%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Withdrawal owing to adverse effects												
2	observational studies	serious [1]	not serious	not serious	not serious	publication bias strongly suspected [3]	0/18 (0.0%)	0/28 (0.0%)	not pooled	see comment	⊕◯◯◯ VERY LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a three times per week treatment regimen	a daily treatment regimen	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. Case series, no control groups
2. Wide variation between studies
3. Data based on case series. There are likely unpublished case series that were not included.

Table E3.14. Question XIV: In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months?

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	14/14 (100.0%)	14/14 (100.0%)	RR 1.00 (0.88 to 1.14)	0 fewer per 1,000 (from 120 fewer to 140 more)	⊕⊕◯◯ LOW	CRITICAL
Recurrence												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	1/14 (7.1%)	0/14 (0.0%)	RR 3.00 (0.13 to 67.91)	0 fewer per 1,000 (from 0 fewer to 0 fewer)	⊕⊕◯◯ LOW	CRITICAL
Culture Conversion												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	14/14 (100.0%)	14/14 (100.0%)	RR 1.00 (0.88 to 1.14)	0 fewer per 1,000 (from 120 fewer to 140 more)	⨁⨁◯◯ LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of Antibiotic Resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Adverse Drug Effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No blinding, unclear concealment
2. Few events

Table E3.15. Question XV: In patients with *M. xenopi* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a quinolone containing regimen	regimen without a fluoroquinolone	Relative (95% CI)	Absolute (95% CI)		
Death (follow up: 5 years)												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	8/17 (47.1%)	5/17 (29.4%)	RR 1.60 (0.66 to 3.91)	18 more per 100 (from 10 fewer to 86 more)	⊕⊕◯◯ LOW	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Cure of NTM disease (follow up: 5 years)												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	6/17 (35.3%)	6/17 (35.3%)	RR 1.00 (0.40 to 2.48)	0 fewer per 100 (from 21 fewer to 52 more)	⊕⊕◯◯ LOW	CRITICAL
Recurrence (relapse) (follow up: 5 years)												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a quinolone containing regimen	regimen without a fluoroquinolone	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious [1]	not serious	not serious	serious [3]	none	0/17 (0.0%)	2/17 (11.8%)	RR 0.20 (0.01 to 3.88)	9 fewer per 100 (from 12 fewer to 34 more)	⨁⨁◯◯ LOW	CRITICAL
Culture conversion - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Severe adverse effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Any adverse effects (follow up: 2 years)												
1	randomised trials	serious [1]	not serious	serious [4]	serious [5]	none	38/185 (20.5%)	37/186 (19.9%)	RR 1.03 (0.69 to 1.55)	1 more per 100 (from 6 fewer to 11 more)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. Participants and investigators were not blinded
2. Only 13 events; CI does not exclude an appreciable benefit with either intervention
3. Only 2 events and 34 patients in total
4. AEs were not reported separately for M. xenopi
5. Only 75 events and CI does not exclude appreciable benefit with either intervention

Table E3.16. Question XVI: In patients with *M. xenopi* pulmonary disease, should a two, three or four-drug regimen be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a two drug regimen	a three drug regimen	Relative (95% CI)	Absolute (95% CI)		
Death (follow up: 5 years)												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	11/22 (50.0%)	13/20 (65.0%)	RR 0.77 (0.45 to 1.30)	150 fewer per 1,000 (from 195 more to 358 fewer)	⊕⊕◯◯ LOW	CRITICAL
Cure of NTM												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	5/22 (22.7%)	2/20 (10.0%)	RR 2.27 (0.50 to 10.43)	127 more per 1,000 (from 50 fewer to 943 more)	⊕⊕◯◯ LOW	CRITICAL
Recurrence												
1	randomised trials	serious [1]	not serious	not serious	serious [2]	none	2/22 (9.1%)	0/20 (0.0%)	RR 4.57 (0.23 to 89.72)	0 fewer per 1,000 (from 0 fewer to 0 fewer)	⊕⊕◯◯ LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												

Quality assessment							**№ of patients**		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a two drug regimen	a three drug regimen	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture Conversion - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No blinding, unclear if properly randomized/concealed
2. Wide confidence interval, small number of events

Table E3.17. Question XVII: In patients with *M. xenopi* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Parenteral	no parenteral agent	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM disease - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Death - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Recurrence (relapse) - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Culture conversion - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Adverse drug effects - not measured												
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL
Development of antibiotic resistance - not measured												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Parenteral	no parenteral agent	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	see comment	-	CRITICAL

CI: Confidence interval

Table E3.18. Question XVIII: In patients with *M. xenopi* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months after culture conversion?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
2	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	6/27 (22.2%)	13/27 (48.1%)	RR 0.54 (0.26 to 1.13)	221 fewer per 1,000 (from 63 more to 356 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence												
2	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	6/27 (22.2%)	10/27 (37.0%)	RR 0.58 (0.26 to 1.30)	156 fewer per 1,000 (from 111 more to 274 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Culture conversion												
1	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	2/4 (50.0%)	4/7 (57.1%)	RR 0.88 (0.27 to 2.82)	69 fewer per 1,000 (from 417 fewer to 1,000 more)	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	<12 months of treatment after culture negativity	>/= 12 months of treatment after culture negativity	Relative (95% CI)	Absolute (95% CI)		
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Adverse drug effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounding
2. Not a direct comparison
3. Wide confidence interval

Table E3.19. Question XIX: In patients with *Mycobacterium abscessus* pulmonary disease, should a macrolide-based regimen or a regimen without a macrolide be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a macrolide-containing regimen	a non-macrolide containing regimen	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
2	observational studies	serious [1]	Not serious	not serious	not serious	publication bias strongly suspected [2]	48/75 (64.0%)	3/7 (42.9%)	RR 2.18 (0.98 to 4.84)	506 more per 1,000 (from 9 fewer to 1,000 more)	⊕◯◯◯ VERY LOW	CRITICAL
Death												
1	observational studies	serious [3]	not serious	not serious	not serious	publication bias strongly suspected [2]	2/65 (3.1%)	-	-	-	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (Relapse)												
1	observational studies	serious [3]	not serious	not seririous	not serious	publication bias strongly suspected [2]	9/47 (19.1%)	-	-	-	⊕◯◯◯ VERY LOW	CRITICAL
Culture Conversion												
1	observational studies	serious [3]	not serious	not serious	not serious	publication bias strongly suspected [2]	47/65 (72.3%)	-	-	-	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a macrolide-containing regimen	a non-macrolide containing regimen	Relative (95% CI)	Absolute (95% CI)		
Any adverse effect												
1	observational studies	serious [3]	not serious	not serious	not serious	publication bias strongly suspected [2]	14/65 (21.5%)	-	-	-	⨁◯◯◯ VERY LOW	CRITICAL
Withdrawal owing to adverse effect												
1	observational studies	serious [3]	not serious	not serious	not serious	publication bias strongly suspected [2]	6/65 (9.2%)	-	-	-	⨁◯◯◯ VERY LOW	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounding
2. Data limited to case series and likely that there have been unpublished case series not captured

3. No control group

Table E3.20. Question XX: How many antibiotics should be included within multidrug regimens for treatment of Mycobacterium abscessus pulmonary infection

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	two drugs	three vs. four drugs	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM disease (follow up: median 445 days)												
1	observational studies	serious [1]	not serious	serious [2]	serious	none	13/17 (76.5%)	20/24 (83.3%)	RR 0.92 (0.67 to 1.26)	67 fewer per 1000 (from 217 more to 275 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse) (follow up: median 445 days)												
1	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	3/13 (23.1%)	1/20 (5.0%)	RR 4.62 (0.54 to 39.73)	181 more per 1000 (from 23 fewer to 1000 more) [2]	⊕◯◯◯ VERY LOW	CRITICAL
Any adverse effect (follow up: median 445 days)												
1	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	3/17 (17.6%)	15/24 (62.5%)	RR 0.28 (0.10 to 0.83)	450 fewer per 1000 (from 106 fewer to 563 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Culture conversion												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	two drugs	three vs. four drugs	Relative (95% CI)	Absolute (95% CI)		
1	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	The study reported no significant difference between the two groups, but only reported a p-value of 0.698 without specifying exact numbers.				⊕◯◯◯ VERY LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. Observational study without blinding, randomization
2. Unclear subspecies of M abscessus
3. large range in confidence interval, few events

Table E3.21. Question XXI: In patients with *Mycobacterium abscessus* pulmonary disease, should shorter or longer duration of therapy be used for treatment?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	shorter therapy duration	longer therapy duration	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
1	observational studies	serious [1]	not serious	serious [2]	serious [3]	none	9/13 (69.2%)	4/4 (100.0%)	RR 0.75 (0.47 to 1.20)	250 fewer per 1,000 (from 200 more to 530 fewer)	⨁◯◯◯ VERY LOW	CRITICAL
Recurrence (relapse) - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Culture conversion - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Quality of life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Development of antibiotic resistance - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Death - not reported												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	shorter therapy duration	longer therapy duration	Relative (95% CI)	Absolute (95% CI)		
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL
Adverse drug effects - not reported												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounding
2. Not a direct comparison, various regimens and course length
3. Wide confidence interval

Table E3.22. Question XXII: Should surgery plus medical therapy or medical therapy alone be used to treat NTM pulmonary disease?

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	surgery	medical therapy	Relative (95% CI)	Absolute (95% CI)		
Cure of NTM												
1	observational studies	serious [1]	not serious	not serious	serious [2]	none	13/23 (56.5%)	13/46 (28.3%)	not estimable		⊕◯◯◯ VERY LOW	CRITICAL
Death												
10	observational studies	serious [3]	not serious	not serious	serious [2]	publication bias strongly suspected [4]	20/486 (4.1%)	13/83 (15.7%)	not estimable		⊕◯◯◯ VERY LOW	CRITICAL
Recurrence												
9	observational studies	serious [1,3]	not serious	not serious	serious [2]	publication bias strongly suspected [4]	22/391 (5.6%)	12/102 (11.8%)	not estimable		⊕◯◯◯ VERY LOW	CRITICAL
Culture conversion												
10	observational studies	serious [1,3,5]	not serious	not serious	serious [2]	publication bias strongly suspected [4]	283/331 (85.5%)	18/46 (39.1%)	not estimable		⊕◯◯◯ VERY LOW	CRITICAL
Surgical Complication												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	surgery	medical therapy	Relative (95% CI)	Absolute (95% CI)		
9	observational studies	serious [1,3]	not serious	not serious	not serious	publication bias strongly suspected [4]	111/563 (19.7%)	0/0	not pooled	see comment	⨁◯◯◯ VERY LOW	CRITICAL
Quality of Life - not measured												
-	-	-	-	-	-	-	-	-	-	-	-	CRITICAL

CI: Confidence interval; RR: Risk ratio

1. No control for confounding
2. wide confidence interval
3. case series, no control group

Evidence to Decision Tables (E4.1-22)

Table E4.1. Question I

Should patients with NTM pulmonary disease be treated with antimicrobial therapy or followed for evidence of progression ("watchful waiting")?

POPULATION:	treatment of NTM pulmonary infection
INTERVENTION:	any treatment
COMPARISON:	watchful waiting
MAIN OUTCOMES:	Cure of NTM; Death; Culture Conversion; Any adverse effect; Quality of Life; Recurrence; Development of antibiotic resistance;

Assessment

DESIRABLE EFFECTS

How substantial are the desirable anticipated effects?

○ Trivial
○ Small
● Moderate
○ Large

○ Varies
○ Don't know

Any treatment compared to watchful waiting for NTM pulmonary infection

Outcomes	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with watchful waiting	**Risk with any treatment**			
Cure of NTM	348 per 1000	**706 per 1000** (153 to 1000)	**RR 2.03** (0.44 to 9.30)	94 (2 observational studies)	⨁◯◯◯ VERY LOW [1,2]
Death	457 per 1000	**352 per 1000** (292 to 420)	**RR 0.77** (0.64 to 0.92)	438 (5 observational studies)	⨁◯◯◯ VERY LOW [1,3]
Culture Conversion	505 per 1000	**713 per 1000**	**RR 1.41** (0.50 to	168 (2 observational	⨁◯◯◯ VERY LOW

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
● Small
○ Trivial

○ Varies
○ Don't know

ADDITIONAL CONSIDERATIONS

			(253 to 1000)	4.02)	studies)	[1,2,4]
	Any adverse effect	A total of 43 out of 100 patients in the treatment group had adverse effects. In neither study was it specified if there were any adverse effects in the watchful waiting group (of 67 patients), but presumably there were none.			167 (2 observational studies)	⊕◯◯◯ VERY LOW [1]
	Quality of Life - not measured	-	-	-	-	-
	Recurrence - not measured	-	-	-	-	-
	Development of antibiotic resistance - not measured	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

- ● Very low
- ○ Low
- ○ Moderate
- ○ High

- ○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕◯◯◯ VERY LOW
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW
Quality of Life	CRITICAL	-
Recurrence	CRITICAL	-
Development of antibiotic resistance	CRITICAL	-

VALUES

Is there important uncertainty about or variability in how much

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an

The is no definitive evidence. The cited studies are only on

people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

association between QOL scores and lung function.

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

quality of life and do not compare the outcome with or without treatment. The decision for treatment is often dependent on clinical symptoms and the more severe patients in term of symptoms will probably benefit most from treatment.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
○ Does not favor either the intervention or the comparison
● Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

Any treatment compared to watchful waiting for NTM pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with watchful waiting	**Risk with any treatment**			
Cure of NTM	348 per 1000	**706 per 1000** (153 to 1000)	**RR 2.03** (0.44 to 9.30)	94 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Death	457 per 1000	**352 per 1000** (292 to 420)	**RR 0.77** (0.64 to 0.92)	438 (5 observational studies)	⊕◯◯◯ VERY LOW [1,3]
Culture Conversion	505 per 1000	**713 per 1000** (253 to 1000)	**RR 1.41** (0.50 to 4.02)	168 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,4]
Any adverse effect	A total of 43 out of 100 patients in the treatment group had adverse effects. In neither study was it specified if there were any adverse effects in the watchful waiting group (of 67 patients), but			167 (2 observational	⊕◯◯◯ VERY LOW [1]

		presumedly there were none.				studies)	
		Quality of Life - not measured	-	-	-	-	-
		Recurrence - not measured	-	-	-	-	-
		Development of antibiotic resistance - not measured	-	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.					
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.					
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ○ Probably no impact ○ Probably increased	No research evidence was identified.					

	○ Increased ● Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ○ Probably yes ● Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	**Moderate**	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	**Small**	Trivial		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	

	JUDGEMENT							IMPLICATIONS
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	**Varies**	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know	

Conclusions

Should patients with NTM pulmonary disease be treated with antimicrobial therapy or followed for evidence of progression ("watchful waiting")?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ●	Strong recommendation for the intervention ○
RECOMMENDATION	In patients who meet the diagnostic criteria for NTM pulmonary disease, we suggest initiation of treatment rather than watchful waiting, especially in the context of positive acid-fast bacilli sputum smears and/or cavitary lung disease (conditional recommendation, very low confidence in estimates of effect). The expert panel voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION	For those who have a positive acid-fast smear and/or cavitary disease, there may be increased rate of progression and poor treatment outcomes if treatment is delayed.				
SUBGROUP CONSIDERATIONS	Some subgroups (minimal nodular/bronchiectatic disease) may be safely followed without therapy but those with cavitary disease should not be followed expectantly. In very frail patients with very mild nodular-bronchiectatic disease, the balance between efficacy and tolerability may favor watchful waiting.				
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION					
RESEARCH PRIORITIES	Research is needed to better determine the criteria for treatment according to risk factors (age, sex, comorbidities, respiratory function score, etc) in less pathogenic organisms.				

Table E4.2. Question II

Should patients with NTM pulmonary disease be treated empirically or based on *in vitro* drug susceptibility test results?

POPULATION:	NTM pulmonary infection
INTERVENTION:	empiric treatment
COMPARISON:	susceptibility-based treatment
MAIN OUTCOMES:	Quality of Life; Cure of NTM Disease; Death; Development of antibiotic resistance; Recurrence; Culture Conversion;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ○ Moderate ○ Large ○ Varies ● Don't know	**Empiric treatment compared to susceptibility-based treatment for NTM pulmonary infection**	The one identified study for this question was felt to be only indirectly related and not useful evidence upon which to base a recommendation. Additionally, it was felt that the methods of performing susceptibility testing were outdated and not relevant to current practice. The utility of *in vitro* drug susceptibility testing is entirely dependent on the NTM species being treated and the drugs being tested.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ○ Trivial ○ Varies ● Don't know		The results of standardized and validated drug susceptibility testing are useful for guiding treatment, in particular for drugs where there has been a correlation between *in vitro* activity and treatment outcome, e.g. macrolides, amikacin.

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with susceptibility-based treatment	Risk with empiric treatment			
Quality of Life - not measured	-	-	-	-	-
Cure of NTM Disease - not reported	-	-	-	-	-
Death	Authors report no significant difference between empiric vs culture-based regimens (80 vs 75%)			(1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]

		Development of antibiotic resistance - not measured	-	-	-	-	-
		Recurrence - not measured	-	-	-	-	-
		Culture Conversion - not reported	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

- ● Very low
- ○ Low
- ○ Moderate
- ○ High

- ○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Quality of Life	CRITICAL	(not measured)
Cure of NTM Disease	CRITICAL	(not measured)
Death	CRITICAL	⊕◯◯◯ VERY LOW
Development of antibiotic resistance	CRITICAL	(not measured)
Recurrence	CRITICAL	(not measured)
Culture Conversion	CRITICAL	(not measured)

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

- ○ Important uncertainty or variability
- ● Possibly important uncertainty or variability
- ○ Probably no important uncertainty or variability
- ○ No important uncertainty or variability

Values and preferences:

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
● Don't know

Empiric treatment compared to susceptibility-based treatment for NTM pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with susceptibility-based treatment	Risk with empiric treatment			
Quality of Life - not measured	-	-	-	-	-
Cure of NTM Disease - not reported	-	-	-	-	-
Death	Authors report no significant difference between empiric vs culture-based regimens (80 vs 75%)			(1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]
Development of antibiotic resistance - not measured	-	-	-	-	-
Recurrence - not measured	-	-	-	-	-
Culture Conversion -	-	-	-	-	-

There are other studies such as those by Jenkins, et al (Resp Med 2003) referenced in the Andrejak paper that measured outcomes of interest for two different treatment regimens for *M. xenopi* and looked to see whether outcomes were different based on resistance patterns on *in vitro* susceptibility tests (in this study they were not for the 29/40 patients who had the tests performed). In the observational study of *M. abscessus* treatment results by Jeon, et al (Am J Respir Crit Care Med 2009), the authors compared microbiologic response based on results of *in vitro* susceptibility testing and found a significant correlation for clarithromycin but not for the other antibiotics tested. The study by Kobashi, et al (J Infect Chemother 2006) showed similar findings for patients with *M. avium* complex disease with good correlation between clarithromycin susceptibility and clinical outcomes and no correlation for the other tested drugs. While these studies don't look at treatment modified based on *in vitro* susceptibility tests, they do provide some insight into this question.

		not reported	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No data available.	
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No data available.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased	No data available.	

	○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No data available.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of *M. abscessus* and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for *M. abscessus* contained a macrolide.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	**Don't know**	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

Should patients with NTM pulmonary disease be treated empirically or based on *in vitro* drug susceptibility test results?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ●	Strong recommendation for the intervention ○
RECOMMENDATION	In patients with MAC pulmonary disease, we suggest susceptibility-based treatment for macrolides and amikacin (conditional recommendation, very low confidence in estimates of effect). In patients with *M. kansasii* pulmonary disease, we suggest susceptibility-based treatment for rifampicin (conditional recommendation, very low confidence in estimates of effect). In patients with *M. xenopi* pulmonary disease, the committee feels there is insufficient evidence to make a recommendation for or against susceptibility-based treatment. In patients with *M. abscessus* pulmonary disease we suggest susceptibility-based treatment for macrolides and amikacin (conditional recommendation, very low confidence in estimates of effect). For macrolides, a 14-day incubation and/or sequencing of the *erm*(41) gene should be performed to evaluate for potential inducible macrolide resistance. While we recommend testing of other drugs in order to guide *M. abscessus* therapy there is insufficient data to make specific recommendations in this regard. The panel members voted unanimously for a conditional recommendation for the intervention with regards to MAC *M. kansasii*, and *M. abscessus*. The panel members also voted unanimously for no recommendation for *M. xenopi*.				
JUSTIFICATION	There is indirect evidence of poor outcomes in cases of macrolide or amikacin resistance. There is evidence from randomized clinical trials that correlated *in vitro* activity with amikacin and treatment outcomes. Although *in vitro-in vivo* correlations have not yet been proven for all major antimycobacterial drugs and some drugs are in regimens for synergy rather than efficacy, baseline susceptibility testing is recommended according to the CLSI guidelines for NTM isolates from patients with definite disease.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS	While the available evidence may be scarce, there is a need for proper drug susceptibility testing in guiding therapy. If acquired resistance can be ruled out, AST may not be required if proper species /subspecies identification is done, as drug susceptibility to a large extent is a species /subspecies specific character. However, for certain species/drug combinations there is also significant drug heterogeneity, e.g. tetracyclines and *M. abscessus* subsp. *abscessus* and *M. fortuitum*. The molecular basis for				

	this intra-species heterogeneity is not known yet.
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	Quality clinical trials of fixed vs susceptibility-guided regimens for different species of NTM.

Table E4.3. Question III

Should macrolide-susceptible MAC pulmonary disease be treated with a three-drug regimen with a macrolide or without a macrolide?

POPULATION:	treatment of MAC pulmonary infection
INTERVENTION:	three drugs with a macrolide
COMPARISON:	three drugs without a macrolide
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Culture conversion; Any adverse effect; Serious advere effect; Withdrawal owing to adverse effect; Quality of Life;

Assessment

DESIRABLE EFFECTS

JUDGEMENT

How substantial are the desirable anticipated effects?

○ Trivial
● Small
○ Moderate
○ Large

○ Varies
○ Don't know

RESEARCH EVIDENCE

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Quality of the evidence (GRADE)	Comments
	Risk with three drugs without a macrolide	Risk with three drugs with a macrolide				
Cure of NTM	Study population		**RR 0.93** (0.62 to 1.37)	190 (2 observational studies)	⨁◯◯◯ VERY LOW[a b]	
	354 per 1,000	**329 per 1,000** (220 to 485)				
Death	Study population		**RR 1.61** (1.09 to 2.39)	170 (1 observational	⨁◯◯◯ VERY LOW[a b]	
	299 per	**481 per**				

ADDITIONAL CONSIDERATIONS

The committee felt that macrolide regimens are more effective based on their clinical experience and retrospective cohort studies. There were a number of concerns with the two studies included from the literature search. These concerns included the small sample size in the studies, under-dosing of the macrolide used in the studies, and a population not representative of usual clinical practice. Additionally, the overall mortality seen in the one study that had this outcome was noted to be quite large for this disease, raising question to the validity of this result.

The committee unanimously felt that macrolides are a critical component to MAC treatment. Although one study appeared to have higher death rates in patients on a macrolide-containing regimen than on a regimen without, the committee felt this study was not

			1,000	**1,000** (326 to 714)		study)		applicable for the reasons previously stated.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ● Small ○ Trivial ○ Varies ○ Don't know	Recurrence (relapse)	Study population		**RR 0.87** (0.37 to 2.01)	190 (2 observational studies)	⨁◯◯◯ VERY LOW[a b]	
			104 per 1,000	**91 per 1,000** (39 to 209)				
		Culture conversion	Study population		**RR 0.98** (0.67 to 1.43)	197 (2 observational studies)	⨁◯◯◯ VERY LOW[a b c]	
			850 per 1,000	**833 per 1,000** (570 to 1,000)				
		Any adverse effect	Study population		**RR 0.23** (0.03 to 1.82)	27 (1 RCT)	⨁⨁◯◯ LOW[a b]	
			308 per 1,000	**71 per 1,000** (9 to 560)				
		Serious advere effect	Study population		not estimable	27 (1 RCT)	⨁⨁◯◯ LOW[b]	
			0 per 1,000	**0 per 1,000** (0 to 0)				
		Withdrawal owing to adverse effect	Study population		**RR 0.46** (0.05 to 4.53)	27 (1 RCT)	⨁⨁◯◯ LOW[a b]	
			154 per 1,000	**71 per 1,000** (8 to 697)				
		Quality of Life - not	**-**	**-**	-	-	-	

		measured a. Wide confidence interval b. Unclear control for confounders c. One study favors w/ macrolide and one favors w/o
CERTAINTY OF EVIDENCE	**What is the overall certainty of the evidence of effects?** ● Very low ○ Low ○ Moderate ○ High ○ No included studies	**The relative importance or values of the main outcomes of interest:**
VALUES	**Is there important uncertainty about or variability in how much people value the main**	Values and preferences:

Outcome	Relative importance	Certainty of the evidence(GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (relapse)	CRITICAL	⊕◯◯◯ VERY LOW
Culture conversion	CRITICAL	⊕◯◯◯ VERY LOW
Any adverse effect	CRITICAL	⊕⊕◯◯ LOW
Serious advere effect	CRITICAL	⊕⊕◯◯ LOW
Withdrawal owing to adverse effect	CRITICAL	⊕⊕◯◯ LOW
Quality of Life	CRITICAL	-

outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function.

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
● Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Quality of the evidence (GRADE)	Comments
	Risk with three drugs without a macrolide	Risk with three drugs with a macrolide				
Cure of NTM	Study population		**RR 0.93** (0.62 to 1.37)	190 (2 observational studies)	⨁◯◯◯ VERY LOW[a b]	
	354 per 1,000	**329 per 1,000** (220 to 485)				
Death	Study population		**RR 1.61** (1.09 to 2.39)	170 (1 observational study)	⨁◯◯◯ VERY LOW[a b]	
	299 per	**481 per 1,000**				

	1,000	(326 to 714)				
Recurrence (relapse)	Study population		**RR 0.87** (0.37 to 2.01)	190 (2 observational studies)	⊕◯◯◯ VERY LOW[a b]	
	104 per 1,000	**91 per 1,000** (39 to 209)				
Culture conversion	Study population		**RR 0.98** (0.67 to 1.43)	197 (2 observational studies)	⊕◯◯◯ VERY LOW[a b c]	
	850 per 1,000	**833 per 1,000** (570 to 1,000)				
Any adverse effect	Study population		**RR 0.23** (0.03 to 1.82)	27 (1 RCT)	⊕⊕◯◯ LOW[a b]	
	308 per 1,000	**71 per 1,000** (9 to 560)				
Serious advere effect	Study population		not estimable	27 (1 RCT)	⊕⊕◯◯ LOW[b]	
	0 per 1,000	**0 per 1,000** (0 to 0)				
Withdrawal owing to adverse effect	Study population		**RR 0.46** (0.05 to 4.53)	27 (1 RCT)	⊕⊕◯◯ LOW[a b]	
	154 per 1,000	**71 per 1,000** (8 to 697)				
Quality of Life - not measured	**-**	**-**	-	-	-	

		a. Wide confidence interval b. Unclear control for confounders c. One study favors w/ macrolide and one favors w/o	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes	No research evidence was identified.	

	○ Varies ○ Don't know		
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of *M. abscessus* and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for *M. abscessus* contained a macrolide.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	**Small**	Trivial		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

Should macrolide-susceptible MAC pulmonary disease be treated with a three-drug regimen with a macrolide or without a macrolide?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ○	Strong recommendation for the intervention ●
RECOMMENDATION	In patients with macrolide susceptible MAC pulmonary disease, we recommend a three-drug regimen that includes a macrolide over a three-drug regimen without a macrolide (strong recommendation, very low confidence in estimates of effect). (16 Agree, 0 Conditional, 2 Abstain) The panel members voted for a strong recommendation despite a very low confidence in estimates of effect.				
JUSTIFICATION	Historical case series data have demonstrated that macrolide containing regimens are associated with higher culture conversion rates than nonmacrolide containing regimens. Macrolide susceptibility has been a consistent predictor of treatment success for pulmonary MAC, whereas susceptibility to other drugs has not been a predictor. This suggests that the macrolides have a key role in MAC treatment.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION	ECG monitoring may be relevant in patients using other drugs that can prolong the QTc interval				
RESEARCH PRIORITIES					

Table E4.4. Question IV

In patients with newly diagnosed macrolide susceptible MAC pulmonary disease, should an azithromycin-based regimen or a clarithromycin-based regimen be used?

POPULATION:	patients with newly diagnosed pulmonary MAC
INTERVENTION:	azithromycin-based regimen
COMPARISON:	clarithromycin-based regimen
MAIN OUTCOMES:	Death; Quality of life; Culture Conversion; Recurrence (relapse); Development of antibiotic resistance; Serious adverse effects; Withdrawal from study due to AEs; Any Adverse Effect;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ● Moderate ○ Large ○ Varies ○ Don't know	**Azithromycin-based regimen compared to clarithromycin-based regimen in patients with newly diagnosed pulmonary MAC**	Azithromycin has fewer drug interactions compared with clarithromycin. Azithromycin may be better tolerated than clarithromycin Toxicity of azithromycin may be resolved by lowering dose, while this may not be possible with clarithromycin. Clarithromycin may have more QT-interval prolongation.

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Quality of the evidence (GRADE)
	Risk with clarithromycin-based regimen	**Risk with azithromycin-based regimen**			
Death - not reported	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
● Trivial

○ Varies
○ Don't know

Culture Conversion	82 per 100	**72 per 100** (60 to 86)	**RR 0.88** (0.73 to 1.05)	368 (4 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Recurrence (relapse) - not measured	-	-	-	-	-
Development of antibiotic resistance	9 per 100	**5 per 100** (1 to 26)	**RR 0.51** (0.07 to 2.79) [4]	189 (3 observational studies)	⊕◯◯◯ VERY LOW [1,3]
Serious adverse effects	0 per 100	**0 per 100** (0 to 0)	not estimable	59 (1 observational study)	⊕◯◯◯ VERY LOW [1,5]
Withdrawal from study due to AEs	14 per 100	**15 per 100** (6 to 30)	**RR 1.02** (0.45 to 2.07)	191 (3 observational studies)	⊕◯◯◯ VERY LOW [1,6]
Any Adverse Effect	41 per 100	**31 per 100** (18 to 52)	**RR 0.75** (0.44 to 1.28)	483 (6 observational studies)	⊕◯◯◯ VERY LOW [1,7,8]

In panel members observation clarithromycin may have lower ototoxicity than azithromycin. However, there was no consensus and more studies would be helpful.

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Death	CRITICAL	-
Quality of life	CRITICAL	-
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (relapse)	CRITICAL	-

		Development of antibiotic resistance	CRITICAL	⊕◯◯◯ VERY LOW
		Serious adverse effects	CRITICAL	⊕◯◯◯ VERY LOW
		Withdrawal from study due to AEs	CRITICAL	⊕◯◯◯ VERY LOW
		Any Adverse Effect	CRITICAL	⊕◯◯◯ VERY LOW
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ○ Possibly important uncertainty or variability ● Probably no important uncertainty or variability ○ No important uncertainty or variability	We identified 1 study including 51 mainly middle-aged to older women in Canada (mean age 67y, MAC and M. abscessus) that measured QoL (Mehta and Marras. Respiratory Medicine 2011,105:1718-1725). Mean SF-36 scores (scale 0-100, higher scores indicate better QoL; MID~5-10 points) were consistently much lower compared to population normal: Physical Functioning (58 vs. 86; Δ28) Role Physical (54 vs. 82; Δ28) Bodily Pain (63 vs. 76; Δ13) General Health Perceptions (41 vs. 77; Δ36) Energy/Vitality (49 vs. 66; Δ17) Social Functioning (63 vs. 86; Δ23) Role Emotional (75 vs. 84; Δ10) Mental Health (69 vs. 76; Δ9) Mean SGRQ scores (scale 0-100, lower scores indicate better QoL; MID ~4-5 points based on COPD population) were lower compared to population normal consistently across all domains. Mean difference in total SGRQ in NTM patients compared to normal population was 31 points lower (39 vs. 8 points lower).		Number of pills per day is smaller with azithromycin which may increase adherence and be better accepted by patients. Based on patient observations and panel member experience clarithromycin has a metallic taste and more frequently causes nausea, which make it less preferred option.

		We found no other study in the population of interest that would evaluate patient attitudes towards other outcomes or treatments of interest.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ● Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**Azithromycin-based regimen compared to clarithromycin-based regimen in patients with newly diagnosed pulmonary MAC**	

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with clarithromycin-based regimen	**Risk with azithromycin-based regimen**			
Death - not reported	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-
Culture Conversion follow up: range 4 to 12 months	82 per 100	**72 per 100** (60 to 86)	**RR 0.88** (0.73 to 1.05)	368 (4 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Recurrence (relapse) - not measured	-	-	-	-	-
Development of antibiotic resistance follow up: range 4 to 12 months	9 per 100	**5 per 100** (1 to 26)	**RR 0.51** (0.07 to 2.79) [4]	189 (3 observational studies)	⊕◯◯◯ VERY LOW [1,3]
Serious adverse effects follow up: 4 months	0 per 100	**0 per 100** (0 to 0)	not estimable	59 (1 observational study)	⊕◯◯◯ VERY LOW [1,5]
Withdrawal from study due to AEs	14 per 100	**15 per 100**	**RR 1.02** (0.45 to	191 (3	⊕◯◯◯ VERY LOW

		follow up: range 4 to 6 months		(6 to 30)	2.07)	observational studies)	[1,6]	
		Any Adverse Effect follow up: range 4 to 12 months	41 per 100	**31 per 100** (18 to 52)	**RR 0.75** (0.44 to 1.28)	483 (6 observational studies)	⊕◯◯◯ VERY LOW [1,7,8]	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research evidence was identified.						In the experience of panel members there is large variability in the cost of azithromycin and clarithromycin. Cost should be considered on an individual patient level. However, panel members thought it would be unlikely that cost difference would influence general recommendation favoring azithromycin.
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.						
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased	No research evidence was identified.						

	○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ○ Probably yes ● Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ● No ○ Probably no ○ Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	Panel members could not think of any barriers to implementation, other than cost of the drug in jurisdictions where azithromycin is more expensive.

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	**Moderate**	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	**Trivial**		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	Possibly important uncertainty or variability	**Probably no important uncertainty or variability**	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know	
FEASIBILITY	**No**	Probably no	Probably yes	Yes		Varies	Don't know	

Conclusions

In patients with newly diagnosed macrolide susceptible MAC pulmonary disease, should an azithromycin-based regimen or a clarithromycin-based regimen be used?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ●	Strong recommendation for the intervention ○
RECOMMENDATION	In patients with macrolide-susceptible MAC pulmonary disease we suggest azithromycin-based treatment regimens rather than clarithromycin-based regimens. (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION					
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION	Because of potential for ototoxicity patients should be regularly asked about hearing loss or tinnitus. Some panel members perform baseline audiogram and then repeat based on symptoms or yearly. Because of potential for QTc prolongation some experts perform baseline EKG in patients starting macrolides, especially those receiving drug regimens that include other QTc prolonging drugs and them repeat periodically.				
RESEARCH PRIORITIES	Estimate the risk of QTc prolongation, hearing loss in patients receiving azithromycin vs clarithromycin. Randomized trials with therapy adjusted based on monitoring drug levels to see if this prevents toxicity.				

Table E4.5. Question V

Should patients with macrolide susceptible MAC pulmonary disease be treated with a parenteral amikacin or streptomycin-containing regimen or without a parenteral amikacin or streptomycin-containing regimen?

POPULATION:	MAC pulmonary infection
INTERVENTION:	a treatment regimen with a parenteral agent
COMPARISON:	a treatment regimen without a parenteral agent
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Culture Conversion; Any adverse reaction; Serious adverse events; Quality of life; Development of antibiotic resistance;

Assessment

DESIRABLE EFFECTS

How substantial are the desirable anticipated effects?

○ Trivial
● Small
○ Moderate
○ Large

○ Varies
○ Don't know

Parenteral compared to no parenteral agent for MAC

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no parenteral agent	**Risk with Parenteral**			
Cure of NTM - not measured	-	-	-	-	-
Death	27 per 1000	**27 per 1000** (4 to 189)	**RR 1.00** (0.14 to 6.91)	146 (1 RCT)	⊕⊕⊕◯ MODERATE [3]

ADDITIONAL CONSIDERATIONS

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
● Moderate
○ Small
○ Trivial

○ Varies
○ Don't know

The undesirable anticipated effects of amikacin are larger when given for 3 months.

Recurrence (relapse)	351 per 1000	**309 per 1000** (169 to 559)	**RR 0.88** (0.48 to 1.59)	89 (1 RCT)	⊕⊕⊕◯ MODERATE	
Culture Conversion	507 per 1000	**715 per 1000** (542 to 933)	**RR 1.41** (1.07 to 1.84)	146 (1 RCT)	⊕⊕⊕◯ MODERATE [3]	
Any adverse reaction	205 per 1000	**247 per 1000** (136 to 450)	**RR 1.20** (0.66 to 2.19)	146 (1 RCT)	⊕⊕⊕◯ MODERATE [3]	
Serious adverse events	0 per 1000	**0 per 1000** (0 to 0)	not estimable	146 (1 RCT)	⊕⊕⊕⊕ HIGH	
Quality of life - not measured	-	-	-	-	-	
Development of antibiotic resistance - not measured	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

○ Very low
○ Low
● Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕⊕⊕◯ MODERATE
Recurrence (relapse)	CRITICAL	⊕⊕⊕◯ MODERATE
Culture Conversion	CRITICAL	⊕⊕⊕◯ MODERATE
Any adverse reaction	CRITICAL	⊕⊕⊕◯ MODERATE

Serious adverse events	CRITICAL	⊕⊕⊕⊕ HIGH	
Quality of life	CRITICAL	-	
Development of antibiotic resistance	CRITICAL	-	

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Values and preferences:

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
○ Does not favor either the intervention or the comparison
● Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

Intervention is with a parenteral agent.

Parenteral compared to no parenteral agent for MAC

Outcomes	**Anticipated absolute effects* (95% CI)**		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no parenteral agent	**Risk with Parenteral**			
Cure of NTM - not measured	-	-	-	-	-
Death	27 per 1000	**27 per 1000**	**RR 1.00** (0.14 to	146	⊕⊕⊕◯

			(4 to 189)	6.91)	(1 RCT)	MODERATE [3]	
		Recurrence (relapse)	351 per 1000	**309 per 1000** (169 to 559)	**RR 0.88** (0.48 to 1.59)	89 (1 RCT)	⊕⊕⊕◯ MODERATE
		Culture Conversion	507 per 1000	**715 per 1000** (542 to 933)	**RR 1.41** (1.07 to 1.84)	146 (1 RCT)	⊕⊕⊕◯ MODERATE [3]
		Any adverse reaction	205 per 1000	**247 per 1000** (136 to 450)	**RR 1.20** (0.66 to 2.19)	146 (1 RCT)	⊕⊕⊕◯ MODERATE [3]
		Serious adverse events	0 per 1000	**0 per 1000** (0 to 0)	not estimable	146 (1 RCT)	⊕⊕⊕⊕ HIGH
		Quality of life - not measured	-	-	-	-	-
		Development of antibiotic resistance - not measured	-	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.					Varies with the health system, but regardless it is likely associated with a significant cost due to need for indwelling catheter, infusion center, nursing care, cost of medication.

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ● No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ● Varies ○ Don't know	No research evidence was identified.	It depends on the health system coverage. If patients are not covered, there will be a reduction in equity as they should pay for the treatment to be administered (cost of the drug and administration).
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified. The expert panel felt that patients would prefer to avoid parenteral therapy when no clear benefit could be identified. However, in the setting of extensive or drug resistant disease, most patients would accept the intervention.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of *M. abscessus* and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for *M. abscessus* contained a macrolide.	In settings in which patients cannot access an infusion center, may not be able to self infuse at home. Availability of certain medications (streptomycin, amikacin, etc) in different regions/countries

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	**Moderate**	Small	Trivial		Varies	Don't know	
CERTAINTY OF EVIDENCE	Very low	Low	**Moderate**	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	**Varies**	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

Should patients with macrolide susceptible MAC pulmonary disease be treated with a parenteral amikacin or streptomycin-containing regimen or without a parenteral amikacin or streptomycin-containing regimen?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ●	Strong recommendation for the intervention ○
RECOMMENDATION	For patients with fibro-cavitary or advanced/severe bronchiectatic or macrolide resistant MAC pulmonary disease, we suggest that parenteral streptomycin or amikacin be included in the initial treatment regimen (conditional recommendation, moderate confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION					
SUBGROUP CONSIDERATIONS	The addition of parenteral agents (i.e; aminoglycosides) should be discussed according to the severity of the disease and according to the radiological features (cavitary or nodular bronchiectatic disease).				
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION	renal function, hearing/ototoxicity, vestibular toxicity, electrolyte disturbances				
RESEARCH PRIORITIES					

Table E4.6. Question VI

In patients with macrolide-susceptible MAC pulmonary disease, should a regimen with inhaled amikacin or a regimen without inhaled amikacin be used for treatment?

POPULATION:	MAC pulmonary infection
INTERVENTION:	a regimen with inhaled antibiotics
COMPARISON:	a regimen without inhaled antibiotics
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Culture Conversion; Any Adverse Effect; Serious Adverse Effect; Withdrawal owing to adverse effects; Quality of Life; Development of Antibiotic Resistance;

Assessment

<table>
<tr><th></th><th>JUDGEMENT</th><th>RESEARCH EVIDENCE</th><th>ADDITIONAL CONSIDERATIONS</th></tr>
<tr><td>DESIRABLE EFFECTS</td><td>How substantial are the desirable anticipated effects?

○ Trivial
○ Small
○ Moderate
○ Large

○ Varies
● Don't know</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>UNDESIRABLE EFFECTS</td><td>How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
○ Trivial

○ Varies
● Don't know</td></tr>
</table>

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Quality of the evidence (GRADE)	Comments
	Risk with a regimen with inhaled antibiotics	Risk with a regimen without inhaled antibiotics				
Cure of NTM	Study population		not estimable	3 (1 observational study)	⨁◯◯◯ VERY LOW[a]	
	3/3 (100%)	--				
Death	Study population		-	9	⨁◯◯◯	

	2/9 (22.2%)	--		(2 observational studies)	VERY LOW[a]	
Recurrence (relapse)	Study population		-	21 (1 RCT and 2 observational studies)	⊕⊕⊕◯ MODERATE	
	9/21 (42.9%)	--				
Culture Conversion	Study population		-	68 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b c]	
	16/40 (40.0%)	1/28 (3.6%)				
Any Adverse Effect	Study population		-	104 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b d]	
	46/59 (78.0%)	40/45 (88.9%)				
Serious Adverse Effect	Study population		-	104 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b e]	
	8/59 (13.6%)	4/45 (8.9%)				
Withdrawal owing to adverse effects	Study population		-	124 (1 RCT and 3 observational studies)	⊕⊕◯◯ LOW[b f]	
	15/79 (19.0%)	0/45 (0.0%)				
Quality of Life	Study used Quality of Life - Bronchiectasis - Nontuberculous Mycobacteria Module scores with no significant difference (p-0.204) between the inhaled antibiotic group (-7.9 [14.2], n=36) and placebo group (-2.8 [13.7], n=36).		-	(1 RCT)	⊕⊕⊕◯ MODERATE[g]	
Development	Study population		not	89	⊕⊕⊕◯	

		of Antibiotic Resistance	3/44 (6.8%)	2/45 (4.4%)	estimable	(1 RCT)	MODERATE[g]	

a. Studies were case series without a control group
b. Included 2 case series without a control group
c. Conversion with inhaled antibiotics ranged from 30% to 80%
d. Adverse effects ranged from 30% in case series to over 90% in RCT
e. Ranged from 0% in case series to nearly 20% in RCT
f. Ranged from 0% to 35% in inhaled group.
g. Included both MAC and M abscessus

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or

Values and preferences:

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function.

	variability	Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know		

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Quality of the evidence (GRADE)	Comments
	Risk with a regimen with inhaled antibiotics	Risk with a regimen without inhaled antibiotics				
Cure of NTM	Study population		not estimable	3 (1 observational study)	⊕◯◯◯ VERY LOW[a]	
	3/3 (100.0%)	--				
Death	Study population		-	9 (2 observational studies)	⊕◯◯◯ VERY LOW[a]	
	2/9 (22.2%)	--				
Recurrence (relapse)	Study population		-	21 (1 RCT and 2 observational studies)	⊕⊕⊕◯ MODERATE	
	9/21 (42.9%)	0/0				
Culture Conversion	Study population		-	68 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b c]	
	16/40 (40.0%)	1/28 (3.6%)				

Any Adverse Effect	Study population		-	104 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b d]	
	46/59 (78.0%)	40/45 (88.9%)				
Serious Adverse Effect	Study population		-	104 (1 RCT and 2 observational studies)	⊕⊕◯◯ LOW[b e]	
	8/59 (13.6%)	4/45 (8.9%)				
Withdrawal owing to adverse effects	Study population		-	124 (1 RCT and 3 observational studies)	⊕⊕◯◯ LOW[b f]	
	15/79 (19.0%)	0/45 (0.0%)				
Quality of Life	Study used Quality of Life - Bronchiectasis - Nontuberculous Mycobacteria Module scores with no significant difference (p-0.204) between the inhaled antibiotic group (-7.9 [14.2], n=36) and placebo group (-2.8 [13.7], n=36).		-	(1 RCT)	⊕⊕⊕◯ MODERATE[g]	
Development of Antibiotic Resistance	Study population		not estimable	89 (1 RCT)	⊕⊕⊕◯ MODERATE[g]	
	3/44 (6.8%)	2/45 (4.4%)				

a. Studies were case series without a control group
b. Included 2 case series without a control group
c. Conversion with inhaled antibiotics ranged from 30% to 80%
d. Adverse effects ranged from 30% in case series to over 90% in RCT
e. Ranged from 0% in case series to nearly 20% in RCT
f. Ranged from 0% to 35% in inhaled group.
g. Included both MAC and M abscessus

RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	The cost of parenteral amikacin (which would be used in the nebulizer) varies, but may cost the patient between $150-400/ month depending on frequency and dosing. Some patients are able to obtain amikacin through insurance so for them out of pocket costs are low. For patients who must pay full price, it is an expensive intervention. The cost of amikacin liposomal inhaled suspension varies but in the United States is approximately $300 a vial. As this is an FDA approved drug, insurance is likely to cover most of the costs for most patients.
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?**	No research evidence was identified.	

	○ Reduced ● Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of *M. abscessus* and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for *M. abscessus* contained a macrolide.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	**Probably reduced**	Probably no impact	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with macrolide-susceptible MAC pulmonary disease, should a regimen with inhaled amikacin or a regimen without inhaled amikacin be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	●
RECOMMENDATION	In patients with MAC pulmonary disease, we suggest neither the use of commercially available parenteral amikacin nor amikacin liposomal inhaled suspension as part of the initial treatment regimen. (conditional recommendation, very low confidence in estimates of effect). The panel members voted for a conditional recommendation for the intervention. In patients with MAC pulmonary disease who have failed therapy after at least six months of guideline-based therapy, we recommend the use of amikacin liposomal inhaled suspension as part of the treatment regimen. (strong recommendation, moderate confidence in estimates of effect). (5 Strong, 4 Conditional, 9 Abstain) Expert panel members that had declared a conflict of interest with Insmed had to abstain from voting on whether a strong or conditional recommendation was made. Among the voting members, 5 of 9 voted for a strong recommendation for the intervention.				
JUSTIFICATION	There are no good data to support the use of inhaled antibiotics as an initial treatment option. There may be a risk of developing acquired mutational amikacin resistance with either inadequate companion medications or poor and irregular				

	antibiotic deposition in the lung with areas of low amikacin concentration. Given the high morbidity and mortality in patients who fail treatment with an initial regimen, it is reasonable to consider inhaled therapy as part of a salvage regimen to aggressively treat MAC pulmonary disease.
SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	Pretreatment with a bronchodilator.
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	Clinical trials evaluating safety and efficacy of inhaled amikacin (liposomal or non), comparing various dosing regimens to see which are most effective. Clinical trials to determine the optimal companion medications to inhaled amikacin in the treatment of MAC pulmonary infection.

Table E4.7. Question VII

In patients with macrolide susceptible MAC pulmonary disease, should a three-drug or a two-drug macrolide-containing regimen be used for treatment?

POPULATION:	treatment of MAC pulmonary infection
INTERVENTION:	a three drug regimen
COMPARISON:	a two drug regimen
MAIN OUTCOMES:	Culture Conversion; Serious Adverse Effects; Withdrawal owing to adverse effect; Quality of Life; Cure of NTM Disease; Death; Development of antibiotic resistance; Recurrence (relapse);

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know		
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ● Trivial ○ Varies ○ Don't know		In non-pulmonary disease, there is known to be high rates of antibiotic resistance with 2 drug therapy regimens.

A three drug regimen compared to a two drug regimen for treatment of MAC pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with a two trug regimen	**Risk with a three drug regimen**			
Culture Conversion	550 per 1000	**407 per 1000** (275 to 600)	**RR 0.74** (0.50 to 1.09)	119 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Serious Adverse Effects	0 per 1000	**0 per 1000** (0 to 0)	not estimable	119 (1 RCT)	⊕⊕⊕◯ MODERATE [1]

Withdrawal owing to adverse effect	267 per 1000	**373 per 1000** (213 to 565)	**RR 1.40** (0.80 to 2.12)	119 (1 RCT)	- [1,2]	
Quality of Life - not measured	-	-	-	-	-	
Cure of NTM Disease - not measured	-	-	-	-	-	
Death - not reported	-	-	-	-	-	
Development of antibiotic resistance - not reported	-	-	-	-	-	
Recurrence (relapse) - not measured	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

○ Very low
● Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Culture Conversion	CRITICAL	⊕⊕◯◯ LOW
Serious Adverse Effects	CRITICAL	⊕⊕⊕◯ MODERATE
Withdrawal owing to adverse effect	CRITICAL	-
Quality of Life	CRITICAL	-
Cure of NTM Disease	CRITICAL	-

		Death	CRITICAL	-
		Development of antibiotic resistance	CRITICAL	-
		Recurrence (relapse)	CRITICAL	-
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**A three drug regimen compared to a two trug regimen for treatment of MAC pulmonary infection** Outcomes | **Anticipated absolute effects* (95% CI)** (**Risk with a two trug regimen** | **Risk with a three drug regimen**) | Relative effect (95% CI) | Nº of participants (studies) | Quality of the evidence (GRADE)		

		Culture Conversion	550 per 1000	**407 per 1000** (275 to 600)	**RR 0.74** (0.50 to 1.09)	119 (1 RCT)	⊕⊕◯◯ LOW [1,2]
		Serious Adverse Effects	0 per 1000	**0 per 1000** (0 to 0)	not estimable	119 (1 RCT)	⊕⊕⊕◯ MODERATE [1]
		Withdrawal owing to adverse effect	267 per 1000	**373 per 1000** (213 to 565)	**RR 1.40** (0.80 to 2.12)	119 (1 RCT)	- [1,2]
		Quality of Life - not measured	-	-	-	-	-
		Cure of NTM Disease - not measured	-	-	-	-	-
		Death - not reported	-	-	-	-	-
		Development of antibiotic resistance - not reported	-	-	-	-	-
		Recurrence (relapse) - not measured	-	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.					

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No	A study by Adjemian, et al in 2014 evaluated treatment of M abscessus and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for M abscessus contained a macrolide.	

	○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know		

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	**Trivial**		Varies	Don't know	
CERTAINTY OF EVIDENCE	Very low	**Low**	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with macrolide susceptible MAC pulmonary disease, should a three-drug or a two-drug macrolide-containing regimen be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	○
RECOMMENDATION	In patients with macrolide susceptible MAC pulmonary disease, we suggest a treatment regimen with at least three drugs (including a macrolide and ethambutol) over a regimen with two drugs (a macrolide and ethambutol alone). (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				

JUSTIFICATION	
SUBGROUP CONSIDERATIONS	In patients with severe, particularly fibrocavitary disease, addition of amikacin or streptomycin (possible with clofazimine) in the initial 3 months of treatment is worth serious consideration.
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	Renal function, audiometry, EKG
RESEARCH PRIORITIES	

Table E4.8. Question VIII

In patients with macrolide susceptible MAC pulmonary disease, should a daily or an intermittent macrolide-based regimen be used for treatment?

POPULATION:	patients with pulmonary MAC
INTERVENTION:	a three times per week macrolide-based regimen
COMPARISON:	daily macrolide-based regimen
MAIN OUTCOMES:	Death; Quality of life; Cure of NTM Disease; Culture Conversion; Recurrence; Development of Antibiotic Resistance; Serious adverse effects; Discontinuation of the initial treatment due to adverse effects; Adverse Effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know	**A three times per week macrolide-based regimen compared to daily macrolide-based regimen in patients with pulmonary MAC**	In one study 75% had to discontinue daily treatment owing to adverse events. Panel members have seen many more patients in their practice than there were in these combined studies. In the experience of some panel members the proportion of patients not tolerating daily treatment may be smaller than seen in these studies.

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with daily macrolide-based regimen	Risk with a three times per week macrolide-based regimen			
Death - not reported	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-

		Cure of NTM Disease follow up: 12 months	76 per 100	**73 per 100** (55 to 86)	**RR 0.97** (0.72 to 1.14)	217 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]	This applies to nodular or bronchiectatic disease and not to cavitary.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ● Trivial ○ Varies ○ Don't know	Culture Conversion follow up: range 6 to 12 months	74 per 100	**76 per 100** (69 to 84)	**RR 1.03** (0.93 to 1.14)	597 (5 observational studies)	⊕◯◯◯ VERY LOW [1,4]	There is some concern about potentially increased recurrence, however, this has been based on 4 events total.
		Recurrence assessed with: microbiological recurrence of two or more positive cultures after an initial negative conversion during antibiotic therapy follow up: 12 months	1 per 100	**4 per 100** (0 to 34)	**RR 2.78** (0.30 to 26.16)	158 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,5]	
		Development of Antibiotic Resistance follow up: range 6 to 12 months	12 per 100	**3 per 100** (1 to 9)	**RR 0.23** (0.07 to 0.74)	232 (4 observational studies)	⊕◯◯◯ VERY LOW [1,4,6]	
		Serious adverse effects - not reported	-	-	-	-	-	
		Discontinuation of the initial treatment due to adverse effects follow up: range 6 to 12 months	22 per 100	**10 per 100** (2 to 48)	**RR 0.44** (0.09 to 2.16)	564 (4 observational studies)	⊕◯◯◯ VERY LOW [1,7,8]	
		Adverse Effects follow up: range 6 to 12 months	39 per 100	**24 per 100** (10 to 60)	**RR 0.63** (0.25 to 1.55)	445 (4 observational studies)	⊕◯◯◯ VERY LOW [1,8]	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Death	CRITICAL	-
Quality of life	CRITICAL	-
Cure of NTM Disease	CRITICAL	⊕◯◯◯ VERY LOW
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence	CRITICAL	⊕◯◯◯ VERY LOW
Development of Antibiotic Resistance	CRITICAL	⊕◯◯◯ VERY LOW
Serious adverse effects	CRITICAL	-

VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ○ Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ● No important uncertainty or variability	We identified 1 study including 51 mainly middle-aged to older women in Canada (mean age 67y, MAC and M. abscessus) that measured QoL (Mehta and Marras. Respiratory Medicine 2011,105:1718-1725). Mean SF-36 scores (scale 0-100, higher scores indicate better QoL; MID~5-10 points) were consistently much lower compared to population normal: Physical Functioning (58 vs. 86; Δ28) Role Physical (54 vs. 82; Δ28) Bodily Pain (63 vs. 76; Δ13) General Health Perceptions (41 vs. 77; Δ36) Energy/Vitality (49 vs. 66; Δ17) Social Functioning (63 vs. 86; Δ23) Role Emotional (75 vs. 84; Δ10) Mental Health (69 vs. 76; Δ9)	

		Mean SGRQ scores (scale 0-100, lower scores indicate better QoL; MID ~4-5 points based on COPD population) were lower compared to population normal consistently across all domains. Mean difference in total SGRQ in NTM patients compared to normal population was 31 points lower (39 vs. 8 points lower). We found no other study in the population of interest that would evaluate patient attitudes towards other outcomes or treatments of interest.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ● Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	No research evidence was identified.	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ● Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	Cost will depend on drug regimen but it will be lower with 3 times weekly compared to daily treatment because the total weekly dose of ethambutol and azithromycin will be higher. For example, for a 70 kg person, they will take 7 tablets of azithromycin a week versus 6 tablets with three times weekly dosing and 17.5 tables of ethambutol a week versus 13 given three times a week. The number of rifampin capsules will remain the same whether administered daily or three times a week.

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ○ Probably no impact ● Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	Except for cost - no.
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ○ Probably yes ○ Yes ● Varies ○ Don't know	No research evidence was identified.	There may be lower or higher adherence with three times weekly regimen. Also clinicians may be less or more prone to prescribe three times weekly vs daily.
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ○ Probably yes ● Yes ○ Varies	No research evidence was identified.	

	○ Don't know		

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	**Trivial**		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	Possibly important uncertainty or variability	Probably no important uncertainty or variability	**No important uncertainty or variability**				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	**Moderate savings**	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	Probably no impact	**Probably increased**	Increased	Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
ACCEPTABILITY	No	Probably no	Probably yes	Yes		**Varies**	Don't know	
FEASIBILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know	

Conclusions

In patients with macrolide susceptible MAC pulmonary disease, should a daily or an intermittent macrolide-based regimen be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	○
RECOMMENDATION	Recommendation 8a: In patients with nodular/bronchiectatic macrolide susceptible MAC pulmonary disease, we suggest a three times per week macrolide-based regimen rather than a daily macrolide-based regimen. (conditional recommendation, very low confidence in estimates of effect). Recommendation 8b. In patients with fibrocavitary macrolide susceptible MAC pulmonary disease we suggest a daily macrolide-based regimen rather than three times per week macrolide-based regimen. (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				

JUSTIFICATION	Recommendation to use three times weekly in non-cavitary is based on similar efficacy, fewer adverse reactions and lower costs. Recommendation to use daily administration in cavitary disease is based on a single study reporting very low culture conversion rates and the experience of the committee members given high risk of treatment failure and recurrence with cavitary disease.
SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	Is there a differences in response based on MAC species?

Table E4.9. Question IX

In patients with macrolide susceptible MAC pulmonary disease, should patients be treated with less than 12 months of treatment after culture negativity or 12 or more months of treatment after culture negativity?

POPULATION:	pulmonary MAC infection
INTERVENTION:	<12 months of treatment after culture negativity
COMPARISON:	>/= 12 months of treatment after culture negativity
MAIN OUTCOMES:	Culture conversion; Cure of NTM disease; Recurrence (relapse); Quality of Life; Development of antibiotic resistance; Death; Adverse drug effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ● Moderate ○ Large ○ Varies ○ Don't know	**<12 months compared to >12 months for MAC**	Dautzenberg 1994 10 months from culture conversion? While not a controlled study, (Wallace, et al, 1996 Am J Respir Crit Care Med) showed high rates of relapse in patients who could only tolerate a shorter antibiotic course.

Outcomes	**Anticipated absolute effects* (95% CI)**	Relative effect	Nº of participants	Quality of the evidence

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
○ Trivial

○ Varies
● Don't know

	Risk with >12 months	Risk with <12 months	(95% CI)	(studies)	(GRADE)
Culture conversion	856 per 1000	**222 per 1000** (111 to 453)	**RR 0.26** (0.13 to 0.53)	207 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Cure of NTM disease - not reported	-	-	-	-	-
Recurrence (relapse) - not reported	-	-	-	-	-
Quality of Life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Death - not reported	-	-	-	-	-
Adverse drug effects - not reported	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Culture conversion	CRITICAL	⊕◯◯◯ VERY LOW
Cure of NTM disease	CRITICAL	
Recurrence (relapse)	CRITICAL	

		Quality of Life	CRITICAL	
		Development of antibiotic resistance	CRITICAL	
		Death	CRITICAL	
		Adverse drug effects	CRITICAL	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
● Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

<12 months compared to >12 months for MAC

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with >12 months	Risk with <12 months			
Culture conversion	856 per 1000	**222 per 1000** (111 to 453)	**RR 0.26** (0.13 to 0.53)	207 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Cure of NTM disease - not reported	-	-	-	-	-
Recurrence (relapse) - not reported	-	-	-	-	-
Quality of Life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Death - not reported	-	-	-	-	-
Adverse drug effects - not reported	-	-	-	-	-

Comparison is >12 months of treatment

The specter of early disease relapse merits a conservative approach in the absence of more convincing data for shorter course therapy.

RESOURCES REQUIRED

How large are the resource requirements (costs)?

○ Large costs
○ Moderate costs
● Negligible costs and savings
○ Moderate savings
○ Large savings

○ Varies
○ Don't know

No research evidence was identified.

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	**Moderate**	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	**Probably favors the comparison**	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with macrolide susceptible MAC pulmonary disease, should patients be treated with less than 12 months of treatment after culture negativity or 12 or more months of treatment after culture negativity?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ●	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ○	Strong recommendation for the intervention ○
RECOMMENDATION	We suggest that patients with MAC pulmonary disease should receive treatment for at least 12 months after culture conversion (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION	Optimal treatment length is not known. Treatment for greater than 12 months after culture negativity is a conservative approach given risks of relapse. The microbiologic goal is 12 months of culture negativity while on treatment				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION	6 month cultures - sputum culture, but no need for bronchoscopy to obtain this				
RESEARCH PRIORITIES	Clinical trial with strict definitions looking at culture conversion time (patients who do not convert by 6 months) Treatment length, intermittent treatment for relapse/reinfection				

Table E4.10. Question X

In patients with *M. kansasii* pulmonary disease, should an isoniazid-containing regimen or a macrolide-containing regimen be used for treatment?

POPULATION:	Mycobacterium kansasii
INTERVENTION:	a INH-containing regimen
COMPARISON:	a macrolide-contaning regimen
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Development of antibiotic resistance; Quality of life; Culture conversion; Adverse drug effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ○ Moderate ○ Large ○ Varies ● Don't know	**INH compared to no INH for *Mycobacterium kansasii*** Outcomes: Cure of NTM - not measured Anticipated absolute effects* (95% CI): Risk with no INH: - ; Risk with INH: - Relative effect (95% CI): - Nº of participants (studies): - Quality of the evidence (GRADE): - Outcomes: Death - not measured Anticipated absolute effects* (95% CI): Risk with no INH: - ; Risk with INH: - Relative effect (95% CI): - Nº of participants (studies): - Quality of the evidence (GRADE): - Outcomes: Recurrence (relapse) Anticipated absolute effects* (95% CI): Risk with no INH: - ; Risk with INH: - Relative effect (95% CI): - Nº of participants (studies): - Quality of the evidence (GRADE): -	One study from the Research Committee of the British Thoracic Society in 1994 was a prospective study of 9 months treatment with rifampin and ethambutol. They found: 9/149 deaths, 68% had negative sputum (32% had no sputum, 0% positive at 9 months). There was a 9.7% relapse rate - this study had a shorter duration of therapy and did not have INH. Removing the potential for INH toxicity is a desirable anticipated effect. The importance of INH in the treatment regimen for *M. kansasii* is at best questionable, more so in an era when safer and more effective agents are available.

UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ○ Trivial ○ Varies ● Don't know	Development of antibiotic resistance - not measured	-	-	-	-	-	
		Quality of life - not measured	-	-	-	-	-	
		Culture conversion - not reported	-	-	-	-	-	
		Adverse drug effects - not reported	-	-	-	-	-	
CERTAINTY OF EVIDENCE	**What is the overall certainty of the evidence of effects?** ○ Very low ○ Low ○ Moderate ○ High ● No included studies	No research evidence was identified.						
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ○ Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability ● No known undesirable outcomes	No research evidence was identified.						

BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	No research evidence was identified.	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased	No research evidence was identified.	

	○ Increased ○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	

	JUDGEMENT							IMPLICATIONS
CERTAINTY OF EVIDENCE	Very low	Low	Moderate	High			**No included studies**	
VALUES	Important uncertainty or variability	Possibly important uncertainty or variability	Probably no important uncertainty or variability	No important uncertainty or variability			**No known undesirable outcomes**	
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with *M. kansasii* pulmonary disease, should an isoniazid-containing regimen or a macrolide-containing regimen be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ●	Conditional recommendation for the intervention ○	Strong recommendation for the intervention ○
RECOMMENDATION	In patients with rifampicin susceptible *M. kansasii* pulmonary disease, we suggest a regimen of rifampicin, ethambutol, and either isoniazid or macrolide. (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for either the intervention or comparison.				
JUSTIFICATION	Isoniazid is widely used at present for treatment of *M. kansasii* and in clinical studies and the experience of the committee members, there have been good outcomes when using this. There have been higher relapse rates in regiments without INH (or macrolides), albeit in non-comparative studies. Based on the results of two small retrospective cohort studies and the experience of the committee, a macrolide may be effectively substituted for INH.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION					
RESEARCH PRIORITIES					

Table E4.11. Question XI

In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

POPULATION:	M kansasii pulmonary infection
INTERVENTION:	a treatment regimen with a parenteral agent
COMPARISON:	a treatment regimen without a parenteral agent
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Culture Conversion; Any adverse effect; Serious Adverse Effect; Withdrawal owing to adverse effects; Quality of Life; Development of Antibiotic Resistance;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know	**Parenteral compared to no parenteral agent for M kansasii**	Except for rifampin-resistant *M. kansasii* disease, parenteral agents ae seldom needed to treat use with *M. kansasii*.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ● Small ○ Trivial ○ Varies ○ Don't know		Success rate is so high with current regimens, parenteral agents are rarely being used - risk of toxicity and adverse effects may outweigh benefit

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no parenteral agent	Risk with Parenteral			
Cure of NTM	8/10 (80.0%)	-	-	10 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Death	30/121 (24.8%)	not pooled	not pooled	121 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]

Recurrence (relapse)	6/115 (5.2%)	not pooled	not pooled	115 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]	
Culture Conversion	42/44 (95.5%)	not pooled	not pooled	44 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]	
Any adverse effect	11/75 (14.7%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]	
Serious Adverse Effect	0/75 (0.0%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]	
Withdrawal owing to adverse effects	7/75 (9.3%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]	
Quality of Life - not measured	-	-	-	-	-	
Development of Antibiotic Resistance - not measured	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW

Death	CRITICAL	⊕◯◯◯ VERY LOW	
Recurrence (relapse)	CRITICAL	⊕◯◯◯ VERY LOW	
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW	
Any adverse effect	CRITICAL	⊕◯◯◯ VERY LOW	
Serious Adverse Effect	CRITICAL	⊕◯◯◯ VERY LOW	
Withdrawal owing to adverse effects	CRITICAL	⊕◯◯◯ VERY LOW	
Quality of Life	CRITICAL	-	
Development of Antibiotic Resistance	CRITICAL	-	

VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function	

		Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
● Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

Parenteral compared to no parenteral agent for M kansasii

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no parenteral agent	Risk with Parenteral			
Cure of NTM	8/10 (80.0%)	-	-	10 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Death	30/121 (24.8%)	not pooled	not pooled	121 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Recurrence (relapse)	6/115 (5.2%)	not pooled	not pooled	115 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Culture Conversion	42/44 (95.5%)	not pooled	not pooled	44 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Any adverse effect	11/75 (14.7%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Serious Adverse Effect	0/75 (0.0%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Withdrawal owing to adverse effects	7/75 (9.3%)	-	-	75 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]

		Quality of Life - not measured	-	-	-	-	-	
		Development of Antibiotic Resistance - not measured	-	-	-	-	-	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.						
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.						
EQUITY	**What would be the impact on health equity?** ○ Reduced ● Probably reduced ○ Probably no impact ○ Probably increased ○ Increased	No research evidence was identified.						In some settings, parenteral may only be available to select patients based on financial resources.

	○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	**Small**	Trivial		Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	**Probably favors the comparison**	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	**Probably reduced**	Probably no impact	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ●	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ○	Strong recommendation for the intervention ○
RECOMMENDATION	We suggest that neither amikacin nor streptomycin be used routinely for treating patients with *M. kansasii* pulmonary disease (Conditional recommendation, very low confidence in estimates of effect). (10 Strong, 5 Conditional, 3 Abstain) The panel members voted for a strong recommendation against the intervention despite a very low confidence in estimate of effect.				
JUSTIFICATION	Treatment outcomes in *M. kansasii* pulmonary disease are very good when using a rifamycin-based regimen with ethambutol and a second companion drug, either isoniazid or a macrolide. Unless the severity of the disease warrants intravenous therapy, *M. kansasii* can be treated with a rifamycin-based combination of 3 orally available drugs. Given generally high rates of culture conversion and treatment success observed with oral regimens for *M. kansasii* and the high risk of adverse effects associated with amikacin and streptomycin, the committee felt strongly that parenteral agents should not be used as first-line therapy for *M. kansasii.*				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION					
RESEARCH PRIORITIES					

Table E4.12. Question XII

In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

POPULATION:	M kansasii pulmonary infection
INTERVENTION:	a regimen with a fluoroquinolone
COMPARISON:	a regimen without a fluoroquinolone
MAIN OUTCOMES:	Cure of NTM Disease; Development of antibiotic resistance; Recurrence (relapse); Quality of Life; Culture Conversion; Death; Adverse drug effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ○ Moderate ○ Large ○ Varies ● Don't know	**Fluoroquinolone compared to no fluoroquinolone for *M. kansasii***	The use of a fluoroquinolone (or a macrolide) means that INH can be dropped from the regimen with the attendant risk for INH toxicity.

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no Fluoroquinolone	Risk with Fluorquinolone			

UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ○ Trivial ○ Varies ● Don't know	Cure of NTM Disease - not measured	-	-	-	-	-
		Development of antibiotic resistance - not measured	-	-	-	-	-
		Recurrence (relapse) - not measured	-	-	-	-	-
		Quality of Life - not measured	-	-	-	-	-
		Culture Conversion - not measured	-	-	-	-	-
		Death - not measured	-	-	-	-	-
		Adverse drug effects - not measured	-	-	-	-	-
CERTAINTY OF EVIDENCE	**What is the overall certainty of the evidence of effects?** ○ Very low ○ Low ○ Moderate ○ High ● No included studies	No research evidence was identified.					
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects					

and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
● Don't know

Fluorquinolone compared to no Fluoroquinolone for M kansasii

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no Fluoroquinolone	Risk with Fluorquinolone			
Cure of NTM Disease - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Recurrence (relapse) - not measured	-	-	-	-	-

		Quality of Life - not measured	-	-	-	-	-
		Culture Conversion - not measured	-	-	-	-	-
		Death - not measured	-	-	-	-	-
		Adverse drug effects - not measured	-	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research evidence was identified.					
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.					
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced	No research evidence was identified.					

	● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE	Large	Moderate	Small	Trivial		Varies	**Don't know**	

	JUDGEMENT							IMPLICATIONS
EFFECTS								
CERTAINTY OF EVIDENCE	Very low	Low	Moderate	High			**No included studies**	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	**Don't know**	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

Should a regimen with a fluoroquinolone vs. a regimen without a fluoroquinolone be used for *M. kansasii* pulmonary infection?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	●	○	○	○
RECOMMENDATION	In patients with rifampicin susceptible *M. kansasii* pulmonary disease, we suggest using a regimen of rifampicin, ethambutol, and either isoniazid or macrolide instead of a fluoroquinolone (conditional recommendation, very low confidence in estimates of effect). In patients with rifampicin resistant *M. kansasii* or intolerance to one of the first line antibiotics we suggest a fluoroquinolone (e.g., moxifloxacin) be used as part of a second-line regimen (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation against the intervention.				
JUSTIFICATION	Treatment success of *M. kansasii* pulmonary disease with a rifamycin-based drug regimen is excellent. The optimal choice of companion drugs is not clear. While ethambutol is usually the preferred companion drug, the choice of the second companion drug may be isoniazid or a macrolide. Which of these drugs is superior for the treatment of *M. kansasii* is unclear at present. As there is more experience and better evidence for treatment regimens that include isoniazid or a macrolide as the second companion drug, these drugs should be the preferred choice. Fluoroquinolones have excellent in vitro activity but there are no treatment studies using these for the treatment of *M. kansasii*.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION					

RESEARCH PRIORITIES	Randomized clinical trials comparing regimens with macrolides to regimens with moxifloxacin.

Table E4.13. Question XIII

In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should a three times per week or daily treatment regimen be used?

POPULATION:	M kansasii pulmonary infection
INTERVENTION:	a three times per week treatment regimen
COMPARISON:	a daily treatment regimen
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (relapse); Culture Conversion; Any Adverse Effect; Serious adverse effects; Withdrawal owing to adverse effects; Quality of Life; Development of antibiotic resistance;

Assessment

DESIRABLE EFFECTS

How substantial are the desirable anticipated effects?

○ Trivial
● Small
○ Moderate
○ Large

○ Varies
○ Don't know

M kansasii TIW compared to daily for M kansasii

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with daily	Risk with M kansasii TIW			
Cure of NTM	0/0	115/182 (63.2%)	not pooled	182 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,3]
Death	0/18 (0.0%)	39/229 (17.0%)	not pooled	247 (3 observational studies)	⊕◯◯◯ VERY LOW [2,3]
Recurrence (relapse)	0/14 (0.0%)	16/178 (9.0%)	not pooled	192 (3 observational studies)	⊕◯◯◯ VERY LOW [1,3]

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
○ Trivial

○ Varies
● Don't know

Culture Conversion	17/18 (94.4%)	238/257 (92.6%)	not pooled	275 (4 observational studies)	⊕◯◯◯ VERY LOW [1,3]	
Any Adverse Effect	0/18 (0.0%)	0/0	not estimable	18 (1 observational study)	⊕◯◯◯ VERY LOW [1,3]	
Serious adverse effects	0/18 (0.0%)	0/28 (0.0%)	not pooled	46 (2 observational studies)	⊕◯◯◯ VERY LOW [1,3]	
Withdrawal owing to adverse effects	0/18 (0.0%)	0/28 (0.0%)	not pooled	46 (2 observational studies)	⊕◯◯◯ VERY LOW [1,3]	
Quality of Life - not measured	-	-	-	-	-	
Development of antibiotic resistance - not measured	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

- ● Very low
- ○ Low
- ○ Moderate
- ○ High

- ○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (relapse)	CRITICAL	⊕◯◯◯ VERY LOW
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW

		<table><tr><td>Any Adverse Effect</td><td>CRITICAL</td><td>⊕◯◯◯ VERY LOW</td></tr><tr><td>Serious adverse effects</td><td>CRITICAL</td><td>⊕◯◯◯ VERY LOW</td></tr><tr><td>Withdrawal owing to adverse effects</td><td>CRITICAL</td><td>⊕◯◯◯ VERY LOW</td></tr><tr><td>Quality of Life</td><td>CRITICAL</td><td>-</td></tr><tr><td>Development of antibiotic resistance</td><td>CRITICAL</td><td>-</td></tr></table>	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
● Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

M kansasii TIW compared to daily for M kansasii

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with daily	Risk with M kansasii TIW			
Cure of NTM	0/0	115/182 (63.2%)	not pooled	182 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,3]
Death	0/18 (0.0%)	39/229 (17.0%)	not pooled	247 (3 observational studies)	⊕◯◯◯ VERY LOW [2,3]
Recurrence (relapse)	0/14 (0.0%)	16/178 (9.0%)	not pooled	192 (3 observational studies)	⊕◯◯◯ VERY LOW [1,3]
Culture Conversion	17/18 (94.4%)	238/257 (92.6%)	not pooled	275 (4 observational studies)	⊕◯◯◯ VERY LOW [1,3]
Any Adverse Effect	0/18 (0.0%)	0/0	not estimable	18 (1 observational study)	⊕◯◯◯ VERY LOW [1,3]

		Serious adverse effects	0/18 (0.0%)	0/28 (0.0%)	not pooled	46 (2 observational studies)	⊕◯◯◯ VERY LOW [1,3]	
		Withdrawal owing to adverse effects	0/18 (0.0%)	0/28 (0.0%)	not pooled	46 (2 observational studies)	⊕◯◯◯ VERY LOW [1,3]	
		Quality of Life - not measured	-	-	-	-	-	
		Development of antibiotic resistance - not measured	-	-	-	-	-	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ● Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.						
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.						
EQUITY	**What would be the impact on**	No research evidence was identified.						

	health equity? ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ○ Probably yes ○ Yes ● Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	**Moderate savings**	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	Probably yes	Yes		**Varies**	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with rifampicin susceptible *M. kansasii* pulmonary disease, should a three times per week or daily treatment regimen be used?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	●	○	○

RECOMMENDATION

In patients with nodular/bronchiectatic *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol and macrolide regimen, we suggest either daily or three times weekly treatment. (conditional recommendation, very low confidence in estimates of effect).

The panel members voted unanimously for a conditional recommendation for either the intervention or comparison.

In patients with fibrocavitary *M. kansasii* pulmonary disease treated with a rifampicin, ethambutol and macrolide-based regimen, we suggest daily treatment as opposed to three times weekly treatment. (conditional recommendation, very low confidence in estimates of effect).

The panel members voted unanimously for a conditional recommendation for the comparison.

In all patients with *M. kansasii* pulmonary disease treated with an isoniazid, ethambutol and rifampicin regimen, we suggest treatment be given daily. (conditional recommendation, very low confidence in estimates of effect).

The panel members voted unanimously for a conditional recommendation for the comparison.

JUSTIFICATION	Cavitary disease has higher morbidity and mortality and warrants a more aggressive treatment approach.
SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	Randomized trial comparing three times weekly vs daily regimens in cavitary and nodular/bronchiectatic *M. kansasii.* Role of higher doses of antimicrobial drugs and therapeutic drug monitoring should be explored to determine whether optimizing drug levels is beneficial

Table E4.14. Question XIV

In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months?

POPULATION:	M kansasii pulmonary infection
INTERVENTION:	<12 months of treatment after culture negativity
COMPARISON:	>/= 12 months of treatment after culture negativity
MAIN OUTCOMES:	Cure of NTM; Recurrence; Culture Conversion; Quality of Life; Development of Antibiotic Resistance; Death; Adverse Drug Effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know	**<12 months compared to >12 months for M kansasii**	There are a number of studies that describe outcomes of *M. kansasii* with "short" or "long" duration of treatment, but without direct comparison. For instance, Santin, et al., published results on a 12 month treatment approach (retrospective cohort - ERJ 2009;33:148-52), reporting 6.6% relapse rate.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ● Small ○ Trivial ○ Varies ○ Don't know		The undesirable anticipated effect might be inadequate treatment with progressive disease morbidity and prolonged exposure to antibiotic toxicity

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with >12 months	Risk with <12 months			
Cure of NTM	1000 per 1000	**1000 per 1000** (880 to 1000)	**RR 1.00** (0.88 to 1.14)	28 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Recurrence	0 per 1000	**0 per 1000** (0 to 0)	**RR 3.00** (0.13 to 67.91)	28 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Culture Conversion	1000 per	**1000 per 1000**	**RR 1.00** (0.88 to	28	⊕⊕◯◯

		1000	(880 to 1000)	1.14)	(1 RCT)	LOW [1,2,3]
		Quality of Life - not measured	-	-	-	-	-
		Development of Antibiotic Resistance - not measured	-	-	-	-	-
		Death - not reported	-	-	-	-	-
		Adverse Drug Effects - not reported	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

- ● Very low
- ○ Low
- ○ Moderate
- ○ High

- ○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence	CRITICAL	⊕◯◯◯ VERY LOW
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW
Quality of Life	CRITICAL	
Development of Antibiotic Resistance	CRITICAL	
Death	CRITICAL	
Adverse Drug Effects	CRITICAL	

VALUES

Is there important uncertainty about or variability in how much

Values and preferences:

people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
● Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

<12 months compared to >12 months for M kansasii

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with >12 months	Risk with <12 months			
Cure of NTM	1000 per 1000	**1000 per 1000** (880 to 1000)	**RR 1.00** (0.88 to 1.14)	28 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Recurrence	0 per 1000	**0 per 1000** (0 to 0)	**RR 3.00** (0.13 to 67.91)	28 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Culture Conversion	1000 per 1000	**1000 per 1000** (880 to 1000)	**RR 1.00** (0.88 to 1.14)	28 (1 RCT)	⊕⊕◯◯ LOW [1,2,3]
Quality of Life - not measured	-	-	-	-	-
Development of Antibiotic	-	-	-	-	-

		Resistance - not measured					
		Death - not reported	-	-	-	-	-
		Adverse Drug Effects - not reported	-	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.					
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.					
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased	No research evidence was identified.					

	○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	**Small**	Trivial		Varies	Don't know	
CERTAINTY OF	**Very low**	Low	Moderate	High			No included studies	

	JUDGEMENT							IMPLICATIONS
EVIDENCE								
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	**Probably favors the comparison**	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with rifampicin-susceptible *M. kansasii* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	●	○	○	○
RECOMMENDATION	We suggest that patients with rifampicin susceptible *M. kansasii* pulmonary disease be treated for at least 12 months regardless of when culture conversion occurs (conditional recommendation, very low confidence in estimates of effect). The expert panel voted unanimously for a conditional recommendation for the comparison.				
JUSTIFICATION	*M. kansasii* can be associated with significant lung destruction if undertreated. However, if treated appropriately, treatment outcomes are excellent. Therefore, a conservative treatment approach is warranted, favoring a longer treatment course.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION					
RESEARCH PRIORITIES	Clinical trials to determine optimal duration of therapy. Clinical trial of shorter regimens: 9 months rifampin/ethambutol/macrolide vs. 12 months isoniazid/rifampin/ethambutol. Clinical trial of 6 vs 12 months - moxifloxicin/clarithromycin/rifampin.				

Table E4.15. Question XV

In patients with *M. xenopi* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

POPULATION:	patients with newly diagnosed pulmonary M. xenopii infection
INTERVENTION:	a quinolone containing regimen
COMPARISON:	regimen without a fluoroquinolone
MAIN OUTCOMES:	Death; Quality of life; Cure of NTM disease; Recurrence (relapse); Culture conversion; Development of antibiotic resistance; Severe adverse effects; Any adverse effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ● Trivial ○ Small ○ Moderate ○ Large ○ Varies ○ Don't know	**A quinolone containing regimen compared to regimen without a fluoroquinolone in patients with newly diagnosed pulmonary M. xenopii infection**	An ongoing study by C. Andrejak, et al (CaMoMy study), has shown no difference between groups for 6 month sputum conversion, adverse events.
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ● Trivial ○ Varies ○ Don't know		

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with regimen without a fluoroquinolone	Risk with a quinolone containing regimen			
Death follow up: 5 years	29 per 100	**47 per 100** (19 to 100)	**RR 1.60** (0.66 to 3.91)	34 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Quality of life - not measured	-	-	-	-	-

Cure of NTM disease follow up: 5 years	35 per 100	**35 per 100** (14 to 88)	**RR 1.00** (0.40 to 2.48)	34 (1 RCT)	⊕⊕◯◯ LOW [1,2]	
Recurrence (relapse) follow up: 5 years	12 per 100	**2 per 100** (0 to 46)	**RR 0.20** (0.01 to 3.88)	34 (1 RCT)	⊕⊕◯◯ LOW [1,3]	
Culture conversion - not reported	-	-	-	-	-	
Development of antibiotic resistance - not measured	-	-	-	-	-	
Severe adverse effects - not reported	-	-	-	-	-	
Any adverse effects follow up: 2 years	20 per 100	**20 per 100** (14 to 31)	**RR 1.03** (0.69 to 1.55)	371 (1 RCT)	⊕◯◯◯ VERY LOW [1,4,5]	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

○ Very low
● Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Death	CRITICAL	⊕⊕◯◯ LOW
Quality of life	CRITICAL	-
Cure of NTM disease	CRITICAL	⊕⊕◯◯ LOW
Recurrence (relapse)	CRITICAL	⊕⊕◯◯ LOW
Culture conversion	CRITICAL	-

Development of antibiotic resistance	CRITICAL	-
Severe adverse effects	CRITICAL	-
Any adverse effects	CRITICAL	⊕◯◯◯ VERY LOW

VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function. Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**A quinolone containing regimen compared to regimen without a fluoroquinolone in patients with newly diagnosed pulmonary M. xenopii infection**	Intervention is fluoroquinolone-containing regimen.

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with regimen without a fluoroquinolone	**Risk with a quinolone containing regimen**			
Death follow up: 5 years	29 per 100	**47 per 100** (19 to 100)	**RR 1.60** (0.66 to 3.91)	34 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Quality of life - not	-	-	-	-	-

		measured					
		Cure of NTM disease follow up: 5 years	35 per 100	**35 per 100** (14 to 88)	**RR 1.00** (0.40 to 2.48)	34 (1 RCT)	⊕⊕◯◯ LOW [1,2]
		Recurrence (relapse) follow up: 5 years	12 per 100	**2 per 100** (0 to 46)	**RR 0.20** (0.01 to 3.88)	34 (1 RCT)	⊕⊕◯◯ LOW [1,3]
		Culture conversion - not reported	-	-	-	-	-
		Development of antibiotic resistance - not measured	-	-	-	-	-
		Severe adverse effects - not reported	-	-	-	-	-
		Any adverse effects follow up: 2 years	20 per 100	**20 per 100** (14 to 31)	**RR 1.03** (0.69 to 1.55)	371 (1 RCT)	⊕◯◯◯ VERY LOW [1,4,5]
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research evidence was identified.					

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ○ Probably yes ● Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ○ Probably yes ● Yes	No research evidence was identified.	

	○ Varies ○ Don't know		

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	**Trivial**		Varies	Don't know	
CERTAINTY OF EVIDENCE	Very low	**Low**	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
ACCEPTABILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know	
FEASIBILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know	

Conclusions

In patients with *M. xenopi* pulmonary disease, should a treatment regimen that includes a fluoroquinolone or a regimen without a fluoroquinolone be used?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	●	○	○
RECOMMENDATION	In patients with *M. xenopi* pulmonary disease, we suggest using a treatment regimen that includes moxifloxacin or a macrolide. (conditional recommendation, low confidence in estimates of effect).				
JUSTIFICATION	There is *in vitro* evidence that macrolides and fluoroquinolones are active against *M. xenopi*, while rifampin and ethambutol are inactive alone and in combinations. From this perspective, a regimen that utilizes a macrolide or fluoroquinolone is likely most active. There are preliminary data from a randomized trial in favor of a non inferiority of fluoroquinolones in comparison to macrolides in treatment of *M. xenopi* infections. These data should be confirmed with final results of CaMoMy study. Limited evidence for optimal choice of optimal fluoroquinolone or macrolide - ciprofloxacin, moxifloxacin, and clarithromycin have been studied, but unclear if effects represent entire class of drugs.				

SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	ECG monitoring for potential QTc interval prolongation with long term of use macrolides and/or fluoroquinolones
RESEARCH PRIORITIES	Clinical trial of rifampin/ethambutol/moxifloxacin vs. rifampin/ethambutol/azithromycin vs. rifampin/ethambutol/moxifloxacin/azithromycin.

Table E4.16. Question XVI

In patients with *M. xenopi* pulmonary disease, should a two, three or four-drug regimen be used for treatment?

POPULATION:	treatment of M. xenopi pulmonary infection
INTERVENTION:	a two drug regimen
COMPARISON:	a three drug regimen
MAIN OUTCOMES:	Death; Cure of NTM; Recurrence; Quality of Life; Development of antibiotic resistance; Culture Conversion;

Assessment

DESIRABLE EFFECTS

JUDGEMENT

How substantial are the desirable anticipated effects?

- ● Trivial
- ○ Small
- ○ Moderate
- ○ Large

- ○ Varies
- ○ Don't know

RESEARCH EVIDENCE

A two drug regimen compared to a three drug regimen for treatment of M. xenopi pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with a three drug regimen	Risk with a two drug regimen			
Death follow up: 5 years	650 per 1000	**501 per 1000** (293 to 845)	**RR 0.77** (0.45 to 1.30)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]

ADDITIONAL CONSIDERATIONS

In vitro, clarithromycin and moxifloxacin are of equal efficacy (Ferro BE et al, Antimicrob Agents Chemother 2015) against *M. xenopi*. In mouse models, adding either of the two to a rifampicin-ethambutol backbone leads to 3 drug regimens of equal efficacy (Andrejak C, et al., J Antimicrob Chemother. 2013 Mar;68(3):659-65.).

There is one more informative comparative treatment trial looking at two 3 drug regimens, RE with macrolide or fluoroquinolone (BTS Thorax 63, 627; 2008) but that doesn't address the 2 vs 3 drug regimen. The most recent *M. xenopi* treatment data comes from case series (Andrejak et al, Thorax 64, 291; van Ingen et al EID, 2008).

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
● Trivial

○ Varies
○ Don't know

Cure of NTM	100 per 1000	**227 per 1000** (50 to 1000)	**RR 2.27** (0.50 to 10.43)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Recurrence	0 per 1000	**0 per 1000** (0 to 0)	**RR 4.57** (0.23 to 89.72)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Quality of Life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Culture Conversion - not reported	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

○ Very low
● Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Death	CRITICAL	⊕⊕◯◯ LOW
Cure of NTM	CRITICAL	⊕⊕◯◯ LOW
Recurrence	CRITICAL	⊕⊕◯◯ LOW
Quality of Life	CRITICAL	-
Development of antibiotic resistance	CRITICAL	-

		<table><tr><td>Culture Conversion</td><td>CRITICAL</td><td>-</td></tr></table>	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
● Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies
○ Don't know

A two drug regimen compared to a three drug regimen for treatment of M. xenopi pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with a three drug regimen	Risk with a two drug regimen			
Death follow up: 5 years	650 per 1000	**501 per 1000** (293 to 845)	**RR 0.77** (0.45 to 1.30)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Cure of NTM	100 per 1000	**227 per 1000** (50 to 1000)	**RR 2.27** (0.50 to 10.43)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Recurrence	0 per 1000	**0 per 1000** (0 to 0)	**RR 4.57** (0.23 to 89.72)	42 (1 RCT)	⊕⊕◯◯ LOW [1,2]
Quality of Life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Culture Conversion - not reported	-	-	-	-	-

RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies	No research evidence was identified.	

	○ Don't know		
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	**Trivial**		Varies	Don't know	
CERTAINTY OF EVIDENCE	Very low	**Low**	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or**	Probably no important uncertainty or	No important uncertainty or variability				

	JUDGEMENT							IMPLICATIONS
		variability	variability					
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with *M. xenopi* pulmonary disease, should a two, three or four-drug regimen be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	●	○	○	○
RECOMMENDATION	In patients with *M xenopi* pulmonary disease, we recommend a daily regimen that includes at least three drugs: rifampicin, ethambutol, and either a macrolide and/or a fluoroquinolone (e.g. moxifloxacin) (conditional recommendation, very low confidence in estimates of effect). (3 Strong, 13 Conditional, 2 Abstain). The panel members voted for a conditional recommendation for the comparison.				
JUSTIFICATION	In animal and *in vitro* models, regimens of rifampicin, ethambutol, and either clarithromycin or moxifloxacin are efficacious. Given the very high mortality with *M. xenopi*, some members of expert panel felt the large risk of treatment failure with a two drug regimen warranted a strong recommendation for a three drug treatment regimen. However, the majority of the members voted for a conditional recommendation for three or more drugs.				
SUBGROUP CONSIDERATIONS					
IMPLEMENTATION CONSIDERATIONS	Moxifloxacin may not be available in all settings and activity of gemifloxacin or gatifloxacin has not been studied				
MONITORING AND EVALUATION	ECG for QTc prolongation, tendinopathy				
RESEARCH PRIORITIES	Clinical trials of rifampin/ethambutol/azithromycin vs. rifampin/ethambutol/moxifloxacin vs. rifampin/ethambutol/azithromycin/moxifloxacin. Clinical trials of a three times weekly regimen vs daily regimen.				

Table E4.17. Question XVII

In patients with *M. xenopi* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

POPULATION:	M xenopi pulmonary infection
INTERVENTION:	a treatment regimen with a parenteral agent
COMPARISON:	a treatment regimen without a parenteral agent
MAIN OUTCOMES:	Cure of NTM disease; Death; Recurrence (relapse); Quality of life; Culture conversion; Adverse drug effects; Development of antibiotic resistance;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ○ Moderate ○ Large ○ Varies ● Don't know	**Parenteral compared to no parenteral agent for M xenopi**	A systematic review on M. xenopi outcomes by treatment was published in 2009 (INT J TUBERC LUNG DIS 13(10):1210–1218). With the exception of one clinical trial, all were retrospective case series. The clinical trials did not study injectable agents. The small signal was against aminoglycosides, but the comparison was undoubtedly biased strongly by disease severity. Success rates lower in injectables, lots of confounding by selection bias (used injectables in sicker patients). Until there is better understanding of why mortality is so high with M xenopi disease, an aggressive M xenopi therapeutic regimen is warranted. The only data we have are on murine models of M. xenopi

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with no parenteral agent	Risk with Parenteral			
Cure of NTM disease - not measured	-	-	-	-	-
Death - not measured	-	-	-	-	-
Recurrence (relapse) - not measured	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-

		Culture conversion - not measured - - - - -	infection. In this study, mice treated with parenteral agent (amikacin) have a lower CFU count after 2 months of treatment
UNDESIRABLE EFFECTS	**How substantial are the undesirable anticipated effects?** ○ Large ○ Moderate ○ Small ○ Trivial ○ Varies ● Don't know	Adverse drug effects - not measured - - - - - -	
		Development of antibiotic resistance - not measured - - - - - -	
CERTAINTY OF EVIDENCE	**What is the overall certainty of the evidence of effects?** ○ Very low ○ Low ○ Moderate ○ High ● No included studies	**The relative importance or values of the main outcomes of interest:** **Outcome** / **Relative importance** / **Certainty of the evidence (GRADE)** Cure of NTM disease / CRITICAL / - Death / CRITICAL / - Recurrence (relapse) / CRITICAL / - Quality of life / CRITICAL / - Culture conversion / CRITICAL / - Adverse drug effects / CRITICAL / - Development of antibiotic resistance / CRITICAL / -	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical	

	○ Probably no important uncertainty or variability ○ No important uncertainty or variability	normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ● Don't know	No research evidence was identified.	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ● No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ● Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ○ Probably yes ○ Yes	No research evidence was identified.	

	● Varies ○ Don't know		

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	Very low	Low	Moderate	High			**No included studies**	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	**Don't know**	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	**No included studies**	
EQUITY	Reduced	**Probably**	Probably no	Probably	Increased	Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
		reduced	impact	increased				
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	Probably yes	Yes		**Varies**	Don't know	

Conclusions

In patients with *M. xenopi* pulmonary disease, should amikacin or streptomycin be included in the treatment regimen?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	○
RECOMMENDATION	In patients with fibro-cavitary or advanced/severe bronchiectatic *M. xenopi* pulmonary disease, we suggest adding parenteral amikacin to the treatment regimen and obtaining expert consultation. (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION	Barring compelling evidence to the contrary, *M. xenopi* patients should be treated aggressively given the high morbidity and mortality of the disease. In murine models of *M. xenopi* infection, mice treated with amikacin have a lower CFU count after 2 months of treatment.				
SUBGROUP CONSIDERATIONS					

IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	renal function, audiometry (see monitoring section)
RESEARCH PRIORITIES	Randomized study comparing 3 drug regimen with and without an aminoglycoside

Table E4.18. Question XVIII

In patients with *M. xenopi* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months after culture conversion?

POPULATION:	Mycobacterium xenopi pulmonary disease
INTERVENTION:	<12 months of treatment after culture negativity
COMPARISON:	>/= 12 months of treatment after culture negativity
MAIN OUTCOMES:	Cure of NTM; Recurrence; Culture conversion; Quality of life; Development of antibiotic resistance; Death; Adverse drug effects;

Assessment

DESIRABLE EFFECTS

How substantial are the desirable anticipated effects?

- ● Trivial
- ○ Small
- ○ Moderate
- ○ Large
- ○ Varies
- ○ Don't know

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

- ○ Large
- ○ Moderate
- ○ Small
- ○ Trivial
- ○ Varies
- ● Don't know

RESEARCH EVIDENCE

<12 months compared to >12 months for Mycobacterium xenopi

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with >12 months	Risk with <12 months			
Cure of NTM	481 per 1000	**260 per 1000** (125 to 544)	**RR 0.54** (0.26 to 1.13)	54 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,3]
Recurrence	370 per 1000	**215 per 1000** (96 to 481)	**RR 0.58** (0.26 to 1.30)	54 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,3]

ADDITIONAL CONSIDERATIONS

Because of the apparent very high mortality with M xenopi disease, insuring adequate therapy is important. Without compelling evidence, and with the potential for significant morbidity and mortality with untreated disease, a conservative approach is likely warranted.

Culture conversion	571 per 1000	**503 per 1000** (154 to 1000)	**RR 0.88** (0.27 to 2.82)	11 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
Quality of life - not measured	-	-	-	-	-	
Development of antibiotic resistance - not measured	-	-	-	-	-	
Death - not reported	-	-	-	-	-	
Adverse drug effects - not reported	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence	CRITICAL	⊕◯◯◯ VERY LOW
Culture conversion	CRITICAL	⊕◯◯◯ VERY LOW
Quality of life	CRITICAL	-
Development of antibiotic resistance	CRITICAL	-
Death	CRITICAL	-

		Adverse drug effects | CRITICAL | -	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ● Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**<12 months compared to >12 months for Mycobacterium xenopi** Outcomes | **Anticipated absolute effects* (95% CI)** | Relative effect (95% CI) | Nº of participants (studies) | Quality of the evidence (GRADE) **Risk with >12 months** | **Risk with <12 months** Cure of NTM | 481 per | **260 per 1000** | **RR 0.54** (0.26 to | 54 (2 observational | ⨁◯◯◯ VERY LOW	

			1000	(125 to 544)	1.13)	studies)	[1,2,3]	
		Recurrence	370 per 1000	**215 per 1000** (96 to 481)	**RR 0.58** (0.26 to 1.30)	54 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2,3]	
		Culture conversion	571 per 1000	**503 per 1000** (154 to 1000)	**RR 0.88** (0.27 to 2.82)	11 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
		Quality of life - not measured	-	-	-	-	-	
		Development of antibiotic resistance - not measured	-	-	-	-	-	
		Death - not reported	-	-	-	-	-	
		Adverse drug effects - not reported	-	-	-	-	-	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research evidence was identified.						

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	**Does not favor either the intervention or the comparison**	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with *M. xenopi* pulmonary disease, should treatment be continued for less than 12 months or 12 or more months after culture conversion?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	●	○	○	○

RECOMMENDATION	In patients with *M. xenopi* pulmonary disease, we suggest that treatment be continued for at least 12 months beyond culture conversion (conditional recommendation, very low confidence in estimates of effect). The panel members voted unanimously for a conditional recommendation for the comparison.
JUSTIFICATION	Because of the significant morbidity and mortality of untreated *M. xenopi* disease and without compelling evidence to the contrary, a conservative approach should be undertaken with treatment of at least 12 months beyond culture conversion.
SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	

Table E4.19. Question XIX

In patients with *M. abscessus* pulmonary disease, should a macrolide-based regimen or a regimen without a macrolide be used for treatment?

POPULATION:	Mycobacterium abscessus pulmonary infection
INTERVENTION:	a macrolide-containing regimen
COMPARISON:	a non-macrolide containing regimen
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence (Relapse); Culture Conversion; Any adverse effect; Withdrawal owing to adverse effect; Development of antibiotic resistance; Quality of life;

Assessment

<table>
<tr><th></th><th>JUDGEMENT</th><th>RESEARCH EVIDENCE</th><th>ADDITIONAL CONSIDERATIONS</th></tr>
<tr><td>DESIRABLE EFFECTS</td><td>How substantial are the desirable anticipated effects?

○ Trivial
○ Small
○ Moderate
○ Large

○ Varies
● Don't know</td><td>
Macrolide compared to No macrolide for Mycobacterium abscessus pulmonary infection
<table>
<tr><th>Outcomes</th><th>Anticipated absolute effects* (95% CI)</th><th>Relative effect</th><th>№ of participants (studies)</th><th>Quality of the evidence</th></tr>
</table>
</td><td>It is important to consider identification of the M abscessus subspecies because of the difference in response to macrolide therapy based on the presence or absence of the inducible macrolide resistance (erm) gene.</td></tr>
</table>

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
○ Trivial

○ Varies
● Don't know

	Risk with No macrolide	Risk with Macrolide	(95% CI)		(GRADE)
Cure of NTM	429 per 1000	934 per 1000 (420 to 1000)	**RR 2.18** (0.98 to 4.84)	82 (2 observational studies)	⊕◯◯◯ VERY LOW [1,2]
Death	no data	2/65 (3.1%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW [2,3]
Recurrence (Relapse)	no data	9/47 (19.1%)	-	47 (1 observational study)	⊕◯◯◯ VERY LOW [2,3]
Culture Conversion	no data	47/65 (72.3%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW [2,3]
Any adverse effect	no data	14/65 (21.5%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW [2,3]
Withdrawal owing to adverse effect	no data	6/65 (9.2%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW [2,3]
Development of antibiotic resistance - not measured	no data	no data	-	-	-
Quality of life - not measured	no data	no data	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (Relapse)	CRITICAL	⊕◯◯◯ VERY LOW
Culture Conversion	CRITICAL	⊕◯◯◯ VERY LOW
Any adverse effect	CRITICAL	⊕◯◯◯ VERY LOW
Withdrawal owing to adverse effect	CRITICAL	⊕◯◯◯ VERY LOW
Development of antibiotic resistance	CRITICAL	-
Quality of life	CRITICAL	-

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Values and preferences:

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function.

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and healthy subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores.

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens

		for *M. abscessus* (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ● Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**Macrolide compared to No macrolide for Mycobacterium abscessus pulmonary infection**	Intervention is considered macrolide-containing regimens

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with No macrolide	Risk with Macrolide			
Cure of NTM	429 per 1000	934 per 1000 (420 to 1000)	**RR 2.18** (0.98 to 4.84)	82 (2 observational studies)	⊕◯◯◯ VERY LOW[1,2]
Death	no data	2/65 (3.1%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW[2,3]
Recurrence (Relapse)	no data	9/47 (19.1%)	-	47 (1 observational study)	⊕◯◯◯ VERY LOW[2,3]
Culture Conversion	no data	47/65 (72.3%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW[2,3]
Any adverse effect	no data	14/65 (21.5%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW[2,3]
Withdrawal owing to adverse effect	no data	6/65 (9.2%)	-	65 (1 observational study)	⊕◯◯◯ VERY LOW[2,3]
Development of antibiotic resistance - not measured	no data	no data	-	-	-
Quality of life - not	no data	no data	-	-	-

		measured	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.	
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ● Probably no impact ○ Probably increased ○ Increased	No research evidence was identified.	

	○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of M abscessus and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for M abscessus contained a macrolide.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	

	JUDGEMENT							IMPLICATIONS
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	**Probably no impact**	Probably increased	Increased	Varies	Don't know	
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with *M. abscessus* pulmonary disease, should a macrolide-based regimen or a regimen without a macrolide be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention ○	Conditional recommendation against the intervention ○	Conditional recommendation for either the intervention or the comparison ○	Conditional recommendation for the intervention ○	Strong recommendation for the intervention ●
RECOMMENDATION	In patients with *M. abscessus* pulmonary disease caused by strains without inducible or mutational resistance, we recommend a macrolide-containing multidrug treatment regimen. (strong recommendation, very low confidence in estimates of effect). (16 Strong, 0 Conditional, 2 Abstain). The expert panel voted for a strong recommendation for the intervention. In patients with *M. abscessus* pulmonary disease caused by strains with inducible or mutational macrolide resistance, we suggest a macrolide-containing regimen if the drug is being used for its immunomodulatory properties; however, the macrolide should not be counted as an active drug in the multidrug regimen (conditional recommendation, very low confidence in estimates of effect). The expert panel voted unanimously for a conditional recommendation for the intervention.				
JUSTIFICATION	Macrolides are very active *in vitro* against *M. abscessus*. Indirect evidence supports use of macrolides in macrolide-susceptible cases. *M. abscessus* can be life threatening and the use of macrolides is potentially of great benefit.				
SUBGROUP CONSIDERATIONS	Disease caused by strains with and without inducible macrolide resistance should be treated differently.				
IMPLEMENTATION CONSIDERATIONS					
MONITORING AND EVALUATION	Audiograms, EKG				

RESEARCH PRIORITIES	Need to provide precise speciation in future trials and perform randomized trial including macrolide vs no macrolide in *M. abscessus* subspecies with macrolide resistance (inducible and acquired subgroups).

Table E4.20. Question XX

In patients with *M. abscessus* pulmonary disease, how many antibiotics should be included within multidrug regimens?

POPULATION:	treatment of Mycobacterium abscessus pulmonary infection
INTERVENTION:	two drugs
COMPARISON:	three vs. four drugs
MAIN OUTCOMES:	Cure of NTM disease; Recurrence (relapse); Any adverse effect; Culture conversion; Quality of Life; Development of antibiotic resistance; Death;

Assessment

DESIRABLE EFFECTS

How substantial are the desirable anticipated effects?

● Trivial
○ Small
○ Moderate
○ Large

○ Varies
○ Don't know

Two drugs compared to three vs. four drugs for *Mycobacterium abscessus* pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with three vs. four drugs	**Risk with two drugs**			
Cure of NTM disease follow up: median 445 days	833 per 1000	**767 per 1000** (558 to 1000)	**RR 0.92** (0.67 to 1.26)	41 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Recurrence (relapse) follow up: median 445 days	50 per 1000	**231 per 1000** (27 to 1000)	**RR 4.62** (0.54 to 39.73)	33 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]

ADDITIONAL CONSIDERATIONS

It is not possible to determine the outcomes for treatment of *M. abscessus* subspecies *abscessus* as the isolates were not speciated and not randomly distributed amount the patients in this observational cohort.

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
● Moderate
○ Small
○ Trivial

○ Varies
○ Don't know

Any adverse effect follow up: median 445 days	625 per 1000	**175 per 1000** (63 to 519)	**RR 0.28** (0.10 to 0.83)	41 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
Culture conversion	The study reported no significant difference between the two groups, but only reported a p-value of 0.698 without specifying exact numbers.			(1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
Quality of Life - not measured	-	-	-	-	-	
Development of antibiotic resistance - not measured	-	-	-	-	-	
Death - not reported	-	-	-	-	-	

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

- ● Very low
- ○ Low
- ○ Moderate
- ○ High

- ○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM disease	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (relapse)	CRITICAL	⊕◯◯◯ VERY LOW
Any adverse effect	CRITICAL	⊕◯◯◯ VERY LOW
Culture conversion	CRITICAL	⊕◯◯◯ VERY LOW
Quality of Life	CRITICAL	

		Development of antibiotic resistance	CRITICAL	
		Death	CRITICAL	

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for M abscessus (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
● Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

○ Varies

Two drugs compared to three vs. four drugs for Mycobacterium abscessus pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with three vs. four drugs	Risk with two drugs			

	○ Don't know	Cure of NTM disease follow up: median 445 days	833 per 1000	**767 per 1000** (558 to 1000)	**RR 0.92** (0.67 to 1.26)	41 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]	
		Recurrence (relapse) follow up: median 445 days	50 per 1000	**231 per 1000** (27 to 1000)	**RR 4.62** (0.54 to 39.73)	33 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
		Any adverse effect follow up: median 445 days	625 per 1000	**175 per 1000** (63 to 519)	**RR 0.28** (0.10 to 0.83)	41 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
		Culture conversion	The study reported no significant difference between the two groups, but only reported a p-value of 0.698 without specifying exact numbers.			(1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]	
		Quality of Life - not measured	-	-	-	-	-	
		Development of antibiotic resistance - not measured	-	-	-	-	-	
		Death - not reported	-	-	-	-	-	
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research data available.						

COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	Comparison is considered three drugs in this case.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ● Varies ○ Don't know	No research data available.	This is dependent on the respective health care system.
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ● Probably no ○ Probably yes ○ Yes ○ Varies ○ Don't know	No research data available.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ○ Probably yes ○ Yes ● Varies ○ Don't know	No research data available.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know	
UNDESIRABLE EFFECTS	Large	**Moderate**	Small	Trivial		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	**Probably favors the comparison**	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	Probably no	Probably	Increased	**Varies**	Don't know	

	JUDGEMENT							IMPLICATIONS
			impact	increased				
ACCEPTABILITY	No	**Probably no**	Probably yes	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	Probably yes	Yes		**Varies**	Don't know	

Conclusions

In patients with *M. abscessus* pulmonary disease, how many antibiotics should be included within multidrug regimens?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	○

RECOMMENDATION	In patients with *M. abscessus* pulmonary disease, we suggest a multidrug regimen that includes at least three active drugs (guided by *in vitro* susceptibility). (conditional recommendation, very low confidence in estimates of effect). The expert panel voted unanimously for a conditional recommendation for the comparison.
JUSTIFICATION	The severity of disease associated with *M. abscessus,* poor treatment outcomes, and high recurrence rates, warrants consideration of three or four drugs even if associated with a higher risk of adverse effects and higher cost.
SUBGROUP CONSIDERATIONS	The choice of drugs may be different in patients with extensive exposure to key antimycobacterial drugs (macrolides, aminoglycosides) in whom resistance may be a serious risk.
IMPLEMENTATION CONSIDERATIONS	Barriers/facilitators for limitation include infrastructure and financial support for intravenous therapy and for expensive oral agents.
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	There is a need for an RCT evaluating the optimal number of drugs (3 vs. 4 or more) with and without parenteral agents in treatment for *M. abscessus*, separated by subspecies.

Table E4.21. Question XXI

In patients with *M. abscessus* pulmonary disease, should shorter or longer duration therapy be used for treatment?

POPULATION:	Mycobacterium abscessus pulmonary infection
INTERVENTION:	shorter therapy duration
COMPARISON:	longer therapy duration
MAIN OUTCOMES:	Cure of NTM; Recurrence (relapse); Culture conversion; Quality of life; Development of antibiotic resistance; Death; Adverse drug effects;

Assessment

	JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
DESIRABLE EFFECTS	**How substantial are the desirable anticipated effects?** ○ Trivial ○ Small ○ Moderate ○ Large ○ Varies ● Don't know	**Shorter therapy duration compared to longer therapy duration for Mycobacterium abscessus pulmonary infection**	

Outcomes	Anticipated absolute effects* (95% CI)	Relative effect	Nº of participants	Quality of the evidence

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
○ Small
○ Trivial

○ Varies
● Don't know

	Risk with longer therapy duration	Risk with shorter therapy duration	(95% CI)	(studies)	(GRADE)
Cure of NTM	1000 per 1000	**750 per 1000** (470 to 1000)	**RR 0.75** (0.47 to 1.20)	17 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]
Recurrence (relapse) - not measured	-	-	-	-	-
Culture conversion - not reported	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Death - not reported	-	-	-	-	-
Adverse drug effects - not reported	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence (relapse)	CRITICAL	
Culture conversion	CRITICAL	
Quality of life	CRITICAL	

		<table><tr><td>Development of antibiotic resistance</td><td>CRITICAL</td><td></td></tr><tr><td>Death</td><td>CRITICAL</td><td></td></tr><tr><td>Adverse drug effects</td><td>CRITICAL</td><td></td></tr></table>	
VALUES	**Is there important uncertainty about or variability in how much people value the main outcomes?** ○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Values and preferences: Three relevant studies were identified that provide data on patient values and preferences: Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and health subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for M abscessus (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	

BALANCE OF EFFECTS

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

○ Favors the comparison
○ Probably favors the comparison
○ Does not favor either the intervention or the comparison
○ Probably favors the intervention
○ Favors the intervention

● Varies
○ Don't know

Shorter therapy duration compared to longer therapy duration for Mycobacterium abscessus pulmonary infection

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with longer therapy duration	Risk with shorter therapy duration			
Cure of NTM	1000 per 1000	**750 per 1000** (470 to 1000)	**RR 0.75** (0.47 to 1.20)	17 (1 observational study)	⊕◯◯◯ VERY LOW [1,2,3]
Recurrence (relapse) - not measured	-	-	-	-	-
Culture conversion - not reported	-	-	-	-	-
Quality of life - not measured	-	-	-	-	-
Development of antibiotic resistance - not measured	-	-	-	-	-
Death - not reported	-	-	-	-	-
Adverse drug effects - not reported	-	-	-	-	-

RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ○ Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ● Varies ○ Don't know	No research evidence was identified.	
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.	
EQUITY	**What would be the impact on health equity?** ○ Reduced ○ Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ● Varies ○ Don't know	No research evidence was identified.	
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ○ Probably yes ○ Yes ● Varies	No research evidence was identified.	

	○ Don't know		
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	A study by Adjemian, et al in 2014 evaluated treatment of M abscessus and MAC, looking at compliance with the 2007 ATS/IDSA guidelines. This study found poor adherence with only 13% of antibiotic regimens compliant with guidelines. Of prescribed regimens for MAC, only 44% contained a macrolide, while 36% of regimens for M abscessus contained a macrolide.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE EFFECTS	Trivial	Small	Moderate	Large		Varies	**Don't know**	
UNDESIRABLE EFFECTS	Large	Moderate	Small	Trivial		Varies	**Don't know**	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the	Probably favors	Does not favor either the	Probably favors	Favors the	**Varies**	Don't know	

	JUDGEMENT							IMPLICATIONS
	comparison	the comparison	intervention or the comparison	the intervention	intervention			
RESOURCES REQUIRED	Large costs	Moderate costs	Negligible costs and savings	Moderate savings	Large savings	**Varies**	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	**Varies**	Don't know	
ACCEPTABILITY	No	Probably no	Probably yes	Yes		**Varies**	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

In patients with *M. abscessus* pulmonary disease, should shorter or longer duration therapy be used for treatment?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or	Conditional recommendation for the intervention	Strong recommendation for the intervention

	○	○	the comparison ●	○	○	
RECOMMENDATION	In the absence of data to support a shorter or longer treatment course for *M. abscessus* pulmonary disease, the expert panel decided not to make a recommendation on the length of treatment. The expert panel voted unanimously for a conditional recommendation for either the intervention or the comparison.					
JUSTIFICATION	The one study identified was a very small study that indirectly addressed this question and was felt to be too low quality evidence upon which to base a recommendation.					
SUBGROUP CONSIDERATIONS	Nodular and cavitary disease need to be considered separately.					
IMPLEMENTATION CONSIDERATIONS						
MONITORING AND EVALUATION						
RESEARCH PRIORITIES	Urgent need for biomarkers to individualize the duration of therapy. Randomized clinical trials of fixed regimens of different durations for both nodular and cavitary disease.					

Table E4.22. Question XXII

Should surgery or medical therapy be used to treat NTM pulmonary disease?

POPULATION:	NTM pulmonary infection
INTERVENTION:	surgery
COMPARISON:	medical therapy
MAIN OUTCOMES:	Cure of NTM; Death; Recurrence; Culture conversion; Surgical Complication; Quality of Life;

Assessment

<table>
<tr><th></th><th>JUDGEMENT</th><th>RESEARCH EVIDENCE</th><th>ADDITIONAL CONSIDERATIONS</th></tr>
<tr>
<td>DESIRABLE EFFECTS</td>
<td>How substantial are the desirable anticipated effects?

○ Trivial
○ Small
● Moderate
○ Large

○ Varies
○ Don't know</td>
<td>
Surgery compared to medical therapy for NTM pulmonary infection
<table>
<tr><th>Outcomes</th><th>Anticipated absolute effects* (95% CI)</th><th>Relative effect</th><th>Nº of participants</th><th>Quality of the</th></tr>
</table>
</td>
<td>Data obtained from case series and outcomes with medical therapy not comparable with surgery outcomes.</td>
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</table>

UNDESIRABLE EFFECTS

How substantial are the undesirable anticipated effects?

○ Large
○ Moderate
● Small
○ Trivial

○ Varies
○ Don't know

	Risk with medical therapy	Risk with surgery	(95% CI)	(studies)	evidence (GRADE)
Cure of NTM	13/46 (28.2%)	**13/23 (56.5%)**	not estimable	69 (1 observational study)	⊕◯◯◯ VERY LOW [1,2]
Death	13/83 (15.7%)	**20/486 (4.1%)**	not estimable	569 (10 observational studies)	⊕◯◯◯ VERY LOW [2,3,4]
Recurrence	12/102 (11.8%)	**22/391 (5.6%)**	not estimable	493 (9 observational studies)	⊕◯◯◯ VERY LOW [1,2,3,4]
Culture conversion	18/46 (39.1%)	**283/331 (85.5%)**	not estimable	377 (10 observational studies)	⊕◯◯◯ VERY LOW [1,2,3,4,5]
Surgical Complication	not pooled	**111/563 (19.7%)**	not pooled	563 (9 observational studies)	⊕◯◯◯ VERY LOW [1,3,4]
Quality of Life - not measured	-	-	-	-	-

CERTAINTY OF EVIDENCE

What is the overall certainty of the evidence of effects?

● Very low
○ Low
○ Moderate
○ High

○ No included studies

The relative importance or values of the main outcomes of interest:

Outcome	Relative importance	Certainty of the evidence (GRADE)
Cure of NTM	CRITICAL	⊕◯◯◯ VERY LOW
Death	CRITICAL	⊕◯◯◯ VERY LOW
Recurrence	CRITICAL	⊕◯◯◯ VERY LOW
Culture conversion	CRITICAL	⊕◯◯◯ VERY LOW
Surgical Complication	CRITICAL	⊕◯◯◯ VERY LOW
Quality of Life	CRITICAL	-

VALUES

Is there important uncertainty about or variability in how much people value the main outcomes?

○ Important uncertainty or variability
● Possibly important uncertainty or variability
○ Probably no important uncertainty or variability
○ No important uncertainty or variability

Values and preferences:

Three relevant studies were identified that provide data on patient values and preferences:

Mehta and Marras, 2011 evaluated the impact of pulmonary NTM on health-related quality of life. In this study, patients with pulmonary NTM had significantly impaired health-related quality of life with two QOL measures significantly lower than historical normal controls. Multivariable analysis showed an association between QOL scores and lung function

Hong, et al, 2014 also evaluated the impact of pulmonary NTM on health-related quality of life. This was a direct comparison between patients with NTM disease and health subjects and found patients with NTM reported more health status issues and anxiety/depression issues than healthy controls. Lung function was also

		independently associated with QOL scores. Czaja, et al 2015 evaluated change in quality of life in response to various treatment regimens for M abscessus (many patients had coinfection with MAC or Pseudomonas). Mean QOL score was significantly improved after treatment at 3, 6, 12, and 24 months.	
BALANCE OF EFFECTS	**Does the balance between desirable and undesirable effects favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ● Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know	**Surgery compared to medical therapy for NTM pulmonary infection**	

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nº of participants (studies)	Quality of the evidence (GRADE)
	Risk with medical therapy	**Risk with surgery**			
Cure of NTM	13/46 (28.2%)	**13/23 (56.5%)**	not estimable	69 (1 observational study)	⊕◯◯◯ VERY LOW[1,2]
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Surgical	not pooled	**111/563**	not	563 (9 observational	⊕◯◯◯ VERY

		Complication	**(19.7%)**	pooled	studies)	LOW[1,3,4]
		Quality of Life - not measured -	-	-	-	-
RESOURCES REQUIRED	**How large are the resource requirements (costs)?** ○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	No research evidence was identified.				
COST EFFECTIVENESS	**Does the cost-effectiveness of the intervention favor the intervention or the comparison?** ○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	No research evidence was identified.				
EQUITY	**What would be the impact on health equity?**	No research evidence was identified.				

	○ Reduced ● Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ○ Varies ○ Don't know		
ACCEPTABILITY	**Is the intervention acceptable to key stakeholders?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	
FEASIBILITY	**Is the intervention feasible to implement?** ○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	No research evidence was identified.	

Summary of judgments

	JUDGEMENT							IMPLICATIONS
DESIRABLE	Trivial	Small	**Moderate**	Large		Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
EFFECTS								
UNDESIRABLE EFFECTS	Large	Moderate	**Small**	Trivial		Varies	Don't know	
CERTAINTY OF EVIDENCE	**Very low**	Low	Moderate	High			No included studies	
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability				
BALANCE OF EFFECTS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	**Probably favors the intervention**	Favors the intervention	Varies	Don't know	
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know	
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies	
EQUITY	Reduced	**Probably reduced**	Probably no impact	Probably increased	Increased	Varies	Don't know	

	JUDGEMENT							IMPLICATIONS
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know	

Conclusions

Should surgery plus medical therapy or medical therapy alone be used to treat NTM pulmonary disease?

TYPE OF RECOMMENDATION	Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
	○	○	○	●	○

RECOMMENDATION	In selected patients with NTM pulmonary disease, we suggest surgical resection as an adjuvant to medical therapy after expert consultation (conditional recommendation, very low confidence in estimates of effect). The expert panel voted unanimously for a conditional recommendation for the intervention.
JUSTIFICATION	Consider whether surgical resection can improve treatment outcomes or potential to be curative. Prognosis can be improved in select cases: hemoptysis, localized cavitary disease, macrolide resistance.
SUBGROUP CONSIDERATIONS	
IMPLEMENTATION CONSIDERATIONS	
MONITORING AND EVALUATION	
RESEARCH PRIORITIES	