RESEARCH NOTE

Performance of Lipoarabinomannan Assay using Cerebrospinal fluid for the diagnosis of Tuberculous meningitis among HIV patients [version 2; peer review: 2 approved]

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Abstract

Background: The diagnostic utility of the Mycobacteria tuberculosis lipoarabinomannan (TB-LAM) antigen lateral flow assay on cerebrospinal fluid (CSF) for the diagnosis of tuberculous meningitis (TBM) has not been extensively studied and the few published studies have conflicting results.

Methods: Lumbar CSF from 59 HIV-positive patients with suspected TBM was tested with TB-LAM and Xpert MTB/Rif Ultra. The diagnostic performance of CSF TB-LAM was compared to positive CSF Xpert MTB/Rif Ultra (definite TBM) and a composite reference of probable or definite TBM according to the uniform case definition.

Results: Of 59 subjects, 12 (20%) had definite TBM and five (9%) had probable TBM. With reference to definite TBM, CSF TB-LAM assay had a diagnostic sensitivity of 33% and specificity of 96%. When compared to a composite reference of probable or definite TBM, the sensitivity was 24% and specificity was 95%. There were two false positive tests with TB-LAM (3+ grade). In-hospital mortality in CSF TB-LAM positive patients was 17% compared to 0% in those with definite TBM by Xpert MTB/Rif Ultra but negative LAM.

Conclusions: Lumbar CSF TB-LAM has a poor performance in diagnosing TBM. Both urine TB-LAM and Xpert Ultra should be further investigated in the diagnosis of TBM.

Keywords

Tuberculous meningitis, extra-pulmonary TB, lipoarabinomannan, TB-LAM, Xpert MTB/Rif Ultra, HIV, Diagnostics, cerebrospinal fluid
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Competing interests: No competing interests were disclosed.

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Introduction

In many human immunodeficiency virus (HIV) endemic countries, tuberculous meningitis (TBM) is the second most common cause of adult meningitis after cryptococcal meningitis, and accounts for 1–5% of all tuberculosis (TB) cases. TBM is the most severe form of TB and causes substantial morbidity and mortality in children and immunocompromised adults. HIV infection is known to increase the risk of death in patients with TBM, as does TBM stage at the time of treatment initiation. As is the case in cryptococcosis, high-quality nursing care is a critical component in managing TBM patients.

Similarly, diagnosis of TBM is very challenging, especially in resource-limited settings where diagnosis relies on a combination of clinical, radiological and laboratory findings. The World Health Organisation (WHO) recommends Xpert MTB/RIF Ultra for the diagnosis of TBM using cerebrospinal fluid (CSF). Culture has many limitations related to turnaround time and sensitivity, and also requires considerable infrastructure and costs. Therefore, the development of early point of care diagnosis for TBM is a priority. Recent studies have demonstrated that the next generation Xpert MTB/RIF Ultra is the most sensitive diagnostic test in HIV-positive adults. However, Xpert MTB/RIF Ultra is not a bedside test, and thus access to same day results remain a challenge in many settings.

Assays based on the detection of mycobacterial lipoarabinomannan (TB-LAM) antigen in urine have emerged as potential point-of-care tests for extra-pulmonary TB. There is evidence that urine TB-LAM may help to reduce mortality and predict poor outcomes. The WHO recently added the TB-LAM assay onto its essential diagnostic list and recommended TB-LAM in hospitalised HIV positive adults with signs and symptoms of TB. However, there are conflicting results about TB-LAM assay sensitivity for TBM diagnosis in CSF. With reference to definitive TBM, Cox et al. found a 75% sensitivity using CSF from the fourth ventricle in an autopsy cohort from 91 HIV-infected adults. However, Bahr et al. had no positive TB-LAM tests using lumbar CSF from 67 HIV patients with meningitis. In light of these results, and now that Xpert MTB/RIF Ultra is used instead of Xpert MTB/RIF, we aimed to further explore the utility of CSF TB-LAM test for the diagnosis of TBM among HIV-positive adults presenting with suspected meningitis.

Methods

Study setting and participants

Between April 2018 and June 2019, we assessed and performed diagnostic lumbar punctures on HIV-positive patients admitted to Mulago National Referral Hospital with suspected meningitis in Kampala, Uganda. Screening for TB was performed cross-sectionally as part of the High Dose Rifampicin for Tuberculous Meningitis (RIFT) trial (ISRCTN registration number ISRCTN42218549, last updated 24/04/2018). Therefore, we did not calculate a sample size for the current study but included all participants that fit the screening criteria for the RIFT trial. All included participants were HIV-infected adults (≥18 years old) who provided written informed consent by participant or surrogate, with a suspected diagnosis of TB (meningitis symptoms, clinical signs of meningitis). Demographic information and baseline characteristics for participants were collected through clinical reviews using customized meningitis screening case report forms approved by the relevant ethics committees (Mulago Hospital Research Ethics Committee, Uganda National Council of Science and Technology, and the University of Minnesota). Opening pressures for CSF were measured using a manometer, followed by standard microbiology analysis (CrAg, cell count, protein, glucose, lactate, culture).

Diagnostic tests

In addition to standard microbiology analysis, CSF was tested with TB-LAM (Alere, Massachusetts, USA), and the test strip interpreted as per manufacturer’s instructions. Briefly, the protective foil cover was removed from each test and the strip labelled with the participant’s number. Two drops (or 60μL) of CSF were added to the sample pad. The test was then read after 25 minutes under standard indoor lighting conditions. The reference card was used in interpretation of the results by holding it alongside the patient window. For positive results, purple/gray bars appeared in both the control window and the patient window of the strip. For negative results, one purple/gray bar appeared in the control window of the strip and no bar appeared in the patient window of the strip. If there was no bar
in the control window of the strip, the result was considered invalid and the test repeated. The strips were retained and cross checked by a second researcher to corroborate the finding.

CSF was also tested with Xpert MTB/Rif Ultra (Cepheid). Briefly, 2ml of sample reagent was added to 1ml of whole CSF and then left to stand at room temperature for 15 minutes. Then, 2ml of the sample mixture was transferred into the Xpert MTB/Rif Ultra cartridge and loaded into the Xpert machine. The test was run for 90 minutes and results from the assay indicate whether or not Mycobacteria TB (MTB) was detected in the sample. If MTB was detected, the results also stated whether resistance to rifampin was detected.

Test analysis
Data were analyzed using STATA version 14 (STATA, College Station, Texas). The disease prevalence, sensitivity, specificity, positive predictive values, negative predictive values and test accuracy were estimated at 95% confidence interval (CI). The diagnostic performance of CSF TB-LAM was compared to positive CSF Xpert MTB/Rif Ultra (definite TBM) and a composite reference of probable or definite TBM according to the uniform case definition10. Summaries were made in frequency & percentages for each baseline characteristic considered as a categorical, and medians (interquartile range) when each characteristic is considered as a continuous variable. For baseline variables with some missing data, we calculated the statistics using the available numbers.

Ethical statement
Institutional review board approvals for the study and the associated screening process were obtained locally in Uganda (Mulago Hospital Research Ethics Committee, approval number MREC 1260); and from the London School of Hygiene and Tropical Medicine, UK (14388), University of Minnesota (1304M31361) and by the Uganda National Council of Science and Technology (HS1363ES). Written informed consent for participation in the study and data publication was obtained from all participants or from their surrogates (e.g. family member or guardian) where the patient had altered mental status and did not have the capacity to provide consent.

Results
Overall, 59 HIV-positive hospitalized participants with suspected meningitis underwent diagnostic lumbar punctures, of which 20% (12/59) had definite TBM, 9% (5/59) had probable TBM, 25% (15/59) had possible TBM, and 46% (27/59) had not-TBM11. Of those with not-TBM (n=27), 10 had cryptococcosis. Women comprised 50% of participants with an overall median age for all participants of 33 years (interquartile range [IQR]: 28, 40). Only 29% of the participants were receiving antiretroviral therapy at diagnosis. Among participants reporting a headache (n=57), the median duration of headache was 14 days (IQR: 14, 24). The CSF opening pressures at baseline (n=45) had a median of 200 mmH2O (IQR: 120, 260). Overall, 55% (n=36) had an acellular CSF, whilst those with a CSF lymphocytic pleocytosis had a median CSF white blood cell of 160 cells/μL (IQR: 135, 268) (Table 1). Only about 10% of the participants had cerebral imaging done as the CT scanner was dysfunctional for part of the study period. About twenty five percent of the patients had a positive TB-LAM while 20% had a positive urine MTB/Rif Ultra.

With respect to the reference standard of definite TBM (positive CSF Xpert TB/Rif Ultra), the CSF TB-LAM assay had a sensitivity of 33% (4/12), specificity of 96% (45/47), positive predictive value (PPV) of 67% (4/6), and negative predictive value (NPV) of 85% (45/53). When compared to a composite reference of definite/probable TBM, the TB-LAM assay had a sensitivity of 24% (4/17), specificity of 95% (40/42), PPV of 67% (4/6), NPV of 76% (40/53) (Table 2). There were two false positive tests with TB-LAM (3+ grade), without any CSF pleocytosis, normal protein, normal glucose, negative cryptococcal antigen, and normal CSF opening pressure. One patient was discharged alive without TB therapy. The second patient had a headache for 60 days at presentation, but they were lost to follow up (i.e. self-discharged) without an etiologic diagnosis. In-hospital mortality in CSF TB-LAM positive patients was 17% (1/6) compared to 0% (0/8) in those with definite TBM by Xpert MTB/Rif Ultra but negative LAM. About 17% of patients had unknown outcome. This was because the study population included patients screened for a clinical trial but only a minority were subsequently enrolled into the trial. We endeavoured to follow screen failures through to hospital discharge but this was not possible in all cases.

Conclusion
In conclusion, a rapid CSF point of care test for TBM is needed; however, this study demonstrated a poor diagnostic performance of the existing Alere TB-LAM on CSF among HIV-associated tuberculous meningitis. Our results corroborate the findings of a recent Zambian study which demonstrated 22% sensitivity for CSF LAM against a reference standard of TB culture12. While the relatively modest sample size is a limitation, a larger sample size is unlikely to fundamentally alter the findings of sensitivity. One explanation could be that TB-LAM is likely not be found in sufficient quantities in lumbar CSF. TB culture was not used, which is also a limitation of the accuracy analysis. However, Xpert Ultra has a sensitivity that is greater than culture in our setting13. The novel Fujifilm SILVAMP TB-LAM (FujiLAM) assay has been shown to have higher sensitivity in urine than the Alere TB-LAM and
Table 1. Characteristics of the study population.

<table>
<thead>
<tr>
<th>Baseline characteristics</th>
<th>Overall (N=59)</th>
<th>Definite TBM (n=12)</th>
<th>Probable TBM (n=5)</th>
<th>Possible TBM (n=15)</th>
<th>Not-TBM (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N* Statistic</td>
<td>N* Statistic</td>
<td>N* Statistic</td>
<td>N* Statistic</td>
<td>N* Statistic</td>
</tr>
<tr>
<td>Women, n (%)</td>
<td>58 (29/50)</td>
<td>12 (6/50)</td>
<td>5 (3/60)</td>
<td>15 (4/26.7)</td>
<td>26 (16/61.5)</td>
</tr>
<tr>
<td>Age in years, median (IQR)</td>
<td>58 (33-28-40)</td>
<td>12 (29-28-33)</td>
<td>5 (26-24-34)</td>
<td>15 (35-32-43)</td>
<td>26 (34-26-46)</td>
</tr>
<tr>
<td>On ART, n (%)</td>
<td>47 (29/62)</td>
<td>11 (7/63.6)</td>
<td>2 (2/100)</td>
<td>11 (3/27.3)</td>
<td>23 (17/73.9)</td>
</tr>
<tr>
<td>Headache, n (%)</td>
<td>57 (46/81)</td>
<td>12 (10/83.3)</td>
<td>5 (4/80)</td>
<td>14 (12/85.7)</td>
<td>26 (20/76.9)</td>
</tr>
<tr>
<td>Duration of headache, median (IQR) days</td>
<td>45 (14-14-24)</td>
<td>10 (17.5-14-30)</td>
<td>4 (14-10-5-17.5)</td>
<td>12 (17.5-14-31.5)</td>
<td>19 (14-7-30)</td>
</tr>
<tr>
<td>Glasgow Coma Scale score, mean (SD)</td>
<td>55 (13.2.6)</td>
<td>12 (12.5-2.9)</td>
<td>5 (11.8-2.4)</td>
<td>14 (12.7-2.9)</td>
<td>24 (14.3-2.1)</td>
</tr>
<tr>
<td>CSF CrAg positive, n (%)</td>
<td>58 (10/17)</td>
<td>12 (0/0)</td>
<td>5 (0/0)</td>
<td>15 (0/0)</td>
<td>26 (10/38.4)</td>
</tr>
<tr>
<td>CSF Opening Pressure, median (IQR) mmH2o</td>
<td>45 (200-120-260)</td>
<td>7 (180-70-240)</td>
<td>3 (260-95-400)</td>
<td>13 (190-120-270)</td>
<td>22 (215-120-260)</td>
</tr>
<tr>
<td>Acellular CSF, n (%)</td>
<td>55 (36/55)</td>
<td>11 (3/27.3)</td>
<td>5 (1/20)</td>
<td>14 (11/78.6)</td>
<td>25 (21/84)</td>
</tr>
<tr>
<td>CSF WBC in those with CSF WBC pleocytosis, median (IQR) cells/μL</td>
<td>55 (160-135-268)</td>
<td>8 (280-162.5-575)</td>
<td>4 (173-130-237.5)</td>
<td>3 (80-35-160)</td>
<td>4 (145-87.5-210)</td>
</tr>
<tr>
<td>CSF protein, median (IQR) mg/dL</td>
<td>52 (57-28-141)</td>
<td>11 (184-107-316)</td>
<td>5 (158-147-215)</td>
<td>13 (44-35-72)</td>
<td>23 (31-22-61)</td>
</tr>
<tr>
<td>CSF glucose, median (IQR) mg/dL</td>
<td>32 (65-34-82)</td>
<td>7 (44-19.8-61)</td>
<td>3 (90-68-108)</td>
<td>8 (86-56.3-104)</td>
<td>14 (61-31-80)</td>
</tr>
<tr>
<td>CSF lactate, median (IQR) mmol/L</td>
<td>36 (3.9-2.2-9)</td>
<td>8 (9.7-8.2-11.2)</td>
<td>4 (9.2-6.3-11.1)</td>
<td>8 (3.4-2.3-8.1)</td>
<td>16 (2.4-1.9-3.8)</td>
</tr>
<tr>
<td>Duration of hospitalization, median (IQR) days</td>
<td>46 (7-4-14)</td>
<td>9 (11-9-14)</td>
<td>4 (14.5-10-16.5)</td>
<td>9 (4-14)</td>
<td>24 (5-2-12.5)</td>
</tr>
<tr>
<td>Status at discharge</td>
<td>59</td>
<td>12 (86.7)</td>
<td>3 (25)</td>
<td>2 (40)</td>
<td>15 (85.3)</td>
</tr>
<tr>
<td>Alive, n (%)</td>
<td>40 (68)</td>
<td>8 (66.7)</td>
<td>3 (25)</td>
<td>2 (40)</td>
<td>8 (53.3)</td>
</tr>
<tr>
<td>Dead, n (%)</td>
<td>9 (15)</td>
<td>3 (62.5)</td>
<td>1 (6.3)</td>
<td>2 (63.3)</td>
<td>2 (37.5)</td>
</tr>
<tr>
<td>Unknown, n (%)</td>
<td>10 (17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data presented are percentages (%), medians and interquartile ranges (IQR). N= number of participants with data for each parameter. * Participants with data available. ART = antiretroviral therapy, CSF = cerebrospinal fluid, WBC = white blood cells.

Table 2. Summary of diagnostic performance of cerebrospinal fluid mycobacterial lipoarabinomannan assay for tuberculous meningitis.

<table>
<thead>
<tr>
<th>Reference standard</th>
<th>Disease prevalence</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>Test Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definite/probable TBM</td>
<td>28.8% (17/59)</td>
<td>23.5% (4/17)</td>
<td>95.2% (40/42)</td>
<td>66.7% (4/6)</td>
<td>75.5% (40/53)</td>
<td>74.6% (44/59)</td>
</tr>
<tr>
<td>95% CI</td>
<td>17.8 to 42.1%</td>
<td>6.8 to 49.9%</td>
<td>83.8 to 99.4%</td>
<td>28.7 to 90.8%</td>
<td>70.1 to 80.2%</td>
<td>61.6 to 85%</td>
</tr>
<tr>
<td>Definite TBM</td>
<td>20.3% (12/59)</td>
<td>33.3% (4/12)</td>
<td>95.7% (45/47)</td>
<td>66.7% (4/6)</td>
<td>84.9% (45/53)</td>
<td>83.1% (49/59)</td>
</tr>
<tr>
<td>95% CI</td>
<td>10.9 to 32.8%</td>
<td>9.9 to 65.1%</td>
<td>85.5 to 99.5%</td>
<td>29.3 to 90.6%</td>
<td>78.9 to 89.4%</td>
<td>71 to 91.6%</td>
</tr>
</tbody>
</table>

Data presented are the percentage, numerator/denominator, and 95% confidence intervals (CI). Test Accuracy = overall probability that a patient will be correctly classified. PPV = Positive predictive value, NPV = negative predictive value, TBM = tuberculous meningitis.

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

Acknowledgements
We thank institutional support from the IDI research office.

warrants evaluation for diagnosis of TB meningitis both in urine and CSF19.

Data availability
Underlying data
References


5. WHO: The use of lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV. Geneva, Switzerland. 2015. Reference Source


15. Cresswell FV, Seebambuldi K, Grint D, et al.: High dose oral and intravenous rifampicin for improved survival from adult tuberculous meningitis: a phase II open-label randomised controlled trial (the RifT study) [version 1; peer review: 2 approved]. Wellcome Open Res. 2018; 3: 83. Published Abstract | Publisher Full Text | Free Full Text


Open Peer Review

Current Peer Review Status: ✔ ✔

Version 2

Reviewer Report 02 October 2019

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Maryline Bonnet
Institute of Research for Development (IRD), Montpellier, France

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Clinical research on tuberculosis.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 16 September 2019

https://doi.org/10.21956/wellcomeopenres.16813.r36425

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Vinod Patel
Department of Neurology, Nelson R. Mandela School of Medicine, University of KwaZulu-Natal (UKZN), Durban, South Africa

The article is well written with no major flaws.

Regarding the non-TBM category, although 10 patient had cryptococcal meningitis, detail regarding the non-TBM diagnoses is important as this is a control group and a patient without a clinical meningitis may allow for better specificity. I note that some CSF’s were acellular, what were these diagnoses?
Please provide detail (a table with confirmatory findings for TB such as CXR, abdominal ultrasound, scan findings, CSF findings etc.) regarding the aspects considered to arrive at a diagnosis of probable and possible TBM. A similar consideration for possible TBM. This would add clarity on the reliability of the test outcomes.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Assessing novel tests in the diagnosis of tuberculous meningitis.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 26 Sep 2019

**Richard Kwizera**, College of Health Sciences, Makerere University, Kampala, Uganda

The article is well written with no major flaws.

**Response:** Thank you.

Regarding the non-TBM category, although 10 patient had cryptococcal meningitis, detail regarding the non-TBM diagnoses is important as this is a control group and a patient without a clinical meningitis may allow for better specificity. I note that some CSF’s were acellular, what were these diagnoses? Please provide detail (a table with confirmatory findings for TB such as CXR, abdominal ultrasound, scan findings, CSF findings etc.) regarding the aspects considered to arrive at a diagnosis of probable and possible TBM. A similar consideration for possible TBM. This would add clarity on the reliability of the test outcomes.

**Response:** A cellular CSF is common in this population with advanced HIV disease even in the setting of a confirmed TB or CM infection (Cresswell, Int J Infect Dis 2018). The not-TBM group scored <6 points on the uniform case definition (n=16) or had a confirmed alternative diagnosis (n=10 with CM).
Maryline Bonnet  
Institute of Research for Development (IRD), Montpellier, France

This manuscript reports the results of a nested study in a large clinical trial, evaluating the accuracy of the CSF LAM for diagnosis of tuberculosis meningitis using both definite TB and composite reference of probable and definite TB based on standard case definitions. The study reports low sensitivity and high specificity and concludes on the modest role of the CSF LAM for diagnosis of TB meningitis. These results are important and the manuscript is well written.

No major comments.

Minor comments:
In the introduction, I suggest the authors adding the recent publication by Siddiqi et al.(2019)\(^1\) in their references.

In Results, I would suggest the authors to present the characteristics of patients with diagnosis of probable TB using the uniform case definitions. I am surprised by the low proportion of probable TB as compared to definite TB. It would be interesting to know the score of patients with probable TB using the uniform case definition criteria. Were cerebral imaging criteria used? It would be also interesting to know the proportion of patients that fit the score of possible TB meningitis using the uniform case definitions. It is indeed important to know the proportion of possible TB meningitis cases based on the uniform cases definitions that were finally classified as non TB meningitis for the accuracy analysis.

It would be interesting to know the proportion of patients with TB positive results from another specimen than CSF, which is also an important criteria for diagnosis of probable TB meningitis. One option could be to present the patients’ characteristics by definite TB, probable TB and others in Table 1.

How do the authors explain that 17% of patients had unknown outcome of death or alive at discharge? It is quite high in a context of a nested study in a clinical trial.

TB culture was not used, which is a limitation of the accuracy analysis. However, Xpert Ultra has a sensitivity that is very close to culture. This could be mentioned as a limitation.

It would be also very interesting to have the results of the urine LAM if used. In the study by Siddiqui et al. the urine LAM had higher sensitivity than the CSF LAM in patients with presumptive TB meningitis.

In the conclusion, the authors could mention the Fuji LAM that is a new LAM POC test that has higher
sensitivity in urine than the determine LAM POC and should also be evaluated for diagnosis of TB meningitis both in urine and CSF.

References

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Clinical research on tuberculosis.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 26 Sep 2019
Richard Kwizera, College of Health Sciences, Makerere University, Kampala, Uganda

This manuscript reports the results of a nested study in a large clinical trial, evaluating the accuracy of the CSF LAM for diagnosis of tuberculosis meningitis using both definite TB and composite reference of probable and definite TB based on standard case definitions. The study reports low sensitivity and high specificity and concludes on the modest role of the CSF LAM for diagnosis of TB meningitis. These results are important and the manuscript is well written.

Response: Thank you
No major comments.

Minor comments:
Comment: In the introduction, I suggest the authors adding the recent publication by Siddiqi et al...
Comment: I am surprised by the low proportion of probable TB as compared to definite TB.
Response: This is likely to be because we used Ultra and not culture or Xpert as the reference standard. We have found Ultra to be better at confirming TBM in our population (Bahr, Lancet ID, 2018).

Comment: Were cerebral imaging criteria used?
Response: Only about 10% (n/N) of the participants had cerebral imaging done as the CT scanner was dysfunctional for part of the study period.

Comment: It would be also interesting to know the proportion of patients that fit the score of possible TB meningitis using the uniform case definitions.
Response: These have been added in Table 1.

Comment: How do the authors explain that 17% of patients had unknown outcome of death or alive at discharge? It is quite high in a context of a nested study in a clinical trial.
Response: This study population included patients screened for a clinical trial but only a minority were subsequently enrolled into the trial. We endeavoured to follow screen failures through to hospital discharge but this was not possible in all cases.

Comment: TB culture was not used, which is a limitation of the accuracy analysis. However, Xpert Ultra has a sensitivity that is very close to culture. This could be mentioned as a limitation.
Response: We have found Ultra to be more sensitive than culture (70% versus 43% against definite/probable) for the diagnosis of TBM in our population (Bahr, Lancet ID, 2018). However we agree addition to culture would have been positive so this has been added to the limitations.

Comment: It would be also very interesting to have the results of the urine LAM if used. In the study by Siddiqui et al. the urine LAM had higher sensitivity than the CSF LAM in patients with presumptive TB meningitis.
Response: 25% of the patients were positive with urine TB-LAM LFA (Alere). The details of the urine TB diagnostics are being analysed currently and will be presented separately.
Comment: In the conclusion, the authors could mention the Fuji LAM that is a new LAM POC test that has higher sensitivity in urine than the determine LAM POC and should also be evaluated for diagnosis of TB meningitis both in urine and CSF.

Response: Thank you for this suggestion. This has been added in the conclusion.

Competing Interests: No competing interests were disclosed.