Table 3. Recommended treatment for cryptococcosis.

Clinical syndromes	Antifungal drugs	Duration	Comments
Non-immunosuppressed patients			
Meningitis Standard therapy	AmB 0.7 - 1 mg/kg/day and 5-FC 25 mg/kg q6h OR	≥ 4 weeks	5-FC can be discontinued when CSF culture becomes negative. If 5-FC is used for > 2 weeks, 5-FC levels should be measured. Peak level (obtained 2 hours after the dose): 70-80 ug/ml, and trough level: 30-40 ug/ml.
	AmBisome* 4 - 5 mg/kg/day and 5-FC 25 mg/kg q6h	≥ 6 weeks	Lipid formulation of AmB* is less nephrotoxic, but experience is limited.
Alternative therapy	AmB 0.7 - 1 mg/kg/day and 5-FC 25 mg/kg q6h followed by fluconazole 400 mg/day	≥ 2 weeks ≥ 2 months	AmB and 5-FC until CSF culture becomes negative. Alternative therapy is recommended for less severely ill patients.
Pulmonary	**Asymptomatic patients:** Treatment can be withhold. **Symptomatic patients:** Fluconazole 200-400 mg/day or itraconazole 200-400 mg/day	6-12 months	A lumbar puncture should be performed to rule out meningeal involvement. especially in symptomatic patients. For severe symptoms, recommend treating as for cryptococcal meningitis with AmB with or without 5-FC. Therapy can be changed to fluconazole when infection is stable.
Non-pulmonary, extra-neural	Fluconazole 200-400 mg/day or itraconazole 200-400 mg/day	6-12 months	A lumbar puncture should be performed to rule out meningeal involvement. For severe infection, recommend treating as for cryptococcal meningitis.

Clinical syndromes	Antifungal drugs	Duration	Comments
AIDS patients			
Meningitis Standard therapy	**Acute therapy:** AmB 0.7 - 1 mg/kg/day and 5-FC 25 mg/kg q6h followed by fluconazole 400 mg/day **Chronic suppressive therapy:** Fluconazole 200 mg/ day or AmB 1 mg/kg/week	≥ 2 weeks ≥ 10 weeks lifelong	Induction therapy with AmB and 5-FC until clinically stable and CSF culture becomes negative. AmB can be replaced by lipid formulation* (ABLC or AmBisome at 4-5 mg/kg/day) to lessen nephrotoxicity. Chronic suppressive therapy can be safely discontinued when CD_4 > 100/mm^3 and undetectable HIV viral load for > 3 months on HAART.
Alternative therapy	**Acute therapy:** Fluconazole 800 mg/day and 5-FC 25 mg/kg q6h **Chronic suppressive therapy:** As above.	≥ 6 weeks	This regimen can be considered in less severely ill patients. 5-FC can be discontinued when CSF culture becomes negative.
Pulmonary or other extra-neural infection.	Fluconazole 200-400 mg/day or itraconazole 200-400 mg/day followed by lifelong chronic suppressive therapy with fluconazole 200 mg/day	6-12 months	A lumbar puncture should be performed to rule out cryptococcal meningitis. All patients should be treated. For severe symptoms, recommend treating as for cryptococcal meningitis with AmB with or without 5-FC. Therapy can be changed to fluconazole when infection is stable. Chronic suppressive therapy can be safely discontinued when CD_4> 100//mm^3 and undetectable HIV viral load for > 3 months on HAART.

Clinical syndromes	Antifungal drugs	Duration	Comments
Non-AIDS, immunocompromised hosts			
Meningitis	**Acute therapy:** AmB 0.7 - 1 mg/kg/day and 5-FC 25 mg/kg q6h OR	≥ 6 weeks	5-FC can be discontinued when CSF culture becomes negative or patient is clinically improved, whatever is longer. If 5-FC is used for > 2 weeks, 5-FC levels should be measured. Peak level (obtained 2 hours after the dose): 70-80 ug/ml, and trough level: 30-40 ug/ml.
	AmBisome* 4 - 5 mg/kg/day and 5-FC 25 mg/kg q6h **Chronic suppressive therapy:** Fluconazole 400-800 mg/day then fluconazole 200 mg/day	≥ 6 weeks 8-10 weeks ≥ 12 months	Lipid formulation of AmB* is less nephrotoxic, but experience is limited. Lipid formulation of AmB might be a preferred treatment for transplant recipients. For patients receiving chronic corticosteroid therapy, reduce steroid dosage to an equivalence of 10 mg/day of prednisone is recommended.
Pulmonary or other extra-neural infection.	Fluconazole 200-400 mg/day or itraconazole 200-400 mg/day	≥ 6-12 months	A lumbar puncture should be performed to rule out cryptococcal meningitis. All patients should be treated. Treatment should be continued until the infection is fully resolved. For severe symptoms, recommend treating as for cryptococcal meningitis with AmB with or without 5-FC. Therapy can be changed to fluconazole when infection is stable.

Note: ABLC might be comparable to AmBisome in efficacy but is more nephrotoxic.