TABLE 4. Treatment of anal intraepithelial neoplasia (AIN)*

	Lesion location			
	AIN-1 (anal condolymata)		AIN-2 or AIN-3	
Lesion size	**Perianal**	**Intra-anal**	**Perianal**	**Intra-anal**
Discrete, <1 cm^2 at base	A,B,C,D,E	A,B,E,F,G,H	A,B,E,F	A,B,E,F,G
Discrete lesion >1 cm^2 at base, not circumferential	A,B,C,D,E,F,G,H	E,F,G,H	E,F,G	E,F,G
Diffuse or circumferential lesions	C,D,E,F,G,H	H	E,F,G,H	H

Key:
A 85% trichloroacetic acid
B Liquid nitrogen
C Imiquimod
D Podophyllotoxin
E Electrocautery
F Laser
G Surgical cold scalpel excision
H Observation only
* Recommendations based on clinical experience (**CIII**) and not randomized clinical trials.

TABLE 5. Recommended dose adjustments when patients are administered rifabutin concurrently with antiretroviral drugs

Antiretroviral regimen	Rifabutin Dose*	Antiretroviral dose adjustment
Protease inhibitors (PI) regimens		
Nelfinavir, indinavir, amprenavir, or fosamprenavir (plus two nucleoside reverse transciptase inhibitors [NRTIs])	Decrease daily dose to 150 mg; use 300 mg for three times weekly therapy	Nelfinavir: use 1,250 mg every 12 hours Indinavir: consider increase to 1,000 mg every 8 hours Amprenavir or fosamprenavir: no change
Ritonavir (plus two NRTIs, other PIs, and/or non-NRTIs [NNRTIs])	Decrease to 150 mg twice or three times weekly†	None
Lopinavir/ritonavir (Kaletra) (plus two NRTIs and/or a NNRTI)	Decrease to 150 mg twice or three times weekly†	None
Atazanavir (plus two NRTIs)	Decrease to 150 mg twice or three times weekly†	None
NNRTI regimens		
Efavirenz (plus two NRTIs)	Increase to 450 QD or 600 mg twice or three times weekly	None
Nevirapine (plus two NRTIs)	300 mg daily or three times weekly	None
NRTI regimens		
Triple regimen (e.g., zidovudine, lamivudine, and abacavir)§	300 mg daily or three times weekly	None
PI plus NNRTI regimens		
Efavirenz or nevirapine and protease inhibitor (except ritonavir)	300 mg daily or three times weekly	Consider increasing dose of indinavir to 1,000 mg every 8 hours

* Avoid twice-weekly rifabutin therapy among patients with $CD4^+$ T-cell count <100 cells/μL at the time of tuberculosis diagnosis.
† When the dose of rifabutin is decreased, adherence with ritonavir, Kaletra, or atazanavir should be monitored because discontinuation of these drugs might result in underdosing with rifabutin.
§ Rifampin increases concentrations of zidovudine and probably abacavir. Although the clinical significance of these changes is not clear, using rifabutin with triple NRTIs is prudent.