Stellingen

behorende bij het proefschrift

Multi-Drug Tuberculosis in the Netherlands
Personalised treatment and outcome

1. Short course sterilising treatment for drug-susceptible as well as multidrug resistant forms of TB is paramount to attain the elimination target.

2. Enhancing immunity in subjects infected with *Mycobacterium tuberculosis* will add considerably to the speed of eliminating TB.

3. Retrospective studies may show promising results in MDRTB treatment but only prospective randomized studies are helpful to draft robust guidelines.

4. Given the enormous global burden of TB, it is a shame that promising results of retrospective studies take so long to be tested prospectively.

5. Drug sensitivity testing with pharmacokinetic data will constitute a quantum leap forward also in low resource high TB burden countries.

6. Since dosing of aminoglycosides based of individually measured drug exposure in relation to drug susceptibility measurements typically result in dose reduction by 50%, WHO-propagated fixed dosing of injectables should be put to the test.

7. Aminoglycoside therapy based on the AUC_{0-24h}/MIC ratio should be compared with C_{max}/MIC ratio in a hollow-fibre model.

8. Having little toxicity, efficacy of ertapenem should be compared with the group B injectables in a prospective randomized study.

9. A consensus-based, widely accepted set of core research definitions in DR-TB clinical trials is urgently needed to advance the field.

10. The recommendations on MDR-TB in the Millenium Development Goals as well as in the Sustainable Development Goals are expert opinion-based, and miss clear definitions and measurable goals.

11. Waarom voorspellingen doen over wanneer TB de wereld uit zal zijn? Van (veel groter) belang is het maken en uitvoeren van plannen dit te bereiken.
    (The poverty of historicism, Karl Popper)

12. There is medicine that works and there is alternative medicine.
    (adapted from Richard Dawkins)

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