

Colorado Adult TB Risk Assessment User Guide



COLORADO
Department of Public
Health & Environment

Avoid testing persons at low risk

Routine testing of low-risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all foreign-born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within the past 1 year
- end-stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of the head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤ 20
- history of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

United States Preventive Services Task Force

The USPSTF has recommended testing persons born-in or former residents of a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to infectious TB nor among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Local recommendations

Local recommendations and mandates should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with Colorado Department of Public Health and Environment TB Program: (303) 692-2656 or Denver Metro TB Clinic: (303) 602-7240 for local recommendations.**

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede

any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger foreign-born persons when all foreign-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Children

This risk assessment tool is intended for adults. A risk assessment tool created for use in California for children is available here: <http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf>

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with infectious TB cases, high TB prevalence of TB in travel location, non-tourist travel).

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB. In fact, **a negative TST or IGRA in a patient with active TB can be a sign of extensive disease and poor outcome.**

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, and hemoptysis.

Decision to test is a decision to treat

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks

*The CDC currently recommends DOT for this regimen; however, preliminary data suggests that SAT is non-inferior to DOT in the United States. Many clinicians are using SAT or modified DOT.

CDPH 12-dose isoniazid + rifapentine regimen Fact Sheet:

<http://cdph.ca.gov/programs/tb/Documents/TBCB-INH-RIF-LTBI-fact-sheet.pdf>

DOT = Directly observed therapy; **SAT** = Self-administered therapy; **IGRA** = Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB);

BCG = Bacillus Calmette-Guérin; **TST** = tuberculin skin test; **LTBI** = latent TB infection