

Tuberculosis Diagnosis and Isolation Care Guide

April 2015



**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES**

SUMMARY

GOALS

- ✓ Rapid identification of suspect TB patients
- ✓ Prompt masking and isolation of suspect TB patients
- ✓ Thorough and timely evaluation of suspect TB patients
- ✓ Prompt treatment of high suspect TB patients
- ✓ Respiratory protection for staff
- ✓ Ensure patient understanding of care plan

ALERTS

- Never start LTBI treatment in suspect TB cases until all respiratory culture results return as negative
- TST may be negative with active TB disease (in 25% of cases)
- TST and CXR may be negative in HIV patients with active TB disease (or CXR may be atypical)
- TB disease may coexist with other conditions (e.g., cancer, coccidioidomycosis, etc.)

TB DIAGNOSTIC AND INITIAL MANAGEMENT

DIAGNOSIS

ASSESS SUSPECT FOR TB DISEASE

- Symptoms: cough (usually > 2-3 weeks duration), fevers, night sweats, weight loss
- Physical findings: possible pulmonary findings
- History of TB infection or disease
- Epidemiologic factors: exposure history, residence in or travel to endemic area
- Radiographic abnormalities: usually infiltrate or cavitary lesion

CLASSIFY AS LOW OR HIGH TB SUSPECT

Low suspect: Clinical suspicion for TB disease that is not high enough to warrant TB treatment.

High suspect: High clinical suspicion for TB disease (patients placed on TB treatment prior to disease confirmation).

ASSESS RISK FOR MULTIDRUG RESISTANCE (MDR-TB)

INITIAL MANAGEMENT

ISOLATE (Airborne infection isolation room)

Immediately mask patients suspected of having TB disease based on clinical criteria and isolate in an airborne infection isolation room (AIIR) as soon as possible until they meet the criteria for return to the general population. (Provide specimen collection information to community hospitals [pages 9-10]).

REPORT CASE

Within one working day, report TB suspects to the California Correctional Health Care Services (CCHCS) Public Health Branch (PHB)* and to the Local Health Department (LHD) using the Correctional Facility Tuberculosis Patient Plan (CFTP) form (see page 2).

COLLECT SPECIMENS

- Smear and Culture – collect (according to the MTB respiratory specimen collection protocol, page 3) three respiratory specimens for Acid Fast Bacilli (AFB) smears and MTB cultures;
- NAAT– test one of the respiratory specimens by a nucleic acid amplification test (NAAT); **and**
- Human Immunodeficiency Virus (HIV) test (for HIV negative patients, if most recent HIV test was more than 6 months in the past).

RELEASE FROM ISOLATION AND FOLLOW-UP

RELEASE FROM AIRBORNE ISOLATION

LOW SUSPECT PATIENTS

- Most low suspect patients can be evaluated for TB in < 2 days and released from isolation after fulfilling the

low suspect release protocol (see page 4).

- The CCHCS PHB must approve release from AIIR of all low suspect TB patients.

HIGH SUSPECT PATIENTS

- Patients with high suspect TB are released from respiratory isolation depending on their tolerance of TB medications and their clinical, radiological, and laboratory findings (e.g., smear and NAAT results).
- The CCHCS PHB, along with the LHD TB Controller, must approve all releases from AIIR of patients on TB medications.

CULTURE FOLLOW-UP

- Culture results may take up to 6 weeks to return.
- Monitor for return of culture results as TB disease may be present even if smear and NAAT results were negative.
- **Ensure all TB culture results are reported back as negative before starting treatment for latent TB infection (LTBI).**

*PH Branch Warmline: (916) 691-9901, on-call physician available 24/7 every day of year