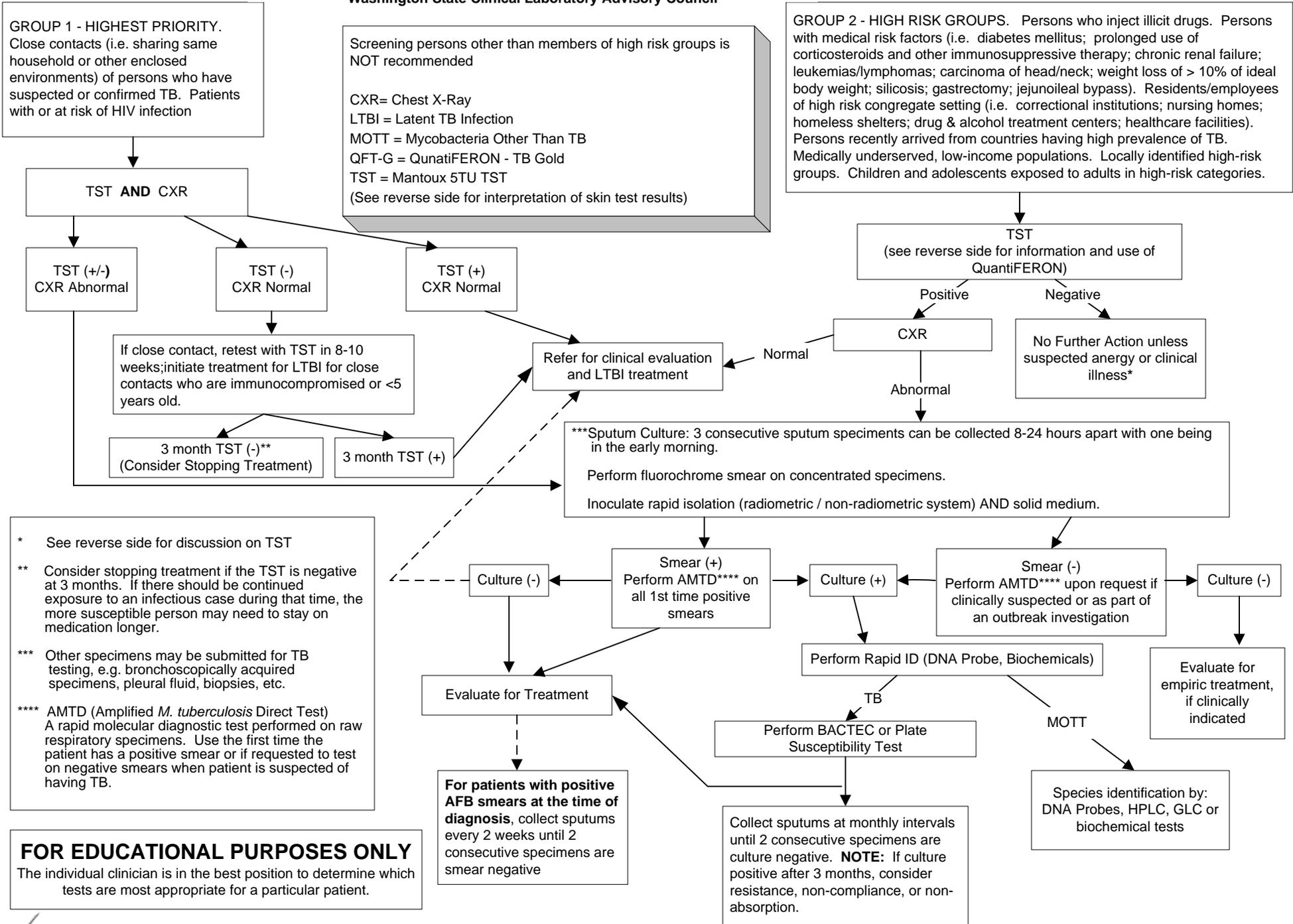


TUBERCULOSIS SCREENING GUIDELINES

Washington State Clinical Laboratory Advisory Council



* See reverse side for discussion on TST

** Consider stopping treatment if the TST is negative at 3 months. If there should be continued exposure to an infectious case during that time, the more susceptible person may need to stay on medication longer.

*** Other specimens may be submitted for TB testing, e.g. bronchoscopically acquired specimens, pleural fluid, biopsies, etc.

**** AMTD (Amplified *M. tuberculosis* Direct Test) A rapid molecular diagnostic test performed on raw respiratory specimens. Use the first time the patient has a positive smear or if requested to test on negative smears when patient is suspected of having TB.

FOR EDUCATIONAL PURPOSES ONLY
The individual clinician is in the best position to determine which tests are most appropriate for a particular patient.



INTERPRETATION OF TUBERCULIN SKIN-TEST (TST) RESULTS

<p>A. $\geq 5\text{mm}$ is positive for:</p> <ul style="list-style-type: none"> . Recent close contacts of persons with active TB . Persons with HIV infection . Persons with fibrotic CXR consistent with healed TB . Organ transplant recipients and other immunosuppressed patients 	<p>B. $\geq 10\text{mm}$ is positive for persons who do not meet the criteria in (A.) and who belong to one or more of the following:</p> <ul style="list-style-type: none"> . Injection-drug users . Persons with other medical conditions reported to increase risk of progressing from latent to active TB (see list in Group 2 box on the reverse side) . Residents/employees of high-risk congregate settings (i.e. correctional institutions, nursing homes, homeless shelters, drug & alcohol treatment centers, healthcare facilities) . Persons recently arrived from countries having high prevalence of TB (e.g. ≤ 5 years since arrival) . Medically underserved, low-income populations . Locally identified high-risk groups . Children of any age exposed to adults in high-risk categories 	<p>C. $\geq 15\text{mm}$ is positive for persons with no risk factors for TB</p>
<p>ANERGY</p> <ul style="list-style-type: none"> . Anergy testing is poorly standardized or can be selective (e.g. anergy or reactivity to mumps or candida may not reliably predict anergy or ability to respond to TST). . Should not be routinely used as part of screening for TB even in HIV infected patients. 	<p>BOOSTER EFFECT</p> <ul style="list-style-type: none"> . Persons with TB infection may have negative TST when tested many years after infection . Initial TST may stimulate (boost) ability to react to PPD . Positive reactions to subsequent tests may be misinterpreted as new infection . See Two-Step Testing 	<p>TWO-STEP TESTING</p> <p>For baseline skin testing of adults who will be retested periodically to distinguish boosted reactions from reactions due to new infections:</p> <ul style="list-style-type: none"> . If first test is (+), consider person infected at baseline . If first test (-), give second test 1-3 weeks later . If second test (+), consider person infected at baseline . If second test (-), consider person uninfected at baseline

QuantiferON (QFT): The Centers for Disease Control and Prevention (CDC) Guidelines for the use of QFT in diagnosing Latent *Mycobacterium tuberculosis* Infection (LTBI) can be found in the Morbidity Mortality Weekly Report (MMWR), January 31, 2003, Volume 52, pages 15-18 (<http://www.cdc.gov/mmwr/PDF/rr/rr5202.pdf>). CDC states that QFT can aid in detecting *M. tuberculosis* infections among certain populations who are at increased risk for LTBI including recent immigrants from countries with a high prevalence of TB infection, injection-drug users, residents and employees of prisons and jails, and healthcare workers that, after their pre-employment assessment, are considered at increased risk for exposure to TB. CDC states that QFT may also be used for military personnel screening, hospital staff and health-care workers whose risk of prior exposure to TB was low, and U.S.-born students at certain colleges and universities. The full text of the CDC document can be found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5202a2.htm>.

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