Procedure for the Prevention, Control and Management of Tuberculosis

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1 Introduction

This document gives guidance which will improve the identification, treatment and management of all patients with Tuberculosis, and the screening of contacts of index cases of tuberculosis.

1.1 Objectives

- To ensure patients diagnosed with active TB are managed/ supported appropriately to ensure successful treatment outcomes.
- To ensure patients diagnosed with latent TB are offered treatment and managed appropriately.
- To ensure that effective contact tracing is carried out for all cases of Pulmonary/Laryngeal TB.
- To ensure that any patient with HIV related tuberculosis or drug resistant tuberculosis are managed appropriately.
- To ensure that there is a BCG vaccination programme in place which complies with Department of Health recommendations.
- To raise awareness of Tuberculosis amongst staff working with at risk groups.

2 Prevention and Control of TB

2.1 Surveillance and Notification

The Consultant in Communicable Disease Control (CCDC), in conjunction with the Respiratory Physicians, Consultant Microbiologist, and Community Infection Control/TB Nurse Specialists are responsible for surveillance of tuberculosis in Warrington. Surveillance is based on statutory notifications and laboratory reports of isolates of Mycobacterium Tuberculosis.

Statutory notification:

Notification of all forms of tuberculosis to the CCDC is a statutory responsibility of the clinician making and/or suspecting the diagnosis. Cases strongly suspected on clinical and/or microbiological or histological grounds should be notified within a week of diagnosis.

Culture confirmed case due to M. tuberculosis complex (including M. tuberculosis, M. bovis, M. africanum or M. microti)

In the absence of culture confirmation, a case that meets the following criteria:
- a clinician’s judgement that the patient’s clinical and/or radiological signs and/or symptoms are compatible with tuberculosis,

AND
- a clinician’s decision to treat the patient with a full course of anti-TB therapy.

The requirement to notify applies if there is reasonable ground for suspecting that a patient has died with, but not necessarily from, active TB (including post mortem diagnoses).

Notification requirement applies also to UK residents who are diagnosed abroad but continue with their anti-TB therapy in the UK and to non-UK residents diagnosed in the UK, even if anti-TB therapy is not initiated in the UK.
Laboratory Reports.
The Consultant in Communicable Disease control (CCDC) should be informed by the laboratory of positive microscopy and culture results.

All clinicians notifying confirmed or suspected cases of Tuberculosis (TB) made using the Public Health England proforma and should be faxed through to 0151 236 2488

Urgent notification should be made to the CCDC by telephoning Public Health England – Cheshire and Merseyside on Tel: 0344 225 0562 (option 1) for:

- Healthcare workers with tuberculosis
-Clusters of TB cases
- Multi-Drug-resistant TB

The TB Nurse Specialists also have access to the Enhanced Tuberculosis Surveillance system (ETS) and are required to notify all cases of confirmed TB via the system within 4 working days of diagnosis.

3 Active TB

3.1 Diagnosing active TB in all age groups

Tuberculosis should always be considered as a diagnosis if there are clinical signs and symptoms consistent with a diagnosis of TB. TB culture should be requested for all specimens however even if this is not requested microbiology staff should consider carrying out TB culture on samples.

Treatment can be started for patients with clinical signs and symptoms consistent with a diagnosis of TB without waiting for culture results.

3.2 Diagnosing pulmonary (including laryngeal) TB in all age groups

Take a chest X-ray and do further diagnostic investigations according to NICE (2016) if chest X-ray appearances suggest TB.

Send 3 deep cough sputum samples, preferably including 1 early morning sample) for TB microscopy and culture. This should done before starting treatment or within 7 days of starting treatment.

If it is not possible to spontaneously induce sputum consider induction bronchoscopy and lavage in adults.

Send samples for TB culture from autopsy samples if pulmonary or laryngeal TB is a possibility.

Request rapid diagnostic nucleic acid amplification tests for the *M. tuberculosis* complex (*M. tuberculosis*, *M. bovis*, *M. africanum*) on primary specimens according to NICE (2016) if there is clinical suspicion of TB disease, and:

- the person has HIV or
- rapid information about mycobacterial species would alter the person's care or the need for a large contact-tracing initiative is being explored.
3.3 Diagnosing pulmonary (including laryngeal) TB in children and young people

In children aged 15 years or younger with suspected pulmonary TB, offer rapid diagnostic nucleic acid amplification tests for the *M. tuberculosis* complex (*M. tuberculosis, M. bovis, M. africanum*).

In young people aged 16–18 years use the same criteria as in adults to decide whether to request rapid diagnostic nucleic acid amplification tests.

Obtain 3 gastric lavages or 3 inductions of sputum in children and young people.

3.4 Diagnosing extra pulmonary TB in all age groups

Discuss the advantages and disadvantages of both biopsy and needle aspiration with the patient, with the aim of obtaining adequate material for diagnosis.

Do not place part or all of any of the samples in formalin (or other fixative agent) when sending for TB culture.

Diagnosis of extra pulmonary TB should use site-specific investigations as tabled in NICE 2016. Table 1 to Table 11. (1.3.5)

Think about a diagnosis of extra pulmonary TB even if rapid diagnostic tests in, for example, cerebrospinal fluid, pleural fluid or ascitic fluid are negative.

Offer all patients presenting with extra pulmonary TB a chest X-ray and, if possible, culture of a spontaneously-produced respiratory sample to exclude or confirm coexisting pulmonary TB.

Once a diagnosis of active TB is made the patient should be referred to the Respiratory consultant who should have experience and training in Tuberculosis.

The clinician responsible for care should refer the person with TB to a clinician with training in, and experience of, the specialised care of people with TB. The TB service should include specialised nurses, and active TB in children should be managed by a TB specialist and by paediatric trained nursing staff, where possible.

3.5 Treatment of Adults with Active TB.

Most patients with tuberculosis can be treated at home. It is not necessary to separate an infectious person (i.e. with smear positive Pulmonary/Laryngeal disease) on treatment from other household members except where there is a newborn unimmunised baby in the household.

Out-patient management is not appropriate for infectious or potentially infectious patients if they live in a hostel or other communal establishment, unless single room accommodation is available and the room is vented to the air outside the building and the door can be closed.

Out-patient management may also not be appropriate for patients with suspected or proved multiple drug-resistant tuberculosis, who will normally require at least initial assessment and treatment in hospital. Patients with multi drug resistant TB should be managed by Consultant
Respiratory Physician in consultation with the Infectious Diseases team at Royal Liverpool Hospital.

Treatment of Tuberculosis is based on NICE guidelines (NICE, 2016). Patients with mycobacterium tuberculosis should be treated with 4 antibiotics – Rifampicin, Isoniazid, Pyrazinamide, and Ethambutol for the first two months and then the treatment schedule reduced to Rifampicin and Isoniazid for a further four months. Standard TB treatment is 6 months although some forms of TB will need treating for a longer time scale.

For people with active TB without central nervous system involvement, offer: isoniazid (with pyridoxine), rifampicin, pyrazinamide and ethambutol for 2 months then isoniazid (with pyridoxine) and rifampicin for a further 4 months.

For people with active TB of the central nervous system, offer: isoniazid (with pyridoxine), rifampicin, pyrazinamide and ethambutol for 2 months then isoniazid (with pyridoxine) and rifampicin for a further 10 months.

Treat active peripheral lymph node TB in people who have had an affected gland surgically removed with the standard recommended regimen. For people with active TB of the lymph nodes, do not routinely extend treatment beyond 6 months for newly enlarged lymph nodes or sinus formation, or for residual enlargement of the lymph nodes or sinuses.

All adults with active tuberculosis who are on anti TB therapy or chemo prophylactic treatment are supervised by a Consultant Respiratory Physician and Infection Control/TB Specialist Nurse. Patients will have a named TB nurse who will support the patient with treatment and monitor compliance.

All patients with active TB should have a risk assessment to identify their needs and whether they should have enhanced case management including directly observed therapy.

If the person has a comorbidity or coexisting condition such as HIV, severe liver disease, for Chronic kidney disease, diabetes, eye disease or impaired vision or pregnancy/ breastfeeding, a history of alcohol or substance misuse the TB nurse should liaise with the specialist multidisciplinary team with experience of managing TB and co morbidity/co existing conditions.

Patients with TB affecting the central nervous system should be prescribed a suitable corticosteroid regime according to NICE guidance (2016).

Offer all patients presenting with extra pulmonary TB a chest X-ray and, if possible, culture of a spontaneously-produced respiratory sample to exclude or confirm coexisting pulmonary TB.

Once a patient with Pulmonary/Laryngeal TB has received treatment for a 2 week period they are deemed to be non-infectious and can socialise normally. This is providing that there is full compliance with treatment, no history or suggestion of drug resistance and the patient’s clinical condition is showing signs of improvement i.e Improvement in respiratory symptoms.

If treatment is interrupted due to concerns with hepatotoxicity, treatment should be re-established using guidance from NICE (2016) 1:7:4.

3.6 Treatment of Children with Active TB

All children with active tuberculosis who are on anti TB therapy or chemo prophylactic treatment should be supervised by a Consultant Paediatrician and Infection Control/TB Specialist Nurse. If additional information/support is required this should be obtained from
Consultant Paediatrician in Infectious Diseases at Alder Hey Children’s Hospital.

Infants and young children who have been in close contact with an index case of pulmonary smear positive TB should be followed up as soon as possible by a Consultant Paediatrician as they are more prone to transmission. The time scales for follow up of infants and children are outlined in the NICE TB pathways and the Northwest Paediatric TB Pathway.

3.7 Direct Observed Therapy (DOT)

Direct Observed Therapy is when direct observation of the patient is required by the health professional or family member when taking the anti TB medications.

All patients should have a risk assessment for adherence to treatment and DOT should be considered for patients who are identified as having risk factors which may affect compliance with treatment.

- Patients who are not adhering to treatment now or have not adhered in the past.
- Patients who are in denial of their TB diagnosis.
- Patients who are homeless or shelter-dwelling.
- Patients who have a history of alcohol/ drug abuse
- Patients with unstable mental health
- Patients with major psychiatric, memory or cognitive disorder.
- Patients with multi drug resistant TB
- Patients who are too ill to administer their own medications.

The treatment schedule for supervised treatment should be implemented as recommended in the NICE guidelines (NICE, 2016). Supervised treatment should be taken three times a week usually, Monday, Wednesday and Friday.

Treatment can be supervised by a member of the TB team, Family members, or other health professionals who may have contact with the index case.

4 Latent TB

4.1 Diagnosing latent TB in children and young people

Children and young people who are contacts of index cases of Tuberculosis are assessed and consideration is made as to whether the index case has Pulmonary / Laryngeal TB or non-pulmonary TB. If the index case has Pulmonary /Laryngeal TB, an assessment is made as to whether the index case has smear positive or smear negative Tuberculosis. Children and young people should be assessed by a Paediatrician with experience and training in TB, or a general Paediatrician with advice from a specialised TB clinician.

All children and young people should be assessed according to NICE guidance (2016), TB pathways and the North West Paediatric TB pathway should be used to aid decision making. These give clear guidance on the time scales by which the child should be assessed by.

4.2 Diagnosing latent TB in all age groups

New Entrants from High risk Countries
For new registered patients, GP practice staff should be aware of high risk countries (Appendix1) for TB and the sign and symptoms of TB. Any new entries to the country who
have symptoms suggestive of TB or who have had a recent contact with an active case of TB should be referred to the TB nurses.

Contact tracing following contact with a case of active TB.
Once a person has been diagnosed with active TB, the diagnosing physician should inform the TB nursing service of the diagnosis so that contact tracing can be carried out as required. Contact tracing should not be delayed until statutory notification.

Screening should be offered to the household contacts of any person with active TB, irrespective of the site of infection. Household contacts are defined as those who share a bedroom, kitchen, bathroom or sitting room with the index case. Contact tracing should identify contacts who have had a cumulative 8 hour contact or greater. NICE TB pathways should be followed.

For patients with sputum smear positive TB, other close contacts should be assessed. These may include boyfriends or girlfriends and frequent visitors to the home of the index case. Occasionally a workplace associate may be judged to have had contact equivalent to that of household contacts, and should be assessed in the same way.

Casual contacts of people with TB, who will include the great majority of workplace contacts, should not normally be assessed.

The need for tracing casual contacts of people with TB should be considered if:
- the index case is judged to be particularly infectious, or
- any casual contacts are known to possess features that put them at risk of infection.

Contacts – incident situation
In an incident situation when large numbers of people may need to be screened, consider a single interferon-gamma release assay for people aged 18–65 years. For children and young people, only consider using interferon-gamma release assays alone if Mantoux testing is not available or is impractical. This includes for example, situations in which large numbers need to be tested.

4.3 Managing latent TB in all age groups

Be aware that certain groups of people with latent TB are at increased risk of going on to develop active TB, including people who:
- are HIV-positive
- are younger than 5 years
- have excessive alcohol intake
- are injecting drug users
- have had solid organ transplantation
- have a haematological malignancy
- are having chemotherapy
- have had a jejunooileal bypass
- have diabetes
- have chronic kidney disease or receive haemodialysis
- have had a gastrectomy
- are having treatment with anti-tumour necrosis factor-alpha or other biologic agents have silicosis.

For people, including those with HIV, aged younger than 65 years with evidence of latent TB who have been in close contact with people who have suspected
infectious or confirmed active pulmonary or laryngeal drug-sensitive TB, offer treatment for latent TB according to NICE (2016).

For adults between the ages of 35 and 65 years, offer drug treatments only if hepatotoxicity is not a concern.

Patients with latent TB who are on treatment should remain under the care of the TB nurse and be monitored accordingly. Manage treatment with caution, ensuring careful monitoring of liver function in:

- people with non-severe liver disease
- people with abnormal liver function (including abnormal transaminase levels) before starting treatment for latent TB infection
- people who misuse alcohol or drugs.

Ensure people having treatment for latent TB who also have social risk factors, such as misusing alcohol or drugs or being homeless, are linked to support services. Patients should also have an assessment of social needs and stability, including potential barriers to adherence or treatment completion.

Any patients who refuse treatment for latent TB or following assessment are deemed not suitable due to concerns with compliance should be given standard “inform and advise” information regarding signs and symptoms of TB and information on contacting TB team or GP if they require additional advice or should they develop symptoms in the future.

Adults who are to commence treatment for latent TB should be offered testing for HIV, Hepatitis B and Hepatitis C.

Consider testing children and young people for Hepatitis B and C before starting treatment for latent TB.

5 Drug-resistant TB

Drug-resistant TB is defined as disease due to *mycobacterium tuberculosis* and is resistant to one or more anti-TB drugs.

Multiple drug-resistant TB is defined as disease due to *mycobacterium tuberculosis* resistant to isoniazid and rifampicin with or without resistance to other anti-TB drugs.

Extensively drug-resistant TB (XDR TB) is a rare type of multidrug-resistant tuberculosis (MDR TB) that is resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of three injectable second-line drugs (i.e., amikacin, kanamycin, or capreomycin).

For people with clinically suspected TB, a TB specialist should request rapid diagnostic nucleic acid amplification tests for rifampicin resistance on primary specimens if a risk assessment for multidrug resistance identifies any of the following risk factors:

- history of previous TB drug treatment, particularly if there was known to be poor adherence to that treatment
- contact with a known case of multidrug-resistant TB
- birth or residence in a country in which the World Health Organisation reports that a high proportion (5% or more) of new TB cases are multidrug-resistant.
Patients with suspected of confirmed TB should be managed with a multidisciplinary team with experience of managing Drug-resistant TB. Patients in Warrington are referred to the Infectious Disease team at Royal Liverpool Hospital. Patients will require Direct Observed therapy for the initial stage of treatment.

Patients should be treated following guidance from NICE (2016) Information is held in 1.4.2. Table 13 (Treatment regimen for people with TB that is resistant to 1 drug)

6  Managing residents with TB in Care homes and other non-healthcare settings

Any patient who is resident in a care home or other settings such as hostels/day centres/detention centres and is diagnosed with TB will be managed by the Respiratory Consultant and will have a Named TB nurse. The TB nurse will support and advise care home staff on the correct management of the patient.

If the resident has been diagnosed with Pulmonary/Laryngeal TB the TB nurse will carry out contact tracing for care home staff and any visitors who have had a cumulative 8 hour contact with the index case. Staff who work in the care home but reside outside of Warrington will be referred to the appropriate TB service for screening.

The following should be promoted:

- promote simple respiratory hygiene
- ensure adequate ventilation of resident’s rooms.
- Ensure residents are in single rooms which are ventilated to the outside and it is possible to keep the door closed during the initial 14 day period.

7  Managing TB in prisons

Prisoners should be screened for TB by:

- a health questionnaire on each entry to the prison system, then for those with signs and symptoms of active TB,
- a chest X-ray and
- three sputum samples including a morning sputum sample.

Patients in prison with confirmed/ suspected active TB will be managed by the TB nurses in conjunction with advice from the Public Health England local area team.

Any prisoners with a cough of more than three weeks duration must be medically assessed for tuberculosis.

Prisoners with suspected or confirmed Pulmonary/Laryngeal TB must be isolated in a single cell for the initial 14 days of treatment. If there is evidence of good compliance with treatment, the patient is responding to treatment and there is no indication of drug resistance, isolation can be stopped after this time. The local Health Protection Team and the local NHS TB service must be informed as soon as possible, and will determine, in liaison with the prison healthcare team, the extent of any contact tracing and screening necessary.

All prisoners receiving treatment for active or latent TB should receive Direct Observed Therapy. Prisoners on TB treatment must be placed on medical hold until they have been established on the appropriate TB treatment and are considered to be no longer infectious.
Prison health services should have contingency, liaison and handover arrangements to ensure continuity of care before any prisoner on TB treatment is transferred between prisons or released.

Contingency plans for the early discharge of inmates should be drawn up to ensure that any inmate leaving prison service has been referred to the relevant area for clinical follow-up and treatment monitoring in the intended district of residence. The Infection Control/ TB Nurse Specialist will pass the patient’s details to Public Health England local area team to be referred onto the relevant TB service.

8 **Tuberculosis amongst Homeless People**

Healthcare professionals working with people with TB should reinforce and update education about TB, and referral pathways, to primary care colleagues, social workers and voluntary workers who work with homeless people.

9 **Contact Tracing in Schools and Nurseries**

Following diagnosis of TB in a school pupil or member of staff, advice should be sought from the CCDC at Public Health England. Advice on managing these incidents and their public relations is available from the Public Health England local area team and the local authority.

If a school pupil is diagnosed with smear-positive TB, carry out a risk assessment of the need to test the rest of his or her class (if there is a single class group), or the rest of the year group who share classes, as part of contact tracing.

If a teacher has smear-positive TB, assess the pupils in his or her classes during the preceding 3 months as part of contact tracing.

Consider extending contact tracing in schools to include children and teachers involved in extracurricular activities, and non-teaching staff, on the basis of:

- the degree of infectivity of the index case
- the length of time the index case was in contact with others
- whether contacts are unusually susceptible to infection
- the proximity of contact.

Treat secondary cases of smear-positive TB as index cases for contact tracing.

If the index case of a school pupil's TB infection is not found, and the child is not in a high-risk group for TB, contact tracing and screening (by either symptom enquiry or chest X-ray) should be considered for all relevant members of staff at the school.

When an adult who works in childcare is diagnosed with smear-positive TB. Contacts should be identified which looks for children and adults who have had a cumulative eight hour contact. Adult and child contacts should be assessed according to NICE (2016).

10 **Opportunistic Case Finding**

10.1 **New entrants from high incidence countries**
Assess and manage TB in new entrants from high incidence countries who present to healthcare services as follows:

- assess risk of HIV, including HIV prevalence rates in the country of origin, and take this into account when deciding whether to give a BCG vaccination
- Consider offering testing for latent TB, assess for active TB if the test for latent TB is positive.
- offer treatment to people aged 65 years or younger in whom active TB has been excluded but who have a positive Mantoux test or a positive interferon-gamma test.
- consider offering BCG for unvaccinated people who are Mantoux- or interferon-gamma release assay-negative
- give 'inform and advise' information to people who do not have active TB and are not being offered BCG or treatment for latent TB infection

10.2 People in prisons and remand centres.

Healthcare professionals in prisons and immigration removal centres should ensure prisoners and detainees are screened for TB within 48 hours of arrival.

TB nurses should visit every confirmed TB case in a prison within 5 working days.

Patients in prisons who have active TB should have Direct Observed Therapy as standard.

10.3 Follow up of patients after treatment completion.

It is not necessary to follow up patients in clinics routinely. Patients should be advised to observe for symptoms of relapse and should be given information on how to contact the TB nurses if advice is required.

Patients who have had drug-resistant TB should be considered for follow-up for 12 months after completing treatment. Patients who have had multidrug-resistant TB should be considered for prolonged follow-up.

11 BCG vaccination

Bacillus Calmette-Guerin (BCG) is an attenuated live vaccine derived from a *mycobacterium bovis* strain. The most effective use of vaccine is to give it as soon as possible after birth to prevent infants at increased risk of exposure to TB from becoming infected. These infants are at greatest risk of developing severe disease, such as miliary TB and TB meningitis.

Warrington has a low incidence of TB and therefore BCG vaccine is only offered on a risk based programme to neonates who:

- have one or more parents or grandparents who were born in a high incidence country (40 per 100,000 or greater – see appendix -- for list of high risk countries)
- have a family history of TB in the past 5 years.

Health care professionals should opportunistically identify unvaccinated children and young people who qualify for BCG vaccine and have not been vaccinated.

BCG vaccine should also be offered to previously unvaccinated tuberculin-negative individuals under 16 years of age who are contacts of cases of Pulmonary/Laryngeal TB.
11.1 BCG vaccination for contacts of people with active TB

Offer BCG vaccination to mantoux-negative contacts of people with pulmonary and laryngeal TB if they:

- have not been vaccinated previously
- are aged 35 years or younger
- are aged 36 years and older and a healthcare or laboratory worker who has contact with patients or clinical materials.

11.2 BCG vaccination for New Entrants

Offer BCG vaccination to new entrants who are Mantoux-negative who:
are from high-incidence countries and are previously unvaccinated and are aged:

- younger than 16 years or
- 16–35 years from sub-Saharan Africa or a country with a TB incidence of 500 per 100,000 or more.

11.3 BCG vaccination for healthcare workers

Offer BCG vaccination to healthcare workers and other NHS employees who have contact with patients or clinical specimens, irrespective of age, who:

- are previously unvaccinated
- are Mantoux-negative

11.4 BCG vaccination for other groups

Offer BCG vaccination to previously unvaccinated, Mantoux-negative people aged 35 years or younger in the following groups at increased risk of exposure to TB, in accordance with the Green Book:

- veterinary and other staff such as abattoir workers who handle animal species known to be susceptible to TB, such as simians
- prison staff working directly with prisoners
- staff of care homes for older people
- staff of hostels for people who are homeless and facilities accommodating refugees
- and asylum seekers
- people going to live or work with local people for more than 3 months in a high-incidence country.

11.5 Referrals for BCG vaccination.

Referrals for BCG vaccine should only be accepted for patients who fit the current Department of Health criteria for vaccination.

Referrals for BCG vaccine can be made by letter, fax or phone to the Infection Control / TB Nurse Specialists at the following address:

Infection Control / TB Nurse Specialist
1st floor Spencer House
Dewhurst Road
Birchwood
12 Consultation Process

This procedure has been reviewed by the TB Nurse Specialists, with guidance from the NICE guidance – Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. (NICE, 2016). It has been circulated to the Public Health Infection Control Group for consultation.
13 References


European Centre for Disease Prevention and Control guidance (2012) Management of contacts of MDR TB and XDR TB patients

https://www.nice.org.uk/guidance/ng33/resources/tuberculosis-1837390683589.


Public Health England (2013) Tuberculosis (TB) by country: rates per 100,000 people. 


WHO treatment guidelines for Drug Resistant TB. (WHO, 2016)
Appendix 1

High risk countries – Countries with rates of TB over 40/100,000 of the population

Afghanistan, Algeria, Angola, Armenia, Azerbaijan
Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia, & Herzegovina, Botswana, Brazil, Brunei Darussalam, Burkina Faso, Burundi
Cape Verde, Cambodia, Cameroon, Central African Republic, Chad, China including Hong Kong SAR, China including Macao SARS, Congo, Cote D'Ivoire
Djibouti, Dominican Republic
Ecuador, El Salvador, Equatorial Guinea, Eritrea, Ethiopia,
Fiji
Gabon, Gambia, Georgia, Ghana, Greenland, Guam, Guatemala, Guinea, Guinea – Bissau, Guyana,
Haiti, Honduras, Hong Kong SAR,
India, Indonesia, Iraq,
Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Korea (Republic Of)
Lao People’s Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania,
Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania,
Micronesia, Mongolia, Morroco, Mozambique, Myanmar
Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Northern Mariana Islands,
Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines
Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda
Sao Tome and Principe, Senegal, Sierra Leone, Singapore, Solomon Islands,
Somalia, South Africa, Sri Lanka, South Sudan, Sudan, Swaziland,
Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Turkmenistan, Tuvalu,
Uganda, Ukraine, Uzbekistan Vanuatu, Vietnam
Yemen
Zambia, Zimbabwe.