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**STANDARD  
NURSE PROTOCOLS  
FOR  
TUBERCULOSIS (TB)**

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## **STANDARD NURSE PROTOCOL FOR ACTIVE TUBERCULOSIS (TB) DISEASE AGE 15 AND OVER**

### **DEFINITION**

Tuberculosis (TB) is an infectious disease transmitted through the air in droplet nuclei that are produced when a person with active TB disease of the lung or larynx sneezes, coughs, speaks, or sings. Persons breathing air contaminated with these droplet nuclei may become infected with TB.

Generally, a positive culture or positive Nucleic Acid Amplification test (NAAT) for *Mycobacterium tuberculosis* is necessary to confirm the diagnosis of a tuberculosis case. However, suspected cases may be diagnosed on the basis of: a positive sputum/specimen smear for acid-fast bacilli (AFB); lung histology showing necrotizing granulomas with or without AFB; or clinical syndrome, even when a culture or pathologic specimen has not been, or cannot be, obtained.

### **ETIOLOGY**

Causative agent of TB is the *Mycobacterium tuberculosis* (*M.tb*) complex (*M. tuberculosis*, *M. bovis*, *M. africanum*, *M. microti*, *M. canettii*, *M. caprae*, *M.mungi* and *M. pinnipedii*).

### **SUBJECTIVE**

- 1. May have history of exposure to a known case**
- 2. May have history of active TB disease or Latent TB infection**
- 3. May have one or more of the following symptoms related to TB:**
  - a. Productive, prolonged cough (usually more than two or three weeks duration)
  - b. Fever
  - c. Chest pain or pleuritic pain
  - d. Chills
  - e. Night sweats
  - f. Easy fatigability
  - g. Loss of appetite
  - h. Weight loss without dieting
  - i. Hemoptysis (coughing up blood)
  - j. Headache

- k. Muscle/bone/joint pain

**Note: a complete medical history is required to determine if there are any diseases/illnesses present that would require consultation or referral to delegating physician (conditions are listed on page 6.3)**

**OBJECTIVE            Physical examination performed according to guidelines may reveal the following criteria that are useful in identifying a TB suspect/case:**

- a. Coughing or shortness of breath
- b. Fever/sweating
- c. Appears ill or fragile
- d. Vital signs (height, weight, BMI, blood pressure, respiratory rate)
- e. Jaundice of sclera or skin
- f. Abdominal tenderness
- g. Joint swelling or redness
- h. Difficulty walking, tremors
- i. Dizziness, syncope, memory loss

## **LABORATORY FINDINGS**

1. A positive interferon gamma release assay (IGRA) or a positive Mantoux tuberculin skin test. (The absence of a positive IGRA or reaction to the skin test does not rule out the diagnosis of TB disease or latent TB infection).
2. Positive staining of acid-fast bacillus (AFB) in sputum(s), bronchial brush, wash or lung tissue biopsy. (However, cases can be smear negative).
3. Chest x-ray showing abnormalities compatible with TB disease. (Radiographic findings of healed, inactive TB and reactivating TB sometimes cannot be distinguished).
4. The following criteria (one or more) are required for a confirmed diagnosis of TB:
  - a. Pathology findings compatible with the diagnosis of TB.

- b. Specimens with positive culture or positive Nucleic Acid Amplification test (NAAT) for *Mycobacterium tuberculosis*.

- ASSESSMENT**
- 1. Pulmonary tuberculosis OR
  - 2. Extra-pulmonary tuberculosis OR
  - 3. Suspected case of pulmonary tuberculosis OR
  - 4. Suspected case of extra-pulmonary tuberculosis

**NOTE:** For patients with the following conditions, consultation with the delegating physician is required for patients to be treated under this protocol. Consultation must be documented in the patient's record.

- 1. BMI greater than 30 (obese)
- 2. Diabetes mellitus
- 3. Pregnant/Breastfeeding
- 4. Liver disease
- 5. Extra-pulmonary TB not requiring 2<sup>nd</sup> line TB drugs or use of corticosteroid therapy. (Excludes: Central Nervous System (CNS) TB, TB pericarditis: these cases must be referred for physician management).
- 6. Allergic reactions not requiring 2<sup>nd</sup> line TB drugs
- 7. Decision to extend continuation phase using first-line TB drugs, e.g. bone/joint TB, miliary TB.
- 8. Treatment interruptions
  - a. During the initial phase of treatment if the lapse is 14 days or more in duration
  - b. During the continuation phase of treatment:
    - If patient is smear positive initially and received less than 80% of the planned total doses for continuation phase
    - Any patient whose lapse is 3 months or more in duration

**NOTE:** The following patients will be REFERRED to the delegating physician for management and NOT managed under this protocol:

- 1. TB treatment for children birth through 14 years of age

2. Any known drug resistance to anti-TB medications
3. Known HIV infection
4. Central Nervous System (CNS) TB
5. TB pericarditis
6. TB patient requiring adjunctive use of corticosteroid therapy.
7. Use of once-weekly INH and Rifapentine in continuation phase for active TB disease
8. Renal insufficiency with estimated creatinine clearance less than 70 ml/min
9. End-stage renal disease on hemodialysis
10. Any TB patient requiring 2<sup>nd</sup> line TB drugs
11. Treatment failure (positive culture of *M. tuberculosis* after 4 months of treatment)

**PLAN**

The desired outcomes of treatment are: biologic cure, prevention of drug resistant TB and prevention of transmission of TB to individuals exposed to persons with active TB.

**DIAGNOSTIC STUDIES**

1. If positive results for either an interferon gamma release assay (IGRA) or a tuberculin skin test cannot be verified (including millimeters [mm] of induration), perform a Mantoux tuberculin skin test or interferon gamma release assay (IGRA). Vaccination with live viruses may interfere with either of these test reactions. For persons scheduled to receive a tuberculin skin test, testing should be done as follows: Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine. At least one month after smallpox vaccination.
2. Collect three (3) sputum specimens on consecutive days and send them to the Georgia Public Health Laboratory (GPHL) in Decatur.

Use the lab slip found on the GPL website at <http://dph.georgia.gov/lab>. Look at the related files at the bottom of the page for the GPL Submission Form. Check

- a. Smear, Culture, and Sensitivity
- b. NAAT (Nucleic Acid Amplification Testing)

The public health nurse (PHN) will obtain the first sputum specimen and provide the patient with two additional containers for collection and mailing of the next two specimens. Instructions should be given to both patient and family on how to properly produce sputum for examinations. At least one of the specimens collected must be an early morning specimen as they provide the highest yield for detecting *M.tb*. Ideally the initial specimens should be collected over a three day period, however multiple samples may be collected in the same day provided that 8 hours has elapsed between collections and at least one is an early morning specimen. Specimens not mailed the day of collection should be refrigerated until mailed. Seek patient confirmation regarding mailing of specimens and check with the laboratory to confirm receipt of the specimens. If necessary, the PHN should collect and mail the specimens. Optimum sputum specimens contain an 8-10 ml sample; however any amount collected will be tested at the state lab. Specimens received by the lab that contain less than a .5 ml sample may have an insufficient quantity of material for all lab testing to be performed.

- 3. Collect blood to obtain baseline measurements for the following lab tests:
  - a. Obtain aspartate aminotransferase (AST) [formerly, serum glutamic oxaloacetic transaminase (SGOT)], alanine aminotransferase (ALT) [formerly, serum glutamic-pyruvic transaminase (SGPT)], bilirubin, alkaline phosphatase, CBC with platelet count, serum uric acid, serum creatinine, glucose, and Hepatitis C antibody for all adults. If glucose is above normal range (per reported parameters), obtain a hemoglobin A1C at next visit. On known diabetics, obtain a hemoglobin A1C with baseline lab tests.
  - b. Hepatitis B profile should be obtained for all adults (regardless of birth country) and anyone less than 18 years old who is foreign-born.
  - c. All individuals will be tested for HIV using the opt-out approach. Consent is inferred unless patient declines testing. If HIV-infected, collaborate with HIV Program to

obtain CD4 T-cell count, then refer to consulting physician.  
(See REFERRAL section on pp. 6.17).

4. Obtain baseline visual acuity testing and red/green color discrimination for patients being placed on ethambutol.
5. Pregnancy test, if indicated.
6. Refer patient to have chest x-ray performed in order to detect abnormalities compatible with TB disease. (Radiographic findings of healed, inactive TB and reactivating TB sometimes cannot be distinguished).

## THERAPEUTIC

### PHARMACOLOGIC

**NOTE:** Order medications for treatment with directly observed therapy (DOT) from drug stock and send a copy of the drug order(s) to the District Pharmacist or District Drug Coordinator.

1. Order DOT for all doses until completion of treatment (see Tables 1 and 2 on pages 6.6 and 6.7 for options and dosages). DOT is required for all suspected and/or confirmed active cases.
2. Pyridoxine (Vitamin B<sub>6</sub>) 25 - 50 mg PO daily, to prevent the development of isoniazid-induced peripheral neuropathy.
3. If a patient is referred to the delegating physician, the nurse may not dispense ANY of the prescribed medications. **A Pharmacist or Dispensing Physician can dispense the TB medications or the prescription may be called in to a pharmacy by the physician.**
4. Nurses may not dispense 2<sup>nd</sup> line TB medications. If 2<sup>nd</sup> line medications are ordered, **a Pharmacist or Dispensing Physician can dispense the 2<sup>nd</sup> line TB medications or the prescription may be called in to a pharmacy.**

**Table 1: Regimen Options - Treatment of Patients with Drug-Susceptible TB**

Option	Total Duration (Months)	Initial Phase		Continuation Phase <sup>1</sup>		Comments
		Drugs	Interval & Dose # (minimal duration)	Drugs	Interval & Dose # (minimal duration)	
1	6	Isoniazid Rifampin Pyrazinamide Ethambutol	Daily DOT for 40 doses (8 wks.)	Isoniazid Rifampin	Daily DOT for 90 doses (18 wks.) OR Twice-weekly** DOT for 36 doses (18 wks.) OR Thrice-weekly DOT for 54 doses (18 wks.)	Regimen must be Directly observed. Continue ethambutol until susceptibility to isoniazid and rifampin is demonstrated.
2*	6	Isoniazid Rifampin Pyrazinamide Ethambutol	Daily DOT for 10 doses (2 wks.), then twice-weekly DOT for 12 doses (6 wks.)	Isoniazid Rifampin	Twice-weekly** DOT for 36 doses (18 wks.)	Regimen must be directly observed. Include ethambutol in initial phase. After the initial phase, continue ethambutol until susceptibility to isoniazid and rifampin is demonstrated.

\*NOTE: Option 2 should NOT be used for patients with HIV infection, cavitory pulmonary TB disseminated TB, vertebral TB or for patients who have co-morbid medical conditions such as diabetes mellitus, end-stage renal disease or liver disease.

\*\*Twice-weekly doses should optimally be given at least two days apart, unless given to “catch up” on a missed dose. A dose given two consecutive days is discouraged.

**NOTE:** Daily DOT = 5 days/week (Monday through Friday). Self-administered doses (including those on weekends) will not be counted toward the total doses.

**NOTE:** 5 daily doses of DOT equal 2 twice-weekly doses of DOT

**NOTE:** Pyridoxine (Vitamin B<sub>6</sub>) 25- 50 mg/daily should be added to all regimens to prevent development of isoniazid-induced peripheral neuropathy.

\***NOTE:** Option 2 should NOT be used for patients with HIV infection, cavitory pulmonary TB disseminated TB, vertebral TB or for patients who have co-morbid medical conditions such as diabetes mellitus, end-stage renal disease or liver disease.

**NOTE:** Split dosing should be avoided.

**NOTE:** Rifamate, a fixed combination of Rifampin 300 mg, and Isoniazid 150 mg, may be used to minimize the number of pills. Intermittent dosing is not recommended with fixed combination medications.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interaction.

<sup>1</sup> TB treatment may be extended beyond 6 months minimal duration as determined by consultation with and documentation from delegating physician.

**Table 2: First-Line TB Drugs**

Drugs	Adult Dose based on body weight in kilograms (kg)*			Adverse Reactions
	Daily	Twice-Weekly	Thrice-Weekly	
Isoniazid	300 mg (5 mg/kg Maximum Dose 300 mg)	900 mg (15 mg/kg Maximum Dose 900 mg)	900 mg (15 mg/kg Maximum Dose 900 mg)	<ul style="list-style-type: none"> <li>• Gastrointestinal (GI) upset</li> <li>• Liver enzyme elevation</li> <li>• Acute Hepatitis</li> <li>• Peripheral neuropathy</li> <li>• Mild effects on central nervous system</li> <li>• Drug interactions</li> </ul>
Rifampin	600 mg (10 mg/kg Maximum Dose 600 mg)	600 mg (10 mg/kg Maximum Dose 600 mg)	600 mg (10 mg/kg Maximum Dose 600 mg)	<ul style="list-style-type: none"> <li>• Orange discoloration of body fluids and secretions</li> <li>• Drug interactions</li> <li>• GI upset</li> <li>• Hepatitis</li> <li>• Easy bruising / bleeding</li> <li>• Influenza-like symptoms</li> <li>• Rash</li> </ul>
Pyrazinamide**	40-55 kg: 1000 mg 56-75 kg: 1500 mg 76+ kg: 2000 mg	40-55 kg: 2000 mg 56-75 kg: 3000 mg 76+ kg: 4000 mg	40-55 kg: 1500 mg 56-75 kg: 2500 mg 76+ kg: 3000 mg	<ul style="list-style-type: none"> <li>• GI upset</li> <li>• Joint aches</li> <li>• Hepatitis</li> <li>• Rash</li> <li>• Hyperuricemia</li> <li>• Gout (rare)</li> </ul>
Ethambutol**	40-55 kg: 800 mg 56-75 kg: 1200 mg 76+ kg: 1600 mg	40-55 kg: 2000 mg 56-75 kg: 2800 mg 76+ kg: 4000 mg	40-55 kg: 1200 mg 56-75 kg: 2000 mg 76+ kg: 2400 mg	<ul style="list-style-type: none"> <li>• Optic neuritis</li> </ul>

\*Formula used to convert pounds to kilograms: Divide pounds by 2.2 to get kilograms. *Example: Patient weighs 154 pounds ÷ 2.2 = 70 kilograms.*

\*\* Calculate Pyrazinamide and Ethambutol doses using actual body weight. NOTE: Round up fractions of a dose to the nearest whole number. Obese patients' (BMI over 30) dosing should be determined in collaboration with the district delegating/contract TB physician.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**NOTE:** Ethambutol and Pyrazinamide dosage adjustment may be needed if there is renal impairment. Patients with estimated creatinine clearance less than 50 ml/min or those with end-stage renal disease on dialysis are considered complicated cases and dosing should be determined by district contract TB physician.

## PATIENT EDUCATION/COUNSELING

Education/communication should use methods adapted to patient's cultural and linguistic background. Provide education to the patient and his/her family, when family is available, and document in the patient record.

1. The "12 Points of Tuberculosis (TB) Patient Education" and the "Patient Tuberculosis Education Record" is located on the TB web pages at [http://dph.georgia.gov/sites/dph.georgia.gov/files/TB-ClinicForm12\\_Points\\_PtEd.pdf](http://dph.georgia.gov/sites/dph.georgia.gov/files/TB-ClinicForm12_Points_PtEd.pdf)
  - a. Transmission of Tuberculosis
  - b. Differences between latent TB infection (LTBI) and active TB disease
  - c. Progression of LTBI to active TB disease
  - d. Signs and symptoms of TB disease
  - e. Importance of HIV testing
  - f. Respiratory isolation and use of masks
  - g. Infectious period
  - h. Importance of chemotherapy as prescribed
  - i. Side effects and adverse medication reactions
  - j. Directly Observed Therapy
  - k. Importance of regular medical assessments
  - l. Importance of contact investigation
  
2. The rationale for using an alternative or back-up method of birth control (e.g., copper-bearing IUD such as ParaGard, condoms, diaphragm) is that when rifampin is prescribed, it reduces effectiveness (degree depending on method) of combined oral contraceptives, progestin-only oral contraceptives, levonorgestrel implants, Depo-Provera, patch and ring. Advise condom back-up. (Table 4 on page 6.19 – Drug Interactions - Rifampin).
  
3. The patient's immunization status. Assess and refer or administer vaccines indicated according to the current Advisory Committee on Immunization Practices (ACIP) childhood and adult immunization schedule. Patients who need a tuberculin skin test (TST) can and should be immunized. All vaccines, including MMR, can be given on the same day as a TST, or any time after a TST is applied. For most vaccines, there are no TST timing restrictions. MMR vaccine may decrease the response to a TST, potentially causing a false-negative response in someone who actually has an infection with tuberculosis.

MMR can be given the same day as a TST, but if MMR has been given and 1 or more days have elapsed, in most situations a wait

of at least 4 weeks is recommended before giving a routine TST. No information on the effect of varicella-containing vaccine or LAIV (live attenuated influenza vaccine) on a TST is available. Until such information is available, it is prudent to apply rules for spacing measles vaccine and TST to varicella vaccine and LAIV. See the Georgia Immunization Program Manual, Recommended Schedule and Guidelines, for current ACIP schedules and administration guidelines for each vaccine. The Georgia Immunization Manual may be accessed online at <http://dph.georgia.gov/immunization-section>

4. If smoker or tobacco user, refer to a local cessation program and/or the Georgia Tobacco Quit Line, 1-877-270-STOP (7867).
5. If substance abuse known or suspected, refer for appropriate counseling.

#### **FOLLOW-UP**

1. Continued patient management/follow-up by a case management team comprised of the patient, nurse, physician and others determined by an individual needs assessment. Refer to the ***TB Program Policy and Procedure Manual, 2014*** and *Tuberculosis Nursing: A Comprehensive Guide to Patient Care, 2<sup>nd</sup> Edition* located in each county health department and “Scaled Goal Matrix Tool: Uniform Clinical Performance Measures for TB Nurse Case Managers, 2006” located on the TB web pages at <https://dph.georgia.gov/tb-public-health-clinic-forms>
2. After the nursing assessment, the Public Health Nurse (PHN) will use the “*Case Management Timeline – A Tracking Form for TB Medical Records*” located on the TB web pages at <https://dph.georgia.gov/tb-public-health-clinic-forms> to determine documents to forward for review by the district TB coordinator, the district’s contract physician and the state office. The district’s TB Coordinator will forward pertinent records to the state office, including (but not limited to) the following:
  - a. Complete health history and pertinent physical findings.
  - b. Hospital discharge summaries (if available).
  - c. Treatment assessment and plan for DOT.
  - d. All other pertinent clinical data (e.g., prior chest x-rays, if available, and lab work).

3. Review the respiratory isolation status for the patient. All 3 of the following criteria must be met in order for isolation to be discontinued:
  - a. Patient has three consecutive negative AFB sputum smear results.
  - b. Patient has received standard anti-tuberculosis treatment for a minimum of two weeks.
  - c. Patient has demonstrated clinical improvement.

During the initial treatment, it may be necessary to expedite meeting these criteria. There must be a minimum of 8 hours between collection times if two samples are obtained on the same day. Early morning collection time is highest yield for detecting *M.tb*. Mark on the lab slip to perform “AFB Smear Only” for these specimens.

4. Monitor patient(s) monthly for adverse drug reactions, drug-drug interactions, drug-food interactions, drug-lab interactions, infectious status, and clinical and bacteriologic response to therapy (see Tables 3, 4 and 5 on pages 6.18 – 6.19 for drug interactions).
5. Provide HIV test results with post-test counseling to patient and, if positive, appropriate referrals to HIV care. Seek confirmation that patient kept referral appointment for HIV care.
6. Conduct a contact investigation following the ***Tuberculosis Policy and Procedure Manual***, the *Tuberculosis Nursing: A Comprehensive Guide to Patient Care, 2<sup>nd</sup> Edition*, and the *CDC Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis* (current edition) to include:
  - a. The initial interview of the index patient should be done by the PHN or designee (e.g., Communicable Disease Specialist) for all cases and suspects in the hospital (preferred) within one to three working days of health department notification. The follow-up interview should occur 1-2 weeks later, preferably in the patient’s home.
  - b. Start screening with high priority contacts in home, work, school and social environments. High priority contacts would be those persons with the greatest intensity, frequency and duration of exposure to the person who has infectious TB. Take into consideration risk factors (see item c immediately below) as well as exposure in determining high priority contacts. **NOTE:** High-

priority contacts should be examined within seven working days. Medium priority contacts should be examined within fourteen calendar days. Low priority contacts should be examined within thirty calendar days.

- c. High priority contacts that are considered a medical risk should be examined immediately regardless of initial TST or IGRA. Persons at particularly high risk of developing TB disease once infected with *M. tb* include: children less than 5 years of age and persons with immune systems compromised by HIV infection, immunosuppressive medications (prednisone, cancer chemotherapy, anti-rejection drugs for cancer therapy, tumor necrosis factor alpha agents antagonists) and certain medical conditions (diabetes mellitus, silicosis, end stage renal disease, cancer of the head and neck, reticuloendothelial diseases [e.g., lymphoma, leukemia], gastric or jejunoileal bypass surgery). Those contacts should have a chest x-ray and if the chest x-ray is negative for active TB disease, they should be placed on presumptive latent TB infection treatment for the window period. At the 8-10 week follow-up TST evaluation, LTBI will be confirmed or ruled out and the decision to continue treatment or to discontinue treatment will be made. (See LTBI/Presumptive LTBI protocol p. 6.23).
  - d. Expand the contact investigation if there is evidence of recent transmission such as a higher than expected infection rate in high priority contacts, a secondary case of TB disease, infection in a child less than five years, or a converter.
  - e. Contact information should be entered on the *TB Contact Investigation Report Form* (Form #3126) and promptly entered into SENDSS.
7. After the baseline 3 consecutive sputum specimens, collect follow-up sputum samples as follows for diagnosed or suspected pulmonary TB cases:
- a. You may collect up to three sputum samples in a week until three consecutive negative AFB smears are obtained to determine when to discontinue respiratory isolation. Only one sputum sample that week should be marked on the lab form for smear/culture/sensitivity. Any additional sputum samples of the same week should be examined for AFB smear only.
  - b. After three consecutively negative sputum smears are obtained, collect only one sputum specimen for smear/culture/sensitivity weekly until culture converts to negative.

- c. After sputum culture converts to negative, collect one sputum specimen monthly thereafter for smear/culture/sensitivity.
    - d. Collect one sputum specimen at 60 days after medication treatment initiation for smear/culture/sensitivity test. A positive culture at this point identifies patients at increased risk for relapse. If the culture is still positive, refer patient for treatment to the contract physician.
    - e. If the patient is unable to produce sputum, document the collection attempt.
8. Perform the following blood chemistry tests monthly to monitor reactions to TB drugs:
  - a. AST (SGOT), ALT (SGPT)
  - b. Bilirubin
  - c. Alkaline phosphatase
  - d. CBC with platelets
  - e. Serum uric acid and serum creatinine monthly if there are abnormalities at baseline or there are clinical reasons to obtain the measurements (e.g., hepatitis B or C virus infection, alcohol abuse, and abnormal kidney function).
9. Discontinue the isoniazid or rifampin and report immediately to the consulting physician if any of the following occur:
  - a. AST/ALT levels equal to or greater than 3 times the upper limit of normal in the presence of symptoms of adverse events.
  - b. AST/ALT levels equal to or greater than 5 times the upper limit of normal in an asymptomatic patient.
  - c. Patient reporting symptoms of adverse reactions.
10. Monitor the vision of patients taking ethambutol by providing vision checks monthly, including visual acuity and red/green color discrimination.
11. Adherence should methodically be assessed on a monthly basis at a minimum. Results should be discussed during the regular case reviews with the staff and/or TB Coordinator. Strategies to address issues should be discussed and implemented before they become a major problem. Use incentives and enablers to enhance adherence to therapy. These may be as simple as offering a cup of coffee and talking with a patient who is waiting in

the clinic, or as complex as providing food and housing for a homeless patient.

12. Observe the patient for isoniazid-induced peripheral neuropathy e.g., tingling, numbness, pain, during the course of therapy and report to the delegating physician.
13. Treatment completion is defined by the number of doses taken as well as the duration of treatment. The number of doses required is listed in Table 1, page 6.7.

## CONSULTATION

**NOTE: Consultation with delegating physician (and documentation of the consultation in the patient record) is required before patients with the following findings and/or conditions can be treated under this protocol :**

1. **BMI greater than 30 (obese)**
2. **Diabetes mellitus**
3. **Pregnant/Breastfeeding**
4. **Liver disease**
5. **Extra-pulmonary TB not requiring 2<sup>nd</sup> line TB drugs or use of corticosteroid therapy. (Excludes: Central Nervous System (CNS) TB, TB pericarditis,; these cases must be referred for physician management).**
6. **Allergic reactions not requiring 2<sup>nd</sup> line TB drugs**
7. **Decision to extend continuation phase using first-line TB drugs, e.g. bone/joint TB, miliary TB.**
8. **Treatment interruptions**
  - a. **During the initial phase of treatment if the lapse is 14 days or more in duration**
  - b. **During the continuation phase of treatment:**
    - **If patient is smear positive initially and received less than 80% of the planned total doses for continuation phase**
    - **Any patient whose lapse is 3 months or more in duration**

**Consult delegating physician when further medical guidance is needed and/or the TB nursing protocol is not applicable for therapeutic treatment of patient.**

## **REFERRAL**

1. Refer patients for other medical and social services as needed, particularly alcohol or drug abuse treatment, diabetes care (if hemoglobin A1C is 6.5% or higher) and HIV care. You may contact the TB state office Social Services Provider for assistance with these issues.
2. If any of the following conditions are present or develop, the case is considered a complicated TB case and TB treatment must be ordered by the district contract TB physician:
  - a. **TB treatment for children birth through 14 years of age**
  - b. **Any known drug resistance to anti-TB medications**
  - c. **Known HIV infection**
  - d. **Central Nervous System (CNS) TB**
  - e. **TB pericarditis**
  - f. **TB patient requiring adjunctive use of corticosteroid therapy**
  - g. **Use of once-weekly INH and Rifapentine in continuation phase for active TB disease**
  - h. **Renal insufficiency with estimated creatinine clearance less than 70 ml/min**
  - i. **End-stage renal disease on hemodialysis**
  - j. **Any TB patient requiring 2<sup>nd</sup> line TB drugs**
  - k. **Treatment failure (positive culture of *M. tuberculosis* after 4 months of treatment)**

**NOTE: Consult delegating physician when further medical guidance is needed and/or the TB nursing protocol is not applicable for therapeutic treatment of patient.**

3. Refer patient to a licensed dietitian if indicated. This will be especially important if the patient has a history of drug or alcohol abuse, is breast-feeding, is HIV-infected, has GI side effects from TB drugs or if desirable weight is not maintained.

**Table 3: TREATMENT OF TB - DRUG INTERACTIONS (Format 1)**

DRUG INTERACTIONS – RIFAMPIN	
Drug A	Rifampin Effects on Drug A
Anticoagulants (warfarin, coumadin)	↓ serum concentration
Cardiac glycosides (digoxin)	↓ serum concentration
Sulfonylureas (e.g. glipizide, glyburide, glimepiride)	↓ serum concentration
Thiazolidinediones (e.g. rosiglitazone, pioglitazone)	↓ serum concentration
Oral contraceptives, contraceptive implants, patch, ring, Medroxyprogesterone injections	↓ serum concentration
Fluconazole, Voriconazole, Itraconazole	↓ serum concentration
Corticosteroids	↓ serum concentration
Narcotics/analgesics (methadone)	↓ serum concentration
Atovaquone ( <b>mepro</b> n)	↓ serum concentration
Dapsone	↓ serum concentration
Cyclosporine	↓ serum concentration
Quinidine	↓ serum concentration
Protease inhibitors	↓ serum concentration
Lamotrigine (Lamictal)	↓ serum concentration
Phenytoin ( <b>Dilantin</b> )	↓ serum concentration
Valproic acid and derivatives (depakene, depakote)	↓ serum concentration
Buspirone (buspar)	↓ serum concentration
Thyroid hormone replacement	↓ serum concentration

DRUG INTERACTIONS – ISONIAZID	
Drug A	Isoniazid Effects on Drug A
Diazepam (valium)	↓ serum concentration    ↑ <b>half-life</b>
Phenytoin (Dilantin)	↑ serum concentration    ↑ toxicity
Carbamazepine (tegretol)	↑ serum concentration    ↑ toxicity
Citalopram (celexa)	↑ serum concentration    ↑ toxicity

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**Table 4: TREATMENT OF TB - DRUG INTERACTIONS (Format 2)**

**DRUG INTERACTIONS – RIFAMPIN/RIFAPENTINE**

Rifampin or Rifapentine plus...	
Adefovir	Increases risk of side effects.
Amprenavir	Should not be used together.* Significantly decreases amprenavir levels in blood.
Anticoagulants	May decrease effectiveness of anticoagulants.
Atovaquone	Decreases atovaquone levels by 50% in blood.
AZT	May decrease AZT levels in blood.
Barbiturates	May decrease effectiveness of barbiturates.
Clarithromycin	Decreases clarithromycin levels by 120% in blood.
Corticosteroids	May decrease corticosteroid levels in blood.
Cyclosporine	May decrease cyclosporine levels in blood.
Dapsone	Decreases dapsone levels by 7- to 10-fold in blood.
Delavirdine	Should be taken together otherwise delavirdine levels in blood significantly decreased.
Diazepam	May decrease effectiveness of diazepam.
Digitalis	May decrease effectiveness of digitalis.
Disopyramide	May decrease effectiveness of disopyramide.
Efavirenz	Decreases efavirenz levels by 26% in blood.
Estrogen	May decrease effectiveness of estrogen.
Ethinyl Estradiol (birth control pills)	May decrease ethinyl estradiol levels in blood.
Fluconazole	Decreases fluconazole levels by 23% in blood.
Halothane	May increase risk of liver toxicity.
Indinavir	May increase rifampin levels in blood. Should not be used together.*
Isoniazid	May increase risk of liver toxicity.
Itraconazole	May decrease itraconazole levels in blood.
Lopinavir/ritonavir	Decreases lopinavir levels by 75% in blood. Should not be used together.
Methadone	May decrease effectiveness of methadone.
Mexiletine	May decrease effectiveness of mexiletine.
Nelfinavir	Decreases nelfinavir levels by 82% in blood. Should not be used together.*
Nevirapine	May affect rifampin and/or nevirapine levels in blood.
Probenecid	Increases rifampin levels in blood.
Progesterone	May decrease effectiveness of progesterone.
Quinidine	May decrease quinidine levels in blood.
Ritonavir	Decreases ritonavir levels by 35% in blood.

Rifampin or Rifapentine plus...	
Theophylline	May decrease theophylline levels in blood.
Verapamil	May decrease effectiveness of verapamil.
Voriconazole	May decrease voriconazole levels in blood.

\* The information on interactions with rifampin and HIV antiretroviral therapy (ART) is constantly changing. Consult with the consulting physician/contract physician. In general, only certain HIV medications can be used and rifampin may be replaced by rifabutin. Rifabutin is in the formulary at the state pharmacy.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**Table 5: DRUG INTERACTIONS – ISONIAZID**

Isoniazid plus...	
Alcohol	May increase risk of isoniazid associated hepatitis.
Antacids	Should be taken two hours apart otherwise isoniazid will have no effect.
Carbamazepine	Decreases carbamazepine metabolism.
Cycloserine	May increase risk of central nervous system toxicity.
Ethionamide	May increase risk of encephalopathy (dysfunction of the brain) and may increase isoniazid levels in blood.
Phenytoin	Decreases phenytoin metabolism.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

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**STANDARD NURSE PROTOCOL FOR  
LATENT TUBERCULOSIS INFECTION (LTBI) AND PRESUMPTIVE LTBI**

## DEFINITION

Latent tuberculosis infection (LTBI) means that a person has been infected with *M. tuberculosis* (*M. tb*) but has no clinical or radiographic evidence of TB. Individuals who are infected but do not have active disease are not infectious but, if not adequately treated, are at risk for developing disease and becoming infectious in the future.

Presumptive LTBI treatment is the practice of providing window period prophylaxis treatment to high-risk contacts of infectious TB cases for presumed *M. tb* infection when the contact has an initial negative TB skin test (TST) reaction (less than 5mm induration) or an initial negative IGRA test result and the test was performed less than 8 weeks from the contact's last exposure to the index case. The window period is the time span between the date of an initial TST or IGRA with a negative reaction and the date of the follow-up TST or IGRA.

Contacts at particularly high risk of developing TB disease once infected with *M. tb* include: children less than 5 years of age and persons with immune systems compromised by HIV infection, immunosuppressive medications (prednisone, cancer chemotherapy, anti-rejection drugs for cancer therapy, tumor necrosis factor alpha agents antagonists) and certain medical conditions (diabetes mellitus, silicosis, end stage renal disease, cancer of the head and neck, reticuloendothelial diseases [e.g., lymphoma, leukemia], gastric or jejunioileal bypass surgery).

Candidates for treatment of LTBI include:

1. Persons in the following high-risk groups should be given treatment for LTBI if they have positive skin test results of equal to or greater than 5 mm or if they have a positive interferon gamma release assay (IGRA) result:
  - a. HIV-positive persons.
  - b. Recent contacts to a TB case.
  - c. Persons with fibrotic changes on chest radiograph consistent with old TB.
  - d. Persons with organ transplants and other immune-suppressed persons (those receiving the equivalent of equal to or greater than 15 mg daily of prednisone for 1 month or longer).
2. Persons in the following high-risk groups should be considered for treatment of LTBI if their reaction to the tuberculin skin test is equal to or greater than 10 mm or if they have a positive interferon gamma release assay (IGRA) result:

- a. Recent arrivals (less than 5 years) from high prevalence countries.
  - b. Injection drug users.
  - c. Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes and other long-term facilities for the elderly, homeless shelters, residential facilities for AIDS patients, hospitals and other health care facilities).
  - d. Mycobacteriology laboratory personnel.
  - e. Persons with clinical conditions that place them at high risk of progression to TB disease (e.g., substance abuse, infection with *M. tb* within the past two years, diabetes, hematologic or reticuloendothelial malignancies, chronic renal failure, post-gastrectomy, silicosis, immunosuppressive therapy, chronic malabsorption syndromes or candidates being considered for treatment with tumor necrosis factor (TNF) antagonists such as injectable Remicade [Infliximab] for rheumatologic conditions or ulcerative colitis prior to initiation of therapy).
  - f. Children less than 5 years of age, or children and adolescents exposed to adults in high-risk groups.
3. Persons with no risk factors for TB should be considered for treatment of LTBI if their reaction to the tuberculin skin test is greater than or equal to 15 mm or if they have a positive interferon gamma release assay (IGRA) result.

Candidates for treatment of presumptive LTBI include:

1. Candidates for presumptive LTBI treatment who would benefit from a full course of LTBI treatment include contacts that are immunosuppressed due to the following conditions:
  - a. HIV infection.
  - b. Prolonged corticosteroid therapy.
  - c. Persons with organ transplants.
  - d. Persons on TNF-alpha inhibitors
2. Candidates for presumptive LTBI treatment who can stop treatment after the window period if the follow-up TST/IGRA is negative include contacts that are:

- a. Children <5 years of age.
- b. Persons with any of the following conditions:
  - a. Diabetes mellitus.
  - b. Silicosis.
  - c. End stage renal disease
  - d. Gastrectomy
  - e. Jejunioileal bypass
  - f. Leukemia
  - g. Lymphoma
  - h. Cancer of the head or neck

Treatment of LTBI or presumptive LTBI might NOT be indicated for:

- 1. Persons at increased risk for adverse reactions to isoniazid and persons for whom isoniazid is contraindicated.
- 2. Persons who cannot tolerate isoniazid or rifampin.
- 3. **Persons likely to be infected with drug-resistant *M. tb.* should be referred to the consulting physician.**
- 4. Persons who are not likely to complete a course of treatment for LTBI (e.g., some homeless persons or migrant farm workers).

Treatment of LTBI might NOT be completed on:

- 1. **Persons who are a contact to a TB suspect later found not to have TB should be referred to the consulting physician.**

**ETIOLOGY** The agent is the *Mycobacterium tuberculosis* complex.

**SUBJECTIVE**

- 1. Patient may have a history of known exposure to TB
- 2. Asymptomatic/Absence of symptoms of TB

**OBJECTIVE**

- 1. Physical examination performed according to programmatic guidelines. No signs of active TB disease present.
- 2. If signs and symptoms of TB disease are evident, patient should have 3 consecutive negative sputum smears and cultures with evaluation by a clinician before starting treatment for LTBI.

- ASSESSMENT**
1. Latent tuberculosis infection (LTBI) (without signs/symptoms of tuberculosis disease) **OR**
  2. Presumptive *M. tb* infection during the window period

**PLAN**

**DIAGNOSTIC STUDIES**

1. A positive Mantoux tuberculin skin test or a positive interferon gamma release assay (IGRA) result and no clinical symptoms of active disease **OR** a negative TST or IGRA on the initial evaluation of a high-risk contact during the course of a contact investigation and it is less than eight to ten (8 – 10) weeks since the last exposure to the index case and no clinical symptoms of active disease

**AND**

2. Chest x-ray negative for evidence of tuberculosis disease
3. Absence of clinical signs of TB, both pulmonary and extra-pulmonary

NOTE: If documented tuberculin skin test results (including millimeters [mm] of induration), or a positive interferon gamma release assay (IGRA) result cannot be verified, perform a Mantoux tuberculin skin test or an IGRA test. Vaccination with live viruses may interfere with tuberculin skin test reactions. For persons scheduled to receive a tuberculin skin test, testing should be done as follows: Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine. At least one month after smallpox vaccination.

4. Collect blood to obtain baseline measurements for the following lab tests:
  - a. AST (SGOT), ALT (SGPT), alkaline phosphatase and bilirubin.
  - b. All individuals will be tested for HIV using the opt-out approach. Consent is inferred unless patient declines testing.
  - c. Hepatitis B and C profile, if indicated (risk groups below):
    - i. Men who have sex with men
    - ii. Individuals diagnosed with a sexually transmitted disease (STD)
    - iii. Illicit drug users (injecting, inhaling, snorting, pill popping)

- iv. Sex contacts or close household members of a person infected with Hepatitis B or C
  - v. Persons born in countries where hepatitis B is common (Asia, Africa, South America, Pacific Islands, Eastern Europe, and the Middle East)
  - vi. Individuals born to parents who have emigrated from countries where hepatitis B is common (see above)
- d. Baseline complete blood count with platelets for patients on the Isoniazid-Rifapentine regimen or rifampin regimen.

**NOTE:** The baseline lab measurements are not mandatory for children less than 16 years of age, unless a complicating medical condition (e.g., HIV, liver disease, renal disease, cardiac disease) or lifestyle is known or suspected.

- 4. Pregnancy test, if indicated.
- 5. Refer patient to have chest x-ray performed in order to detect abnormalities compatible with TB disease. (Radiographic findings of healed, inactive TB and reactivating TB sometimes cannot be distinguished).

## THERAPEUTIC

### PHARMACOLOGIC

Refer to options, dosages and interactions of Isoniazid, Rifampin and Isoniazid/Rifapentine in Tables A – I on pages 6.35 – 6.46

- 1. Order medication for treatment in children and adults from drug stock and send copies of the drug orders to the District Pharmacist/Drug Coordinator.
- 2. Add pyridoxine (Vitamin B<sub>6</sub>) 25-50 mg PO daily for adults on isoniazid, to prevent the development of isoniazid - induced peripheral neuropathy (see TABLE A on page 6.35).

Nurses may dispense all first line TB medications under nurse protocol for LTBI and/or presumptive LTBI treatment. Nurses may also dispense Rifapentine for LTBI treatment when given in conjunction with Isoniazid. Nurses may not dispense any 2<sup>nd</sup> line medications for LTBI treatment. **If 2<sup>nd</sup> line medications are ordered for LTBI treatment, a**

**Pharmacist or Physician can dispense the 2<sup>nd</sup> line TB medications or the prescription may be called in to a pharmacy.**

**NOTE:** DOT is REQUIRED for:

- All children less than 5 years of age being treated for LTBI/presumptive LTBI
- All persons being treated for LTBI/presumptive LTBI who are co-infected with HIV
- All persons being treated for LTBI/presumptive LTBI on an intermittent dosing regimen
- All persons on the combined isoniazid and Rifapentine regimen for LTBI

If financial resources allow, DOT is strongly recommended for:

- Persons infected with LTBI/presumptive LTBI that are at risk for active disease (e.g., close contacts, immunocompromised persons, converters, etc.)
- All children five through fifteen (5 – 15) years of age being treated for LTBI/presumptive LTBI
- Any person being treated for LTBI/presumptive LTBI that has adherence problems

**NOTE:** When using the Isoniazid/Rifapentine regimen, review the CDC guidelines at [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6048a3.htm?s\\_cid=mm6048a3\\_e%0d%0a](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6048a3.htm?s_cid=mm6048a3_e%0d%0a).

## **PATIENT EDUCATION/COUNSELING**

Education/communication should use methods adapted to patient's cultural and linguistic background. Provide education to the patient and his/her family regarding the following:

1. The rationale for treatment of LTBI and the importance of attending regularly scheduled clinic appointments.
2. The difference between "latent TB infection" (LTBI) and "TB disease" and what a "positive skin test" means.

3. The signs and symptoms of TB disease and the need to report immediately if anyone has these symptoms.
4. The symptoms of adverse reactions to isoniazid, rifampin, or isoniazid/Rifapentine including: GI disturbances (anorexia, heartburn, nausea, vomiting, gas, cramps, diarrhea), hepatitis (loss of appetite, persistently dark urine, yellowish skin/sclera, malaise, unexplained fever for three or more days, abdominal tenderness) and peripheral neuropathy (see Table C on page 6.39). Advise the patient to report immediately to the Public Health Nurse or clinician if any such symptoms occur during treatment.
5. The relationship between HIV infection and TB infection and the importance of HIV testing for all TB-infected individuals.
6. The rationale for using an alternative or back-up method of birth control when Rifampin is prescribed (e.g., copper-bearing IUD such as ParaGard, condoms, diaphragm) is the medication reduces effectiveness (degree depending on method) of combined oral contraceptives, progestin-only oral contraceptives, levonorgestrel implants, Depo-Provera, patch and ring. Advise back-up method if condoms are primary method of contraception.
7. The patient's immunization status. Assess and administer vaccines indicated according to the current Advisory Committee on Immunization Practices (ACIP) childhood or adult immunization schedule. See the Georgia Immunization Program Manual, Recommended Schedule and Guidelines, for current ACIP schedules and administration guidelines for each vaccine.
8. If smoker or tobacco user, refer to a local cessation program and/or the Georgia Tobacco Quit Line, 1-877-270-STOP (7867).
9. If substance abuse known or suspected, refer for appropriate counseling.

### **FOLLOW-UP**

1. At least once a month, evaluate the patient following the **TB Program Policy and Procedure Manual, (most recent version)** for:
  - a. Adherence to the prescribed regimen.
  - b. Symptoms of hepatitis (nausea, loss of appetite, vomiting, persistently dark urine, yellowish skin, malaise, unexplained

- elevated temperature for more than three days, abdominal tenderness and/or right upper quadrant tenderness).
- c. Symptoms of neurotoxicity such as paresthesia of hands or feet.
  - d. Maintenance of desirable weight.
  - e. Adverse effects of prescribed regimen.
2. At follow-up visits, ask patients about adherence to therapy.
  3. Provide the HIV test result with post-test counseling and, if the test is positive, appropriately refer for HIV care. Seek confirmation that patient kept referral appointment for HIV care.
  4. All patients on LTBI therapy should be assessed for the presence of symptoms of hepatotoxicity at every encounter. Patients considered at risk of hepatotoxicity should have an AST and ALT done monthly. Those considered at risk include:
    - a. Those with admission of frequent past or any current alcohol use
    - b. Those with admission of past or current IV drug use
    - c. HIV
    - d. Hepatitis B or C
    - e. Pregnancy / postpartum state
  5. Observe for isoniazid-induced peripheral neuropathy during the course of isoniazid therapy. When peripheral neuropathy is present and/or persists, report to the **delegating physician**.
  6. **Pregnant women, particularly African-American and Hispanic women, may be at increased risk for fatal hepatitis associated with isoniazid, according to some reports. This risk may be increased during the postpartum period. These patients should be closely monitored for adverse reactions throughout the course of treatment. The risk of hepatitis from isoniazid in pregnant/post-partum women does NOT preclude treatment of LTBI if these women are at extremely high risk for developing active TB (e.g., close contact, HIV-infected, or with documented recent infection or conversion).**

- 7. Discontinue the Isoniazid, Rifampin or Isoniazid/Rifapentine and immediately consult with the delegating physician if any of the following occur:**
- a. AST/ALT levels equal to or greater than 3 times the upper limit of normal in the presence of symptoms of adverse events.
  - b. AST/ALT levels equal to or greater than 5 times the upper limit of normal in an asymptomatic patient.
  - c. If the patient reports any symptoms of adverse reactions obtain AST/ALT immediately and notify consulting physician.
  - d. Any hospital admissions or deaths due to adverse reactions are to be reported immediately to the State TB Program.
8. Obtain monthly complete blood count with platelets for patients on the Isoniazid-Rifapentine regimen or Rifampin regimen.

**NOTE: Children under the age of 16 receiving LTBI treatment of any regimen is not required to have regular follow-up labs.**

9. At eight to ten (8 – 10) weeks after last exposure, a follow-up TST/IGRA is to be done on contacts on window period prophylaxis
- a. If the follow-up TST/IGRA is positive, treatment is to continue until a full course of LTBI treatment is completed.
  - b. If the follow-up TST/IGRA is negative in a contact who is immunosuppressed including any of the following conditions, then treatment is to continue until a full course of LTBI treatment is completed:
    - i. HIV infection.
    - ii. Prolonged corticosteroid therapy.
    - iii. Persons with organ transplants.
    - iv. Persons on TNF-alpha inhibitors
  - c. If the follow-up TST/IGRA is negative in any other contact, then the window period treatment may be discontinued.
10. At the end of month three (3), identify those patients who are eligible for the Telephone Nurse Monitoring Program (TNMP) according to the procedure in the *Tuberculosis Policy and Procedure Manual, most recent version*.

- a. Discuss the TNMP benefits and enroll interested patients.
  - b. Follow the procedure in the *TB Policy and Procedure Manual, most recent version*.
  - c. Order and issue a 90 day supply of Isoniazid at the clinic visit at the end of month three (3) and at the clinic visit at the end of month six (6).
11. A clinical symptom screen is required for all patients who have a lapse in treatment. A repeat chest x-ray/evaluation is required for patients who are symptomatic or who have had a lapse in therapy for LTBI for two months or more.
  12. Treatment completion is defined by the number of doses taken as well as the duration of treatment. The number of doses required is listed in Tables A and B, pp. 6.35 – 6.38.

### CONSULTATION

Consult with the TB Program medical consultant or **delegating** physician:

1. Regarding any complications of treatment for LTBI with patients placed on Isoniazid, rifampin or Isoniazid/Rifapentine (see Tables A - F on pages 6.32 – 6.40 for drug interactions, drug adverse reactions and drug monitoring).
2. If a patient's HIV test result is positive, or if a patient at risk refuses HIV testing.
3. **To report any abnormal lab test results.**
4. **Consult delegating physician when further medical guidance is needed and TB nursing protocol is not applicable for therapeutic treatment of patient.**

### REFERRAL

1. Refer patients for other medical and social services as needed, particularly alcohol or drug abuse treatment and HIV care.
2. Refer children aged 2 through 11 years of age who are close contacts for whom the Isoniazid and Rifapentine regimen may be considered because it offers practical advantages or because the child is unlikely to complete 9 months of daily Isoniazid.

**Table A: TREATMENT OF LTBI - RECOMMENDED DRUG REGIMENS FOR ADULTS (persons 18 and over)**

Drug	Interval and Duration	Adult Dosage	Criteria for Completion	Comments
Isoniazid	Daily self-adm* for 9 months  Daily DOT for 9 months ♦  Twice-weekly** DOT for 9 months	300 mg PO (5 mg/kg - Maximum Dose 300 mg)  300 mg PO (5 mg/kg - Maximum Dose 300 mg)  900 mg PO (15 mg/kg - Maximum Dose 900 mg)	270 doses within 12 months  190 doses within 12 months  76 doses within 12 months	In HIV-infected patients, isoniazid may be taken concurrently with nucleoside reverse transcriptase inhibitors (NRTIs), protease inhibitors, or non-nucleoside reverse transcriptase inhibitors (NNRTIs).  <i>DOT must be used with twice-weekly dosing.</i>  NOTE: Not recommended for HIV-infected patients.  Consider adding pyridoxine (Vitamin B6) 25 – 50 mg to be given with each dose of isoniazid as a preventive measure against Isoniazid-induced peripheral neuropathy.
Rifampin	Daily self-adm* for 4 months (18 weeks)  Daily DOT for 4 months (18 weeks) ♦	600 mg PO (10 mg/kg - Maximum Dose 600 mg)  600 mg PO (10 mg/kg - Maximum Dose 600 mg)	120 doses within 6 months  90 doses within 6 months	Rifampin therapy may be used for persons who are contacts of patients with isoniazid-resistant, rifampin susceptible TB but may also be chosen for other persons with LTBI.
Isoniazid and Rifapentine	Once weekly by DOT for 12 doses	Isoniazid: 15 mg/kg PO (rounded up to the nearest 50 or 100 mg); 900 mg PO maximum  Rifapentine: 10.0-14.0 kg 300 mg PO 14.1-25.0kg 450 mg PO 25.1-32.0 kg 600 mg PO 32.1-49.9 kg 750 mg PO Equal to or over 50.0 kg 900 mg (maximum dose) PO	11 doses within 16 weeks (doses may be given no more frequently than every 72 hours)	Isoniazid and Rifapentine is recommended as an equal alternative to 9 months of daily self-administered Isoniazid for treating LTBI in otherwise healthy patients aged 12 years and older at high risk for developing active TB: close contacts, recent converters, HIV infected (NOT on antiretrovirals) and those with old healed TB on chest x-ray.  Isoniazid and Rifapentine can also be used in situations where it offers practical advantages or for individuals unlikely to complete 9 months of daily isoniazid. Isoniazid and Rifapentine is NOT recommended for the following patients: children age less than 2 years; HIV infected persons receiving antiretroviral treatment; pregnant women or women expecting to become pregnant during treatment; and patients who have LTBI with presumed isoniazid or rifampin resistance.

\*Daily self-administered = 7 days/week

\*\*Twice-weekly doses should optimally be given at least two days apart, unless given to “catch up” on a missed dose. A dose given two consecutive days is discouraged.

◆ Daily DOT = 5 days/week (Monday through Friday)

**NOTE:** One month is 4.3 week

**NOTE:** Formula used to convert pounds to kilograms: Divide pounds by 2.2 to get kilograms. *Example: Patient weighs 154 pounds  $\div$  2.2 = 70 kilograms.*

**NOTE:** Isoniazid is available in 100 and 300 mg tablets (both are scored for dividing in half ( $\frac{1}{2}$ )). Rifapentine is available in 150 mg tablets only.

**NOTE:** Consider adding pyridoxine (Vitamin B6) 25 – 50 mg to be given with each dose of isoniazid as a preventive measure against Isoniazid-induced peripheral neuropathy.

Table B: TREATMENT OF LTBI - RECOMMENDED DRUG REGIMENS FOR CHILDREN (from birth through 17 years)

Drug	Interval and Duration	Pediatric Dosage*	Criteria for Completion	Comments
Isoniazid	Daily self-adm* for 9 months (39 weeks)	10-15 mg/kg PO (Maximum Dose 300mg)	270 doses within 12 months	Isoniazid for 9 months is the preferred regimen children under 18.  DOT must be used with twice-weekly dosing.  NOTE: Not recommended for HIV-infected patients.
	Daily DOT ♦ for 9 months (39 weeks)	10-15 mg/kg PO (Maximum Dose 300mg)	190 doses within 12 months	
	Twice-Weekly DOT** for 9 months (39 weeks)	20-30 mg/kg PO (Maximum Dose 900mg)	76 doses within 12 months	
Rifampin	Daily self-adm* for 6 months (26 weeks)	10-20 mg/kg PO (Maximum Dose 600mg)	180 doses within 9 months	Rifampin therapy may be used for persons who are contacts of patients with isoniazid-resistant, rifampin susceptible TB but may also be chosen for other persons with LTBI.
	Daily DOT ♦ for 6 months (26 weeks)	10-20 mg/kg PO (Maximum Dose 600mg)	130 doses within 9 months	
Isoniazid and Rifapentine	Once weekly by DOT for 12 doses	Isoniazid: 15 mg/kg PO rounded up to the nearest 50 or 100 mg; 900 mg PO maximum  Rifapentine: 10.0-14.0 kg 300 mg PO 14.1-25.0kg 450 mg PO 25.1-32.0 kg 600 mg PO 32.1-49.9 kg 750 mg PO Equal to or over 50.0 kg 900 mg (Maximum dose) PO	11 doses within 16 weeks (doses may be given no more frequently than every 72 hours)	Isoniazid and Rifapentine is recommended as an equal alternative to 9 months of daily self-administered isoniazid for treating LTBI in otherwise healthy patients aged 12 years and older at high risk for developing active TB: close contacts, recent converters, HIV infected (NOT on antiretrovirals) and those with old healed TB on chest x-ray.  Refer to the contract physician children aged 2 through 11 years of age who are close contacts for whom the Isoniazid and Rifapentine regimen may be considered because it offers practical advantages or because the child is unlikely to complete 9 mo. of daily Isoniazid.  Isoniazid and Rifapentine is NOT recommended for the following patients: children age less than 2 years; HIV infected persons receiving antiretroviral treatment; pregnant women or women expecting to become pregnant during treatment; and patients who have LTBI with presumed Isoniazid or rifampin resistance.

\*Daily self-administrated (adm) = 7 days/week

\*\*Twice-weekly doses should optimally be given at least two days apart, unless given to “catch up” on a missed dose. A dose given two consecutive days is discouraged. ♦

Daily DOPT = 5 days/week (Monday through Friday).

NOTE: One month is 4.3 weeks.

NOTE: Formula used to convert pounds to kilograms: Divide pounds by 2.2 to get kilograms. *Example: Patient weighs 154 pounds  $\div$  2.2 = 70 kilograms.*

**NOTE:** Directly Observed Therapy (DOT) is REQUIRED for all patients less than 5 years of age, patients on ANY intermittent dosing regimen (including the combined isoniazid and Rifapentine regimen). Directly Observed Therapy (DOT) is recommended for all children up to the age of 15 years.

**NOTE:** Isoniazid is available in 100 and 300 mg tablets (both are scored for dividing in half ( $\frac{1}{2}$ )). Rifapentine is available in 150 mg tablets only.

**Table C: TREATMENT OF LTBI - DRUG ADVERSE REACTIONS AND MONITORING**

Drug	Adverse Reactions	Monitoring	Comments
Isoniazid	Gastrointestinal (GI) upset, hepatic enzyme elevations, hepatitis, peripheral neuropathy, mild effects on central nervous system, drug interactions	Baseline measurements of AST for adults.  Repeat measurements: – if baseline results are abnormal – if patient is at high-risk for adverse reactions – if patient has symptoms of adverse reactions	Hepatitis risk increases with age and alcohol consumption.  Pyridoxine can prevent isoniazid-induced peripheral neuropathy.
Rifampin and Rifapentine	Orange discoloration of body fluids (secretions, tears, urine), GI upset, drug interactions, hepatitis, thrombocytopenia, rash, fever, Influenza-like symptoms, hypersensitivity reaction*	Complete blood count, platelets and liver function tests.  Repeat measurements if: – baseline results are abnormal – patient has symptoms of adverse reactions	Hepatitis risk increases with age and alcohol consumption.

\* Hypersensitivity reaction to Rifamycins (rifampin or Rifapentine):

Hypersensitivity reactions may include a flu like syndrome (e.g. fever, chills, headaches, dizziness, and musculoskeletal pain), thrombocytopenia, shortness of breath or other signs and symptoms including wheezing, acute bronchospasm, urticaria, petechiae, purpura, pruritus, conjunctivitis, angioedema, hypotension or shock.

- If moderate to severe reaction (e.g., thrombocytopenia, hypotension), hospitalization or life-threatening event:  
Discontinue treatment
- If mild reaction (e.g., rash, dizziness, fever):  
Continue to monitor patient closely with a low threshold for discontinuing treatment

**Table D: TREATMENT OF LTBI - DRUG INTERACTIONS (Format 1)**

DRUG INTERACTIONS – RIFAMYCINS (Rifampin, Rifapentine\*)

\* Rifapentine has interactions similar to rifampin. It induces cytochromes P4503A4 and P4502C8/9 (less than rifampin)

Drug A	Rifampin Effects on Drug A
Anticoagulants (warfarin, coumadin)	↓ serum concentration
Cardiac glycosides (digoxin)	↓ serum concentration
Sulfonylureas (e.g. glipizide, glyburide, glimepiride)	↓ serum concentration
Thiazolidinediones (e.g. rosiglitazone, pioglitazone)	↓ serum concentration
Oral contraceptives, contraceptive implants, patch, ring, medroxyprogesterone injection	↓ serum concentration
Fluconazole, Voriconazole, Itraconazole	↓ serum concentration
Corticosteroids	↓ serum concentration
Narcotics/analgesics (methadone)	↓ serum concentration
Atovaquone (mepron)	↓ serum concentration
Dapsone	↓ serum concentration
Cyclosporine	↓ serum concentration
Quinidine	↓ serum concentration
Protease inhibitors	↓ serum concentration
Lamotrigine (lamictal)	↓ serum concentration
Phenytoin (dilantin)	↓ serum concentration
Valproic acid and derivatives (depakene, depakote)	↓ serum concentration
Buspirone (buspar)	↓ serum concentration
Thyroid hormone replacement	↓ serum concentration

DRUG INTERACTIONS – ISONIAZID

Drug A	Isoniazid Effects on Drug A
Diazepam (Valium)	↓ serum concentration
Phenytoin (Dilantin)	↑ serum concentration    ↑ toxicity
Carbamazepine (tegretol)	↑ serum concentration    ↑ toxicity
Citalopram (Celexa)	↑ serum concentration    ↑ toxicity

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**Table E: TREATMENT OF LTBI - DRUG INTERACTIONS (Format 2)**

DRUG INTERACTIONS – RIFAMPIN/RIFAPENTINE

Rifampin or Rifapentine plus...	
Adefovir	Increases risk of side effects.
Amprenavir	Should not be used together.* Significantly decreases amprenavir levels in blood.
Anticoagulants	May decrease effectiveness of anticoagulants.
Atovaquone	Decreases atovaquone levels by 50% in blood.
AZT	May decrease AZT levels in blood.
Barbiturates	May decrease effectiveness of barbiturates.
Clarithromycin	Decreases clarithromycin levels by 120% in blood.
Corticosteroids	May decrease corticosteroid levels in blood.
Cyclosporine	May decrease cyclosporine levels in blood.
Dapsone	Decreases dapsone levels by 7- to 10-fold in blood.
Delavirdine	Should be taken together otherwise delavirdine levels in blood significantly decreased.
Diazepam	May decrease effectiveness of diazepam.
Digitalis	May decrease effectiveness of digitalis.
Disopyramide	May decrease effectiveness of disopyramide.
Efavirenz	Decreases efavirenz levels by 26% in blood.
Estrogen	May decrease effectiveness of estrogen.
Ethinyl Estradiol (birth control pills)	May decrease ethinyl estradiol levels in blood.
Fluconazole	Decreases fluconazole levels by 23% in blood.
Halothane	May increase risk of liver toxicity.
Indinavir	May increase rifampin levels in blood. Should not be used together.*
Isoniazid	May increase risk of liver toxicity.
Itraconazole	May decrease itraconazole levels in blood.
Lopinavir/ritonavir	Decreases lopinavir levels by 75% in blood. Should not be used together.
Methadone	May decrease effectiveness of methadone.
Mexilitine	May decrease effectiveness of mexilitine.
Nelfinavir	Decreases nelfinavir levels by 82% in blood. Should not be used together.*
Nevirapine	May affect rifampin and/or nevirapine levels in blood.
Probenecid	Increases rifampin levels in blood.
Progesterone	May decrease effectiveness of progesterone.
Quinidine	May decrease quinidine levels in blood.
Ritonavir	Decreases ritonavir levels by 35% in blood.

Rifampin or Rifapentine plus...	
Theophylline	May decrease theophylline levels in blood.
Verapamil	May decrease effectiveness of verapamil.
Voriconazole	May decrease voriconazole levels in blood.

\* The information on interactions with rifampin and HIV antiretroviral therapy (ART) is constantly changing. Consult with the consulting physician/contract physician. In general, only certain HIV medications can be used and rifampin may be replaced by rifabutin. Rifabutin is in the formulary at the state pharmacy.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**Table F: DRUG INTERACTIONS – ISONIAZID**

Isoniazid plus...	
Alcohol	May increase risk of isoniazid associated hepatitis.
Antacids	Should be taken two hours apart otherwise isoniazid will have no effect.
Carbamazepine	Decreases carbamazepine metabolism.
Cycloserine	May increase risk of central nervous system toxicity.
Ethionamide	May increase risk of encephalopathy (dysfunction of the brain) and may increase isoniazid levels in blood.
Phenytoin	Decreases phenytoin metabolism.

**NOTE:** Refer to current drug reference or drug package insert for a complete list of adverse drug reactions and drug interactions.

**Table G: PEDIATRIC DOSAGE - ISONIAZID IN CHILDREN AND ADOLESCENTS**

DAILY DOSAGE OF ISONIAZID IN CHILDREN AND ADOLESCENTS

Child's Weight in lbs.	Child's Weight in kg	Daily Dose (mg) 10-15 mg/kg
6 – 14	3 – 6	50
14.5 – 21	6.5 – 9.5	100
22 – 29	10 – 13	150
30 – 35	13.5 – 16	200
36 – 43	16.5 – 19.5	250
44 +	20 +	300

TWICE-WEEKLY DOSAGE OF ISONIAZID IN CHILDREN AND ADOLESCENTS

Child's Weight in lbs.	Child's Weight in kg	Twice-weekly Dose (mg) 20-30 mg/kg
6.5 – 10	3 – 4.5	100 mg PO
11 – 14	5.0 – 6.0	150 mg PO
14.5 – 18	6.5 – 8.0	200 mg PO
18.5 – 21.5	8.5 – 9.5	250 mg PO
22 – 24	10.0 – 11	300 mg PO
25 – 29	11.5 – 13	350 mg PO
29.5 – 32	13.5 – 14.5	400 mg PO
33 – 35	15 – 16	450 mg PO
36 – 40	16.5 – 18.	500 mg PO
40.5 – 43	18.5 – 19.5	550 mg PO
44 – 48	20 – 21.5	600 mg PO
48.5 – 51	22 – 23	650 mg PO
52 – 54.5	23.5 – 24.5	700 mg PO
55 – 57.5	25 – 26	750 mg PO
58 – 62	26.5 – 28	800 mg PO
62.5 – 65	28.5 – 29.5	850 mg PO
66 +	30 +	900 mg PO

**NOTE:** Isoniazid Syrup should not be refrigerated (keep at room temperature). Isoniazid tablets are scored and also can be crushed for oral administration.

**Table H: PEDIATRIC DOSAGES - RIFAMPIN IN CHILDREN AND ADOLESCENTS**

DAILY DOSAGE OF RIFAMPIN IN CHILDREN AND ADOLESCENTS

Child's Weight in lbs.	Child's Weight in kg	Daily Dose (mg) 10-20 mg/kg
15 – 32	7 – 14.5	150
33 – 48.5	15 - 22	300
49 – 65	22.5 – 29.5	450
66 +	30 +	600

**Table I: ISONIAZID and RIFAPENTINE DOSE AMOUNTS for PATIENTS (children and adults) prescribed weekly INH/Rifapentine for Treatment of Latent TB Infection**

Patient's Weight in lbs.	Patient's Weight in kg	Isoniazid Weekly dose (mg) 15 mg/kg	Rifapentine Weekly dose (mg) 20 mg/kg
22 – 29.3	10 – 13.3	200	300
29.4 – 30.9	13.4 – 14.0	250	300
31.0 – 36.6	14.1 – 16.6	250	450
36.7 – 44.0	16.7 – 20.0	300	450
44.1 – 51.4	20.1 – 23.3	350	450
51.5 – 55.0	23.4 – 25.0	400	450
55.1 – 58.8	25.1 – 26.7	400	600
58.9 – 66.0	26.8 - 30	450	600
66.1 – 70.5	30.1 – 32.0	500	600
70.6 – 73.3	32.1 – 33.3	500	750
73.4 – 80.9	33.4 – 36.7	550	750
81.0 – 88.0	36.8 - 40	600	750
88.1 – 95.5	40.1 – 43.3	650	750
95.6 – 102.9	43.4 – 46.7	700	750
103.0 – 110.0	46.8 – 49.9	750	750
110.1 – 117.4	50 – 53.3	800	900
117.5 – 124.9	53.4 – 56.7	850	900
125+	56.8+	900	900

**NOTE:** Isoniazid is available in 100 and 300 mg tablets (both are scored for dividing in half (½)). Rifapentine is available in 150 mg tablets only. This means a patient of average weight (125 lbs. or more) will need to take 3 tablets of Isoniazid and 6 tablets of Rifapentine. Patients need to be aware of the pill burden when offered this regimen.

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