BC Centre for Disease Control
Provincial Health Services Authority

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Date: **October 24, 2023** **Administrative Circular: 2023:28**

Attn: Medical Health Officers and Branch Offices
Public Health Nursing Administrators and Assistant Administrators
Holders of Communicable Disease Control Manuals

Re: **Update to the Communicable Disease Control Manual – Chapter 4: Tuberculosis (TB)**

CDC Manual-Chapter 4: Tuberculosis

If printing, please replace the following Sections/Appendices with new documents dated October 2023.

- Section 1: Introduction
- Section 2: Definitions
- Section 3: Tuberculosis
- Section 4(a): TB Screening Overview
- Section 4(b): TB Screening DST
- Section 6: TB Preventive Treatment
- Appendix A: Tuberculin Skin Testing Procedure
- Appendix C: Collection of Specimens for TB Testing
- Appendix G: Resources For Health Care Providers

Overview of Changes:

The manual was updated to reflect current and evidence-informed best practices clearly, consistently and concisely.

Updates to all Sections and Appendices

- Practice recommendations in alignment with the Canadian TB Standards, 8th edition (CTBS)
- TB terminology is inconsistent in the literature. In alignment with the CTBS the use of the updated terminology TB disease (formerly active TB disease), TB infection (formerly latent TB infection) and TB preventive treatment (formerly LTBI treatment) are used throughout the updated sections.
- Person-first language and use of words or terms that reduce TB stigma and promote empathy

NOTE: Content related to immigration screening, de-isolation recommendations, and treatment of TB disease, outlined in the CTBS, are under review.

Section 1: Introduction

- Updated information about the next steps for the BC TB Strategic Plan

Section 2: Definitions

- Updated to align with the TB Screening Form and the CTBS glossary
- High TB incidence country defined as 50 per 100,000 persons or higher; use WHO country profile list to support practice
- Definition of extensively drug-resistant TB (XDR-TB) was updated to align with the WHO January 2021 revision
- Included reference list.

Section 3: Tuberculosis

- Updated information on Non Tuberculous Mycobacteria (NTM) resources
- Aligned Table 3.2 Risk factors for the development of active TB with CTBS
- Updated the global, national, and provincial TB data

Section 4(a): TB Screening Overview

- **NEW** – Title of section (previously TB Screening and Testing)
- **NEW** – Section describing considerations for key populations offered TB screening and testing
- **REMOVED** – TB screening flowchart. Refer to Population-Based TB Screening Tables instead.
- **REMOVED** – Section 4.5 Guidelines for Ongoing TB Screening of Clients with HIV Infection. Refer to Section 4(b) TB DST instead.
- Clarity on TB screening risk assessment and when somebody may not need a TST or CXR
- Included resources for TST and IGRA interpretation and links to IGRA guidelines
- Streamlined CXR content
- Updated definition of lab confirmation of TB disease and lab flowcharts and timelines
- Updated Immigration, Refugees and Citizenship Canada (IRCC) medical surveillance process

Section 4(b): TB Screening DST

- **NEW** sections – Practice Update, Focus, Practice Level, Applicability, Key Points, HCP Resources
- **NEW** – 14 Practice Statements highlighting clinical pearls
- **NEW** – Table 14 is organized into Pre and Post-Test discussions

General Practice Changes:

- HIV testing – recommend offering an HIV test at the same time as the IGRA test
- Table 4 – A TST of 5mm is considered positive for clients:
  - Prior to organ transplant and receipt of immunosuppressive treatment
  - Prior to receipt of biologic drugs
  - Prior to receipt of steroid treatments (15 mg or more per day for 1 month or longer)
- Table 6 – Recommendation that CXR within the past 6 months for immune-compromised, excluding Person living with HIV (PLWH) is valid if the client is asymptomatic
- Window period prophylaxis is recommended to include contacts 5 years old or younger and people living with untreated HIV.

Improved content on:

- The importance of a communication plan if placing a client in the community in isolation
- Clinical decision-making when testing for TB infection. Refer to the “Approach to TB skin testing” framework.

Section 4(b): TB Screening DST continued…

- A complete referral to Provincial TB Services (TBS)
- The impact of colonization on the health and well-being of Indigenous people
- Risk factors for TB exposure and TB infection and Risk factors for developing TB disease if infected with TB. Refer to Tables 1 and 2.
- The timing of TB testing related to post-exposure, illness, dual testing, immune suppression, vaccination and COVID-19 information. Refer to Table 5.
- Sputum collection – Practitioner Alert on when STAT sputum is indicated
    - A **NEW** section on sputum collection practices

UPDATED – Population-Based TB Screening Tables & Figures

- Renamed and changed the order of tables, incorporated content on how prior TB testing and treatment impact screening
- **NEW** – Table 7a: TB Screening for work, school or volunteers with no TB testing or treatment history
- **NEW** – Table 7b: TB Screening for work, school or volunteers with TB testing or treatment history
- Table 8: TB Screening for Clients with Medical Risk Factors
    - Includes both transplant recipients and donors; delineates different immune suppression treatments and/or conditions
- Table 9: TB Screening for Clients Entering Congregate Settings
    - Includes practice statement and updates to reflect that TST testing should not delay or otherwise impact admission into congregate settings since ruling out active TB disease is the primary objective
- Table 10: TB Screening for People Living with HIV
    - Content combined into one table and aligned with the CTBS and the BC Centre of Excellence in HIV/AIDS primary care guidelines. The table outlines TB screening at baseline, upon exposure, or if PLWH has TB symptoms.
    - **NEW** - Routine annual TB screening is not recommended
- Figure 1: Management of clients when there is a high degree of clinical evidence for active TB disease clarified what is a “high degree of clinical evidence”
- Table 11: TB screening for contacts to active TB within the past 2 years
    - Guidance that the priority in transient or marginalized populations is ruling out active TB. For a contact with a history of TB treatment (either TB Preventive Treatment (TPT) or active), they only need CXR at 8 weeks (not at initial assessment)
    - **NEW** – footnote on children under 5 as high-priority regardless of the nature of the contact. If a child under 5 presents at greater than 8 weeks after the exposure, a CXR is required, regardless of the TST result.
- Table 12: Immigration Medical Surveillance Screening now in table format and revised content on focused nursing assessment

Section 6: Treatment of TB Infection

- **NEW** – Title of section and tables revised to reflect new terminology (TB Infection and TB Preventive Treatment). As a new term, TB infection more accurately reflects the importance of testing and treating TB infection.
- Aligned list of people at higher risk for progression to active TB
- **NEW** – Section 6.8 Blood Testing with CBC monitoring and guidance content, including a new Table 6-4: CBC Grading Severity and Management Guideline
- **NEW** – Table 6-8 Potential advantages and disadvantages of providing DOPT
- **NEW** – Sections 6.14.2, 6.14.3 and 6.14.4 content on select populations

Section 6: Treatment of TB Infection continued…

Practice Change:

- The first-line regimens for TPT include 4 months of rifampin or isoniazid and rifapentine once weekly for 12 weeks. Isoniazid daily for 9 months is now an alternate regimen.
- Routine blood work at the end of TPT is not necessary unless requested by TBS.

Improved content on:

- Figure 6-1 – Flowchart for initiation of TPT includes details such as allergies, prescription and over-the-counter meds; baseline blood work should include AST, bilirubin and CBC & updated footnotes
- Table 6-2 – Summary of drugs and dosing for TPT regimens includes updated footnotes on rifapentine, rifabutin and guidance on administering crushed rifapentine
- Table 6-3 – Added content that rifamycins may discolour sputum and teeth
- Table 6-6 – Emphasized assessment of flu-like symptoms at weeks 3 and 4 for clients on isoniazid-rifapentine since if this side effect occurs, it's most likely at this point in treatment

Appendices

Appendix A

- Update and reorganization of existing content.
- **NEW** sections – Common Expected Reactions; Informed Consent section; Client Education and After Care

Improved content on:

- Adverse Reactions and Reporting section
- Limitations to TST – more clarity on BCG implications
- Table A-1 – Potential causes of false-negative and false-positive TSTs
- Preparation of Tubersol – do not preload syringes; use an aseptic technique
- Administering the TST – content on accidental subcutaneous or IM injection
- Practitioner Alert that self-reading, virtual reading and self-reporting are not acceptable for TST results
- Reading the TST – added content on documentation of TST result

Appendix C

- Reorganized section and included TB testing consultation contact information
- Added content on collection requirements of gastric lavages and body fluids that are bloody

Appendix G

- Updated content
- **NEW** – TB Stories, Cultural Safety & Humility sections

If you have questions about this manual update, please contact TB Services Provincial Nurse Educators, Maria MacDougall, RN(c), MSc(A)N, BSc (maria.macdougall@bccdc.ca) and Jessica Harper, RN, BScN (jessica.harper2@bccdc.ca).

If you have any concerns, please contact Anna Ryan, RN, MSN, BScN, TB Services Senior Practice Lead (anna.ryan@bccdc.ca).

Sincerely,

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Chief Medical Officer & Deputy Provincial Health Officer
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