

 INFECTION PREVENTION IN LONG TERM CARE

Tuberculosis

Massachusetts Department of Public Health

**DISEASE OVERVIEW**

Tuberculosis (TB) is caused by bacteria (tubercle bacilli) that make up the *Mycobacterium tuberculosis* complex. Other mycobacteria occasionally produce disease clinically indistinguishable from tuberculosis. *M. tuberculosis* causes most TB in the United States.

Tuberculosis exists on a continuum between latent infection and active disease.

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| Latent TB Infection | Latent TB infection (LTBI) involves a small number of TB bacteria living in the body in a suppressed metabolic state and successfully contained by the host’s immune system without causing illness. The only manifestation of latent TB infection is a positive tuberculin skin test reaction or interferon gamma release assay (IGRA); the chest radiograph is normal or shows lesions reflecting this contained infection. People with latent TB infection do not feel sick and have no symptoms. They are not infectious and therefore cannot spread the infection to others. However, individuals with latent TB infection remain at risk of developing active TB disease throughout their lifetime if immune containment breaks down. In the United States, 80% of active TB cases are a result of untreated latent TB infection. |
| TB Disease | Active TB is an infectious disease that occurs when latent TB organisms overcome immune containment and begin to multiply. TB can affect any part of the body, but usually affects the lungs (where it is called pulmonary TB). Systemic symptoms of TB disease include fever, fatigue, weight loss, and night sweats. Signs and symptoms specific to pulmonary TB include cough (often progressing from nonproductive to productive); in more advanced stages, blood-tinged sputum (hemoptysis); and an abnormal chest radiograph, ranging from infiltrates/ opacities to open cavities as the disease progresses untreated. These radiographic changes are not specific for TB and may be confused for pneumonia caused by other organisms. Symptoms and signs of extra-pulmonary TB (TB outside the lungs) may include fevers, weight loss, malaise, as well as symptoms related to the specific organ or tissue involved. However, symptoms need not be present, or the patient may deny or fail to recognize symptoms and still be ill with TB. Demonstration of acid-fast bacilli (AFB) in stained smears from sputum or other bodily fluids or tissues makes a presumptive diagnosis of TB and usually warrants initiation of treatment. Definitive diagnosis is based on positive cultures for *M. tuberculosis* complex organisms or, for sputum, a positive nucleic acid amplification test (PCR).  |

**Modes of Transmission**

Tuberculosis is transmitted person-to-person through the air by droplet nuclei (small particles 1–5 micrometers in size), generated by persons with infectious TB. Droplet nuclei are produced when persons with pulmonary or laryngeal TB cough, sneeze, speak, or sing. Droplet nuclei may also be produced by procedures such as sputum induction, bronchoscopy, suctioning, or vigorous wound irrigation that produce aerosols. Except for rare circumstances, persons with TB disease that is entirely outside the lungs or airways (extrapulmonary) are not infectious. Infection occurs when persons have prolonged or repeated close exposure to an infectious person, with shared air space, and they inhale the organisms.

**INFECTION CONTROL AND PREVENTION**

###### **Employees/Health Care Personnel:**

Health care personnel (HCP) screening for latent tuberculosis infection (LTBI or latent TB infection), follow-up medical evaluations, and chest X-rays are performed according to federal Occupational Safety and Health Administration (OSHA) regulations. In 2019, updated guidance was published: [Tuberculosis screening, testing, and treatment of U.S. health-care personnel](https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm): Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. These recommendations update the screening and testing recommendations in the [2005 guidelines for preventing the transmission of TB in health care settings](https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e). The changes reflect the overall decrease of TB cases and the low incidence of TB among HCP in the U.S. due to occupational exposure. There are no changes to the 2005 guidelines regarding facility risk assessments and infection control practices.

**The Massachusetts Department of Public Health (MDPH) recommendations are in alignment with the 2019 NTCA/CDC guidance:**

1. Screen HCP for TB using an individual [TB risk assessment](https://www.mass.gov/lists/tuberculosis-information-for-health-care-providers-and-public-health#tb-risk-assessment-) and symptom evaluation at baseline (preplacement/preemployment).
2. Test HCP without documented prior TB disease or latent TB infection (LTBI) using an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST). For HCP with a positive test who are asymptomatic, unlikely to be infected with *M. tuberculosis*, and at low risk for progression based on their risk assessment, perform a second test (either an IGRA or a TST). Interpret the result as *M.tuberculosis* infection only if both tests are positive.
3. If TST is used *and* the person has not had a TST within 12 months *and* the baseline TST is negative, repeat the test in 1-2 weeks to account for faded immune memory if not exposed to TB antigens recently. Record the result of the second test as the baseline test result.
4. For most HCP, routine serial TB testing at any interval after baseline in the absence of a known exposure or ongoing transmission is not recommended.
5. Encourage treatment for all HCP with untreated LTBI, unless treatment is contraindicated, and support individuals through treatment.
6. Conduct an annual symptom and risk screening for HCP with LTBI, regardless of prior treatment; review benefits of treatment.
7. Provide annual TB education for all HCP including review of non-occupational health exposure risks.

Central to the updated HCP recommendation is that the **routine**practice of annual testing of HCP is no longer recommended for most HCP.  Annual/periodic testing may be considered for those HCP at risk for occupational exposure (e.g., pulmonary physicians, respiratory therapists, emergency department staff, TB clinic staff). For those HCP who will have annual testing, TST is preferred due to high rates of false conversions/reversions with serial IGRA. Review of experience of unexpected test conversions over the past 3-5 years of annual testing may indicate if risk for a specific group or facility area warrants serial testing. Additional resources are listed at the end of this document.

Data on tuberculosis cases in Massachusetts are posted on the MDPH website at <https://www.mass.gov/lists/tuberculosis-data-and-statistics>.

For assistance in determining the risk level for your facility, contact the MDPH Tuberculosis Program at 617-983-6970.

###### **Residents:**

**Rationale:** Many older persons were infected with *Mycobacterium tuberculosis* (TB) earlier in life, either in the U.S. when TB was more prevalent or in their country of origin. This population constitutes a large repository of latent TB infection.

In long term care (LTC) facilities, where residents spend prolonged periods sharing the same air, the potential for TB transmission is high if a person (resident or staff) has unsuspected/untreated pulmonary tuberculosis. Facilities need to establish **baseline** presence of latent TB infection in new residents by means of the tuberculin skin test (TST) or a gamma-interferon release assay (IGRA, e.g., T-Spot.TB [Oxford Immunotech] or QuantiFERON TB Gold in-tube [Qiagen]). Subsequent TB testing of residents with negative baseline tests is only necessary as a response to known or suspected exposure to active TB and should be performed using the same test that was used to establish baseline status. Persons with a confirmed baseline-positive test should not be re-tested.

Assessment and TB Testing of New Residents:

1. **Assess new residents for signs and symptoms of TB**, such as a cough of three or more weeks’ duration, unexplained weight loss, or unexplained fever. If signs or symptoms are present, promptly refer for a medical evaluation and chest X-ray.
2. **Routine baseline chest X-rays on admission are not required or recommended.**
3. **Test all new residents as soon as possible after admission, unless there is documentation of a previous positive TB test** (TST reaction of 10 mm or greater, or positive IGRA).

***Note on residents with previous positive TB test***: Persons with a documented previous positive TST or IGRA should not undergo repeat testing unless that test result is in question. A positive test should have been followed by a clinical evaluation for active TB that included a chest radiograph. Results of that evaluation should be acquired by the facility and be included in the patient’s record.

If documentation of this evaluation cannot be obtained, a clinical evaluation with a chest radiograph should be performed. In the absence of symptoms, this can be delayed up to one week following admission.

***Notes on testing by TST***:

* The standard test method for the TST (Mantoux test) is intradermal administration of 5 tuberculin units of purified protein derivative (PPD).
* If an initial TST result is negative, a two-step TST procedure may be required to “boost” a potential reaction that has waned over time in order to establish a reliable baseline (see above). If a recent (within the past year) negative TST result is documented, a single-step test is acceptable. (see <https://www.mass.gov/service-details/booster-or-recall-effect-and-two-stage-tuberculin-skin-testing>
* The TST is administered and read by a trained person and recorded in mm of induration (actual swelling, not redness alone) in the resident’s medical chart. Absence of induration is recorded as 0 mm.
* If the initial TST is positive and the patient does not accept the result, an IGRA may be considered. However, for the medical record, the person should be considered TB infected and evaluated with chest X-ray and examination regardless of the IGRA result.
1. **Evaluate residents with positive TB test results**. All residents with reactions of 10 mm or greater (5mm if recent contact, immune suppressed eg HIV, or chest radiograph consistent with prior TB), using the two-step method where applicable, or a new positive IGRA, must have a chest X-ray and medical evaluation. (See *Medical Evaluation and Chest X-ray after positive TB test* section below.)
2. **Document and prominently display the resident’s latent TB infection status** in the medical record. Latent TB infection is reportable to MDPH, per regulation. Case reporting forms are available at <https://www.mass.gov/how-to/report-a-case-of-tuberculosis-disease-or-latent-tb-infection>
3. **All residents with latent TB infection should be considered and evaluated for treatment to prevent active disease if not treated previously.** Information on treatment of latent TB infection may be found at https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm

**Repeat TST or IGRA testing after an initial negative test only in the following circumstances:**

1. An exposure to an active case of tuberculosis.
2. As a diagnostic aid when a resident is suspected of having active TB.
3. When the long-term care facility has evidence of ongoing TB transmission within the facility.
4. Prior to a resident’s initiating treatment with tumor necrosis factor-alpha (TNF-α) antagonists or other biologics that cause immunosuppression. In such cases, additional testing with multiple test platforms may be needed to help exclude latent TB infection.
5. Extended recent travel to a TB endemic area.

**Medical Evaluation and Chest X-ray after positive TB test:**

1. Any asymptomatic resident with a new positive TST or IGRA must have a medical evaluation and chest X-ray within one week.
2. For a resident with symptoms of pulmonary TB and an abnormal chest X-ray consistent with TB disease, evaluation should be done as soon as possible with the patient placed into airborne infection isolation. This usually will require hospital admission. The medical evaluation should include three (3) sputum specimens for acid fast smear and culture, collected at least 8 hours apart, with at least one collected in early morning. At least one specimen should be sent for nucleic acid amplification (NAA) testing.
3. Screen residents with active tuberculosis disease, or latent TB infection, for HIV infection. Medical management of TB disease, or latent TB infection, may be altered in the presence of HIV infection.
4. Once active TB disease is ruled out, consider the resident for treatment of latent TB infection according to current guidelines from the American Thoracic Society (ATS) and Centers for Disease Control and Prevention (CDC).
5. **Periodic chest X-rays of persons with a history of positive TST or IGRA are not advised and are not necessary unless the individual develops signs and symptoms of tuberculosis disease or has had close exposure to an infectious case and is immune compromised.**
6. Follow-up of residents with new positive TST/IGRA after repeat testing:

All residents with a new positive TST or IGRA need a medical evaluation, a chest X-ray, and consideration for treatment of their latent TB infection once active TB disease is ruled out. Residents who convert their skin test (defined as >10 mm induration increase within a two-year period) or have a new positive IGRA following contact to an active case are at highest risk of developing active tuberculosis and should be offered treatment for latent TB infection, unless medically contraindicated.

**Admission of residents with suspected or confirmed tuberculosis pulmonary tuberculosis into a LTC facility with no ability to provide airborne infection isolation (AII)**

1. Residents with ***suspected*** pulmonary or upper respiratory tract TB, as evidenced by clinical evaluation and an abnormal chest radiograph consistent with TB, can be admitted to the LTC facility, if TB is not highly suspected clinically and the patient is not infectious. Criteria used to determine non-infectiousness can be similar to those used to release a hospitalized TB suspect from AII. These include either:
* Three (3) AFB smear-negative sputum specimens collected at least 8 hours apart, with at least one collected in early morning, and low clinical suspicion for infectious TB, or
* Two (2) GeneXpert MTB-Rif® negative sputum specimens collected at least 8 hours apart, with at least one collected in early morning, and low clinical suspicion for infectious TB. (*For the consensus statement on the use of Cepheid Xpert MTB/RIF®assay in making decisions to discontinue airborne infection isolation in healthcare settings*; 2016. See <http://www.tbcontrollers.org/docs/resources/NTCA_APHL_GeneXpert_Consensus_Statement_Final.pdf>
1. Residents with a ***confirmed diagnosis*** of pulmonary or upper respiratory tract TB who are receiving multi-drug anti-tuberculosis therapy can be admitted, if not infectious. Criteria that may be used to determine non-infectiousness in this instance include:
* Receiving an appropriate treatment regimen,
* Clinical and radiographic improvement, and
* Declining numbers of acid-fast bacteria (AFB) reported in quantitative sputum smears from serial specimens obtained following treatment initiation, if initially AFB-smear-positive.
1. Residents diagnosed with extra-pulmonary tuberculosis with no lung or airway involvement are not infectious and can be admitted.

**Treatment Monitoring:**

1. Licensed staff, trained to monitor for signs and symptoms of drug toxicity, should administer treatment for active TB disease or latent TB infection. Doses of TB medications should be witnessed and documented. Patients should be questioned about adverse effects of medications prior to each dose and, if signs or symptoms of drug toxicity are noted, or if TB symptoms are worsening, the next dose should be held until cleared by the prescribing clinician.
2. For individuals with diagnosed pulmonary TB, monthly sputum specimens should be collected until at least two sequential, monthly specimens are culture negative, in order to ensure treatment effectiveness and culture conversion.
3. Clinical and/or laboratory monitoring for toxicity should be performed by a trained provider at least monthly as recommended by American Thoracic Society/Centers for Disease Control/Infectious Disease Society of America guidelines for treatment of drug-susceptible tuberculosis (<https://academic.oup.com/cid/article/63/7/e147/2196792/Official-American-Thoracic-Society-Centers-for#82765795).(this> does not exist)
4. MDPH Clinical Nursing Staff will be in regular communication with LTC Facility nursing staff to ensure treatment adherence, medication tolerance, and continuity of care.

**REPORTING RESPONSIBILITIES**

Massachusetts Department of Public Health officials rely on local boards of health, healthcare providers, laboratories, and other public health personnel to report the occurrence of notifiable diseases as required by law (Massachusetts General Laws, Chapter 111, sections 3, 6, 7, 109, 110, 111 and 112 and Chapter 111D, Section 6. These laws are implemented by regulation under Chapter 105, Code of Massachusetts Regulations (CMR), Section 300.000: Reportable Diseases, Surveillance, and Isolation & Quarantine Requirements.)

Tuberculosis is a notifiable disease. The reporting regulation includes active or suspected active TB (pulmonary and extra-pulmonary), and latent TB infection.

For additional information, see <https://www.mass.gov/regulations/105-CMR-30000-reportable-diseases-surveillance-and-isolation-and>-quarantine

MDPH reporting forms for TB are available on-line at <https://www.mass.gov/how-to/report-a-case-of-tuberculosis-disease-or-latent-tb-infection>

**REFERENCES**

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