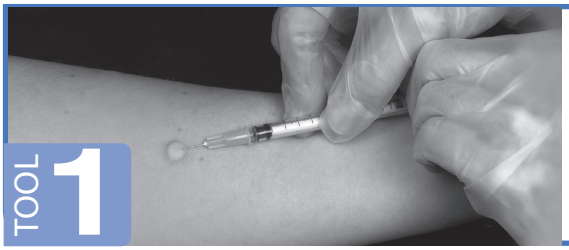

TOOL 1

1991 vs. Culture and Directly Observed Therapy Tuberculosis Technical Instructions

CATEGORY	1991	CDOT
CXR	• Persons ≥15 years: PA; <15 years: in specific circumstances • Frontal and lateral views in children	• Required for all applicants ≥15 years. • Applicants <15 years undergo CXR if they have a TST ≥10 mm or a positive IGRA (when required based on estimated TB incidence rate in country of origin) or have signs and symptoms suggestive of TB, or HIV infection. Frontal and lateral views in children <10 years of age.
TST or IGRA	• TST: not routine; used infrequently in specific circumstances; IGRA: not used	• All applicants 2–14 years of age living in countries with a WHO-estimated incidence rate ≥20 per 100,000. All applicants who are contacts of a known TB case.

Tuberculosis (TB) laboratory screening	• Persons ≥15 years with CXR and/ or symptoms suggestive of active disease: AFB smears x 3, or Children <15 years of age who are contacts, have history of TB disease, or signs or symptoms): AFB smears x 3	• Persons with TB symptoms, abnormal physical examination, or CXR suggestive of TB disease, or who are HIV positive:
		  • Sputum for AFB smears x 3 and for TB cultures x 3, &
		  • Drug-susceptibility testing (DST) on positive cultures (for persons who cannot produce sputum: specimen collection by other means such as induced sputum or gastric aspirates).

Initial patient management prior to laboratory results	• Not applicable	• Consider treatment for other lower respiratory infection (no fluoroquinolones) if applicable.
Management of persons with positive TST or IGRA	• Not applicable	• Applicants 2–14 years of age or contacts who have a TST ≥10 mm or a positive IGRA, but who otherwise have a negative evaluation for TB, will be classified for U.S. follow-up as Class 2 B2 TB, LTBI Evaluation, with TST results and treatment status documented.
TB treatment and management	• TB treatment outdated, and minimal guidance for drug-resistant TB	• Treating physicians should follow ATS/CDC/IDSA guidelines. • Directly observed therapy (DOT) should be implemented for treatment of pulmonary and extrapulmonary TB. • For drug-resistant patients, refer also to written guidance from the *Francis J. Curry National Tuberculosis Center and California Department of Health Services, 2004: Drug-Resistant Tuberculosis: A Survival Guide for Clinicians*. • MDR TB expert consultations and CDC consultations recommended. • Treatment of drug-resistant and MDR TB should be done by or in close consultation with experts in the management of such cases and in coordination with the Division of Global Migration and Quarantine (DGMQ). • Identification of applicants with MDR TB should be reported to DGMQ.

Sources of TB drugs	• Source not specified	• Quality-assured drugs:
		  • WHO Global Drug Facility for first-line drugs and International Dispensary Association and
		  • WHO Green Light Committee for second-line drugs.

Laboratory monitoring during TB treatment	• No monitoring after AFB smear becomes negative	• Drug susceptible, drug resistant (but not MDR) TB: two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy until cultures are negative for 2 consecutive months. • MDR TB: two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy. • No drug-susceptibility testing results (culture negative): one sputum specimen should be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy.
Laboratory monitoring after TB treatment	• Not applicable	• All applicants to have two sputum specimens collected and submitted for AFB microscopy and mycobacteria culture at the end of therapy. Applicants may not be cleared unless results are negative.

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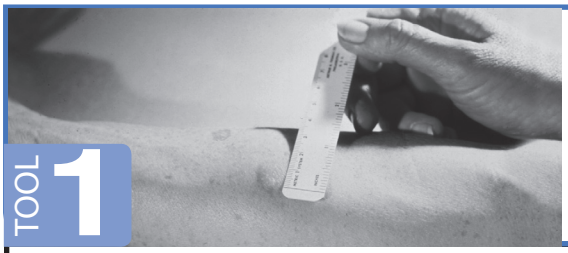
National Center for Emerging and Zoonotic Infectious Diseases
Division of Global Migration and Quarantine



TOOL 1

CATEGORY	1991	CDOT

Management of known TB contacts	• Not applicable	• All contacts should receive a TST or IGRA.
		• If the TST is ≥5 mm or IGRA is positive, the contact should be further evaluated with medical history, physical examination, and CXR.
		• If the contact is not started on LTBI therapy, he or she should receive an evaluation with medical history, physical examination, and CXR every 3 months until departure.
		• If the TST is <5 mm, or the IGRA is negative, and the contact is not placed on prophylaxis, the TST or IGRA should be repeated every 3 months until
		  • ≥8 weeks after contact ends, the index case has negative sputum smears for 2 consecutive months, OR
		  • TST become ≥5 mm or IGRA becomes positive.
		• Children <4 years of age and applicants with impaired immunity who are contacts of a known TB case (that is not isoniazid resistant) and who have a negative evaluation for TB disease, should begin directly observed preventive therapy (DOPT) regardless of TST or IGRA results.
		• Preventive therapy may be discontinued if TST is <5mm or IGRA is negative 8 weeks after conclusion of exposure to the infectious case.
		• Contacts cleared for travel should receive a Class B3 TB, Contact Evaluation classification.

Validity of TB screening examination	• 12 months if normal; 6 months if Class A condition or Class B1 or B2 TB condition	• 6 months if no TB classification or only Class B2 TB or Class B3 TB. • 3 months if Class B1 TB, Pulmonary or Class B1 TB, Extrapulmonary, or No TB Class and B- Other, HIV infection.

Pre-departure clearance examination	• Not applicable	• Additional screening immediately prior to departure (pre-departure evaluation) may be required.
		  • in the event of an outbreak of TB disease or
		  • in the setting of extremely elevated rates of TB disease.
		• CDC will inform panel physicians and Consulates when this additional screening is required.
		• When required, pre-departure screening would occur within 3 weeks of departure for all applicants with findings suggestive of TB disease on medical history, physical examination, or CXR but with negative sputum smears and negative cultures.
		• Pre-departure screening would consist of medical history, physical exam, CXR, and at least 3 sputum smears for AFB microscopy (cultures not required).

Information transfer to CDC and state and local public health departments	• Paper: DS medical forms travel with refugees and immigrants and are processed at port of entry and CDC headquarters	• Paper: DS medical forms and additional information on TB treatment travel with applicants and are processed at port of entry and CDC headquarters. DS forms from initial medical examination for applicants diagnosed with Class A TB and undergoing repeat medical examination after completing treatment should be included. • Electronic data transfer of DS medical forms, including TB screening, diagnosis and treatment, when available. • Class A and B1 cases reported to U.S. Embassy upon detection. • Panel physicians are required to make 3 copies of all DS forms for all refugees and for immigrants with Class A conditions or any Class B TB condition.

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