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contents:

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REQUEST FOR COMMENTS ON THE ATS-CDC JOINT STATEMENT ON THE TREATMENT OF TUBERCULOSIS*

The American Thoracic Society and the Centers for Disease Control have issued a new joint statement on the treatment of tuberculosis. The joint statement, "Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children," makes recommendations for both the treatment of tuberculosis disease and preventive therapy.

The Texas Department of Health (TDH) Tuberculosis Control Division is reviewing these recommendations (summarized below) for their application to tuberculosis control in Texas. **The Division solicits the opinions of all physicians who are involved in the management of tuberculosis.** To obtain copies of the **complete** joint statement, contact the Tuberculosis Control Division, TDH, 1100 West 49th Street, Austin, Texas 78756; (512) 458-7447 or STS 824-9447.

I. TREATMENT OF TUBERCULOSIS:

1. A 6-month regimen consisting of isoniazid, rifampin, and pyrazinamide given for 2 months followed by isoniazid and rifampin for 4 months is effective treatment in patients with fully susceptible organisms who comply with the treatment regimen. It may be advisable to include ethambutol in the initial phase when isoniazid resistance is suspected.

2. A 9-month regimen consisting of isoniazid and rifampin is also highly successful. The need for an additional drug in the initial phase is not certain unless isoniazid resistance is suspected, in which case ethambutol should be included until susceptibility tests have been reported.

3. In the presence of documented resistance to isoniazid, rifampin and ethambutol (perhaps supplemented initially by pyrazinamide) should be given for a minimum of 12 months.

4. Children should be treated in essentially the same ways as adults using appropriately adjusted doses of the drugs. However, consideration must be given to the important differences in the approach to management in children (See complete joint statement).

5. Extrapulmonary tuberculosis should be managed according to the principles and with the drug regimens outlined for pulmonary tuberculosis.

6. The major determinant of the outcome of treatment is patient compliance. Careful attention should be paid to measures designed to foster compliance and to ensure that patients take the drugs as prescribed.

II. TREATMENT OF TUBERCULOSIS INFECTION:

1. Preventive therapy with isoniazid given for 6 to 12 months is effective in decreasing the risk of future tuberculosis.

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* American Thoracic Society, CDC. Treatment of tuberculosis and tuberculosis infection in adults and children. Am Rev Respir Dis 1986;134:355-63.

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2. Persons for whom preventive therapy is indicated include: 1) household members and other close contacts of potentially infectious persons; 2) newly infected persons; 3) persons with past tuberculosis or with a significant tuberculin reaction and abnormal chest films in whom current tuberculosis has been excluded; 4) infected persons in special clinical situations such as silicosis, diabetes mellitus, adrenocorticosteroid therapy, immunosuppressive therapy or diseases, AIDS or positive tests for antibodies to AIDS virus, hematologic and reticuloendothelial malignancies, end-stage renal disease, and clinical conditions associated with rapid weight loss or chronic undernutrition; and 5) tuberculin skin test reactors younger than 35 years of age.

3. In persons younger than 35 years of age, routine monitoring for adverse effects of isoniazid should consist of a monthly symptom review. For persons 35 and older, in addition to monthly symptom review, hepatic enzymes should be measured prior to starting isoniazid and periodically throughout treatment.

4. Persons at high risk of developing severe forms of tuberculosis, if infected due to contact with a patient having isoniazid-resistant organisms, should be treated with rifampin rather than isoniazid. Lower-risk contacts can be treated with isoniazid and observed carefully.

5. As with treatment of tuberculosis, the key to success of preventive therapy is patient compliance.

* * *

TDH GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS AMONG INDIVIDUALS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

Tuberculosis morbidity has failed to decline since 1984, as expected in Texas and nationwide. This may be due in part to the occurrence of mycobacterial infections among persons infected with human immunodeficiency virus (HIV). Individuals found to be infected with HIV should be evaluated for *Mycobacterium tuberculosis* and nontuberculous mycobacterial infection and/or disease.

I. REFERRAL OF HIV POSITIVE INDIVIDUALS FOR EVALUATION OF MYCOBACTERIAL INFECTION AND DISEASE

1. Individuals who are found to be HIV seropositive should be given a Mantoux skin test with 5 tuberculin units of purified protein derivative as part of their clinical evaluation, unless the individual can document a history of previously treated tuberculosis disease or infection or can document a history of a significant reaction.

2. Individuals with a history of a significant reaction should be evaluated and managed as described in paragraph II.3 and II.4. This includes individuals who have received a BCG vaccination.

3. If the Mantoux skin test cannot be administered at the clinic providing the HIV test, then the HIV positive individual should be referred to a private physician or appropriate clinic where the individual can be evaluated for tuberculosis infection or disease. This may be the same physician or clinic that will perform the medical evaluation for the HIV positive individual.

4. Tuberculin testing materials for the Mantoux test can be provided by the Texas Department of Health to physicians or clinics if necessary. If the individual referred has a significant tuberculin test, further evaluation is indicated. Evaluation and/or treatment for infection or disease can be provided to the HIV/PPD positive individual by established tuberculosis control program services.

5. It is important that HIV positive individuals understand the importance of being evaluated for tuberculous infection or disease. Each HIV positive individual should be told to inform the evaluating party that he or she is HIV positive and that a skin test has been recommended or that the individual is known to have had a previous significant tuberculin reaction. While it may be that certain physicians or clinics have different requirements regarding identification of individuals in need of tuberculosis services, strict confidentiality must be maintained.

II. EVALUATION OF HIV POSITIVE INDIVIDUALS FOR TUBERCULOSIS

1. Guidelines for evaluation of HIV positive individuals for tuberculosis are in accordance with the CDC guidelines provided in the October 11, 1986, PDN article, "Diagnosis and Management of Mycobacterial Infection and Disease in Persons with Human T-Lymphotrophic Virus Type III/Lymphadenopathy-associated Virus Infection."

2. Those involved in the administration of skin tests should follow strict needle handling precautions recommended for HIV contaminated materials. These include disposal of uncapped needles and the attached syringes (recapping needles results in a major portion of needlestick accidents among health care personnel) into appropriate containers and safe disposal of the containers.

3. The development of a significant skin test in an infected person depends on competent T-cell mediated immunity. Since this is the type of cell which may be destroyed by HIV, the absence of a significant skin test reaction does not rule out the possibility of tuberculosis infection (or disease) in an individual infected with HIV. Even in the presence of a non-significant skin test, the possibility of tuberculosis must be kept in mind for any HIV infected person who develops pulmonary symptoms or symptoms suggestive of extrapulmonary disease.

4. Individuals with a verifiable history of significant skin test reaction who never completed preventive therapy or treatment for disease should be evaluated in the same manner as a recently identified significant reactor. In the absence of evidence of disease, such a person should be placed on preventive therapy. (If the history of significant skin test reaction cannot be verified, a skin test should be administered.)

For additional information, refer to Texas Preventable Disease News, Vol. 46/No. 41, October 11, 1986, or contact the Tuberculosis Control Division, TDH, 1100 West 49th Street, Austin, Texas 78756; (512) 458-7447 or STS 824-9447.

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INFLUENZA ALERT

An outbreak of flu-like illness has been reported from the high plains area of west Texas. On Monday, December 8, 1986, a 1,600-child school district experienced 20% absenteeism among students; 16 teachers were also ill. Reported symptoms, including fever (as high as 102°F), headache, muscle aches and pain, weakness, and upper respiratory symptoms, are consistent with influenza. Although laboratory confirmation is pending, it is probable that this represents, in Texas, the first community-wide influenza outbreak of the 1986-87 season. PDN week 49 reported sporadic cases identified by viral isolation and predicted increased influenza virus activity during the month of December.

The United States Public Health Service and the Texas Department of Health recommend that aspirin and aspirin-containing medications **NOT** be used to treat influenza in children and

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teenagers less than 18 years old. The use of aspirin to treat symptoms of flu and flu-like illnesses in children and teenagers is associated with an increased risk of Reye syndrome, a rare but serious disease.

Persons with chronic disease and the elderly are at increased risk for complications due to influenza and are strongly encouraged to obtain appropriate vaccination immediately if they have not done so already.[1,2] The development of an antibody response following vaccination takes about two weeks. Vaccine can be given to both children and adults up to and even after influenza virus activity is documented in a region, although temporary chemoprophylaxis with amantadine may be indicated when influenza outbreaks are occurring. Further preventive measures include avoidance of persons with flu-like illness.

REFERENCES:

1. CDC. ACIP: Prevention and control of influenza. MMWR; 35:317-25.

2. TDH. ACIP: Monovalent influenza A (H1N1) vaccine, 1986-1987. TPDN;46:No. 37, September 13, 1986.

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