Tuberculosis Control Program
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Los Angeles County Department of Public Health TB Control Program (TBCP) De-Isolation Recommendations (Pulmonary or Laryngeal TB)

Criteria for removal from isolation:

- For AFB smear-negative disease, at least 5 continuous days of a stable and likely effective multidrug treatment regimen administered via Directly Observed Therapy (DOT).
- For AFB smear-positive disease, at least 14 continuous days of a stable and likely effective multidrug treatment regimen administered via DOT.

AND all the following are TRUE:

- Clinical evidence of improvement or stability (e.g., decreased fever, cough, etc.)
- No high suspicion for resistance to core agents in the patient's current multidrug treatment regimen based on epidemiologic risk.
- No confirmed or suspected resistance to core agents in the patient's current multidrug treatment regimen based on results of molecular testing for drug resistance, such as GeneXpert or other advanced molecular diagnostics, and phenotypic drug susceptibility testing, if available.

*Some patients can remain de-isolated while receiving alternate regimens (e.g. so-called "liver-sparing" or "bridging") that consist of at least 3 likely effective anti-TB agents (at least 2 of which are potent or exhibit early bactericidal activity).

Potential Indications for Resuming Isolation

- Interruption of effective multidrug TB treatment for ≥ 14 days in intensive phase or ≥ 30 days in the continuation phase.[1]
- Suspicion for treatment failure and/or disease progression based on a constellation of factors including clinical worsening (such as increasing cough, fevers, weight loss, etc.), radiographic worsening, and reversion or persistence of AFB smear- or culture-positivity*.
- Newly identified drug resistance to core agents in the current multidrug regimen.
- If resumption of isolation is considered for these or other reasons, then the case should be discussed with the regional TBCP physician consultant.
- All decisions to resume isolation for patients tolerating a stable and likely effective multidrug regimen should consider the potential risks/harms of re-isolation weighed against the theoretical community benefit.
- **Decisions regarding resumption or continuation of isolation for patients receiving likely effective multidrug treatment regimen via DOT for more than 14 days should be reviewed on a weekly basis.**

*Note: If a patient has previously grown multiple non-tuberculous mycobacteria in prior sputa, it is unlikely that re-isolation is needed for apparent bacteriologic reversion or persistence, pending identification of new AFB.

Patient Movement Considerations

- All discharge/transfer care plans for hospitalized patients with possible or proven TB disease continue to require approval from the local health officer, or his/her designee, in accordance with California Health and Safety Code, Division 105, Part 5, Chapter 1, Section 121361.
- Patients may continue to be discharged to home on isolation precautions if they do not meet criteria for de-isolation, as long as an appropriate, approved discharge plan that includes prompt initiation of Directly Observed Therapy is arranged and implemented.
- Within hospital de-isolation can generally follow the same criteria as for community de-isolation; please consider requesting TBCP consultation.
- Use of a well-fitted, good quality mask may continue to be recommended when patients enter some moderate-risk or high-risk settings, including but not limited to indoor public areas, public transportation, crowded outdoor events, and medical settings with appropriate administrative and environmental controls.
- Interjurisdictional discharges and transfers may require additional coordination by TBCP; in most situations, abiding by the receiving jurisdiction's criteria for de-isolation may be most appropriate, if and when the receiving jurisdiction's criteria are substantively different from these guidelines.

[1] Because the timing of recurrent infectiousness cannot be determined with precision during interruptions of effective multidrug TB treatment in most patients who had previously fulfilled minimum treatment duration criterion for de-isolation, these practical estimates are proposed.

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Other Comments:

- These de-isolation recommendations assume that patients will continue to receive DOT, or an equivalent mode of daily verified medication administration by a licensed healthcare professional, on at least 5 days per week for the duration of anti-TB treatment. For patients with AFB smear-positive disease without access to DOT, longer isolation and presumed infectious periods may be considered, and de-isolation recommendations may incorporate more conservative criteria—including fulfillment of bacteriologic treatment milestones such as sputum AFB smear-conversion.
- Prompt initiation of window prophylaxis in high-risk contacts, such as severely immunocompromised persons or children <5 years old, is recommended regardless of the index patient's fulfillment of deisolation criteria.
- Frequency of sputum specimen collection for AFB smear and culture should not be modified from current practice solely based on these guidelines, as documentation and precise timing of smear- and culture-conversion are useful milestones for guiding clinical decisions regarding regimen and total treatment duration.
- Situations involving possible or proven TB outbreaks, some high-risk settings such as health facilities and correctional settings, or other special circumstances may merit prolonged isolation for individuals at the discretion of TBCP.
- The occupations listed in the CalOSHA/ATD Standard should have access to personal protective equipment if caring for individuals with TB who are AFB smear-positive or who have MDR-TB and have not culture-converted.
- The TBCP may decide to de-isolate or re-isolate an individual patient based upon other criteria.

References

1) Shah M, Dansky Z, Nathavitharana R, et al. NTCA Guidelines for Respiratory Isolation and Restrictions to Reduce Transmission of Pulmonary Tuberculosis in Community Settings. Clin Infect Dis. Published online April 18, 2024. doi:10.1093/cid/ciae199
2) Goswami N, Reed C. Duration of Effective Tuberculosis Treatment, not Acid-Fast Bacilli (AFB) Smear Status, as the Determinant for Deisolation in Community Settings. Clin Infect Dis. Published online April 18, 2024. doi:10.1093/cid/ciae198
3) California Code of Regulations Title 8, §5199.1 – Aerosol Transmissible Diseases Subchapter 7. General Industry Safety Orders Graoup 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes, https://www.dir.ca.gov/title8/5199.html
4) The California workplace guide to Air Transmissible Diseases, 2023. https://www.dir.ca.gov/dosh/dosh_publications/ATD-Guide.pdf