Tuberculosis Control Program
123 W. Manchester Blvd. Rm. 228
Inglewood, CA 90301
Phone: (213) 745-0800; Fax: (213) 749-0926

Summary of Important Los Angeles County Tuberculosis Control Program Treatment Guidelines

1. **Reporting - Confidential Morbidity Report (CMR) FAX Reporting Form**
   - All health care providers are mandated to report within one (1) day of diagnosis all patients with suspected or confirmed tuberculosis (TB) (California Health and Safety Code, Division 4, Chapter 5, Sections 121361 and 121362).
   - Prior to discharge, all patients under evaluation and confirmed with TB in hospitals have an individualized, written discharge plan approved by the Tuberculosis Control Program (California Health and Safety Code, Division 4, Chapter 5, Section 121361).
   - All health care providers are mandated to provide information related to the treatment of patients under evaluation or confirmed with TB disease to ensure that individuals under evaluation and treatment for TB disease are receiving timely diagnosis and effective treatment (California Health and Safety Code, 120175)
   - The County of Los Angeles, Department of Public Health, is mandated to maintain a record of clinical follow-up of all TB patients (California Health and Safety Code, Division 4, Chapter 5, Section 121362). The public health nurse assigned as a case manager for your patient will be requesting information about your patient's clinical care that is needed for the required public health surveillance reporting. Please see attachment for an example of the information needed.

2. **HIV testing for persons with suspected and confirmed TB disease is the national and local standard of care.** https://www.cdc.gov/tb/programs/evaluation/indicators/default.htm

3. **Initial TB Treatment Guidelines**
   - **INH Susceptibility Not Known and if Xpert Mtb/RIF assay does not show RIF resistance detected,**
     - Isoniazid + Rifampin + Pyrazinamide + Ethambutol given for two (2) months (four drugs daily); initiate within 7 days of laboratory confirmation of TB diagnosis.
     - Isoniazid + Rifapentine + Moxifloxacin + Pyrazinamide given for 8 weeks (four drugs daily)*
     - Patients should be seen at least monthly for a history and physical examination, and bloodwork while on anti-TB treatment to manage side effects and monitor for toxicity.
   - **If Xpert MTB/RIF assay shows RIF resistance detected, or drug susceptibilities indicate drug resistance to isoniazid, rifampin, ethambutol, or pyrazinamide, refer to the Department of Public Health (DPH) for clinical care**

     *Do not advise starting this regimen unless rifapentine drug supply is secured for the entire four-month regimen; additional molecular testing is needed for this regimen to confirm no fluoroquinolone resistance mutations. Consultation is advised if initiating this regimen. Call 213 745 0800 to request a consultation.

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4. **With culture confirmation and susceptibility data**
   - **If INH Susceptible and the patient has completed standard isoniazid + rifampin + ethambutol + pyrazinamide for two months**
     - Then continue Isoniazid + Rifampin for at least four (4) months.
     - Pyrazinamide and Ethambutol are discontinued.
     - Complete a total of six to nine (6-9) months of total anti-TB therapy. Consult your DPH clinician for duration of therapy.

5. **Directly Observed Therapy (DOT)**
   - The best practice standard for TB treatment in the United States is to receive anti-TB treatment by DOT, as DOT ensures that patients complete an adequate course of TB treatment.
   - DOT is defined as delivery of every dose of medication by a health care worker who observes and documents that the patient actually ingests or is injected with the medication. In LA County, DOT is provided through trained personnel at DPH.
   - Delivery alone to the patient without observation and documentation is not DOT.
   - In LA County, the following patients with TB under evaluation (Class V) and known, active TB disease (Class III) are recommended to receive DOT:
     - HIV coinfection
     - Current substance use disorder
     - Experiencing homelessness in the last year
     - Previous history of TB
     - Evidence of drug resistance
     - Incarceration with a current episode of TB
     - Treatment failure
     - Non-daily regimen
     - Nonadherence to anti-TB regimen
     - Patient has been served a health officer's order
   - If your patient is experiencing drug toxicity or intolerance, you may request a referral for TB care that will include DOT at one of our Health Centers.

6. **Isolation**: In most cases, a person with TB can be released from isolation once they meet these three standard criteria:
   - **Effective treatment:** The patient has been on an appropriate multi-drug TB treatment regimen for at least two weeks and has tolerated the medication. For drug-resistant TB, this duration may be longer.
   - **Clinical improvement:** The patient is showing signs of improvement on anti-TB treatment. This can include reduced coughing, resolution of fever, and a decrease in night sweats.
   - **Negative sputum smears:** The patient has provided three consecutive sputum smears that test negative for AFB. The samples must be collected at least eight hours apart.

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7. **Sputum and Chest Radiograph**
   - For all patients under evaluation for TB disease, initial chest radiography and sputum for AFB for patients with abnormal chest x-rays or with evidence of extrapulmonary disease is recommended.
   - Monthly sputum specimens for AFB smear and culture are obtained on ALL TB cases after initiation of therapy for at least three (3) months or until two final consecutive negative cultures are obtained after a positive Mtb culture.
   - Additional specimens should be collected on a more frequent basis, e.g., weekly, in any patient that continues to remain smear positive after one month of treatment and/or is still culture positive after 2 months of treatment or appears to be responding slowly to treatment until an appropriate response is documented.
   - High-quality sputum can be obtained by collecting an expectorated sample first thing in the morning, immediately after waking up. The mucociliary clearance that occurs overnight often produces more productive sputum.
     - Induced sputum - inhaling an aerosolized sterile hypertonic saline (3–5%) solution can stimulate sputum production.
     - Alternative methods: For children or others unable to produce sputum, alternative methods such as gastric aspiration, stool collection, or bronchoscopy may be used.
     - Requests for induced sputum through a DPH clinic when spontaneous early morning expectorated specimens cannot be collected should be requested through the patient's DPHN or DPH clinician consultant
   - Repeat chest radiograph of pulmonary TB cases is recommended at 2 to 3 months after start of therapy and every 3 months until completion of therapy.

8. **Contact Investigation Service Conducted by Public Health Nurse**
   - Contact investigation is an epidemiological investigation that must be done for every new reported laboratory-confirmed index case of TB and is an essential component of reducing transmission of TB in the community
   - Contact investigation allows for early detection and treatment of new infection in persons who are documented to have had close contact with an infectious person with TB disease.
   - Contact investigation identifies, examines, and evaluates all persons who are at risk of infection with TB due to recent exposure to a person with confirmed TB or on treatment for possible TB. Children < 5 years old require an investigation to determine the source case.
   - If you are the treating provider for individuals who are close contacts to your patient, a public health nurse will request information about the evaluation and treatment of these patients.