

TUBERCULOSIS (TB)

REPORTING INFORMATION

- **Class B1:** Report by the close of the next business day after the case or suspected case presents and/or a positive laboratory result to the county TB control unit where the patient resides. If patient residence is unknown, report to the county TB control unit in which the reporting health care provider is located.
- Reporting Form(s) and/or Mechanism: [Ohio Confidential Reportable Disease form](#) (HEA 3334, rev. 1/09), [Positive Laboratory Findings for Reportable Disease form](#) (HEA 3333, rev. 8/05), the county TB control unit via the Ohio Disease Reporting System (ODRS), or telephone.
- For the county TB control unit, all information on the [Report of Verified Case of Tuberculosis](#) (RVCT; CDC 72.9A, revised 9/08) is required to be reported in ODRS for all cases and suspected cases. All the information on the [Follow-up Report – 1](#) (CDC 72.9B, revised 9/08) is required to be reported in ODRS for all culture-positive cases to report the results of drug susceptibility testing. All the information on the [Follow-up Report – 2](#) (CDC 72.9C, revised 9/08) is required to be reported in ODRS for all cases and suspected cases to report when and why treatment stopped or to report that a suspected case does not have TB.
- Additional reporting information, with specifics regarding the key fields for ODRS Reporting can be located in [Section 7](#).

AGENTS

Mycobacterium tuberculosis complex, which includes *M. tuberculosis*, *M. bovis*, *M. bovis BCG*, *M. africanum*, *M. microti*, *M. canetti*, and *M. pinnipedii*.

SUSPECT DEFINITION (Ohio, 2009)

- A person with signs or symptoms of TB that are sufficient for the physician to suspect that the individual has TB prior to the completion of diagnostic studies.
- A person with or without a positive Mantoux tuberculin skin test or blood assay *Mycobacterium tuberculosis* (BAMT) test positive who meets any of the following criteria:
 - has a specimen that is positive for acid-fast bacilli (AFB) on smear *or*
 - has been prescribed two or more anti-tuberculosis medications for the treatment of active TB *or*
 - has a radiologic finding consistent with active TB *or*
 - has clinical symptoms or findings consistent with active TB

CASE DEFINITION

Clinical Description

A chronic bacterial infection caused by *Mycobacterium tuberculosis*, usually characterized pathologically by the formation of granulomas. The most common site of infection is the lung, but other organs may be involved.

Clinical Case Definition

A case that meets all of the following criteria:

- A positive tuberculin skin test or positive interferon gamma release assay for *M. tuberculosis* *and*
- Other signs and symptoms compatible with TB (e.g. abnormal chest radiograph, abnormal chest computerized tomography scan, or other chest imaging study, or clinical evidence of current disease) *and*

- Treatment with two or more anti-TB medications *and*
- A completed diagnostic evaluation

Laboratory Criteria for Diagnosis

- Isolation of *M. tuberculosis* from a clinical specimen¹ *or*
- Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification (NAA)² *or*
- Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated

Case Classification

Suspect: A patient that meets the suspect definition

Confirmed: A case that meets the clinical case definition or is laboratory confirmed. A suspected TB case may also be confirmed when it does not meet either the laboratory or clinical case definition if a provider diagnoses TB. This is confirmed as a “Provider Diagnosed” case.

Not a Case: This status will not generally be used when reporting a case, but may be used to reclassify a report if investigation revealed that it was not a case.

Comment

However, a case occurring in a patient who had previously had verified TB disease should be reported and counted again if more than 12 months have elapsed since the patient completed therapy. A case should also be reported and counted again if the patient was lost to supervision for greater than 12 months and TB disease can be verified again. Mycobacterial disease other than those caused by *M. tuberculosis* complex should not be counted in TB morbidity statistics unless there is concurrent tuberculosis. However, mycobacterial disease other than TB (MOTT) and Hansen Disease (leprosy, *M. leprae*) are should be reported using ODRS as both are designated as Class B2.

SIGNS AND SYMPTOMS

Indications of tuberculosis range from a significant PPD test in an asymptomatic patient to fever, diaphoresis, weight loss, productive cough, hemoptysis, and extensive infiltration with cavitation in the lung on chest x-ray in the very ill patient. *Mycobacterium tuberculosis* complex can cause disease in any organ of the body. Most patients will experience symptoms of malaise, fatigue, anorexia, productive cough, and a low-grade fever. More specific symptoms will depend on the organs involved and the extent of disease process.

DIAGNOSIS

The definitive diagnosis of tuberculosis requires the isolation of *Mycobacterium tuberculosis* complex from the patient. The greatest single problem in recovering mycobacteria from clinical specimens is the presence of large numbers of contaminating microorganisms. This

¹ Use of rapid identification techniques for *M. tuberculosis* (e.g., DNA probes and mycolic acid high-pressure liquid chromatography (HPLC) performed on a culture from a clinical specimen) are acceptable under this criterion.

² Nucleic acid amplification (NAA) tests must be accompanied by culture for mycobacteria species for clinical purposes. A culture isolate of *M. tuberculosis* complex is required for complete drug susceptibility testing and genotyping. However, for surveillance purposes, CDC will accept results obtained from NAA tests approved by the Food and Drug Administration (FDA) and used according to the approved product labeling on the package insert, or a test produced and validated in accordance with applicable FDA and Clinical Laboratory Improvement Amendments (CLIA) regulations.

problem is partially solved by obtaining a fresh specimen and by refrigeration of any specimen that cannot be processed promptly.

Since mycobacteria might be released from the lung sporadically, sputum specimen quality may fluctuate. For this reason, a minimum of three specimens collected in 8-24 hour intervals should be obtained from patients suspected of having pulmonary tuberculosis. Urine may also be submitted for analysis. The preferred specimen is a first morning, cleanly voided midstream sample. One specimen each day for three consecutive days should be evaluated. Do not use bottles with preservatives. A minimum of 40 ml of urine is required.

The ODH Laboratory, in addition to preparing smears, culturing, and identifying mycobacteria, also provides confirmation and antibiotic susceptibility testing on *M. tuberculosis* complex. Reference cultures sent to the ODH Laboratory may be shipped at ambient temperatures.

EPIDEMIOLOGY

Source

Mycobacterium tuberculosis complex (*M. tuberculosis*, *M. bovis*, *M. bovis BCG*, *M. africanum*, *M. microti*, *M. canetti*, and *M. pinnipedii*) is found primarily in humans.

Occurrence

Present in all parts of the world. Incidence normally increases with age, is higher in males than in females, and is higher among the poor.

Mode of Transmission

Person-to-person, by inhaling the organism coughed or sneezed into the air by a person with infectious disease.

Period of Communicability

As long as infectious tubercle bacilli are being discharged and the patient is untreated or inadequately treated, the tuberculosis organism is communicable.

Incubation Period

It takes about 4 to 12 weeks for a person to progress from infection to demonstrable primary lesion. Risk of progressive disease is greatest during the first 1-2 years after infection, yet can persist for a lifetime if the infection is untreated.

PUBLIC HEALTH MANAGEMENT

Case

All pulmonary/laryngeal suspects/cases are to be interviewed within three days to identify persons who were exposed during the infectious period, in accordance with section 339.80 of the Ohio Revised Code (ORC). Cases must be monitored to insure that they become non-infectious and complete adequate treatment. Anyone at high risk for non-adherence is a candidate for directly observed therapy (DOT) in accordance with section 339.82 of the (ORC). When pediatric TB is diagnosed, an interview should be done to identify a possible source case.

Treatment

Treatment should be made available to all individuals with suspected or active tuberculosis in accordance with section 339.73 of the ORC. The current recommended treatment guidelines from the Centers for Disease Control and Prevention and the

American Thoracic Society should be followed.

Isolation

Ohio Administrative Code (OAC) 3701-3-13 (AA) states:

“Tuberculosis (TB): a person with infectious tuberculosis shall be isolated according to Chapter 3701-15 of the Administrative Code until the person has three negative AFB sputum smear results, collected eight to twenty-four hours apart (with at least one being an early morning specimen) and the person has responded clinically to an antituberculosis treatment regimen consistent with the results of any susceptibility testing performed and until the local authorized TB authority, as set out in section 339.72 of the Revised Code, or his or her designee approves that person's removal from isolation.”

Contact

All persons identified as being exposed to an infectious suspect/case should be administered a tuberculin skin test (TST) using the Mantoux method with 5-TU (tuberculin units) –PPD antigen or BAMT test. All contacts with an initial non-significant TST should have a repeat TST three months following the last date of exposure to the suspected/active case. If the reaction of either test is significant, a chest x-ray and medical evaluation are necessary to determine if there is current disease. All contacts who are infected and do not have active disease should receive preventive treatment with Isoniazid (INH) for at least nine continuous months. Uninfected contacts (<15 years of age) should receive prophylactic treatment with INH, which can be discontinued if the TST is non-significant at three months.

Prevention and Control

An individual who has been diagnosed as having active tuberculosis shall be instructed to follow contagion precautions in accordance with section 339.82 of the ORC. Contagion precautions should include covering their mouth and nose when coughing and sneezing, and adhering to the treatment program as prescribed.

What is tuberculosis?

Tuberculosis (TB) is a bacterial disease usually affecting the lungs (pulmonary TB), caused by *Mycobacterium tuberculosis* complex, which includes *M. tuberculosis*, *M. bovis*, and *M. africanum*. Other parts of the body (extrapulmonary TB) can also be affected, for example, brain, lymph nodes, kidneys, bones, joints, larynx, intestines, or eyes.

Who gets tuberculosis?

The bacteria causing tuberculosis are spread through the air. When a person with tuberculosis, who is not taking appropriate medication, coughs or sneezes, the germs get into the air. Prolonged exposure to the tuberculosis bacteria is normally necessary for infection to occur.

What is the difference between tuberculosis infection and tuberculosis disease?

Tuberculosis infection may result after close contact with a person who has tuberculosis disease. Tuberculosis **infection** is diagnosed by a significant reaction to the Mantoux skin test with no symptoms of tuberculosis and no TB bacteria found in the sputum.

Tuberculosis **disease** is characterized by the appearance of symptoms, a significant reaction to a Mantoux skin test, and TB bacteria found in the sputum.

To spread the TB bacteria, a person must have TB disease. Having TB infection is not enough to spread the bacteria. Tuberculosis may last for a lifetime as an infection, never developing into disease. Tuberculosis disease is most likely to develop during the first 2 years after acquiring the infection. Additionally, individuals with weakened immune systems, such as persons infected with HIV, are at high risk of developing TB disease if TB infection is left untreated.

What are the symptoms of tuberculosis?

The symptoms of TB include low-grade fever, night sweats, fatigue, weight loss, and persistent cough. Some people do not have obvious symptoms.

How soon do symptoms appear?

Evidence of infection (a positive skin test) usually occurs 4-12 weeks after exposure. The most common period for developing clinical disease is 12-24 months after infection. Infection can remain latent with disease occurring much later in life.

When and for how long is a person able to spread tuberculosis?

TB disease may remain contagious until the person has been on appropriate treatment for several weeks. It is important to note that a person with TB infection, but not disease, cannot spread the infection to others, since there are no TB bacteria in the sputum.

What is the treatment for tuberculosis?

People with active TB disease must complete the prescribed course of medicine, which usually involves taking medications for 6 to 12 months. TB infection is treated with isoniazid alone; treatment of TB disease usually requires three or more drugs. The exact medication plan must be determined by a physician.

What can be the effect of not being treated for tuberculosis?

In addition to spreading the disease to others, an untreated person can become severely ill or die.

What can be done to prevent the spread of tuberculosis?

The most important way to stop the spread of tuberculosis is to cover the mouth and nose when coughing and to take prescribed medicine as directed. Persons with disease should have respiratory precautions until symptoms are improved and there is documentation of adequate response to therapy by three consecutive negative sputum smears collected on different days. All household and close contacts of a person with active TB disease should be screened, using the Mantoux skin test or BAMT, for evidence of infection. All contacts with evidence of infection should be evaluated for treatment by a physician. All high-risk populations should be TB skin tested routinely.