



FOLLOW-UP PROTOCOLS FOR PATIENTS WITH A POSITIVE PPD

Patients with prior adequate treatment for latent TB infection (LTBI)

1. Adequate LTBI treatment decreases the lifetime risk of reactivation TB to less than 1.6 percent. Therefore, patients with prior treatment do not need rigorous follow-up unless they have TB symptoms or are re-exposed to individuals with contagious pulmonary TB.
2. Adequate treatment is defined as:
 - **Adults with normal CXR:** 6-9 months of INH
 - **Immune compromised adults or patients with abnormal CXRs consistent with old inactive TB:** 9 months of INH or 4 months of INH and rifampin
 - **Children:** 6-9 months of INH (current ATS and SF recommendation for LTBI Rx is 9 months of INH. SF recommendations before 2001 was 6 months)

Recommendation: *In general, patients with prior adequate LTBI treatment do not need medical follow up or CXRs unless they have symptoms of TB, are re-exposed to individuals with contagious pulmonary TB or a CXR is required by their work or school.*

Patients without prior adequate treatment or for LTBI

Risk of TB reactivation in these individuals will depend on medical risk factors for TB.

Recommendations:

If there are no medical risk factors present: An annual TB symptom review and risk assessment should be performed as part of routine health maintenance. A CXR should be done ONLY if symptoms are present or TB screening is required for entry into a congregate setting (such as a residential facility, nursing home, shelter, drug treatment program, school, etc.). If the patient is asymptomatic AND without new medical risk factors, a normal CXR done within the prior 6-12 months should be sufficient for required screening.

If medical risk factors are present: The frequency of TB screening and repeat CXRs should depend on the risk of disease. The listed groups below should be offered LTBI treatment because they represent TB Control's highest priority for prevention. However, if treatment is rejected, these patients should be educated on the signs and symptoms of TB and followed-up as described below:

- **HIV infection or other severe immune compromise (e.g. cancer chemotherapy, organ transplant, hematological malignancies, chronic prednisone 15mg/day > 2wks):** Symptom review every 3 months and CXR every 6 month



- **PPD conversion to positive within the past 2 years:** CXR and symptom review every 6 months for a 2-year period
- **Arthritis or autoimmune disease being treated with immune modulating medication:** Symptom review every 3-6 months and CXR annually
- **End-stage renal disease, silicosis, jejunioileal bypass or carcinoma of the head or neck:** Symptom review every 6 months and CXR annually
- **Evidence of old inactive TB on CXR:** Annual symptom review at minimum. Would also have a low threshold for sputum collection and repeat CXR if any chronic pulmonary symptoms are present
- **Other medical risks: (diabetes, injection drug use, gastrectomy, under weight by >15%):** Annual symptom review at minimum and CXR if symptomatic without definite etiology

Any patient regardless of prior treatment should get a CXR and medical evaluation if TB symptoms of chronic cough and/or unexplained weight loss of more than 5 lbs are present.