

# Diagnosis of Tuberculosis Disease

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# Introduction

## Purpose

Use this section to understand and follow national and Ohio guidelines to do the following:

- Classify patients with tuberculosis (TB) disease and TB infection (TBI).
- Detect suspected cases of TB.
- Know when to report suspected or confirmed cases of TB.
- Diagnose TB disease.

It is important to understand when a person should be evaluated further for TB disease. Not recognizing TB symptoms promptly leads to delays in treating a TB case—and to more infection, TB disease, and contacts to evaluate.

In the 2005 guideline, “Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, Centers for Disease Control and Prevention, and the Infectious Diseases Society of America,” one of the recommended strategies to achieve the goal of reduction of TB morbidity and mortality is early and accurate detection, diagnosis, and reporting of TB cases, leading to initiation and completion of treatment.<sup>1</sup>



Contacts are mentioned within this section, but their evaluation and follow-up and contact investigation are covered in more depth in the Contact Investigation section. For information on treatment, refer to the Treatment of Tuberculosis Disease section.

Improvement in the detection of TB cases is essential to progress toward elimination of TB in the United States.<sup>2</sup> Case detection includes the processes that lead to the presentation, evaluation, receipt of diagnosis, and reporting of persons with active TB.<sup>3</sup> Detecting and reporting suspected cases of TB are key steps in stopping transmission of *Mycobacterium tuberculosis* because it leads to prompt initiation of effective multiple-drug treatment, which rapidly reduces infectiousness.<sup>4</sup>

TB is commonly diagnosed when a person seeks medical attention for symptoms caused by the disease or a concomitant medical condition. Thus, healthcare providers, particularly those providing primary healthcare to populations at high risk, are key contributors to TB case detection.<sup>5</sup> However, the majority of pulmonary TB cases continue to be diagnosed at an advanced stage. Earlier diagnosis would result in less individual morbidity and death, greater success in treatment, less transmission to contacts, and fewer outbreaks of TB.<sup>6</sup>

A diagnosis of TB disease is usually based on positive cultures for *M. tuberculosis*. However, TB may also be diagnosed on the basis of clinical signs and symptoms in the absence of a positive culture.

## Policy

In Ohio:

- Persons who show or report signs and symptoms of TB should be evaluated for TB disease as described in the “Diagnosis of Tuberculosis Disease” topic in this section and reported as suspected cases of TB as described in the “Reporting Tuberculosis” topic in the Surveillance section.
- Contacts should be evaluated as described in the Contact Investigation section.



For roles and responsibilities, refer to the “Roles, Responsibilities, and Contact Information” topic in the Introduction.

## State Laws and Regulations

Ohio laws and rules on tuberculosis are located in the Ohio Revised Code 339.71 thru 339.89 and Ohio Administrative Code

### **Ohio Revised Code**

339.71 TB Control unit definitions

339.72 Designation of TB control unit

339.73 Treatment to be available to all persons with TB

339.74 TB record bureau

339.75 County Commissioners may contract for treatment

339.76 TB clinics established by county commissioners

339.79 Reporting case of TB that is resistant to one or more drugs

339.80 Investigations

339.81 Confidential information

339.82 Duties of individual diagnosed with active or communicable TB

339.83 Notice to individual diagnosed with active or communicable TB

339.84 Order compelling compliance with duties

339.85 Injunctions

339.86 Detaining noncomplying individual

339.87 Emergency detention order

339.88 Expenses of detaining noncomplying individual

339.89 Spiritual treatment in lieu of medical treatment for TB

5705.20 Special levy for tuberculosis treatment or clinics

## State Laws and Regulations

### **Ohio Administrative Code**

#### Tuberculosis

- 3701-15-01 Definitions
- 3701-15-02 Acceptable Tuberculosis Programs
- 3701-15-03 Tuberculosis Standards
- 3701-15-04 Tuberculin Testing in Schools (rescinded)

#### Adult Care Facilities

- 3701-20-14 (renumbered 5122-33-13) Facility staff requirements
- 3701-20-18 (renumbered 5122-33-18) Resident requirements

#### Nursing Homes

- 3701-17-07 Nursing home personnel

#### Reporting & Isolation Requirements

- 3701-3-01 Reportable disease definitions
- 3701-3-02 Reportable diseases
- 3701-3-03 Reportable disease notification
- 3701-3-04 Lab reporting
- 3701-3-05 Time of report
- 3701-3-06 Reporting to ODH
- 3701-3-08 Release of medical records
- 3701-3-13 Isolation requirements

#### Quarantine

- 3701-13 Powers of Health Department
- 3701-34 Health Commissioner Authority
- 3701-56 Enforcement of Quarantine
- 3707-04 Quarantine regulations



See <http://codes.ohio.gov/>

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# Case Finding

## Identifying Suspected Tuberculosis Cases

The majority of tuberculosis (TB) cases are detected during the medical evaluation of symptomatic illnesses. Persons experiencing symptoms ultimately attributable to TB usually seek care not at a public health TB clinic but rather from other medical practitioners in other healthcare settings.<sup>7</sup> Professionals in the primary healthcare sector, including hospital and emergency department clinicians, should be trained to recognize patients with symptoms consistent with TB.<sup>8</sup>

Be alert for cases of TB among persons who have not sought medical care during evaluation of contacts to patients with pulmonary TB and to other persons with newly diagnosed infection with *Mycobacterium tuberculosis*. Perform screening for TB also during evaluation of immigrants and refugees with Class B1 or Class B2 TB notification status, during evaluations of persons involved in TB outbreaks, and occasionally in working with populations with a known high incidence of TB. Also, screen for TB disease when the risk for TB in the population is high and when the consequences of an undiagnosed case of TB are severe, such as in jails, prisons, and other correctional facilities.<sup>9</sup>



Factors that identify persons at high risk of TBI infection and/or of progression to TB disease are listed in the “High-Risk Groups” topic in the section on Diagnosis of Tuberculosis Infection.

Suspect pulmonary TB and initiate a diagnostic investigation when the historic features, signs, symptoms, and radiographic findings listed in Table 1 occur among adults. The clinical presentation of TB varies considerably as a result of the extent of the disease and the patient’s response. TB should be suspected in any patient who has a persistent cough for more than two to three weeks, or other compatible signs and symptoms.<sup>10</sup>

Note that these symptoms should suggest a diagnosis of TB but are not required. TB should still be considered a diagnosis in asymptomatic patients who have risk factors for TB and chest radiographs compatible with TB.



All persons who have a chronic cough for more than two to three weeks<sup>11</sup> should be evaluated and be asked to use a mask or tissue to cover their mouth. Hemoptysis, or coughing up blood, is a serious symptom, and patients who cough up blood should be evaluated as soon as possible. Be sure to have these patients use a mask and tissues.

Table 1: WHEN TO SUSPECT PULMONARY TUBERCULOSIS IN ADULTS<sup>12</sup>

<p><b>Historic Features</b></p>	<ul style="list-style-type: none"> <li>▪ Exposure to a person with infectious tuberculosis (TB)</li> <li>▪ Positive test result for <i>Mycobacterium tuberculosis</i> infection</li> <li>▪ Presence of risk factors, such as immigration from a high-prevalence area, human immunodeficiency virus (HIV) infection, homelessness, or previous incarceration*</li> <li>▪ Diagnosis of community-acquired pneumonia that has not improved after 7 days of treatment †,13</li> </ul>
<p><b>Signs and Symptoms Typical of TB</b></p>	<ul style="list-style-type: none"> <li>▪ Prolonged coughing (≥2–3 weeks) with or without production of sputum that might be bloody (hemoptysis)§,14</li> <li>▪ Chest pain<sup>15</sup></li> <li>▪ Chills<sup>16</sup></li> <li>▪ Fever</li> <li>▪ Night sweats</li> <li>▪ Loss of appetite<sup>17</sup></li> <li>▪ Weight loss</li> <li>▪ Weakness or easy fatigability<sup>18</sup></li> <li>▪ Malaise (a feeling of general discomfort or illness)<sup>19</sup></li> </ul>
<p><b>Chest Radiograph: Immunocompetent patients</b></p>	<ul style="list-style-type: none"> <li>▪ Classic findings of TB are upper-lobe opacities, frequently with evidence of contraction fibrosis and cavitation¶</li> </ul>
<p><b>Chest Radiograph: Patients with advanced HIV infection</b></p>	<ul style="list-style-type: none"> <li>▪ Lower-lobe and multilobar opacities, hilar adenopathy, or interstitial opacities might indicate TB</li> </ul>
<p>* See Table 1: Persons at High Risk for Tuberculosis Infection and Progression to Tuberculosis Disease in the section on Diagnosis of Tuberculosis Infection.</p> <p>† Patients treated with levofloxacin or moxifloxacin may have a clinical response when TB is the cause of the pneumonia.</p> <p>§ Do <b>not</b> wait until sputum is bloody to consider a productive cough a symptom of TB. Sputum produced by coughing does <b>not</b> need to be bloody to be a symptom of TB.</p> <p>¶ These features are not specific for TB, and, for every person in whom pulmonary TB is diagnosed, an estimated 10–100 persons are suspected on the basis of clinical criteria and must be evaluated.</p>	

Source: Adapted from: ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):33.

## Extrapulmonary Tuberculosis

If a patient has a positive tuberculin skin test or interferon gamma release assay (IGRA), consider signs and symptoms of extrapulmonary TB.

## Follow-up on Suspected Cases of Tuberculosis

When a suspected case of TB is identified, the following should be done:



When a suspected case of pulmonary TB is identified, refer to Table 2: **Guidelines for the Evaluation of Pulmonary Tuberculosis in Adults in Five Clinical Scenarios** in the “Diagnosis of Tuberculosis Disease” topic in this section. This table presents guidelines for the initial steps of TB case detection in five clinical scenarios encountered by providers of primary health care, including those serving in medical emergency departments.<sup>20</sup>



For a summary of the TB classification numbers, refer to the “Tuberculosis Classification System” topic in the Surveillance section.



To formally report a suspected case of TB, see the “Reporting Tuberculosis” topic in the Surveillance section.



The patient should be masked and immediately excluded from the workplace or placed in airborne infection isolation (AII) until confirmed noninfectious. For more information, see the “Isolation” topic in the Infection Control section of this manual.



Laboratories should report positive smears or positive cultures, and primary healthcare providers should report suspected or confirmed cases of TB to the health department, as specified in the “Reporting Tuberculosis” topic in the Surveillance section. Prompt reporting allows the health department to organize treatment and case management services and to initiate a contact investigation as quickly as possible.<sup>21</sup>



Within 48 hours of suspect identification, administer a tuberculin skin test (TST) or perform an interferon gamma release assay (IGRA) and/or provide a chest radiograph. Evaluate the patient for TB disease as specified in the “Diagnosis of Tuberculosis Disease” topic in this section.

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# Diagnosis of Tuberculosis Disease

Consideration of tuberculosis (TB) disease as a possible diagnosis is the first step that must be taken before further evaluation, diagnosis, and management can occur. The diagnosis of TB disease is often overlooked because of the failure to consider it among possible diagnoses. While a definitive diagnosis may involve the addition of laboratory and radiographic findings, a high degree of suspicion can be based on epidemiology, medical history, and physical examination. In considering TB disease, it is also important to consider factors that may affect the typical presentation of TB, such as the patient's age, nutritional status, and coexisting diseases.

An individual who is suspected of having TB disease requires a complete medical evaluation, including the following:

- Medical history, including exposure, symptoms, previous treatment for TB, and risk factors
- Human immunodeficiency virus (HIV) screening
- Physical examination
- Tuberculin skin test (TST) or interferon gamma release assay (IGRA)
- Chest radiography
- Bacteriologic examination

When a suspected case of pulmonary TB is identified, refer to Table 2 for guidelines on the initial steps of TB case detection in five clinical scenarios encountered by providers of primary healthcare, including those serving in medical emergency departments.<sup>22</sup>

Table 2: GUIDELINES FOR THE EVALUATION OF PULMONARY TUBERCULOSIS IN ADULTS IN FIVE CLINICAL SCENARIOS<sup>23</sup>

Patient and Setting	Recommended Evaluation
Any patient with a cough of $\geq 2$ –3 weeks' duration	Chest radiograph: If suggestive of tuberculosis (TB)*, collect 3 sputum specimens for acid-fast bacilli (AFB) smear microscopy, culture, and nucleic acid amplification (NAA), if available <sup>24</sup>
Any patient at high risk for TB with an unexplained illness, including respiratory symptoms of $\geq 2$ –3 weeks' duration <sup>†</sup>	Chest radiograph: If suggestive of TB, collect 3 sputum specimens for AFB smear microscopy, culture, and NAA, if available
Any patient with human immunodeficiency virus (HIV) infection and unexplained cough or fever	Chest radiograph, and collect 3 sputum specimens for AFB smear microscopy, culture, and NAA, if available
Any patient at high risk for TB with a diagnosis of community-acquired pneumonia who has not improved after 7 days of treatment <sup>†</sup>	Chest radiograph, and collect 3 sputum specimens for AFB smear microscopy, culture, and NAA, if available
Any patient at high risk for TB with incidental findings on chest radiograph suggestive of TB even if symptoms are minimal or absent <sup>‡</sup>	Review of previous chest radiographs, if available, 3 sputum specimens for AFB smear microscopy, culture, and NAA, if available
<p>* Opacities with or without cavitation in the upper lobes or the superior segments of the lower lobes.<sup>25</sup></p> <p><sup>†</sup> See Table 1: Persons at High Risk for Tuberculosis Infection and Progression to Tuberculosis Disease in the section on Diagnosis of Tuberculosis Infection.</p> <p><sup>‡</sup> Chest radiograph performed for any reason, including targeted testing for TB infection and screening for TB disease.</p>	

Source: Adapted from: ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):33.

## Medical History

The clinician should interview patients to document their medical histories. A written record of a patient's medical history should include the following:

- Exposure to infectious TB
- Symptoms of TB disease (as listed in Table 1: **When to Suspect Pulmonary Tuberculosis in Adults**, Table 2: **Guidelines for the Evaluation of Pulmonary Tuberculosis in Adults in Five Clinical Scenarios**, and Table 3: **Symptoms of Tuberculosis Disease**)
- Previous TB infection or disease
- Risk factors (as listed in Table 1: **Persons at High Risk for Tuberculosis Infection and Progression to Tuberculosis Disease** in the section on Diagnosis of Tuberculosis Infection)
- Recent medical encounters (e.g., going to the emergency department for pneumonia)
- Previous antibiotic therapy

## **1. Exposure to Infectious TB:**

### **Ask patients if they have spent time with someone with infectious TB.**

Question patients about whether they know of any contact in the recent or distant past with persons diagnosed with pulmonary or laryngeal TB. It is important to note that patients often refer to TB infection (TBI) as TB disease. Be aware that most persons become infected with *Mycobacterium tuberculosis* without knowing they were exposed. Clinicians should also consider demographic factors that may increase a patient's risk for exposure to TB disease and drug-resistant TB, such as country of origin, age, ethnic or racial group, occupation, and residence in congregate settings (such as a jail, homeless shelter, or refugee camp).

## **2. Symptoms of TB Disease:**

### **Ask patients about their symptoms.**

Although TB disease does not always produce symptoms, most patients with TB disease have one or more symptoms that led them to seek medical care. When symptoms are present, they usually have developed gradually and been present for weeks or even months. Occasionally, however, TB is discovered during a medical examination for an unrelated condition, such as ruling out a cancer diagnosis (e.g., through a chest radiograph given to patients before surgery).

The symptoms in Table 3 below may be caused by other diseases, but they should prompt the clinician to suspect TB disease. For historic features and chest radiograph results that should raise suspicion of pulmonary TB disease, refer to Table 1: **When to Suspect Pulmonary Tuberculosis in Adults.**

Table 3: SYMPTOMS OF TUBERCULOSIS DISEASE<sup>26</sup>

Pulmonary	General: Pulmonary and Extrapulmonary	Extrapulmonary
<ul style="list-style-type: none"> <li>▪ Coughing</li> <li>▪ Coughing up sputum or blood</li> <li>▪ Pain in the chest when breathing or coughing</li> </ul>	<ul style="list-style-type: none"> <li>▪ Chills<sup>27</sup></li> <li>▪ Fever</li> <li>▪ Night sweats</li> <li>▪ Loss of appetite<sup>28</sup></li> <li>▪ Weight loss</li> <li>▪ Weakness or easy fatigability<sup>29</sup></li> <li>▪ Malaise (a feeling of general discomfort or illness)<sup>30</sup></li> </ul>	<p>The symptoms depend on part of body affected by tuberculosis (TB) disease:</p> <ul style="list-style-type: none"> <li>▪ TB of the spine may cause pain in the back.</li> <li>▪ TB of the kidney may cause blood in the urine.</li> <li>▪ Meningeal TB may cause headaches or psychiatric symptoms.</li> <li>▪ Lymphatic TB may cause swollen and tender lymph nodes, often at the base of the neck.</li> </ul>

Source: Adapted from: ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):33.

### 3. Previous TB Infection or TB Disease:

**Ask patients whether they have ever been diagnosed with or treated for TB infection or disease.**

- **Patients who have had TB disease before** should be asked when they had the disease and how the disease was treated. Ask how many pills were taken per day (to determine what treatment regimen was used and whether they received injections). If the regimen prescribed was inadequate or if the patient did not follow the recommended treatment, TB may recur, and it may be resistant to one or more of the drugs used.
- **Patients known to have a positive skin test reaction** probably have TB infection. If they were infected within the past two years, they are at high risk for TB disease if certain immunosuppressive conditions exist or if immunosuppressive therapies are being taken. (See Table 1: **Persons at High Risk for Tuberculosis Infection and Progression to Tuberculosis Disease** in the section on Diagnosis of Tuberculosis Infection.)<sup>31</sup> For persons previously skin tested, an increase in induration of 10 mm within a two-year period is classified as a conversion to positive.

#### **4. Risk Factors for Developing TB Disease: Determine whether patients have any conditions or behaviors that are risk factors for developing TB disease.**

For a list of behaviors and conditions that appear to increase the risk that TB infection will progress to disease, see Table 1: **Persons at High Risk for Tuberculosis Infection and Progression to Tuberculosis Disease** in the section on Diagnosis of Tuberculosis Infection.

### Human Immunodeficiency Virus Screening

Voluntary counseling and testing for human immunodeficiency virus (HIV) is recommended for all patients with TB. HIV counseling and testing has also been recommended for contacts of persons with TB.<sup>32</sup>

The Centers for Disease Control and Prevention (CDC) recommends the following:

- Routine HIV screening for all patients ages 13–64 seeking health care for any reason, without regard to any patient’s known risks for HIV infection
- Annual HIV screening of patients known to be at high risk<sup>33</sup>

### Physical Examination

A physical examination is an essential part of the evaluation of any patient. It cannot be used to confirm or rule out TB, but it can provide valuable information about the patient’s overall condition; other factors, such as human immunodeficiency virus (HIV) infection, which may affect how TB is manifested; and the presence of extrapulmonary TB.<sup>34</sup>

### Tuberculin Skin Test and Interferon Gamma Release Assays



For information on interferon gamma release assays (IGRAs), refer to the “Interferon Gamma Release Assays” topic in the section on Diagnosis of Tuberculosis Infection.

Use the Mantoux tuberculin skin test (TST) or an interferon gamma release assay (IGRA) to test for *M. tuberculosis* infection. Note that for patients with a previous documented positive TST reaction, a TST is not necessary. However, an IGRA can be done if there is suspicion that the TST result was a false positive. Additional tests, such as chest radiography and bacteriologic examination, are required to confirm TB disease.

For both the TST and IGRA, additional tests, such as chest radiography and bacteriologic examination, are required to confirm TB disease.<sup>35</sup>

Persons with a positive TST, QFT-G, or QFT™ result, regardless of signs or symptoms, should be evaluated for TB disease before TBI is diagnosed. At minimum, a chest radiograph should be examined for abnormalities consistent with TB disease.<sup>36</sup>

A negative TST does not rule out TB disease<sup>37</sup>—**as many as 20% of patients with TB disease have a negative TST reaction.**<sup>38</sup> A negative TST, QFT-G, or QFT™ result should not be used alone to exclude *M. tuberculosis* infection in persons with symptoms or signs suggestive of TB disease. Medical evaluation of such persons should include a history and physical examination, chest radiograph, bacteriologic studies, serology for human immunodeficiency virus (HIV), and, when indicated, other tests or studies.<sup>39</sup>



For more information on the Mantoux TST, see the Diagnosis of Tuberculosis Infection section. For more information on IGRAs and the QuantiFERON®-TB Gold (QFT-G) Test, see the CDC's "Guidelines for Using the QuantiFERON®-TB Gold Test for Detecting *Mycobacterium tuberculosis* Infection, United States" (*MMWR* 2005;54[No. RR-15]) at this hyperlink:

<http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf> .

## Chest Radiography

A posterior-anterior radiograph of the chest is the standard view used for the detection and description of chest abnormalities in adults. In some instances, other views (e.g., lateral, lordotic) or additional studies (e.g., computed tomography [CT] scans) may be necessary.



Children younger than five years of age should receive posterior-anterior and lateral radiographs.<sup>40</sup>

Certain abnormalities on chest radiographs are suggestive, but are not diagnostic, of TB. In pulmonary TB, radiographic abnormalities are often seen in the apical and posterior segments of the upper lobe or in the superior segments of the lower lobe. However, lesions may appear anywhere in the lungs and may differ in size, shape, density, and presence or absence of cavitation, especially in HIV-infected and other immunosuppressed persons.

In HIV-infected persons, pulmonary TB may present atypically on the chest radiograph. For example, TB may cause opacities without cavities in any lung zone, or it may cause mediastinal or hilar lymphadenopathy with or without accompanying opacities and/or cavities. In HIV-infected persons, almost any abnormality on a chest radiograph may indicate TB. In fact, the radiograph of an HIV-infected person with TB disease may even appear entirely normal.<sup>41</sup>



For more information on chest radiography, see the Francis J. Curry National Tuberculosis Center's *Radiographic Manifestations of Tuberculosis: A Primer for Clinicians* (2006) at this hyperlink:

[http://www.nationaltbcenter.ucsf.edu/products/product\\_details.cfm?productID=EDP-04](http://www.nationaltbcenter.ucsf.edu/products/product_details.cfm?productID=EDP-04) .

## Bacteriologic Examination

Refer to Table 4 below to determine the types of specimens needed to assist in the diagnosis of TB.

Table 4: SPECIMENS FOR DIAGNOSING TUBERCULOSIS DISEASE

Suspected Diagnosis	Specimen Needed
<b>Pulmonary or laryngeal tuberculosis (TB)</b>	<p>Sputum (phlegm from deep in the lungs) samples for smear and culture examination.</p> <p>If a diagnosis of pulmonary TB cannot be established from sputum smear, other procedures may be necessary, including nucleic acid amplification (NAA), bronchoscopy, and gastric aspiration in children.</p>
<b>Extrapulmonary TB</b>	<p>Depending on the anatomical site, other clinical specimens are necessary, such as:</p> <ul style="list-style-type: none"><li>▪ Urine</li><li>▪ Cerebrospinal fluid</li><li>▪ Pleural fluid</li><li>▪ Pus or other aspirated fluid</li><li>▪ Biopsy specimens</li></ul>

Refer to Table 5 below for information on the bacteriologic tests used to diagnose TB.

Table 5: BACTERIOLOGIC TESTS USED IN DIAGNOSING TUBERCULOSIS DISEASE<sup>42</sup>

Test	Description	Laboratory Turnaround Times
<b>Acid-Fast Bacilli (AFB) Smear</b>	<ul style="list-style-type: none"> <li>Provides the physician with a preliminary confirmation of the diagnosis. It usually is the first bacteriologic evidence of the presence of mycobacteria in a clinical specimen.</li> <li>If positive, gives a semiquantitative estimate of the number of bacilli being excreted (which is of vital clinical and epidemiologic importance in assessing the patient's infectiousness).</li> </ul>	<ul style="list-style-type: none"> <li>On-site test: within 24 hours from specimen collection</li> <li>Off-site test: within 24 hours from laboratory receipt of specimen (time from specimen collection to laboratory receipt should be 24 hours or less)<sup>43</sup></li> </ul>
<b>Nucleic Acid Amplification (NAA) Assay<sup>44</sup></b>	<ul style="list-style-type: none"> <li>A test done on sputum specimens for the direct and rapid identification of the <i>Mycobacterium tuberculosis</i> complex.</li> <li>Allows for the amplification of specific target sequences of nucleic acids that will be detected by a nucleic acid probe.</li> <li>Does not replace the need for routine AFB smear and culture.<sup>45</sup></li> </ul>	<ul style="list-style-type: none"> <li>Within 48 hours from specimen collection<sup>46,47</sup></li> </ul>
<b>Culture</b>	<ul style="list-style-type: none"> <li>Usually necessary for species identification of all clinical specimens suspected of containing mycobacteria.</li> <li>Required for drug susceptibility testing and genotyping.</li> </ul>	<ul style="list-style-type: none"> <li>Mycobacterial growth detection: within 14 days from specimen collection</li> <li>Identification of mycobacteria: within 21 days from specimen collection<sup>48,49</sup></li> </ul>
<b>Drug Susceptibility Testing</b>	<ul style="list-style-type: none"> <li>For first-line drugs: performed on initial isolates of all patients to identify an effective antituberculosis regimen.</li> <li>For both first-line and second-line drugs: repeated on interim isolates when a patient remains culture-positive after 3 months of treatment.<sup>50,51</sup></li> </ul>	<ul style="list-style-type: none"> <li>First-line drugs: within 30 days from specimen collection</li> <li>Second-line drugs: within 4 weeks from date of request</li> </ul>

Sources: ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):19; and Tenover, R., et al. The resurgence of tuberculosis: is your laboratory ready? *Journal of Clinical Microbiology* 1993;767-770.

Laboratories should report positive smears or positive cultures, and primary healthcare providers should report suspected or confirmed cases of TB to the health department, as specified in the “Reporting Tuberculosis” topic in the Surveillance section. Prompt reporting allows the health department to organize treatment and case management services and to initiate a contact investigation as quickly as possible.<sup>52</sup>



For information on reporting, see the “Reporting Tuberculosis” topic in the Surveillance section.



For a list of all of the laboratory services available and information on specimen collection and shipment, see the Laboratory Services section.



For laboratory services available in Ohio, contact ODH Lab at (614) 644-4669.

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# Resources and References

## Resources

- ATS, CDC, IDSA. “Diagnostic Standards and Classification of Tuberculosis in Adults and Children” (*Am J Respir Crit Care Med* 2000;161[4 Pt 1]). Available at: <http://www.cdc.gov/tb/publications/PDF/1376.pdf>.
- CDC. *Self-Study Modules on Tuberculosis* (Division of Tuberculosis Elimination Web site; 1999). Available at: <http://www.cdc.gov/tb/education/ssmodules/default.htm> .
- CDC. *Core Curriculum on Tuberculosis (2013)* (Division of Tuberculosis Elimination Web site; updated July 2013). Available at [http://www.cdc.gov/tb/education/corecurr/pdf/corecurr\\_all.pdf](http://www.cdc.gov/tb/education/corecurr/pdf/corecurr_all.pdf)
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- <sup>1</sup> ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):15.
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- <sup>3</sup> ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):32.
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- <sup>5</sup> ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):15–16.
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- <sup>7</sup> ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):32.
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