This tool is designed to help healthcare personnel select adults for tuberculosis infection testing who are at high-risk for tuberculosis exposure or progression to TB disease.

TB testing should not be repeated in a person who has been determined to be previously TST or IGRA negative unless a **new** risk factor has been documented since the last test.

Do not treat for LTBI until active TB has been excluded.

### Tuberculosis Risk Assessment for Adults

Test for tuberculosis by interferon gamma release assay (IGRA) or tuberculin skin test (TST) (unless otherwise contraindicated) if **ANY** of the below are selected.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
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| Immunosuppression | Current or planned.  
- HIV infection, diabetes, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication. |
| Close contact | To someone who has had infectious TB disease since the last TB test. |
| Temporary or permanent residence | Of ≥1 month consecutively in a country with high TB rate.  
- Any country other than United States, Canada, Australia, New Zealand, or a country in western or northern Europe.  
- IGRA is preferred over TST for foreign-born persons. |
| Have you experienced any of the following symptoms in the past year? |  
- A bad cough that lasts 3 weeks or longer  
- Hemoptysis (coughing up blood)  
- Unexplained weight loss of 10 pounds or more  
- Fever, Chills or night sweats for no known reason  
- Weakness or unexplained fatigue  
- Chest pain |

| Name: |
| Assessment Date: |
| ☐ New Hire Assessment | ☐ Annual Assessment |
Mandatory Testing
There are no mandates or statues that require people to be tested for tuberculosis in North Dakota.

Local Recommendations
It is recommended that all persons who test positive for tuberculosis infection, either latent or active disease, be screened for HIV infection.

TB Testing
TB testing should include anyone working or volunteering in health-care settings. Persons (health care personnel and non-health care personnel) who have face to face contact or potential exposure to TB through shared air or pace with infectious patient(s) should be part of the TB program.

A baseline test should be given prior to employment. The result of this test can be compared with later tests (due to potential exposure) to help determine if recent TB transmission has occurred in the facility.

There are two types of testing for TB in health care personnel.
- Two-step testing with a TB skin test
- TB Blood test (IGRA such as QFT or T-Spot)

Annual or Serial Testing
You may need to test for TB on a regular basis. To standardize the interpretation of results, the same type of test should be used for the baseline and the later tests (i.e. TSTs or IGRA).

When to Repeat a Test
Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment. In general, this would include new close contact to an infectious TB case or new immunosuppression but could also include foreign travel in certain circumstances.

Foreign Travel
Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with infectious TB cases, high TB prevalence of TB in travel location, non-tourist travel). Testing should be performed 8-10 weeks after return to the US.

IGRA preference in BCG vaccinated
Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST on these persons. Most persons born outside of the United States have been vaccinated with BCG.

Negative Test for LTBI Does Not Mean No Active TB
It is important to remember that a negative TST or IGRA result does not rule out active TB. In fact, negative TST or IGRA in a patient with active TB can be a sign of extensive disease and poor outcome.

Emphasis on Short Course for Treatment of LTBI
Shorter regimens for treating LTBI have been shown to more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Frequency</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>Isoniazid/Rifapentine (3HP)</td>
<td>1X Week</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Rifampin</td>
<td>Daily</td>
<td>4 months</td>
</tr>
<tr>
<td>Isoniazid</td>
<td>Daily</td>
<td>9 months</td>
</tr>
</tbody>
</table>

DOT = Directly observed therapy; IGRA = Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG = Bacillus Calmette-Guérin; TST = tuberculin skin test; LTBI = latent TB infection