Webinar Q&A- "TB Infection: Identify! Report! Treat!"
Broadcast on: February 15, 2019
Responses provided by Lara Beth Gadkowski, MD, MPH, MS

<table>
<tr><th>Question Asked</th><th>Answer Given</th></tr>
<tr><td>With immigrant children, when should you suspect BCG vaccination and how do you handle this when immunization history is unknown?</td><td>Visit the BCG altas website (bcgatlas.org) for country specific information. If possible, use an IGRA for the test for infection.</td></tr>
<tr><td>Is there still training available for TST reading?</td><td>You can visit the CDC webpage to view an online training (https://tools.cdc.gov/medialibrary/index.aspx#/media/id/302210). You can also reach out to your local health department for training.</td></tr>
<tr><td>With the two types of IGRAs, is one more sensitive than the other?</td><td>They have comparable sensitivity and specificity. I, Dr. Beth Gadkowski, personally prefer T-Spot in people living with HIV with low CD4 counts.</td></tr>
<tr><td>We've had a positive T-Spot occur, followed by a negative QuantiFERON. The patient didn't like the T-Spot result, so had their PCP do the QuantiFERON.</td><td>This is where the likelihood of having LTBI and the risk of progressing to active TB are helpful in determining how to interpret these discordant tests. If the individual has a high likelihood of having LTBI or progressing to active TB, take the positive test result. If they are at low risk, take the negative test result.</td></tr>
<tr><td>Are R76.11 and R76.12 the only diagnosis codes that require reporting for LTBI?</td><td>R76.11 is the LTBI diagnosis code for a positive TST and R76.12 is the LTBI diagnosis code for a positive IGRA.
<table>
<tr><th colspan="3">TB Skin Test</th><th colspan="3">QFT-GIT Testing</th></tr>
<tr><td>Z11.1</td><td colspan="2">TB Skin Test Negative</td><td>Z11.1</td><td colspan="2">QFT-GIT Negative</td></tr>
<tr><td>R76.11</td><td colspan="2">TB Skin Test Positive</td><td>R76.12</td><td colspan="2">QFT-GIT Positive</td></tr>
<tr><th colspan="3">T-Spot Testing</th><td>R76.8</td><td colspan="2">QFT-GIT Indeterminate</td></tr>
<tr><td>Z11.1</td><td colspan="2">T-spot Negative</td><td>R76.9</td><td colspan="2">QFT-GIT Unsatisfactory</td></tr>
<tr><td>R76.12</td><td colspan="2">T-spot Positive</td><td>Z53.8</td><td colspan="2">QFT-GIT Not Performed</td></tr>
<tr><td>R76.8</td><td colspan="2">T-spot Borderline</td><th colspan="3">TB Infection</th></tr>
<tr><td>R76.9</td><td colspan="2">T-spot Invalid</td><td>R76.11</td><td colspan="2">TB Skin Test Positive</td></tr>
<tr><td>Z53.8</td><td colspan="2">T-spot Not Performed</td><td>R76.12</td><td colspan="2">QFT-GIT Positive</td></tr>
<tr><td></td><td colspan="2"></td><td>R76.12</td><td colspan="2">T-spot Positive</td></tr>
<tr><th>TB Suspect (without symptoms)</th><th>TB Suspect (with symptoms)</th><th>TB Contact</th><th>TB Inactive (Healed)</th><th>Personal History of TB</th><th>B-notification Evaluation</th></tr>
<tr><td>Z03.89</td><td>Use symptoms code(s)</td><td>Z20.1</td><td>B90.9 (code first the condition resulting from the sequela)</td><td>Z86.11</td><td>Z02.89</td></tr>
</table></td></tr>
<tr><td>Are there any changes in managing MDR TB patients who need imaging/treatment/admission to hospital (from Infection Prevention standpoint)?</td><td>Infection control precautions should be the same. MDR treatment regimens are different. The best resource for MDR treatment is the "Drug Resistant Tuberculosis: A Survival Guide for Clinicians" produced by the Curry International Tuberculosis Center. It can be downloaded from their website: https://www.currytbcenter.ucsf.edu/products/view/drug-resistant-tuberculosis-survival-guide-clinicians-3rd-edition</td></tr>
<tr><td>Is latent TB treatment directly-observed by VDH? What about non-compliant patients or those who refuse latent TB treatment?</td><td>VDH recommends Directly Observed Therapy (DOT) for the 12 week 3HP treatment regimen. This DOT can be done by Video Enhanced Therapy (VET) or in person. VDH also recommends DOT sometimes</td></tr>
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	referred to as DOPT (Directly Observed Preventive Therapy) for young children, HIV positive individuals, and others at a very high risk, for the INH x 9mo and Rif x 4mo regmiens. Dealing with non-compliant patients is done on a case by case basis.
How is Virginia tracking a person with a positive latent TB test that is non-compliant that may convert to active and be infectious.	At this time, Virginia is not tracking those who have a positive TB test for infection but are not taking treatment.
Is the IGRA test done only once?	Usually. However, it can be repeated in the same scenarios that would call for TST to be repeated.
What induration is considered a positive in a healthy adult who will begin patient contact in a training program but who has never been a health care worker in the past?	If absolutely no risks are identified, the induration would need to be 15mm or greater.
Will money be allocated for treatment of LTBI by VDH?	Patients who receive treatment through the health department in Virginia can receive their medications at no charge, however, other visit fees may apply and depend on the local health department.
In your slide, you note that 4-6% of patients with LTBI will go on to develop active TB disease. In general, we have used the figure of 10%. Is the 10% figure too high?	The 10% figure is not too high as this is the general life time risk figure that is often quoted.
For a diabetic with LTBI, what is the lifetime risk of progression to active TB disease?	In general we say that a person with diabetes has a 3x greater risk for progression to active TB disease than a healthy adult.
How can you follow up with a patient who already took LTBI treatment, but for example after treatment they continue to visit their country with a high TB incidence (ex. Peru) 3 or 4 times a year?	Studies suggest that individuals who have completed LTBI treatment are less likely to be re-infected. However, there is no objective way to follow these individuals. The affected individual needs to be aware of signs and symptoms of active TB.