

# **Santa Clara County Tuberculosis Screening Requirement for School Entrance Effective June 1, 2014**

## **Frequently Asked Questions**

### **A child has history of BCG vaccination, should they have TST or IGRA?**

According to the American Academy of Pediatrics Red Book (2012), Interferon Gamma Release Assay (IGRA) is the preferred test for children  $\geq 5$  years of age that have a history of BCG vaccination. For children  $\leq 5$  years of age, TST is preferred but IGRA is acceptable.

Among TB experts, IGRA blood tests, e.g. QuantiFeron or T-spot, which must be done in the U.S., are reliable for children who are at least 4 years old at the time the blood test is done. There is insufficient data on the sensitivity of IGRA and reports of high indeterminate results among children 0-2 years of age.

Of note, effective March 1, 2014, Medi-Cal removed the age restriction on Medi-Cal reimbursement for IGRA tests for children under 5 years old. The California Department of Health Care Services posted this announcement on their website: "Effective for dates of service on or after March 1, 2014, the minimum patient age for reimbursement with CPT-4 codes 86480 (tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon) and 86481 (tuberculosis test, enumeration of gamma interferon-producing T-cells in cell suspension) is lowered from 5 to 0 years."

### **Are there ever indications for doing both a TST AND an IGRA?**

In general, a provider should choose the appropriate test and avoid doing both tests or using IGRA results to validate positive TST results. A child with a positive result for either TST or IGRA should have a chest X-ray and be treated appropriately.

There are some indications for doing both tests but this should not be routine. If an initial IGRA is indeterminate or borderline, do a TST. Or if an initial test (TST or IGRA) is negative AND there is clinical suspicion for TB disease or risk of infection, progression and poor outcome is higher. For children who are immunocompromised do both tests AND obtain a chest X-ray.

### **Okay, you said not to, but I did both TST and IGRA and get different results. What do I do now?**

Obtain a chest-X ray. If there is a high index of suspicion for active TB disease or risk of progression from infection (i.e. young child, immunocompromised) then treat if either test is positive. If you have questions, please call the TB Prevention and Control Program at (408) 885-4214.

### **The BCG vaccination may have affected the TST result. What do I do?**

Any new TST result  $\geq 10$  mm induration will be read as a positive TB screening result regardless of whether or not the child received a BCG vaccination. The student must demonstrate that they are free of communicable disease. In most cases, this will require a chest x-ray done in the United States up to 12 months prior to school registration.

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## **What if the student has a previous positive TST/IGRA from outside the country?**

The student will be required to obtain an IGRA and/or undergo a chest x-ray in the United States.

## **This student left the county for an extended vacation. Do they still need a TB screening test?**

If the student has traveled for greater than 1 week to a country in Africa, Asia, Latin America, or Eastern Europe they should be re-evaluated by a healthcare provider and evaluated for possible exposure to TB but this will not be required for school re-entry.

## **What is considered an adequate regimen for latent TB Infection?**

The recommended regimen for latent TB infection is isoniazid for 9 months, usually co-administered with vitamin B6. Children 12 years and older may be considered for weekly dosing of rifapentine and isoniazid by directly observed therapy (DOT) for 12 weeks. An alternate regimen, usually reserved for children exposed to drug resistant TB, is rifampin for six months. See Table on page 7

For review of LTBI treatment regimens other than isoniazid see the table below or contact the TB Prevention and Control Program at (408) 885-4214.

## **What will be the “Catch-Up” procedure for students who were deferred due to the Tuberculin shortage in 2013?**

Students who were tracked because they did not receive a TST or any TB risk assessment evaluation due to the tuberculin shortage should receive instruction to follow-up with their health care provider and undergo TB risk assessment screening assessment. These students should return TB Risk Assessment form prior to starting the 2014-2015 school year.

All other questions regarding the Mandate should be directed to the Public Health Department’s TB Prevention and Control Program at (408) 885-4214. Please follow the prompts below to speak with a PHD staff member:

- Press option 1 for English/2 for Spanish then,
- Press option 6 for “All other TB calls” and you will be connected with PH staff prepared to accept your call.

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**Table. Latent Tuberculosis Infection Treatment Regimens for Children**

Drug(s)	Duration	Dose	Frequency	Total Doses
Isoniazid (INH)	9 months	Children: 10-20 mg/kg** Maximum dose: 300 mg	Daily	270
Isoniazid (INH) and Rifapentine (RPT)	3 months	Adults and Children 12 and over: <b>INH*</b> : 15 mg/kg rounded up to the nearest 50 or 100 mg; 900 mg maximum <b>RPT*</b> : 10.0–14.0 kg 300 mg 14.1–25.0 kg 450 mg 25.1–32.0 kg 600 mg 32.1–49.9 kg 750 mg ≥50.0 kg 900 mg maximum	Once weekly by DOT †	12
Rifampin (RIF)	6 months	Children: 10-20 mg/kg*** Maximum dose: 600 mg	Daily	120

\*Isoniazid (INH) is formulated as 100 mg and 300 mg tablets. Rifapentine (RPT) is formulated as 150 mg tablets in blister packs that should be kept sealed until usage.

\*\* The American Academy of Pediatrics recommends an INH dosage of 10-15 mg/kg for the daily regimen.

† DOT: Directly observed therapy

\*\*\*In the United States, the recommended regimen for treatment of LTBI in children is a 9-month course of INH. For the treatment of LTBI in infants, children, and adolescents when INH could not be tolerated or the child has had contact with a case patient infected with an isoniazid-resistant but rifamycin-susceptible organism the American Academy of Pediatrics recommends 6 months of daily rifampin (RIF) (180 doses) at a dosage of 10-20 mg/kg.

### References

American Academy of Pediatrics, Committee on Infectious Diseases. Tuberculosis. In L.K. Pickering (Ed.), 2009 *Red Book: Report of the Committee on Infectious Diseases*. 27<sup>th</sup> ed. Elk Grove Village, IL: American Academy of Pediatrics, 2009:680-701.

Pang J, Teeter LD, Katz DJ, et al. Epidemiology of Tuberculosis in Young Children in the United States. *Pediatrics*, 2014:494-504.

Pediatric Tuberculosis Collaborative Group. Targeted Tuberculin Skin Testing and Treatment of Latent Tuberculosis Infection in Children and Adolescents. *Pediatrics* 2004; 114 (14):1175-1201.

Centers for Disease Control and Prevention Tuberculosis Information: <http://www.cdc.gov/tb/>