



Tuberculosis: Opportunities for Prevention

Kern County Public Health TB Healthcare Provider Symposium
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Objectives

1. Understand the basics of tuberculosis (**TB**) disease and latent TB infection (**LTBI**), and the differences between them
2. Define the **burden** of TB globally and in California, and explain the relevance of LTBI in California
3. Identify patient populations at risk for TB and how to test for TB infection, including preferential use of interferon gamma release assay (**IGRA**) **testing for non-U.S.-born persons**
4. Understand the importance of diagnosing and treating LTBI to prevent TB disease, and describe and apply preferred **short-course LTBI treatment regimens** to improve treatment completion outcomes
5. Describe and perform a proper clinical **evaluation to exclude TB disease**, and describe and apply next steps in care for a patient with TB disease including reporting, treatment regimens, and case management



TB/LTBI Background and Epidemiology

Tuberculosis Basics

- Infectious disease caused by organisms of the ***Mycobacterium tuberculosis (MTB) complex***
 - Acid-fast aerobic bacillus with lipid cell wall
 - Bacterium discovered in 1882
- First TB drugs developed in 1940s-50s
- **Airborne spread**, person-to-person
- Lungs most common site of disease

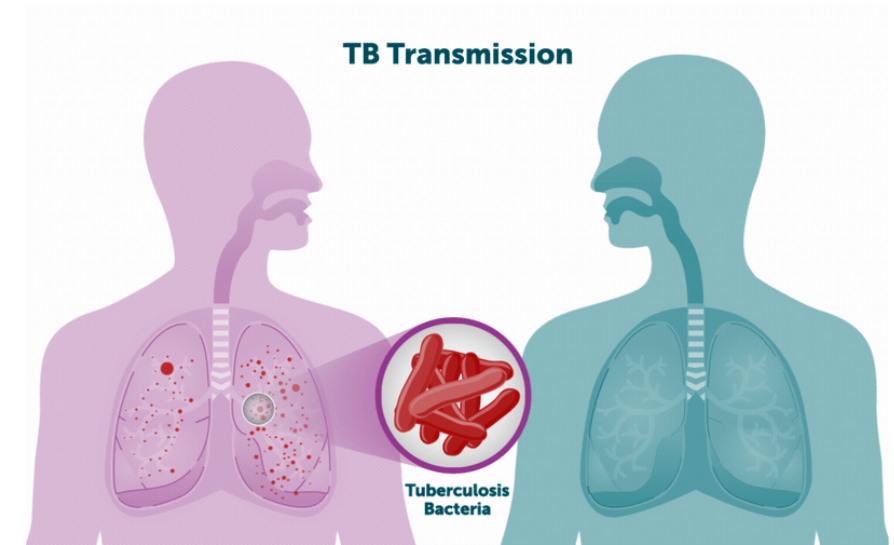
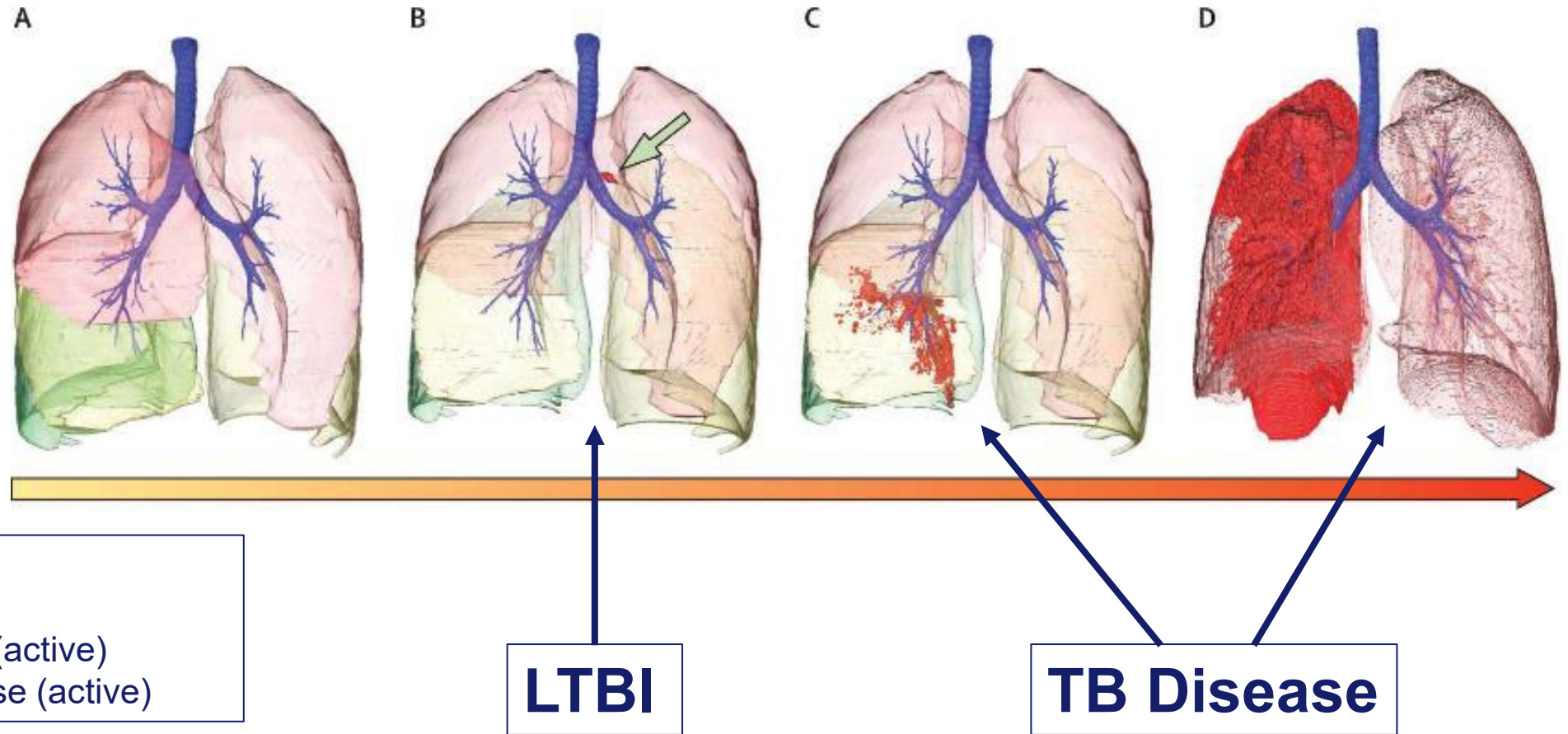


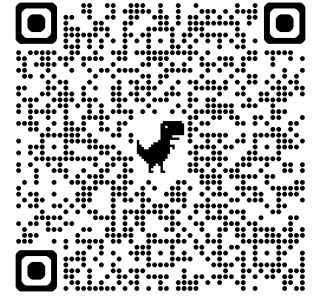
Image: CDC

The Spectrum of TB



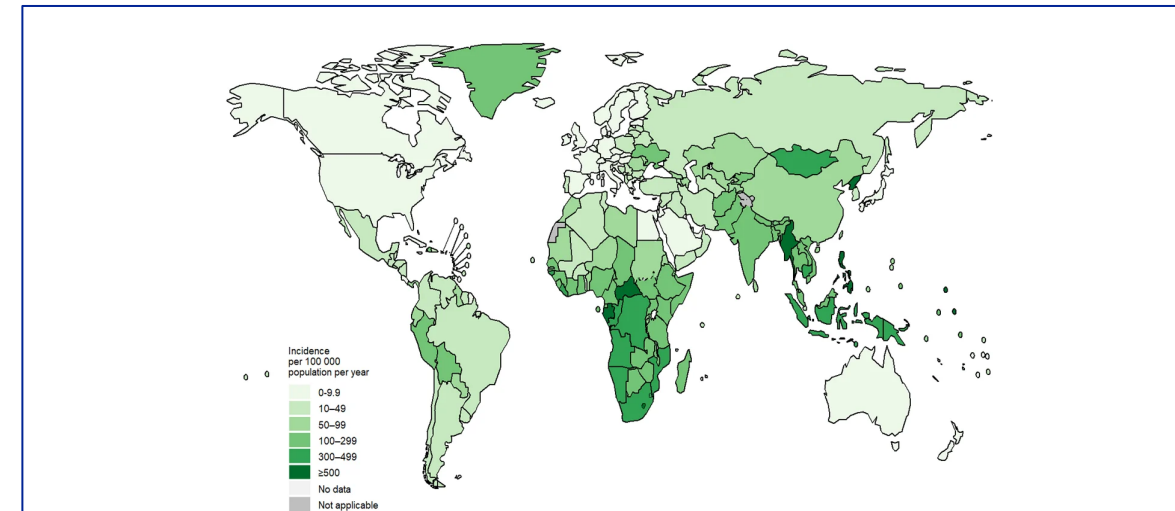
Global Burden of TB

- **#1 cause of death** from a single infectious agent, and among the top 10 causes of death
 - In 2024, 10.7 million developed TB and 1.23 million died
 - Leading cause of death among those living with HIV
- **Estimated 25% of global population has LTBI (~1.7 billion)**



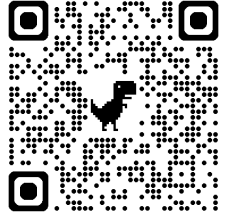
WHO High-Burden
Countries for TB

Estimated TB Incidence rates, 2024



WHO Global Tuberculosis Report 2025

TB in California, 2025



TB in CA 2025 Snapshot

- **5.4 cases** per 100,000 persons (2x U.S. rate!)
- **2,150 persons** with new diagnosis of TBD
 - Half are hospitalized
 - 1 in 6 die within 5 years of diagnosis
 - *83% attributable to progression of LTBI to TBD*
- TB disease reported in 45 of 61 local health jurisdictions
- **Estimated >2 million Californians have LTBI (~6% of population)**

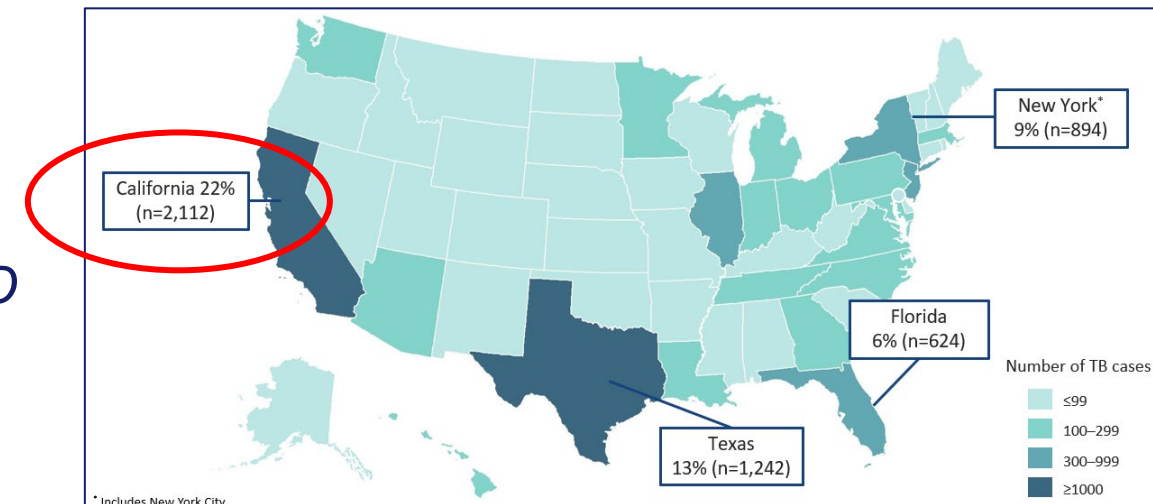
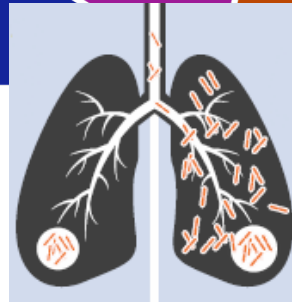


Image: CDC, 2024

TBCB CDPH, 2025



LTBI

- **No TB symptoms**
- **Not infectious**
- Positive TB test (TST¹ or IGRA²)
- Chest x-ray (CXR) normal
- May be unaware of infection
- Treat with 1-2 drugs (3-4 mos)

¹TB skin test

²Interferon gamma release assay

CDC, 2020

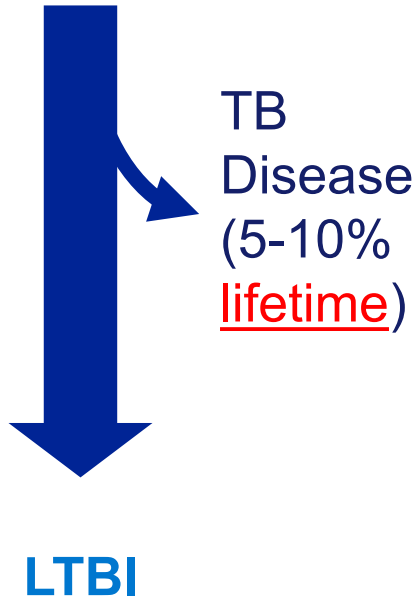
TB Disease

- **Symptoms (cough, fever, weight loss)**
- **Infectious and can be deadly**
- TST or IGRA usually positive
- CXR usually abnormal
- Respiratory specimens usually culture positive; smear positive for ~50%
- Treat with multiple drugs (6+ mos)

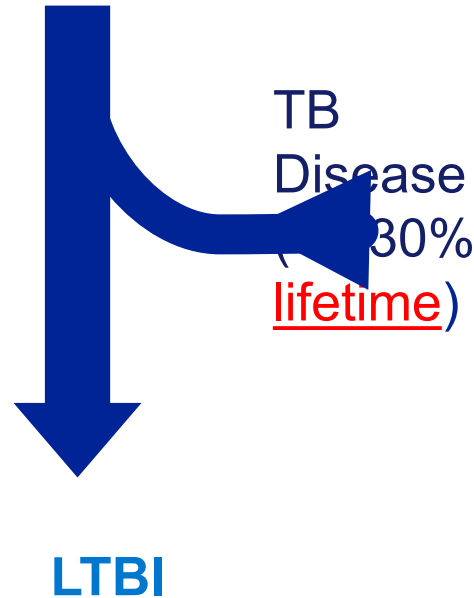
Always rule out TB disease before starting treatment for LTBI!

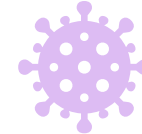
Co-morbidities increase risk of progression from LTBI to TB disease:

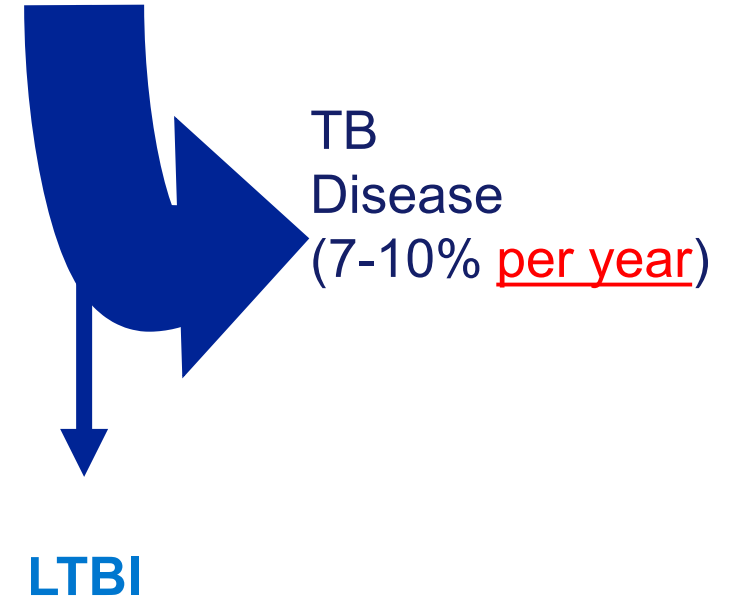
 TB infection
No risk factors



 TB infection
and diabetes



 TB infection
and HIV (untreated)



Why Address TB Prevention?



*No effective TB vaccine
(LTBI treatment = prevention)*



Evidence-based recommendations



*Part of California Health and
Safety Code (AB 2132), as of 2025*

Costs & Consequences of TB



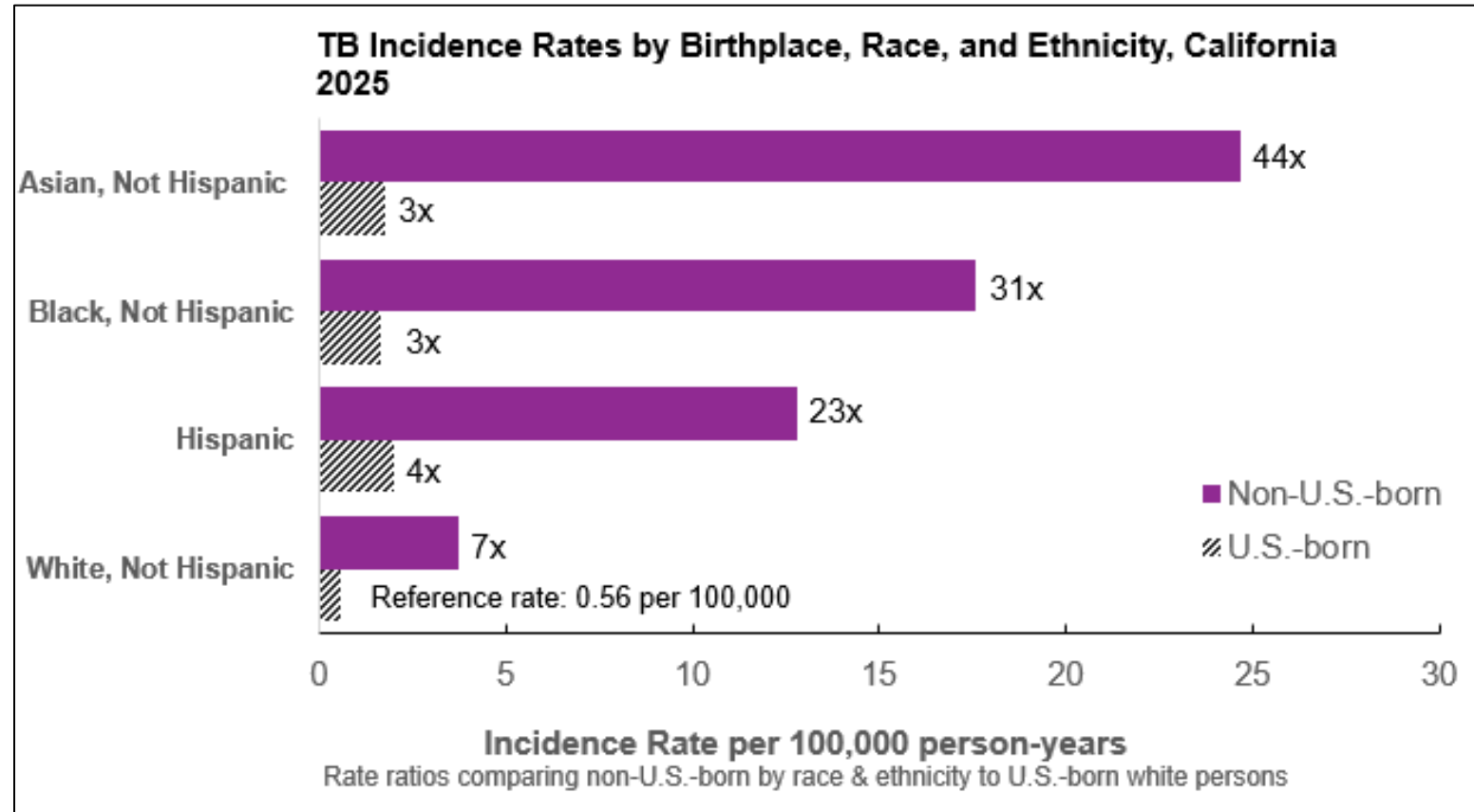
- **Death, disability, hospitalization**
- **Lifetime risk of progressing to TB ~10%**
 - Higher in certain risk groups (HIV, diabetes)
 - Treatment reduces risk of progression **~90%**
- TB prevention cheaper than treating TB disease
 - In CA: TB prevention **(\$857/person)** vs disease **(\$43,000/person)**
- Protect individuals, families, and the community

USPSTF, 2023; TBCB 2021

TB Contributes to Health Disparities

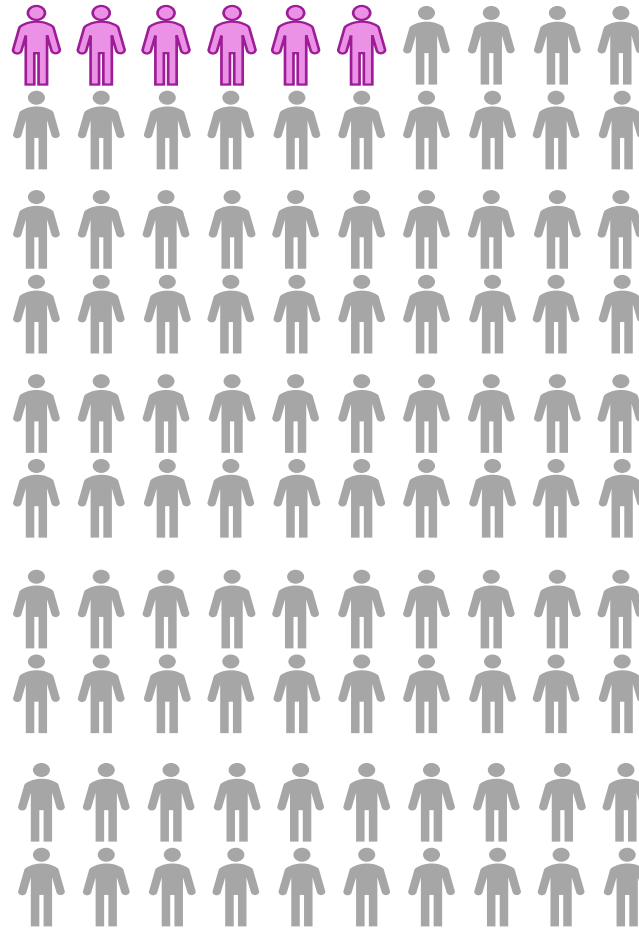
In California, 2025:

- **Race/ethnicity of those with TB disease:**
 - 47% non-Hispanic Asian
 - 43% Hispanic
- **Place of birth:**
 - TB disease rates among non-U.S.-born persons of color compared to white U.S.-born **23-44 times greater**



LTBI in California

Estimated >2 million Californians have LTBI (~6% of population)

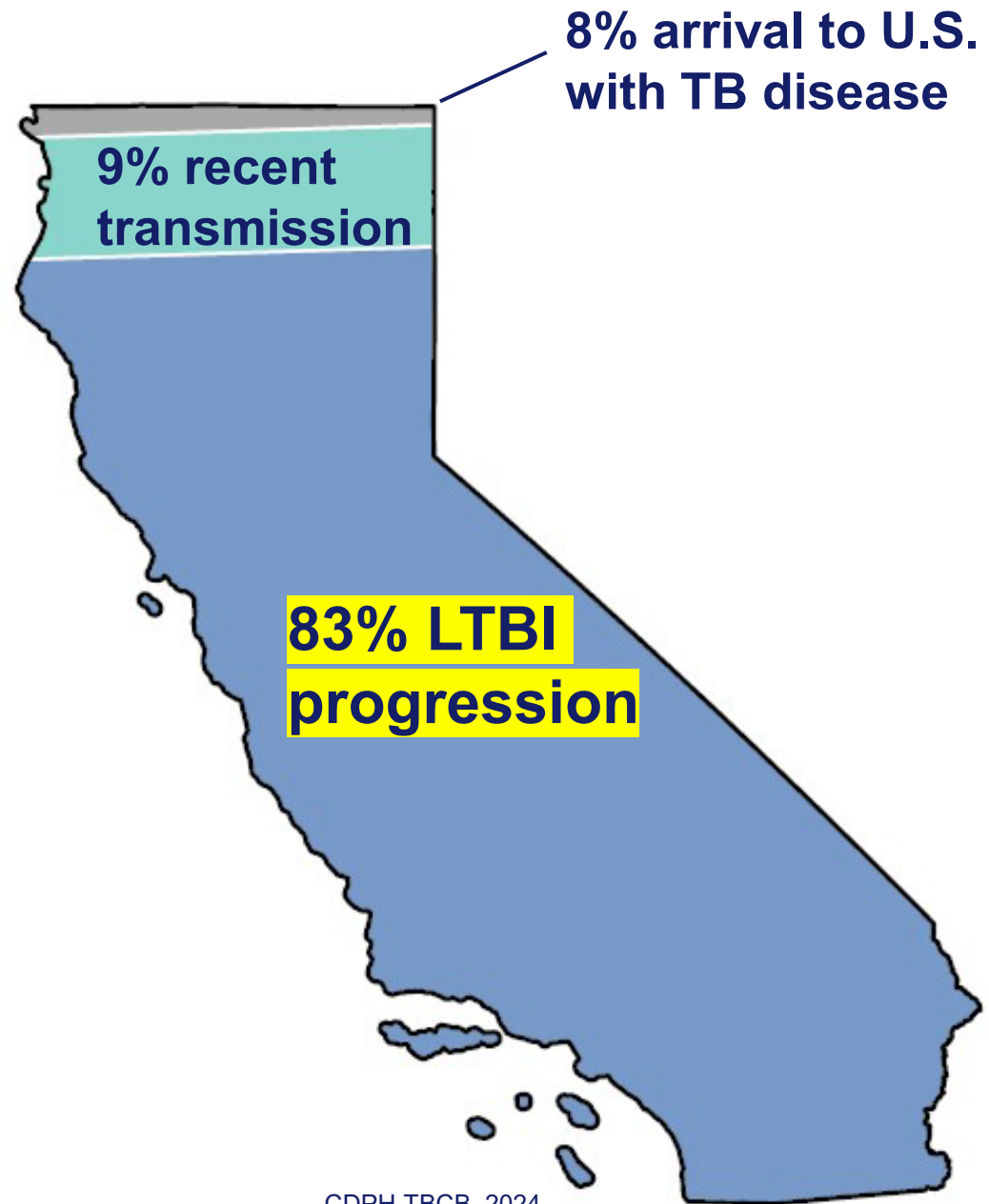


Majority unaware and untreated

***4,200** deaths from TB could be prevented by 2040*

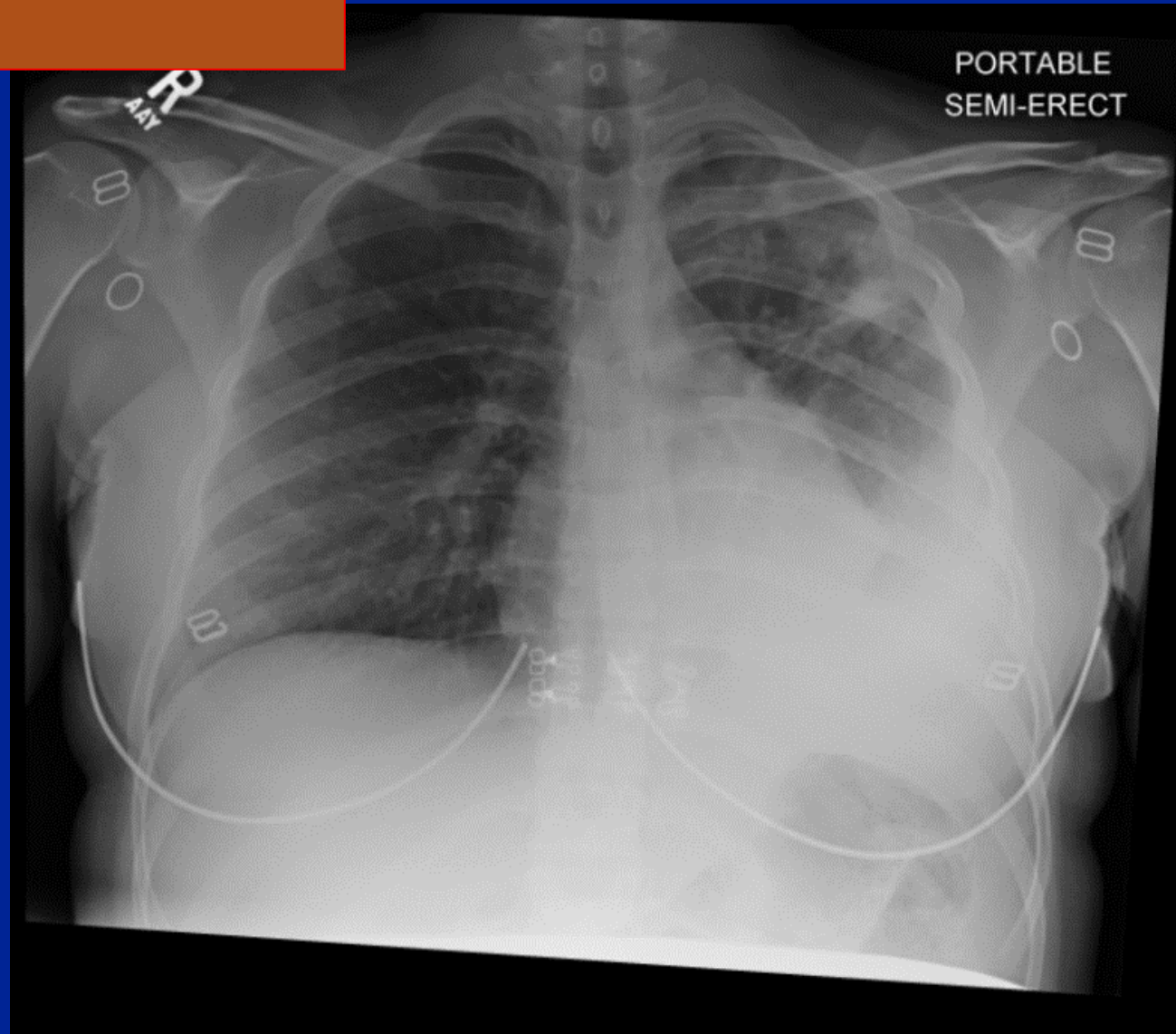
Relevance of LTBI in California, 2025

- ❖ *2,150 new TB cases reported*
- ❖ *Nearly half of non-U.S.-born TB occurred >20yrs after U.S. arrival*



TB/LTBI Diagnostics & Treatment

Example of what we want to avoid:
“active” TB disease

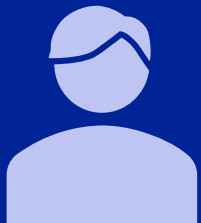


20-year-old female, prior residence in Mexico, 32 weeks pregnant



Question #1

Case 1 Part 1



38 y/o M, with positive IGRA. Born in Central America, identified as part of a workplace contact investigation for TB.

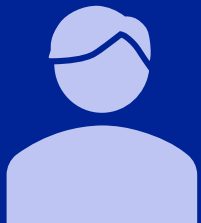
What do you do?

- A. Nothing – he's had sufficient evaluation
- B. Additional workup is needed
- C. Offer treatment for LTBI
- D. Encourage treatment for LTBI
- E. Other



Question #1

Case 1 Part 1



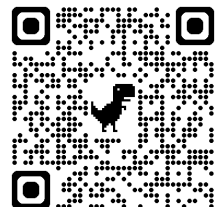
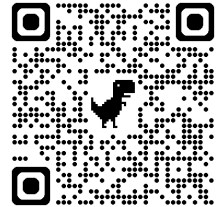
38 y/o M, with positive IGRA. Born in Central America, identified as part of a workplace contact investigation for TB.

What do you do?

- A. Nothing – he's had sufficient evaluation
- B. **Additional workup is needed**
- C. Offer treatment for LTBI
- D. Encourage treatment for LTBI
- E. Other

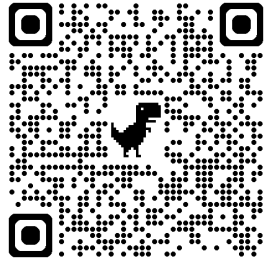
Evidence-Based Steps to Preventing TB Disease

Screen	*Screen for TB risk factors
Test	Test using IGRA, if risk present
Treat	Treat with 3- to 4-month rifamycin-based regimens



*non-U.S.-born or prolonged travel, immunocompromised, TB contact, history of homelessness or incarceration

Why Test for TB Infection?



CA TB
Elimination Plan,
2021-2025



- TB is **preventable and treatable**
- Without treatment, **1 in 10** persons with LTBI will progress to TB disease
- *Goal: TB elimination in California by 2050*

CDC, 2023; CDPH 2021

Who to Test for TB Infection?

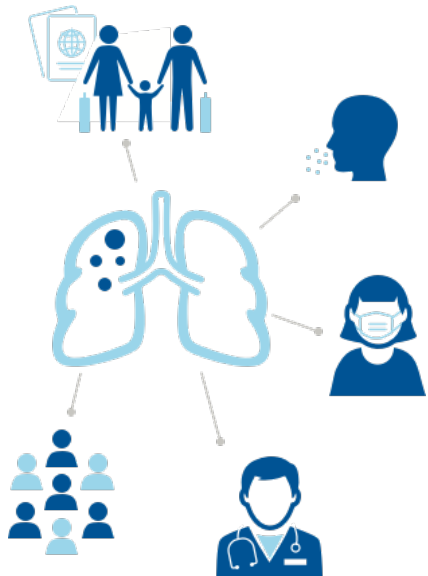


Image: CDC Think. Test. Treat TB

- Use **California TB Risk Assessments**
- Test patients with TB **risk factors**
 - Birth/travel/residence outside U.S. >1 month
 - Contacts of TB cases
 - Immunosuppressed
 - Homelessness or incarceration
- Testing populations with low prevalence may result in **false-positive results**
- Most with positive test should be treated, **after TB disease ruled out**



CA TB Risk Assessments



California Tuberculosis Risk Assessment



LTBI testing is recommended if any of the boxes below are checked.

Only repeat TB testing if there is a new risk factor since last screening

☐ **Birth, travel, or residence** for at least 1 month, or frequent border crossing in a country with an elevated TB rate*

Interferon Gamma Release Assay (IGRA) is preferred over Tuberculin Skin Test (TST), especially for non-U.S.-born persons

☐ **Immunosuppression**, current or planned

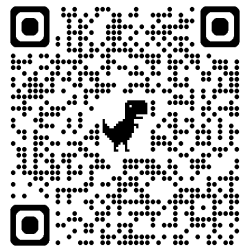
HIV infection, organ transplant recipient, treated with biologic agents including TNF-alpha antagonist (e.g., infliximab, adalimumab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

☐ **Homelessness or incarceration**, current or past

Persons experiencing homelessness or residing in high-risk congregate settings including homeless shelter or correctional facility during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is excluded.





Question #2:

Who should be tested for TB?

- a) 40 F, grew up in Philippines. PMHx GERD. Works as accountant.
- b) 20 M, grew up in Modesto, CA. PMHx HIV on ART, meth use. Employed as a food service worker.
- c) 20 F, grew up Guatemala. No PMHx, currently pregnant. OB asking about TB testing as part of prenatal labs.
- d) 40 M, grew up in SF. Has new diagnosis of rheumatoid arthritis, soon to start infliximab.



Question #2:

Who should be tested for TB?

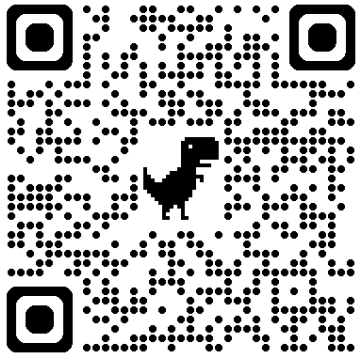
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How to Test for TB Infection?

Two Types of Tests Can Be Used to Diagnose TB Infection



Image: CDC



CDC testing & diagnosis for TB

1. **IGRA:** QuantiFERON-TB Gold Plus (QFT-Plus) and T-SPOT.TB

- Blood test
- More **specific** than TST
- No boosted response
- **Preferred test** (>6mos, esp. history of BCG)

2. **TST:** Mantoux tuberculin skin test

- Intradermal
- Cheap
- **Cross-reacts** with BCG and other NTM
- Requires 2 visits, 48-72 hours apart



Question #3:

Which test distinguishes "active" TB disease from LTBI?

- A. IGRA
- B. TST
- C. Both
- D. Neither



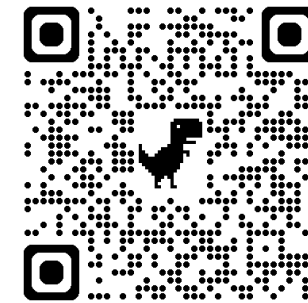
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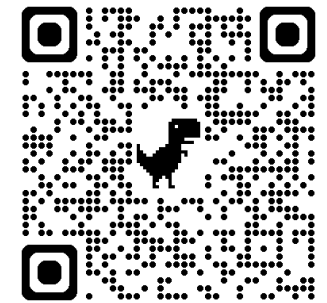
- A. IGRA
- B. TST
- C. Both
- D. **Neither**

My patient has a positive TST or IGRA...*now what?*

- Neither TST nor IGRA distinguishes LTBI from TB disease
- Before diagnosing and treating LTBI, **must first rule out TB disease!**
- Most people with LTBI should be treated to prevent TB disease



Curry TB Center
Warmline
Consultation Service



CDPH TB
Control
Branch

Ruling out TB Disease

1. Symptom Screen

- Cough
- Hemoptysis
- Weight loss
- Fevers/sweats
- Extreme fatigue

2. Chest X-Ray

- Infiltrate
- Cavitory lesion
- Nodule
- Effusion
- Hilar lymphadenopathy

3. Sputum Collection

- *Only collect if symptoms &/or CXR findings present
- AFB smear and culture
- MTB PCR (gene Xpert)



Image: BC CDC



Image: CDC

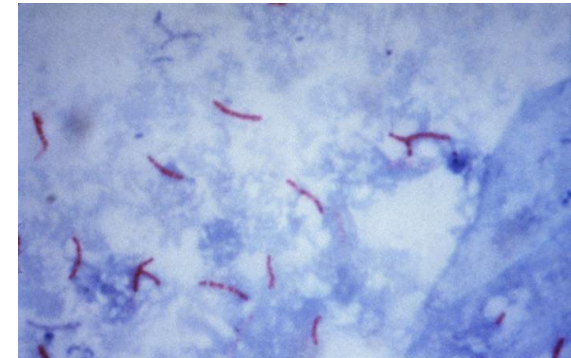


Image: CDC

**Suspected or confirmed TB must be reported to the local Health Officer within 24 hours*

Diagnosing TB from Sputum

AFB Smear

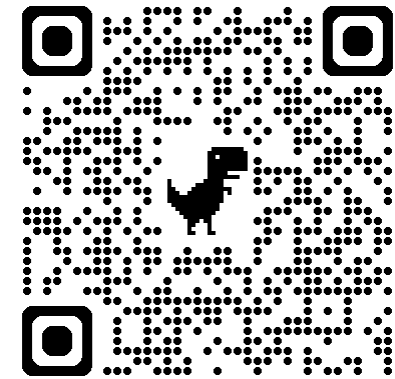
- Least sensitive
- Correlate to infectiousness (1+ to 4+)
- Fast (hours)

NAAT/ PCR/ Xprt

- More sensitive than smear
- Can detect rifampin resistance mutations
- Fast (hours)

AFB Culture

- **Most sensitive**
- **Gold standard for diagnosis**
- Slow (6-8 weeks)



CDC Clinical & Laboratory
Diagnosis for TB

Drugs for Treating TB Disease

First-line: “**RIPE**” or “**HRZE**”
(for drug-susceptible TB)

Rifampin (**RIF**)
Isoniazid (**INH**)
Pyrazinamide (**PZA**)
Ethambutol (**EMB**)



CDC Clinical Treatment of TB

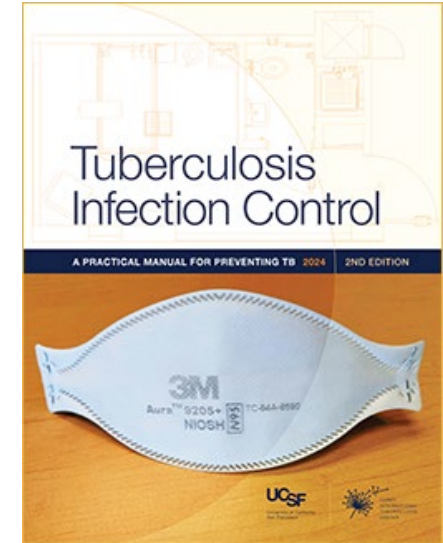
TB Disease Treatment (drug-susceptible)

- Usually 6 months (for drug-susceptible)
- *Initial Phase* (first 2 months)
 - **Always treat with at least 4 agents initially** (i.e., RIPE)
 - EMB covers INH resistance until susceptibility known
 - PZA allows shortening overall duration in some
- *Continuation Phase* (subsequent 4-7 months)
 - Once susceptibility confirmed, can narrow to RIF + INH
 - **NEVER treat with single drug** → acquired resistance



TB Infection Control

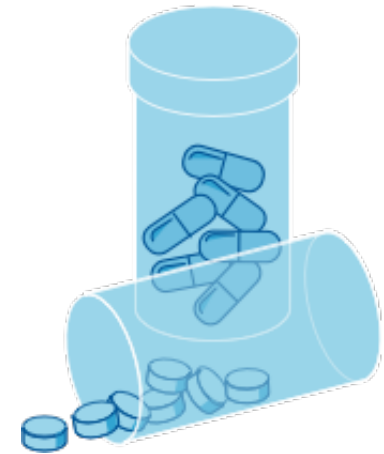
- **Hospital:**
 - “Airborne precautions”
 - Providers: N95 Respirators / Powered Air Purifying Respirator (PAPR)
 - Mask the patient (surgical mask)
 - Rapid diagnosis and initiation of 4-drug therapy
- **Community (local public health department/TB Controller):**
 - TB disease treatment
 - Directly Observed Therapy (DOT)
 - Case management and support/enablers
 - Respiratory isolation guidance and clearance
 - Contact investigations (contact tracing)
 - TB prevention
 - Testing and treatment policies



If TB disease is excluded...

how do I treat patients for LTBI?

- 3- or 4- month rifamycin-based regimens are preferred
 - Strongly preferred regimens for LTBI are:
 - *rifampin daily for 4 months (4R)*
 - *isoniazid + rifapentine weekly for 12 doses (3HP)*
- Isoniazid is a second-line regimen
 - isoniazid daily for 9 or 6 months (9H or 6H)
 - lower completion rates and higher risks of hepatotoxicity than first line therapies
- **Always rule out TB disease before treating LTBI!**

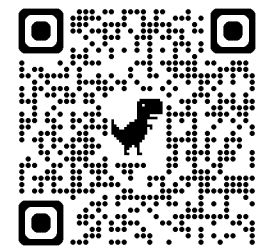


LTBI Treatment Chart, CDC

DRUG	DURATION	FREQUENCY	TOTAL DOSES	DOSE AND AGE GROUP
ISONIAZID[†] AND RIFAPENTINE^{††} (3HP) 	3 months	Once weekly	12	Adults and children aged ≥12 yrs INH: 15 mg/kg rounded up to the nearest 50 or 100 mg; 900 mg maximum RPT: 10–14.0 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
				Children aged 2–11 yrs INH [†] : 25 mg/kg; 900 mg maximum RPT ^{††} : See above
RIFAMPIN[§] (4R) 	4 months	Daily	120	Adults: 10 mg/kg; 600 mg maximum Children: 15–20 mg/kg [‡] ; 600 mg maximum
ISONIAZID[†] AND RIFAMPIN[§] (3HR) 	3 months	Daily	90	Adults INH [†] : 5 mg/kg; 300 mg maximum RIF [§] : 10 mg/kg; 600 mg maximum
				Children INH [†] : 10–20 mg/kg [‡] ; 300 mg maximum RIF [§] : 15–20 mg/kg; 600 mg maximum
ISONIAZID[†] (6H/9H) 	6 months	Daily	180	Adults Daily: 5 mg/kg; 300 mg maximum Twice weekly: 15 mg/kg; 900 mg maximum
		Twice weekly [¶]	52	
	9 months	Daily	270	Children Daily: 10–20 mg/kg [‡] ; 300 mg maximum Twice weekly: 20–40 mg/kg [‡] ; 900 mg maximum
		Twice weekly [¶]	76	

3HP: Weekly meds
 Ok for >2yrs
 (some PLHIV)
 High pill burden

4R: Daily meds
 Ok for all ages
 (but not PLHIV)
 Drug-drug interactions



LTBI Treatment: Patient Monitoring

- At least *monthly**: 
 - Assess for s/s of TB disease, med adherence, adverse effects
 - Perform baseline/periodic laboratory testing as indicated
 - Offer HIV testing for those with unknown status
- Educate patients to **STOP and CALL** if any symptoms of adverse drug effects suspected 
- Frequent and effective communication is important to ensure patient does not miss doses or appointments  



Image: CDC

**Does not have to be in-person visit*

NTCA, 2025

LTBI Treatment: Adverse Drug Events



- **Rifamycins** are associated with:
 - rash, GI upset, thrombocytopenia
 - orange discoloration of body fluids (not harmful)
- INH can also cause peripheral neuropathy
- Risk of hepatitis is **lower with rifampin (4R)** compared to INH (6H or 9H)
 - Risk of hepatotoxicity w/ 4R does not seem to be age-related¹
 - Risk of hepatotoxicity w/ INH increases with age (especially in age >65)
- U.S. guidelines: no upper age limit recommendation for testing/treatment

NTCA, 2025

1. Campbell JR et al. Lancet Infect Dis 2020

LTBI Treatment: Drug-Drug Interactions

- Many **rifamycin** drug interactions can be managed with clinical monitoring and/or dose adjustment
- Find your favorite **resource**:
 - Lexicomp
 - Micromedex
 - Curry Center Rifamycin Drug-Drug Interactions guide
 - Heartland TB Medication Drug and Food Interactions guide
 - HIV.gov Guidelines for the Use of Antiretroviral Agents
 - University of Liverpool HIV Drug Interactions checker



CITC Rifamycin DDI Guide

Baseline Labs During LTBI Treatment



Image: Johns Hopkins Medicine

Who needs them? (CBC, CMP)

- Persons living with HIV
- Pregnancy/early postpartum (<3 months)
- Liver disease (HBV, HCV, alcoholic hepatitis, cirrhosis)
- Regular EtOH use or currently injecting drugs
- Consider others **based on clinical discretion**:
 - Statin/other hepatotoxic meds
 - Age >50 years
 - Other comorbidities (DM, renal disease, etc.)
 - Meds with known interactions with INH or RIF

NTCA, 2025



Question #4:

Case 1 Part 2



38 y/o M, with positive IGRA. Born in Central America, identified as part of a workplace contact investigation for TB.

What do you do?

- A. Nothing – this is likely a false positive related to BCG**
- B. Offer treatment for LTBI**
- C. Symptom screen and chest x-ray**
- D. Refer to health department for treatment of TB disease**
- E. Other**



Question #4:

Case 1 Part 2



38 y/o M, with positive IGRA. Born in Central America, identified as part of a workplace contact investigation for TB.

What do you do?

- A. Nothing – this is likely a false positive related to BCG
- B. Offer treatment for LTBI
- C. **Symptom screen and chest x-ray**
- D. Refer to health department for treatment of TB disease
- E. Other



Question #5:

Case 1 Part 3



38 y/o M, with positive IGRA. Born in Central America, identified as part of a workplace contact investigation for TB. CXR normal, no symptoms of TB disease.

- PMHx: DM2
- Meds: metformin

What do you do?

- A. Collect sputa samples
- B. Encourage treatment with 9 months of INH
- C. Encourage treatment with either 4 months of Rifampin (4R) or 3 months of INH + RPT (3HP); check drug-drug interactions
- D. Do not encourage treatment – patient's age and co-morbidities make adverse events likely



Question #5:

Case 1 Part 3



38 y/o M, with positive IGRAs. Born in Central America, identified as part of a workplace contact investigation for TB. CXR normal, no symptoms of TB disease.

- PMHx: DM2
- Meds: metformin

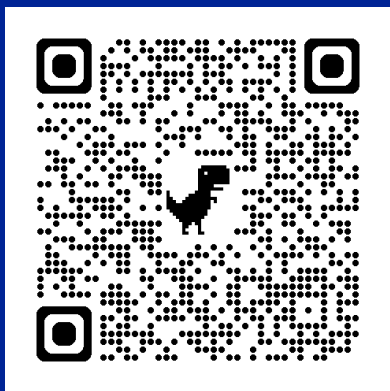
What do you do?

- A. Collect sputa samples
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- C. **Encourage treatment with either 4 months of Rifampin (4R) or 3 months of INH + RPT (3HP); check drug-drug interactions**
- D. Do not encourage treatment – patient's age and co-morbidities make adverse events likely



Image: CDC

Treating LTBI in Pregnant Persons



TB in Pregnancy Toolkit
CDPH MCAH

- ***Provide treatment immediately if:**
 - Immunosuppressed
 - TB contact
 - And/or TB test conversion in past 2 years
- Many patients lost to follow-up postpartum
- Preferred treatment: 4 months RIF (**4R**)
 - 9H possible but not preferred
 - Avoid 3HP
- Breastfeeding is not a contraindication

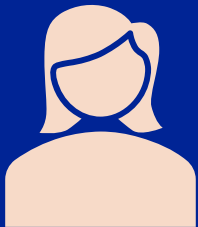
****Must always first rule out TB disease!***

Kilpatrick et al., 2017; Miele et al., 2020; NTCA, 2025



Question #6:

Case 2



26 y/o F born in Guatemala, referred to you by OB with positive QFT performed with prenatal labs.

She is G2P1, and 13 weeks pregnant. Healthy, asymptomatic, and has no known contact to a patient with TB disease.

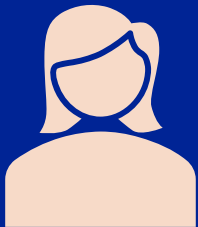
What will you do next?

- A. Wait on doing CXR and symptom screen until she is 6 months postpartum
- B. CXR and symptom screen now – if negative she's done
- C. CXR and symptom screen now – if negative, offer LTBI treatment immediately
- D. CXR and symptom screen now – if negative, offer LTBI treatment at 3-6 months postpartum
- E. Other



Question #6:

Case 2



26 y/o F born in Guatemala, referred to you by OB with positive QFT performed with prenatal labs.

She is G2P1, and 13 weeks pregnant. Healthy, asymptomatic, and has no known contact to a patient with TB disease.

What will you do next?

- A. Wait on doing CXR and symptom screen until she is 6 months postpartum
- B. CXR and symptom screen now – if negative she's done
- C. **CXR and symptom screen now – if negative, offer LTBI treatment immediately**
- D. CXR and symptom screen now – if negative, offer LTBI treatment at 3-6 months postpartum
- E. Other



Image: TB Alliance

Treating LTBI in Children

- ***Why to treat:**
 - Higher risk for progression to TB disease
 - Infection more likely to have been recent
 - Medications generally well tolerated
- Treatment options:
 - **4R preferred** (3HP ok for >2yrs)
 - Meds may be crushed, or capsules opened
 - Liquid formulations compounded by pharmacy
- Window period treatment
 - LTBI treatment given for neg test results if recent close contact to pulmonary TB disease
 - Usually for children **<5 years of age**
 - 8-10 weeks after last potential exposure

****Must always first rule out TB disease!***



Question #7:

Pediatric

Case 3



Child with increased risk of TB progression: Crohn's disease

- 10 y/o otherwise healthy child with new diagnosis of Crohn's disease, planning to start TNF-alpha antagonist therapy
- No TB exposure risk factors

What evaluation should you do?

- A. IGRA
- B. Medical/Symptom history
- C. Physical exam
- D. CXR
- E. A, B, and C
- F. All of the above



Question #7:

Pediatric

Case 3



Child with increased risk of TB progression: Crohn's disease

- 10 y/o otherwise healthy child with new diagnosis of Crohn's disease, planning to start TNF-alpha antagonist therapy
- No TB exposure risk factors

What evaluation should you do?

- A. IGRA
- B. Medical/Symptom history
- C. Physical exam
- D. CXR
- E. **A, B, and C**
- F. All of the above

Treating LTBI in Older Adults



- LTBI prevalence increases with age
- **25-30%** of TB cases in 65+ age group
 - *Age is a risk factor for death if develop TB disease
- No upper limit of age set for TB screening
 - Consider individual:
 - Risks
 - Comorbidities
 - Life expectancy
- Risk factor for **hepatotoxicity**
 - Short-course, RIF-based, 3- or 4-month LTBI treatment regimens recommended (**4R** or **3HP**)

****Must always first rule out TB disease!***



Question #8:

Case 4



68 y/o M, born in China, with positive QFT. Your clinical evaluation for TB disease is negative.

- PMHx: CAD s/p stent in 2011, DM2
- Meds: ASA, metoprolol, metformin, lisinopril and pravastatin

You counsel him about LTBI treatment and he agrees to take 3HP, with careful monitoring of BP and glucose.

Would you suggest checking LFTs during therapy?

- A. Yes
- B. No



Question #8:

Case 4



68 y/o M, born in China, with positive QFT. Your clinical evaluation for TB disease is negative.

- PMHx: CAD s/p stent in 2011, DM2
- Meds: ASA, metoprolol, metformin, lisinopril and pravastatin

You counsel him about LTBI treatment, and he agrees to take 3HP, with careful monitoring of BP and glucose.

Would you suggest checking LFTs during therapy?

- A. **Yes**
- B. **No**



Treating LTBI in TB Contacts

- **Recent contacts** at greatest risk of progression to TB disease
 - Especially those <5 years old and/or immunosuppressed
- *Adjust treatment based on drug-susceptibility testing (DST) of source case
- Contacts of multi-drug resistant (MDR) TB:
 - 6 months fluroquinolone (FQ)
 - Contact state or local MDR expert

****Must always first rule out TB disease!***

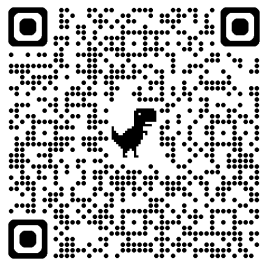
Bamrah S, et al., 2014; NTCA, 2025

Communication, Tools & Resources

How to Counsel Patients re: TB/LTBI?

Common concerns

- “Why should I take medication if I am not sick?”
- “I had the vaccine when I was a child, how can I get TB?”
- “What will happen to me if people find out I have LTBI?”



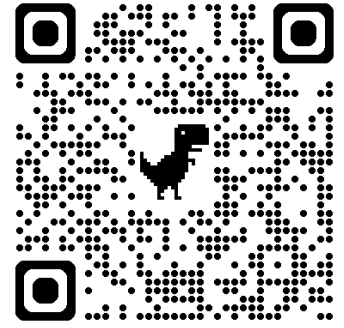
[Provider Script for Talking to Adult patients about LTBI](#)



Talking points

- TB germs can hide in the body for years. People with hidden (“latent”) TB do not feel sick. However, latent infection can eventually make you ill.
- The TB vaccine (called BCG) does not work in all cases, and it ***does not protect you for your whole life.***
- Your test results will be confidential. People with LTBI do not have to be reported.
- ***Protect your family from exposure to TB*** by taking LTBI treatment.

TB/LTBI Resources



California

1. [CTCA Directory of TB Control Staff in California](#)
2. [TB Free California](#)
3. [CDPH TB Control Branch](#)
4. [Prevent Tuberculosis in 4 steps: A Guide for Medical Providers](#)
5. [California TB Risk Assessments](#)
6. [How to talk to adult patients about LTBI & How to talk to pediatric patients about LTBI](#)
7. [Curry International Tuberculosis Center \(UCSF\)](#)
8. [California Tuberculosis Controllers Association: For Providers](#)

National

1. **[NTCA 2025 LTBI Clinical Guide](#)**
2. [CDC LTBI Testing & Treatment: Summary of U.S. Recommendations](#)
3. [CDC Guidelines for Diagnosis of Tuberculosis in Adults and Children](#)
4. [The Spectrum of TB from Infection to Disease](#)
5. [TB Case Management: A Guide for Nurses](#)
6. [CDC Core Curriculum on TB: What the Clinician Should Know](#)

For Pregnant People and New Parents

Answering your questions about Tuberculosis (TB)



TB disease can make you and your baby very sick, but it is preventable. I protect you and your family. Talk to your health care provider about getting medication if needed.

**2 MILLION CALIFORNIANS
HAVE LATENT TUBERCULOSIS (TB)
INFECTION AND MAY NOT KNOW IT!**



اگر شما در این اواخر از
افغانستان تازه رسیده اید، یا
با شخص مصاب به توبرکلوز
زندگی کرده اید، در خطر
مصاب شدن به توبرکلوز
هستید.

با داکتر تان صحبت کنید
تا همین امروز آزمایش
انجام دهید.



TBFREECALIFORNIA.ORG

Are you at risk for TB?

Tuberculosis (TB) is an infectious disease caused by bacteria. It spreads from person to person through the air.



Were you born in a country where TB is common? Or have you:

- traveled to; OR
- lived in; OR
- often crossed the border to

a country where TB is common?

A country where TB is common is anywhere, EXCEPT: United States, Canada, western or northern Europe, Australia, New Zealand



Have you lived with or spent time with someone who has had TB?



Are you a person living with HIV/ AIDS or have you received an organ transplant? Do you take medication that weakens your immune system?



Do you live, or have you lived, in a group setting, such as a homeless shelter or a jail or a prison?

YES NO

☐☐☐☐

Did you know?

1 in 7 Asian Americans in California has latent TB infection.

Early care can prevent you from getting sick and infecting your family.

Talk to your doctor about getting tested for latent TB today.



LEARN MORE ABOUT LATENT TB
bit.ly/CDPHTB



TB Provider Resources

Who to test



Adult Risk Assessment



Pediatric Risk Assessment

Benefits of TB prevention



Rifamycin Drug-Drug Interaction Guide



Prevent TB in 4-steps

How to test and treat



Cost & Consequences of TB in California



AB2132/HS C 121560 Resources



Summary

Screen

Test

Treat

1. Most cases of TB disease in California could be **prevented** by treating LTBI
2. Test patients with **risk factors**, preferably with an **IGRA** (especially if history of BCG vaccine)
3. Neither TST nor IGRA can distinguish LTBI from TB disease
4. Treat LTBI with 3- or 4-month rifamycin-based regimens (**3HP or 4R** strongly preferred), *after TB disease is ruled out*
5. Diagnosis of **TB disease** requires a symptom screening, chest x-ray (&/or other imaging), and sputa collection for smear, PCR, and AFB cultures
 - Suspected or confirmed TB disease must be reported to the local public health department
 - Treatment includes 4-drug regimen (RIF, INH, EMB, PZA) for 6 months, unless resistance suspected

Contact



For follow-up questions/comments:

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- ❖ Jocelyn.Martinez@cdph.ca.gov
- ❖ TBCB@cdph.ca.gov (clinical/MDR Q's)



Thank you!