

**SUMMARY**

**DECISION SUPPORT**

**PATIENT EDUCATION/SELF MANAGEMENT**

**GOAL**

- ✓ Perform surveillance to protect CDCR Patients and CCHCS staff from *Mycobacterium tuberculosis* (TB) infection and disease.
- ✓ Identify patients with active (infectious) TB disease-Isolate, treat, and prevent transmission.
- ✓ Identify patients with new TB infection. Offer latent tuberculosis (LTBI) treatment to prevent development of TB disease (If LTBI treatment refused, closely monitor for TB disease for first 2 years after infection [and rapidly isolate if TB develops]).
- ✓ Identify patients with remote TB infection, consider LTBI treatment to prevent development of TB disease.

**ALERTS**

- Identify all symptomatic patients
- Monitor newly infected patients for development of symptoms
- Ensure LTBI treatment is offered to all infected patients

**DIAGNOSTIC CRITERIA/EVALUATION**

**SYMPTOM SCREENING:** Refer for assessment if the patient has cough more than 3 weeks, fever, weight loss, night sweats or hemoptysis.

**TUBERCULIN SKIN TEST (TST)** (Standard method in CCHCS for detection of TB infection, recent or past):

- Recorded in millimeters (mm) of induration (palpable, firm swelling, not non-palpable erythema)
- Interpreted as “positive” or “negative” dependent on clinical factors or known exposure to TB
- Those with documented severe necrotic reaction to the TST should have an interferon gamma release assay (IGRA) instead of TST
- Pregnancy, lactation, or previous BCG vaccinations are not contraindications for a TST

**HIGH RISK CONDITION (High risk of developing TB disease):**

- Recent contact with a person with active TB (all contacts in a contact investigation);
- Abnormalities on a chest x-ray (CXR) consistent with old TB disease;
- HIV-infected or has an unknown HIV infection status;
- Has had an organ transplant and is on transplant immunosuppression; or
- Is otherwise immunosuppressed (e.g., receiving the equivalent of  $\geq 15$  mg/day of prednisone for  $\geq$  one month, chemotherapy for cancer, or tumor necrosis factor (TNF)-alpha antagonists).

**POSITIVE TST IN CDCR PATIENTS:**

- Induration of  $\geq 5$  mm for patients with a high risk condition
- Induration of  $\geq 10$  mm for all others

**EXCLUSION FROM TESTING** - TST is not needed on arrival at reception center or during annual screening if the patient has:

- Documented positive TST or positive IGRA (interferon gamma release assay)
- Documented negative TST or negative IGRA in past 30 days (negative TST is  $< 5$ mm with high risk condition or  $< 10$  mm in all others)
- Documented prior active TB disease

**TST CONVERSION:** An increase in induration of the TST of  $\geq 10$  mm in a 2 year period

**INFECTION:** Acquisition of TB infection

**RECENT TB INFECTION:** Infection with TB occurring in the past 2 years

- Known recent exposure to a TB case and a new  $\geq 5$  mm TST (these patients are most often identified during a contact investigation)
- Newly positive TST found at annual screening or on arrival at reception center ( $\geq 5$  mm induration if in a high risk group for progression to TB disease [e.g., immunocompromised] or  $\geq 10$  mm induration with no known risk factors)
- A TST conversion in the past 2 years

**REMOTE TB INFECTION:** Documented TB infection more than 2 years prior

**TB DISEASE:** Clinical evidence of TB disease

**CHEST X-RAY (CXR)** - New CXR indicated for:

- Newly positive TST
- Any patient with a documented prior positive TST at arrival to a reception center (new arrival or parole violator, not a transfer from another CDCR institution)
- Any patient prior to starting LTBI treatment (even if remotely infected and asymptomatic)
- New arrivals at reception centers with a high risk condition

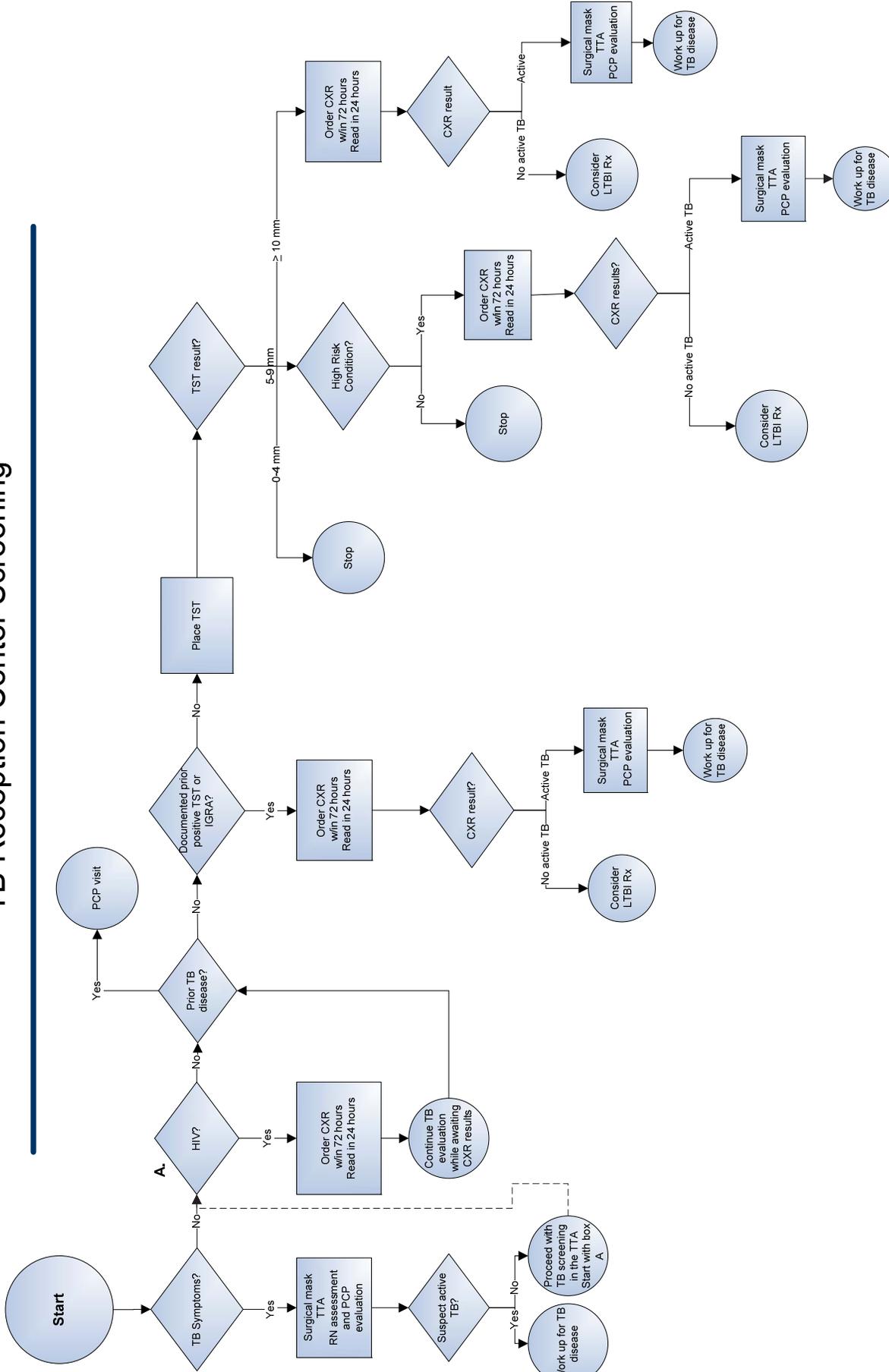
Baseline CXR

- Baseline CXR is a chest x-ray taken after TB infection is identified for which the x-ray itself is accessible through CDCR

**MONITORING (EXCLUDING CONTACT INVESTIGATIONS)**

ACTIVE TB SYMPTOM SCREENING
<ul style="list-style-type: none"> <li>▪ Annually (all patients)</li> <li>▪ Upon arrival at reception center</li> <li>▪ Transfers between institutions and category S (short stays from other agencies)</li> <li>▪ Returns from out to court (OTC)</li> </ul>
TB SKIN TEST
<ul style="list-style-type: none"> <li>▪ Annually and at reception center intake unless documented negative IGRA or negative TST (<math>&lt; 5</math> mm with high risk condition, <math>&lt; 10</math> mm for all others) in prior 30 days or documentation of LTBI (positive IGRA or Positive TST)</li> <li>▪ For clinical assessment of symptoms consistent with TB if no documented prior positive</li> </ul>

## TB Reception Center Screening



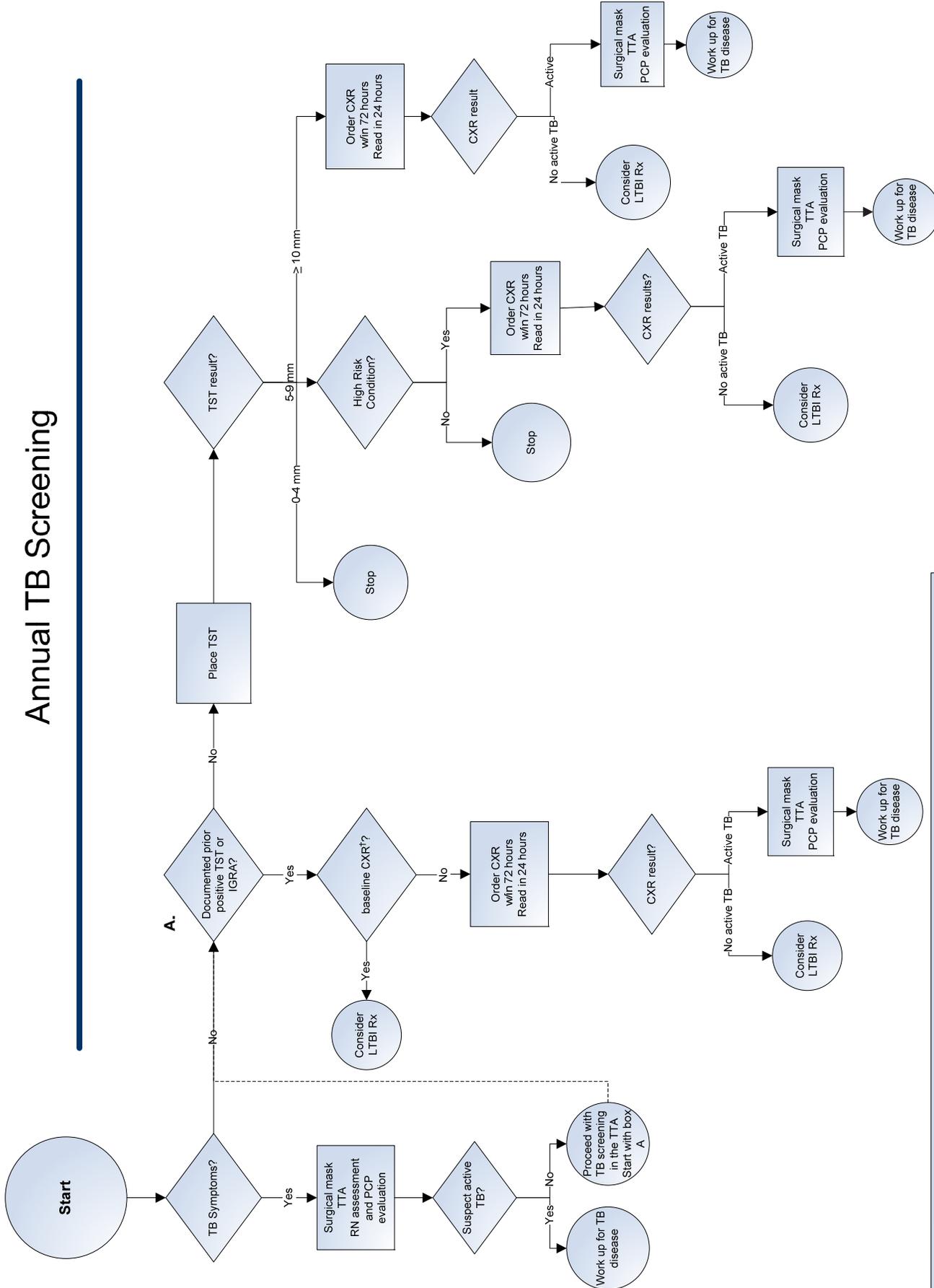
**\*High Risk Condition**

- Has had recent contact with a person with active TB (all contacts in a contact investigation);
- Has abnormalities on a chest xray (CXR) consistent with old TB disease;
- Is HIV-infected or has an unknown HIV infection status;
- Has had an organ transplant and is on transplant immunosuppression; or
- Is otherwise immunosuppressed (e.g., receiving the equivalent of ≥15 mg/day of prednisone for > one month, chemotherapy for cancer, or TNF- $\alpha$  antagonists)

Baseline CXR is a chest x-ray taken after TB infection identified for which a reading is available in CDCR. This CXR could have been taken many years in the past. A new CXR is not necessary unless there is a positive symptom screen, new positive TB test, or if starting new LTBI

LTBI Rx – follow current treatment guidelines

## Annual TB Screening



**\*High Risk Condition**

- Has had recent contact with a person with active TB (all contacts in a contact investigation);
- Has abnormalities on a chest X-ray (CXR) consistent with old TB disease;
- Is HIV-infected or has an unknown HIV infection status;
- Has had an organ transplant and is on transplant immunosuppression; or
- Is otherwise immunosuppressed (e.g., receiving the equivalent of  $\geq 15$  mg/day of prednisone for  $\geq$  one month, chemotherapy for cancer, or TNF- $\alpha$  antagonist).

**†**Baseline CXR is a chest x-ray taken after TB infection identified for which a reading is available in CDCR. This CXR could have been taken many years in the past. A new CXR is not necessary, unless there is a positive symptom screen, new positive TB test, or if starting new LTBI.

**‡**LTBI Rx - follow current treatment guideline

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## SCREENING/EVALUATION AND TESTING

### ARRIVALS TO RECEPTION CENTERS

**Symptom screening:** All patients shall be screened for symptoms of active TB immediately on arrival.

**SYMPTOMS PRESENT**

- All patients with symptoms or signs of TB (regardless of the TST result) shall be surgically masked and referred to TTA to be evaluated for active TB disease. Workup will include medical evaluation and, if clinically indicated, a CXR and sputum smears and cultures for AFB.
- Contact the sending institution to obtain additional available medical information.

**ASYMPTOMATIC PATIENTS**

Patients with prior negative TST or unknown or inadequate documentation of TB infection status shall:

- Have a TST placed within 72 hours of arrival at a Reception Center.
- TST is not indicated for:*
- Documented TST < 5 mm in past 30 days for patient with a high risk condition.
  - Documented TST < 10 mm in past 30 days for patient without a high risk condition.
  - Documented TST with mm reading interpreted as 'positive' at any time in the past.
  - Documented IGRA test interpreted as positive.

**HIV infected**

- Asymptomatic patients known to be HIV infected shall also receive a CXR within 72 hours of arrival at reception unless their records contain documentation of a normal or stable CXR within the preceding 30 days. The CXR should be read in 24 hours.
- Any HIV infected patient with a CXR abnormality that cannot be documented as stable for 60 or more days by previous records, with the exception of an isolated calcified granuloma or apical pleural thickening, shall be isolated and evaluated by a clinician even if asymptomatic.

**Workup after TST reading**

- < 5 mm TST reading in patients who are asymptomatic and HIV negative do not require a CXR or further work up.
- All patients with TST ≥ 5 mm must have a repeat symptom screen completed at time of test reading.
- Patients with a TST of 5-9 mm with a high risk condition for TB disease must have a CXR within 72 hours of test reading to evaluate for TB disease.
- All patients with a TST of ≥ 10 mm must have CXRs within 72 hours of test reading to evaluate for TB disease.

CXR for asymptomatic patients with no known history of active TB disease.		
TST (mm)	High Risk condition	CXR recommendation
0 ≤ 4 mm	NA	No CXR
5-9 mm	Yes	Obtain CXR to evaluate for TB disease
5-9 mm	No	No CXR
≥10 mm	NA	Obtain CXR to evaluate for TB disease

NA is not applicable

High Risk Condition is:

- HIV-infected or has an unknown HIV infection status;
- Has had an organ transplant and is on transplant immunosuppression; or
- Is otherwise immunosuppressed (e.g., receiving the equivalent of ≥15 mg/day of prednisone for ≥ one month, chemotherapy for cancer, or TNF-alpha antagonists).

Documented prior positive TST - Patients with written documentation of a positive Interferon Gamma Release Assay (IGRA) test or a positive TST with a written record of a mm read and a positive interpretation (≥ 5mm with risk factors or ≥ 10 mm without risk factors) shall:

- ⇒ Be considered for treatment for Latent TB Infection (LTBI) if there is no documentation of treatment or if previous treatment was incomplete or inadequate.
- ⇒ Have a CXR within 72 hours of arrival at a reception center.
- ⇒ Have a repeat CXR taken If prior CXR taken more than six months before entry or re-entry into CDCR.
- ⇒ Have a CXR and further workup as clinically indicated to rule out TB disease before offering LTBI treatment.

Documented prior TB disease - Patients with history of prior TB disease shall be evaluated by a health care provider; their records will be reviewed to ensure that they completed the indicated TB treatment course.

## SCREENING/EVALUATION AND TESTING

### ANNUAL SCREENING

Annual evaluation for TB includes:

- Symptom screening of **all** patients
- TST Testing for all patients except those with:
  - Documented positive TST or positive IGRA (interferon gamma release assay) in past (induration of  $\geq 5$  mm for patients with high risk condition, induration of  $\geq 10$  mm for all others).
  - Documented negative TST or negative IGRA in past 30 days (negative TST is  $< 5$  mm with high risk condition or  $< 10$  mm in all others).
  - Documented prior active TB disease.
  - History of severe necrotic reaction to TST (IGRA recommended).

*(The Annual Patient TB Evaluation and Testing Program complies with Penal Code [PC] Sections 7570 to 7576, which mandate annual [and medically necessary] screening and evaluation of all patients for TB. Annual patient test results are used to calculate TB prevalence and new infection [incidence] rates for each institution and overall for patients in CDCR facilities).*

Mass annual evaluation and testing is usually scheduled during the last weekend in April.

Each institution is responsible for:

- 1) Preparing the local procedures to evaluate and test patients.
- 2) Determining staffing needs and schedules.
- 3) Ordering supplies, report forms and educational materials.
- 4) Training new staff in the process.

Whenever possible, staff schedules are adjusted to accommodate the needs of the institution while minimizing the use of overtime. Patient movement between and within institutions must stop at 0001 hours on Friday or Saturday until 0001 hours on the following Tuesday or sooner if released by institution medical staff. The key test dates for the Annual Patient Evaluation and TST Program are: on Friday or Saturday, conduct screening and administer the TSTs; and on Monday, read and interpret the TSTs.

#### PATIENT EDUCATION (To increase understanding and to reduce confusion and refusals)

- Each institution must inform the patients of the annual TB Evaluation Program, including the purpose and legal mandate. Each institution shall have patient education materials and information including videos, in English and Spanish, which will be shown over closed-circuit television.

#### INTERPRETATION OF TST RESULTS

- Patients with a  $< 5$  mm TST reading who are asymptomatic and HIV negative do not require a CXR or further work up.
- All patients with TST  $\geq 5$  mm must have repeat symptom screen completed at time of test reading.
- Patients with a TST of 5-9 mm *who have risk factors for progression to TB disease* (high risk condition) must have a CXR within 72 hours of test reading to evaluate for TB disease; the CXR should be read within 24 hours.
- All patients with a TST of  $\geq 10$  mm must have CXRs within 72 hours of test reading to evaluate for TB disease.

CXR for asymptomatic patients with no known history of active TB disease.		
TST (mm)	High Risk condition	CXR recommendation
$0 \leq 4$ mm	NA	No CXR
5-9 mm	Yes	Obtain CXR to evaluate for TB disease
5-9 mm	No	No CXR
$\geq 10$ mm	NA	Obtain CXR to evaluate for TB disease

NA is not applicable

High Risk Condition:

- Is HIV-infected or has an unknown HIV infection status;
- Has had an organ transplant and is on transplant immunosuppression; or
- Is otherwise immunosuppressed (e.g., receiving the equivalent of  $\geq 15$  mg/day of prednisone for  $\geq$  one month, chemotherapy for cancer, or TNF-alpha antagonists).

#### CXR

- Patients with a new positive TST (patients with a TST of 5-9 mm with risk factors, and patients with a TST of  $\geq 10$  mm with or without risk factors) shall have a CXR to assess for radiographic evidence of active TB disease within 72 hours. (Isolated calcified granulomas and apical pleural thickening are not considered radiographic evidence of active TB disease.)
- If the CXR has no radiographic evidence of active TB disease and the patient is asymptomatic, treatment for LTBI may be indicated.

#### EVALUATION FOR CXR FINDINGS CONSISTENT WITH ACTIVE TB DISEASE

If the CXR has abnormalities consistent with TB or if the CXR is normal, but the patient has symptoms consistent with tuberculosis, the patient should wear a surgical mask and be sent to the TTA to be evaluated for active TB disease. Treatment for LTBI should be delayed until active TB disease has been ruled out. If sputum specimens for AFB smear and culture are collected as part of the evaluation, LTBI treatment should not be started until there is documentation of 3 negative TB cultures (from adequate specimens collected at least 8 hours apart).

If the CXR is abnormal in the setting of a newly positive TST, AFB smear and culture should be obtained even when the radiographic abnormalities appear stable (excluding isolated calcified granulomas and apical pleural thickening). Treatment for LTBI should not be initiated until three culture results are reported as negative for TB disease (from adequate sputum specimens collected at least 8 hours apart).

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**SCREENING/EVALUATION AND TESTING**

**PATIENTS RETURNING FROM OUT TO COURT (OTC),  
TRANSFERRED FROM ONE INSTITUTION TO ANOTHER AND ENROUTERS (SHORT STAY PATIENTS)  
PATIENTS ARRIVING FOR AN OVERNIGHT STAY WHILE EN ROUTE TO ANOTHER INSTITUTION**

**Symptom screening:** All patients shall be screened for symptoms of active TB immediately on arrival.

**ASYMPTOMATIC**

- Patients who return from OTC after spending  $\geq 1$  night in a jail, transfer between institutions, or who are short stay patients with no known recent exposure to an active TB patient do not require testing for TB infection. (Symptom screening IS required.)

**SYMPTOMS PRESENT**

- All patients with symptoms or signs of TB (regardless of the TST result) shall be surgically masked and referred to the TTA to be evaluated for active TB disease. Workup will include medical evaluation and, if clinically indicated, a CXR and sputum smears and cultures for AFB. When indicated, symptomatic patients will be isolated per clinician order.
- Contact the sending institution to obtain additional available medical information.
- HIV infected patients with symptoms suggestive of TB shall be masked and evaluated by a PCP, regardless of CXR findings.
- Any HIV infected patient with a CXR abnormality that cannot be documented as stable for 60 or more days by previous records, with the exception of an isolated calcified granuloma or apical pleural thickening, shall be isolated and evaluated by a clinician, even if asymptomatic.

**CATEGORY “S” PATIENTS (CATEGORY “S” PATIENTS ARE PATIENTS TRANSFERRED INTO STATE INSTITUTIONS FROM COUNTY/CITY JAILS FOR REASONS SUCH AS RIOTS OR AN EARTHQUAKE)**

**Symptom screening:** All category “S” patients shall be screened for symptoms of active TB immediately upon arrival.

**SYMPTOMS PRESENT**

- All patients with symptoms or signs of TB (regardless of the TST result) shall be surgically masked and referred to TTA to be evaluated for active TB disease. Workup will include medical evaluation and, if clinically indicated, a CXR and sputum smears and cultures for AFB. When indicated, symptomatic patients will be isolated per clinician order.
- Contact the sending institution to obtain additional available medical information.
- Prior to return of the patient to his or her original place of confinement the facility must be informed of the need to isolate the patient until active TB has been excluded.
- HIV infected patients with symptoms suggestive of TB disease shall be isolated and evaluated by a clinician regardless of x-ray findings.
- Any HIV infected patient with a CXR abnormality that cannot be documented as stable for 60 or more days by previous records, with the exception of an isolated calcified granuloma or apical pleural thickening, shall be isolated and evaluated by a clinician, even if asymptomatic.

**ASYMPTOMATIC**

- Asymptomatic category “S” patients without known exposure to TB do not require testing for TB infection. (Symptom screening IS required.)

## SUMMARY

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## SCREENING/EVALUATION AND TESTING

## INVOLUNTARY ISOLATION FOR INMATES WHO MAY HAVE INFECTIOUS TB

Per Penal Code Section 7573, the Chief Medical Executive must ensure that inmates have a TB test or examination “upon incarceration and at least annually thereafter.” To ensure compliance with this penal code section in CCHCS, inmates who refuse either the TB screening on entry to CDCR, or during the CCHCS annual evaluation must be assessed by an RN using appropriate screening tools.

Patients with symptoms which could indicate infectious TB must be referred to a provider for evaluation. If the provider determines that the patient’s symptoms are suspicious for infectious TB, the patient shall be placed in respiratory isolation and indicated tests to confirm TB shall be performed.

If the patient is reasonably suspected of being “infected with tuberculosis in an infectious stage” and the patient refuses the order for isolation, the patient shall be isolated involuntarily.

Note: Because TB testing does not indicate infectiousness, patients who are TB suspects should not be involuntarily tested for TB.

## PREGNANT PATIENTS

- The TST has no adverse effects on pregnancy.
- No documented episodes of fetal harm have resulted from a TST.
- Pregnancy shall not exclude a female from receiving a TST.
- Pregnant women have a greater likelihood of a false-negative TST.
- All pregnant women shall be screened for signs and symptoms of TB disease, and, if the TST is negative, the TST shall be repeated 6 to 12 weeks postpartum.
- When indicated, a CXR shall be delayed if at all possible (if there are no TB signs or symptoms) until the second trimester, and proper precautions will be taken to shield the abdomen from the effects of radiation.
- When indicated in pregnancy, the CXR shall be repeated after delivery for consideration of treatment for LTBI. *(During pregnancy and the first six weeks postpartum the risk of progression from TB infection to TB disease is high and these patients shall be monitored closely for symptoms of TB disease.)*

## TB TESTING AND INCREASING THE DETECTION OF LTBI

The TST is not completely specific; patients infected with other mycobacterial species or who received BCG immunization may have a reaction to the TST despite not being infected with TB. Prior BCG recipients with positive TSTs must undergo TB evaluation. The TST is also not completely sensitive in detecting TB infection; patients with active TB disease or TB infected immunocompromised patients may have a TST of 0 mm. The TST cannot be used as a sole criteria to exclude active TB as a diagnosis, but it is a useful screening test for TB infection despite these limitations.

Use of Interferon Gamma Release Assays (IGRAs)

IGRAs (e.g., Quantiferon TB Gold In-tube test and T-Spot) are blood tests that can be used to detect TB infection. Some IGRAs are more specific for TB than TSTs and are thus less likely to cause a false positive reaction after infection with nontuberculous (atypical) mycobacteria or after sensitization with BCG vaccination. However, IGRAs are NOT more sensitive than TSTs and are not more likely to detect true TB infections when used alone (or in place of a TST). IGRAs should NOT be used as confirmatory tests for TSTs. IGRAs can be useful in evaluating for TB infection in certain patients (e.g., those with a history of a necrotic reaction to a TST (but no mm read documented), in a patient who refuses a TST but is willing to have a blood test for TB infection). The CCHCS Public Health Unit should be consulted in deciding whether or not to use an IGRA test in a patient normally eligible for a TST.

Increasing the detection of LTBI (e.g., before prescribing immunosuppressive drugs)

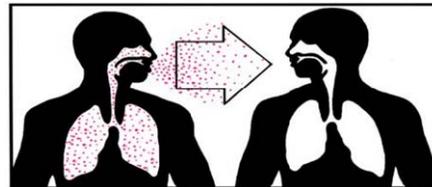
Neither TSTs nor IGRAs are completely sensitive in the detection of TB infection and false negative reactions (a negative test in a person with TB infection) occur with both tests. The sensitivity of both of these tests is about the same, however the sensitivity of detecting TB infection is increased when both tests are used. Certain clinical circumstances may warrant increased efforts to detect TB infection, such as a plan to initiate immunosuppressive treatment (e.g., TNF-alpha antagonists) which could result in reactivation of LTBI. Using the results of both a TST and an IGRA test can improve the detection of LTBI. The patient may be tested with both tests at the same time and, if one or both tests are positive, the patient is considered to be TB infected. Alternatively, if the patient had a recent negative TST, the IGRA test can be performed and, if the IGRA test is positive, the patient is considered TB infected. Similarly if the patient had a recent negative IGRA test, a TST can be placed and, if the TST is positive, the patient is also considered TB infected.

## TB SKIN TEST (MANTOUX): WHAT YOU SHOULD KNOW

**Q: What is the TB Skin Test?**

**A:** The tuberculosis (TB) skin test, sometimes called a “Mantoux,” is a simple, harmless way to find out if you have latent TB infection.

**Q: What is latent TB infection?**



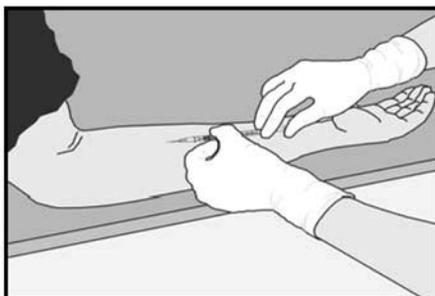
**A:** There are two phases of TB. Both phases can be treated with medicine. When TB germs first enter your body, they cause latent (silent) TB infection. You will have no symptoms with latent infection. Without treatment, latent TB infection can become active TB disease. Anyone can get TB because it spreads from one person to another through the air.

Phase 1 – Latent TB Infection	Phase 2 – Active TB Disease
TB germs are “asleep” in your body. This phase can last for a long time (even many years).	TB germs are active and spreading. They are damaging tissue in your body. TB disease usually effects the lungs but it may affect other organs.
You don’t look or feel sick. Your chest x-ray is usually normal.	You usually feel sick. Your doctor will do special tests to find where TB is harming your body.
You can’t spread TB to other people.	If the TB germs are in your lungs, you can spread TB to other people by coughing, sneezing, talking, or singing.
Usually treated by taking 1 or 2 medicines for 3 to 9 months.	Treated with 4 medicines for at least 2 months, then usually 2 medicines for at least another 4 months.

**Q: How can I tell if I have latent TB infection?**

**A:** A TB skin test (“Mantoux”) can show if you have latent TB infection. You could have latent TB infection if you have ever spent time close to someone with active TB disease (even if you didn’t know they were sick).

Your nurse will use a small needle to inject some harmless testing fluid (called “tuberculin”) under the skin on your arm.



**Your nurse MUST check your arm 2 or 3 days after the TB skin test, even if your arm looks OK to you.**

If you have a reaction to the test, it will look like a raised bump. Your nurse will measure the size of the reaction. If there is a bump, it will go away in a few weeks.

## TB SKIN TEST (MANTOUX): WHAT YOU SHOULD KNOW (CONT.)

### Q: How do I take care of my arm after the TB skin test?

- A:**
- Don't cover the spot with a bandage or tape.
  - Be careful not to rub it or scratch it.
  - If the spot itches, put a cold cloth on it.
  - You can wash your arm and dry it gently.

### Q: What if my TB skin test is negative?

**A:** The test is "negative" if there is no bump (or only a very small bump) at the spot where the fluid was injected. A negative TB skin test usually means that you don't have TB infection or disease.

In some situations, you may need to have another TB skin test later.

### Q: What if my TB skin test is positive?

**A:** The test is "positive" if there is a bump of a certain size where the fluid was injected. This means you probably have TB germs in your body. Most people with a positive TB skin test have latent TB infection. To be sure, your doctor will examine you and give you a chest x-ray. You may need other tests to see if you have active TB disease.

### Q: You should have a TB skin test if:

- A:**
- You work or live in a prison, nursing home, clinic, hospital, homeless shelter.
  - You have had frequent close contact with someone who has active TB disease.
  - You have lived in a country where many people have TB.
  - You have HIV infection or certain other health problems.

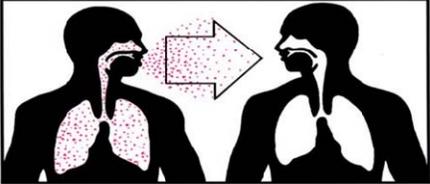
### Q: What if I've had BCG vaccine?

- A:**
- Even if you have had BCG vaccine, you can have a TB skin test.
  - People who have had BCG vaccine still can get latent TB infection and active TB disease.
  - BCG vaccine may help protect young children from getting very sick with TB. This protection goes away as people get older.
  - BCG vaccine may sometimes cause a positive TB skin test reaction. However, if you have a positive reaction to the TB skin test, it probably is from TB germs in your body - not from your BCG vaccine.

**PRUEBA CUTÁNEA PARA DETECTAR LA TUBERCULOSIS (MANTOUX): LO QUE DEBE SABER**

**P: ¿Qué es la prueba cutánea para detectar la tuberculosis?**  
**R:** La prueba cutánea para detectar la tuberculosis (TB), a veces denominada “Mantoux,” es una manera sencilla e inocua de averiguar si tiene una infección latente de TB.

**P: ¿Qué es una infección latente de TB?**

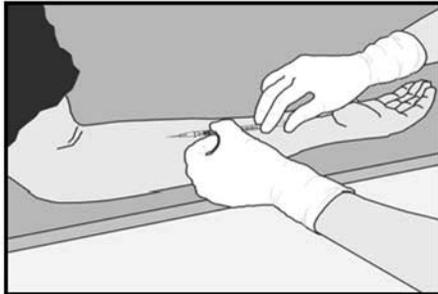


**R:** La TB tiene dos fases. Ambas fases se pueden tratar con medicina. Cuando los gérmenes de la TB entran por primera vez a su cuerpo, causan la infección latente de TB (silenciosa). Este tipo de infección no produce síntomas. Sin tratamiento, la infección latente de TB puede convertirse en la enfermedad activa de TB. Cualquier persona puede contraer la TB, porque se propaga de una persona a otra a través del aire.

Fase 1 – Infección latente de TB	Fase 2 – Enfermedad activa de TB
Los gérmenes de la TB están “dormidos” en su cuerpo. Esta fase puede durar mucho tiempo (incluso muchos años).	Los gérmenes de la TB están activos y propagándose. Están dañando los tejidos en su cuerpo. La enfermedad de TB generalmente afecta los pulmones pero puede afectar otros órganos.
No se ve ni se siente enfermo. Una radiografía del tórax es generalmente normal.	Generalmente se siente enfermo. Su médico le hará exámenes especiales para encontrar dónde la TB está dañando su cuerpo.
No puede propagar la TB a otras personas.	Si los gérmenes de la TB están en sus pulmones, puede propagar la TB a otras personas al toser, estornudar, hablar o cantar.
Normalmente, el tratamiento consiste en tomar 1 o 2 medicinas durante 3 o 9 meses.	Se trata con 4 medicinas durante por lo menos 2 meses, luego 2 medicinas durante por lo menos 4 meses más.

**P: ¿Cómo puedo saber si tengo la infección latente de TB?**  
**R:** Una prueba cutánea de TB (“Mantoux”) puede mostrar si tiene la infección latente de TB. Podría tener la infección latente de TB si alguna vez ha pasado un tiempo cerca de alguien con la enfermedad activa de TB (incluso si no sabía que la persona estaba enferma).

Su enfermera utilizará una aguja pequeña para inyectar un líquido de prueba inocuo (llamado “tuberculina”) bajo la piel de su brazo.



**La enfermera DEBE revisar su brazo 2 o 3 días después de la prueba cutánea de TB, aun si a usted le parece bien el brazo.**

Si tiene una reacción a la prueba, se verá como un abultamiento. La enfermera medirá el tamaño de la reacción. Si hay un abultamiento, desaparecerá dentro de unas semanas.

## RESUMEN

## APOYO PARA TOMAR DECISIONES

## EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

**PRUEBA CUTÁNEA PARA DETECTAR LA TB (MANTOUX): LO QUE DEBE SABER (CONT.)****P: ¿Cómo debo cuidar mi brazo después de la prueba cutánea de TB?**

- R:**
- No cubra el sitio de la inyección con un vendaje o adhesivo.
  - Tenga cuidado de no frotarlo ni rascarlo.
  - Si le da comezón, ponga un paño frío en el sitio.
  - Puede lavarse el brazo y secarlo suavemente.

**P: ¿Qué sucede si mi prueba cutánea de TB es negativa?**

**R:** La prueba es “negativa” si no hay abultamiento (o solo un abultamiento muy pequeño) en el sitio donde se inyectó el fluido. Una prueba cutánea negativa de TB generalmente significa que no tiene la infección o enfermedad de TB.

En algunas situaciones, es posible que necesite otra prueba cutánea de TB más adelante.

**P: ¿Qué sucede si mi prueba cutánea de TB es positiva?**

**R:** La prueba es “positiva” si hay abultamiento de cierto tamaño en el sitio donde se inyectó el fluido. Esto significa que probablemente tiene los gérmenes de TB en su cuerpo. La mayoría de las personas con una prueba cutánea de TB positiva tienen una infección latente de TB. Para estar seguro, su médico lo examinará y le hará una radiografía del tórax. Es posible que necesite otras pruebas para ver si tiene la enfermedad activa de TB.

**P: Debe realizarse una prueba de TB si:**

- R:**
- Trabaja o vive en una prisión, un hogar de ancianos, una clínica, un hospital, o un refugio para desamparados.
  - Ha tenido contacto cercano frecuente con alguien que tiene la enfermedad activa de TB.
  - Ha vivido en un país donde mucha gente tiene TB.
  - Tiene la infección por VIH o algunos otros problemas de salud.

**P: ¿Y si ya me he aplicado la vacuna BCG?**

- R:**
- Aunque haya recibido la vacuna BCG, se le puede realizar la prueba cutánea de TB.
  - Las personas que han recibido la vacuna BCG todavía pueden contraer la infección latente de TB y la enfermedad activa de TB.
  - La vacuna BCG puede ayudar a proteger a los niños de enfermarse gravemente con TB. Esta protección desaparece a medida que las personas envejecen.
  - La vacuna BCG a veces puede causar una reacción positiva de la prueba cutánea de TB. Sin embargo, si tiene una reacción positiva a la prueba, probablemente es debido a los gérmenes de TB que tiene en el cuerpo, y no a la vacuna BCG.