



# County of Santa Clara

## Public Health Department

Tuberculosis Prevention & Control Program  
976 Lenzen Avenue, Suite 1700  
San José, CA 95126  
408.885.2440



### Testing Methods

An Interferon Gamma Release Assay (IGRA, i.e. QuantiFERON or T-SPOT.TB) or Mantoux tuberculin skin test (TST) should be used to test those at increased risk. An IGRA can be used in all children  $\geq 2$  years old and is preferred in BCG-vaccinated children to avoid a false positive TST result. A TST of  $\geq 10$ mm induration is considered positive. If a child has had contact with someone with active TB disease (yes to question 2 on reverse), or the child is immunosuppressed, then TST  $\geq 5$  mm is considered positive. If a BCG-vaccinated child has a positive TST, and an IGRA is subsequently performed and is negative, testing is considered negative unless the child was exposed to someone with TB disease or is immunosuppressed. For immunosuppressed children, screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review.

### Evaluation of Children with Positive TB Tests

- All children with a positive IGRA/TST result must have a medical evaluation, including a CXR (posterior-anterior and lateral is recommended for children  $<5$  years old). A CXR is not required for a positive TST with negative IGRA in a BCG-vaccinated child, or if the child has documentation of prior treatment for TB disease or treatment for latent TB infection.
- For children with TB symptoms (e.g. cough for  $>2-3$  weeks, shortness of breath, hemoptysis, fever, weight loss, night sweats) or an abnormal CXR consistent with active TB disease, report to the County of Santa Clara Public Health Department TB Program within one day. The child will need to be evaluated for TB disease with sputum AFB smears/cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease in a patient with symptoms or signs of TB disease. The child cannot enter school unless active TB disease has been excluded or treatment has been initiated.
- If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI). Do not treat for LTBI until active TB disease has been excluded.
- Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid

### Treatment Regimens for Latent TB Infection

- Rifampin 15 - 20 mg/kg (max. 600 mg) daily for 4 months
- 12-dose Weekly Isoniazid/Rifapentine (3HP) Regimen:
- Isoniazid
  - 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
  - $\geq 12$  years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
- Rifapentine
  - 10.0-14.0 kg: 300 mg
  - 14.1-25.0 kg: 450 mg
  - 25.1-32.0 kg: 600 mg
  - 32.1-50.0 kg: 750 mg
  - $>50$  kg: 900 mg
- Vitamin B6 50 mg weekly
- Isoniazid 10 mg/kg (range, 10-15 mg/kg; max. 300 mg) daily for 9 months. Recommended pyridoxine dosage is 25 mg for school-aged children (or 1-2 mg/kg/day).

For additional information: [www.sccphd.org/tb](http://www.sccphd.org/tb) or contact the TB Control Program at (408) 885-2440.