

International Standards For Tuberculosis Care

Introduction

The purpose of the International Standards for Tuberculosis Care (ISTC) is to describe a widely accepted level of care that all practitioners, public and private, should seek to achieve in managing patients who have, or are suspected of having, Tuberculosis. The Standards are intended to facilitate the effective engagement of all care providers in delivering high-quality care for patients of all ages, including those with sputum smear-positive, sputum smear-negative, and extra pulmonary TB.

The basic principles of care for persons with, or suspected of having, TB are the same worldwide: a diagnosis should be established promptly and accurately; standardized treatment regimens of proven efficacy should be used with appropriate treatment support and supervision; the response to treatment should be monitored; and the essential public health responsibilities must be carried out. Prompt, accurate diagnosis and effective treatment are not only essential for good patient care- they are the key elements in the public health response to TB and the cornerstone of TB control. Thus, all providers who undertake evaluation and treatment of patients with TB must recognize that, not only are they delivering care to an individual, they are assuming an important public health function that entails a high level of responsibility to the community, as well as to the individual patient..

Standards for Diagnosis

Standard 1. All persons with otherwise unexplained productive cough lasting two-three weeks or more should be evaluated for TB.

Standard 2. All patients (adults, adolescents, and children who are capable of producing sputum) suspected of having pulmonary TB should have at least two, and preferably three, sputum specimens obtained for microscopic examination. When possible, at least one early morning specimen should be obtained.

Standard 3. For all patients (adults, adolescents, and children) suspected of having extrapulmonary TB, appropriate specimens from the suspected sites of involvement should be obtained for microscopy and, where facilities and resources are available, for culture and histopathological examination.

Standard 4. All persons with chest radiographic findings suggestive of TB should have sputum specimens submitted for microbiological examination.

Standard 5. The diagnosis of sputum smear-negative pulmonary TB should be based on the following criteria: at least 3 negative sputum smears (including at least one early morning specimen); chest radiography findings consistent with TB; and lack of response to a trial of broad-spectrum antimicrobial agents. For such patients, if facilities for culture are available, sputum cultures should be obtained

Standard 6. The diagnosis of intrathoracic (i.e., pulmonary, pleural, and mediastinal or hilar lymph node) TB in symptomatic children with negative sputum smears should be based on the finding of chest radiographic abnormalities consistent with TB and either a history of exposure to an infectious case or evidence of TB infection (positive tuberculin skin test). For such patients, if facilities for culture are available, sputum specimens should be obtained (by expectoration, gastric washings, or induced sputum) for culture.

Standards for Treatment

Standard 7. Any practitioner treating a patient for TB is assuming an important public health responsibility. To fulfill this responsibility the practitioner must not only prescribe an appropriate regimen but, also, be capable of assessing the adherence of the patient to the regimen and addressing poor adherence when it occurs. By so doing, the provider will be able to ensure adherence to the regimen until treatment is completed.

Standard 8. All patients who have not been treated previously should receive an internationally accepted first-line treatment regimen using drugs of known bioavailability. The initial phase should consist of 2 months of isoniazid, rifampicin, pyrazinamide, and ethambutol. The preferred continuation phase consists of isoniazid and rifampicin given for four months. The doses of anti-TB drugs used should conform to international recommendations. Fixed-dose combinations of two (isoniazid and rifampicin, three (isoniazid, rifampicin, and pyrazinamide), and four (isoniazid, rifampicin, pyrazinamide; and ethambutol) drugs are highly recommended.

Standard 9. To assure adherence, a patient-centered approach to administration of drug treatment, based on the patient's needs and mutual respect between the patient and the provider, should be developed for all patients.

Supervision and support should be gender-sensitive and age-specific, including patient counseling and education.



Standard 10. All patients should be monitored for response to therapy, best judged in patients with pulmonary TB by follow-up sputum microscopy (2 specimens) at least at the time of completion of the initial phase of treatment (2 months), at 5 months, and at the end of treatment. Patients who have positive smears during the 5th month of treatment should be considered as treatment failures and have therapy modified appropriately. In patients with extrapulmonary TB and in children, the response to treatment is best assessed clinically. Follow-up radiographic examinations are usually unnecessary and may be misleading.

Standard 11. A written record of all medications given, bacteriologic response, and adverse reactions should be maintained for all patients.

Standard 12. In areas with high prevalence of HIV infection, HIV counseling and testing is indicated for all TB patients as part of their routine management. In areas with lower prevalence rates of HIV, HIV counseling and testing is indicated for TB patients with symptoms and/or signs of HIV-related conditions and in TB patients having a history suggestive of high risk of HIV exposure.

Standard 13. All patients with TB and HIV infection should be evaluated to determine if antiretroviral therapy is indicated during the course of treatment for TB.

Standard 14. An assessment of the likelihood of drug resistance, based on history of prior treatment, exposure to a possible source case having drug-resistant organisms, and the community prevalence of drug resistance, should be obtained for all patients. Patients who fail treatment and chronic cases should always be assessed for possible drug resistance. For patients in whom drug resistance is considered to be likely, culture and drug susceptibility testing for isoniazid, rifampicin, and ethambutol should be performed promptly.

Standard 15. Patients with TB caused by drug-resistant (especially- MDR) organisms should be treated with specialized regimens containing second-line anti-TB drugs. At least 4 drugs to which the organisms are known or presumed to be susceptible should be used, and treatment should be given for at least 18 months.

Standards for Public Health Responsibilities

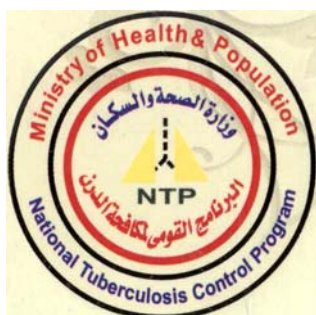
Standard 16. All providers of care for patients with TB should ensure that persons (especially children under 5 years of age and persons with HIV infection) who are in close contact with patients who have infectious TB are evaluated and managed in line with international recommendations.

Children under 5 years of age and persons with HIV infection who have been in contact with an infectious case should be evaluated for both latent infection with *M. tuberculosis* and for active tuberculosis.

Standard 17. All providers must report both new and retreatment tuberculosis cases and their treatment



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