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RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX DU NUNAVIK
NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

Inuulitsivik
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UNGAVA TULATTAVIK HEALTH CENTER
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EMBOSSER ICI LA CARTE DU CSI OU CSTU, SI NON DISPONIBLE, INSCRIRE LES NOM, PRÉNOM, DATE DE NAISSANCE ET NUMÉRO DE DOSSIER

EMBOSS THE CARD OF THE IHC OR UTHC HERE, IF NOT AVAILABLE, WRITE THE NAME, SURNAME, DATE OF BIRTH AND FILE NUMBER

LATENT TB INFECTION

ADULT AND PEDIATRIC (2 to 65 years)
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER • **3HP (Rifapentine-Isoniazid) DOT 1 x / week**

Purpose: To ensure a standard process for the management of latent TB infection (LTBI) cases and the medical prescription of the necessary follow-up by the relevant health professionals.

Objectives:

a) Ensure use of the most effective prophylaxis for latent TB infection (LTBI) and in so doing, prevent the development of active TB disease.
b) Quickly detect adverse reactions and ensure their management.
c) Quickly identify any issues regarding compliance and offer the appropriate support.

This order must be initialed by a physician at the time of the LTBI diagnosis and the prescription of treatment.

Notes: →To reach the attending physicians in pneumology:

- Pediatric (pneumology): write to MCHTB@MUHC.MCGILL.CA or to Zofia Zysman-Colman (physician) at zofia.zysman-colman.med@ssss.gouv.qc.ca.
- Adult (pneumology): Turn to the SAFIR system: Connect to SAFIR (gouv.qc.ca). If SAFIR is unavailable, write to: Faiz Ahmad Khan faiz.ahmad.khan.med@ssss.gouv.qc.ca or Richard Menzies, Dr. dick.menzies@mcgill.ca.
- On-call pneumologist at MUHC: **514 934-1934**.

→ Whenever a new LTBI diagnosis is made, you must notify the Public Health TB team (NRBHSS) at tuberculose-santepublique.nrbhss@ssss.gouv.qc.ca.

Important note: All individual medical prescriptions will have priority over the "Standard" follow-up described in this procedure.

Instructions regarding use of the protocol

The following order, once signed and dated by the physician, will constitute a medical prescription for the tests and paraclinical exams required to enable the follow-up of patients with LTBI. Nurses and physicians must check off and sign the boxes related to their specific tasks as soon as the prescribed actions are completed. However, prescriptions for medications are made on the prescription forms specific to LTBI treatment.

Written by:	Dr. Valérie Messier and Dr. Geneviève Auclair, consulting physicians in matters of infectious diseases for the NRBHSS, and Pascale Desjardins and Marie-Neige Dion, advisors in matters of infectious diseases, NRBHSS
Revised by:	Dr. Gabriel Chouinard, IHC Dr. Julie Desjardins and Jessica Trahan, NRBHSS Dr. Zofia Zysman-Colman
Approved by:	CMDPSF executive committee, IHC, 2023-09-12 CMDPSF executive committee, UTHC, 2023-12

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Positive QuantiFERON-TB Gold test on: ___yyyy___/___mm___/___dd___ (if applicable)

TST result: ______mm **Date:** ___yyyy___/___mm___/___dd___

Threshold values for TST and indications regarding LTBI treatment	
TST	**Indications regarding preventive treatment**
≥ 5 mm	☐ **Persons living in a priority village**[1] ☐ Mass screening in the event of an outbreak AND as per Nunavik Public Health. ☐ Children who received the BCG vaccine less than 24 months earlier.
≥ 5 mm	☐ HIV infection ☐ Recent contact with a contagious tuberculosis case. ☐ Presence of fibronodular disease on chest x-ray (healed TB, but not previously treated or treated inadequately). ☐ Organ transplant (related to immune suppressant therapy). ☐ Other immunosuppressive drugs, e.g., corticosteroids (equivalent of ≥ 15 mg/day of prednisone for 1 month or more; the risk of active TB disease increases with the dose and the duration of treatment). ☐ Renal failure requiring hemodialysis. ☐ TNF (tumour necrosis factor) alpha inhibitor use.
≥ 10 mm	☐ Persons living in a village not considered a priority by Nunavik Public Health. ☐ Shift in the last 2 years with no known exposure. ☐ Shift following a recent contact, regardless of the time elapsed between the 2 TST. ☐ Other immunodeficiency (neck and brain cancer). ☐ Silicosis. ☐ People (of any age) having travelled to a country with a high rate over the past 2 years, depending on the length of stay and type of activities. ☐ Users of injected drugs who are HIV-negative. • Residents and workers of health institutions or correctional facilities. • Workers in homeless shelters. • Homeless people who can be administered a preventive treatment under direct observation. ☐ All other high-risk patients (persons with diabetes mellitus, who are underweight or who smoke at least one pack of cigarettes per day).

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[1] To view the list of priority villages prepared by Public Health, see Tuberculosis Toolbox.

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Time	F-up	Interventions and investigations	Date and Signature
Prior to treatment ___/___/___ YY/ MM/ DD	**MD**	**Before prescribing 3HP, ensure that:** ☐ Patient is between the ages of 2 and 65 (If > 65, assess on a case by case basis). ☐ Patient has no known allergies or severe side effects (hepatotoxicity, hypersensitivity, thrombocytopenia) to Isoniazid (INH), Rifapentine (RPT) or Rifampicin (RIF). ☐ A chest X-ray was done recently (< 8 weeks if LTBI diagnosis over the past 24 months or < 12 weeks in all other instances). ☐ If bacteriological specimens were requested, all results (smears/cultures) were negative (unless otherwise indicated by the treating pneumologist). ☐ If patient is a female of child-bearing age: negative results from a urine β-hCG test and not planning to get pregnant in the near future (12 to 16 weeks). ☐ If patient gave birth recently, ensure ≥ 3 months postpartum and not breastfeeding. **Also check for:** 1. Prior active TB: ☐ Yes ☐ No 2. History of abnormal liver function (AST-ALT ≥ 3 times normal) or porphyria: ☐ Yes ☐ No 3. Index case resistant to RIF or INH[2]: ☐ Yes ☐ No **Note:** If **YES** to 1, 2 or 3, consult the pediatric or adult pneumologist. If **NO** to 1, 2 and 3, initiate the LTBI treatment *(ITL_PRESC-MED-3HP_EN).* **Prescribe:** ☐ Initial blood tests: ☐ Liver function, creat., CBC ☐ HIV[3] (verbal consent) ☐ Syphilis[4] ☐ Follow-up blood test after 1st month of treatment if patients ≥ 12 years: liver function ☐ Follow-up blood tests every month PRN[5]: liver function, creat., CBC. ☐ Initial and monthly β-hCG urine[6] test. **Other:** ☐ Check with pharmacist for potential interactions with other drugs (e.g., Dilantin) *(DSPu-TB_INTERACTIONS_MED_EN).* ☐ Plan medication dosage or adjustment (e.g., Dilantin levels) during treatment if required. ☐ Counselling with regard to contraceptive use: if hormonal contraceptives are being used, promote adding another method (barrier contraception, such as condom).	______ Signature ___/___/___ YY/ MM/ DD

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yyyy mm dd

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[2] If the antibiogram of the index case is unknown when prescribing the preventive treatment, make sure to adjust the patient's plan as soon as any resistance to the prescribed TB treatment is confirmed.

[3] HIV is a major risk factor for the progression of latent tuberculosis infection to active tuberculosis.

[4] Offer opportunistic screening for syphilis to people aged 14 years or more.

[5] If symptomatic **OR** if abnormal results after initial workup **OR** ≥ if 50 years old **OR** in the presence of one of the following conditions: cirrhosis or chronic hepatitis, all causes combined, hepatitis C, hepatitis B, chronic alcohol consumption or alcohol abuse, intake of hepatotoxic medications, history of hepatitis provoked by medications.

[6] Should there be a risk or signs of pregnancy while treatment is underway (unprotected sexual relations, late period, pregnancy symptoms, etc.), advise the physician.

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Time*	F-up	Interventions and investigations	Date and Signature
1st day/date of the onset of treatment ___/___/___ YY/ MM/ DD	**Nurse**	**Before initiating 3HP:** ☐ Make sure there are no active TB symptoms. In case of symptoms, request a medical opinion STAT. ☐ Take the patient's blood pressure and weight *(ITL_EVAL-CLIN-HEBDO-3HP_EN)*. ☐ Initiate 3HP according to the medical order. ☐ Inform the patient (treatment, compliance, side effects). ☐ Prepare to complete follow-up forms: ☐ Registration of the medication *(ITL-ENREG-MED-INH-DIE_EN).* ☐ Weekly clinical evaluation *(ITL_EVAL-CLIN-HEBDO-3HP_EN)* As per the medical order: ☐ Do initial blood tests: liver function, creat., CBC, HIV[3], Syphilis[4] ☐ Have a urine β-hCG test done[7].	________ Signature ___/___/___ YY/ MM/ DD
End of the 4th week of treatment ___/___/___ YY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. ☐ Medication follow-up and provide support to the patient (*ITL_ENREG-MED-3HP_EN*) ☐ Complete clinical evaluation for each dose administered *(ITL_EVAL-CLIN-HEBDO-3HP_EN)* As per the medical order: ☐ Do follow-up blood tests PRN: liver function, creat., CBC. ☐ Have a urine β-hCG test done[7].	________ Signature ___/___/___ YY/ MM/ DD
End of the 8th week of treatment ___/___/___ YY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. ☐ Medication follow-up and provide support to the patient (*ITL_ENREG-MED-3HP_EN*) ☐ Complete clinical evaluation for each dose administered *(ITL_EVAL-CLIN-HEBDO-3HP_EN)* As per the medical order: ☐ Do follow-up blood tests PRN: liver function, creat., CBC. ☐ Have a urine β-hCG test done[7].	________ Signature ___/___/___ YY/ MM/ DD

***NOTE:** Apply the End of treatment interventions if the treatment is completed before the 12th week.

MD signature:____________________________ License no.:__________ Date: ____/____/____
yyyy mm dd

[7] If there are risks or signs of pregnancy while treatment is underway (unprotected sexual relations, late period, pregnancy symptoms, etc.), wait before administering the dose and advise the physician.

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Time	F-up	Interventions and investigations	Date and Signature
End of Treatment (12th week) ___/___/___ YY/ MM/ DD	**MD**	☐ Document compliance and treatment outcome. ☐ Complete and sign the *Clinical and radiological follow-up guide* during the post-treatment phase (*TB-ACT-ITL_GUIDE-SCR_EN)* <u>once the treatment has ended</u>. ☐ Update the list of problems (prior history) in the patient's chart.	______ Signature ___/___/___ YY/ MM/ DD
	Nurse	☐ **<u>Regular monthly follow-up</u>**: Notify the physician if abnormal. ☐ Medication follow-up and provide support to the patient (*ITL_ENREG-MED-3HP_EN).* ☐ Complete clinical evaluation for each dose administered *(ITL_EVAL-CLIN-HEBDO-3HP_EN).* As per the medical order: ☐ Do follow-up blood tests PRN: liver function, creat., CBC. ☐ Have a urine β-hCG test done[7]. ☐ Plan for clinical and radiological follow-up as required, *Clinical and radiological follow-up guide (TB-ACT-ITL_GUIDE-SCR_EN).* ☐ Send all completed documents to Public Health team.	______ Signature ___/___/___ YY/ MM/ DD

MD signature:____________________________ License no.:__________ Date: ____/____/____
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FOLLOW-UP GUIDE FOR ADDITIONAL WEEKS

Extension of the planned duration of the treatment

To be followed if the treatment is extended beyond the 12-week period. Apply the interventions in the End of treatment line if one or more additional weeks are needed to complete the treatment. Beyond 16 weeks, the prophylaxis is considered inadequate if fewer than 11 doses were administered.

Time	Follow-up	Interventions and investigations	Date and Signature
End of treatment (12 to 16 weeks) ___/___/___ YY/ MM/ DD	**MD**	☐ Document compliance and treatment outcome. ☐Complete and sign the *Clinical and radiological follow-up guide* once the treatment has ended (*TB-ACT-ITL_GUIDE-SCR_EN*). ☐ Update the list of problems (prior history) in the patient's chart.	Signature ___/___/___ YY/ MM/ DD
	Nurse	☐ **Regular monthly follow-up**: Notify the physician if abnormal. ☐ Medication follow-up and provide support to the patient (*ITL_ENREG-MED-3HP_EN*). ☐ Complete clinical evaluation for each dose administered (*ITL_EVAL-CLIN-HEBDO-3HP_EN*). As per the medical order: ☐ Do follow-up blood tests PRN: liver function, creat., CBC ☐ Have a urine β-hCG test done[7]. ☐ Plan for clinical and radiological follow-up as required, *Clinical and radiological follow-up guide* (*TB-ACT-ITL_GUIDE-SCR_EN*). ☐ Send all completed documents to Public Health team.	Signature ___/___/___ YY/ MM/ DD

MD signature:____________________________ License no.:__________ Date: _yyyy/_mm/____