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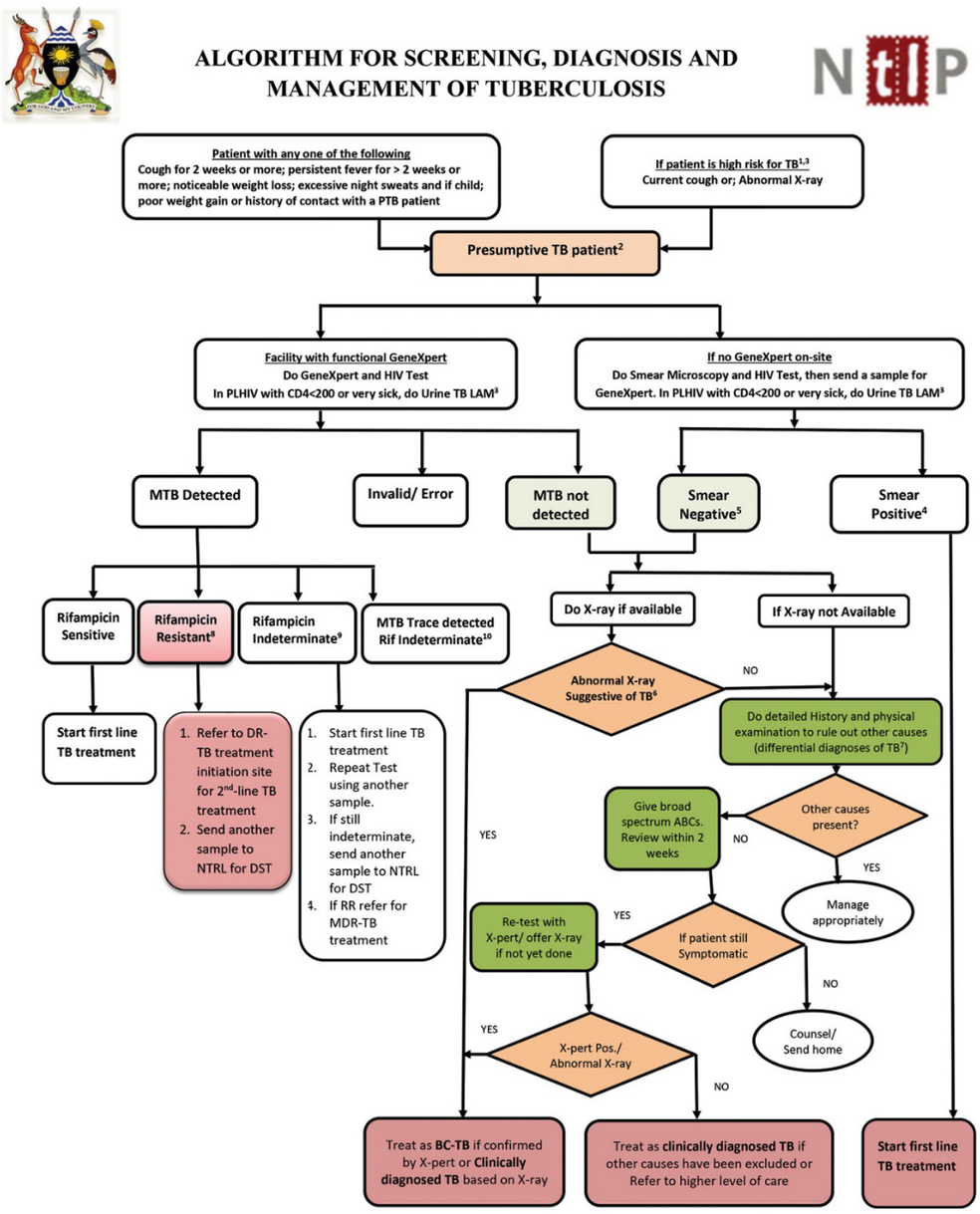
Treatment Outcomes for Tuberculosis Infection and Disease Among Persons Deprived of Liberty, Uganda, 2020

Appendix



1. **High risk for TB:** includes PLHIV, previously treated TB patients, prisoners, contacts of TB patients, diabetic patients, health workers, miners and refugee populations
2. **Presumptive TB** is presence of any or a combination of the following symptoms; cough≥ 2weeks or current cough if high risk patient, fever, night sweats, history of contact with a TB case, weight loss or poor weight gain for children. Also consider abnormal chest x-ray in a high-risk patient as presumptive TB
3. **HIV positive patients:** Presumptive or diagnosed TB patients who are HIV positive should be offered comprehensive HIV care services. In HIV positive individuals with CD4 ≤ 200 or very sick **(Temperature >39˚C, Respiratory Rate >30 breaths/min, Heart Rate >120 beats/min, New Seizure, Unable to walk without assistance / Bed-ridden)**, do **Urine TB LAM.** If Urine TB LAM is positive, the Patient should be started on TB Treatment and a sputum sample should be collected for genexpert testing to rule out Rifampicin resistance **(Refer to algorithm for TB screening and diagnosis in PLHIV).**
4. **Smear positive** (AFB positive): is defined as at least one positive smear
5. **Smear negative**: defined as two negative smears. Carry out other investigations such as CXR **if available**. Those with **CXR suggestive of TB[2]** should be treated as clinically diagnosed TB. If **not available** or CXR not suggestive, do further history, physical examination and other investigations to exclude **other causes of chronic cough, fever and weight loss.**
6. **Features of abnormal X-ray suggestive of TB:** Heterogeneous opacities and cavitation in the upper parts of the lung, mediastinal L/nodes, pleural effusion and milliary picture
7. **Differential Diagnoses of TB:** Chronic Obstructive Pulmonary Disease (COPD), heart disease, asthma, bronchiectasis, emphysema; Histoplasma pneumonia, trypanosomiasis, brucellosis; Fungal infection of the lung; Malignancy (lung cancer, lymphoma etc.)
8. **If MTB detected RIF resistance detected**, Refer patient for MDR-TB treatment. Send another sample to NTRL for culture and DST (Sample should be sent by DR-TB treatment initiation site).
9. **If MTB detected Rifampicin Resistance Indeterminate;** Start first line TB treatment, Repeat Test using another sample. If still indeterminate, send another sample to NTRL for DST. If RR, refer for MDR-TB treatment.
10. If **MTB TRACE Detected, Rifampicin Resistance Indeterminate ("trace calls"):** Start first line TB treatment if **HIV Positive, child or EPTB;** if HIV Negative, repeat test using early morning specimen result for decision. Send another sample to NTRL for culture and DST. If Invalid/error X-pert result, repeat Test. Manage as per second result.
11. **Treatment monitoring;** Follow up sputum smear microscopy should be done at the end of 2, 5 & 6 months for susceptible TB and monthly smear and culture for DR-TB.
12. **Recording & Reporting:** All diagnosed TB patients should be notified in the Unit TB register and their Drug Susceptibility (rifampicin resistance) status updated. For PLHIV who test TB LAM positive, record as Pulmonary Bacteriologically Confirmed (P-BC) TB. All notified TB patients should be reported in the various HMIS reporting tools: HMIS Form 033b Weekly report, HMIS Form 105 Monthly report and HMIS Form 106a Quarterly report.

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Appendix Figure. Algorithm used in Uganda for screening, diagnosis, and management of tuberculosis.