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Home-Based Monitoring of Treatment-Related Adverse Events during Drug-Resistant Tuberculosis Treatment, India, 2020–2024

Appendix

Appendix Table. Frequency of drug-resistant TB patients by National Tuberculosis Elimination Program-defined treatment regimens in Dharavi, Mumbai, December 2020–June 2022

Regimen	Type	No. (%)	LFX	R	Z	E	BDQ	MFX	ETO	CFZ	H	LZD	CS	AM	KM	PAS	CM
All oral H-mono/poly-resistance DR TB regimen	DR	51 (5.2%)	Y	Y	Y	Y	–	–	–	–	–	–	–	–	–	–	–
Shorter MDR TB regimen	MDR	151 (15.5%)	Y	–	Y	Y	Y	Y	Y	Y	Y	–	–	–	–	–	–
All oral longer MDR TB regimen	MDR	523 (53.7%)	Y	–	Y	–	Y	Y	Y	Y	–	Y	Y	–	–	–	–
Conventional MDR TB regimen	MDR	139 (14.3%)	–	–	Y	Y	–	Y	Y	Y	–	–	Y	–	Y	–	–
Modified MDR/RR TB and FQ or SLI resistance regimen	MDR	31 (3.2%)	–	–	Y	Y	–	Y	Y	Y	–	Y	Y	–	Y	–	–
XDR TB regimen	XDR	26 (2.7%)	–	–	Y	Y	Y	Y	Y	Y	–	Y	Y	–	–	Y	Y
Modified for mixed pattern resistance regimen	DR	5 (0.5%)	–	–	Y	Y	–	Y	Y	Y	–	Y	Y	–	Y	Y	Y
New drug MDR TB and FQ/SLI resistance regimen	MDR	14 (1.4%)	–	–	Y	–	Y	–	Y	Y	–	Y	Y	–	Y	–	Y
New XDR TB regimen	XDR	10 (1.0%)	–	–	Y	Y	Y	–	Y	Y	–	Y	Y	–	–	–	Y
New MDR TB failure regimen	MDR	3 (0.3%)	–	–	–	–	Y	Y	Y	Y	–	Y	Y	–	–	–	–
New XDR TB failure regimen	XDR	2 (0.2%)	–	–	–	–	Y	Y	Y	Y	–	Y	Y	–	–	–	–
Shorter BDQ regimen	MDR	19 (2.0%)	–	–	Y	Y	–	Y	Y	Y	Y	Y	Y	Y	Y	–	–

Abbreviations: TB – tuberculosis, DR – drug-resistant TB, mono – single resistance to isoniazid, or other first-line drug (not rifampin), MDR – multi drug-resistant (i.e., resistance ≥ 2 first-line drugs but not to both isoniazid and rifampin), XDR – extensively drug-resistant (i.e., MDR and resistance to any fluoroquinolone and a second-line injectable drug), RR – rifampin-resistant, SLI – second-line injectable, H – isoniazid, FQ – fluoroquinolone, LFX – levofloxacin, R – rifampin, Z – pyrazinamide, E – ethambutol, BDQ – bedaquiline, MFX – moxifloxacin, ETO – ethionamide, CFZ – clofazimine, LZD – linezolid, CS – cycloserine, AM – amikacin, KM – kanamycin, PAS – para-aminosalicylic acid, CM – capreomycin

ETBD-F1 Adverse drug reaction (ADR) screening and referral form

(Fill in triplicate with carbon paper in sheets. Send one copy to the unit where patient is referred, give one copy to patient, and retain one copy for records)

Patient ID : Month (number) ___ Date of screening: _/ _/ _

Mode of patient contact: Phone Home visit Hospital visit

1 Headache सर दर्द <input type="checkbox"/>	9 Visual disturbances द्रष्टि का कम होना/ द्रष्टि मे बाधा <input type="checkbox"/>	17 Constipation कब्ज <input type="checkbox"/>
2 Dizziness चक्कर आना <input type="checkbox"/>	10 Heart pounding छाती में धड़धड़ होना <input type="checkbox"/>	18 Joint pain जोडो मे दर्द <input type="checkbox"/>
3 Sleep disturbances नींद में परेशानियाँ <input type="checkbox"/>	11 Nausea/Vomiting जी मचलाना/ उलटी होना <input type="checkbox"/>	19 Fatigue थकावट <input type="checkbox"/>
4 Seizures अकड़ी <input type="checkbox"/>	12 Loss of appetite भूख ना लगना <input type="checkbox"/>	20 Skin rash/itching त्वचा पे लाल चटके/हीक्स/खुजली <input type="checkbox"/>
5 Psychosis मनोविकृति <input type="checkbox"/>	13 Abdominal pain पेट में दर्द <input type="checkbox"/>	21 Yellowish discoloration of skin and eyes त्वचा और आँखों का पीलापन होना <input type="checkbox"/>
6 Diminished/lost hearing कम सुनाई देना/ सुनाई नहीं देना <input type="checkbox"/>	14 Diarrhoea दस्त <input type="checkbox"/>	22 Neck/ face swelling गर्दन में सुजन/ चहरे में सुजन होना <input type="checkbox"/>
7 Ringing in ears कानों का बजना <input type="checkbox"/>	15 Difficulty in urination मूत्र होने में कठिनाई होना <input type="checkbox"/>	23 Change in behaviour व्यवहार में बदलाव <input type="checkbox"/>
8 Depression/Suicidal thoughts डिप्रेसन/ आत्महत्या का विचार <input type="checkbox"/>	16 Tingling/pain/numbness in hands or feet झुनझुनाहट होना/ दर्द होना/ हाथ व पांव का सुन होना <input type="checkbox"/>	24 Other अन्य <input type="checkbox"/>
		No adverse drug reaction <input type="checkbox"/>

ADR number	Severity* 1.Severe 2.Not severe	Date of onset	Duration	Frequency/episodes (# per day)	Action taken 1.Not referred 2.Referred for ADR management	Remarks

* Severe: Life-threatening condition, requires inpatient hospitalization, resulting in disability or incapacity or death.

Name of health worker _____ Designation _____

Date of screening _____ Sign _____

If referred for AE management

Name/address of health institution to which patient is referred _____

Date referred: _/ _/ _

For use of the health institution where the patient has been referred

Patient ID _____ Date of referral _/ _/ _

The above case reported to this health institution on _____ for _____ at OPD/IPD.

Brief discharge summary (Diagnosis/Investigations/Treatment/follow-up/Hospitalized)

Diagnosis: _____

Action: Drug stopped Dose reduced Not changed Hospitalized: Yes/No

Outcome: Fatal Recovering No change Recovered Unknown Other (specify) _____

Medical Officer/Physician _____ Date _/ _/ _ sign _____

(Send this slip back to the referring health institution/facility)

Appendix Figure. “End DRTB in Dharavi slum” adverse event screening form and referral form.