From The Chief Medical Officer:
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To Chief Executives of Boards
Directors of Public Health, HSS Boards
Consultants in Communicable Disease Control, HSS Boards
Chief Executives of Trusts
Medical Directors of Trusts
Directors of Nursing at Boards
Directors of Nursing at Trusts
Directors of Pharmacy at Boards
Directors of Pharmacy at Trusts
Consultant Microbiologists
Consultant Respiratory Physicians
Consultant Paediatricians
Consultant Occupational Physicians
Consultant GUM Physicians
CDSC (NI) (Dr B Smyth)
EMAS (Dr D Skan)
Prison Medical Service (Dr McClements)
All GPs in NI
NICS Occupational Health (Dr K Addley)

Dear Colleague

Joint Tuberculosis Committee of the British Thoracic Society Guidelines

1. **Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Thorax 2000;55:887-901**

2. **Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998. Thorax 1998;53:536-548**

3. **Management of opportunist mycobacterial infections: Joint Tuberculosis Committee guidelines 1999. Thorax 2000;55:210-218**

Summary

1. The purpose of this letter is to provide you with updated guidance on the prevention and control of Tuberculosis (TB). Copies of the above three guidelines are enclosed and endorsed by DHSSPS for use by health and personal social services in Northern Ireland. These guidelines constitute best practice in the management of TB and many of these recommendations are already being followed here.

   Previous guidance 'Prevention and Control of Tuberculosis in N Ireland' was issued in March 1997, based on earlier British Thoracic Society guidelines. Much of the guidance in that document is updated in these more recent guidelines.

2. Use of the guidelines 'Control and Prevention of Tuberculosis in the United Kingdom' and Chemotherapy and Management of Tuberculosis in the United Kingdom' will ensure a consistent approach to the control, prevention and treatment of tuberculosis. 'Management of Opportunist Mycobacterial Infections' gives some guidance on the treatment of opportunistic mycobacterial infections.

Action: Boards and trusts should ensure that their policies are revised as necessary in accordance with this guidance.

Background

3. Tuberculosis remains a public health concern both worldwide and in the UK. World wide it continues to cause two million deaths per year; the majority in sub-Saharan Africa. Higher incidence abroad is reflected in the high incidence of tuberculosis in minority ethnic groups in the UK. The HIV epidemic has contributed to the resurgence of tuberculosis, as people with HIV infection are more susceptible to tuberculosis. Multidrug resistant tuberculosis (MDR-TB) is uncommon in the UK but has caused worrying outbreaks. There were two cases of MDR-TB in the Republic of Ireland in 1999. MDR-TB is causing particular problems in the USA and elsewhere, and importation of drug resistant strains remains a risk to public health here.

   Other recent concerns in the UK have included outbreaks of tuberculosis in schools, and an increase in *Mycobacterium bovis* infection in cattle and in humans.

Tuberculosis in N Ireland

4. The incidence of tuberculosis in N Ireland is low, with a crude rate of 3.6 per 100,000 population. This compares with 12.9 per 100,000 population in the South of Ireland. .

   Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Thorax 2000;55:887-901

5. Attention is drawn to a number of key areas of change from previous guidance. Health professionals dealing with cases of TB should familiarise themselves with the content of the full document.

5.1 There is extended advice on control of tuberculosis in hospitals, with emphasis on making risk assessments for the likelihood of infectiousness and MDR-TB. Specific guidance on prevention of spread of MDR-TB, and precautions to be taken in HIV settings is outlined.

5.2 There are changes in pre-employment procedures for health care workers and others at similar risk of contacting tuberculosis. A tuberculin test is now only necessary in those who do not have either a definite BCG scar or documentary evidence of a previous BCG. Those who are negative or Heaf grade 1 on tuberculin testing should have BCG vaccination regardless of age. Those with Heaf grades 2, 3 or 4 only need follow-up if they have symptoms or a history of contact with tuberculosis on careful history. There are special considerations for those workers who are, or are at risk of being, HIV positive, as these people are at greater risk from contact with patients with tuberculosis.

5.3 Screening of close contacts of patients who have smear-negative pulmonary disease, irrespective of culture results, continues to be recommended, although fewer cases will be found in this group than contacts of smear-positive disease. BCG vaccination is recommended only for those under 16 years who are persistently tuberculin negative, unless they are at increased risk. Chemoprophylaxis recommendations have been updated. Routine radiographic follow-up is now only recommended for those who are eligible for but do not receive chemophrophylaxis.

5.4 Recent UK experience has led to the addition of:

- New advice on bovine tuberculosis
- Extended advice on tuberculosis in schools, with increased emphasis on confirmation of infection and widening of contacts to be followed up
- Increased advice on outbreak investigation
- Increased advice on follow-up of tuberculosis on aircraft

Those at increased risk of tuberculosis, including the homeless and immigrants, continue to require special attention.

Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998. Thorax 1998;53:536-548

6. These guidelines outline current best practice in the treatment of TB and should be followed for every case of tuberculosis in every setting.

Management of opportunist mycobacterial infections: Joint Tuberculosis Committee guidelines 1999. Thorax 2000;55:210-218

7. Opportunist mycobacterial infections remain uncommon but are increasing in the UK. People infected with HIV are at particular risk of suffering disease caused by opportunistic infection, but incidence appears to have risen in the wider population. Guidance on the often problematic treatment of some of these infections is given in this guideline.

Further information available from:

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Yours sincerely

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