County of San Diego Tuberculosis Report

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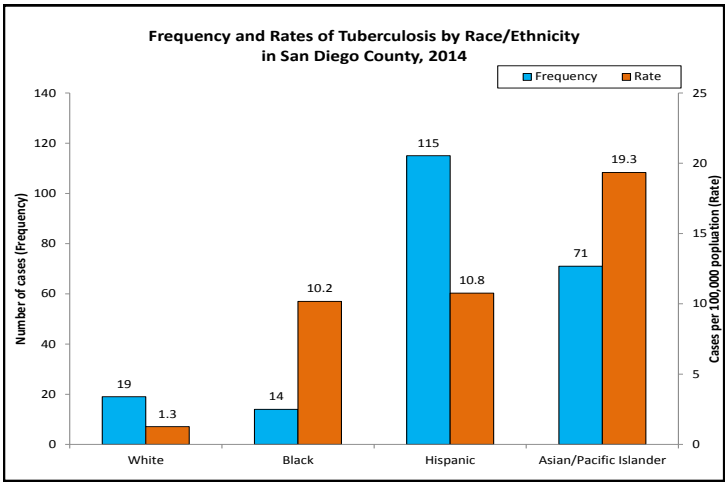
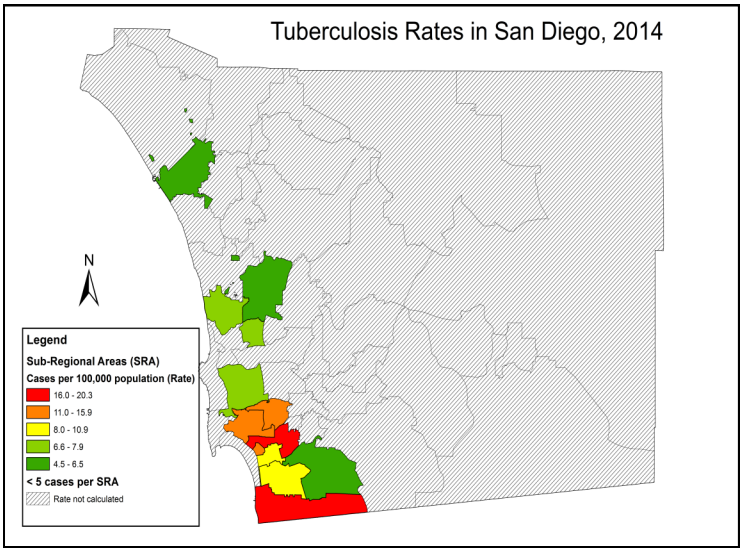
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Table 1. Tuberculosis Cases and Rates per 100,000 Population in San Diego County

2014		2015	
Jan-Jun cases	*Annual Rate**	*Jan-Jun cases*	*Annualized Rate***
116	6.9	107	6.7

Note: Rates calculated using 2014 SANDAG population estimates.
* Denotes actual overall rate based on 220 total cases counted in 2014
** Estimated rate based on case count from January through June





Note: *Case counts are based on the date of health department confirmation. Updates to monthly totals are ongoing as case reports are processed. Annual morbidity totals are finalized in January for the previous calendar year.*

Update on Regimens for Latent Tuberculosis Infection (LTBI)

The number of individuals reported with active TB in San Diego County declined 53% between 1993 (469 cases) and 2014 (220 cases).[1] In recent years, however, the downward trend has slowed locally, as well as across the United States. Modeling studies[2] suggest that to reach TB elimination goals (1 case per million), it will not be enough to merely identify and treat those who have active TB disease. It will be imperative to increase TB prevention several-fold specifically by testing, identifying, and treating individuals with LTBI before they develop active TB disease.

To advance efforts, providers should be aware of new tools and strategies in the fight against TB and put them into practice:

Use more specific tests for TB infection when possible. While not a panacea, the interferon gamma release assays [IGRA (QuantiFERON®, TSpot.TB®)] are more specific for TB infection than the TB skin test, especially for those with prior vaccination for TB. It is the preferred test for your patients with a history of vaccination for TB or those who may not return for their TB skin test to be read.[3] The specificity afforded by IGRAs will reduce the number of patients who are falsely positive and permit increased focus on those who are most likely to benefit from treatment.

Shorter course treatment options can increase adherence. Isoniazid (INH) for 9 months remains a recommended treatment option for individuals with LTBI. However, in 2011, the CDC added the 12 dose, once weekly (3 month) regimen of INH and rifapentine (rifamycin with longer half-life) to their recommended regimens.[4] Health departments across the US are increasingly using a daily 4-month regimen of rifampin based on CDC guidance and a lower risk profile.[5] Beyond having less risk of hepatotoxicity, both short-course regimens have shown higher rates of patient adherence and completion than 9 months of INH.

Focus on risk. Although an estimated 4% of the US population has LTBI,[6] not all are at the same risk of progression to TB disease. Increased attention is needed to assure the highest risk groups are prioritized for testing and subsequent treatment. Specific groups to consider for routine testing are diabetics, patients with end-stage renal disease, and those with HIV infection or other significant immune compromising conditions.[7] From 2010-2013, 34% of those with active TB in San Diego had at least one of these conditions. Be especially cognizant of testing your patients with one of these medical conditions if they were born in, travel to, or visit friends and relatives outside the US (including Mexico). It is also important to test your patients who are from Asia, Africa and Latin America; children, young adults, and new entrants from these areas are groups to consider for routine testing for LTBI.

For more information go to cdc.gov/tb/education/provider_edmaterials.htm or cdc.gov/tb or sandiegotbcontrol.org or call 619-692-8621.

References

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