Section 8: Care of Clients with Latent TB Infection (LTBI)

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Steps in Caring for a Client with LTBI

Treatment of LTBI (also known as 'preventive treatment' or previously called 'TB prophylaxis') can substantially reduce the risk for development of active TB and is prescribed for clients with positive tuberculin skin test (TST) results and/or positive interferon gamma release assays (IGRA), once active TB has been ruled out.

The physician recommends treatment of LTBI based on a review of the individual's medical history and risk factors for the development of active TB.

In the Labrador-Grenfell Health (LGH) Region, LTBI treatment is directly observed by Community Health staff. Under special circumstances, treatment may be administered by the Regional Nurse or other healthcare provider within Nunatsiavut or LGH.

The following tool estimates the risk of active tuberculosis for an individual with a tuberculin skin test reaction of ≥5 mm, based on his/her clinical profile and can be used to decide on treatment for LTBI.

http://www.tstin3d.com/en/calc.html

Step 1: Discuss LTBI and LTBI Treatment with Client

- Initial results of the TST are provided by the community health nurse. IGRA results, chest x-ray findings, and (if available) sputum test results are provided by the TB/Community physician.
    - These results are carefully reviewed with the client, by the Community Health Nurse, in preparation for recommended LTBI treatment.
    - The community health nurse shall review the following **TB Fact Sheets (Appendix E)** with the client (and/or the parent/guardian) and document in the client note that this was completed:
        - Latent TB Infection vs. Active TB Disease
        - Latent TB Infection (LTBI) Treatment with 3HP (12 doses)
        - Latent TB Infection (LTBI) with INH
        - Latent TB Infection Treatment (LTBI) with Rifampin

- TB Medications and Alcohol
- TB Medications and Acetaminophen (Tylenol)
- TB Medications and Your Liver
- TB and Smoking

- Have the client or their designate sign the form indicating consent or refusal for LTBI treatment and send the form to the CDCN; **Consent/Refusal for Tuberculosis Infection (LTBI) Treatment and Window Period Prophylaxis (WPP) (Appendix D)**

- Initiate LTBI Surveillance if treatment is declined.
  - Consult with the CDCN regarding TB surveillance and follow-up.
  - Document the date LTBI Treatment was discussed and declined.
  - Record the due date for the first surveillance assessment in the client's progress notes and the follow up list.

Regardless of whether a client begins LTBI treatment, it is essential that s/he remain alert for TB signs/symptoms (see Table 8.1), and report to a health care provider quickly should any signs/symptoms develop.

Table 8.1: TB signs/symptoms

Systemic TB signs/symptoms	Signs/Symptoms of respiratory TB disease	Signs/symptoms of non-respiratory TB disease
• Fever* • Night sweats* • Weight loss or failure to gain weight (i.e. failure to thrive) • Fatigue • Loss of appetite	Systemic TB signs/symptoms **AND** • Cough ≥3 weeks (dry or productive) • Chest pain • Shortness of breath • Bloody phlegm (hemoptysis)	Systemic TB signs/symptoms **AND** pain or dysfunction at the involved site, e.g.: • Swollen lymph nodes (TB lymphadenitis) • Headache, irritability, photophobia, stiff neck (TB meningitis)

**Can be absent in the very young and the elderly.*

Step 2: Prepare to Begin LTBI Treatment

- Consult with the CDCN to ensure all baseline testing has been done, including:
    - Posterior/anterior and lateral chest x-rays.
    - Three sputum specimens sent for TB testing.
    - Blood tests: AST, ALT, total bilirubin, CBC, uric acid, creatinine, hepatitis B surface antigen (HbsAg), hepatitis C, and HIV serology (See **Appendix D** for **sample laboratory requisition**).

NOTE: HbsAg, hepatitis C, and HIV testing are **NOT REQUIRED** for clients with pre-existing positive test results. Results from blood tests done within one-month prior can be used as baseline measurements provided they are within normal limits for the client's age.

- For all clients, obtain a weight, document it on the client's chart and send a copy to the CDCN for prescription dosage.
- Consult the CDCN to obtain a prescription for LTBI treatment.
    - Put a copy of the prescription on the client's TB chart and send a copy of the prescription to the regional community clinic if applicable.
- Advise the client (or the parent/guardian) that LTBI treatment can begin once a prescription has been received.
    - In Nunatsiavut communities, medications are shipped from the Labrador Health Center pharmacy, and can be picked up at the Regional Community Clinic.
    - When LTBI treatment is to be provided to a child outside of the public healthcare setting without parent/guardian present, the parent/guardian must sign the **Medication Consent Form for School** or **Medication Consent Form for Day Care. (Appendix D).** Review the side effects of the medication with the parent/guardian before administering the medication.

Step 3: Begin LTBI Treatment

Once a prescription has been received, initiate Direct Observed Treatment (DOT).

Before administering the first dose of LTBI treatment:

- Ensure baseline blood test results are within normal limits for the clients' age. Consult the CDCN about abnormal baseline results, including new positive Hepatitis B surface antigen (HbsAg), hepatitis C, or HIV tests.

- Confirm the client's weight and document it on the **Latent TB Infection (LTBI) DOT Record**. Compare the current weight against the prescription dosage to ensure the dosing is adequate. Consult the CDCN if dosage adjustments are required. See the following tables located later in this section:

    - **Table 8.6: Summary of recommended regimens, doses and treatment times to completion, for LTBI treatment**
    - **Table 8.7: Recommended drug doses for three months of once weekly doses of Rifapentine, INH and Pyridoxine (Vitamin B6)**
    - **Table 8.8: Recommended drug doses for nine months of twice-weekly LTBI treatment with isoniazid (INH) and pyridoxine (vitamin B6)**
    - **Table 8.9: Recommended drug doses for daily LTBI treatment with Rifampin**

- Review information with the client (and/or the parent/guardian) on:

    - The planned treatment regimen.

    - Potential TB drug side effects/adverse responses to LTBI treatment (see **Table 8.2**) and a clear written plan of action should symptoms occur including how to contact the CHN.

    - **There must be at least two calendar days between twice-a-week doses of INH**. For this reason, LTBI treatment with INH is usually given on Mondays and Thursdays. When a twice-weekly dose is not given on a Monday (for example, when a DOT dose is missed or a statutory holiday falls on a Monday), give treatment on Tuesday and Friday that week. When a twice-weekly dose is missed on a Thursday, it can be taken the next day (Friday). **Consult the CDCN if you are uncertain whether/when to give a next dose.**

    - The importance of avoiding acetaminophen (Tylenol®) and/or alcohol during LTBI treatment (see Fact Sheets **TB Medications and Acetaminophen (Tylenol)** and **TB Medications and Alcohol**).

    - The importance of adherence to LTBI treatment.

After administering the initial dose of LTBI treatment:

- Document the initial treatment dose on the **Latent TB Infection (LTBI) DOT Record.**
- Confirm a plan for the next dose.

- Missed doses are made up by adding them to the end of the LTBI treatment term.

Preparation of doses of TB drugs is a nursing function. **Community health aides are NOT authorized to prepare TB drugs or dispense doses from stock medication supplies.**

Step 4: Monitoring LTBI Treatment

Side effects/adverse events associated with drugs used for LTBI treatment

TB drugs can lead to side effects and adverse responses. See **Table 8.2**: **Common and/or important side effects/adverse responses associated with isoniazid, rifampin and rifapentine.**

Clients (and/or parents/guardians), Community Health Aides, and nurses managing the care of clients on LTBI treatment **share responsibility for**:

- Preventing and identifying TB drug side effects/adverse responses to treatment.
- Identifying signs/symptoms that could indicate development of active TB.
- Ensuring that the regional community clinic is aware of all medications the client is taking (or starts taking) during LTBI treatment.
- Ensuring potential interruptions in or barriers to LTBI treatment adherence (e.g. travel) are identified and addressed (or minimized).

Community Health Aides administering DOT for LTBI are to report any side effects to the nurse and document a progress note in the client's chart.

Table 8.2: Common and/or important side effects/adverse responses associated with isoniazid, rifampin and rifapentine.

Adapted from: Menzies R, Wong T. Canadian Tuberculosis Standards. 7th ed. Canadian Thoracic Society and the Public Health Agency of Canada; 2014.

TB drug	Common side effects/adverse responses	Uncommon but important side effects/adverse responses
Isoniazid (INH)	• Rash • Hepatitis[1] • Neuropathy • Nausea/vomiting[2,3] • Fatigue • Drowsiness, headache • Mild hair loss	• Central nervous system, toxicity[4] • Anemia
Rifampin	• Drug interactions • Rash • Saliva, urine, and tears can become orange/red in colour (harmless but could stain contact lenses)	• Hepatitis[1] • 'Flu like' illness • Neutropenia • Thrombocytopenia
Rifapentine	• Possible hypersensitivity[5]	• Rash • Hepatotoxicity • Thrombocytopenia • Other toxicities

[1]Symptoms can include: loss of appetite, nausea and/or vomiting; abdominal discomfort, unexplained fatigue, dark-coloured urine; scleral icterus; jaundice.
[2]Especially with intermittent regimens administered in combination with rifampin.
[3]Can also be a symptom of drug-induced hepatitis.
[4]Symptoms can include: slurred speech; peripheral neuritis, dizziness; stupor; seizures; coma.
[5]Can include flu-like symptoms (such as fever, chills, headaches, dizziness, musculoskeletal pain) and shortness of breath, wheezing, acute bronchospasm, urticaria, petechiae, purpura, pruritus, conjunctivitis, angioedema, hypotension or shock.

Monitoring Requirements

- Monitor clients taking DOT for LTBI as per **Table 8.3**, **Table 8.4** and **Table 8.5,** depending on medication regimen or as directed by the CDCN and/or the treating physician. Monitoring requirements for clients taking rifampin are determined by the treating physician.

NOTES:

- Monitoring requirements may be adjusted by the treating physician for clients:
  - With abnormal baseline blood test results,

- At increased risk for hepatotoxicity or other adverse effects, and
- Who develop side effects/adverse response during LTBI treatment.

- Blood tests after baseline are NOT routinely required during LTBI treatment with INH and vitamin B6 for clients under 13 years of age.

- In the course of treatment, if immediate concerns are identified, refer clients to the Regional Community Clinic or Health Center for assessment and notify the CDCN.

- Document assessments on the **Latent TB Infection (LTBI) DOT Record**. Consult the CDCN or the treating physician about abnormal results.

- Clinical monitoring of any client whose LTBI treatment is provided by a Community Health Aide must include a face-to-face assessment by a nurse or a physician **AT LEAST WEEKLY** (more frequently if there are any concerns).

- Clients attending TB clinic for an assessment with the TB physician must have sputum specimens collected prior to attending the TB clinic. The CDCN will review the sputum results to determine whether the client can travel by air.

Key Aspects of Monitoring during LTBI Treatment

- **Hepatotoxicity**

Severe and potentially fatal hepatotoxicity can occur during LTBI treatment. Hepatotoxicity is defined as liver enzyme (AST/ALT) levels **FIVE** times the upper limit of normal without symptoms **OR THREE** times the upper limit of normal with symptoms.

Clients at increased risk for hepatotoxicity during LTBI treatment include:

- Pregnant clients and clients who are up to three months postpartum.
- Those over the age of 65 especially if they have comorbidities. *(The risks and benefits of LTBI treatment should be considered very carefully over the age of 65, although therapy may be reasonable in those at high risk of reactivation and without comorbidities).*
- Those with a history of previous drug-induced hepatitis.
- Those with current cirrhosis or chronic active hepatitis of any cause.

- Those with hepatitis C.
- Those with hepatitis B and abnormal transaminases.
- Those who consume alcohol daily or who are undergoing concomitant treatment with other hepatotoxic drugs (e.g. methotrexate).

If signs/symptoms consistent with hepatotoxicity are present:

- **Hold treatment.**
- Consult the CDCN or the treating physician.
- Refer to the regional community clinic or health center for bloodwork as ordered by the treating physician.

Signs/symptoms consistent with hepatotoxicity include:

- Loss of appetite
- Nausea and/or vomiting
- Abdominal discomfort
- Unexplained fatigue
- Dark-coloured urine
- Scleral icterus or jaundice
- Fever and chills

(Adapted from: Menzies R, Wong T. Canadian Tuberculosis Standards. 7th ed. Canadian Thoracic Society and the Public Health Agency of Canada; 2014.)

- **Potential for other Adverse Effects/Concerns**
  - Use clinical judgment to determine whether the CDCN should be consulted or whether the client should be referred to the regional community clinic or health center for assessment.
  - **Monitor clients taking anticonvulsants closely** as both INH and rifampin can affect the metabolism and serum levels of anticonvulsants.
  - Consult the CDCN immediately if any TB signs/symptoms are noted

- **Changes in Weight**

    - Document weight on the **Latent TB Infection (LTBI) DOT Record** monthly.

    - Maintain a growth chart for clients five years of age and under.

    - Ensure adequate dosing is maintained by comparing the client's current weight against the last month's weight, and against the prescription dosage**.** Consult the CDCN when dosage adjustments are required. See the following tables located later in this section:

        - **Table 8.6: Summary of recommended regimens, doses and treatment times to completion, for LTBI treatment**
        - **Table 8.7: Recommended drug doses for three months of once weekly doses of Rifapentine, INH and Pyridoxine (Vitamin B6)**
        - **Table 8.8: Recommended drug doses for nine months of twice-weekly LTBI treatment with isoniazid (INH) and pyridoxine (vitamin B6)**
        - **Table 8.9: Recommended drug doses for daily LTBI treatment with Rifampin**

  NOTE: Notify the CDCN immediately about weight loss in any client or failure to gain weight in a growing child as this could reflect an adverse response to treatment or development of active TB.

- **Adherence**

    - Consult the CDCN if three doses in a row are missed and/or if adherence falls below 80% in a calendar month.

      To calculate adherence as a percentage, divide the number of DOT doses taken by the number of DOT doses due. Multiply the result by 100. Example: seven DOT doses taken divided by nine doses due (i.e. two doses missed) = 78% adherence.

  NOTE: Ask about travel plans during each visit. Consult the CDCN when arranging for continuation of LTBI treatment during travel (see **TB Travel/Transfer Form** in **Appendix D**).

See **Section 10: Guidelines for Working with Clients** for information on DOT, the use of incentives and enablers, and helpful information on administering TB drugs.

- **Pregnancy**

- Refer clients to the CDCN to arrange follow-up with TB physician, if there is a positive pregnancy test result.

Table 8.3: Summary of routine monitoring during LTBI treatment with isoniazid and vitamin B6. *(Unless otherwise directed by a Physician.)*

Menzies R, Wong T. Canadian Tuberculosis Standards. 7th ed. Canadian Thoracic Society and the Public Health Agency of Canada; 2014.)

Monitoring	End of Month 1	End of Month 2	End of Month 3	End of Month 4	End of Month 5	End of Month 6	End of Month 7	End of Month 8	End of Month 9
Weight (kg.)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Check dose against current weight	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assess side effects	Ask about side effects and possible hepatoxicity prior to each dose of medication.								
Assess for TB signs and symptoms	Consult CDCN if there is worsening or recurrence of TB signs or symptoms								
AST, ALT, Bilirubin*	✓	✓	✓	✓	✓	✓	✓	✓	✓
CBC, Serum creatinine, uric acid	Repeat after baseline if ordered by the Physician								
Sputum for AFB smear and TB culture			X 3						X 3
PA and lateral chest x-rays			✓						✓
Pregnancy	Ask women of childbearing age about possibility of pregnancy monthly.								
Travel	Ask about travel plans during each DOT visit.								

Note: *Clients attending TB clinic for an assessment with the TB physician must have sputum samples collected prior to the TB clinic.*
**For children, routine monitoring of serum liver enzymes post baseline is not necessary unless the child has risk factors for hepatotoxicity.*
A physician order is required prior to taking shielded chest x-rays of a client who is or might be pregnant

Table 8.4: Summary of routine monitoring during LTBI treatment with rifampin.
(Unless otherwise directed by a Physician.)

Monitoring	End of Month 1	End of Month 2	End of Month 3	End of Month 4
Weight in Kg.	✓	✓	✓	✓
Check dose against current weight	✓	✓	✓	✓
Assess side effects	Ask about side effects and possible hepatoxicity prior to each dose of medication.			
Assess for TB signs and symptoms	Consult CDCN if there is worsening or recurrence of TB signs or symptoms			
AST, ALT, Bilirubin*	✓	✓	✓	✓
CBC, Serum creatinine, uric acid	Repeat after baseline if ordered by the Physician			
Sputum for AFB smear and TB culture				X 3
PA and lateral chest x-rays				✓
Pregnancy	Ask women of childbearing age about possibility of pregnancy monthly.			
Travel	Ask about travel plans during each DOT visit.			

Note: *Clients attending TB clinic for an assessment with the TB physician must have sputum samples collected prior to travelling out to TB clinic.*
**For children, routine monitoring of serum liver enzymes post baseline is not necessary unless the child has risk factors for hepatotoxicity.*

Table 8.5: Summary of routine monitoring during LTBI treatment with rifapentine and isoniazid and vitamin B6 *(Unless otherwise directed by a Physician)*

Monitoring	End of Month 1	End of Month 2	End of Month 3
Weight (kg.)	✓	✓	✓
Check dose against current weight	✓	✓	✓
Assess side effects	Ask about side effects and possible hepatoxicity prior to each dose of medication.		
Assess for TB signs and symptoms	Consult CDCN if there is worsening or recurrence of TB signs or symptoms		
AST, ALT, Bilirubin*	✓	✓	✓
CBC, Serum creatinine, uric acid	Repeat after baseline if ordered by the Physician		
Sputum for AFB smear and TB culture			X 3
PA and lateral chest x-rays			✓
Pregnancy	Ask women of childbearing age about possibility of pregnancy monthly.		
Travel	Ask about travel plans during each DOT visit.		

Note: *Clients attending TB clinic for an assessment with the TB physician must have sputum samples collected prior to travelling out to TB clinic.*
**For children, routine monitoring of serum liver enzymes post baseline is not necessary unless the child has risk factors for hepatotoxicity.*

Step 5: Document LTBI Treatment Outcome when Completed

Note: Please be advised that treatment is dose-dependent rather than scheduled monthly-based treatment plans. Missed doses must be accounted for and added to the end.

To document the end of LTBI treatment outcome:

- Review TB signs/symptoms with the client (**Table 8.1**). Remind the client (and/or the parent/guardian) to remain alert for TB signs/symptoms, and to report to a health care provider quickly should any develop. It is possible for people who have completed LTBI treatment and to later develop active TB;

- Ensure the current **Latent TB Infection (LTBI) DOT Record (Appendix D)** is complete, including number of doses taken that month and number of doses taken to date. Send the **Latent TB Infection (LTBI) DOT Record** to the CDCN, along with an updated growth chart for clients under five years of age. File the original **Latent TB Infection (LTBI) DOT Record** in the client's chart.

- When the last dose is taken, complete **Parts 1 to 4** of the **LTBI Treatment Outcome Form** and send it to the CDCN.

- After consulting the TB Physician, the CDCN will complete **Part 5: Treatment Outcome and Surveillance Recommendations** and return it.

- Review the **LTBI Treatment Outcome Form** for the surveillance recommendation when it is returned by the CDCN.

    - If surveillance **WAS NOT** recommended, file the **LTBI Treatment Outcome Form** in the client's chart and write a note. Send a copy of the form to the Regional Community Clinic or Medical Records Department as appropriate.

    - If surveillance **WAS** recommended initiate the **Tuberculosis Surveillance and Outcome Form (Appendix D**) and follow the steps in **Section 13: TB Surveillance**. File the **LTBI Treatment Outcome Form** in the client's chart and send a copy to the Regional Community Clinic or Medical Records Department as appropriate.

Follow-up after LTBI Treatment

Follow-up of individuals with LTBI depends on when LTBI was diagnosed and compliance with treatment. The following points offer guidance but the final decision rests with the TB physician.

- Inadequately or untreated LTBI acquired in the last two years: follow every six months for two years

- Inadequately or untreated LTBI of undetermined date AND risk factors for TB **OR** clinical findings requiring follow up: follow once in 12 months

- Inadequately or untreated LTBI of undetermined date with no risk factors or no clinical findings for follow up: no surveillance is required.

- Adequately treated LTBI: follow once at six months after the end of treatment.

- See **Section 13: TB Surveillance** for the surveillance protocol including the definition of adequate treatment.

NOTES:

- **Partial treatment of LTBI does not provide protection against development of active TB in future.** Encourage clients with incomplete LTBI treatment to consider completing treatment in future unless contraindicated (e.g. due to drug-induced liver toxicity or other adverse reactions to treatment). **DO NOT resume LTBI treatment without consulting the CDCN.**

- **A history of prior LTBI treatment does not provide protection against re-infection with TB bacteria.** Clients who are exposed to active TB after LTBI treatment should undergo routine contact follow-up assessments (see **Section 12: Contact Investigation, Window Period Prophylaxis and Source Case Investigation**).

- For those who are unable to take DOT or decline DOT or have incomplete treatment see **Section 13: TB Surveillance**.

LTBI Treatment Regimens and Recommended TB Drug Dosages

Table 8.6: Summary of recommended regimens, doses and treatment times to completion, for LTBI treatment

Drugs	Duration	Schedule	Mode	Doses	Time
Standard Regimen					
INH	9 months	Daily	SAP	270	12 months
Acceptable Alternative Regimens					
INH	6 months	Daily	SAP	180	8 months
INH/RMP	3 months	Daily	SAP	90	16 weeks
INH/RPT	3 months	Once weekly	DOT	12	16 weeks
RMP	4 months	Daily	SAP	120	6 months
INH	6-9 months	Twice weekly	DOT	52-78	8-12months
INH/RMP	3 months	Twice weekly	DOT	24	16 weeks

INH = Isoniazid, RMP = Rifampin, RPT = Rifapentine, SAP = Self-Administered Prophylaxis, DOT = Direct Observed Treatment, Doses = Number of doses in Treatment regimen, Time = acceptable time period for completion of regimen

Source: Canadian Tuberculosis Standards, 7th Edition, https://www.phac-aspc.gc.ca

Brief periods of non-compliance are acceptable, but the course of preventive therapy needs to be completed within a specified time period, as indicated in chart above.

In the Labrador-Grenfell Health region, a once weekly dosage of Rifapentine and INH has become the regimen of choice for LTBI, until a total of 12 doses have been directly observed. Supplemental pyridoxine (vitamin B6) is prescribed with INH to prevent peripheral neuropathy (numbness/tingling in fingers and/or toes).

Table 8.7: Recommended drug doses for three months of once weekly doses of Rifapentine, INH and Pyridoxine (Vitamin B6)

TB Drug	Dosage	Maximum Dose
Isoniazid (INH)	15 mg/kg rounded to nearest 50/100 mg in patients > 12 years	900 mg
	25 mg/kg rounded to the nearest 50/100 mgs in patients 2-11 years	
Rifapentine	10.0 - 14.0 kg = 300 mg	900mg
	14.1 - 25.0 kg = 450 mg	
	25.1 – 32.0 kg = 600 mg	
	32.1 – 49.9kg = 750 mg	
Rifapentine tablets can be crushed and administered with semi-solid food for children unable to swallow pills.		
Pyridoxine (Vitamin B6)	50 mg	50 mg

Source: https://www.cdph.ca.gov

Note: The following are not recommended for the INH/ Rifapentine (3HP) weekly treatment:

- *Children under two years of age*
- *HIV infected persons taking antiretrovirals (there are potential drug interactions with Rifapentine and antiretrovirals)*
- *Individuals taking medications that may have drug interactions that are difficult to manage with the 12-dose treatment*
- *Persons presumed infected with M. tuberculosis resistant to INH or Rifampin*
- *Pregnant women or women planning to become pregnant during treatment*
- *Individuals who have had prior adverse events or hypersensitivity to INH or Rifampin*

Isoniazid (INH) with Pyridoxine (Vitamin B6)

LTBI is also frequently treated with isoniazid (INH), taken twice-weekly, until a total of 78 doses have been directly observed (refer to **Table 8.6** for **all LTBI Treatment Regimens**). Supplemental pyridoxine (vitamin B6) is prescribed with INH to prevent peripheral neuropathy (numbness/tingling in fingers and/or toes).

Table 8.8: Recommended drug doses for nine months of twice-weekly LTBI treatment with isoniazid (INH) and pyridoxine (vitamin B6)

Note: The treating physician will determine whether dosing is daily or intermittent.

TB Drug	Children under 13 years of Age	Adolescents and Adults
Twice-Weekly Dose (Monday and Thursdays)		
Isoniazid (INH)	20 to 30 mg/kg Maximum: 900 mg	15 mg/kg Maximum: 900 mg
Pyridoxine (Vitamin B6)	As ordered, usually 12.5 to 25 mg	As ordered, usually 25 to 50 mg
Daily Dose (5 days a week, Monday to Friday OR as ordered)		
Isoniazid (INH)	10 mg/kg (10 to 15 mg/kg) Maximum: 300 mg	5 mg/kg Maximum: 300 mg/kg
Pyridoxine (Vitamin B6)	As ordered, usually 12.5 mg	As ordered, usually 25 mg

Long R, Ellis E. eds. Canadian Tuberculosis Standards (6th edition). Canada: Canadian Lung Association, 2007: 182-201.
Menzies R, Wong T. Canadian Tuberculosis Standards. 7th ed. Canadian Thoracic Society and the Public Health Agency Canada; 2014.
American Thoracic Society. Targeted tuberculin testing and treatment of latent tuberculosis infection. Am J Respir Crit Care Med 2000; 161:S221-S247.

Table 8.9: Recommended drug doses for daily LTBI treatment with Rifampin

Menzies R, Wong T. *Canadian Tuberculosis Standards*. 7th ed. Canadian Thoracic Society and the Public Health Agency Canada; 2014.

TB Drug	**Children Under 13 years of Age**	**Adolescents and Adults**
Daily Dose (5 days a week, Monday to Friday OR as ordered)		
Rifampin	**15 mg/kg** **(10 to 20 mg/kg)** **Maximum: 600 mg**	**10 mg/kg** **Maximum: 600 mg**

Travel during LTBI Treatment

Consult the CDCN as soon as a client indicates s/he plans to travel. Be prepared to discuss:

- Anticipated travel dates.
- The reason for travel.
- Arrangements for continuation of treatment (e.g., prescriptions, DOT provider, ongoing monitoring).
- Whether treatment should be held at any point during the anticipated travel period.
- Whether TB drugs should be sent with the client.
- Complete a **Tuberculosis Travel/Transfer Form (Appendix D).**

When a client is travelling within the LGH Region:

- Notify the CDCN and call local Community Health staff to notify of transfer and review the follow-up.
- Send the completed **Tuberculosis Travel/Transfer form** to the Community Health office, and if applicable, to the Regional Community Clinic of the destination community.

When a client is travelling outside the LGH region:

- Send the CDCN the completed **Tuberculosis Travel/Transfer Form**. The CDCN will arrange transfer to the receiving community, including all paperwork.