DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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BUMEDINST 6224.8D
BUMED-N4
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BUMED INSTRUCTION 6224.8D

From: Chief, Bureau of Medicine and Surgery

Subj: TUBERCULOSIS SURVEILLANCE AND CONTROL PROGRAM

Ref: (a) 10 U.S.C.
(b) NMCPHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix, August 2015
(c) ASW(HA) Policy memo of 20 April 2012
(d) NTTP 4-02.10 of October 2021 (NOTAL)
(e) BUMEDINST 6220.12D
(f) NMCFHPC M-6224, Tuberculosis Control Guide for the U. S. Navy Fleet, November 2025 (NOTAL)
(g) Sterling TR, Njie G, Zenner D, et al. Guidelines for the Treatment of Latent Tuberculosis Infection: Recommendations from the National Tuberculosis Controllers Association and CDC, 2020.
(h) CDC CPG: Diagnosis of Tuberculosis in Adults and Children, 2017
(i) DoD Instruction 6490.07 of 5 February 2010
(j) BUMEDINST 1300.6
(k) NTTP 4-02.6 of March 2022 (NOTAL)

Encl: (1) Tuberculosis Screening and Testing
(2) Evaluation and Management of New Positive Tests for Latent Tuberculosis Infection
(3) Initial Tuberculosis Patient Management, Reporting Requirements, and Contact Investigation
(4) List of Tuberculosis Consultants

1. Purpose. To provide policy and procedures for screening, testing, treating, documenting, and tracking individuals at risk of tuberculosis (TB) infection. This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6224.8C.

3. Scope and Applicability. This instruction applies to Navy Medicine commands and Navy medical department representatives (MDR) (e.g., Navy and Marine Corps health care personnel) supporting operational and installation units. This instruction is issued under the authority granted to the Bureau of Medicine and Surgery (BUMED) via reference (a), sections 8071, 8072, and 8077 to make health care policy for the Department of the Navy (DON). While this policy is grounded in the Centers for Disease Control and Prevention (CDC) guidance, screening and testing activities apply to active-duty and operational personnel. When conducting TB control efforts in special populations (such as healthcare workers, inmates, and child development centers), routine application of reference (b), CDC and OSHA guidelines will be appropriate. MDRs performing surveillance and reporting activities in support of Defense Health Agency (DHA) military medical treatment facilities (MTF) should also follow DHA guidance.

4. Background. TB is resurging in many parts of the world and remains a force health protection threat for the DON. Introductions of TB into the DON population occur regularly from foreign-born personnel and from exposures in high prevalence countries. Recruit training centers and ships represent high-risk transmission settings due to close living quarters, making them uniquely vulnerable to disease spread. Nearly two-thirds of active duty TB cases in the DON have occurred in these high-risk environments, underscoring the need for vigilant public health measures. TB control through early detection, rapid response, and sustained disease management is essential to ensure force health protection and mission preservation in DON.

5. Program Summary. The strategy to control TB is:

a. To promptly detect, isolate, treat, and report persons who have developed clinically active (infectious) TB.

b. To identify persons who have been infected with TB through regular screening assessments and targeted testing. Latent tuberculosis infection (LTBI) will be fully treated to reduce progression to active TB.

c. To assess and protect persons in close contact with patients diagnosed with infectious TB.

d. To prevent in military and civil service mariner (CIVMAR) personnel through accession testing followed by regular screening, targeted testing, and effective treatment for LTBI, as described in enclosures (1) through (3). After accession, Active and Reserve Component personnel and CIVMARs will be tested for LTBI only when they have high-risk exposures, high-risk occupations, or clinical conditions that increase the risk of progression from LTBI to active TB disease, per reference (c).

e. To conduct TB screening and targeted testing in non-military occupational populations based on the medical certification guidance contained in reference (b).

f. To assure through contracting oversight that DON contractors, especially in deployment and shipboard settings, are evaluated for TB infection. Contracts for healthcare workers must contain language that specifies screening for risk of exposure to TB, and treatment, if applicable.

6. Responsibilities

a. BUMED Public Health and Safety (BUMED-N44) must:

(1) Define Navy TB control program requirements in alignment with Department of War (DOW), CDC, and World Health Organization guidelines.

(2) Coordinate with Naval Medical Forces Development Command to establish minimum training requirements for designated Navy Medicine personnel executing TB control program functions.

(3) Coordinate with Navy and Marine Corps Force Health Protection Command (NAVMCFORHLTHPRTCMD) to develop and maintain technical manuals and subject matter expertise necessary to support TB investigations in the operational environment.

b. Commander, Naval Medical Forces Atlantic and Naval Medical Forces Pacific must:

(1) Ensure Navy Medicine Readiness and Training Commands and Navy Medicine Readiness and Training Units implement TB screening, testing, and treatment protocols, per the guidance in this instruction.

(2) Provide public health subject matter expertise in preventive medicine, environmental health, and occupational health in support of installations and component commands to guide TB control. Program areas essential to TB control include medical surveillance, immunization and chemoprophylaxis and deployment readiness activities.

c. Commander, Navy Medical Forces Development Command must:

(1) Maintain an awareness that TB poses a threat to operational forces and incorporate mitigation and response practices into curriculum.

(2) Train Hospital Corpsman Basic "A" School, Preventive Medicine Technician "C" School, and Surface Warfare Medical Institute students to screen and test for TB, place intradermal tuberculin skin test (TST) and interpret the results and recognize clinical disease.

(3) Review curriculum changes with preventive medicine staff at NAVMCFORHLTH-PRTCMD to ensure training content is adequate and current.

d. Commanding Officers and Officers in Charge, Navy Medicine Readiness and Training Commands and Navy Medicine Readiness and Training Units must:

(1) Maintain awareness of TB risk in their supported populations. Advise supported commanders on TB exposure risks and mitigation strategies as appropriate.

(2) Conduct routine TB screening and testing for new accessions, deploying personnel, and high-risk populations per this instruction. Coordinate with local DHA MTF if they provide healthcare services to these populations.

(3) Ensure treatment to completion of diagnosed LTBI and active TB patients. Coordinate with appropriate medical department personnel at both gaining and losing commands to ensure continuity of treatment for transferring personnel. Coordinate patient treatment and tracking activities with DHA MTFs as appropriate.

(4) When active TB disease is suspected:

(a) Implement immediate infection control measures, including isolation of potentially contagious TB patients, per reference (d).

(b) Coordinate with closest DHA MTF to facilitate prompt evaluation and treatment of suspected TB cases by pulmonary or infectious disease specialists.

(c) Notify area Navy Environmental Preventive Medicine Unit (NAVENPVNTMEDU) for awareness and consultative support if investigation activities involve high-risk, active duty settings (e.g., ship, training center).

(5) When active TB disease is identified:

(a) Initiate contact tracing and targeted testing activities in coordination with area DHA MTF. Report cases of TB, per reference (e).

(b) Upon completion of contact investigation, file a TB contact investigation report using Disease Reporting System internet (DRSi) or with your nearest NAVENPVNTMEDU if internet access is limited.

(6) Ensure appropriate personnel are trained to meet and sustain the competencies needed to carry out TB screening, testing, and contact investigation activities.

e. Type Command, Fleet, and Fleet Marine Force Surgeons must:

(1) Ensure operational medical departments comply with and maintain competencies to carry out the activities within this instruction.

(2) Maintain awareness of TB risk in their supported populations, and ensure medical personnel retain an appropriate index of suspicion for TB.

(3) Ensure control of TB in their supported populations by managing local control efforts according to this instruction per reference (f), reference (g) available at https://www.cdc.gov/mmwr/volumes/69/rr/rr6901a1.htm, and reference (h) which is available at https://www.atsjournals.org/doi/10.1513/AnnalsATS.201608-636CME. OSHA guidance, Federal law, State law, and local ordinance, including Host Nation (HN) laws, should be considered when establishing local control efforts.

(4) Contact their supporting NAVENPVNTMEDU for guidance in the conduct, completion, and reporting of TB contact investigations.

f. MDRs of Operational Units must:

(1) Maintain awareness of TB risk in their supported populations. Notify Fleet and Fleet Marine Force commanders of TB exposure and implemented mitigation strategies.

(2) Conduct routine TB screening and testing for personnel and high-risk populations per this instruction.

(3) Ensure treatment of diagnosed LTBI and active TB infections to completion. Coordinate with appropriate medical department personnel at both gaining and losing commands to ensure continuity of treatment for transferring personnel. Coordinate patient tracking activities with DHA MTFs as appropriate. Per reference (i), active TB is a deployment-limiting medical condition, and treatment must be completed, resolution of active TB, and determination of deployability made by a trained DOW healthcare provider before deployment of DOW personnel with a recent or past diagnosis of active TB.

(4) When active TB disease is suspected:

(a) Implement immediate infection control measures, including isolation of potentially contagious TB patients, per reference (f). Work with shipboard engineering and damage control personnel to ensure ventilation is modified to maximize isolation measures, per reference (d).

(b) As soon as practicable, transport suspected active TB cases to the closest appropriate medical facility to facilitate prompt evaluation and treatment of suspected TB cases by pulmonary or infectious disease specialists. Ensure source control measures are maintained throughout transport.

(c) Notify cognizant NAVENPVNTMEDU within 24 hours, per reference (e).

(5) When active TB disease is identified:

(a) Initiate contact tracing and targeted testing activities. NAVENPVNTMEDU will provide preventive medicine guidance as required.

(b) Report cases of TB, per reference (e). Upon completion of the contact investigation, file a TB contact investigation report using DRSi or with your nearest NAVENPVNTMEDU if internet access is limited.

(c) Update the case's deployability category status in the electronic medical record to reflect deployability category 3 (temporarily non-deployable), based on reference (j), until treatment for active TB has been completed.

g. Commanding Officer, NAVMCFORHLTHPRTCMD will:

(1) Maintain subject matter expertise for Navy TB control program policy, programs, and guidance on behalf of BUMED.

(2) Develop and maintain technical Navy TB control program guidance to include standardized procedures for implementation in isolated, distributed maritime environments.

(3) Monitor Navy and Marine Corps-wide TB data and information for identification of events with potential global, policy, or programmatic impact. Ensure BUMED-N44 has situational awareness of events with impact on operations, recruit training pipelines, or with outbreak potential.

(4) Evaluate TB control program activities at least every 3 years. Coordinate with BUMED-N44 to develop plans to address those gaps through policy, program, or system changes.

h. Officers in Charge, NAVENPVNTMEDUs must:

(1) Provide TB surveillance and control technical support to all Navy and Marine Corps units in their geographic area of responsibility.

(2) Support commanders in their efforts to conduct TB public health management and contact investigations when active-duty personnel are exposed to a case. If direct support is provided, submit an investigation report to the command, cognizant Fleet or type command surgeon, and NAVMCPUBHLTHCEN upon completion of the contact investigation.

7. Consultations. Clinical TB consultations for individual patient care should be obtained from infections disease or pulmonary disease specialists at local MTFs or nearest major military

medical center. For investigative support, public health, and communicable disease, consultation can be obtained from the cognizant NAVENPVNTMEDU. Refer to enclosure (4) for a list of clinical and public health contacts.

8. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules found on Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Office of the Chief of Naval Operations (OPNAV) Records Management Program (DNS-16).

9. Review and Effective Date. Per OPNAVINST 5215.17A, BUMED-N44 will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, DOW, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if this instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

10. Forms. The listed NAVMED forms are available at: https://www.med.navy.mil/Directives/NAVMED-Forms/.

a. NAVMED 6224/7 Initial Tuberculosis Exposure Risk Assessment

b. NAVMED 6224/8 Tuberculosis Exposure Risk Assessment

c. NAVMED 6224/9 Monthly Evaluation for Patients Receiving Treatment for Latent Tuberculosis Infection (LTBI).

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Acting

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, https://www.med.navy.mil/Directives/Instructions/

TUBERCULOSIS SCREENING AND TESTING

1. For consistency in this instruction, "screening" refers to the assessment of TB risk factors (e.g., risk assessment questionnaire) in order to inform a decision of whether or not to test an individual for TB. Testing refers to usage of a TST or an interferon gamma release assay (IGRA) to determine if an individual has been exposed to Mycobacterium tuberculosis.

2. TB testing at accession, followed by routine TB screening and targeted testing, is the primary strategy used to ensure rapid identification of new cases among the DON population. Over 40 percent of DON active-duty personnel diagnosed with active TB are identified at accession. Active TB poses a significant threat in high-transmission settings such as recruit training and aboard ship, and it is essential that individuals with active TB are rapidly identified and treated to avoid disease spread.

3. Individuals with LTBI are infected with Mycobacterium tuberculosis but unlike persons with active TB, they are not contagious. However, without treatment, 5 to 10 percent of those with LTBI will go on to develop active TB disease, with those recently infected or with compromised immunity at higher risk for developing the disease. Early detection and treatment reduce the risk of LTBI becoming active TB in future assignments, which is of particular concern aboard ships where TB could spread rapidly and adversely impact both force and mission.

4. Testing for TB on Entry into Naval Service

a. All Navy and Marine Corps accessions, and all individuals beginning employment as CIVMARs, must be tested for TB by either TST or IGRA unless there is documentation of previous TB infection as described in subparagraph 4b.

b. Individuals with a history of active TB, a positive TST or IGRA, or treatment for LTBI must provide medical documentation of clinical evaluations, hospitalizations, diagnoses, and treatments. Documentation includes copies of pertinent medical records, treatment records, or a physician's statement on letterhead stationery. Pertinent information should be transcribed into the medical record. If documentation of a previous positive TB test or treatment is not available, see paragraph 7 of this enclosure.

c. Individuals with a history of receiving Bacille Calmette-Guérin (BCG) vaccine may have a false positive TB skin test. IGRA blood tests are preferred in this population.

5. TB Screening and Testing at Times Other than Service Entry

a. Routine Screening. Screen all Active and Reserve Component military personnel annually using form NAVMED 6224/8 to determine their TB exposure history and assess their risk of acquiring TB. This screening may take place in conjunction with the Periodic Health

Assessment. Individuals answering "yes" to one or more questions on this form may be at increased risk and require medical evaluation and possibly testing. CIVMAR screening will be performed per relevant Military Sealift Command policy.

b. Force Health Protection. Additional TB exposure risk screening and targeted TB testing will be performed if directed by a combatant command or component surgeon as part of Force Health Protection guidance (e.g. pre-deployment or post-deployment).

c. Contact Tracing. TB testing after an exposure as part of a contact tracing investigation should be guided by preventive medicine personnel. Testing of an entire ship after a suspected or confirmed active TB case is rarely recommended. The cognizant NAVENPVNTMEDU will provide contact tracing guidance and testing recommendations as part of their overall reach-back support.

d. Targeted Testing of Contractors. Contracting officers and their representatives will include requirements in all contracts to ensure that contractors and their employees undergo TB screening and targeted testing whenever said employees are working in an environment in which DON employees would normally be required to undergo this testing. TB screening, targeted testing, and treatment will be paid for by the contractor.

e. HN Personnel. HN personnel from nations with a high prevalence of TB (greater than 20 cases per 100,000 population) are particularly likely to introduce active TB to a ship if not carefully evaluated prior to boarding. Prior to boarding a U.S. Navy vessel, HN personnel may be required to undergo TB screening or testing. For example, per reference (k), HN personnel and their escorts are required to have a chest radiograph prior to boarding a hospital ship for surgical care or must remain masked until a chest radiograph is obtained aboard. Consultation with preventive medicine staff or the NAVENPVNTMEDU is recommended for specific guidance.

6. TB Testing Administration. The purpose of TB testing is to identify TB cases, which require treatment, and LTBI cases who require prophylactic therapy to prevent progression to active TB. Unnecessary testing of low-risk individuals increases the likelihood of a false positive diagnosis resulting in unneeded treatment and should be avoided.

a. TST

(1) TST application. TSTs must only be performed by medical personnel trained to perform intradermal injection and to read and interpret the results. Several "pseudo-outbreaks" have occurred due to poor technique and misinterpretation of TST reactions.

(2) Recording Administration. Enter the date administered, type and strength of tuberculin, manufacturer, lot number, and route of administration into the electronic medical record and into the Medical Readiness Reporting System (MRRS) if active duty.

(3) Measurement. The TST reaction must be read at least 48 hours after purified protein derivative (PPD) placement but before 72 hours after PPD placement. Measure palpable induration (not redness) to the nearest whole millimeter (mm). If a person returns more than 72 hours after TST placement, record the result as "Not Read" and apply a TST on the opposite forearm. If the person does not return at all, enter "Not Read" on the appropriate forms, recall the person, and administer another TST.

(4) Recording Result. Enter TST result in mm of induration into MRRS if active duty and the electronic medical record. If there is no palpable induration, record result as "zero mm." A TST record is not complete without clear documentation of all required data elements and entry into an authorized electronic immunization tracking system for electronic data storage and reporting.

b. IGRA

(1) Assays. Any U.S. Food and Drug Administration approved IGRA may be used for LTBI testing. Guidance on LTBI test selection and interpretation of IGRA results is available in reference (h). Note that IGRA is preferred over TST if patient has had previous BCG vaccination.

(2) Recording Result. As with the TST, IGRA results must be recorded in detail in the medical record. Include the date of the blood draw, specific test used, quantitative assay measurements in specific units (e.g., international units per milliliter or number of spots to nil), and the qualitative test interpretation (e.g., positive, negative, borderline, or indeterminate).

c. Choice of Test. Both TST and IGRA are regularly used for TB testing and have similar sensitivities in detecting TB. Table 1 outlines advantages and disadvantages of both tests, which may guide the choice of test in specific patients or clinical care settings.

	TST	IGRA
Advantages	Inexpensive Does not require laboratory	Single visit Not affected by BCG Rapid results Higher specificity
Disadvantages	Requires extra training for both placement and reading Requires two visits, 48 to72 hours apart Potential false positive with BCG Potential false positive with non-TB mycobacteria Potential false negative with live virus vaccine Potential false negative in immune compromised	Requires advanced laboratory capability Time sensitive sample (must be processed rapidly) More expensive than TST May require second test or PPD if indeterminate or borderline Potential false positive with non-TB mycobacteria

Table 1. Advantages and Disadvantages of the TST and IGRA for TB Testing

7. Previous Positive TB Test

a. If a person gives an undocumented history of a positive IGRA or TST without documentation of an adequate course of treatment for LTBI or active TB, perform an IGRA. If the person's IGRA is positive, assess for symptoms and manage as a new positive test, per enclosure (2).

b. If a person has a documented past positive TST or IGRA, do not perform another LTBI test. Document whether the individual received an adequate course of treatment for LTBI or active TB, along with dates and type of treatment received. If the person did not receive an adequate course of treatment for LTBI, the person should be assessed for symptoms and managed as a newly positive test, per enclosure (2). Adequate treatment for LTBI is defined as completing one of the treatment regimens outlined in the CDC's Core Curriculum on Tuberculosis: What the Clinician Should Know, available at, https://www.cdc.gov/tb/hcp/education/core-curriculum-on-tuberculosis.html. Enclosure (2) outlines the approach to missed doses or interrupted treatment for LTBI. Adequate treatment for active TB is more extensive and should be coordinated with an infectious disease specialist at the closest MTF.

c. After documented completion of a full course of LTBI treatment, chest radiograph is only required in the event of TB symptoms. Serial or periodic chest radiograph is not required, however, experience has shown that 30 percent of active TB cases among active duty personnel from 2008 to 2021 occurred in patients who had completed full courses of LTBI therapy. Providers should be cognizant that prior treatment for LTBI does not eliminate the risk of subsequent active TB, and TB must remain high in the clinical differential of any pulmonary symptoms.

EVALUATION AND MANAGEMENT OF NEW POSITIVE TESTS FOR LATENT TUBERCULOSIS INFECTION

1. TST Interpretation. Evaluate all individuals with a TST induration greater than 5 mm to determine if their test is positive based on the risk factors outlined in Table 1 and discussed in reference (h). In addition, an increase in reaction size of 10 mm or more within a 2-year period, is considered a positive test. Service accessions without exposure or clinical risk factors for acquiring TB are the low-risk group in Table 2, and those TSTs are considered positive only for indurations greater than 15 mm. Note that IGRA is the preferred test in patients who have previously received the BCG vaccine, as BCG can result in false positive TSTs. TST remains acceptable if IGRA is not available. If TST is positive in a patient that has a history of BCG vaccination, re-testing with IGRA can be considered if it is readily available. If IGRA testing is not available, patients must be further evaluated for latent TB infection or TB disease as if they were not vaccinated with BCG. IGRA is also now preferred for patients at high risk for TB infection (e.g. high priority close contacts).

High Risk: Reaction greater than 5 mm of induration is considered positive in:	Medium Risk: Reaction greater than 10 mm of induration is considered positive in:	Low Risk: Reaction greater than 15 mm of induration is considered positive in:
- Recent close contacts of active (infectious) TB disease patients - Persons with fibrotic or other changes on chest radiograph consistent with prior TB - Patients suspected of having active TB disease - People living with human immunodeficiency virus - Other immunosuppressed patients - Patients with organ transplants	- People born in countries where TB disease is common (greater than 20 per 100.000), including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala - People who misuse drugs or alcohol - Mycobacteriology laboratory workers - People who live or work in high-risk congregate settings (e.g. correctional facilities, homeless shelters) - People with medical conditions that place them at high risk for TB - People less than <90 percent of ideal body weight - Children less than 5 years old - Infants, children, and adolescents exposed to adults in high-risk categories	- Persons with no known risk factors for TB.

Table 2 Criteria for Determining a Positive TST Reaction

2. IGRA Interpretation. Unlike the TST, IGRA results may be positive, negative or indeterminate (also reported as invalid or borderline). The test can be challenging for laboratory personnel, and delays in processing due to shipping requirements may affect results. Patients with borderline or indeterminate results should be retested; either TST or IGRA is acceptable for the retest.

3. Initial Evaluation: Persons with Positive IGRA or TST. A positive TST or IGRA cannot differentiate LTBI from active TB. It is essential that all persons newly identified as having a positive IGRA or a positive TST are evaluated by a medical officer, nurse practitioner, physician assistant, or independent duty corpsman to rule out active TB disease. Consultation with an infectious disease or pulmonology specialist may also be required. As a critical action, any symptomatic person with suspected active TB should be masked with a surgical mask and isolated immediately and then referred to a pulmonary or infectious disease specialist at an MTF for evaluation, diagnosis, and initial treatment. If active TB is suspected, the evaluating provider (e.g. medical officer, nurse practitioner, physician's assistant, and independent duty corpsman) should wear a particulate respirator (e.g. N95). The evaluation of all persons with a positive test must include:

a. Physical Examination and Medical History. Document history on NAVMED 6224/7 or other form or electronic record system that captures same information.

b. Chest Radiograph. Examine chest radiograph for fibrotic changes consistent with old TB infection and for any signs of active pulmonary TB.

c. Sputum Examination. When radiographic signs of active TB or symptoms suggestive of TB disease are present, submit sputa for acid fast bacilli smear microscopy, diagnostic nucleic acid amplification testing, and culture.

4. LTBI Treatment and Management. Once active TB is ruled out, LTBI treatment should be initiated unless medically contraindicated. Treatment regimens for LTBI therapy are described in the CDC's Core Curriculum on Tuberculosis: What the Clinician Should Know, https://www.cdc.gov/tb/hcp/education/core-curriculum-on-tuberculosis.html. Short-course, rifamycin-based regimens for treating LTBI are recommended over 6 or 9-month isoniazid (INH) monotherapy, per reference (h). Additionally, per the CDC's Core Curriculum on Tuberculosis: What the Clinician Should Know, the clinician can implement either directly observed therapy or self-administered therapy. Where appropriate, directly observed therapy can be completed via a video-telehealth visit. Directly observed therapy should be considered for patients who are at high risk of TB disease and for those who may have difficulty adhering to self-administered therapy. Directly observed therapy must be used for patients receiving the intermittent INH monotherapy dosing regimen (e.g., twice-weekly INH), however, directly observed therapy or self-administered therapy may be used for the 3-month regimen of INH and rifapentine.

a. Baseline and Routine Laboratory Testing. Laboratory testing, either at baseline or for routine monitoring, is not routinely indicated for patients being treated for LTBI. Liver function tests are only indicated for patients who have underlying liver disease or whose initial evaluation suggests an elevated risk for a liver disorder, such as persons who abuse alcohol. Consider avoiding INH-based treatment regimens in these patients.

b. Clinical Monitoring. Regular follow up of individuals receiving treatment for LTBI must be conducted until treatment is completed. The healthcare provider should evaluate patient compliance, possible side effects, and indications of active TB. Documentation of evaluations should be performed on NAVMED 6224/9, or equivalent. Those creating encounter templates in an electronic medical record should use NAVMED 6224/9 as a guide and select the appropriate LTBI international classification of diseases diagnosis code.

5. Patient Education. Patients must be educated about the implications of their positive IGRA or TST results, the benefits and risks of LTBI treatment, and the potential signs of both TB and adverse drug effects. The need for strict adherence to the prescribed course of treatment in the absence of untoward side effects must be strongly emphasized throughout the course of treatment. Patients should be advised to contact the clinic if they develop any signs TB or any worrisome medication side effects. Document patient education and counseling in the patient's medical record.

6. Completion of Treatment for LTBI. Document successful completion of the LTBI treatment regimen in the electronic medical record. No additional LTBI testing, or chest radiograph is required unless otherwise indicated.

7. Adherence to LTBI Treatment. CDC's Core Curriculum on Tuberculosis: What the Clinician Should Know, discusses missed medication doses and strategies to improve patient adherence to LTBI treatment regimens. The National Society of Tuberculosis Clinicians' Testing and Treatment of Latent Tuberculosis Infection in the United States, located at https://tbcontrollers.org/resources/tb-infection/clinical-recommendations/, provides guidance on how to approach missed doses or incomplete treatment, and is outlined in table 3 (refer to the CDC's Core Curriculum on Tuberculosis: What the Clinician Should Know, for specific medication dosages). In the absence of local infectious disease or pulmonary specialists, consultants listed in enclosure (4) can provide management guidance when LTBI treatment has been interrupted prior to completion of an adequate treatment course.

Regimen	Completion of Treatment Met with the Listed Parameters
INH plus rifapentine, once weekly for 3 months	12 doses within 16 weeks (treatment can be considered complete if 11 doses are taken within 16 weeks). Doses should be separated by greater than 72 hours.
Rifampin, daily for 4 months	120 doses within 6 months.
INH plus rifampin, daily for 3 months	90 doses taken within 4 months.
INH, daily or twice weekly for 6 months	Daily: 180 doses within 9 months. Twice weekly by directly observed therapy: 52 doses within 9 months.
INH, daily or twice weekly for 9 months	Daily: 270 doses within 12 months. Twice weekly by directly observed therapy: 76 doses within 12 months.

Table 3 Management of Treatment Interruption and Determination of Treatment Completion

Please Note: Those unlikely to complete 270 doses, treatment may be considered complete if they have taken the number of doses in the time frame needed to complete the 6-month regimen.

8. Continuity of Care for LTBI. Personnel who transfer from the treating healthcare facility or leave the military Service before completing a course of treatment for LTBI must be counseled on the need for continued treatment, and counseling must be documented on NAVMED 6224/9.

a. The treating medical department will contact the gaining medical departments about all transferring members currently receiving treatment for LTBI.

b. The transferring medical department must ensure the member has enough medication to continue LTBI treatment enroute to the gaining medical department. Gaining medical departments must continue initiated therapy as outlined in paragraph 4 of this enclosure.

c. Members leaving active Service are eligible for continued LTBI treatment and can schedule follow up care at the Department of Veterans Affairs facilities by calling the local Department of Veterans Affairs prior to separation or discharge. Providers will make initial arrangements for the members' follow up, either at a military facility (if member is still eligible for care), at the Department of Veterans Affairs facility closest to their home, or through alternative options such as local health departments or private providers.

INITIAL TUBERCULOSIS PATIENT MANAGEMENT, REPORTING REQUIREMENTS, AND CONTACT INVESTIGATION

1. Protection of Non-Infected Persons in Spaces Occupied by Patients with Infectious TB Disease. Immediately upon suspicion of active TB, patients should wear a surgical mask for source control of respiratory secretions and be placed in isolation. Unless being treated in home isolation, patients with suspected or known active TB should be transferred to an MTF or other appropriate medical facility as soon as practicable for comprehensive evaluation. Particulate respirators (e.g. N95) are not required for patients but are an essential part of personal protective equipment for healthcare personnel taking care of potential TB patients. Visitors to TB patients should be discouraged and must also wear particulate respirators.

2. Reporting Requirements. Within 24 hours of identifying suspected active TB cases among active duty members, along with cases that may be associated with high-risk exposure settings, (e.g., ship, training center, day care) report to the nearest NAVENPVNTMEDU, per reference (e). All clinically compatible cases with radiographic evidence of active TB (referred to as "suspect TB cases") and laboratory-confirmed active TB cases, regardless of beneficiary status, must also be reported within DRSi, per reference (e), or per DHA guidance if reporting on behalf of an MTF.

3. Contact Investigation. Upon confirmation of a case of active (infectious) TB in supported populations, the command must conduct a TB contact investigation typically led by the MDR. Routine, shore-based contact tracing can proceed per the Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National tuberculosis Controllers Association and CDC, available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a1.htm. Guidance with amplifying information on conducting TB contact investigations aboard ship can be found in reference (f). The MDR is responsible for ensuring the contact investigation is initiated rapidly and that command support for the NAVENPVNTMEDU's recommended public health interventions is maintained until the investigation is completed. Personnel transferring from the command during a contact investigation must have appropriate documentation in their medical record, and the receiving command must be notified of their status. Personnel who are enrolled in a contact investigation but are separating from the Service before the 8 to 10-week repeat test for TB infection, must be identified to the local public health department for follow-up testing. Upon completion of the TB contact investigation, file a TB contact investigation report in DRSi.

LIST OF TUBERCULOSIS CONSULTANTS

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