PUBLIC HEALTH INFORMATION

Government of South Australia
SA Health

COMMUNICABLE DISEASE CONTROL BRANCH

- Please bring to the attention of all doctors -

Date: 28 September 2023

Be Alert for Tuberculosis

Since 2022 there has been an increase in tuberculosis (TB) detected in South Australia (SA) with Aboriginal and Torres Strait Islander persons disproportionally represented. As of September 2023, 21 active cases of TB have been notified in Aboriginal and Torres Strait Islander people in SA since May 2022. In comparison, from 2000 to 2021 between 0-4 cases of TB were notified annually among Aboriginal and Torres Strait Islander persons in SA.

People with TB may present to health facilities in metropolitan Adelaide, regional, rural, and remote SA. TB must be considered as a differential diagnosis in patients who are in at-risk groups and present with compatible symptoms. It is particularly important for clinicians working with Aboriginal and Torres Strait Islander communities, and migrants, refugees or students from high burden countries to have a high index of suspicion for TB in the right clinical context. A delayed diagnosis may result in increased morbidity and mortality in TB cases and increase the risk of TB transmission within the South Australian community.

Medical practitioners are advised to be aware of the following groups at increased risk of TB:

People with increased risk of exposure to TB	People with increased risk of progression from latent TB infection to active TB disease
• Aboriginal and Torres Strait Islander people • Close contacts of an infectious TB case • Migrants, refugees or students from high burden countries (see https://bit.ly/3lmrugQ) • People born in Australia prior to the 1960s • Health care workers who have worked in high burden countries	• Infants and children under 5 years with a positive tuberculin skin test (TST) • People with “old healed” TB on chest X ray (CXR) • People with immunosuppressive disorders (e.g. HIV, malignancy) or those requiring prolonged use of corticosteroids or other immunosuppressive agents • People with solid organ transplants • People with medical disorders such as diabetes, kidney disease requiring dialysis, or silicosis

Medical practitioners should consider TB in these risk groups when:

- **Cough or persistent chest infection** is present for more than 2 weeks and does not respond to a standard course of antibiotics and/or,
- Other respiratory symptoms are present – dyspnoea, chest pain, haemoptysis and/or,
- Constitutional symptoms are present – loss of appetite**, weight loss**, **fever**, night sweats, fatigue, lymphadenopathy and/or,
- Other clinical presentations occur such as unilateral pleural effusion, pleuritic chest pain, lymphadenopathy, urinary tract infections, haematuria, bone pain, abdominal swelling, or headaches. These symptoms are typically accompanied by fever and weight loss. TB can affect can organ system.

Medical practitioners should investigate and manage suspected pulmonary TB:

- **Request** radiology. Atypical CXR findings are common in the immune suppressed and elderly – consider a CT chest if clinical suspicion remains.
- **Request** sputum TB culture and acid-fast bacilli (AFB) smear testing – request three sputum specimens collected at least eight hours apart (e.g. early morning) for AFBs.
- **Send** sputum to **SA Pathology** for faster result turnaround time.
- **Seek urgent** advice from SA TB Services or nearest tertiary hospital if sputum is **smear positive.**
- **Recognise** that smear negative sputum results does not exclude TB as culture can take 3-6 weeks.
- **Seek** specialist advice if there is high suspicion of pulmonary and/or extrapulmonary TB.
- **Note** that TST and interferon gamma release assay (IGRA) are NOT recommended for the initial investigation of active TB. A negative result does not exclude the possibility of TB.
- **Telephone** SA TB Services at the Royal Adelaide Hospital on 7117 2967, if advice is required.
- **Notify** SA TB Services of suspected or confirmed cases on 7117 2967.

Dr Louise Flood – Deputy Director, Communicable Disease Control Branch