

REVISED GUIDELINES FOR IMPLEMENTING TUBERCULOSIS CONTROL PROGRAM IN CHILDREN

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I. RATIONALE/BACKGROUND

The goal of the National Strategic Plan to Stop TB 2006-2010 and the Western Pacific Regional Strategic Plan 2006-2010, is to reduce the TB prevalence and mortality by half by 2010 (relative to 2000), contributing to the attainment of the Millennium Development Goal (MDG) come 2015. Among the objectives identified in these plans were: to improve detection of all TB cases, adapt DOTS to respond to high-risks population and ensure equitable access to care of international standards for all TB patients. This would an reaching out to all people with TB; adults and children, infectious and non-infectious, or without HIV and with or without drug resistant TB.

To address TB in children, DOH created the Task Force (TF) on Childhood TB in By virtue of Dept Order (DO) 248-H s. 1998 as amended by DO 66-D s. 2001. This TF was composed of experts both from the public and private sector. In 2002, DOTCh (DOT in children) was piloted in these areas. Two years later, the DOH through the TF, released ^ 1st guidelines for TB in children through Administrative Order (AO) 178 s. 2004 which paved the way for the expansion of the program to 16 cities (1 city per region) nationwide.

In 2006, WHO issued the Guidance for National Tuberculosis Programmes on Management of TB in Children. Because of this, the DOH deemed it necessary to convene the TF and revise the current national guidelines in accordance with that of the WHO and for consistency with the 2005 Manual of Procedure (MOP) for the National Tuberculosis Control Program (NTP) before embarking on a nationwide implementation of the Childhood TB Program.

II. OBJECTIVES

The objectives of these guidelines are: to provide a standard policy for casefinding; treatment of children with TB; contact tracing of children at risk of developing TB for preventive therapy; and to include all childhood TB cases in the routine NTP recording and reporting activities using the DOT strategy.

III. SCOPE/COVERAGE

These guidelines shall apply to all health facilities, agencies and organizations that will implement Tuberculosis Control Program among children 0-14 years old.

IV. DEFINITION OF TERMS

Contacts for screening- all children - 0-4 years (whether sick or well) and children 5-14 years if symptomatic, who are in close contact with a source case

Close contact - is defined as a person living in the same household as or in frequent contact with a source case.

Isoniazid Preventive Therapy (IPT) - taking a course of isoniazid treatment to individuals who have not been infected in order to prevent development of TB disease.

Source case - a case of pulmonary TB (usually sputum smear-positive) which results in infection or disease among contacts.

TB Diagnostic Committee (TBDC) is a committee established at the province, city or district level that will review the sputum smear-negatives with chest x-ray suggestive of Pulmonary TB. It is composed of the NTP medical/nurse coordinators, radiologist and a clinician (internist or pulmonologist).

V. Statements

1. All children 0-14 years old who come to the health facility with signs and symptoms of TB and/or those who are in close contact with a known TB case (usually an adult) shall be screened for TB.
2. The diagnosis of TB in children depends on careful and thorough history and clinical examination and relevant investigations, e.g. Tuberculin Skin Testing (TST), Direct Sputum Smear Microscopy (DSSM) and Chest x-ray (CXR). Atrial of treatment with anti-TB medicines shall not be used as a method of diagnosing TB in children.
3. When a child is diagnosed with TB, an effort should be made to detect and cure the source case.
4. Treatment of TB disease in children and Isoniazid Preventive Therapy (IPT) shall follow the 2006 WHO guidelines' recommend dosages and regimen.
5. Directly Observed Treatment (DOT) shall be followed for all children undergoing therapy
6. Quarterly reports shall be submitted to the Infectious Disease Office through channels
7. To prevent severe types of TB in children and in accordance with the policies and procedures of the Expanded Program on Immunization (EPI), BCG vaccination shall be given to all infants. However, revaccination of BCG is not recommended.

VI. Implementing Guidelines 1 Case Finding

A. TB in children are reported and identified in two instances:

1. The child sought consultation, was screened and was found to have signs and symp- toms of TB.
2. The child was a close contact of a TB case.

B. Approach to diagnosis:

1. Careful history and clinical examination (including growth assessment)
 - i. Symptoms - a child shall be considered as a TB symptomatic if with any three (3) of the following signs and symptoms:
 - Cough/wheezing of 2 weeks or more.
 - Unexplained fever of 2 weeks or more after common causes such as malaria or pneumonia have been excluded.
 - Loss of weight/failure to gain weight/weight faltering/loss of appetite.
 - Failure to respond to 2 weeks of appropriate antibiotic therapy for lower respiratory tract infection.
 - Failure to gain previous state of health 2 weeks after a viral infection or exanthema (e.g. measles).
 - Fatigue/reduced playfulness/lethargy.
 - ii. Physical signs highly suggestive of extrapulmonary TB
 - gibbus, especially of recent onset
 - non-painful enlarged cervical lymphadenopathy with fistula formation

2 Tuberculin Skin Testing (TST)

- i. The Mantoux method of TST is recommended using 2 TU of tuberculin PPDRT 23 or 5TU of tuberculin PPD-S if the former is not available.
- ii. A positive TST is an area of induration of the skin with diameter of 10mm or more read between 48 and 72 hours of injection of the tuberculin solution (whether or not they have received BCG vaccination).
- iii. Only trained health worker shall do tuberculin testing and reading.

3. Investigations relevant for suspected pulmonary or extrapulmonary TB

i. Diagnosis of Suspected Pulmonary TB:

1. Direct Sputum Smear Microscopy (DSSM) and bacteriologic confirmation whenever possible:

- DSSM shall be performed among:
 - younger children (5-9 years old) who can expectorate
 - children (10-14) years old who has cough for 2 weeks
- If DSSM turns out positive, treatment shall be started immediately and TST shall no longer be performed.
- Collection, transport, processing and reporting of sputum specimen shall follow the 2005 MOP for the NTR
- Bacteriological confirmation (culture) is especially important for children who have suspected drug-resistant TB, HIV infection, complicated or severe disease and an uncertain diagnosis

2. Chest x-ray (CXR):

- CXR shall not be used alone in the diagnosis of childhood pulmonary TB unless the finding is miliary tuberculosis.
- Majority of children with pulmonary TB have CXR changes suggestive of TB. The commonest picture is that of persistent opacification in the lung together with enlarged hilar or subcarinal lymph glands.
- Patients with persistent opacification which does not improve after a course of antibiotics should be investigated for TB.

ii. Suspected Extrapulmonary TB are usually diagnosed from the clinical picture and confirmed by histology or other special investigations.

iii. Serological tests, nucleic acid amplification (e.g. polymerase chain reaction), computerized chest tomography and bronchoscopy can be used but are not currently recommended for routine diagnosis of TB in children

iv. The TB Diagnostic Committee (TBDC)

1. In areas with functional TBDC, CXR of children with results suggestive of TB shall be referred to them for evaluation.
2. To minimize delay in the diagnosis and treatment, result of the TBDC evaluation must be available within 2 weeks.

2. Case Definitions in Childhood TB - are determined by the: (i) site of disease r result of any bacteriological tests, (iii) severity of TB disease and (iv) history of previous anti-TB treatment.

A. Classification of TB in children - TB cases shall be classified based on the location of lesions, as well as the

result of DSSM.

B. Types of TB in children - these are categorized based on the history of anti- TB treatment.

Classification and types of TB in children shall follow the case definitions stated in AO 178 and to include those from the 2006 WHO guidelines.

3. Case Holding and Treatment -

A. Caseholding mechanism shall follow AO 178 while treatment regimen for TB disease and corresponding drug dosages shall follow the 2006 WHO guidelines.

B. Fixed-dose combinations of drugs (FDC) shall be used whenever possible. However, single drug formulations can still be used.

C. Hospitalization:

1. Children with severe forms of TB shall be hospitalized initially for intensive management where possible.

2. Conditions that warrant hospitalization include: TB meningitis and miliary TB, respiratory distress, spinal TB and severe adverse events, such as clinical signs of hepatotoxicity (E.g. jaundice)

D. Management of adverse reactions to the drugs

1. Treatment shall be stopped and immediate referral of patient shall be undertaken in the occurrence of liver tenderness, hepatomegaly or jaundice.

2. There is no need to monitor serum liver enzyme levels routinely.

E. Monitoring of response to treatment

1. A smear positive child shall have a follow-up DSSM similar to adult TB cases described in the 2005 MOP.

2. for extra pulmonary and most of childhood TB cases, response to treatment shall be assessed clinically.

3. follow-up CXRs are not routinely required.

F. outcome of treatment

The definition of the treatment outcomes as stated in AO 178 and the 2006 WHO guidelines shall be followed.

4 contact Investigation:

Contact screening and management as described in the 2006 WHO guidelines shall be adopted under these revised guidelines.

5 special circumstances:

Management of special circumstances such as baby born to a mother of infectious TB and contacts of confirmed drug-resistant TB shall be accordingly addressed.

6 Recording and reporting:

A. Age groups for reporting shall be divided into the following age groups:

a. 0-4 years old

b. 5-14 years old.

B. Indicators for this program shall include but not limited to the following:

- a. Number of children screened, categorized by age group
- b. Number treated for TB disease
- c. Proportion of all childhood TB cases by age group
- d. Proportions of children with pulmonary TB and extrapulmonary TB
- e. Proportion of children with miliary TB and TB meningitis
- f. Proportion of children who are cured (smear-positive)
- g. Proportion of children who complete treatment (smear-negative pulmonary and extrapulmonary TB)
- h. Number given IPT and outcome, including treatment completion

VII. Implementing Mechanisms

The roles and responsibilities of the different agencies, health workers and other Partners implementing this program shall be in accordance with the 2005 MOP for the NTP Training modules are also being updated to conform to this revised Administrative Order

VIII. Repealing Clause

Provisions from previous issuances that are inconsistent or contrary to the provisions of this order are hereby rescinded and modified accordingly.

IX. Effectivity

This Order shall take effect immediately.

Adopted: 21 May 2008

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Secretary of Health

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