



Centre de Santé et Services Sociaux Inuulitsivik  
 Inuulitsivik Health & Social Services Centre  
 Puvirnituq, Québec J0M 1P0  
 T 819 988-2957 / F 819 988-2796  
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 UNGAVA TULATTAVIK HEALTH CENTER  
 CENTRE DE SANTÉ TULATTAVIK DE L'UNGAVA

EMBOSSER ICI LA CARTE DU CSI OU CSTU,  
 SI NON DISPONIBLE, INSCRIRE LES NOM, PRÉNOM,  
 DATE DE NAISSANCE ET NUMÉRO DOSSIER  
 EMBOSS HERE THE CARD OF IHC OR UTHC,  
 IF NOT AVAILABLE, WRITE THE NAME, SURNAME,  
 DATE OF BIRTH AND FILE NUMBER

**LATENT TB INFECTION  
 ADULT AND PEDIATRIC  
 FOLLOW-UP PROTOCOL – STANDARD MEDICAL  
 ORDER • RIFAMPICIN (RIF)**

**Purpose:** To ensure a standard process for the management of LTBI (latent TB infection) cases and the medical prescription of the necessary follow-up by the relevant health professionals.

**Objectives:**

- a) Ensure use of the most effective prophylaxis for latent TB infection (LTBI) and in so doing, prevent the development of active TB disease.
- b) Ensure regular and optimal follow-up of people with LTBI who are undergoing treatment.
- c) Quickly identify any issues regarding compliance and offer the appropriate support.
- d) Quickly detect adverse reactions and ensure their management (*Guide TB*, Québec, 2017).

This order must be initialed by a physician at the time of the LTBI diagnosis and the prescription of TB treatment.

**Notes:** → To reach out to the pneumologists:

- Pediatric pneumologist, write to: MCHTB &06CH\_CUSM [MCHTB@MUHC.MCGILL.CA](mailto:MCHTB@MUHC.MCGILL.CA) or Zofia Zysman-Colman (Med) [zofia.zysman-colman.med@ssss.gouv.qc.ca](mailto:zofia.zysman-colman.med@ssss.gouv.qc.ca)
- Adult pneumologist: Use SAFIR system : [Connect to SAFIR \(gouv.qc.ca\)](http://Connect.to.SAFIR(gouv.qc.ca))  
 In case SAFIR is unavailable, write to: Faiz Ahmad Khan [faiz.ahmad.khan.med@ssss.gouv.qc.ca](mailto:faiz.ahmad.khan.med@ssss.gouv.qc.ca) ou Richard Menzies, Dr. [dick.menzies@mcgill.ca](mailto:dick.menzies@mcgill.ca)
- Pneumologist on call at the MUHC: 514 934-1934.

→ Whenever a new LTBI diagnosis is made, you must notify the Public Health TB team (NRBHSS) at [tuberculose-santepublique.nrbhss@ssss.gouv.qc.ca](mailto:tuberculose-santepublique.nrbhss@ssss.gouv.qc.ca).

**Important note: All individual medical prescriptions have priority over the “Standard” follow-up described in this procedure.**

**Instructions regarding use of the protocol**

The following order, once signed and dated by the physician, will constitute a medical prescription for the tests and paraclinical exams required to enable the follow-up of patients with LTBI. Nurses and physicians must check off and sign the boxes related to their specific tasks as soon as the prescribed actions are completed. Medication prescriptions, however, will be prepared on prescription sheets specifically for LTBI treatment.

Written by: Dr. Latoya Campbell, UTHC and Dr. Élise Bélanger-Desjardins, IHC  
 Dr. Jean-François Proulx and the NRBHSS infectious diseases team  
 Dr. Faiz Ahmad Khan and Dr. David Zielinski, pneumologists and TB consultants, MUHC and Nunavik

Revised by: Dr. Latoya Campbell, UTHC and Dr. Élise Bélanger-Desjardins, IHC  
 Dr. Jean-François Proulx and Aurélie Heurtebize, NRBHSS, 2020-10-01

Approved by: CMDPSF executive committee, IHC and UTHC, 2020-12



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**Positive QuantiFERON-TB Gold test on:** vvvv / mm / dd (if applicable)

**TST result:**        mm **Date:** vvvv / mm / dd

**Threshold values for TST and indications regarding LTBI treatment**

TST	Indications regarding preventive treatment
≥ 5 mm	<input type="checkbox"/> <b>Persons living in a priority village<sup>1</sup></b> <input type="checkbox"/> Mass screening in the event of an outbreak AND as determined by Nunavik Public Health Department. <input type="checkbox"/> Children who received the BCG vaccine less than 24 months earlier.
≥ 5 mm	<input type="checkbox"/> HIV infection. <input type="checkbox"/> Recent contact with a contagious tuberculosis case. <input type="checkbox"/> Presence of fibronodular disease on chest x-ray (healed TB, and not previously treated or treated inadequately). <input type="checkbox"/> Organ transplantation (related to immune suppressant therapy). <input type="checkbox"/> Other immunosuppressive drugs, e.g., corticosteroids (equivalent of ≥ 15 mg/day of prednisone for 1 month or more; the risk of active TB disease increases with the dose and the duration of treatment). <input type="checkbox"/> Renal failure requiring hemodialysis. <input type="checkbox"/> TNF (tumour necrosis factor) alpha inhibitor use.
≥ 10 mm	<input type="checkbox"/> Persons living in a village not deemed a priority by Nunavik Public Health Department. <input type="checkbox"/> Shift in the last 2 years with no known exposure. <input type="checkbox"/> Shift following a recent contact, regardless of the time elapsed between the 2 TST. <input type="checkbox"/> Other immunodeficiency (neck and brain cancer). <input type="checkbox"/> Silicosis. <input type="checkbox"/> People (of any age) having travelled to a country with a high rate over the past 2 years, depending on the length of stay and type of activities. <input type="checkbox"/> Users of injected drugs who are HIV-negative. • Residents and workers of health institutions or correctional facilities. • Workers in homeless shelters. • Homeless people who can be administered a preventive treatment under direct observation. <input type="checkbox"/> All other high-risk patients (persons with diabetes mellitus, who are underweight or who smoke at least one pack of cigarettes per day).

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<sup>1</sup> To view the list of priority villages prepared by Public Health, see [Boîte à outils – Tuberculose](#) (English page).



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 ADULT AND PEDIATRIC  
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 ORDER • RIFAMPICIN (RIF)**

When	Who	Interventions and investigations	Date and Signature
Prior to treatment	Doctor	<p><b>Before prescribing RIF:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ensure a CXR has been taken recently (&lt; 12 weeks since the last CXR)</li> <li><input type="checkbox"/> If BK tests are requested, make sure culture results are negative (unless the expert consulted stipulates otherwise)</li> <li><input type="checkbox"/> Check with the pharmacist if any interactions with other drugs (e.g., Dilantin).</li> </ul> <p><b>Also check for:</b></p> <ul style="list-style-type: none"> <li>1. Prior active TB: <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. History of hepatitis following TB treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Index case resistant to Rifampicin (RIF)<sup>2</sup>: <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p><b>Note:</b> - <b>IF YES</b> (1, 2 and/or 3), reach out to the pneumologists<sup>3</sup>            - <b>IF NO</b> (1, 2 and 3), initiate the LTBI treatment (<i>ITL_PRESC-MED-INH-DIE_EN</i>)</p> <p><b>Prescribe :</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <u>Initial blood test</u> : <input type="checkbox"/> FSC, liver function, creat. <input type="checkbox"/> HIV<sup>4</sup> (verbal consent) <input type="checkbox"/> Syphilis<sup>5</sup></li> <li><input type="checkbox"/> <u>Monthly F/up blood test PRN<sup>6</sup></u>: Liver function, creat.</li> <li><input type="checkbox"/> Medication dosing (e.g., Dilantin levels) while treatment is underway, if necessary</li> <li><input type="checkbox"/> Offer advice in the event of oral contraceptive use. Contraceptive implants, IUDs or condoms should be favoured</li> </ul>	<p>Signature</p> <p>YYYY/ MM/ DD</p>
1 <sup>st</sup> day/date of the onset of Tx  ____/____/____ YY/ MM/ DD	Nurse	<p><b>Before initiating RIF:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Make sure there are no active TB disease symptoms. In the presence of any such symptoms, request a medical opinion STAT before initiating treatment.</li> <li><input type="checkbox"/> Initiate RIF as per medical prescription</li> <li><input type="checkbox"/> Educate the patient (treatment, compliance, side effects)</li> <li><input type="checkbox"/> Prepare to complete follow-up forms:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Compliance curve (<i>ITL-COURBE-RIF_EN</i>)</li> <li><input type="checkbox"/> Registration of the medication (<i>ITL-ENREG-MED-INH-DIE_EN</i>)</li> <li><input type="checkbox"/> Monthly clinical assessment (<i>TB-ACT-ITL_EVAL-CLIN-MENS_EN</i>)</li> </ul> </li> <li><input type="checkbox"/> As per medical prescription above, take initial blood test: FSC, liver function, creat. (adult and child), HIV<sup>4</sup>, syphilis<sup>5</sup></li> </ul>	<p>Signature</p> <p>YYYY/ MM/ DD</p>

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 yyyy mm dd

<sup>2</sup> If the antibiogram of the index case is unknown when prescribing the preventive treatment, make sure to adjust the user's plan as soon as any resistance to the prescribed TB treatment is confirmed.  
<sup>3</sup> Contact information for pneumologists is provided on page 1 of this document.  
<sup>4</sup> HIV is a major risk factor for the progression of latent tuberculosis infection to active tuberculosis.  
<sup>5</sup> Offer opportunistic screening for syphilis to people aged 14 years or more.  
<sup>6</sup> **Child** : If symptomatic or abnormal results after initial blood test.  
**Adult** : If symptomatic **OR** ≥ 50 years old **OR** in the presence of one of the following conditions: Pregnancy or childbirth over the past 3 months, progressive cirrhosis or progressive chronic hepatitis, all causes combined, hepatitis C, hepatitis B with abnormal concentrations of transmines, daily alcohol consumption, intake of other hepatotoxic medications, history of hepatitis provoked by medications. (*Guide d'intervention – La tuberculose*, MSSS, 2017)



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When*	Who	Interventions and investigations	Date and Signature
End of 1 <sup>st</sup> month of Tx  YY/ MM/ DD	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat.	Signature YYYY/ MM/ DD
End of 2 <sup>nd</sup> month of Tx  YY/ MM/ DD	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat.	Signature YYYY/ MM/ DD
End of 3 <sup>rd</sup> month of Tx  YY/ MM/ DD	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat.	Signature YYYY/ MM/ DD
End of Tx (4 <sup>th</sup> month)  YY/ MM/ DD	Doctor	<input type="checkbox"/> Document compliance and end of the treatment <input type="checkbox"/> Complete and sign the post-treatment <i>Clinical and radiological follow-up guide</i> ( <a href="#">TB-ACT-ITL_GUIDE-SCR_EN</a> ) <input type="checkbox"/> Update the list of problems (prior history) in the patient record.	Signature YYYY/ MM/ DD
	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat. <input type="checkbox"/> Plan for clinical and radiological follow-up as required, as per medical opinion on the form <i>Clinical and radiological follow-up guide</i> ( <a href="#">TB-ACT-ITL_GUIDE-SCR_EN</a> ) <input type="checkbox"/> Send all completed documents to Public Health Department	Signature YYYY/ MM/ DD

\* **NOTE:** Apply the *End of treatment* interventions if the treatment is completed before the 4<sup>th</sup> month.

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**FOLLOW-UP GUIDE FOR ADDITIONAL MONTHS**  
**Extension of the planned duration of the treatment**  
 To be followed if the treatment is extended beyond the 4-month period. Apply the interventions in the *End of treatment* line if even just one additional month is needed to complete the treatment. Beyond 6 months, preventive treatment is considered inadequate.

When	Who	Interventions and investigations	Date and Signature
End of 5 <sup>th</sup> month of Tx  YY/ MM/ DD	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat.	Signature YYYY/ MM/ DD
End of Tx (5 <sup>th</sup> or 6 <sup>th</sup> month)  YY/ MM/ DD	Doctor	<input type="checkbox"/> Document compliance and end of the treatment <input type="checkbox"/> Complete and sign the post-treatment <i>Clinical and radiological follow-up guide</i> ( <a href="#">TB-ACT-ITL_GUIDE-SCR_EN</a> ) <input type="checkbox"/> Update the list of problems (prior history) in the patient record.	Signature YYYY/ MM/ DD
	Nurse	<input type="checkbox"/> <b>Regular monthly follow-up:</b> Notify the physician if abnormal. <input type="checkbox"/> Medication follow-up and support to the patient ( <a href="#">ITL-COURBE-RIF_EN</a> ) and ( <a href="#">ITL-ENREG-MED-RIF_EN</a> ) <input type="checkbox"/> Monthly clinical Assessment ( <a href="#">TB-ACT-ITL_EVAL-CLIN-MENS_EN</a> ) <input type="checkbox"/> As per medical prescription, take monthly F/up blood test PRN: liver function, creat. <input type="checkbox"/> Plan for clinical and radiological follow-up as required, as per medical opinion on the form <i>Clinical and radiological follow-up guide</i> ( <a href="#">TB-ACT-ITL_GUIDE-SCR_EN</a> ) <input type="checkbox"/> Send all completed documents to Public Health Department	Signature YYYY/ MM/ DD

MD signature: \_\_\_\_\_ License no.: \_\_\_\_\_ Date: yyyy / mm / dd