Centre de Santé et Services Sociaux Inuulitsivik
Inuulitsivik Health & Social Services Centre
Puvirnituq, Québec J0M 1P0
T 819 988-2957 / F 819 988-2796

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

ACTIVE TB
ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

PROBABLE TB CASE AND CONFIRMED TB CASE

Purpose: To ensure a standard process for the management of active TB cases and the medical prescription of the necessary follow-up by the relevant healthcare professionals.

Objectives:

a) Achieve a permanent recovery from the disease while also avoiding the presentation of a drug resistance and preventing any transmission of the infection (*Guide TB*, Québec, 2017).
b) Quickly detect adverse reactions and ensure their management.
c) Promptly identify and address the likely causes that could lead to a failure of the TB treatment (*Guide TB*, Québec, 2017).

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

Notes: → Always advise the on-call public health physician of all new cases of probable or confirmed active TB.
→ To reach out to the pneumologists:

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

Important note: All individual medical prescriptions will 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 active TB. Nurses and physicians must check off 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 active TB treatment.

Written by:	Dr. Latoya Campbell (UTHC) and Dr. Élise Bélanger-Desjardins (IHC) Dr. Jean-François Proulx and the NRBHSS infectious diseases nursing team Dr. Faiz Ahmad Khan and Dr. David Zielinski (pneumologists and TB consultants, MUHC and Nunavik)
Revised by:	Dr. Valérie Messier and Aurélie Heurtebize (NRBHSS) Dr. Latoya Campbell (UTHC) and Dr. Élise Bélanger-Desjardins (IHC) on 2021-02-24
Approved by:	CMDPSF executive committee, IHC, 2021-04-26 and CMDPSF executive committee, UTHC, 2021-04-14

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When	Who	Interventions and investigations	Date and signature
Prior to treatment Time 0 ___/___/___ YYYY/ MM/ DD	**Doctor**	☐ Result of the most recent TST: _____ mm. Date: yyyy /mm /dd ☐ Complete the *Reportable diseases form* (only available in French) and send it to Public Health Department ☐ Prescribe required type of respiratory isolation: ○ Isolation at home AND daily treatment X 14 days duly completed (to consider based on medical assessment, adequate conditions (environment) and discussions with Public Health[1]) **OR** ○ Hospitalization with respiratory isolation: transfer according to the *GeneXpert triage guide* (*DETECT-GUIDE-TRIAGE-GX_EN*) ☐ Prescribe: ☐ BK by induction, unless contraindicated: GeneXpert X1 and BK X3 ☐ Initial workup: ○ FSC, liver function, creat., Hep BsAg, anti-HCV ○ HIV[2] (verbal consent) ○ Syphilis[3] ○ Other : _____ ○ Urinary bHCG PRN ☐ Monthly F/up blood test on Phase 1: FSC, liver function, creat. ☐ Monthly F/up blood test on Phase 2 PRN[4]: Liver function, creat. ☐ Monthly ophthalmological examination while the patient is on Ethambutol	_____ Signature YYYY/ MM/ DD
	Nurse	☐ Ensure individual protection/isolation measures have been implemented ☐ In the event of a hospitalization, initiate transfer to the hospital centre in question, as per medical recommendations ☐ If home isolation for 14 days, refer to *Procedure for home isolation* (*TB-ACT_Procedure-ISO-DOM_EN*) and provide instructions for home isolation to the patient (*Instructions for home isolation*) (*TB-ACT_CONSIGNES-ISO-DOM_EN* or *IN* or *FR*) ☐ Client education. Refer to the document *Talking tuberculosis – An educational resource – By Health Canada* ☐ Check whether there are any high-priority contacts in the patient's immediate environment (*TB-ACT_Procedure-IDENT-CONTACTS_EN and TB ACT- IDENT-CONTACTS_EN*) ☐ Do initial workup as prescribed above by the doctor ☐ Ophthalmological examination, including: ○ Visual acuity tests: Snellen chart (do not do for infants)[5] ○ Colour perception test: Ishihara colour test[5]	_____ Signature YYYY/ MM/ DD

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

[1] Condition: Hospitalization recommended for all cases of pulmonary TB with smear + and/or with cavitation injuries.
[2] HIV is a major risk factor as regard the disease's progression.
[3] Offer opportunistic screening for syphilis to people aged 14 years or more.
[4] **Child :** If symptomatic or abnormal results 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)
[5] Enter on the *Monthly clinical assessment* form (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*).

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ACTIVE TB
ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

Time	Who	Interventions and investigations	Date and signature
Hospitalization **Or** **Isolation at home** **1st day/date of the onset of Tx** ____/___/____ YYYY/ MM/ DD	**Doctor**	**Check for:** 1 - Prior active TB: ☐ Yes ☐ No 2 - Hepatitis secondary to a prior TB treatment: ☐ Yes ☐ No **Note: - IF YES** (1 and/or 2), reach out to the pneumologists[6] **- IF NO** (1 and 2), initiate tritherapy or quadritherapy (*TB-ACT_PRESC-MED-ADULTE-PHASE-1_EN* and 2_EN or *TB-ACT_PRESC-MED-ENFANT-PHASE-1_EN* and *2_EN*) ☐ Check for any interactions with other drugs (e.g., Dilantin) with the pharmacist ☐ Offer advice in the event of oral contraceptive use. → Favour Depo-Provera, Mirena or condoms ☐ Prescribe a CXR at the end of the 2nd month of treatment and again at the end of the 5th month (*DETECT-CONSULT-RXP_EN*)	_____ Signature YYYY/ MM/ DD
	Nurse	☐ Ensure that Infection prevention and control measures, including isolation measures, are appropriate and adhered to ☐ Check whether BK X 3 by induction was done prior to the treatment. ☐ If smear positive, take BK x 3 Q week until 3 negative smears in a row (can be done the same week after the first negative result) ☐ Client education (disease, treatment plan, side effects and necessary follow-up). Refer to the document *Talking tuberculosis – An educational resource – By Health Canada* ☐ Have the patient sign the *Commitment contract relative to mandatory treatment* (*TB-ACT_CONTRAT-ENGAGEMENT_EN*) ☐ Complete *Appendix 4* (epidemiological investigation questionnaire) ☐ Start the *Identification of contacts of an active TB case* (*TB-ACT_Procedure-IDENT-CONTACTS_EN* and *TB ACT- IDENT-CONTACTS_EN*)	_____ Signature YYYY/ MM/ DD
If hospitalization	**Doctor**	☐ In conjunction with Public Health and/or the specialist, plan for the patient's release from hospital, as per the following instructions: ☐ If GeneXpert positive AND initial smear positive: take BK X3 Q week and release the patient after 14 days of treatment AND 3 negative smears in a row ☐ If GeneXpert positive/negative AND 3 initial negative smears: ○ Release the patient after having completed 14 days of treatment. **OR** ○ Early release, but home isolation until daily treatment X 14 days has been duly completed (based on a medical assessment, adequate conditions (environment) and discussions with Public Health[7]) ☐ Send a copy of the hospital summary report to the doctor and nurse who will follow-up on an outpatient basis	_____ Signature YYYY/ MM/ DD

MD signature: License no.: Date: _____/____/____
YYYY / MM / DD

[6] Contact information for pneumologists is provided on page 1 of this document.
[7] Condition: Hospitalization recommended for all cases of active TB with positive smear and/or with cavitation injuries.

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ACTIVE TB
ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

When	Who	Interventions and investigations	Date and signature
Return to the community ____/____/____ YYYY/ MM/ DD	**Doctor/ village nurse**	☐ Make sure the patient file is transferred to the village ☐ Make sure prescription for phases 1 and 2 of the treatment is received by the pharmacy ☐ Schedule the dates of the various nursing and medical follow-up measures provided for in this prescription ☐ Organize the DOT in conjunction with local healthcare workers – Take into consideration the doses received while hospitalized (*TB-ACT_ENREG-MED-PHASE-1_EN*) ☐ Educate clients as to the treatment plan. If not yet done, have the patient read and sign the *Commitment contract relative to mandatory treatment* (*TB-ACT_CONTRAT-ENGAGEMENT_EN*) ☐ Review and complete the form regarding *Identification of contacts of an active TB case* (*TB ACT- IDENT-CONTACTS_EN*)	_____ Doctor signature YYYY/ MM/ DD _____ Nurse Signature YYYY/ MM/ DD
End of 1st month of Tx ____/____/____ YYYY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. a. Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-1_EN*) b. Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) c. As per medical prescription, take monthly F/up blood test: FSC, liver function, creat.	_____ Signature YYYY/ MM/ DD
End of 2nd month of Tx ____/____/____ YYYY/ MM/ DD	**Doctor**	**Child or adult with a probable case of TB (not confirmed by the laboratory):** ☐ Diagnosis of a probable TB upheld for now (continue treatment), then: ☐ Discuss whether the active TB diagnosis should be upheld or revoked with the pneumologists[6] Prior to this: ☐ Check all results of bacteriological analyses to date (GeneXpert, smears, cultures) ☐ If GeneXpert, smear and cultures negative: reach out to a specialist to discuss differential diagnoses (adult) ☐ Verify the clinical response ☐ Check CXR results from the 2nd month ☐ Check whether medication administration is being complied with ☐ For a child aged > 6 months, discuss the relevance of repeating the TST with the Public Health doctor ☐ If a probable TB diagnosis is upheld and the strain from the source case is deemed sensitive to all, stop EMB (if applicable)	_____ Signature YYYY/ MM/ DD

MD signature: License no.: Date: _____/____/____
YYYY / MM / DD

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ACTIVE TB
ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

When	Who	Interventions and investigations	Date and signature
End of 2nd month of Tx (con't) ___/___/___ YYYY/ MM/ DD	**Doctor (con't)**	**Adult or child with laboratory-confirmed TB:** ☐ Review of the file: ☐ Prescribe BK between the 7th and 8th weeks PRN[8] ☐ Check CXR results from the 2nd month ☐ Check initial BK results and antibiogram: ○ If sensitive to all→ stop EMB (if patient on EMB) ○ If drug resistance→ contact the pneumologists[6] ☐ End of **phase 1** (DOT) of the treatment: → Make sure all **60** doses are taken prior to moving on to phase 2[9] ☐ Begin **phase 2** of the treatment[10]. Make sure the medical prescription is completed (*TB-ACT_PRESC-MED-ADULTE-PHASE-2_EN* or *TB-ACT_PRESC-MED-ENFANT-PHASE-2_EN*) ☐ For a patient on EMB: if EMB must be continued and visual exam is abnormal, request an ophthalmological consult ☐ Other situation (TB case that requires a special treatment) Specify: _____	_____ Signature YYYY/ MM/ DD
	Nurse	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-1_EN*) *AND* prepare the form for phase 2 (TB-ACT_ENREG-MED-PHASE-2_EN) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) c. As per medical prescription, take monthly F/up blood test: FSC, liver function, creat. ☐ Look over status of the file after its review by the doctor ☐ As per medical prescription, schedule a CXR (*DETECT-CONSULT-RXP_EN*) ☐ As per medical prescription, repeat BK X 3 by induction between the 7th and 8th week PRN	_____ Signature YYYY/ MM/ DD

MD signature: License no.: Date: _____/____/____
YYYY / MM / DD

[8] Criteria for BK x 3: **A)** Initial cultures positive **B)** Treatment interrupted **C)** Treatment other (different) than the standard treatment **D)** Initial drug resistance **E)** Initial specimen inadequate and the following ones with positive smears **F)** Cavitation observed a few weeks after the onset of treatment **G)** Short bowel syndrome, diabetes or immunosuppressed patient (e.g., HIV).
[9] In the case of erratic treatment in phase 1, reach out to resp-north@mcgill.ca (adult) or mchtb@muhc.mcgill.ca (child) before initiating phase 2.
[10] **IMPORTANT:** Check the modified dosage of Isoniazid (INH) in phase 2 (except for special cases where DAILY treatment is planned for phase 2). The INH dose goes from **5 mg/kg** daily in phase 1 to **10 mg/kg** daily, 3x/week in phase 2.

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ACTIVE TB
ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

When	Who	Interventions and investigations	Date and signature
End of 3rd month of Tx ___/___/___ YYYY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) b. Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) c. As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ Check whether BK had to be repeated at 8 weeks. If yes, verify the results: ○ If a positive culture: notify the doctor and repeat Q month until negative cultures as per medical prescription	_____ Signature YYYY/ MM/ DD
End of 4th month of Tx ___/___/___ YYYY/ MM/ DD	**Doctor**	☐ Review of the file ☐ Check BK results from the 2nd month ○ If a negative culture: continue treatment for a total of 6 months ○ If a positive culture: reach out to the pneumologists[6] - treatment 9 months possible ☐ Special follow-up: _____	_____ Signature YYYY/ MM/ DD
	Nurse	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) c. As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ Look over status of the file after its review by the doctor ☐ As per medical prescription, repeat BK X 3 until negative cultures are obtained	_____ Signature YYYY/ MM/ DD
End of 5th month of Tx ___/___/___ YYYY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) b. Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) c. As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ As per medical prescription, schedule a CXR (*DETECT-CONSULT-RXP_EN*) ☐ As per medical prescription, repeat BK X 3 until negative cultures are obtained	_____ Signature YYYY/ MM/ DD

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ADULT AND PEDIATRIC
FOLLOW-UP PROTOCOL – STANDARD MEDICAL ORDER

When	Who	Interventions and investigations	Date and signature
End of 6th month of Tx ___/___/___ YYYY/ MM/ DD	**Doctor**	☐ Review of the file; ☐ Check CXR results for the 5th month, along with results of BK cultures ☐ Consult the pneumologists[6] to adjust the therapy program in the presence of: - cavitation on initial CXR; - positive cultures at 8 weeks or more into the treatment; - non-standard, incomplete or erratic treatment; - other special circumstances: _____ **When treatment is completed:** ☐ Fill in and sign the *Treatment outcome* form (*TB-ACT_ISSUE-TX_EN*) ☐ Complete and sign the post-treatment *Clinical and radiological follow-up guide* (*TB-ACT-ITL_GUIDE-SCR_EN*) ☐ Update the list of problems (prior history) in the patient record **Child with a probable case of TB (not confirmed by the laboratory):** ☐ Confirm with Public Health whether the TST needs to be repeated. If yes, inquire as to when. ☐ Discuss whether the active TB diagnosis should be upheld or revoked with the pneumologists[6] and Public Health Department	_____ Signature YYYY/ MM/ DD
	Nurse	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) *c.* As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ Look over status of the file after its review by the doctor ☐ Plan the clinical and radiological follow-up (*TB-ACT-ITL_GUIDE-SCR_EN* and *TB-ACT-ITL_SCR-STANDARD_EN*) **When treatment is completed:** ☐ Submit to Public Health Department: - The *Treatment outcome* form (*TB-ACT_ISSUE-TX_EN*) signed by the doctor - Registration of the medication - phases 1 and 2 (*TB-ACT_ENREG-MED-PHASE-1_EN* and *2_EN*) - Monthly clinical assessments (*TB ACT-EVAL-CLIN-MENS_EN*) - The *Clinical and radiological follow-up guide* (*TB-ACT-ITL_GUIDE-SCR_EN*) filled out by the doctor	_____ Signature YYYY/ MM/ DD
End of 7th month of Tx ___/___/___ YYYY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) *c.* As per medical prescription, take monthly F/up blood test PRN: liver function, creat.	_____ Signature YYYY/ MM/ DD

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Chart for additional months: Delay in treatment for the targeted period OR treatment of 9 / 12 months[11]

When	Who	Interventions and investigations	Date and signature
End of 8th month of Tx ___/___/___ YYYY/ MM/ DD	**Nurse**	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) *c.* As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ As per medical prescription, schedule a CXR (*DETECT-CONSULT-RXP_EN*) ☐ Prepare file for medical review at the end of the 9th month	_____ Signature YYYY/ MM/ DD
End of 9th month of Tx ___/___/___ YYYY/ MM/ DD	**Doctor**	☐ Review of the file ☐ Check CXR results from the 8th month ☐ Consult the pneumologists[6] in the presence of: - abnormal initial CXR or cavitation; - positive cultures at 8 weeks or more into the treatment; - extended, non-standard, incomplete or erratic treatment **Once treatment is completed:** ☐ Fill in and sign the *Treatment outcome* form (*TB-ACT_ISSUE-TX_EN*) ☐ Complete and sign the post-treatment *Clinical and radiological follow-up guide* (*TB-ACT-ITL_GUIDE-SCR_EN*) ☐ Update the list of problems (prior history) in the patient record	_____ Signature YYYY/ MM/ DD
	Nurse	☐ **Regular monthly follow-up**: Notify the physician if abnormal. *a.* Medication follow-up and support to the patient (*TB-ACT_ENREG-MED-PHASE-2_EN*) *b.* Monthly clinical assessment (*TB-ACT-ITL_EVAL-CLIN-MENS_EN*) *c.* As per medical prescription, take monthly F/up blood test PRN: liver function, creat. ☐ Look over status of the file after its review by the doctor ☐ Plan the clinical and radiological follow-up (*TB-ACT-ITL_GUIDE-SCR_EN* and *TB-ACT-ITL_SCR-STANDARD_EN*) ☐ **When treatment is completed**: ☐ Submit to Public Health Department: - The *Treatment outcome* form (*TB-ACT_ISSUE-TX_EN*) signed by the doctor - Registration of the medication - phases 1 and 2 (*TB-ACT_ENREG-MED-PHASE-1_EN* and *2_EN*) - Monthly clinical assessments (*TB ACT-EVAL-CLIN-MENS_EN*) - The *Clinical and radiological follow-up guide* (*TB-ACT-ITL_GUIDE-SCR_EN*) filled out by the doctor	_____ Signature YYYY/ MM/ DD

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[11] If treatment is for 12 months, repeat interventions for the 7th, 8th and 9th months in months 10, 11 and 12.