MA Advanced LTBI ECHO Session Summary #2
1/25/24

Key points

1. **It is reasonable to offer an alternate regimen if the first one you try does not work out.** Here, the patient had nausea on RIF, but was better able to tolerate INH.
2. **Get creative with medication administration!** INH tablets can be crushed and mixed with food if this is more palatable to the patient.
3. **Each regimen has some wiggle room for completion.** 9mo of INH (270 doses) must be completed within 12 calendar months, so as long as this patient completes his regimen by 5/23/24 she will be considered adequately treated. 4mo of RIF (120 doses) must be completed within 6 months, and 12 weeks of 3HP (12 doses) must be completed within 16 weeks.
4. **Missing doses of LTBI treatment is not concerning for drug resistance.** By definition, since LTBI is latent and not replicating actively, and a person's bacillary load is low in LTBI, the chance of selecting for resistance with intermittent preventive therapy is low. (By contrast, treating active TB with just one drug or intermittent adherence could lead to drug resistance—this is why we must be careful to rule out active TB before starting LTBI treatment.)
5. **Treating with 6 months of INH is not considered first-line but is an acceptable option.** There is stronger data for adequate LTBI treatment in a 9-month INH regimen when compared to a 6-month regimen. In fact, six months of INH confers 70% reduced risk of later progression to TB disease as compared to 90% with 9 months of INH; for this reason, MA DPH does not recommend 6H as a first-line treatment. However, in a patient unable to continue their planned 9H beyond 6 months (for example, due to side effects or loss to follow-up), it is ok to stop treatment at the 6-month mark and consider them treated. However, you may want to consider longer treatment or retreating in folks who have current or impending immunosuppression.
6. **Consider risk factors and need for screening.** This patient is from an endemic area so does need screening. However, hospitalization in the US medical system by itself is not really a risk factor for TB acquisition, so a patient with multiple inpatient psych hospitalizations *without* this history of residence in an endemic area would not need to be screened.
7. **Consider drug-drug interactions when initiating rifampin.** This patient is on several psychiatric medications and the prescribing provider may have questions about how best to evaluate drug interactions with rifampin. We encourage everyone to use the excellent Curry Center drug interaction resource, available at https://www.currytbcenter.ucsf.edu/products/rifamycin-drugdrug-interactions-a-guide-for-primary-care-providers-treating-latent-tuberculosis. (You can use the "search" function to find drugs of interest.)