Lambton Public Health

Tuberculosis (TB) Reporting Form and Guidance for Health Care Providers in Lambton County

Adapted with permission from Windsor-Essex County Health Unit

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INTRODUCTION

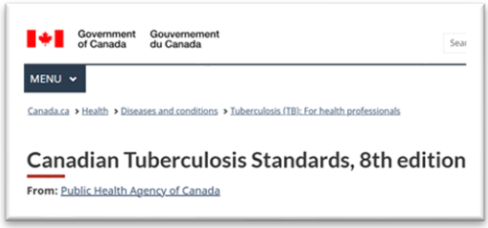
Tuberculosis (TB) is an airborne disease caused by the bacteria *Mycobacterium tuberculosis*, which primarily affects the lungs but can develop in other organs or tissues. There are two forms of TB: active TB disease and TB infection (TBI) (formerly known as latent TB infection or LTBI). Respiratory TB disease can be spread through the air when a person with active TB disease in their lungs or airways coughs, sneezes, or talks (PHO, 2026). Non-pulmonary TB disease is known as extra-pulmonary TB. Common symptoms of TB disease include but are not limited to a persistent cough lasting more than 3 weeks, cough with or without sputum or hemoptysis, chest pain, fatigue, reduced appetite and unintentional weight loss, fever, and/or night sweats. While TB disease is curable, if left untreated the disease can be fatal.

Exposure to TB disease can also result in TBI, without symptoms, and non-infectious (PHO, 2026). If TB preventive medication treatment is provided to individuals with TBI, then active TB disease can usually be prevented. TB preventive treatment is recommended for people with TBI who are at increased risk for the development of TB disease. If the immune system of a contact of active TB disease does not contain the inhaled TB bacteria, the initial TBI may progress immediately to TB disease, known as primary TB, most often occurring in young children (<5 years of age) or immunocompromised individuals. Reactivation TB disease may develop if TBI is not fully treated, occurring in 5 to 10 percent of people with TBI at a later time in their lives, and may occur if an individual's immune system becomes weakened and no longer able to control the TB bacteria, which then overwhelms the immune process. The greatest risk for developing reactivation TB disease is within the first two years after initial infection as a contact to a person with infectious TB disease (UpToDate, 2026).

NATIONAL AND PROVINCIAL TB GUIDANCE

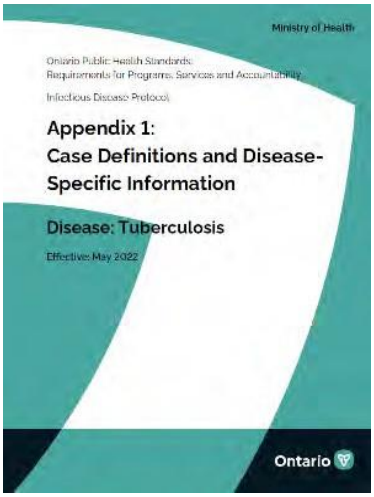
The following summarizes national and provincial guidance for TB screening, testing, reporting to the local public health unit, and management. For more detailed information and guidance, please refer to each cited source, along with other published guidance.

Canadian Tuberculosis Standards, 8th edition



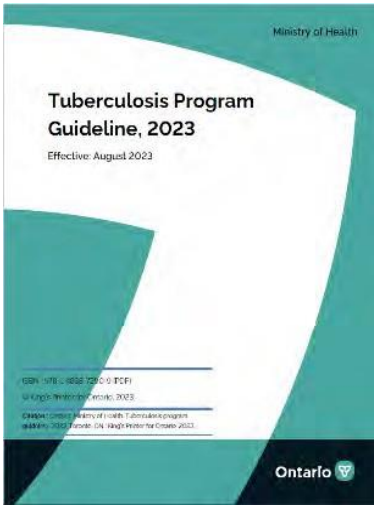
Provides "practical management information on all aspects of the pathogenesis, epidemiology, and management of TB in Canada," jointly funded by the Canadian Thoracic Society and the Public Health Agency of Canada. Edited by the Canadian Thoracic Society and published in collaboration with the Association of Medical Microbiology and Infectious Disease Canada. Each chapter is written by authors from across Canada with expertise in the specific topic. Note, the information is not meant to supersede provincial guidelines or protocols.

Ministry of Health Infectious Disease Protocol – Appendix 1: Tuberculosis



Contains case definitions and disease-specific information to guide testing and public health case and contact investigation and management.

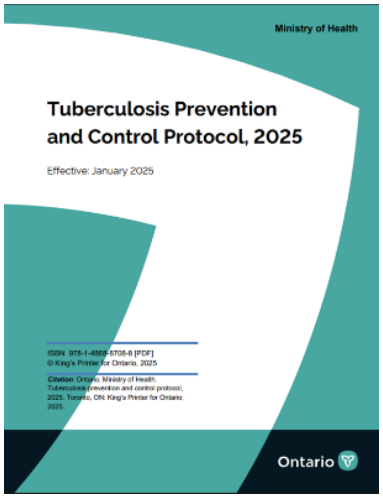
Ministry of Health Tuberculosis Program Guidelines



"Provide boards of health [public health units] with direction for how to approach TB prevention and care through programs and services that work towards achieving the global goal of TB elimination."

Ministry of Health [Tuberculosis Prevention and Control Protocol]

“Provides direction to boards of health [public health units] to reduce the burden of tuberculosis through prevention and control.”



Risk of Developing Active TB Disease after TST or IGRA Positive

The Canadian TB Standards, 8th edition, recommends TBI testing for all foreign-born persons (all ages) originating from countries with a TB incidence ≥50/100,000 and with conditions associated with a high risk of TB reactivation:

- TB incidence by region or country group is found at World Health Organization: Global and regional estimates of TB incidence, numbers (in thousands) and rates (per 100,000 population) in 2024.
- TB incidence by individual country is found at: World Health Organization TB country, regional and global profiles online tool.

Clients at risk for active TB disease in the first 2-3 years after TST or IGRA positive:

Table: Risk of TB disease and the incidence rate ratio of TB disease among different populations stratified by risk (Reference: Canadian TB Standards, Table 2)

Risk Factor	Details	Annual risk of TB disease for the first 2-3 years after testing positive (%)
Very High Risk	People living with HIV	1.7 to 2.7
Very High Risk	Child or adolescent (<18y) tuberculosis contact	2.9 to 14.6
Very High Risk	Adult (≥18y) tuberculosis contact	0.8 to 3.7
Very High Risk	Silicosis	3.7
High Risk	Stage 4 or 5 chronic kidney disease with or without dialysis	0.3 to 1.2
High Risk	Transplant recipients (solid organ or hematopoietic)	0.1 to 0.7
High Risk	Fibronodular disease	0.2 to 0.6
High Risk	Receiving immunosuppressing drugs (e.g., tumor necrosis factor α inhibitors or steroids)	0.5
High Risk	Cancer (lung, sarcoma, leukemia, lymphoma or gastrointestinal)	0.1 to 0.4
Moderate Risk	Granuloma on chest x-ray	0.1
Moderate Risk	Diabetes	0.1 to 0.2
Moderate Risk	Heavy alcohol use (at least 3 drinks/day)	0.1 to 0.2
Moderate Risk	Heavy tobacco cigarette smoker (at least 1 pack/day)	0.1
Low Risk	General (adult) population with no known risk factor	0.03
Low Risk	Persons with a positive two-step TST booster and no known risk factor	0.02

Abbreviations: HIV, human immunodeficiency virus; TST, tuberculin skin test

Footnotes:

- Risks are expected to halve after this period and continue to decrease subsequently

- Risk does not appear significantly elevated with low-dose steroids (i.e., prednisone), but elevated with moderate or high dose (low dose, ≤9 mg/day; medium dose, 10–19 mg/day; and high dose, ≥20 mg/day)

Interpreting and Managing TST and/or IGRA Results

Chapter 4 of the Canadian TB Standards, 8th edition, states the following:

- Interpreting a TST and/or IGRA test result depends on the clinical context.
- There are multiple dimensions to consider when faced with a positive or negative TST or IGRA to help decide whether someone is at risk of developing active TB disease and would likely benefit from TPT. These include:
    - The pretest probability that the person is truly infected (with TBI),
    - The individual risk of TB disease, and
    - The ability of the test to identify persons at risk of disease.
- There are online tools that can help support decisions in interpreting TST or IGRA results among different populations that consider many of these dimensions. These include:
    - The on-line tool TSTin4D which provides estimates of absolute risk of TB disease plus associated death and disability, reduction of those risks with TB preventive therapy, as well as risk of adverse events with therapy.
    - The PERISKOPE TB website tool provides estimates of absolute risk of TB disease.
- If a health care provider decides that a TST or IGRA is truly positive, there is no clinical utility in performing a TST or IGRA in the future, so long as the test is properly performed, read, and interpreted.
- All persons with a positive TST or IGRA must receive a **medical evaluation from an attending clinician to rule out active TB disease** prior to initiating TB preventive medication treatment (TPT). In doing so, clinicians are to complete and send the Health Care Provider Reporting Form and report TBI and active TB disease to Lambton Public Health, with pertinent information included.
- After TB disease is ruled out, TPT should be started as soon as possible and according to guidance in Chapter 6: Tuberculosis preventive treatment in adults **Table 1** and **Section 3**.
- All TPT medications can be ordered and are free through Lambton Public Health. Patients are called by Lambton Public Health throughout TPT, to assess for medication tolerability and to encourage adherence.
- Referral to an Infectious Disease Specialist or Respirologist may be sought by the attending clinician, for TB consult in-person, or via the Ontario eConsult Program (Ministry of Health, Tuberculosis Program Guideline, 2023).

Immigration, Refugees and Citizenship Canada (IRCC) requires individuals who have had past TB disease identified during their Immigration Medical Exam (IME),or may have TBI based on abnormal chest x-ray or other findings discovered during the IME process, or are at higher risk for developing active TB disease, to have a medical follow-up after arriving in Canada. Complete and send PHYSICIAN REPORT – TUBERCULOSIS (TB) MEDICAL SURVEILLANCE FORM for your clients requiring TB medical surveillance upon arrival to Canada.