For better control, tuberculosis deserves better attention

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Tuberculosis (TB) continues to be a major cause of mortality worldwide. The World Health Organization (WHO) global tuberculosis control 2011, reported absolute drop in the number of TB cases since 2006, and also reported drop in the incidence of TB since 2002.[1] This global improvement in TB is achieved through implementation of many of infection control and treatment strategies. However, the incidence of TB in some countries in the region including Saudi Arabia did not show such significant decrease in TB incidence.[2] There are many challenges and problems in dealing with TB control and management. These issues need to be addressed and solved urgently by healthcare policy maker. Al-Hajoj S.A (2010), in his wake-up comprehensive review for better TB management and control, delineated many of major shortcomings in our health system in dealing with TB.[3] I will not re-discuss again these shortcomings. WHO have also published many documents regarding TB elimination strategies and policies to stop TB. These measures are very well known to healthcare authorities and need to be implemented. However, I will emphasize only in few of several practical challenges to successful elimination of TB. One of the major challenges that need to be addressed is lack of specialized TB clinics or program at the major hospitals or at the community’s clinics.

There are many reasons for such specialized TB clinics. It has been reported that physicians who are not dealing with TB are often insufficiently knowledgeable about some aspects of TB management and may fail to follow recommended treatment guidelines, or may not be aware about hospital policies regarding reporting of TB cases or may be not interact effectively with public health programs.[4] To achieve successful case finding in TB and better TB control, it is recommended to establish specialized TB clinics under supervision of expert TB practitioners and supported by all necessary public health nursing, staffing, and appropriate facilities.

Furthermore, the objectives of these specialized TB clinics are not only to start TB therapy, but are also to keep appropriate record for patients, ensure patients’ follow-up, implementation of direct observed therapy (DOT), tracing of contacts with positive sputum for AFB, documentation of compliance with therapy and patient tracing, and appropriate reporting to local authorities. Moreover, establishing such specialized clinics will facilitate referral of the patients by community physicians to such clinics and it will probably limit initiating inappropriate therapy, interruption of the medications, and reducing the risk of defaulting or delaying the diagnosis and treatment of TB cases. In most of the hospitals, these services probably exist; however, it does not follow the same standards and the patient care is fragmented, responsibilities, work organization, and reporting is not clear.

The other important strategies in TB control and early detection of TB drug resistance is incorporating the recent WHO recommendation which support the wider use of rapid drug susceptibility testing for rifampicin and isoniazid or rifampicin alone using molecular techniques.[5] For example, the overall sensitivity and specificity of Xpert MTB/RIF assay in diagnosis for M. tuberculosis is 92% and 99%, respectively and for diagnosis of rifampicin resistance, this test has 98% sensitivity and 98% specificity. Furthermore, other advantage of this test is the availability of rapid result within a few hours.[6] Such facilities are strongly recommended to be available in all hospital which takes care of TB patients.

The other challenge in eliminating of TB is the persistence of a substantial number of individuals with latent TB infection who are at risk of progression to active TB. These individuals must be identified through targeted testing. Recently, consensus statement about targeting latent TB infection has been published by four major Saudi societies including the Saudi Thoracic Society; and the Saudi Society of Medical Microbiology and Infectious Disease about.[7] The aim of this statement was to emphasize on the importance of implementing latent TB treatment in high-risk groups, including close contact with positive-sputum TB cases, children, HIV patients, immunocompromised patients, and healthcare providers. Targeting high-risk latent TB cases is one of the major steps in TB control and elimination.
The implementation of such services, policies, and guidelines will definitely help in achieving the WHO goal for eliminating TB in the near future.

References

1. WHO –Global Tuberculosis control 2011 report. Available from: http://www.who.int/tb/publications/global_report/2011/gtbr11_full.pdf [Last accessed on 2011 Oct 20].
2. MOH-Statistical Book for the year 1430. Available from: http://www.moh.gov.sa/Ministry/Statistics/book/Pages/default.aspx [Last accessed on 2011 Oct 20].
3. Al-Hajoj SA. Tuberculosis in Saudi Arabia: Can we change the way we deal with the disease. J Infect Public Health 2010;3:17-24.
4. Taylor Z, Nolan CM, Blumberg HM. Controlling tuberculosis in the United States Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. MMWR Recomm Rep 2005;54:1-81.
5. Falzon D, Jaramillo E, Schünemann HJ, Arentz M, Bauer M, Bayona J, et al. WHO guidelines for the programmatic management of drug-resistant tuberculosis: 2011 update. Eur Respir J 2011;38:516-28.
6. Policy statement: Xpert MTB/RIF system (WHO/HTM/TB/2011.4) [pdf 930kb] available from: http://whqlibdoc.who.int/publications/2011/9789241501545_eng.pdf [Last Accessed on 2011 Oct 20].
7. Al Jahdali HH, Baharoon S, Abba AA, Memish ZA, Alrajhi AA, AlBarrak A, et al. Saudi guidelines for testing and treatment of latent tuberculosis infection. Ann Saudi Med 2010;30:38-49.

How to cite this article: Al-Jahdali H. For better control, tuberculosis deserves better attention. Ann Thorac Med 2012;7:1-2.