NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
Commissioner

March 26, 2018

2018 Advisory #5: Largest Increase in Tuberculosis Cases Since 1992

In March 2018, the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) released data showing the largest increase in the number of tuberculosis (TB) cases in NYC since 1992. The new data show a 10% increase from the previous year, with 613 cases in 2017.

DOHMH encourages healthcare providers to:

- **Test patients for TB if they are at high risk for TB infection or development of active TB disease**
- **Rule out active TB disease using chest imaging in all patients who have a positive test for TB infection or TB symptoms (e.g., fever, cough, hemoptysis, night sweats, weight loss)**
- **Use new, shorter regimens to treat LTBI**
- **Report all suspected or confirmed TB cases and all children under 5 years old with a positive test for TB infection to DOHMH within 24 hours**
- **Refer patients to a DOHMH Tuberculosis Clinic for free treatment**
- **Seek consultation from TB experts by calling the DOHMH TB Hotline when needed**

The TB rate in NYC is 7.5 per 100,000 persons, more than double the provisional 2017 national rate of 2.8 per 100,000 persons. Sixty-three percent of TB cases occurred among males, 41% of cases occurred among persons age 18-44 years old and 43% of United States (U.S.)-born TB cases occurred among non-Hispanic Black New Yorkers. Eighty percent of TB cases in 2017 were pulmonary TB. The number of people diagnosed with multidrug-resistant TB in NYC also increased from 11 in 2016 to 14 in 2017.

TB continues to disproportionately affect non-U.S.-born New Yorkers. In 2017, 86% of TB cases in NYC were among individuals born outside of the United States. The most common countries of birth for these individuals were China, Dominican Republic, Ecuador, India, and Mexico. Queens remained the borough with the highest TB incidence in 2017 with a rate of 10.6 per 100,000. The NYC neighborhoods with the highest TB rates in 2017 were Sunset Park, Brooklyn (23.2 per 100,000 persons), Western Queens (19.2 per 100,000 persons) and Flushing, Queens (16.2 per 100,000 persons). For additional information, please see the newly released 2017 Tuberculosis Annual Report.

Testing

Blood-based interferon gamma release assays (IGRAs), such as QuantiFERON®-TB Gold In-Tube or T-Spot®.TB, are preferred for patients with a history of Bacille Calmette-Guérin (BCG) vaccination or for patients not likely to return for tuberculin skin test (TST) reading.

Patients should be tested for TB if they meet any of the criteria listed below.

- People who have spent time around a person with active TB disease (i.e. contacts)
- People born in, resided in, or traveled (>1 month) to countries with high rates of TB (includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.)
- People with medical conditions or treatments that weaken the immune system including
    - Existing conditions that can cause immunosuppression (e.g. HIV infection)
    - Currently taking, or planning to take, certain medications that can cause immunosuppression, such as anti-tumor necrosis factor-alpha (TNF-α) treatment (e.g., infliximab, etanercept), corticosteroids, or medications used for organ transplantation

Diagnostic Testing

Patients with a positive TB test result should be evaluated for active TB disease with a medical examination and a chest radiograph (CXR) or other imaging studies as clinically indicated. Patients with TB symptoms or an abnormal CXR should be evaluated for active TB disease by obtaining sputum or other body fluids per site of disease for acid-fast bacilli (AFB) and culture.

Once active TB disease has been ruled out, patients should be considered for treatment for latent TB infection (LTBI). Two new, shorter regimens are available for individuals. These have been shown to increase the likelihood of treatment completion and to be as effective and well-tolerated as longer regimens:

- Four months of daily self-administered rifampin (4R)
- Three months of once-weekly isoniazid (INH) and rifapentine (3HP) for individuals age 2 years and older given under directly observed therapy (DOT)

For more information on diagnosis and treatment for active TB disease and TB infection, see the DOHMH TB Clinical Policies and Practices Manual.

Reporting

Health care providers and laboratories are required to report to the DOHMH:
1. All patients with confirmed TB disease
2. Anyone suspected of having TB disease
3. Children younger than 5 years old with a positive test for TB infection, associated chest imaging results and treatment information

Reports must be made within 24 hours of diagnosis or clinical suspicion, through one of the following mechanisms:

- Report electronically through NYCMED.
- Call the TB Provider Hotline: **(844) 713-0559 (toll-free)**
- Fax a completed Universal Reporting Form (URF) to **844-713-0557/0558 (toll-free)**

When reporting suspected or confirmed TB cases, please refer to DOHMH reporting requirements.

Referring Patients to a DOHMH Tuberculosis Clinic

Healthcare providers are encouraged to refer eligible patients who need further TB evaluation to a DOHMH TB Clinic. TB Clinics provide TB diagnostic services, including testing for LTBI, sputum induction, and chest radiographs, as well as providing medical evaluation, treatment for TB disease and LTBI and DOT services. TB Clinics **services are confidential and free of charge to the individual. We do not ask about immigration status**. Patients must have an appointment to be seen. To refer a patient, call the individual TB Clinic. Refer to the list of DOHMH TB Clinics for hours, locations, available services, contact information and patient eligibility requirements.

If you have further questions or require consultation on any TB related issue, please call the **TB Provider Hotline: (844) 713-0559 (toll-free)**. If your facility is interested in having a DOHMH representative speak with your staff about TB diagnostics, reporting treatment, and/or epidemiology, contact Shaila Rao, Director of Outreach, Bureau of TB Control at srao1@health.nyc.gov.

Sincerely,

Joseph Burzynski, MD, MPH
Assistant Commissioner and Director, Bureau of TB Control