



California Tuberculosis Risk Assessment College and University Students



- Use this tool to identify asymptomatic college or university students for latent TB infection (LTBI) testing.
- Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.
- For TB symptoms or abnormal chest x-ray consistent with active TB disease → Evaluate for active TB disease
Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

Check appropriate risk factor boxes below.

LTBI testing is recommended if any of the 4 boxes below are checked.

If LTBI test result is positive and active TB disease is ruled out, LTBI treatment is recommended.

Foreign-born person from a country with an elevated TB rate

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons

Immunosuppression, current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication

Close contact to someone with infectious TB disease at any time

Foreign travel or residence of ≥ 1 month consecutively in a country with an elevated TB rate

- Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe
- TB testing should occur at least 8 weeks after the student left the country with elevated TB prevalence; tests prior to 8 weeks can be falsely negative

See the [College and University Students Risk Assessment User Guide](#) for more information about using this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

To ensure you have the most current version, go to the RISK ASSESSMENT page at <http://www.cdph.ca.gov/programs/tb>



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Avoid testing persons at low risk

Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations and other risk factors

The core elements listed in the College/University TB Risk Assessment are meant to identify students who need screening for TB. These were selected in order to focus testing on patients at highest risk. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others. Local recommendations should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.**

United States Preventive Services Task Force (USPSTF)

The USPSTF has recommended testing foreign born persons born-in or former residents of a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to infectious TB nor among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Decision to test is a decision to treat

Because testing of persons at low risk of TB infection should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT) have been performed. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

When to repeat a risk assessment testing

Repeat risk assessments should be based on the activities and risk factors specific to the student. Colleges and universities may decide on the need for repeat screening based on the activities and risk factors specific to their student body. Students who volunteer or work in health care settings might require annual testing and should be considered separately.

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

Negative test for latent TB does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB. In fact, a negative TST or IGRA in a patient with active TB can be a sign of extensive disease and poor outcome.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI and evaluated for active TB disease.

IGRA preference in BCG vaccinated students

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST tuberculin skin test in these persons.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks

*The CDC currently recommends DOT for this regimen; however, preliminary data suggests that SAT is noninferior to DOT in the United States. Many clinicians are using SAT or modified DOT.

CDPH 3HP Fact Sheet: available on the CDPH TBCB website: <http://www.cdph.ca.gov/programs/tb>

What if students refuse LTBI treatment when indicated?

Refusal should be documented. Offers of treatment should be made at future encounters with medical services if still indicated. Annual chest radiographs are not recommended in asymptomatic students. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 3 months from the initial evaluation.

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis or excessive fatigue.

No state requirements for LTBI screening in college or university students

These recommendations are considered best practices by the CDPH TCB and are not legally mandated.

Resource: American College Health Association Guidelines on tuberculosis screening available online

DOT=Directly observed therapy; IGRA= Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG=Bacillus Calmette-Guérin; TST= tuberculin skin test; LTBI=latent TB infection

