



Self-Study Modules on Tuberculosis

1 Transmission and Pathogenesis of Tuberculosis

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

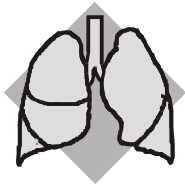
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Division of Tuberculosis Elimination



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Transmission and Pathogenesis of Tuberculosis

1

CONTENTS

■	Background	1
■	Objectives	1
■	New Terms	2
■	Reading Material	5
□	History of TB	5
□	Transmission	8
□	Pathogenesis	12
■	Summary	28
■	Additional Reading	29
■	Answers to Study Questions	30
■	Answers to Case Studies	34



BACKGROUND

In this module, you will learn about the history of tuberculosis (TB). You will also learn how TB is spread from person to person (transmission) and how TB disease develops in the body (pathogenesis). Our understanding of the transmission and pathogenesis of TB has guided us in developing strategies for controlling the spread of TB and for treating latent TB infection (LTBI) and TB disease. As a public health worker, you should understand these concepts so that you can educate the patients you serve.

OBJECTIVES

After working through this module, you will be able to

1. Briefly describe the history of TB.
2. Explain how TB is spread (transmission).
3. Define drug-resistant TB.
4. Explain the difference between LTBI and TB disease.
5. Explain how LTBI and TB disease develop (pathogenesis).
6. Describe the classification system for TB.



NEW TERMS

Look for the following new terms in this module and in the glossary.

AIDS – acquired immunodeficiency syndrome, a condition in which the immune system is weakened and therefore less able to fight certain infections and diseases; AIDS is caused by infection with the human immunodeficiency virus (HIV)

alveoli – the small air sacs of the lung that are at the end of the airway; when droplet nuclei reach these air sacs, TB infection begins

corticosteroid – a type of steroid, either natural or man-made, often used to treat arthritis or certain allergies

diabetes mellitus – a disease in which the body's ability to use sugar is weakened

droplet nuclei – very small droplets (1 to 5 microns in diameter) containing *M. tuberculosis* that may be expelled when a person who has infectious TB coughs, sneezes, speaks, or sings; the droplets can remain suspended in the air for several hours, depending on the environment

drug injection – using a needle and syringe to inject drugs into the body

drug-resistant TB – TB caused by organisms that are able to grow in the presence of a particular drug; TB that is resistant to at least one first-line antituberculosis drug

extensively drug resistant TB (XDR TB) – a rare type of MDR TB that is resistant to isoniazid and rifampin, plus resistant to any fluoroquinolone and at least one of three injectable second-line drugs (i.e., amikacin, kanamycin, or capreomycin)

extrapulmonary TB – TB disease that occurs in places other than the lungs, such as the lymph nodes, the pleura, the brain, the kidneys, or the bones; most types of extrapulmonary TB are not infectious

HIV – human immunodeficiency virus, the virus that causes AIDS

immune system – cells and tissues in the body that protect the body from foreign substances

immunosuppressive therapy – therapy that suppresses, or weakens, the immune system

infectious – capable of spreading infection; a person who has infectious TB disease expels droplets containing *M. tuberculosis* into the air when he or she coughs, sneezes, speaks, or sings

interferon-gamma release assay (IGRA) – a type of blood test that measures a person's immune reactivity to *M. tuberculosis*. In the U.S., QuantiFERON[®]-TB Gold and QuantiFERON[®]-TB Gold In-Tube are currently available IGRAs

latent TB infection (LTBI) – refers to the condition when a person is infected with tubercle bacilli but has not developed TB disease. Persons with LTBI carry the organism that causes TB but do not have TB disease symptoms and they cannot spread TB germs to others. Persons with LTBI usually have a positive result to the Mantoux tuberculin skin test or the QuantiFERON[®]-TB Gold test



Mantoux tuberculin skin test (TST) – a method of testing for TB infection; a needle and syringe are used to inject 0.1 ml of 5 tuberculin units of liquid tuberculin between the layers of the skin (intradermally), usually on the forearm; the reaction to this test, usually a small swollen area (induration), is measured 48 to 72 hours after the injection and is interpreted as positive or negative depending on the size of the reaction and the patient’s risk factors for TB

miliary TB – TB disease that occurs when tubercle bacilli enter the bloodstream and are carried to all parts of the body, where they grow and cause disease in multiple sites; the chest x-ray of patients with miliary TB often looks like millet seeds scattered throughout the lung

mono-resistant TB – TB that is resistant to one TB treatment drug

multidrug-resistant TB (MDR TB) – TB that is resistant to at least the drugs isoniazid and rifampin; MDR TB is more difficult to treat than drug-susceptible TB

mycobacterium – a kind of bacterium; mycobacteria can cause a variety of diseases

Mycobacterium africanum – a type of tuberculous mycobacterium, closely related to *M. tuberculosis*, that can cause a disease similar to TB; it is very rare in the United States

***Mycobacterium avium* complex** – a common type of nontuberculous mycobacterium that can cause disease in humans

Mycobacterium bovis – a type of tuberculous mycobacterium that can cause a disease similar to TB; usually occurs in cows. Before the pasteurization of milk became common practice, these mycobacteria were often spread to humans through contaminated milk; in the United States today, *M. bovis* rarely affects humans

Mycobacterium canetti – a type of tuberculous mycobacterium that can cause disease in humans

Mycobacterium microti – a type of tuberculous mycobacteria that can cause generalized tuberculosis

Mycobacterium tuberculosis – the organism that causes TB in humans and is sometimes called the tubercle bacillus; belongs to a group of bacteria called mycobacteria

nontuberculous mycobacteria – mycobacteria that do not cause TB disease and are not usually spread from person to person; one example is *M. avium* complex

pathogenesis – how an infection or disease develops in the body

poly-resistant TB – TB that is resistant to at least two TB treatment drugs (but not both isoniazid and rifampin); but is not MDR TB

primary drug-resistant TB – drug-resistant TB caused by person-to-person transmission of drug-resistant organisms

pulmonary TB – TB disease that occurs in the lungs typically causing a cough and an abnormal chest x-ray; pulmonary TB is usually infectious if untreated. Most TB cases reported in the United States are pulmonary cases



QuantiFERON®-TB Gold test (QFT-G) – a blood test used to determine TB infection. The QFT-G measures the response to TB proteins when they are mixed with a small amount of blood

secondary drug-resistant TB – also referred to as acquired drug-resistant TB; develops during TB treatment, either because the patient was not treated with the appropriate treatment regimen or because the patient did not follow the treatment regimen as prescribed

silicosis – a lung disease caused by inhaling silica dust, which is used in the production of glass and ceramics; occurs most often in mining and foundry workers

transmission – the spread of an organism, such as *M. tuberculosis*, from one person to another; probability of transmission depends on the contagiousness of the patient, the type of environment, the length of exposure, and the virulence or strength of the organism

tubercle bacilli – another name for the *Mycobacterium tuberculosis* organisms that cause TB disease

tuberculin skin test (TST) – a test used to detect TB infection (see **Mantoux tuberculin skin test** in glossary)

tuberculous mycobacteria – mycobacteria that can cause TB disease or other diseases very similar to TB; the tuberculous mycobacteria include *M. tuberculosis*, *M. bovis*, *M. africanum*, *M. canetti*, and *M. microti*

virulence – refers to the ability of an organism to produce a disease. The virulence (strength) of a bacteria is associated with the severity of the disease



READING MATERIAL

History of TB

.....
TB has affected humans for centuries. Until the 1940s and 1950s, there was no antibiotic treatment for TB.
.....

.....
Until the 1950s, many people with TB were sent to sanatoriums, special rest homes where they followed a prescribed routine every day.
.....

.....
In the 1940s and 1950s, drugs were discovered to treat TB. After this, the death rate for TB in the United States dropped dramatically, and fewer and fewer people got TB.
.....

Tuberculosis — a disease also historically known as consumption, wasting disease, and the white plague — has affected humans for centuries. Until the mid-1800s, people thought that tuberculosis, or TB, was hereditary. They did not realize that it could be spread from person to person through the air. Also, until the 1940s and 1950s, there was no antibiotic treatment for TB. For many people, a diagnosis of TB was often a slow death sentence.

In 1865 a French surgeon, Jean-Antoine Villemin, proved that TB was contagious, and in 1882 a German scientist named Robert Koch discovered the bacterium that causes TB. Yet half a century passed before drugs were discovered that could treat TB. Until then, many people with TB were sent to sanatoriums, special rest homes where they followed a prescribed routine every day. No one knows whether sanatoriums really helped people with TB; even if they did, many people with TB could not afford to go to a sanatorium, and they died at home.

A breakthrough came in 1943. An American scientist, Selman Waksman and one of his assistants, Albert Schatz, discovered a drug that could kill TB bacteria. Between 1943 and 1952, two more drugs were found. After these discoveries, many people with TB were treated, and the death rate for TB in the United States dropped dramatically. Each year, fewer and fewer people got TB.

By the mid-1970s, most TB sanatoriums in the United States had closed. As cases started to decline, people began to hope that TB could be eliminated from the United States, like polio and smallpox.



.....
In the mid-1980s, the number of TB cases started increasing again.
.....

.....
Since 1993, due to enhanced prevention and control efforts, the number of TB cases has been declining.
.....

In the mid-1980s, however, TB cases started increasing again. This rise in cases has been attributed to several factors, which are discussed further in *Module 2, Epidemiology of Tuberculosis*. Because of the rise in TB, federal and state funding for TB control was increased. The increase in funding was used to help health departments and other organizations boost their efforts to prevent and control the disease. These efforts were successful and since 1993, TB cases in the United States overall have been steadily declining. However, prevention and control efforts must be maintained since TB continues to be reported in almost every state throughout the country and not all states have seen a decrease in the number of their TB cases. Moreover, even today, TB can be fatal if not treated. A timeline of major events in the history of TB is shown in Figure 1.1.

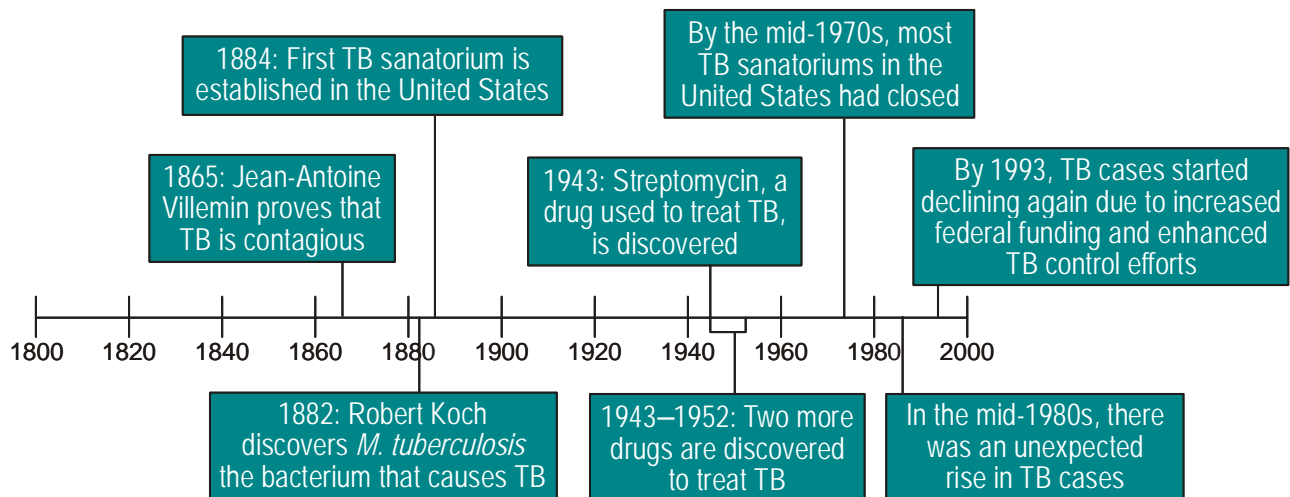


Figure 1.1 Timeline of major events in the history of TB.



Study Question 1.1

- 1.1 In what year was each of the following discoveries made?
- a. TB was proven to be contagious _____
 - b. The bacterium that causes TB was discovered _____
 - c. The first drug that could kill TB bacteria was discovered _____

Answers to study questions are on pages 30 – 33.



Transmission

.....
TB is caused by an organism called *Mycobacterium tuberculosis*.
.....

Mycobacteria are members of the bacteria family. These organisms can cause a variety of diseases. Some mycobacteria are called **tuberculous** because they cause TB or diseases similar to TB. In the United States the vast majority of TB cases are caused by an organism called ***Mycobacterium tuberculosis***. *M. tuberculosis* organisms are also called tubercle bacilli. Other mycobacteria that can cause tuberculous disease include *M. bovis*, *M. africanum*, *M. microti*, and *M. canetti*.

Mycobacteria that do not cause TB are often called **nontuberculous mycobacteria**. One common type of nontuberculous mycobacteria is the ***M. avium complex***. Nontuberculous mycobacteria are NOT usually spread from person to person.

.....
TB is spread from person to person through the air.
.....

TB is spread from **person to person** through the air. When a person with **infectious** TB disease (TB that can be spread) coughs, sneezes, speaks, or sings, tiny particles containing *M. tuberculosis* may be expelled into the air. These particles, called **droplet nuclei**, are about 1 to 5 microns in diameter—less than 1/5000 of an inch. Droplet nuclei can remain suspended in the air for several hours, depending on the environment.

.....
Transmission is the spread of an organism such as *M. tuberculosis* from one person to another.
.....

If another person inhales air that contains these droplet nuclei, **transmission** may occur. Transmission is the spread of an organism such as *M. tuberculosis* from one person to another.

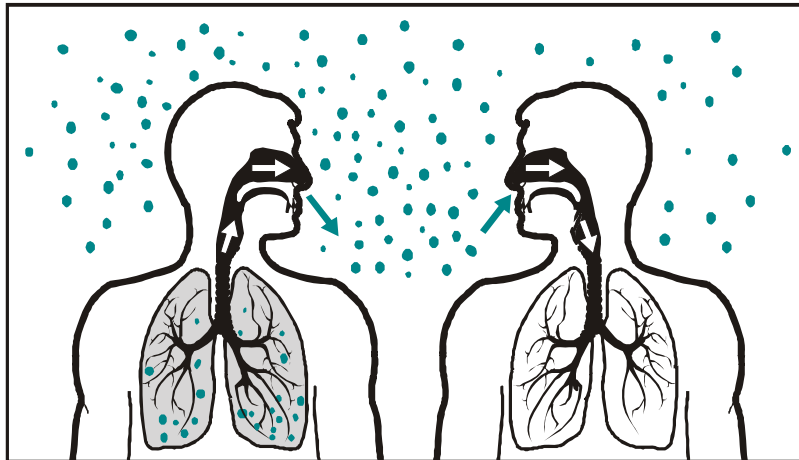


Figure 1.2 Transmission of TB. TB is spread from person to person through the air. The dots in the air represent droplet nuclei containing tubercle bacilli.

.....
 Not everyone who is exposed
 to an infectious TB patient
 becomes infected.

Not everyone who is exposed to an infectious TB patient becomes infected with *M. tuberculosis*. The probability that TB will be transmitted depends on four factors:

- How infectious or contagious is the TB patient?
- In what kind of environment did the exposure occur?
- How long did the exposure last?
- How virulent (strong) are the tubercle bacilli?

.....
 Close contacts of TB patients
 are at highest risk of
 becoming infected.

Close contacts of TB patients are at highest risk of becoming infected with *M. tuberculosis*. They may be family members, roommates, friends, coworkers, or others. Close contacts are more likely to become infected with *M. tuberculosis* than contacts who spent less time with a person while the person was infectious.

The best way to stop transmission is to isolate infectious persons and to start giving them the standard TB treatment as soon as possible. The length of time required for a TB patient to become noninfectious after starting TB therapy varies. However, once the standard TB therapy is started, and as long as the patient follows the prescribed treatment regimen, the infectiousness of the TB patient can rapidly decline.



.....
Drug-resistant TB is caused by *M. tuberculosis* organisms that are resistant to at least one of the first-line TB treatment drugs.
.....

Drug-resistant TB

Drug-resistant TB is caused by *M. tuberculosis* organisms that are resistant to the drugs normally used to treat the disease. This means those drugs can no longer kill the bacteria.

Drug-resistant TB can be **mono-resistant** if the tubercle bacilli are resistant to any one TB treatment drug, or **poly-resistant** if resistant to at least two TB drugs (but not both isoniazid and rifampin). A patient is diagnosed with **multidrug-resistant TB (MDR TB)** if the tubercle bacilli are resistant to at least isoniazid and rifampin, the two best first-line TB treatment drugs. A patient is diagnosed with **extensively drug-resistant TB (XDR TB)** if the tubercle bacilli are resistant to isoniazid and rifampin, plus resistant to any fluoroquinolone and at least one of three injectable second-line drugs (such as amikacin, kanamycin, or capreomycin).

Drug-resistant TB can be transmitted in the same way as drug-susceptible TB. However, drug-resistant TB is more difficult to treat because it can survive in a patient’s body even after treatment with the first-line drugs is started*. Also, because it takes longer to diagnose drug-resistant TB, these patients may be infectious for a longer period of time. This may result in more people being infected.

Drug-resistant TB can be caused in two different ways: **primary** and **secondary** (acquired). Primary resistance is caused by person-to-person transmission of drug-resistant organisms. Secondary resistance develops during TB treatment, either because the patient was not treated with the appropriate treatment regimen or because the patient did not follow the treatment regimen as prescribed. In other words, if patients do not take all of their pills, or if they do not take their pills as often as prescribed, they could develop secondary drug-resistant TB. Patients with drug-resistant TB should be closely monitored to see if they are responding to treatment; they should remain in isolation until it is shown that they are no longer infectious.

* Drug-susceptible TB can be treated with the first-line TB treatment drugs.



Diagnosis and treatment of drug-resistant TB is discussed in more detail in *Module 3, Targeted Testing and the Diagnosis of Latent TB Infection and TB Disease* and *Module 4, Treatment of Latent TB Infection and TB Disease*.

Infectiousness and the transmission of TB is discussed in more detail in *Module 5, Infectiousness and Infection Control*.

Study Questions 1.2–1.6

- 1.2 What organism causes TB? What are four other tuberculous mycobacteria?

- 1.3 How is TB spread?

- 1.4 The probability that TB will be transmitted depends on what four factors?

- 1.5 What is drug-resistant TB?

- 1.6 What is the difference between primary and secondary drug-resistant TB?

Answers to study questions are on pages 30 – 33.



Pathogenesis

.....
Infection begins when droplet
nuclei reach the alveoli.
.....

When a person inhales air that contains water droplets containing *M. tuberculosis*, most of the larger droplets become lodged in the upper respiratory tract (the nose and throat), where infection is unlikely to develop. However, smaller droplet nuclei may reach the small air sacs of the lung (the **alveoli**), where infection may begin (Figure 1.3). The following section describes the **pathogenesis** of TB (the way TB infection and disease develop in the body).

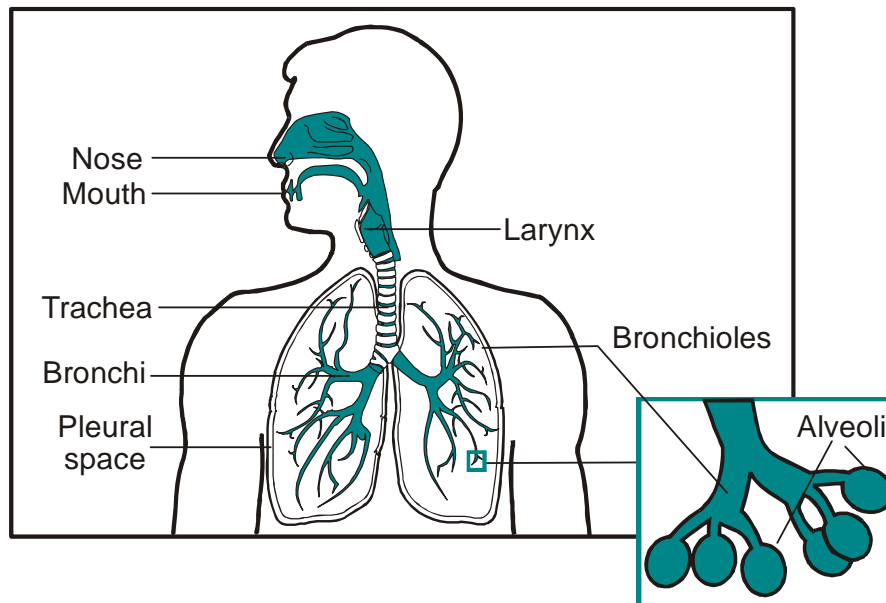


Figure 1.3 The lungs and the alveoli.

In the alveoli, some of the tubercle bacilli are killed, but a few multiply in the alveoli and enter the bloodstream and spread throughout the body. Bacilli may reach any part of the body, including areas where TB disease is more likely to develop. These areas include the upper portions of the lungs, as well as the kidneys, the brain, and bone. Within 2 to 8 weeks, however, the body's immune system usually intervenes, halting multiplication and preventing further spread. The **immune system** is the system of cells and tissues in the body that protect the body from foreign substances. At this point, the person has latent TB infection (LTBI).



Latent TB Infection (LTBI)

.....
LTBI means that tubercle bacilli are in the body but the immune system is keeping them under control.
.....

Latent TB infection (LTBI) means that tubercle bacilli are in the body, but the body's immune system is keeping the bacilli under control and inactive. The immune system does this by producing special immune cells that surround the tubercle bacilli. The cells form a shell that acts as a fence and keeps the bacilli contained and inactive.

.....
LTBI is detected by the tuberculin skin test or the QuantiFERON[®]-TB Gold test.
.....

LTBI is detected by the **Mantoux tuberculin skin test (TST)** or an **interferon-gamma release assay (IGRA)** such as the **QuantiFERON[®]-TB Gold test (QFT-G)**. Most people with LTBI have a positive TST or QFT-G result. *Module 3, Targeted Testing and the Diagnosis of Latent Tuberculosis Infection and Tuberculosis Disease*, discusses the TST and the QFT-G in more detail.

.....
People with LTBI are **NOT** infectious.
.....

People who have LTBI but not TB disease are **NOT infectious** — in other words, they cannot spread the infection to other people. These people usually have a normal chest x-ray. It is important to remember that LTBI is not considered a case of TB. Major similarities and differences between LTBI and TB disease are shown in Table 1.1.



Table 1.1
LTBI vs. TB Disease

Latent TB Infection (LTBI)	TB Disease (in the lungs)
■ Inactive tubercle bacilli in the body	■ Active tubercle bacilli in the body
■ Tuberculin skin test or QuantiFERON [®] -TB Gold test results usually positive	■ Tuberculin skin test or QuantiFERON [®] -TB Gold test results usually positive
■ Chest x-ray usually normal	■ Chest x-ray usually abnormal
■ Sputum smears and cultures negative	■ Sputum smears and cultures may be positive
■ No symptoms	■ Symptoms such as cough, fever, weight loss
■ Not infectious	■ Often infectious before treatment
■ Not a case of TB	■ A case of TB



Study Questions 1.7–1.9

- 1.7 When a person inhales air that contains water droplets containing *M. tuberculosis*, where do the droplet nuclei go?

- 1.8 After the tubercle bacilli reach the small air sacs of the lung (the alveoli), what happens to them?

- 1.9 In people with LTBI (but not TB disease), how does the immune system keep the tubercle bacilli under control?

Answers to study questions are on pages 30 – 33.



Study Questions 1.10–1.11

1.10 How is LTBI detected?

1.11 What are the major similarities and differences between LTBI and TB disease? List characteristics of each.

Answers to study questions are on pages 30 – 33.

Case Study 1.1

A 30-year-old man visits the health department for a tuberculin skin test (TST) because he is required to have one before starting his new job. He has a positive reaction to the TST. He has no symptoms of TB, and his chest x-ray findings are normal.

- **Should this be considered a case of TB?**

- **Should this man be considered infectious?**

Answers to case study questions are on page 34.



TB Disease

.....
 TB disease develops when the immune system cannot keep the tubercle bacilli under control and the bacilli begin to multiply rapidly.

.....
 TB disease can develop very soon after infection or many years after infection.

Some people with LTBI develop TB disease. TB disease develops when the immune system cannot keep the tubercle bacilli under control and the bacilli begin to multiply rapidly. The risk that TB disease will develop is higher for some people than for others. The pathogenesis of LTBI and TB disease is shown in Figure 1.4.

TB disease can develop very soon after infection or many years after infection. In the United States, unless treated, about 5% of the people who have recently been infected with *M. tuberculosis* will develop TB disease in the first year or two after infection. Another 5% will develop TB disease later in their lives. In other words, **about 10% of all people with normal immune systems who have LTBI will develop TB disease at some point in their lives.** The remaining 90% will stay infected, but free of disease, for the rest of their lives (Figure 1.5). However, some conditions can greatly increase the risk of developing TB disease.

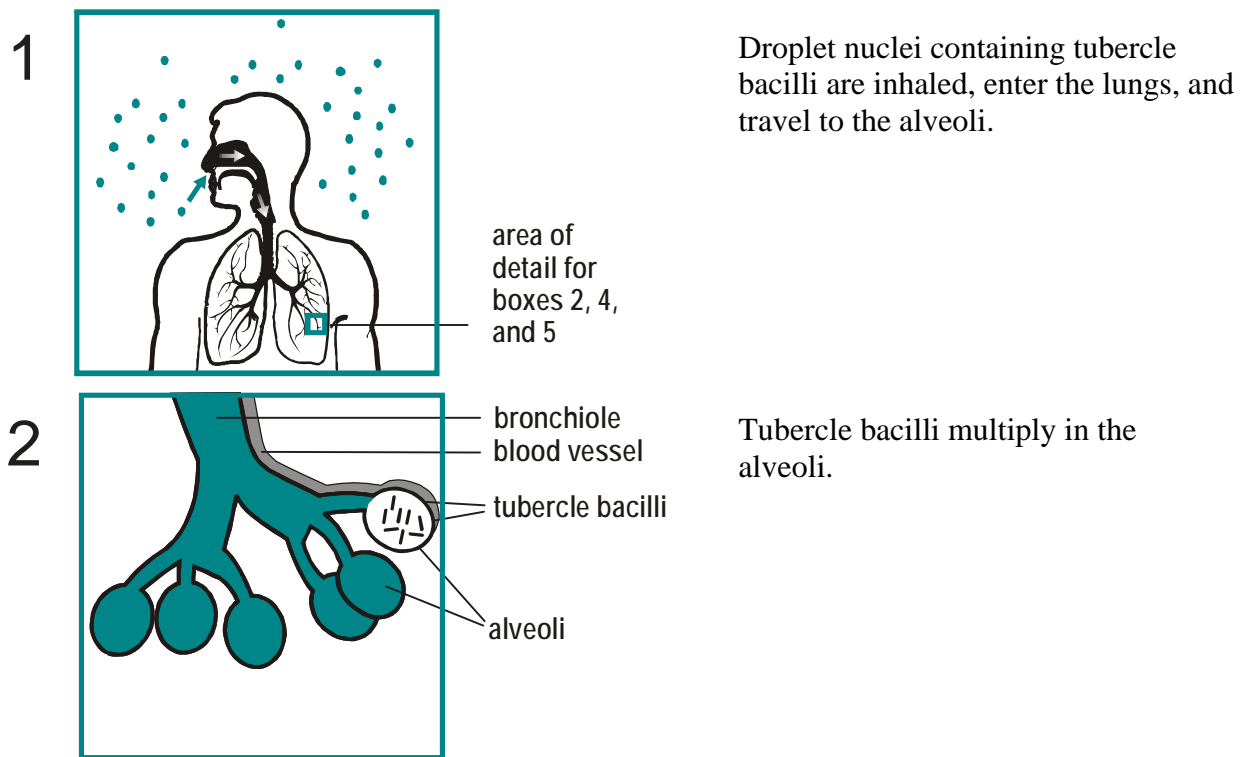


Figure 1.4 Pathogenesis of LTBI and TB disease.

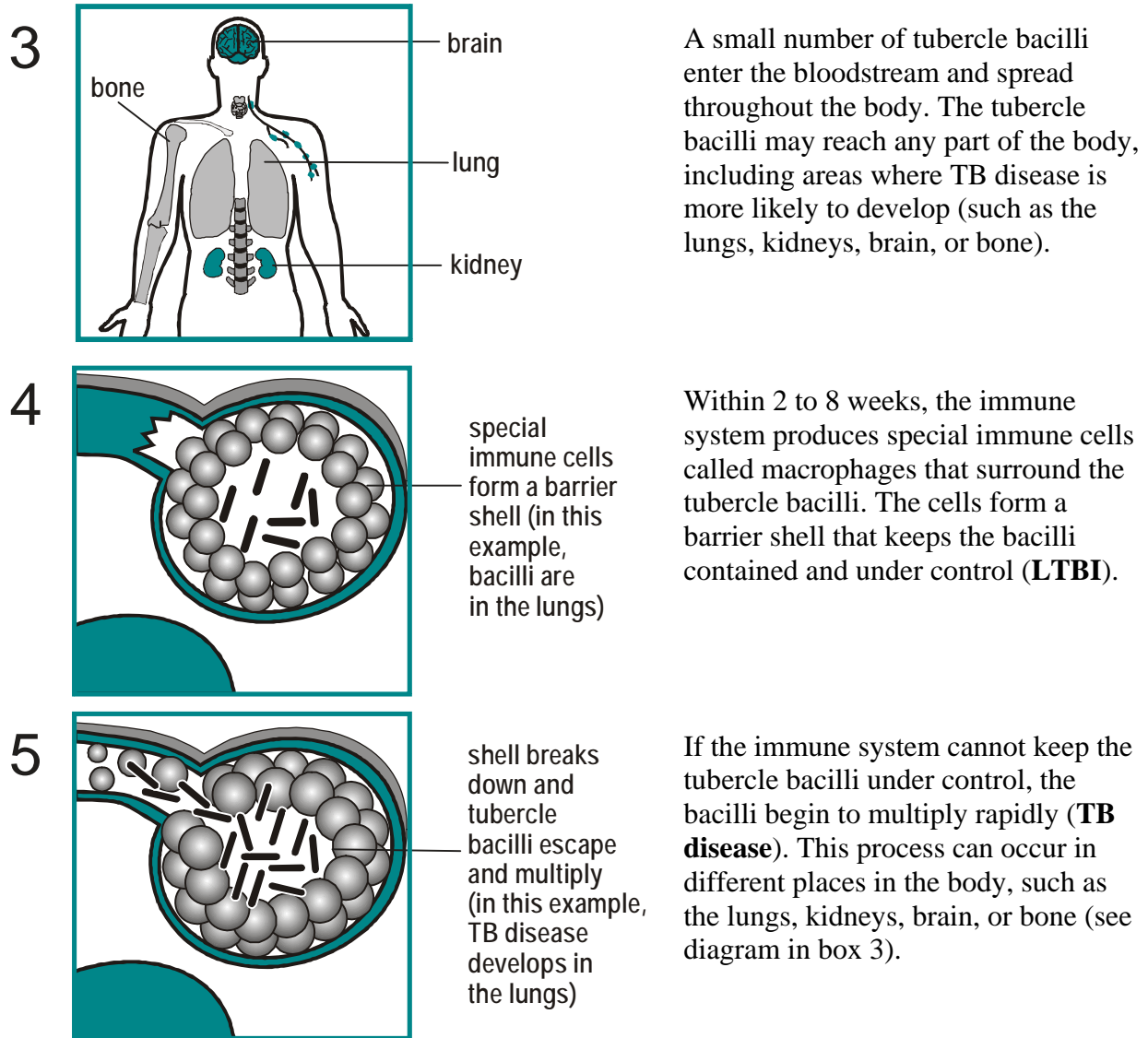


Figure 1.4 Pathogenesis of LTBI and TB disease (continued).

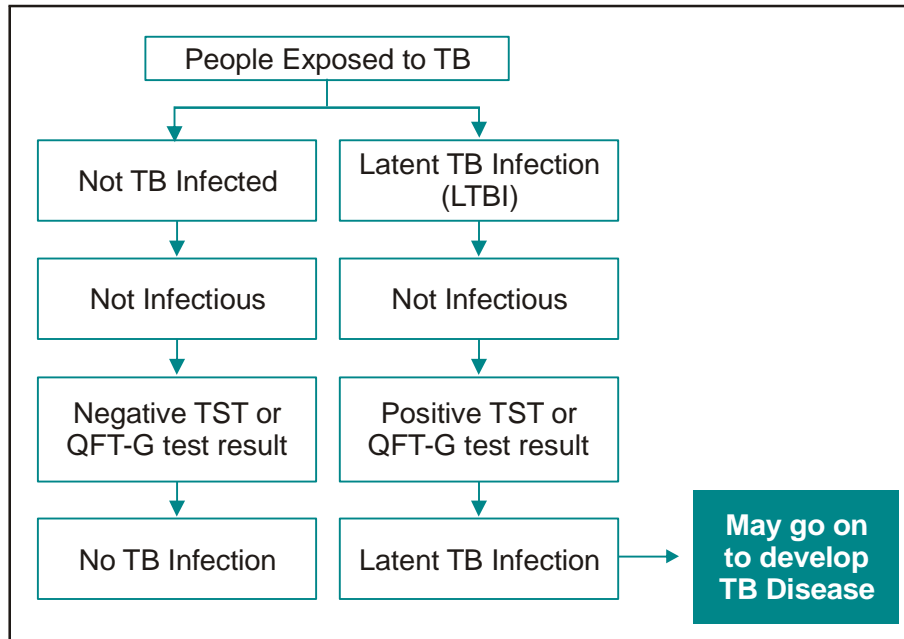


Figure 1.5 Progression of TB. People who are exposed to TB may or may not develop TB infection. People with LTBI may or may not develop TB disease.

.....
 The risk of developing TB disease is highest in the first 2 years after infection.

Because about half the risk of developing TB disease is concentrated in the first 2 years after infection, it is important to detect new infection early. People with LTBI can be given treatment to prevent them from getting TB disease. This is discussed in *Module 4, Treatment of Latent Tuberculosis Infection and Tuberculosis Disease*. Thus, detecting new infection early helps prevent new cases of TB. Table 1.1 shows the major similarities and differences between LTBI and TB disease.



.....
Some conditions increase the risk that LTBI will progress to disease.
.....

Some conditions increase the risk that LTBI will progress to disease. The risk may be about 3 times higher (as with diabetes) to more than 100 times higher (as with **human immunodeficiency virus** [HIV] infection) for people who have these conditions than for those who do not. Some of these conditions that increase the risk are

- Infection with HIV
- Chest x-ray findings suggestive of previous TB
- Substance abuse (especially illegal injection drug use)
- Recent TB infection (within the past 2 years)
- Prolonged therapy with corticosteroids and other immunosuppressive therapy, such as prednisone and tumor necrosis factor-alpha [TNF- α] antagonists
- Organ transplant
- Silicosis
- Diabetes mellitus
- Severe kidney disease
- Certain types of cancer (e.g., leukemia, Hodgkin's disease, or cancer of the head and neck)
- Certain intestinal conditions
- Low body weight (10% or more below ideal)

For definitions of some of these terms, please see the Glossary or the New Terms section at the beginning of this module.



Transmission and Pathogenesis of TB

.....
 People who are infected with both *M. tuberculosis* and HIV are much more likely to develop TB disease than people who are infected only with *M. tuberculosis*.

When the immune system is weakened, the body may not be able to control the multiplication and spread of tubercle bacilli. For this reason, people who are infected with both *M. tuberculosis* and HIV are much more likely to develop TB disease than people who are infected only with *M. tuberculosis*. The risk of developing TB disease is 7% to 10% **each year** for people who are infected with both *M. tuberculosis* and HIV, whereas it is 10% **over a lifetime** for people infected only with *M. tuberculosis*. For people with LTBI and diabetes, the risk is 3 times as high, or about 30% over a lifetime (Figure 1.6).

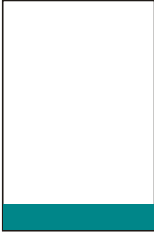
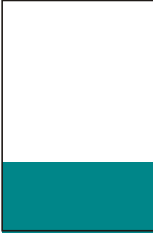
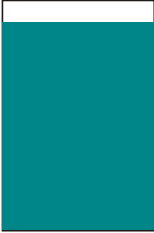
TB infection and no risk factors (about 10% over a lifetime)	TB infection and diabetes (about 30% over a lifetime)	TB infection and HIV infection (a very high risk over a lifetime)
		
For people with TB infection and no risk factors , the risk is about 5% in the first 2 years after infection and about 10% over a lifetime.	For people with TB infection and diabetes , the risk is 3 times as high, or about 30% over a lifetime.	For people with TB infection and HIV infection , the risk is about 7% to 10% PER YEAR, a very high risk over a lifetime.

Figure 1.6 Risk of developing TB disease over a lifetime.

In an HIV-infected person, TB disease can develop in either of two ways. First, a person with LTBI can become infected with HIV and then develop TB disease as the immune system is weakened. Second, a person who has HIV infection can become infected with *M. tuberculosis* and then rapidly develop TB disease.



Case Study 1.2

A 45-year-old woman is referred to the health department by her private physician because she was found to have LTBI. She is an obese woman who has high blood pressure and heart problems. Upon further questioning, she reports that she has injected illegal drugs in the past but has never been tested for HIV infection.

- **What conditions does this woman have that increase the risk that she will develop TB disease?**

Answers to case study questions are on page 34.



Sites of TB Disease

.....
Pulmonary TB occurs in
the lungs.
.....

TB disease can occur in different places in the body (Figure 1.7). **Pulmonary TB** is TB that occurs in the lungs. Most TB cases are pulmonary. Patients with pulmonary TB usually have a cough and an abnormal chest x-ray, and they should be considered infectious until they meet certain criteria (see *Module 5, Infectiousness and Infection Control*).

.....
Extrapulmonary TB occurs in
places other than the lungs.
.....

Extrapulmonary TB occurs in places other than the lungs, such as the larynx, the lymph nodes, the pleura (the membrane surrounding each lung), the brain, the kidneys, or the bones and joints. Extrapulmonary TB occurs more often in HIV-infected or other immunosuppressed persons, or young children. In HIV-infected people, extrapulmonary TB is often accompanied by pulmonary TB. Most types of extrapulmonary TB are not considered infectious (this will be discussed in *Module 5, Infectiousness and Infection Control*).

.....
Miliary TB occurs when
tubercle bacilli enter the
bloodstream and are carried to
all parts of the body, where
they grow and cause disease in
multiple sites.
.....

Miliary TB occurs when tubercle bacilli enter the bloodstream and are carried to all parts of the body, where they grow and cause disease in multiple sites. This condition, which is rare but very serious, is called miliary TB because the chest x-ray has the appearance of millet seeds scattered throughout the lung.

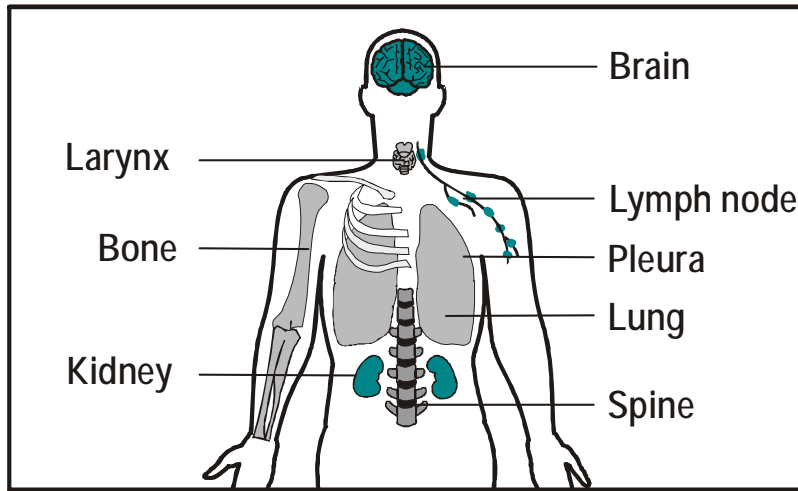


Figure 1.7 Common sites of TB disease.

Classification System

.....
 The current classification
 system is based on the
 pathogenesis of TB.

Many systems have been used to classify people who have TB. The current classification system (Table 1.3) is based on the pathogenesis of TB. Many health departments and private health care providers use this system when describing patients. Thus, it is important for public health workers to be familiar with this system. In particular, public health workers should be aware that any patient with a classification of 3 or 5 should be receiving treatment for TB, and the case or suspected case should be reported promptly to the local or state health department.



Table 1.3
Classification System for TB

Class	Type	Description
0	No TB exposure Not infected	No history of TB exposure Negative result to a TST or to a QFT-G
1	TB exposure No evidence of infection	History of TB exposure Negative result to a TST (given at least 10 weeks after exposure) or to a QFT-G
2	TB infection No TB disease	Positive result to a TST or to a QFT-G Negative smears and cultures (if done) No clinical or x-ray evidence of active TB disease
3	TB, clinically active	Positive culture (if done) for <i>M. tuberculosis</i> Positive result to a TST or to a QFT-G, and clinical, bacteriological, or x-ray evidence of TB disease
4	Previous TB disease (not clinically active)	Medical history of TB disease Abnormal but stable x-ray findings Positive result to a TST or to a QFT-G Negative smears and cultures (if done) No clinical or x-ray evidence of current TB disease
5	TB suspected	Signs and symptoms of TB disease, but evaluation not complete



Study Questions 1.16–1.17

1.16 What part of the body is the most common site for TB disease? What are some other common sites?

1.17 What is the classification system for TB based on? What is it used for?

Answers to study questions are on pages 30 – 33.



SUMMARY

TB has affected humans for centuries. Until the 1940s and 1950s, there was no antibiotic treatment for TB. Many people with TB were sent to sanatoriums, special rest homes where they followed a prescribed routine every day. After anti-TB drugs were discovered, many people with TB were treated, and the death rate for TB dropped dramatically.

TB is caused by an organism called *Mycobacterium tuberculosis* that is spread from person to person through the air. *M. tuberculosis* organisms are also called tubercle bacilli. When a person with infectious TB disease coughs, sneezes, speaks, or sings, droplet nuclei containing tubercle bacilli may be expelled into the air. Other people may inhale the air containing these droplet nuclei and become infected.

Drug-resistant TB is caused by *M. tuberculosis* organisms that are resistant to at least one of the first-line TB treatment drugs. Drug-resistant TB can be transmitted person to person; this is referred to as primary resistance. Secondary resistance develops during TB treatment, either because the patient was not treated with an appropriate regimen or because the patient did not follow the treatment regimen as prescribed.

Drug-resistant TB can be **mono-resistant** if the tubercle bacilli are resistant to any one TB treatment drug, or **poly-resistant** if resistant to at least two TB drugs (but not both isoniazid and rifampin). A patient is diagnosed with **multidrug-resistant TB (MDR TB)** if the tubercle bacilli are resistant to at least isoniazid and rifampin, the two best first-line TB treatment drugs. A patient is diagnosed with **extensively drug-resistant TB (XDR TB)** if the tubercle bacilli are resistant to isoniazid and rifampin, plus resistant to any fluoroquinolone and at least one of three injectable second-line drugs (such as amikacin, kanamycin, or capreomycin).

TB infection begins when the tubercle bacilli multiply in the small air sacs of the lungs. A small number enter the bloodstream and spread throughout the body, but the body's immune system usually keeps the bacilli under control. People with latent TB infection (LTBI) do not have symptoms of TB, and they cannot spread TB to others. They usually have a positive reaction or result to the Mantoux tuberculin skin test (TST) or the QuantiFERON[®]-TB Gold test (QFT-G).

In some people with LTBI, the immune system cannot keep the tubercle bacilli under control and the bacilli begin to multiply rapidly, resulting in TB disease. This can happen very soon after infection or many years after infection. About 10% of people with LTBI will develop disease at some point, but the risk is greatest in the first year or two after infection. Also, the risk is higher for people with certain medical conditions, such as HIV infection, than for other people.

TB disease usually occurs in the lungs (pulmonary TB), but it can also occur in other places in the body (extrapulmonary TB). Miliary TB occurs when tubercle bacilli enter the bloodstream and are carried to all parts of the body, where they grow and cause disease in multiple sites.



Additional Reading

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ANSWERS TO STUDY QUESTIONS

1.1 In what year was each of the following discoveries made? (page 5)

- a. TB was proven to be contagious _____ 1865 _____
- b. The bacterium that causes TB was discovered _____ 1882 _____
- c. The first drug that could kill TB bacteria was discovered _____ 1943 _____

1.2 What organism causes TB? What are four other tuberculous mycobacteria? (page 8)

TB is caused by an organism called *Mycobacterium tuberculosis*. *M. bovis*, *M. africanum*, *M. microti*, and *M. canetti* are four other tuberculous mycobacteria.

1.3 How is TB spread? (page 8)

TB is spread from person to person through the air. When a person with infectious TB disease coughs, sneezes, speaks, or sings, tiny particles containing *M. tuberculosis* may be expelled into the air. These particles, called droplet nuclei, are about 1 to 5 microns in diameter — less than 1/5000 of an inch. Droplet nuclei can remain suspended in the air for several hours, depending on the environment.

1.4 The probability that TB will be transmitted depends on what four factors? (page 9)

- How infectious or contagious is the TB patient?
- In what kind of environment did the exposure occur?
- How long did the exposure last?
- How virulent (strong) is the tubercle bacilli?

1.5 What is drug-resistant TB? (page 10)

Drug-resistant TB is caused by *M. tuberculosis* organisms that are resistant to at least one first-line TB treatment drug. Drug-resistant TB can be difficult to treat.

1.6 What is the difference between primary and secondary drug-resistant TB? (page 10)

Primary resistance is caused by person-to-person transmission of drug-resistant organisms. Secondary resistance develops during TB treatment. Either the patient was not treated with the right TB drugs or the patient did not properly follow the prescribed treatment regimen.



1.7 When a person inhales air that contains water droplets containing *M. tuberculosis*, where do the droplet nuclei go? (page 12)

Most of the larger droplets become lodged in the upper respiratory tract, where infection is unlikely to develop. However, the droplet nuclei may reach the small air sacs of the lung (the alveoli), where infection begins.

1.8 After the tubercle bacilli reach the small air sacs of the lung (the alveoli), what happens to them? (page 12)

At first, the tubercle bacilli multiply in the alveoli and a small number enter the bloodstream and spread throughout the body. Bacilli may reach any part of the body, including areas where TB disease is more likely to develop. These areas include the upper portions of the lungs, as well as the kidneys, the brain, and bone. Within 2 to 8 weeks, however, the body's immune system usually intervenes, halting multiplication and preventing further spread.

1.9 In people with LTBI (but not TB disease) how does the immune system keep the tubercle bacilli under control? (page 13)

The immune system produces special immune cells that surround the tubercle bacilli. The cells form a shell that keeps the bacilli contained and under control.

1.10 How is LTBI detected? (page 13)

LTBI is detected by the Mantoux tuberculin skin test (TST) or an interferon-gamma release assay (IGRA) such as the QuantiFERON[®]-TB Gold test (QFT-G).

1.11 What are the major similarities and differences between LTBI and TB disease? List characteristics of each. (page 14)

LTBI

- Tubercle bacilli are inactive in the body.
- The TST and QFT-G results are usually positive.
- Usually the chest x-ray is normal.
- Sputum smears (or smears from other specimens) and cultures are negative.
- People with LTBI
 - Do not have symptoms (are not sick)
 - Are not infectious
 - Are not counted as being a case of TB

TB disease

- Tubercle bacilli are active in the body.
- The TST and QFT-G results are usually positive.
- Usually the chest x-ray is abnormal (if the disease is in the lungs).



- Sputum smears (or smears from other specimens) and cultures are usually positive for *M. tuberculosis*.
- People with TB disease
 - Usually have symptoms (are sick)
 - Are often infectious before treatment
 - Are counted as being a case of TB

1.12 What happens if the immune system cannot keep the tubercle bacilli under control and the bacilli begin to multiply rapidly? (page 17)

When this happens, TB disease develops. The risk that TB disease will develop is higher for some people than for others.

1.13 What percentage of people who have LTBI (but not HIV infection) usually develop TB disease? (page 17)

In the United States, about 5% of the people who have recently been infected with *M. tuberculosis* will develop TB disease in the first year or two after infection. Another 5% will develop disease later in their lives. In other words, about 10% of all people who have LTBI will develop disease at some point. The remaining 90% will stay infected, but free of disease, for the rest of their lives.

1.14 What conditions appear to increase the risk that LTBI will progress to disease? (page 20)

- HIV infection
- Chest x-ray findings suggestive of previous TB
- Substance abuse (especially injection of illegal drugs)
- Recent TB infection (within the past 2 years)
- Prolonged therapy with corticosteroids and other immunosuppressive therapy, such as prednisone and TNF- α antagonists
- Silicosis
- Diabetes mellitus
- Severe kidney disease
- Certain types of cancer (e.g., leukemia, Hodgkin's disease, or cancer of the head and neck)
- Certain intestinal conditions
- Low body weight (10% or more below ideal)



1.15 How does being infected with both *M. tuberculosis* and HIV affect the risk for TB disease? (page 21)

Because their immune systems are weakened, people who are infected with both *M. tuberculosis* and HIV are much more likely to develop TB disease than people who are infected only with *M. tuberculosis*. Studies suggest that the risk of developing TB disease is 7% to 10% each year for people who are infected with both *M. tuberculosis* and HIV, whereas it is 10% over a lifetime for people infected only with *M. tuberculosis*.

In an HIV-infected person, TB disease can develop in either of two ways. First, a person with LTBI can become infected with HIV and then develop TB disease as the immune system is weakened. Second, a person who has HIV infection can become infected with *M. tuberculosis* and then rapidly develop TB disease.

1.16 What part of the body is the most common site for TB disease? What are some other common sites? (page 24)

- Lungs are the most common site.

Other common sites:

- Larynx
- Lymph nodes
- Pleura (the membrane surrounding the lungs)
- Brain
- Kidneys
- Bones and joints

1.17 What is the classification system for TB based on? What is it used for? (pages 25–26)

The current classification system is based on the pathogenesis of TB. Many health departments and private health care providers use this system when describing patients.



ANSWERS TO CASE STUDIES

1.1 A 30-year-old man visits the health department for a tuberculin skin test because he is required to have one before starting his new job. He has a positive reaction to the tuberculin skin test. He has no symptoms of TB, and his chest x-ray findings are normal.

■ **Should this be considered a case of TB?**

The man described above has TB infection, but he has no evidence of TB disease. Therefore, this is not a case of TB.

■ **Should this man be considered infectious?**

No, he should not be considered infectious. This man has LTBI, not TB disease. People with TB infection and no evidence of TB disease are not infectious.

1.2 A 45-year-old woman is referred to the health department by her private physician because she was found to have LTBI. She is an obese woman who has high blood pressure and heart problems. Upon further questioning, she reports that she has injected illegal drugs in the past but has never been tested for HIV infection.

■ **What conditions does this woman have that increase the risk that she will develop TB disease?**

One condition is injection of illegal drugs. This condition increases the risk that LTBI will progress to TB disease. Another possible condition is HIV infection. This woman is at risk for HIV infection, which is the strongest known risk factor for developing TB disease. This woman should be offered HIV counseling, testing, and referral.

Obesity, high blood pressure, and heart problems are NOT risk factors for TB disease.