

PREGNANCY & TUBERCULOSIS (TB) FREQUENTLY ASKED QUESTIONS

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Do I place a PPD on all pregnant women?

Target pregnant women for tuberculin skin testing only if they have a specific risk factor for Latent Tuberculosis Infection (LTBI). For more information, see Sonoma County LTBI guidelines at www.sonoma-county.org/tb. Prenatal care may be the only time many women with the following risk factors for TB have access to health screening:

- Foreign-born persons from endemic TB countries
- Women with medical risk factors for TB reactivation (diabetes, malnutrition, HIV, taking immunosuppressive drugs, renal dialysis, renal failure, or cancer)
- Symptomatic women with unexplained chronic cough or weight loss
- Residents and employees of high-risk congregate settings (prisons, jails, health care facilities, homeless shelters, substance abuse treatment facilities)
- Homeless individuals, injection drug users
- Contacts to active TB cases

My pregnant patient has a positive PPD and is asymptomatic. Do I need an X-Ray?

A positive PPD (aka. TB skin test (TST)) suggests TB infection and you need to rule out active disease. An undiagnosed untreated woman with active infectious TB has a very high chance of transmitting TB to her neonate. Providers should keep in mind that fatigue, shortness of breath, sweating and tiredness can easily be attributed to the pregnancy.

Does Medi-Cal (and other insurance) reimburse for Chest radiograph (X-Ray)?

Yes. Use ICD-9 code 795.5 for “Tuberculin Skin Test Reactor”.

When should I obtain a screening X-Ray in a PPD+ pregnant patient?

Pregnancy should not preclude usual diagnostic evaluation to rule out active TB. Symptomatic women should be screened as soon as possible. Asymptomatic women should be screened much before third trimester, as early as 15 weeks gestation.

What about the risk of radiation to the fetus for a screening radiograph?

The fetal radiation exposure for a two-view chest radiograph with shielding is 0.1mGy, ten times lower than the nine month cumulative dose of environmental background radiation (1 mGy). The risk of fetal abnormality is considered to be negligible at 50 mGy. The risk of malformations is significantly increased only at doses above 150mGy.

Can't I wait to get a chest X-Ray after delivery?

For the patient's health as well as the risk of transmission to others in health care settings,

it is best obtain the chest radiograph prior to admission to labor and delivery units and dental offices. Obtaining routine X-Rays to rule out active TB can avoid technical limitations of radiographs done in late pregnancy and the immediate postpartum period.

After I've ruled out active TB, when do I start treatment for LTBI?

Pregnant women with documented skin test conversion in the last 24 months (i.e., converters) or pregnant women with HIV infection should start LTBI treatment as soon as possible, even in the first trimester, because progression of LTBI to active disease can endanger both the mother and baby

In contrast, immunocompetent pregnant women with LTBI without documented TST conversion in the last 24 months (i.e., reactors) generally can start LTBI treatment at their 6-week post-partum visit.

When do I need to refer my patient with LTBI to the TB clinic?

Call the TB clinic anytime for technical assistance in evaluating and treating LTBI. Remember that any active TB suspect or case must be reported within one day. Limited funding is available for the TB clinic to see patients with LTBI who have no insurance or no other payment source.

Is Isoniazid (INH) safe?

Isoniazid (INH) is a well-studied and safe medication that has been used for over 50 years. Adequate LTBI treatment reduces your lifetime risk of developing active TB by 90%. The risk for INH-related toxicity must be weighed against the risk for a mother and the child developing active TB disease.

What about the risks of INH to the post-partum mother?

All patients with LTBI on INH should be seen monthly to check adherence and for side effects. Because there may be an increased risk of INH-associated hepatitis during pregnancy and the immediate post-partum period, obtain AST or ALT and Bilirubin at baseline and monthly for post-partum women taking INH for up to three months post-partum. Post-partum mothers should be offered Pyridoxine 50mg/day to reduce the risk of peripheral neuropathy.

What about the risks of INH to the breastfeeding infant?

Breastfeeding is encouraged, even when the mother is being treated for LTBI. About 2% of the maternal dose of INH is secreted into the milk. This small concentration of INH in breast milk has not been reported to cause problems in nursing babies.

References: www.cdc.gov/tb "Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection" MMWR June 9, 2000

"Imaging the Pregnant Patient for Nonobstetric Conditions: Algorithms and Radiation Dose Considerations". RadioGraphics 2007 27: 1705-1722