MA Advanced LTBI ECHO Session Summary #1
1/11/24

1. **It is not recommended to use a different test modality to "confirm" prior testing** (that is, to use IGRA to confirm TST or vice versa). Sensitivity of TST vs. IGRA are similar, while specificity for TST is lower than IGRA (more false positives). In this patient's case, we have two prior negative TSTs. Given that the patient's country of origin (Ghana) is a high-incidence country, the likelihood that this TST represents a true positive is high; we can diagnose her with LTBI based on this test and do not need an IGRA to confirm.

2. **TST cross-reactivity with BCG typically wanes in childhood/adolescence.** This patient's TST is very unlikely to be a false positive, both because cross-reactivity of TST with BCG tends to fade in childhood, and because she has had 2 prior negative TSTs. IGRA does not cross-react with BCG, but again, we don't need to check an IGRA to confirm this test. If you are ever uncertain about someone's BCG status, you can check BCG atlas (https://www.bcgatlas.org/index.php).

3. **Patient communication can be a challenge when there are doubts as to LTBI diagnosis.** Strategies to try include building rapport and showing understanding of the significant stigma attached to LTBI/TB disease; providing patients with materials to read and learn about LTBI after your appointment, as well as ample opportunity to ask questions; empathizing with the fact that LTBI is often quite common in patients' countries of origin; and framing treatment as a preventive strategy to help keep patients well.

4. **Treatment options for this patient are limited by drug interaction between RIF/Nexplanon.** Rifampin can reduce the efficacy of all hormonal contraceptives, so isoniazid is a safer choice for her as it does not interact with her Nexplanon.