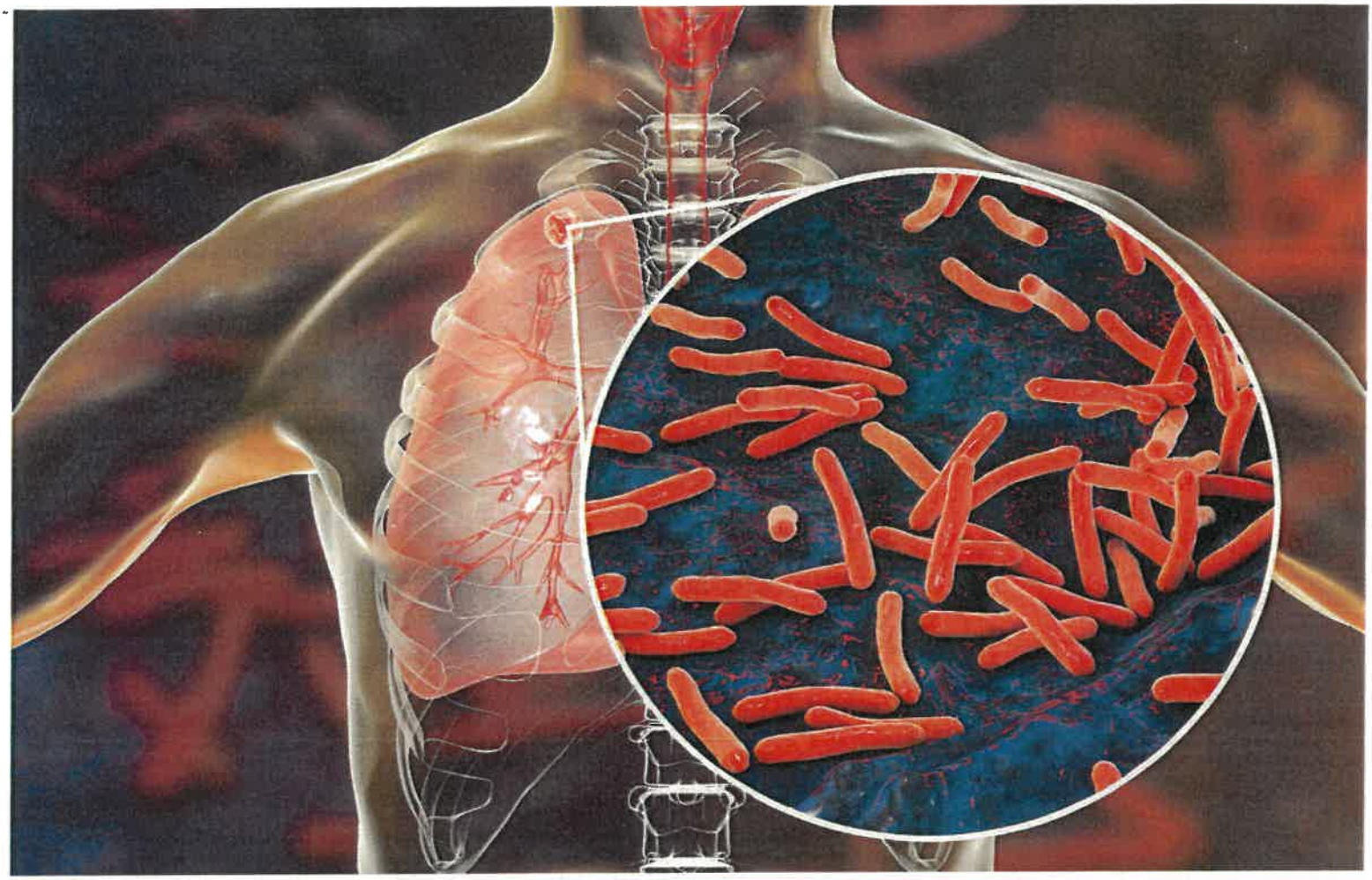

Tuberculosis Clinical Practice Guidelines

ICE Health Service Corps

U.S. Immigration and Customs Enforcement

FOREWORD

These clinical guidelines provide medical providers at IHSC-staffed facilities with general information for managing patients with tuberculosis. The U.S. Immigration and Customs Enforcement (ICE) Clinical Services Division authors and maintains the Tuberculosis Clinical Guidelines. These guidelines apply to all ICE Health Service Corps (IHSC) personnel, including but not limited to U.S. Public Health Service (PHS) officers, civil service employees, and contract personnel.

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DISCLAIMER

The IHSC Clinical Services Division establishes clinical guidelines to provide medical providers at IHSC-staffed facilities with general information for patient management. Guidelines are not statements of policy. Medical providers should consider each case individually, in the context of good clinical judgment and within the provider's experience and comfort level. This guidance does not create any right or benefit, substantive or procedural, enforceable by law by any party in any administrative, civil, or criminal matter.

The following is guidance based on American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America 2016 Practice Guidelines and 2024 Updates. IHSC will update its guidance periodically to align with national guidelines, peer reviewed publications, and agency data. Please consult with clinical leadership as needed. The Infectious Disease Program is always available for formal consultation.

The terms "provider" or "medical provider" in this guidance refer specifically to physicians or advanced practice providers (APPs). The term "patient" refers to aliens in custody.

BACKGROUND

Tuberculosis (TB) remains one of the world's most formidable infectious disease threats due to its transmission, potential for long latency, adaptable clinical manifestations, and emerging drug resistance. The World Health Organization (WHO) estimates a quarter of the global population has a *Mycobacterium tuberculosis* infection, and about 5-10% of people infected with TB will eventually develop active TB disease. Most TB disease cases occur in developing countries, with a disproportionate effect on low-resource, disadvantaged populations.[1]

WHO estimated 10.8 million people fell ill to TB in 2023, and about 1.25 million died.[2] The U.S. has a low incidence of TB disease, and most infections occur in people born outside the U.S.[3] Furthermore, aliens tend to wait longer to see a doctor after experiencing TB symptoms compared to U.S. citizens. This suggests an increased risk for negative outcomes for aliens due to a more advanced disease before starting treatment, as well as an increased risk to public health in terms of disease transmission.[4]

For a subset of aliens in law enforcement custody, early screening for TB disease during intake into detention facilities is an opportunity for early detection and treatment of TB disease.[3]

Previously published surveillance data suggested detained aliens have a 2.5 times higher rate of TB disease compared to the overall alien population in the United States.[3,4,5] Furthermore, over 75% of detained aliens may be asymptomatic at intake, making chest X-ray a best practice for TB disease detection.[4,5] Given multiple risk factors for TB disease among detained aliens, and the potential for spread in the congregate setting, health services staff must identify, isolate, and treat detained aliens with TB. [a]

[a] Congregate Setting: Setting in which a group of individuals reside, meet, or gather either for a limited or extended period in close physical proximity such as in detention

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1. Abbreviations

AFB – Acid fast bacilli

APP – Advanced practice provider

CBC – Complete blood count

CMP – Comprehensive metabolic panel

CXR – Chest X-ray

DST – Drug susceptibility testing

EMB – Ethambutol

IGRA – Interferon-gamma release assay

INH – Isoniazid

IPO – Infection prevention officer

MHU – Medical housing unit

MTB – Mycobacterium tuberculosis

NAA – Nucleic acid amplification

PPD – Purified protein derivative

PZA – Pyrazinamide

RIF – Rifampin

RIPE – Rifampin, isoniazid, pyrazinamide, ethambutol.

RPT-MOX – Rifapentine, moxifloxacin, isoniazid, pyrazinamide

TB – Tuberculosis

TST – Tuberculin skin test

2. Step-By-Step Procedures

The sections below provide step-by-step procedures to guide each stage of the patient's evaluation. The procedures align with eCW templates and order sets available for provider use. Please see Appendix A for an abbreviated guide to diagnostic orders by visit.

3. Initial Appointment

3.1. If the intake symptom screen is positive, or the CXR meets Category A or B criteria (See Appendix B), house the patient individually in respiratory isolation/medical hold.[b]

3.2. If no respiratory isolation rooms are available, send the patient to a local hospital for evaluation and admission. Consider hospital admission for patients with pleural effusion to receive diagnostic thoracentesis.

3.3. Recommend using eCW TB template and order set (initial and medical housing unit (MHU) admission).

3.4. Obtain a TB history including prior exposure, diagnosis, and treatment. If the patient has a history of treatment for TB in the past several years:

3.4.1. APPs should consult with a physician proficient in TB care or the Infectious Disease Program to assess risk of drug resistance or treatment failure.

3.4.2. If treated in the U.S., request records including prior smears, cultures, and DST.

3.4.3. If treated in the U.S., request a compact disc (CD) for the end of treatment CXR.

3.4.4. Once received, ask the IHSC radiology vendor to perform a direct comparison reading to the IHSC admission CXR (Appendix E).

3.5. Conduct a review of systems; must include respiratory and constitutional.

3.6. Order baseline labs: CBC, CMP, HgbA1c, HIV Ab. Use the eCW order sets as guidance.

3.7. Recommend vitamin D 25-OH level (replete if low) for those with smear positive, cavitary, or extensive disease.

[b] Symptom screen positive if patient reports any of the following symptoms lasting two weeks or more: cough, chest pain, hemoptysis (bloody cough), unexplained weight loss, night sweats, fever, loss of appetite.

3.8. Order three consecutive sputum specimens eight to 24 hours apart with hypertonic saline for induction.

3.8.1. One with an AFB smear and culture.

3.8.2. A second AFB smear and culture.

3.8.3. A third AFB smear and culture with an MTB NAA with RIF if possible. Collect this smear before the morning meal.

3.8.4. If the patient produces copious purulent sputum, collect without induction.

3.9. Order a TST or PPD, unless documented positive in the past. The IGRA is an alternative.

3.10. Counsel the patient about their possible TB diagnosis. Until diagnosis is known, the patient must isolate to protect others. See IHSC TB Patient Education Pamphlet under Patient Resources and TB Patient Education Flip Chart under Provider Resources on the Infectious Disease Program SharePoint Page.

3.11. If a patient meets Category B criteria only (See Appendix B), discharge them from respiratory isolation after sputum induction. There is no need to wait for AFB smear results. Empiric RIPE/B6 or RPT-MOX is not indicated.

3.12. If patient meets Category A criteria (See Appendix B), initiate weight based RIPE/B6 or RPT-MOX (See Appendix C) after health care staff collect the third sputum specimen. Consult the pharmacist for dosing and drug-drug interaction questions.

3.13. Order baseline Snellen/Ishihara to assess for red-green color deficiency. Health services staff should document results for Ishihara as "plates correct / plates in book." The eCW has templates to guide Ishihara test entry.

3.14. Inform the infection prevention officer (IPO), or designee, for IHSC to complete its required report to the local health department within 24 hours and enroll the patient into CureTB.

3.15. Update problem list (See Appendix D).

3.16. Please visit TB Flowcharts, a reference on TB processes.

4. FOLLOW-UP APPOINTMENT: ISOLATION

4.1. Minimum - weekly MHU/respiratory isolation appointments.

4.2. Review all labs including smears/NAA. The lab must collect and accession all three sputum specimens. Discuss positive smears/NAA with a physician experienced in TB management.

4.3. If all three initial smears are AFB negative (even if the NAA is positive), the patient received five days of RIPE/B6 or RPT-MOX, and you do not suspect drug resistance, discharge to general population (GP), and clear them for travel.

4.3.1. If any smear is positive and confirmed by NAA to be MTB complex, order and perform another set of three sputum specimens (no NAA) 10-14 days from start of RIPE/B6 or RPT-MOX (14 days if initial smears were >1+) and continue respiratory isolation.[5]

4.3.2. If NAA is negative for MTB (on the same sputum which is at least 1+ for AFB), discharge to GP, defer RIPE/B6 or RPT-MOX and follow cultures. Consult with a physician experienced with TB management.

4.3.3. Order vitamin D 25-OH level and replete if deficient.

4.3.4. If the three smears collected 14 days after start of RIPE/B6 or RPT-MOX are AFB negative, and you do not suspect drug resistance (including a neg RIF [rpoB] on NAA test), discharge the patient to general population.

4.3.5. If one or more smears collected 14 days after the start of RIPE/B6 or RPT-MOX are AFB positive, continue respiratory isolation. Repeat three sputum specimens with AFB smear/culture every one to two weeks until all three are negative.

4.3.6. Once three consecutive smears are negative and you do not suspect drug resistance, discharge the patient to GP.

4.4. Assess for and document drug reactions.

4.4.1. Health services staff must discuss drug reactions with a pharmacist or physician.

4.4.2. Common drug reactions include gastrointestinal (GI) intolerance, rash, transaminitis, and fever.

4.5. Obtain weekly weights, and if weight changes, assess need for drug dose changes.

4.6. Document TST result to the nearest millimeter.

4.7. If baseline labs are normal, order CBC and LFTs for one month later.

4.7.1. If abnormal, consult with a physician on the next testing interval, additional clinically indicated tests, or any adjustments in treatment.

4.7.2. If HIV Ab is positive, consult a physician familiar with HIV/TB coinfection.

4.8. Review Snellen/Ishihara.

4.9. Order an induced sputum for AFB smear/culture for one month from the start of RIPE/B6 or RPT-MOX. Counsel patient on status and results of diagnostics.

4.10. Health services staff initiate enrollment in transnational referral program for continuity of care (CureTB). If not completed, coordinate with IPO or designee before discharge to GP.

4.11. Inform the patient that the local health department or transnational referral program may contact them to obtain information about their TB infection.

4.12. Schedule a single view CXR six weeks after the start of RIPE/B6 or RPT-MOX to compare with initial CXR.

4.13. Update problem list. See Appendix D for pertinent ICD-10 codes.

5. FOLLOW-UP APPOINTMENT: WHILE IN GENERAL POPULATION

5.1. Conduct monthly visits for aliens in GP.

5.2. Review all labs including AFB cultures, DST if culture positive, CBC, and LFTs.

5.3. Schedule monthly CBC/LFTs while on TB treatment.

5.4. Discuss positive AFB cultures with a physician experienced with TB management.

5.5. Assess for and document any drug reactions. Discuss possible drug reactions with a physician or pharmacist who manages complications of TB treatment.

5.6. Schedule monthly Snellen/Ishihara testing while on ethambutol and review results. Decrease in visual acuity or color differentiation should prompt further evaluation (e.g., off-site dilated eye exam).

5.7. Calculate and document the number of days of RIPE/B6 or RPT-MOX. Four drug therapy[c] should not exceed 56 days unless the patient has cultures positive for MTB, and you are waiting for DST results.

[c] Four drug therapy consists of either **INH, RIF, PZA, EMB** or **RPT, MOX, INH, PZA**

5.8. If AFB cultures are positive for MTB, do not stop four drug therapy until DST is available. If DST takes longer than two weeks from the time of positive culture growth, consult with the Infectious Disease Program to investigate the delay.

5.9. Review the six-week CXR result and compare to the original CXR.

5.10. Weigh patients monthly, and if the patient's weight changes, assess the need to change drug doses.

5.11. Update the local health department and CureTB if you confirm or exclude diagnosis.

5.12. Counsel patient on status of diagnosis. A TB Education Flipchart, located in Provider Resources in the TB folder, is available in more than a dozen different languages.

5.13. Update problem list.

5.14. If health services staff finalize AFB cultures as negative, and CXR comparison results are available, health services staff decide whether to continue treatment (continuation phase).

5.15. If the cultures are negative and the CXR is unchanged, discontinue four drug treatment. *This would be your final visit with respect to this TB assessment.*

5.16. If initial cultures are negative, but the CXR has improved or symptoms resolved after starting treatment, this is a confirmed case of Class 3 Culture Negative TB.

5.16.1. If on RIPE/B6 regimen:

- The patient should be on at least eight weeks of four drug therapy. After eight weeks, stop EMB and PZA and continue INH/RIF/B6 for eight more weeks (for a total of 16 weeks of TB treatment).
- If the CXR has cavitary changes or significant fibrosis, continue treatment for a total of 26 weeks (eight weeks of four drug therapy + 18 weeks of INH/RIF/B6, just as if culture positive).

5.16.2. If on RPT-MOX regimen: The patient should be on at least eight weeks of four drug therapy. After eight weeks, Stop PZA and continue RPT/MOX/INH/B6 for nine more weeks (for a total of 17 weeks of TB treatment).

5.16.3. Continue to see the patient monthly until completion of treatment, including monthly CBC and LFTs.

5.16.4. Repeat a CXR after treatment is complete. This will become the patient's new baseline should they undergo assessment for TB in the future.

5.16.5. Counsel the patient on the possibility of both relapse and reinfection in the future.

5.16.6. Assess any signs or symptoms of TB immediately.

5.17. If AFB cultures are MTB complex positive. [d]

5.17.1. Co-manage this patient with a physician experienced in TB treatment or the Infectious Disease Program.

5.17.2. If on RIPE/B6 regimen: The minimum duration of treatment for drug-sensitive MTB is 26 weeks (eight weeks of four drug + 18 weeks of RIF/INH/B6). A physician well versed in TB management should determine treatment duration.

5.17.3. If on RPT-MOX regimen: The minimum duration of treatment for drug-sensitive MTB is 17 weeks (eight weeks of four drug + nine weeks of RPT/MOX/INH). A physician well versed in TB management should determine treatment duration.

5.17.4. Ensure health services staff report DST 2-3 weeks after initial positive culture.

- If not reported, please contact the Infectious Disease Program to investigate further.
- If health services staff detect drug resistance, notify the Infectious Disease Program, and the Public Health, Safety, and Preparedness Unit.
- If unable to reach someone immediately, place the patient back into respiratory isolation/MHU until health services staff can assess the drug resistance and institute appropriate management.
- Inform CureTB since the patient's home country may not have second line drugs.

[d] Any species identified other than MTB are likely to be non-pathogenic; please discuss with a physician knowledgeable in this area.

- Health services staff should induce a single sputum for AFB smear/culture (ideally early morning before breakfast) monthly to assess for "culture conversion" (culture negative on treatment). Once cultures are negative, no further sputum specimens are necessary unless clinically indicated.

5.17.5. Repeat a CXR after treatment is complete. This will become the patient's new baseline should they require assessment for TB in the future.

5.17.6. Counsel the patient on the possibility of both relapse and reinfection in the future. Health services staff should assess any signs or symptoms of TB immediately.

5.17.7. Update the local health department and CureTB on the status of treatment.

6. References

1. World Health Organization. 2023. "Global Tuberculosis Report 2023." Www.who.int. November 7, 2023. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2023.
2. World Health Organization. 2024. "Tuberculosis." World Health Organization. October 29, 2024. https://www.who.int/news-room/fact-sheets/detail/tuberculosis.
3. Centers for Disease Control and Prevention. 2023. "Treatment for TB Disease." CDC. 2023. https://www.cdc.gov/tb/topic/treatment/tbdisease.htm.
4. Schneider, Diana L., and Mark N. Lobato. 2007. "Tuberculosis Control among People in U.S. Immigration and Customs Enforcement Custody." American Journal of Preventive Medicine 33 (1): 9–14. https://doi.org/10.1016/j.amepre.2007.02.044.
5. Achkar, Jacqueline M., Tsering Sherpa, Hillel W. Cohen, and Robert S. Holzman. 2008. "Differences in Clinical Presentation among Persons with Pulmonary Tuberculosis: A Comparison of Documented and Undocumented Foreign-Born versus US-Born Persons." Clinical Infectious Diseases 47 (10): 1277–83. https://doi.org/10.1086/592572.
6. Boardman, Nicole J, Tiffany Moore, Jennifer Freiman, Geri Tagliaferri, Dakota McMurray, Diana Elson, and Edith Lederman. 2020. "Pulmonary Tuberculosis Disease among Immigrant Detainees: Rapid Disease Detection, High Prevalence of Asymptomatic Disease, and Implications for Tuberculosis Prevention." Clinical Infectious Diseases, April. https://doi.org/10.1093/cid/ciaa434.

7. Additional Resources:

1. *Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics*, available in the IHSC Policy Library.
2. ATS/CDC/IDSA 2016 TB Clinical Practice Guidelines: https://www.cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf.

APPENDIX A - DIAGNOSTIC ORDERS BY VISIT

	CXR	PPD or IGRA	HIV 4th gen	Hgba1c	CBC	CMP	LFTs	Snellen and Ishihara	Sputum AFB (induced)
Initial MHU visit	X	X	X	X	X	X		X	three (incl. one with MTB RIF NAA)
MHU 14-day visit, then every 7-14 days if remains smear +									three (no NAA) ONLY if initial were smear +
Four weeks					X		X	X	one
6-8 weeks	X				X		X	X	one
Monthly (Continuation phase)					X		X		one, ONLY if still waiting for culture conversion
End of treatment	X								

APPENDIX B –INITIAL TUBERCULOSIS MANAGEMENT BY SYMPTOM SCREENING AND RADIOGRAPHIC FINDINGS

Category A Patient	Category B Patient	Category C Patient
Initial management		
Airborne infection isolation + diagnostics [e] + empiric treatment	**Diagnostics; Airborne infection isolation only during sputum induction; no empiric treatment**	**No further work up; clear for GP/travel**
Symptom Screening and Radiographic findings		
Any of the following:	***No A criteria but any of the following:***	***No A or B criteria, could include...***
Positive symptom screen **(with or without** abnormal CXR)	Small pleural effusion/costophrenic angle (CPA) blunting	Apical pleural thickening
		Pneumonitis
Retraction and/or volume loss (Includes fibronodularity)	Uncalcified nodule(s) < 1 cm in size	Calcified nodule <= 1 cm
Infiltrate, opacity, density or mass, with or without nodularity, in any location of any size	Linear scar or platelike atelectasis	Bronchovascular markings
Moderate or large pleural effusion [f]	Hilar enlargement	Peribronchial cuffing
Cavity of any size/location	Calcified lesion > 1 cm (if "mass," consider non-con chest CT)	Non-pulmonary findings (e.g. broken rib)
Non-linear scarring		
Miliary infiltrates		
Uncalcified nodule ≥1 cm in size		

1. When an initial CXR is "positive" and a two-view study confirms findings, a provider must review the report to identify any findings consistent with **Category A**. If identified, proceed with full diagnostic evaluation, respiratory isolation, and empiric RIPR/B6 or RPT/MOX regimen.[e] **EXCEPTION**: Treat an upper lobe **Category A** lesion visualized on single view CXR, but not on the two- view, with full diagnostics, isolation, and empiric treatment.
2. If CXR findings are inconsistent with **Category A**, the provider should review Category B. If the CXR report has any findings in Category B, proceed with full diagnostic evaluation, respiratory isolation to collect the sputa, and defer empiric TB

[e] Diagnostics: induced sputum every 8-24 hours x three (including one early AM, fasting) for AFB smear and culture, and at least one with MTB NAA (preferably with RIF molecular testing), CBC, CMP, HIV 4th generation screen, hgba1c, PPD (TST) or QFT.
[f] Patient should also undergo diagnostic thoracentesis.

treatment.[9] This applies to **UPPER LOBE** lesions in Category B visualized on the single view CXR, but not the two views. **Do not report these patients to the local health department, refer to CureTB, or enter into the TB Case Management Tracker**. If AFB smears, NAA, or cultures are positive, contact the Infectious Disease Program for further advisement.

3. If symptom screen and CXR findings are inconsistent with **Category A** or **Category B**, further work up is unnecessary. Clear the patient for general population or travel. Classify the findings as **Category C**. A non-inclusive list of "other" findings is in the table above. The provider should discuss with clinical leadership if unsure.
4. Review assessment of CXR findings in immunocompromised patients on an individual basis with clinical leadership. The table above details a non-inclusive list of "other" findings. If the provider is unsure, the provider should discuss with clinical leadership.

[9] Diagnostics: induced sputum every 8-24 hours x three (including one early AM, fasting) for AFB smear and culture, and at least one with MTB NAA (preferably with RIF molecular testing), CBC, CMP, HIV 4th generation screen, hgba1c, PPD (TST) or QFT.

APPENDIX C – RIPE/B6 AND RPT-MOX DOSING

1. Patients take TB medications once daily by mouth via directly observed pill line.
   - If on RIPE/B6 regimen (total 26 weeks or 182 doses):
     - Intensive phase: patients take INH/RIF/EMB/PZA/B6 for 56 days.
     - Continuation phase: patients take INH/RIF/B6 for 126 days. Renew PZA/EMB if still waiting for cultures and drug susceptibility testing results. Seek assistance from a pharmacist or the Infectious Disease Program if there are questions.
   - If on RPT-MOX[h] regimen (total 17 weeks or 119 doses):
     - Intensive phase: patients take RPT, MOX, INH, and PZA for 56 days.
     - Continuation phase: patients take RPT, MOX, and INH for 63 days.
2. Drug dosing information:[i]
   - Isoniazid: 5 mg/kg, **standard dose for adults is 300 mg**. Consider weight-based dosing for adults <40 kgs; seek guidance from pharmacy/ID.
   - Rifampin (RIF): 10 mg/kg, standard dose for adults is 600 mg. Consider weight-based dosing for adults<40 kgs however studies of high dose RIF have demonstrated (better) efficacy and safety; seek guidance from pharmacy/ID if you are considering a dose less than 600 mg.
   - Rifapentine (RPT): 1200 mg for persons ≥40 kg.
   - Moxifloxacin (MOX): 400 mg for persons ≥40 kg.
   - Pyridoxine (B6): 50 mg.
   - Pyrazinamide (PZA): 40-55 kg = 1000 mg, 56-75 kg = 1500 mg, >75 kg = 2000 mg [j]
   - Ethambutol (EMB): 40-55 kg = 800 mg, 56-75 kg = 1200 mg, >75 kg=1600 mg.[j]

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[h] The 4-month RPT-MOX daily treatment regimen was not studied in, and CDC does not recommend this regimen for, the following patient groups: body weight <40 kg; age <12 years; pregnant or breastfeeding; most types of suspected or documented extrapulmonary TB infection (see exceptions below); history of prolonged QT syndrome or concurrent use of one or more QT-prolonging medications (in addition to MOX); patients receiving medications with known clinically relevant drug-drug interactions with RPT, MOX, INH, or PZA; or patients infected with a baseline *Mycobacterium tuberculosis* isolate known or suspected to be resistant to INH, PZA, rifampin (RIF), or fluoroquinolones.

[i] If patient experiences gastrointestinal (GI) intolerance recommend famotidine 40 mg PO QHS and/or food with TB treatment. Avoid split dosing.

[j] Use estimated lean body weight for any patient with BMI ≥30. Please utilize calculator available at the below link. For any BMI just over/under 30 or weights which are close to the weight intervals (i.e., 56 kg, 76 kg) consider weekly weights to inform dosing changes

APPENDIX D - PERTINENT ICD-10 CODES

1. Positive PPD without active TB – R76.11
2. Contact with and (suspected) exposure to tuberculosis – Z20.1
3. Personal history of tuberculosis - Z86.11
4. Tuberculosis of lung – A15.0 (sub-codes A15.0-A15.9 exist for more specificity)
5. Miliary tuberculosis – A19 (sub-codes A19.0-A19.9 exist for more specificity)
6. Tuberculosis of other organs – A18 (subcodes A18.01-A18.89 exist for more specificity)
7. Resistance to a single antimycobacterial drug – Z16.341
8. Resistance to multiple antimycobacterial drugs – Z16.342

APPENDIX E – INSTRUCTIONS ON REQUESTING A COMPARISON CHEST RADIOGRAPH

1. If the radiology vendor is the same (e.g., Valor interpreted the initial CXR and follow-up CXR), order an "IH X-ray: chest, single view follow up, on TB treatment."
2. If the report does not make a comparison, request an addendum be issued with the comparison and whether it is unchanged, overall improved, or overall worsened. Achieve this by calling the Valor toll free number (1-800-916-6067 x200) or via site's radiology technologist. You may also reach out to the Infectious Disease Program for additional assistance.
3. If the radiology vendors are different, request a CD image from vendor one, upload image or provide CD to vendor two and request "comparison with prior film dated X/Y, patient currently on TB treatment." Call IHSC's vendor directly to alert them of the uploaded image in question (1-800-916-6067 x200); work closely with your radiology technologist and IPO.
4. If the report does not make a comparison, request an addendum be issued with the comparison and whether it is unchanged, overall improved, or overall worsened.