For our readers: The TB Wire will take a brief hiatus as we take a summer vacation. The next TB Wire will be published on September 9th.

Please feel free to forward the TB Wire to others who may be interested. If the file is too large to send, you can refer others to Stop TB USA SIGN UP where they can sign up to receive it (and other Stop TB USA communications) directly. The Stop TB USA Facebook link is now available on the header above and Stop TB USA is now on twitter as well. https://twitter.com/StopTBUSA. As always, suggestions and comments are welcome (setkind@stoptbusa.org)

WASHINGTON UPDATE

Thanks to Nuala Moore for the following updated information. Nuala is the Senior Legislative Representative at the American Thoracic Society Washington Office.

Domestic TB Funding Update

The House Labor-Health and Human Services Appropriations subcommittee, chaired by Rep. Kingston (R-GA), had been scheduled to vote on the FY2014 health research and services spending bill, which funds the NIH and CDC, on July 25, but the subcommittee announced a postponement of the vote. A reschedule date has not yet been announced. The Senate Labor-HHS Appropriations subcommittee approved its FY2014 health funding bill on July 9. The Senate bill provides CDC's Div. of TB Elimination with flat funding at the FY2013 funding level of $140 million.

Global TB Funding

The FY2014 State Department and foreign assistance bill progressed through both House and Senate subcommittee and full Appropriations Committee action, all in the same week. The House and Senate bills fund USAID’s global tuberculosis program at differing levels in contrast to previous years. Neither chamber adopted a 19 percent cut to the program proposed by the President’s 2014 budget, which
would have reduced funding for the program from the FY2013 level of $236 million (prior to the 5 percent sequestration cut) down to $191 million. The House bill provides the higher funding level for the program, at $236 million, which is level with FY2013, while the Senate proposes to fund the program at $225 million, which is the final FY2013 following application of the 5 percent sequestration funding cut. Both the House and Senate bills fund the Global Fund to Fight Aids, Tuberculosis and Malaria at $1.65 billion, which is the President’s FY2014 budget recommendation. This bill now awaits House and Senate floor votes.

ANNOUNCEMENTS

NCHHSTP Leadership Announcement

Dear Colleagues,

As we have previously announced, RADM Kenneth G. Castro, MD, Assistant Surgeon General, Director, Division of Tuberculosis Elimination (DTBE), has agreed to serve as Acting Director of the Division of HIV/AIDS Prevention (DHAP) beginning August 19, 2013. We plan to move forward rapidly to identify the next permanent Director of DHAP and hope to post the position very soon.

In the interim, we are pleased to announce that Dr. Philip LoBue has agreed to serve as Acting Director of DTBE. Dr. LoBue received his undergraduate and medical degrees from the University of Pennsylvania. He received postgraduate training in Internal Medicine and Pulmonary and Critical Care Medicine at the University of California San Diego Medical Center where he was subsequently a Clinical Instructor and Assistant Clinical Professor of Medicine from 1995 to 1999. In 1999, Dr. LoBue joined DTBE as a medical epidemiologist assigned to the Tuberculosis Control Program in San Diego County, CA. In 2004, he moved to CDC headquarters in Atlanta, GA, to become Chief of the Medical Consultation Team of DTBE. In 2006, Dr. LoBue was appointed to his current position as Associate Director for Science, DTBE. His primary duties include oversight of all scientific activities of DTBE, including two national and international research consortia conducting clinical trials and epidemiologic studies.

Dr. LoBue is a fellow in the American College of Physicians and American College of Chest Physicians. He is also a member of the American Thoracic Society (ATS), in which he has served on the Ethics and Conflict of Interest Committee and the Program (chair 2008-2009), Planning, and Executive Committees of the Microbiology, Tuberculosis, and Pulmonary Infections Assembly. Dr. LoBue has authored or co-authored more than 60 publications including peer-reviewed journal articles, book chapters, and Morbidity and Mortality Weekly Report articles. He has chaired or served on more than 10 guidelines and recommendations committees and panels for multiple organizations including CDC, ATS, the US Federal Tuberculosis Task Force, and the World Health Organization. His scholarly interests include tuberculosis diagnosis, treatment, and transmission dynamics, evidence-based guideline development, and human subjects research ethics.

We thank Dr. LoBue for his willingness to serve as Acting Director of DTBE.
Sincerely,

/Jonathan Mermin/
Jonathan H. Mermin, M.D., M.P.H.
Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

NEW RESOURCES

FROM the UNION

TREAT TB launches online operational research training

The Union's onsite operational research training has enabled hundreds of health professionals develop useful research skills, but for many in limited-resource areas, leaving their posts for a course is impossible. TREAT TB’s new virtual learning programme in operational research bridges this gap.


The new MDR-TB guide is now available in print.

FROM FIND TB RESOURCES: Highlight of the Month

This month's highlight is the Tuberculosis in Hispanics/Latinos fact sheet from the CDC Division of Tuberculosis Elimination. This fact sheet presents TB morbidity rates for Hispanic/Latino persons in the United States. These statistics emphasize the need to eliminate TB and to focus on preventing and controlling TB in this minority group. It is also available in Spanish.


Tuberculosis Laboratory Biosafety Manual, from the WHO Stop TB Department.

Clinical and Logistical Benefits of IGRAs vs the TST in At-Risk Populations, from IGRAeducation.com.

HIGHLIGHTED TB REPORTS

FROM RESULTS

Oxana Rucsineanu

Oxana describes the 3 years of tuberculosis treatment she took, one year first for regular TB then 2
years for multi-drug resistant TB as a “tough personal experience”. Although her body is now free from TB, it is still the focus of her life. With other TB patients, Oxana founded the Moldova Society against Tuberculosis (known as “SMIT”) which advocates for partnership and cooperation between TB patients, medical staff and authorities and develops activities to benefit people affected by tuberculosis and engage on issues of how TB is approached in Moldova. Oxana and SMIT focus on issues related to human rights, public awareness and care and support for people directly or indirectly affected by all forms of TB. Oxana and her husband Pavel – currently still a TB patient - make Balti their home and are the proud parents of baby David.


http://www.hereiamcampaign.org/campaign-ambassadors/here-i-am-campaign-ambassador-oxana-rucsineanu-moldova/

Pipeline Report: Pipeline Report: Speed development of, access to products that will address global health needs Imagine a world in which a single once-daily pill that can be taken without food, has few if any side effects, and can control the virus that leads to AIDS, is available, equally, to everyone who needs it. Imagine if governments and health systems all over the world were ready to make use of new (Read more...)

FROM TAG

Rifapentine Accessibility - A recent article on how Sanofi has also failed to make rifapentine accessible globally, and in particular, South Africa, after clinical trials were conducted there. Please see the article here: http://mg.co.za/article/2013-07-05-00-anger-over-drug-access-in-tb-trial

[Read the Document]


It raises a lot of important issues, such as the confluence of TB, imprisonment, and social factors. Note that Partners in Health has made a tremendous impact on treating TB, including drug-resistant TB, in both prisons and in the broader community in Tomsk, Russia.

Rifamycins to INH for treatment of TB - recent article published in the Cochrane Library which summarized some of the medical research comparing rifamycins to INH for treatment of TB

Challenges for HIV/ MDR-TB patients - A qualitative study on the challenges HIV/ MDR-TB patients face is available at the link below.


Open letter to Sequella - Please see the attached open letter to Sequella urging them to pursue the
rapid development of sutezolid, a promising new treatment for tuberculosis. Last week, Sequella acquired the right to develop sutezolid from Pfizer, which had supported the compound’s preliminary development. Sequella has announced that they plan to develop sutezolid under both its own New Drug Application and together with their other anti-TB compound SQ109. We’re asking Sequella to commit to making sutezolid available to public, not-for-profit research consortia so that sutezolid’s potential can be explored in combination studies with other drugs. The AIDS Clinical Trials Group, the Tuberculosis Trials Consortium and the TB Alliance have all designed trials that would include sutezolid, but the drug has not been made available for these critical collaborations.

[Read the Letter Here]

Treatment Action Group Criticizes European Refusal of New Drug to Fight Tuberculosis

Treatment Action Group (TAG) is disappointed by the failure of the Committee for Medicinal Products for Human Use (CHMP) of the European Medicines Agency (EMA) to recommend marketing approval for delamanid, a new drug in development for multidrug-resistant tuberculosis (MDR-TB). The drug, one of the first new compounds to fight tuberculosis (TB) in over 40 years, has demonstrated safety and clinical benefit against multidrug-resistant TB (MDR-TB) in clinical trials to date. The decision by the CHMP was based on the duration of treatment (two months) in the phase IIb randomized controlled trial (Trial 204). It considered that the trial was too short to establish the effectiveness of delamanid in treating TB when added to other anti-TB medicines. Without new treatment options such as delamanid, treatment for people who have the disease will remain intolerable, toxic, lengthy, and ineffective, and patients—of which the European Union and its neighboring countries have many—will continue to die.

“The EMA’s refusal to recommend the approval of a new drug that has more evidence of safety and efficacy than nearly all existing drugs for MDR-TB is both myopic and deeply disappointing,” said Mark Harrington, executive director of Treatment Action Group. “The EMA appears to be willing to delay wide availability and access to a drug with considerable evidence of clinical benefit—including a possible survival advantage—and proven ability to shorten time to TB culture conversion. The EMA is failing to respond to the drug-resistant TB crisis—which affects Europe more than any other region in the world—with appropriate twenty-first-century regulatory approaches.”

Delamanid, a new drug to fight TB, is currently enrolling patients in its phase III clinical trial, after phase II studies indicated improved efficacy and survival: in a comparison of patients taking a background regimen of MDR-TB drugs, those who also took delamanid for six months were 35 percent more likely to be cured than those who took the drug for two months or less, and about seven times less likely to die after 24 months of follow-up. Yet because the six-month data were from an open-label (rather than a randomized) trial, the EMA is preventing this likely lifesaving drug from being available in European Union member countries. If Otsuka, delamanid’s sponsor, appeals to the EMA and is unsuccessful, delamanid could languish an additional three years before EMA approval. Otsuka is also waiting to hear a response regarding its filing with the Japanese regulatory authority.

Treatment Action Group is baffled at how a sophisticated agency such as the EMA can make such an
egregious error by not approving delamanid. Regulatory flexibility in the face of the global emergency of
drug-resistant TB is urgently needed. This decision is another indication that regulators worldwide, with
the exception of the U.S. Food and Drug Administration (FDA), are completely unprepared for
responding appropriately to global health threats such as drug-resistant TB, and that they are not ready
to deal with innovation in the TB field. The EMA has now set a terrible example for developing countries,
which face enormous drug-resistant TB problems. “MDR-TB patients need access to better treatments
now,” said Wim Vandevelde, chair of the Global TB Community Advisory Board and member of the
European AIDS Treatment Group. “While Otsuka waits for regulatory approval, it must also make the
drug available immediately for patients in urgent need under compassionate use mechanisms that allow
for pre-approval access.”

Treatment Action Group urges Otsuka to roll out compassionate use programs and expanded access
studies in high-burden countries as soon as possible to ensure that treatment is available for those
people who may have run out of treatment options. Compassionate use allows the patients access to
the drug through pre-approval access programs. More evidence is needed to confirm delamanid’s safety
and efficacy, but phase III trial results are expected within three years. In that period of time, 1.5 million
people will be diagnosed with drug-resistant TB, and many of them will die, while others, poorly treated
or untreated, will continue to transmit the airborne disease. Bedaquiline, another novel drug for MDR-
TB, received accelerated approval by the FDA in December 2012 based on its phase II trial results, but
enrollment in its sponsor, Janssen’s, phase III trial, has yet to begin. Most other drugs currently used to
treat drug-resistant TB have not been rigorously tested in clinical trials for TB. “The EMA’s failure to
license delamanid increases the likelihood that bedaquiline will be used as a single new agent in failing
DR-TB regimens, enhancing the risk of the emergence of resistance, and delaying the chance to use
these two promising new drugs together in people at the greatest risk of disease progression and
death,” commented TAG’s Harrington. “We urge them to reconsider their dangerous decision.”

FROM THE STOP TB PARTNERSHIP

Canada - The Stop TB Partnership has presented Canada’s Minister for International Development,
Julian Fantino, with an award recognizing Canada’s support and leadership in the fight against
tuberculosis (TB). Accepting the award at a reception on the eve of the Stop TB Partnership
Coordinating Board meeting, which is being held for the first time in Canada, Minister Fantino re-
affirmed Canada’s support to fight TB globally. “Over the past decade, Canada has been a global leader
in the fight against TB,” Minister Fantino said. “We are forging a future where TB is a thing of the past
and where the most vulnerable can live healthier, safer and fuller lives.”

Canada is a founding donor of the Stop TB Partnership and has been a leading investor in two of its
flagship initiatives. The country’s investment in the Global Drug Facility (GDF) has contributed to the
delivery of more than 22 million life-saving TB treatments since 2001. TB REACH, launched in 2010 with
Canadian funding, targets the estimated three million people a year who get TB but aren’t provided with
a proper diagnosis or treatment. Through projects that use innovations such as public-private
partnerships, TB REACH has so far found and treated more than 400 000 people whose TB would
otherwise have gone undetected.
“Thanks to the people of Canada, millions of lives have been saved and people who would otherwise have been forgotten have received quality TB care,” said Dr. Lucica Ditiu, Executive Secretary of the Stop TB Partnership. “Today, as we reach a critical point in the fight against TB, we recognize this contribution and welcome the Government of Canada’s ongoing support. With global efforts to find people with TB stagnating and the threat of drug-resistant TB looming large, it is innovative investments such as Canada’s that will unite governments, nongovernmental organizations and the private sector in accelerating progress towards an overdue end to TB.” The award was presented to Minister Fantino ahead of a panel discussion hosted in partnership with the Aga Khan Foundation and RESULTS Canada. The panel included Dr Aaron Motsoaledi, the Minister of Health of South Africa, Dr Mark Dybul, Executive Director, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Dr Asad Alam, Country Director – South Africa, Botswana, Namibia, Lesotho and Swaziland, The World Bank, Dr Gonzalo G. Alvarez, Associate Professor of Medicine at the University of Ottawa, Associate Scientist at the Ottawa Hospital Research Institute and Respirologist at the Department of Medicine at the Ottawa Hospital and Lucica Ditiu, Executive Secretary of the Stop TB Partnership.

**July Board meeting** - link to the documents being considered at the July meeting of the Stop TB Partnership Coordinating Board. This includes a report on the current hosting arrangement for the partnership plus other useful reports.

http://stoptb.org/about/cb/meetings/23/

“**Partnering and Public Health Practice – Experience of national TB partnerships**” is now published and available on the Stop TB Partnership website at http://www.stoptb.org/countries/partnerships/partandpub.asp as well as on WHO IRIS system at http://apps.who.int/iris/handle/10665/85315. This publication presents the activities and innovative approaches taken by 23 national TB partnerships to support the work of national TB programmes and partners in countries across the six WHO regions. By highlighting best practices and effective examples from existing partnerships, the document aims to explain the work and achievements of current national partnerships and equip others with the necessary information to create their own. The publication was developed through in-depth interviews conducted with the secretariat, national TB programmes and partner representatives from each of the 23 national TB partnerships. We also take this occasion to share with you the webpage dedicated to national partnerships available at http://www.stoptb.org/countries/partnerships/.

**Kochon Prize** - Recognizing excellence in the fight against TB in conflict and refugee areas

Geneva - Nominations for the 2013 Stop TB Partnership Kochon Prize are being accepted until 15 September 2013. Funded by the Kochon Foundation, a non-profit foundation registered in the Republic of Korea, the US$ 65 000 prize is awarded once a year to persons, institutions, or organizations that have made a highly significant contribution to combating tuberculosis (TB). National health bodies and institutions of WHO Member States, Stop TB partners, or former recipients of the prize may submit nominations. This year, the Stop TB Partnership Secretariat has chosen to focus the annual prize on a specific theme: TB in conflict and refugee areas. Nominations are therefore open to individuals or any organizations that focus their work to provide access to TB diagnosis, treatment, support, care and other
services to people living in conflict areas, war zones, natural disasters or places that are difficult to access.

The selection criteria will be: 1) Exceptional commitment in providing TB services to populations living in conflict areas, war zones, natural disaster areas or populations living in ‘difficult to access’ areas; 2) The extent of the impact of their work on TB interventions on the TB-affected communities that they serve; and 3) The extent to which a Stop TB Partnership/Kochon Foundation Award might contribute to furthering the nominee's work. To make a nomination please click here. For any questions that you might have, please contact stoptbprize@who.int. The Kochon Prize was established in 2006 in honour of the late Chairman Chong-Kun Lee (“Kochon”) who was committed throughout his career to improving access to low-cost lifesaving antibiotics and anti-TB drugs. The name of the 2013 winner will be announced at the 44rd Union World Conference on Lung Health in Paris, France.

FROM NIH

“Rapid test allows for earlier diagnosis of tuberculosis in children”

NIH-funded study suggests test may increase treatment in primary care settings

A new test for diagnosing tuberculosis in children detects roughly two-thirds of cases identified by the current culture test, but in a fraction of the time, according to the results of a study in South Africa supported by the National Institutes of Health. The test, known as Xpert MTB/RIF, also detected five times the number of cases identified by examining specimens under the microscope, a preliminary method for diagnosis that is often performed as an initial test, but which must be verified by the culture test. Xpert MTB/RIF results from respiratory secretions were ready in 24 hours, on average, compared with an average of more than two weeks for the culture test used in the study, the researchers found. Previous studies have shown that Xpert MTB/RIF is effective for diagnosing TB in adults and in children with pronounced symptoms of TB who have been admitted to a hospital. Diagnosing TB in children is more difficult than diagnosing it in adults, because children tend to have much lower levels of the TB bacteria than do adults.

The results of the current study indicated that the ease and speed of diagnosis would be useful for children seen in clinics in resource-limited countries, which often lack the resources for traditional testing that are available in hospitals. The test also was able to identify children with drug resistant TB. In addition, the researchers found that Xpert can readily determine when treatment for tuberculosis is not appropriate. Among children who did not in fact have TB, the results of the Xpert test came back negative for TB with 99 percent accuracy. Xpert MTB/RIF was developed with funding from the NIH’s National Institute of Allergy and Infectious Diseases. Testing of Xpert MTB/RIF in children was funded by NICHD.

Preliminary diagnosis of TB is often made by collecting a sample of lung secretions and examining the sample under a microscope to see if it contains the bacteria that cause TB. A sample is also sent to a laboratory so the bacteria can be cultured and identified. It may take as long as six weeks for the culture test to show a positive result. Because, children have lower levels of infectious bacteria than do adults, it
is more difficult to detect the bacteria under a microscope and to grow it in a culture. For this reason, accurately diagnosing TB in children has been difficult. “The availability of this test in primary care settings can help children get appropriate treatment faster,” said Lynne M. Mofenson, M.D., of the Maternal and Pediatric Infectious Disease Branch of the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the NIH institute that funded the study. “Looking at a specimen under the microscope, often used for initial diagnosis of TB in adults, is very inaccurate in children.” The Xpert MTB/RIF test also detects TB strains that are resistant to the drug rifampicin, allowing physicians to more accurately prescribe an appropriate treatment, said Carol Worrell, M.D., also of the NICHD’s MPIDB. This is particularly important in areas where drug-resistant TB is common, such as South Africa. The World Health Organization estimated that in 2011 there were 500,000 TB cases and 64,000 deaths among those younger than 15 years.

The study was led by first author Heather J. Zar, M.D., Ph.D., of the University of Cape Town and Red Cross War Memorial Children’s Hospital, also in Cape Town, South Africa; and Mark P. Nicol, Ph.D, also of the University of Cape Town and the South African National Health Laboratory Service at Groote Schuur Hospital, Cape Town. The findings appear in The Lancet Global Health.

“There has been a perception amongst health care workers that rapid diagnosis of TB in children wouldn’t be possible in primary care, but this study disproves that view, Dr. Zar said. “Given our results, widespread adoption of rapid testing for TB and drug resistance in children may substantially improve public health without greatly increasing costs.” Dr. Zar and her colleagues collected almost 1500 samples from nearly 400 children who went to a primary care clinic with symptoms of TB. Collecting the samples — secretions from the lungs, the nasal passages or both — requires special equipment and trained clinical staff. The researchers compared the results from the Xpert MTB/RIF test, examination of samples under a microscope, and from growing the tuberculosis bacteria in laboratory cultures. Bacterial culture is the most accurate method for diagnosing TB. Of the 30 TB cases detected by culture, 19 (63 percent) were positive by the Xpert MTB/RIF test on lung or nasal samples, while examining the samples under the microscope turned up only four cases (13 percent). Adding a second test (of a second lung or nasal passage sample) improved the detection rate for both culture and Xpert MTB/RIF.

In some cases, researchers started TB treatment for children they suspected had TB based on their symptoms. Xpert MTB/RIF identified seven children who had clinical symptoms of tuberculosis and responded well to treatment for tuberculosis, but whose tuberculosis had not been detected by the tuberculosis culture test. This might occur when a child is sick with TB, but the bacteria are at especially low levels, or because a sample did not contain enough of the bacteria present in the child’s body to appear when cultured, Dr. Mofenson explained. The total number of cases detected by culture (30 cases) and by XpertMTB/RIF (26 cases) was similar. “Because of the global burden of this disease among children, it’s vital to make rapid, accurate diagnostic tests available in primary care settings in order to identify the disease and start treatment before children end up in the hospital,” said Dr. Worrell. “NICHD recognizes the value of supporting research to improve the accuracy of TB diagnosis in children, reduce the number of samples required, and make diagnostic tools widely accessible.”

FROM THE FDA
“FDA Permits Marketing of First U.S. Test Labeled for Simultaneous Detection of Tuberculosis Bacteria and Resistance to the Antibiotic Rifampin”

The U.S. Food and Drug Administration today allowed marketing of the Xpert MTB/RIF Assay, the first FDA-reviewed test that can simultaneously detect bacteria that cause tuberculosis (TB) and determine if the bacteria contain genetic markers that makes them resistant to rifampin, an important antibiotic for the treatment of TB. The new test is less complex to perform than other previous FDA-cleared tests for the detection of TB bacteria. Test results, including the detection of TB bacteria and whether the bacteria are drug resistant, are available in approximately two hours. Traditional methods to detect drug resistant TB usually require one to three months. “Less complex tests such as the Xpert MTB/RIF Assay can be used in more diverse settings,” said Alberto Gutierrez, Ph.D., director of the Office of In Vitro Diagnostics and Radiological Health in the FDA’s Center for Devices and Radiological. “The early and rapid detection of rifampin-resistant TB can help curb the spread of drug-resistant TB, a major public health threat.”

TB is caused by bacteria that belong to a group known as Mycobacterium tuberculosis complex, which usually attacks the lungs. Not everyone infected with M. tuberculosis develops active TB, and only people with active TB can spread the bacteria to other people. Those with weakened immune systems are at a much higher risk for developing TB once infected with the bacteria, and TB can be fatal if left untreated. TB is a leading killer worldwide of people with HIV. Common signs and symptoms of TB disease include: a bad cough lasting three weeks or longer, chest pain, coughing up blood, weakness and fatigue, and weight loss.

“New tools, including rapid and accurate diagnostic tests, are critical to advance the fight against TB,” said RADM Kenneth G. Castro, M.D., director of CDC’s Division of Tuberculosis Elimination. “Early diagnosis and effective treatment for both drug-susceptible and drug-resistant cases are essential for improving patient health, preventing the spread of disease to others, and ultimately, achieving our goal of TB elimination in the U.S.”

The FDA reviewed the Xpert MTB/RIF Assay through the de novo classification process, a regulatory pathway for some low- to moderate-risk medical devices that are not substantially equivalent to an already legally marketed device. In support of the de novo petition the manufacturer submitted data that included an assessment of the test’s accuracy in identifying the TB bacteria and the rifampin-resistant strains of the bacteria as compared to validated test methods. The Xpert MTB/RIF Assay is manufactured and marketed by Cepheid of Sunnyvale, Calif.

FROM CEPHEID

“Cepheid and American Lung Association Partner for Tuberculosis Awareness in U.S.” Jul. 23, 2013

SUNNYVALE, Calif. Cepheid and the American Lung Association today announced a partnership to promote tuberculosis-related awareness in the U.S. and the need for improved TB (tuberculosis) diagnostics. Details of the planned program will be announced at the American Association of Clinical Chemistry and Clinical Lab Expo show in Houston, Texas. The live announcement took place at 10am on
July 30th at Cepheid booth. As part of the program to highlight the need for increased public awareness and education for TB in the U.S., Paul Teutul Jr. and his team at Paul Jr. Designs, will unveil a brand new creation live during the announcement.

FROM NEWS SOURCES

NPIN: UNITED STATES

HAWAII: “TB State Restores Tuberculosis Clearance Requirement”

Star Advertiser (Honolulu) (07.10.2013) On July 15, Hawaii’s Department of Health will resume providing TB skin tests at all state TB clinics since it now has an adequate supply of the Tubersol and Aplisol purified protein derivative used in the skin tests. In April of this year, a nationwide shortage of this solution prompted the state to issue a four-month suspension of mandated TB clearance requirements for certain individuals. The temporary suspension of required TB clearance expires on August 9; students enrolling for the first time in colleges or universities in Hawaii may receive further guidance directly from their schools. Read Full Article

NORTH DAKOTA: “Cost of Grand Fork's TB Fight Rises” Brandi Jewett, Grand Forks Herald (07.09.2013)

City health officials in Grand Forks, N.D., are still in the process of managing and computing the cost of a 2012 TB outbreak. The city experienced 26 TB cases and has tested more than 1,500 individuals since October 2012, when officials detected the first case at an elementary school. Testing continues and, according to Public Health Director Don Shields, officials expect to diagnose more cases as the department tracks down more contacts of infected individuals. Meanwhile, the costs of managing the outbreak continue to increase. The Grand Forks City Council is reviewing a budget amendment to add approximately $40,000 to the health department’s budget. This is a reimbursement from the state Department of Health to cover part of the city’s cost of managing infected patients and testing others. This is the state’s second reimbursement to the city and brings the total amount the city has received to approximately $80,000. Approximately half of the reimbursement will pay salaries, as there is a huge labor cost in making sure that patients adhere to treatment. At present, Shield’s staff is monitoring 23 patients by means of daily visits to ensure they are taking their medication. Part of the problem with the outbreak is that many people who contract TB are low-income or homeless. Also, the nomadic lifestyle of the patients before they were diagnosed impedes the process of tracking others who may have been in contact with them. Officials have placed 10 of the patients with active TB in subsidized housing with food delivery so that the department could keep them in quarantine and minimize the spread of TB. Read Full Article

CALIFORNIA: “Modesto Doctors to Pay $5M After TB Ruined Girl's Spine” Ken Carlson, Modesto Bee (07.08.2013)

By A September 2011 lawsuit filed in Stanislaus County, Calif., Superior Court alleged that a Modesto clinic and its doctors failed to diagnose and treat a now 17-year-old girl with spinal TB as the disease was destroying her cervical spine. Subsequently, she suffered a ruptured vertebra in her neck in August
2010, causing her to lose the use of her arms and legs and to require 24-hour care and medical attention for the remainder of her life. The clinic and doctors have agreed to a $5 million legal settlement, which Judge Roger Beauchesne was set to approve in court on July 8. Attorney David Rancano charged that Pott’s disease, or spinal TB, was curable when diagnosed and treated, but the girl’s doctors did not recognize the disease. Rancano noted the misdiagnosis should not have happened in a county close to Bay Area university hospitals, considered among the best in the world. Read Full Article

FLORIDA: “Case of Tuberculosis Reported at USF’s Tampa Campus” WTSP.com (Tampa Bay, Fla.) (07.16.2013)

The Florida Department of Health has confirmed a case of TB disease involving a University of South Florida (USF) student on the Tampa campus. According to health officials, the student is undergoing treatment in isolation and is no longer a health risk to others. Florida Department of Health–Hillsborough County TB Center Manager Jylmarie Lewis said that USF and the Florida Department of Health were working together to ensure the health and safety of all the campus community. The school and the Department of Health notified approximately 90 students, faculty, staff, and community members at risk for exposure of testing next week. USF students and employees with additional questions may call the Student Health Services nurse line Monday–Friday from 8:00 a.m. to 5:00 p.m. at (813) 974–1797. Read Full Article

UNITED STATES: “To Detect Pulmonary Tuberculosis Among Detainees, ICE Will Administer 200,000 Chest X-Rays Annually” Jacob Goodwin, Government Security News (07.10.2013)

By US Immigration and Customs Enforcement (ICE) officials who oversee enforcement removal operations for detained immigrants released a statement of objectives on July 9. The statement detailed their desire to find a small business to administer approximately 200,000 chest X-rays annually to detainees at ICE facilities across the country, to quickly screen and detect active TB among these individuals. X-ray images could be captured at one location and sent to another through tele-radiology, and would need to be integrated with ICE’s electronic Health Records system. The small business would have to analyze X-rays and provide a response to the agency within four hours. Read Full Article

MINNESOTA: “Tuberculosis Outbreak Shakes Wisconsin City” Richard Knox, NPR News (07.18.2013)

By Sheboygan County, Wisc., recently activated its emergency operation center to contain a multidrug-resistant TB (MDR TB) outbreak in the city of Sheboygan in April. Public Health Nurse Jean Beineman identified the initial MDR TB infection in a woman from a large, close-knit immigrant family. Health workers subsequently diagnosed active TB in three other family members in multiple households; some were middle and high school students. Wisconsin has large immigrant populations from Mexico and Southeast Asia, where TB is common. TB infections among Hmong immigrants from Laos and Cambodia have been the most difficult to cure. To address the outbreak, Sheboygan County borrowed personnel from other counties; provided housing to isolate the MDR TB-infected woman; and supplied TB testing, treatment, and public education for residents. Beineman reported that the health department tested 130 students and teachers who had been in contact with the TB-infected children and located nine cases of active TB in five households; the cases were not as drug-resistant as the first case. Health department
personnel also have supplied education and monitoring to keep TB-infected individuals away from the uninfected population. Because MDR TB is resistant to at least two of the main TB drugs, antibiotic treatment for more resistant cases can cost up to $300,000 per patient. Although the health department had not yet received results from a second round of testing, public health epidemiologists estimated that Sheboygan could find as many as 15 symptomatic MDR TB cases and 200 additional latent cases, which would require nurse-supervised antibiotic treatment for six months to a year. Interruptions in latent TB treatment could result in the development of MDR TB. Sheboygan County sought millions in supplemental state funding to cover the cost of the public health response. Read Full Article

VIRGINIA: “At Least 1,400 Students, Staff at Lee High Should Get TB Tests, Health Officials Say” T. Reese Shapiro, Washington Post (07.22.2013)

Fairfax County, Va., public health officials will offer free TB screening beginning August 3 to all 1,400 faculty, staff, and students of Lee High School, in response to public concern regarding recently diagnosed TB cases. Last spring, three Lee High students tested positive for active TB. In June, the Fairfax County Health Department asked 400 students and 30 staff members who had been in close contact with the TB-infected students to undergo TB testing. Approximately one week later, the health department expanded testing to 60 additional possible contacts from other Fairfax County schools. The screening identified an undisclosed number of additional latent TB cases—a noncontagious form of the bacterial infection—that could progress to active TB if left untreated. The department has tested close to 300 people since the outbreak. Typically, approximately 1 percent of US-born residents would test positive for latent TB; approximately 5 percent of the recently tested US-born Lee High group received a positive test result, according to Fairfax County Health Director Gloria Addo-Ayensu. Spokesperson Glen Barbour stated that incidence among the foreign-born Lee High group tested for TB was comparable to the worldwide TB rate, which ranged from 5 to 33 percent. Jane Moore, director of TB control and prevention for the Virginia Department of Health, reported that Virginia health departments investigate 5–10 TB cases in schools annually. One-third of Virginia’s TB cases in 2012 occurred in Fairfax County. Northern Virginia, home to a diverse immigrant population and many US residents who work internationally, accounted for more than half of all Virginia TB cases. The Fairfax County Health Department scheduled the August 3 testing for all Lee High students, staff, and faculty to alleviate community concern and to identify all TB cases before school reconvened on September 3. Read Full Article


The Alaska Department of Health and Human Services reported that the recent TB outbreak in a Yukon-Kuskokwim Delta village was under control and that the outbreak presented no elevated risk to community members. Alaska Tuberculosis Control Officer Dr. Michael Cooper stated that eight patients with active TB were receiving treatment in the village and all were “doing well.” Cooper declined to name the small village, citing Alaska’s Infectious Disease Program patient privacy policy. Cooper stated the Yukon-Kuskokwim Delta outbreak had its origin in high TB incidence among Alaskan Natives in the 1940s and 1950s. From 1948 to 1951, approximately 89 percent of Alaskan Natives in the region tested...
positive for TB. Cooper attributed the high TB incidence to remote geography, poor healthcare infrastructure, crowded living conditions, and the immigration of nonnatives who brought in “weakening” diseases like measles and influenza from which Alaskan Natives had no immunity. Extending healthcare to the region has helped TB rates plummet throughout the years. However, many Alaskan Natives who were alive during the region’s period of high incidence still have latent TB, which could become active as aging weakened their immune systems. In addition, poor living conditions and lack of access to quality medical care still exist in remote areas.

In 2012, Alaska had more TB cases than any other state, with a rate of nine cases per 100,000 people. Sixty-nine percent of Alaska TB cases occurred among Alaskan Natives, and 66.6 percent of the infections occurred in the Yukon-Kuskokwim Delta. Alaskan Natives accounted for only 15 percent of the state’s population. The decline in Alaska’s TB rates is likely to continue as the state health department identifies and treats latent cases, but the eradication of TB in Alaska is unlikely, according to Cooper. In other states, foreign-born populations accounted for most US TB cases.

NPIN GLOBAL

RUSSIA : TB "Sputnik" Orbits a Russian City, Finding and Healing Tuberculosis" Corey Flintoff, NPR
Berlin (07.11.2013)

By Russia’s Health Ministry and the US nonprofit organization Partners in Health launched an innovative mobile clinic, “Sputnik,” that “orbited” the city of Tomsk to find TB patients and deliver their medicines. The strategy aimed to combat an increase in the incidence of multidrug-resistant TB in Tomsk. The World Health Organization reported in 2012 that nearly 30 percent of TB cases in Siberia were resistant to two of the most powerful TB medications. One Sputnik team included a nurse and a driver/bodyguard who drove the nurse around Tomsk to meet with patients who were sometimes dangerous. Sputnik’s primary targets—the homeless, mentally ill, and drug addicts—could be difficult to find and uncooperative; most either could not or would not go to the hospital for treatment. For example, one female TB patient preferred to meet daily with the Sputnik crew and take her TB regimen in the back seat of the Sputnik car than be in the TB hospital with “drunks, dope addicts, ex-cons, crooks.” The Sputnik crew visited another patient, an alcoholic man, twice daily at his home. The drug regimen for multidrug-resistant TB could require a patient to take as many as 18 pills daily to combat both the TB and side effects of the TB drugs. If patients refused to complete the long course of medicine necessary for the cure, the TB bacteria could rebound and become resistant to TB medications. Dr. Alexander Barnashov, a Tomsk Health Department head physician, stated that the city had other TB strategies, but the Sputnik program had been effective in reducing the most dangerous forms of TB, and other cities were adopting the Sputnik model. However, a new Russian law that required nonprofits receiving funds from sources outside Russia to register as “foreign agents” could threaten Sputnik. Designation as a foreign agent has been equivalent to the label “spy,” and Russian authorities have raided many charities and demanded their records. Thus far, authorities have not challenged Sputnik.

Read Full Article
Report Points at Dual Threat of HIV, TB
NEPAL: “HIV/AIDS, TB” Himalayan Times (07.15.2013)

The National TB Centre (NTC) in Nepal recently revealed the results of a one-year survey of 400 HIV-infected people taking antiretrovirals and 1,000 individuals being treated for TB at its 12 treatment centers. Results showed that 45 percent of the total population was infected with TB, approximately 40,000 people per year contracted TB, 20,000 new sputum positive cases were reported, and 5,000–7,000 people died from TB. Also, 12 of every 100 individuals with HIV were coinfected with TB. The country established treatment centers in many areas and the National TB and National AIDS programs provided free treatment to individuals coinfected with HIV and TB. Sujit Kumar Shah, NTC’s TB and HIV coordinator, noted that the center detected TB and HIV co-infection mostly in migrant workers and their wives, housewives, and female sex workers ages 20–39 years. Read Full Article

SOUTH AND NORTH KOREA: “Battling Tuberculosis in Both South and North Korea” Kang Tae-ho, The Hankyoreh (07.13.2013)

By Dr. Kwonjune Justin Seung, an international expert in multidrug-resistant TB (MDR TB), reviewed TB incidence and prevalence in North and South Korea and described critically needed TB strategies during a seminar hosted by the Eugene Bell Foundation. Seung reported that South Korea had the highest TB incidence, prevalence, and mortality rates of 30 Organisation for Economic Co-operation and Development countries. The World Health Organization (WHO) reported that South Korea had 100 new TB cases per 100,000 people, a prevalence rate of 149 per 100,000 people, and a mortality rate of 4.9 per 100,000 in 2007. WHO figures indicated that South Korea’s TB prevalence increased by approximately 5,000 cases from 2007 to 2011. North Korea had much worse TB incidence and mortality rates than South Korea, with 2.5 times higher incidence and 1.4 times higher prevalence, according to WHO figures for 2011. The growing prevalence of MDR TB in both countries was Seung’s biggest concern. In comparison with a six-month treatment regimen for TB, MDR TB requires a two-year course of expensive treatment with only a 50- to 60-percent chance for full recovery. MDR TB patients also face the danger of their infection developing into “super-TB,” which resists all treatments. Seung stated that “bad” MDR TB treatment—such as providing standard TB medications—was more dangerous than no treatment at all because patients could spread MDR TB through respiratory infections. Without implementation of appropriate treatment, North Korea could become a “high-risk” TB country like Russia, China, and India. South Korea has helped North Korea fight MDR TB since 2008, but North Korea limited assistance to eight treatment centers in North and South Pyongyan Provinces that could treat only 500 patients annually. Seung urged the creation of a general TB center in a location such as Kaesong, North Korea, for diagnosis, testing, surgery, and treatment. Read Full Article


By A recently released national TB survey in Tanzania showed that the disease was more prevalent in rural areas than urban, and affected more men than women. The number of TB patients increased from 62 per 100,000 in 1982 to 261 per 100,000 in 2011, and 295 per 100,000 in 2012. This made Tanzania one of the 22 countries with the highest number of TB cases, as listed by the World Health Organization.
In rural areas, the number of patients is 316 per 100,000; the rate for men is 410 per 100,000, compared to the rate of 207 per 100,000 for women. Dr. Blasdus Njako, National TB and Leprosy Programme acting manager, blamed lack of education and health centers, and long distances to health centers for the high rate in rural areas and noted that his agency was working to send specialists to run screening campaigns in the remote areas of the country. Read Full Article


By The World Health Organization has elevated Uganda’s national TB reference laboratory, located in Wandegeya, to supranational TB reference lab status. Along with one other lab in South Africa, it becomes only the second supranational TB reference lab in Africa and the 33rd such lab globally. According to Dr. Moses Joloba, head of the Wandegeya lab, the facility now has the necessary equipment to diagnose TB in fewer than two hours, including multi-resistant forms of the virus. The lab will be responsible for the quality assurance of all diagnoses within the country and now will be able to undertake research as well. Due to the lab’s new role, the government has agreed to build a new $2.4 million facility for the lab, to be located in the Kampala suburb of Luzira. Read Full Article

AFGHANISTAN : “10,500 People Die from Tuberculosis Every Year in Afghanistan” Ahmad Masoud, Khaama Press (07.31.2013)

According to the World Health Organization (WHO), Afghanistan reported 10,500 TB deaths annually, making it one of 22 countries with the highest TB burden in the world. WHO also reported that Afghanistan diagnosed 53,000 new TB cases annually. The majority of new TB infections (66 percent) occurred among women, and children accounted for 10 percent of new TB cases. Experts attributed Afghanistan’s high TB incidence to poverty, inadequate working and living conditions, lack of access to healthcare and medications, security issues, and lack of TB awareness. Many Afghans believed that TB was incurable. Afghanistan has had some success in implementing the Directly Observed Treatment Short Course (DOTS) strategy to treat TB. Ninety-seven percent of Afghans had access to DOTS in 2011, compared with 14 percent in 2002. Close to 1,200 Afghan health facilities offered DOTS in 2011, compared with 10 facilities in 2000. DOTS implementation required sustained resources to ensure diagnosis by sputum-smear microscopy, short-course anti-TB treatment under direct observation, an uninterrupted supply of high-quality TB medicines, and standardized reporting. Based on DOTS successes, WHO developed the “Stop TB Strategy” to address six challenges countries face in eliminating TB globally: sustaining and expanding DOTS; addressing TB/HIV coinfection, multidrug-resistant TB, and other special challenges; strengthening health systems; engaging healthcare providers; empowering patients and communities; and promoting TB research. Since the majority of Afghans live in rural areas and have little understanding of TB, Afghan experts also recommended the country develop a national TB communication strategy to increase TB awareness and promote TB-safe behavior. Research methods used in developing the communications strategy should include knowledge, attitude, practices, and beliefs; focus groups; and participatory rural appraisal techniques. Research also should focus on women and girls, who traditionally carry out household tasks in unhygienic environments and have higher TB burden. Read Full Article
ZAMBIA: “Govt Aims to Wipe Out TB in Prisons” Nakubiana Shabongo, allAfrica (07.30.2012)

Minister of Home Affairs Alfreda Kansembe announced at an international workshop in Chisamba, Zambia, that the Zambian government would commit the resources required to eradicate TB among its prisoners and corrections staff. The European Union and other stakeholders sponsored and organized the workshop to address challenges facing the Zambian prison system. According to the Centre for Infectious Disease Research in Zambia (CIDRZ), TB prevalence among Lusaka Central Prison inmates was four times higher than in Lusaka’s general population. CIDRZ based this estimate on TB screening of 7,935 Lusaka Central Prison officers and inmates during the Lusaka Central Prison and Kabwe Mukobeko Group of Prison’s TB research project. Kansembe stated that Zambian government efforts to eliminate TB among prisoners and staff would include building more prisons to relieve overcrowding, adding prison clinics and hospitals, and providing technical support to strengthen management structures and decision-making frameworks. Zambia’s entire prison system had only 17 prison clinics, three health posts, and one hospital at the time of the workshop. Commissioner of Prisons Percy Chato urged the Zambian government to provide medical services in the prisons and surrounding communities that would ensure humane treatment and successful reintegration of prisoners into the general population. Read Full Article

JOURNAL ARTICLES

(July 12– Aug 2, 2013)


**Contribution of Seasonality in Transmission of Mycobacterium tuberculosis to Seasonality in**
Tuberculosis Disease: A Simulation Study. SOETENS LC, Boshuizen HC, Korthals Altes H.


Knowledge and acceptability of patient-specific infection control measures for pulmonary tuberculosis. Gonzalez-Angulo Y, Geldenhuys H, Van As D, Buckerfield N, Shea J, Mahomed H, Hanekom W, Hatherill M.

Am J Respir Crit Care Med. 2013 Jul 25. [Epub ahead of print]


Epidemiology of isoniazid resistance mutations and their effect on tuberculosis treatment outcomes. Huyen MN, Cobelens FG, Buu TN, Lan NT, Dung NH, Kremer K, Tiemersma EW, van Soolingen D.


Clinical validation of the analysis of linezolid and clarithromycin in oral fluid of patients with multidrug-resistant tuberculosis. Bolhuis MS, van Altena R, van Hateren K, de Lange WC, Greijdanus B, Uges DR, Kosterink JG, van der Werf TS, Alffenaar JW.

BMC Health Serv Res. 2013 Jul 31;13(1):290. [Epub ahead of print]

The provision and need of social support among adult and pediatric patients with tuberculosis in Lima, Peru: a qualitative study. Paz-Soldán VA, Alban RE, Jones CD, Oberhelman RA.


Comparison of laboratory costs of rapid molecular tests and conventional diagnostics for detection of tuberculosis and drug-resistant tuberculosis in South Africa. Shah M, Chihota V, Coetzee G, Churchyard G, Dorman SE.


Identification of the likely translational start of Mycobacterium tuberculosis GyrB. S. Karkare S, Brown AC, Parish T, Maxwell A.


Interferon γ release assay for the diagnosis of uveitis associated with tuberculosis: a Bayesian evaluation in the absence of a gold standard. Ang M, Wong WL, Li X, Chee SP.


Emerg Infect Dis Volume 19 (7)

Undetected Multidrug-Resistant TB Amplified by First-line Therapy in Mixed Infection S.M. Hingley-Wilson et al.


The new global health. De Cock KM, Simone PM, Davison V, Slutsker L.


Cost effectiveness of high resolution computed tomography with interferon-gamma release assay for tuberculosis contact investigation. Kowada A.

Eur Respir J. 2013 Aug;42(2)


Interview: An insight into cutting-edge tuberculosis vaccine research. Agger EM.


Profile and Outcome of Childhood Tuberculosis Treated with DOTS-An Observational Study. Panigatti P, Ratageri VH, Shivanand I, Madhu PK, Shepur TA.

Infection. 2013 Aug;41(4)

Primary inoculation tuberculosis after an accidental scalpel injury. Huang D, Yin H.


Int J Tuberc Lung Dis. 2013; 17(8)


PubMed: www.amedeo.com/p2.php?id=23827504&s=tb&pm=2


PubMed: www.amedeo.com/p2.php?id=23827036&s=tb&pm=2


Molecular and phenotypic characterisation of Mycobacterium tuberculosis resistant to anti-tuberculosis drugs. IMPERIALE BR, Zumarraga MJ, Di Giulio AB, Cataldi AA, et al.

PubMed: www.amedeo.com/p2.php?id=23827034&s=tb&pm=2


Strain diversity of mycobacteria isolated from pulmonary tuberculosis patients at Debre Birhan Hospital, Ethiopia. GAREDEW L, Miheret A, Mamo G, Abebe T, et al.


Tuberculosis among undocumented boat migrants to Malta: implications for a migrant tuberculosis policy. PACE-ASCIAK A, Mamo J, Calleja N.

Yield of contact tracing from pediatric tuberculosis index cases in Gaborone, Botswana. PURYEAR S, Seropola G, Ho-Foster A, Arscott-Mills T, et al.

Low treatment initiation rates among multidrug-resistant tuberculosis patients in Gauteng, South Africa, 2011. EBONWU JI, Tint KS, Ihekweazu C.


The utility of stool cultures for diagnosing tuberculosis in people living with the human immunodeficiency virus. ORAMASIONWU GE, Heilig CM, Udomsantisuk N, Kimerling ME, et al.

Impact of human immunodeficiency virus and CD4 count on tuberculosis diagnosis: analysis of city-wide data from Cape Town, South Africa. GUPTA RK, Lawn SD, Bekker LG, Caldwell J, et al.

Tuberculous lymphadenopathy: a multicentre operational study of 6-month thrice weekly directly observed treatment. JINDAL SK, Aggarwal AN, Gupta D, Ahmed Z, et al.


Improving screening and chemoprophylaxis among child contacts in India’s RNTCP: a pilot study.


Pasting together the preventive therapy puzzle . SKINNER D, Mandalakas AM.


J Antimicrob Chemother . 2013 Aug;68(8)

Decline in rates of acquired multidrug-resistant tuberculosis after implementation of the directly observed therapy, short course (DOTS) and DOTS-Plus programmes in Taiwan. Chien JY, Lai CC, Tan CK, Chien ST, Yu CJ, Hsueh PR.

High-level resistance to isoniazid and ethionamide in multidrug-resistant Mycobacterium tuberculosis of the Lisboa family is associated with inhA double mutations. Machado D, Perdigão J, Ramos J, Couto I, Portugal I, Ritter C, Boettger EC, Viveiros M.

J Clin Microbiol . 2013 Jul 12. [Epub ahead of print]

Inconsistent Results with the Xpert-MTB/Rif Assay in Detection of Mycobacterium tuberculosis with an rpoB Mutation Associated with Low Level of Rifampin Resistance: Diagnostic Implications. Somoskovi A, Deggim V, Ciardo D, Bloemberg GV.


Rifampin Resistance Missed in Automated Liquid Culture System for Mycobacterium tuberculosis Isolates with Specific rpoB Mutations. Rigouts L, Gumusboga M, de Rijk WB, Nduwamahoro E, Uwizeye C, de Jong B, Van Deun A.


Serodiagnosis of Mycobacterium avium Complex and Mycobacterium abscessus Complex Pulmonary Disease by Use of IgA Antibodies to Glycopeptidolipid Core Antigen. Jeong BH, Kim SY, Jeon K, Lee SY, Shin SJ, Koh WJ.


Multidrug-resistant tuberculosis in Panama is driven by clonal expansion of an MDR-TB strain related to the KZN XDR-TB strain from South Africa. LANZAS F, Karakousis PC, Sacchettini JC, Ioerger TR, et al.


Prevalence of latent tuberculosis infection among healthcare workers in China as detected by two interferon-gamma release assays. Wei Z, Yang M, Quan B, Wang Y, Wu Y, Ji B.


immigrants. Simpson T, Tomaro J, Jobb C.

Intensified case-finding for latent tuberculosis infection among the Baltimore city Hispanic population. Desale M, Bringardner P, Fitzgerald S, Page K, Shah M.

Describing the Burden of Infectious Diseases Among a Population of Detainees in an Immigration Removal Centre (IRC) in the United Kingdom: A Descriptive Epidemiological Approach. McLaren E, Baugh V, Plugge E, O’Moore E.

J Infect. 2013 Jul 26. [Epub ahead of print]

Incidence and outcomes of paradoxical lymph node enlargement after anti-tuberculosis therapy in non-HIV patients. Park KH, Lee MS, Lee SO, Choi SH, Kim YS, Woo JH, Kim SH.


Adjuvant host-directed therapy with types 3 and 5 but not type 4 phosphodiesterase inhibitors shortens the duration of tuberculosis treatment. Maiga M, Ammerman NC, Maiga MC, Tounkara A, Siddiqui S, Polis M, Murphy R, Bishai WR.


Drug resistance in pulmonary tuberculosis in new and previously treated cases: Experience from Turkey. Komurcuoglu B, Senol G, Balci G, Yalniz E, Ozden E.


Major infection events over 5 years: how is media coverage influencing online information needs of health care professionals and the public? Kostkova P, Fowler D, Wiseman S, Weinberg JR.


Making wider use of the world’s most widely used vaccine: Bacille Calmette-Guerin revaccination reconsidered. Dye C.

Universal access to care for multidrug-resistant tuberculosis: an analysis of surveillance data. Falzon D, Jaramillo E, Wares F, Zignol M, Floyd K, Raviglione MC.


Optimal control for a tuberculosis model with reinfection and post-exposure interventions. Silva CJ, Torres DF.


Tuberculosis related stigma and delay in seeking care after the onset of symptoms associated with tuberculosis. Kurspahić-Mujčić A, Hasanović A, Šivić S.


Pediatr Infect Dis J. 2013 Aug;32(8)

Tuberculous Radiculomyelitis Presenting in a Toddler With Lower Extremity Weakness and Seizure. Ramachandran V, Barry J, Abughali N, Friedman NR, Staugaitis SM, Goldfarb J.

Bronchoscopic evaluation in childhood pulmonary tuberculosis: risk factors of airway involvement and contribution to the bacteriologic diagnosis. Cakir E, Kut A, Ozkaya E, Gedik AH, Midyat L, Nursoy M.


Public Health Action: Volume 3 (2)


Occupational health policies and practices related to tuberculosis in health care workers in KwaZulu-Natal, South Africa. Tudor, C.; Van der Walt, M.; Hill, M. N.; Farley, J. E.

Does the type of treatment supporter influence tuberculosis treatment outcomes in Zimbabwe? [Short communication]. Millo, N.; Sandy, C.; Harries, A. D.; Kumar, A. M. V.; Masuka, N.; Nyathi, B.; Edginton, M.; Isaakidis, P.; Manzi, M.; Siziba, N.

Are sputum samples of retreatment tuberculosis reaching the reference laboratories? A 9-year audit in Tanzania


MDR-TB treatment needs in patients previously treated for TB in Cotonou, Benin


Management of latent tuberculous infection in Norway in 2009: a descriptive cross-sectional study

Olsen, A. I. M.; Andersen, H. E.; Åßmus, J.; Djupvik, J. A.; Gran, G.; Skaug, K.; Mørkve, O.

Rapid home-based human immunodeficiency virus testing to reduce costs in a large tuberculosis cohort study [Short communication]


Management of tuberculosis and latent tuberculosis infection in human immunodeficiency virus-infected persons

Lee SS, Meintjes G, Kamarulzaman A, Leung CC.


Mining large-scale response networks reveals 'topmost activities' in Mycobacterium tuberculosis infection

Sambarey A, Prashanthi K, Chandra N.


Diagnosis of latent tuberculosis infection among HIV-infected clients in Far North Queensland: use of an interferon-gamma release assay

Lyne K, Downing S, Russell D.


Enhancing HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Prevention in the United States Through Program Collaboration and Service Integration: The Case for Broader Implementation

Steiner RJ, Aquino G, Fenton KA.


Incidence of Tuberculosis in Deceased-Organ Donors and Transmission Risk to Recipients in Spain

Coll E, Torre-Cisneros J, Calvo R, Garrido G, Matesanz R.


Tuberculosis (Edinb). 2013 Jul 24. [Epub ahead of print]

Molecular snapshot of Mycobacterium tuberculosis population structure and drug-resistance in


COURSES/WORKSHOPS

FROM THE MIGRANT CLINICIANS NETWORK

Don't miss the last webinar in our 7-part series of free webinars in the Clinician Orientation to Migration Health. We will be covering Quality and Meaningful Use in Migration Care on August 7th (Wednesday) 10:00am PT (Noon CT, 1:00pm ET) Register now if you haven't already!

DESCRIPTION: Clinicians play a critical role in the function and quality of care provided by Federally Funded Health Centers. This session will address the impact that clinicians have in overall health center management and function. Ed Zuroweste, MD, MCN's medical director will discuss the overall culture of quality for Federally Funded Health Centers including the role of clinicians in Clinical Core Measures Review, the recruitment and retention of clinical staff, peer review activities, and the role of electronic health records in data gathering. The webinar will conclude with a discussion of the overall shift from productivity to quality outcomes.

The orientation is divided into a series of seven webinars which cover a breadth of knowledge and skills to help clinicians and others provide quality care to one of the most difficult to reach populations in the United States. Each webinar is accredited for 1 hour of continuing nursing education or 1 hour of medical education. Complete all seven modules and you will receive an additional Certificate of Expertise in Migration Health.

NOTE: If you were unable to attend any of the webinars in this series, you may view the archived version at any time by visiting the Orientation page on our website. Select the title of the webinar you wish to view and click the "View Recorded Webinar" button.

FROM THE RTMCCs

The Affordable Care Act and Tuberculosis Control: Navigating New Territory
A National Webinar, August 23, 2013 11:00 AM to 12:30 PM (Pacific Time)

The Curry International Tuberculosis Center is pleased to announce our next webinar: The Affordable Care Act and Tuberculosis Control: Navigating New Territory. This training will clarify key information that TB Programs need to know related to the implementation of the Affordable Care Act (ACA). The webinar will be broadcast live, via the internet on Friday, August 23, 2013. This training will be
presented by TB and ACA experts and also include an expert panel to comment on participant questions. Faculty include: Facilitator, Lisa Chen, MD and Julie Higashi, MD, PhD, San Francisco Department of Public Health, Christine Ho, MD, MPH, CDC, Tom Donohoe, MBA, Pacific AIDS Education and Training Center, UCLA and panel members John Bernardo, MD, Massachusetts Department of Public Health, and Naomi Seiler, JD, George Washington University

Goals: to give a broad overview of changes that the implementation of the ACA will have on TB control; and to understand the steps that public health programs can take to assess the impact of ACA implementation on clinic services for TB

Target Audience: This training is intended for public and private clinicians and allied health personnel who work with tuberculosis. This training opportunity is available to a national audience.

For more information please visit:
http://www.currytbcenter.ucsf.edu/training/nationalwebinar.cfm

You can submit your application online by using the following link:
http://www.currytbcenter.ucsf.edu/training/tbwebaug2013_app.cfm

All applications will be considered and participants will be informed of their registration status after the application deadline of August 9th, 2013.

THE SOUTHEAST NATIONAL TB CENTER (SNTC)
For more information click: http://sntc.medicine.ufl.edu/TrainingOther.aspx

A Practical Approach to Using IGRA in Diagnosing TB
Date: 8/13/2013 - 8/13/2013
Time: 1:00 PM - 3:00 PM Eastern
Location: SNTC
Instructor/speaker: Dr. Robert Belknap
Cost: No Charge
Format: Webinar
“Interferon Gamma Release Assays (IGRAs) have been recommended for use in the diagnosis of Latent TB Infection. Since these recommendations, much has been learned and published regarding the performance of these tests in different clinical situations. This Grand Rounds program will examine “lessons learned” from a “practical” standpoint and share experiences for enhancing the utilization of these tests.”

The event is designed for physicians, nurses, pharmacists, and field staff who are interested in a multidisciplinary and global approach toward the care and management of the patient infected with tuberculosis.

REGISTRATION: This is a free event, open to all regions. However, pre-registration is required. To register, go to http://sntc.medicine.ufl.edu/training.aspx . Registration closes on Tuesday, August 13th,
2013.

Online Webinar: Listen to the lecture and view the presenter's slides on your computer and online via AdobeConnect. Ask questions and participate using the discussion tool. Connection information will be provided by email several days before the event and posted on our home page (http://sntc.medicine.ufl.edu) under What's Happening.

**Comprehensive Clinical TB Course**
Date: 10/7/2013 - 10/10/2013 Location: SNTC
Format: Clinical course
Registration will open soon. This four-day intensive course will familiarize the clinician with all the aspects of tuberculosis infection, disease and clinical care using an interdisciplinary and interactive approach. The curriculum is provided through lecture, interactive case management sessions. The faculty is selected for their unique skill in encouraging interaction and building rapport with participants. The atmosphere is relaxed with an expectation that a free exchange of questions, comments and information will occur.
Additional information: Driving and Lodging, October Flyer

**Tuberculin Skin Test Train-the-Trainer Course**
Date: 10/11/2013 - 10/11/2013 Time: 8:00 AM - 5:00 PM Eastern
Location: SNTC Instructor/speaker: Ellen R Murray, BSN, RN
Format: Lecture/didactic
This one-day skill-building course provides the knowledge needed to plan, teach, and evaluate a Mantoux Tuberculin Skin Test (TST) course. The course content includes skills for planning and conducting a TST training, including adult learning principles and teaching strategies. The curriculum is provided through lecture and participatory activities, including practicum in TST administration and reading and instructional skills demonstration. Each participant must demonstrate proficiency in delivering course content plus administering and reading the TST. Participants will receive feedback from experienced trainers as they practice their skills. Topics include: adult learning principles for instructors, tips and tools to plan and conduct a successful TST training, and TST course curriculum review and demonstration.
Additional information: Flyer, Agenda

**Comprehensive Clinical TB Course**
Date: 12/9/2013 - 12/12/2013 Time: 8:00 AM - 5:00 PM Eastern
Location: SNTC Format: Clinical course
Registration will open soon. This four-day intensive course will familiarize the clinician with all the aspects of tuberculosis infection, disease and clinical care using an interdisciplinary and interactive approach. The curriculum is provided through lecture, interactive case management sessions. The faculty is selected for their unique skill in encouraging interaction and building rapport with participants. The atmosphere is relaxed with an expectation that a free exchange of questions, comments and information will occur.
**Tuberculin Skin Test Train-the-Trainer Course**

7 credit(s) Date: 12/13/2013 - 12/13/2013 Time: 8:00 AM - 5:00 PM Eastern

Location: SNTC Instructor/speaker: Ellen R Murray, BSN, RN Format: Lecture/didactic

This one-day skill-building course provides the knowledge needed to plan, teach, and evaluate a Mantoux Tuberculin Skin Test (TST) course. The course content includes skills for planning and conducting a TST training, including adult learning principles and teaching strategies. The curriculum is provided through lecture and participatory activities, including practicum in TST administration and reading and instructional skills demonstration. Each participant must demonstrate proficiency in delivering course content plus administering and reading the TST. Participants will receive feedback from experienced trainers as they practice their skills. Topics include: adult learning principles for instructors, tips and tools to plan and conduct a successful TST training, and TST course curriculum review and demonstration.

Additional information: [Agenda](#), [Flyer](#)

**THE NEW JERSEY MEDICAL SCHOOL GLOBAL TB INSTITUTE**

**Upcoming Trainings:**

**Pennsylvania TB Update, August 9, 2013, Harrisburg, PA**

This course will provide updates on current topics in tuberculosis, including diagnosis and treatment of latent TB infection, pediatric TB, contact investigations in congregate settings, legal interventions, and TB in correctional facilities. The training will also provide an opportunity to network with colleagues. The format will include lectures, discussions and case studies. For additional information, please contact Jennifer K. Campbell at campbejk@umdnj.edu.

**Maryland TB Today Course, September 17-19, 2013, Marriottsville, MD**

This multi-day comprehensive TB course for health care providers covers TB epidemiology, diagnosis, treatment, laboratory methods, genotyping, contact investigation, case management, and various special topics. Lectures will be combined with interactive discussions as well as ample opportunity for networking. For additional information, please contact Rajita Bhavaraju at bhavarr@umdnj.edu.

**TB Intensive Workshop, September 24-27, 2013, Newark, NJ**

This workshop for clinicians provides comprehensive information on the principles and application of TB diagnosis and treatment, as well as the management of TB in special populations. Topics will include transmission and pathogenesis, diagnosis and treatment, infection control, drug resistance, TB-HIV co-infection, TB in children and adolescents, and key aspects of patient management. The four-day course utilizes a variety of teaching methods, including lectures, interactive discussions, small group work and case studies to enhance TB knowledge and clinical practice. For more information, please contact Anita Khilall at khilalan@umdnj.edu. Additional information for these and other upcoming trainings that are offered by the NJMS Global Tuberculosis Institute can be found at: [http://www.umdnj.edu/globaltb/training/trainingcalendar.html](http://www.umdnj.edu/globaltb/training/trainingcalendar.html)
THE HEARTLAND TB CENTER

Course Schedule  Click Here for Class Information

Aug 22: MDR-ENM, A Case of XDR

Aug 14: Ethical Dilemmas, WEBINAR, Tim Aksamit

Sept. 5, 12, 19, 26: Introduction to TB Nurse Case Management On-line Course (CDC CNE)

Sept. 18: TB Lab 101, WEBINAR, Ken Jost

THE CURRY INTERNATIONAL TUBERCULOSIS CENTER

The Curry International Tuberculosis Center is pleased to announce that our 2013 Training Schedule is now available, please visit: http://www.currytbcenter.ucsf.edu/training/schedule_2013.cfm

October 1-3, 2013 Oakland, CA Tuberculosis Clinical Intensive

The Curry International TB Center in Oakland is pleased to announce our upcoming Tuberculosis Clinical Intensive, scheduled for October 1-3, 2013 in Oakland, CA. This three-day training is designed for physicians and other licensed medical professionals who diagnose and treat tuberculosis (TB). Topics include: diagnosis, management, and treatment of active TB and latent TB infection, TB transmission and pathogenesis, pediatric TB, drug-resistant TB, and more. This training is approved for 19.50 Category 1 ACCME continuing education hours/nursing continuing education hours.

For a complete training description and application information, please visit: http://www.currytbcenter.ucsf.edu/training/tb_clinical_intensive.cfm

October 2, 2013 Washington State Educational Conference

November 12-14, 2013 Oakland, CA Tuberculosis Case Management and Contact Investigation Intensive

Three-day training for nurses, communicable disease investigators, and medical social workers.

*TBD 2013 On-Demand Webinar

*TBD 2013 Nurse-to-Nurse 2

*date to be posted once confirmed.

FROM NATIONAL JEWISH MEDICAL AND RESEARCH CENTER

The 50th Annual Denver TB Course October 9-12, 2013 Denver, Colorado

The purpose of this course is to present this body of knowledge to general internists, public health workers, infectious diseases and chest specialists, registered nurses, and other health care providers who will be responsible for the management and care of patients with tuberculosis. For more
FROM THE UNION

The Union’s International Management Development Programme 2013 Courses: To register for any of these courses, visit www.union-imdp.org or email imdp@theunion.org to receive more information. Course fee for all courses includes lodging, breakfast, lunch, coffee and tea breaks, and course materials.

Influencing, Networking and Partnership 23 – 27 September, 2013 Chicago

Creating partnerships and networks is an important element to the success of a TB program. Participants in this course will learn how relationship building and developing strong partnerships can boost health program results. Key topics the course addresses: Developing useful networks among health organizations; Creating partnerships to expand a project’s reach; Building group consensus to achieve greater results; Balancing relationships to create high-performing teams.

MEETINGS & CONFERENCES

Alphabetically listed by sponsoring organization

AMERICAN EVALUATION ASSOCIATION: October 16-19, Washington, D.C.

Evaluators from around the world are invited to share their knowledge and expertise at Evaluation 2013. Professional development workshops will be held October 14-16 and 20. AEA welcomes proposals on topics that span the breadth and depth of the field and in particular on those focusing on the conference theme of Evaluation Practice in the Early 21st Century.

AMERICAN PUBLIC HEALTH ASSOCIATION (APHA): 141st APHA Annual Meeting: November 2 - November 6, 2013, Boston, Ma

The APHA 141st Annual Meeting and Exposition will take place November 2–6 in Boston. Registration and housing for the Annual Meeting opened June 3. Discounted registration fees will be available until August 22. Opening General Session speakers include attorney and spokesperson on leadership and public issues, Sarah Weddington, internationally acclaimed epidemiologist, Michael Marmot, and Boston Mayor, Thomas Menino. The Closing General Session will focus on the health of native people. Keynote speaker Evan Tlesla Adams will share his experience as British Columbia’s first-ever aboriginal health physician advisor. The meeting will include more than 1,000 scientific sessions and countless networking opportunities. Find more information and register for the APHA Annual Meeting and Expo

FROM THE ASSOCIATION OF PUBLIC HEALTH LABORATORIES (APHL):

8th National Conference on Laboratory Aspects of Tuberculosis: August 19–21, 2013, San Diego, CA
OVERVIEW: This conference will focus on discussion of ongoing shifts in the TB laboratory system in both diagnostic technology and service delivery. Other topics will include: new methods to test for drug resistant tuberculosis; new drugs to treat drug resistant tuberculosis; the latest data on using molecular methods to test for TB; trouble shooting common problems in the TB laboratory; and global implications and practice. As detailed information becomes available APHL will activate the appropriate links. Check back often to find out the latest information. Conference Highlights; Preliminary Program; Online Registration (credit card payment only); Registration Form (payment by check or complimentary) Exhibitor & Sponsorship Prospectus; List of Exhibitors; Conference Evaluations; Hotel Information – Catamaran Resort Hotel For registration questions, please contact Terry Reamer at terry.reamer@aphl.org or 240.485.2776.

Download the Conference Flyer (HERE)

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS (ASTHO): ASTHO Annual Meeting:

THE UNION:

44th World Conference on Lung Health: October 30 - November 3, 2013, Paris, France

The 2013 theme is "Shared air, safe air?" Paris 2013 - Download Brochure The 44th Union World Conference on Lung Health is a 5 day conference covering the latest developments, opportunities and challenges in tuberculosis, HIV, tobacco control, lung health and non-communicable diseases. Registration can be accessed from the website at www.worldlunghealth.org. For more information, consult the registration guidelines and the registration fees. When registering, do not forget to select from the list your workshop or postgraduate course preference. Registration for these sessions is on a first come, first-served basis. The full list of workshops and post-graduate courses is accessible from the Programme menu on the website.

2nd PRESIDENT'S CENTENNIAL DINNER

This year, kick off your week in Paris by attending the 2nd President's Centennial Dinner on Wednesday, 30 October at 7 pm. This gala event supports The Union Centennial Campaign (1920-2020) by raising funds for research and education. To attend, please provide the requested information on your registration form. Learn more about The Union Centennial Campaign here

CALL FOR ABSTRACTS

As of this year, two abstract-driven sessions will be offered at The Union World Conference on Lung Health. The Union/CDC late-breaker session focusing on tuberculosis, and the HIV/TB late-breaker session organised by the HIV section of The Union. The deadline for submitting your abstract for these two late-breaker sessions is 31 July 2013. Don't miss the last opportunity to contribute to the programme of the conference by submitting an abstract! Read more on The Union/CDC late-breaker session on
tuberculosis, or go to HIV/TB late-breaker session for the submission process.

Hotel Booking: You can now book your hotel by submitting your request online. Click here to learn more on the individual and group accommodation booking or click here to proceed with your reservation. Congrex Travel has been appointed to handle accommodation requests. For any queries, contact Congrex at theunion@congrex.com.

Exhibition Booth Booking and Sponsorship Opportunities: A space designed to accommodate exhibitors who wish to present their products and services will be offered. Book your space and get ready to meet delegates representing institutions, governments and agencies from around the world. Click here for more information. Sponsorship opportunities include placing ads in the final and pocket programmes and conference e-newsletters, as well as inserting leaflets into the conference bags received by delegates. Click here for more information.

Post-graduate course highlight: 04. Managing children with drug-resistant tuberculosis: a practical approach

"The diagnosis and treatment of children with drug-resistant tuberculosis can be intimidating. However, given appropriate care, children can achieve excellent outcomes. This one-day course will give health workers practical advice on how to diagnose children and treat them, how to prepare the drugs and manage adverse events, how to provide this care within the context of a family-centred approach and finally how to monitor progress on a programmatic level." Mercedes Becerra (United States of America) and James Seddon (United Kingdom) will present this session on Thursday, 31 October 2013, from 09:00 to 17:00. Click here to view the full description of the course and here to book your seat by registering now!

Registrations are limited so book early to avoid disappointment.

From TAG:

Cascades: Improving TB Care, Friday, November 1, 2013, 18h00 - 22h00 Location: Hôtel Concorde La Fayette Batignolles/ Longchamp Room 3, Place du Général Koenig 75850 Paris Cedex 17 – France (within walking distance of Le Palais des Congrès de Paris)

Conference registration NOT required for attendance. Refreshments and snacks will be served. For more information: Lindsay.Mckenna@treatmentactiongroup.org

THE UNION, NORTH AMERICAN REGION:
18th Annual Conference of The Union, North America Region, February 27 – March 1, 2014, Boston, MA

“Stronger Together: Stopping TB, From Laboratory to Clinic”

REGISTRATION COMING SOON!

CALL FOR ABSTRACTS
We welcome the submission of abstracts for poster and oral presentations of research on all aspects of tuberculosis control, including epidemiologic, clinical, basic science, nursing, social, behavioral, psychosocial and educational studies, as well as outcomes of program initiatives. Abstracts must be submitted in accordance with these guidelines. Deadline for abstract submission: October 7, 2013. To download the forms: click here

**TRAVEL GRANT AWARDS**

We are pleased to offer travel grants to selected individuals within the Americas and the Caribbean who would otherwise be unable to attend the 18th Annual Conference of the Union – North American Region without financial assistance. It is highly recommended that you seek additional sources of funding. Additional mentoring opportunities in the field of TB will be available for selected travel grant recipients. Deadline for Travel Grant Award submission: October 7, 2013. To download the forms: click here

For questions, please contact: Menn Biagtan at biagtan@bc.lung.ca Phone: 604.731.5864 Fax: 604.731.

**VIROLOGY EDUCATION: 6th International workshop on Clinical Pharmacology of TB Drugs**

September 2013, Denver CO, USA

The aim of this abstract driven workshop is to make a significant contribution to the optimization of TB treatment by bringing experts together to present and discuss the latest important scientific findings in the TB clinical Pharmacology field. Ample time is reserved to discuss and translate scientific and regulatory issues to further optimize TB treatment. The format will be a one-day workshop with invited lectures, abstract presentations and sufficient Q&A time to guarantee an intimate and highly interactive event.

We encourage you to submit your data for an oral or poster presentation on the following topics: Pharmacokinetics and Pharmacodynamics of Approved TB Drugs; Pharmacokinetics and Pharmacodynamics of New TB Drugs; Pharmacokinetic- & Pharmacodynamics modeling; Drug-drug and drug-disease state interactions; TB treatment in special populations; New Drug Development MethodS

The Workshop Materials from the edition of this workshop are available on our website.