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**APPROACHES TO IMPROVE SPUTUM SMEAR MICROSCOPY  
FOR TUBERCULOSIS DIAGNOSIS**

**EXPERT GROUP MEETING REPORT**

**GENEVA: 31 OCTOBER 2009**

This report contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization. Endorsement of a technology does not imply endorsement of any specific commercial product.

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## APPROACHES TO IMPROVE SPUTUM SMEAR MICROSCOPY FOR TUBERCULOSIS DIAGNOSIS

### 1. BACKGROUND

Direct sputum smear microscopy is the most widely used test for the diagnosis of pulmonary tuberculosis (TB), available in most primary health care laboratories at health centre level. The majority of laboratories use conventional light microscopy to examine Ziehl-Neelsen stained direct smears, documented to be highly specific in areas with a high prevalence of TB but with varying sensitivity (20-80%). Besides being labour-intensive, direct sputum smear microscopy may have considerable patient costs and inconvenience associated with the need to submit multiple sputum specimens over a period of up to three days. A number of TB control programmes have reported high rates of initial patient default as a result.

Simple rapid diagnostics that can replace direct smear microscopy at the lower levels of health services are urgently needed; however, it is also recognized that these are unlikely to become available in the short to medium term. Considerable recent research has therefore focused on ways to improve smear microscopy and its yield for TB case-finding. A series of systematic reviews commissioned in 2005 by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) covered three ways of improving sputum microscopy: sputum processing methods, fluorescence microscopy, and more efficient direct examination of specimens. An Expert Consultation by WHO was subsequently convened in September 2005 to consider the evidence in these reviews, with the following findings and recommendations:

#### *Sputum processing methods*

The systematic review on sputum processing methods reported that chemical processing (by bleach) prior to concentration by centrifugation or overnight sedimentation improved the sensitivity of smear microscopy by 18% and 23%, respectively. In all studies reported, sensitivity for processed smears was higher than for direct smears, including one study involving HIV-infected individuals (with mycobacterial culture as gold standard) where sensitivity was increased by 11%. The Expert Consultation did, however, not recommend the use of bleach with centrifugation or sedimentation at that time because of large variations in study methodology and inconsistencies in the results reported. Additionally, concerns were raised about the safety of centrifugation-based methods at peripheral laboratory level, and the feasibility of implementing such methods on a large-scale.

The Expert Consultation called for research to develop standardized methods and understand the basis of the wide variability in performance reported. A number of research groups have addressed this in studies since 2005.

#### *Fluorescence microscopy*

The systematic review of fluorescence microscopy (FM) reported sensitivity to be 10% higher than conventional ZN microscopy, and noted that examination of fluorochrome-stained smears took 25% of the time taken to examine ZN-stained smears. The Expert Consultation in 2005 recommended that FM be considered at all levels of the health system, particularly in high HIV prevalence settings and in settings with high laboratory workload. However, it was also acknowledged that FM based on the technology available in 2005 (expensive microscopes with mercury vapour light sources) would be difficult to implement in resource-poor settings. In addition, concern was expressed about the lack of internationally-agreed methods for external quality assessment of FM.

The Expert Consultation called for research to develop fluorescence microscopes that could overcome the limitations of existing equipment, particularly those related to capital costs and maintenance needs. Since then it had been shown that low-cost ultra-bright light-emitting diodes (LEDs) with a long lifespan could replace expensive mercury vapour lamps and enable the development of microscopy systems that are substantially less expensive than conventional FM, offering the possibility for widespread use of LED-based FM in resource-limited settings. In view of these potential advantages, several companies have developed inexpensive, robust LED microscopes or LED attachments for routine use in high-burden countries. Preliminary data suggested that LED microscopy is feasible and as accurate as standard FM and field evaluation studies had been completed in several countries.

#### *Serial sputum specimen examination ('front-loading')*

A systematic review of the yield of serial sputum specimen examinations for the diagnosis of TB confirmed that the majority of TB cases were detected with the first sputum specimen (85.8%), while the average incremental yield of the second and third sputum specimen was 11.9% and 3.1% respectively. The Expert Consultation in 2005 concluded that, although the evidence was compelling, the examination of three specimens would be necessary as long as the definition of a smear-positive case required two positive smears.

The Expert Consultation called for further research on the sensitivity and specificity of a revised case definition based on one positive smear. This research was subsequently undertaken by a number of international partners and presented to the WHO Strategic and Technical Advisory group for TB (STAG-TB). In 2007, the definition of a smear-positive case was revised by WHO and the minimum number of sputum specimens to be examined reduced from three to two in settings where a well-functioning external quality assurance system exists, the workload is high, and human resources are limited. This approach greatly reduces the workload in laboratories, a considerable advantage in countries with high HIV prevalence.

The Expert Consultation in 2005 also called for research on the optimal timing of specimen collection to minimise delays in the patient diagnostic pathway. Currently, most sputum specimens - following the spot-morning-spot system - are examined on the second day that the patient presents. Alternatively, frontloaded microscopy (also called 'same day' or 'one-stop' microscopy) involves sputum smear microscopy approaches that entails the majority (or all) of the specimens being examined on the first day. Studies to determine whether the number of patient visits required for standard TB diagnosis can be reduced, and whether the delay in diagnosis can be cut from three days to one day, have subsequently been conducted, also investigating the possibility that drop-out from the diagnostic pathway can be significantly reduced.

In 2009, three systematic reviews were commissioned by WHO to assess approaches to improve microscopy for TB diagnosis. These included sputum processing methods, frontloaded strategies for sputum investigation, and LED fluorescence microscopy.

## **2. EVIDENCE BASE**

### **2.1 Process**

The systematic, structured, evidence-based process for policy generation as developed recently by WHO was followed: The first step constituted a systematic review and meta-analysis of available data (published and unpublished) using standard methods appropriate for diagnostic accuracy

studies. The second step involved the convening of an Expert Group to a) evaluate the strength of the evidence base; b) recommend operational and logistical considerations for mainstreaming such the methods/approaches into national TB control programmes; and c) identify gaps to be addressed in future research. Based on the Expert Group findings, the third and final step involves WHO policy guidance on the use of these tools/approaches, presented to the WHO Strategic and Technical Advisory Group for TB (STAG-TB) for consideration, and eventual dissemination to WHO member states for implementation.

The Expert Group (Annex 1) consisted of researchers, clinicians, epidemiologists, end-users (programme and laboratory representatives), and evidence synthesis experts. The Expert Group meeting followed a structured agenda (Annex 1) and was chaired by WHO. To comply with current standards for evidence assessment in formulation of policy recommendations, the GRADE system ([www.gradeworkinggroup.org](http://www.gradeworkinggroup.org)), recently adopted by WHO for all policy and guidelines development, was used. The GRADE approach, assessing both the quality of evidence and strength of recommendations, aims to provide a comprehensive and transparent approach for developing policy guidance. Started about 10 years ago to assess treatment interventions, the GRADE approach has recently been refined for diagnostics;<sup>1</sup> however, while the latter process shares the fundamental logic of recommendations for other interventions (notably treatment), it also presents unique challenges, most often due to study limitations related to a lack of data on patient-important outcomes and impact (see below).

Randomised controlled trials (RCTs) of alternative diagnostic approaches represent the ideal study design for informing eventual policy decisions; however, very few such studies are available for diagnostic interventions in general. Data from RCTs were available for the systematic review on front-loading (with outcomes focussed on diagnostic accuracy), but not for the sputum processing or LED microscopy reviews.

Recognising that test results are surrogates for patient-important outcomes, the Expert Group evaluated diagnostic accuracy while also drawing inferences on the likely impact of these approaches on patient outcomes, as reflected by false-negatives (ie. cases missed) or false-positives. In addition, the Expert Group considered the implications of each approach or method for programmatic implementation, including laboratory infrastructure, human resources, interface between patients and laboratory services, diagnosis and initiation of treatment, costs to the health system and to patients, and research gaps.

## **2.2 Systematic reviews and meta-analyses**

Systematic reviews and meta-analyses were commissioned by WHO for each approach under evaluation. One of the standardised objectives was, for each method/approach, to perform a systematic review of available literature (published and unpublished), followed by a meta-analysis (where appropriate), on data examining the diagnostic accuracy of each approach for the detection of TB cases. All systematic reviews and meta-analyses followed standard protocols, using predetermined eligibility criteria for the primary analyses. Detailed methodology is described in individual systematic review reports available at [www.who.int/tb/dots/laboratory/policy](http://www.who.int/tb/dots/laboratory/policy).

## **2.3 Evaluation of the strength of the evidence base**

Evaluation followed the GRADE system for grading quality of evidence and strength of recommendations for diagnostic tests and strategies. The quality of evidence was graded by six criteria:

- *Study design*

- a. Cross-sectional: Random or consecutive selection of patients/specimens at risk (preferred)
- b. Case-control: Selection of patients/specimens according to reference standard

- *Risk of bias (as reflected by the QUADAS tool)*

Compliance of studies with 14 independent quality assessment criteria (Table 1)

- *Directness*

Presence of direct evidence of impact on patient-important outcomes and generalisability

- *Inconsistency*

Unexplained inconsistency in sensitivity or specificity estimates

- *Imprecision*

Wide confidence intervals for pooled sensitivity or specificity estimates

- *Publication/reporting bias*

Publications of research based on their nature and outcome, eg. studies showing poor performance not being published, language bias, etc.

Study limitations were assessed by QUADAS (Quality Assessment of Diagnostic Accuracy Studies) criteria, a validated tool based on a checklist of 14 essential items:<sup>2</sup>

**Table 1: QUADAS**

Item #	Description
1.	Was the spectrum of patients representative of the patients who will receive the test in practice?
2.	Were selection criteria clearly described?
3.	Is the reference standard likely to correctly classify the target condition?
4.	Is the time period between reference standard and index test short enough to be reasonably sure that the target condition did not change between the two tests? (disease progression bias)
5.	Did the whole sample or a random selection of the sample, receive verification using a reference standard of diagnosis? (partial verification bias)
6.	Did patients receive the same reference standard regardless of the index test result? (differential verification bias)
7.	Was the reference standard independent of the index test (i.e. the index test did not form part of the reference standard)? (incorporation bias)
8.	Was the execution of the index test described in sufficient detail to permit replication of the test?
9.	Was the execution of the reference standard described in sufficient detail to permit its replication?
10.	Were the index test results interpreted without knowledge of the results of the reference standard? (test review bias)
11.	Were the reference standard results interpreted without knowledge of the results of the index test? (diagnostic review bias)
12.	Were the same clinical data available when test results were interpreted as would be available when the test is used in practice? (clinical review bias)
13.	Were uninterpretable/ intermediate test results reported?
14.	Were withdrawals from the study explained?

As called for by GRADE, the Expert Group also considered for each method/approach the strength of the recommendation (strong or weak), based on a balance of effects (advantages weighed against disadvantages), patient values and preferences, and - in the case of LED microscopy - costs related to human resources, laboratory infrastructure, equipment and consumables. Given the absence of relevant data from the studies reviewed, assumed patient values and preferences were assessed by test accuracy as a proxy measure, based on the relative importance/impact of false-positive and false-negative results:

- True positives: Benefit to patients from earliest diagnosis and treatment;
- True negatives: Patients spared unnecessary treatment; benefit of reassurance and alternative diagnosis;
- False positives: Likely patient anxiety and morbidity from additional testing, unnecessary treatment; may halt further diagnostic evaluation;
- False negatives: Increased risk of patient morbidity and mortality, and continued risk of community transmission of TB.

The GRADE process allows for systematic reviewers to add additional quality indicators if deemed relevant. The reviews for front-loading and sputum processing methods therefore extracted additional data on external quality assurance from studies.

## **2.4 Meeting procedural issues**

The systematic review reports were made available to the Expert Group for scrutiny before the meeting.

As agreed, interchange by Expert Group meeting participants was restricted to those who attended the Expert Group meeting in person, both for the discussion and follow-up dialogue.

The Expert Group was urged to formulate practical recommendations that countries would be able to use. WHO is committed to ensuring that the highest standards of evidence are used in formulation of recommendations and has therefore standardised the synthesis process based on the GRADE approach. The first paper specifically addressing the GRADE approach to diagnostic tests and strategies was published in 2008 (Schunemann. BMJ 2008; 336:1106-1110) and was made available to the Expert Group in the background documentation for the meeting.

It was explained that individuals were selected to be members of the Expert Group to carefully represent and balance important perspectives for the process of formulating recommendations. Therefore the Expert Group included technical experts, end-users and evidence synthesis methodologists.

As expected, it took some time and energy for the Expert Group to begin to understand and work effectively with the GRADE approach. While the Group appreciated the rationale for using a standardised approach and endorsed the direction provided by the GRADE process, concerns were expressed that GRADE methodology is not yet fully developed or adapted for evaluation of public health strategies or programmatic interventions, which are often complex and multi-factorial. Four issues in particular were highlighted:

- The lack of standardised methodology to search for and objectively synthesize evidence on operational implementation issues, costs to health services, costs to patients, and patient perspectives on new diagnostic tests and approaches;
- The risk that narrative evidence on the above issues may be excluded from search strategies during systematic reviews of studies on diagnostic accuracy;
- Concern that results from qualitative and socio-economic studies may not have been captured in the systematic reviews on diagnostic accuracy of the different approaches;



- The risk that results from studies on microscopy techniques may be under-weighted if mycobacterial culture is used as the only reference standard for comparison, especially in settings where culture capacity does not exist;
- The risk that patient outcomes may not reflect the accuracy or benefit of a diagnostic test/approach in settings with weak overall health infrastructure (eg. rapid or improved microscopy in facilities where stock-outs of anti-TB drugs occur frequently);
- The possible tension (for TB tuberculosis diagnosis and control) between the importances of individual patient outcomes vs public health outcomes (eg. the notion that false-negative sputum smear results may pose a greater public health risk than false-positive results).

The Expert Group felt strongly that these concerns should be fed back to the GRADE Working Group and should also be taken into account when the final recommendations emerging from this consultation are considered by STAG. These concerns should also be addressed by WHO during future systematic reviews and Expert Group consultations.

### **3. RESULTS**

#### **3.1. FRONT-LOADED VS CONVENTIONAL STRATEGIES FOR SPUTUM COLLECTION**

The results from seven studies involving 7,308 patients were reviewed.

##### **3.1.1 Front-loaded vs conventional strategies using two specimens and direct ZN microscopy**

Pooled summary estimates showed that the sensitivity of a front-loaded approach (64%; 95CI 59% - 69%) was similar to that of the conventional two-specimen approach (65%; 95CI 62% - 69%). Pooled specificity estimates were identical (98%; 95CI 97% - 99%;).

One large randomised controlled trial (6,628 patients in four different sites) reported data on differential patient losses to follow-up for the two diagnostic approaches, indicating that patients assigned to the front-loaded scheme were more likely to submit the first two (spot-spot) specimens than patients assigned to the conventional (spot-morning) scheme (97.9% vs 94.3%; difference 3.6%, 95%CI 2.7-4.5%).

##### **3.1.2 Front-loaded vs conventional strategies using three specimens and direct ZN microscopy**

Pooled sensitivity estimates for the two strategies were similar and did not differ statistically: front-loading 71% (95CI 65% - 77%); conventional 68% (95CI 63% - 73%). Pooled specificity estimates were also similar at 98% (95CI 96% - 99%) for front-loading and 99% (95CI 97% - 99%) for the conventional approach.

In the same study mentioned above reporting data on differential losses to follow-up (6,628 patients, four different sites), patients assigned to the front-loaded approach were more likely to submit the third specimen (94.2%) than those assigned to the conventional approach (92.7%), difference 1.5%, 95% CI 0.3%-3.7%.

##### **3.1.3 Yield from two vs three specimens in a front-loaded approach with direct ZN microscopy**

The sensitivity of three-specimen front-loaded microscopy was slightly superior (4.8%) to that of two-specimen front-loaded microscopy, although specificity (98%) did not vary (data not shown).

### **3.1.4 Front-loaded vs conventional strategies in HIV-infected patients**

The abovementioned randomised controlled trial reported data on the performance of front-loaded and conventional strategies in a subset of HIV-infected patients (n=586). For the two-specimen collection strategy, the conventional approach was less sensitive (50%; 95CI 36% - 64%) than front-loaded microscopy (66%; 95CI 52% - 78%) although this difference was not statistically significant. Specificity using front-loaded microscopy was lower (95%; 95CI 91% - 98%) than conventional microscopy (98%; 95CI 95% - 99%), but this difference was not statistically significant). No significantly different results were observed between a three-specimen and two-specimen front-loaded approach.

### **3.1.5 Frontloaded vs conventional strategies using LED fluorescent microscopy**

One study compared front-loaded and conventional strategies, using LED fluorescent microscopy, in a subset of patients (n=2,303) enrolled in the randomised controlled trial mentioned above. Using the two-specimen collection strategy, the sensitivity of front-loaded LED microscopy (68%; 95CI 62% - 74%) did not differ significantly from that of conventional fluorescent microscopy (72%; 95CI 66% - 77%). Specificity of front-loaded LED microscopy (95%; 95CI 93% -96%) was also not statistically different when compared to conventional fluorescent microscopy (94%; 95CI 92% - 95%).

Findings were similar for the three-specimen collection strategy: Sensitivity of front-loaded LED microscopy (75%; 95CI 69% - 80%) did not differ significantly from that of conventional fluorescent microscopy (74%; 95CI 68% - 79%). Specificity also did not differ between the two methods, LED specificity being 92% (95CI 91% - 94%) and that of conventional fluorescent microscopy being 93% (95CI 91% - 94%).

This difference was smaller when the proportion of patients with three smears was considered (94.2% in the frontloaded and 92.7% in the standard scheme, difference 1.5%, 95%CI 0.3%-3.7%).

When three-specimen front-loaded LED microscopy was compared with a two-specimen frontloaded LED approach, sensitivity did not differ statistically although specificity was slightly lower (data not shown).

### **3.1.6 Single specimen microscopy in a front-loaded approach**

Two of the paired observational studies carried out secondary analyses on the yield from two smears prepared from the same sputum specimen (1,849 patients). Overall, the quality of evidence for both studies was rated as low, being downgraded for risk of bias, absence of patient-important outcomes, and inconsistent results. QUADAS criteria (risk of bias) particularly suffered from lack of patient representativeness and uninterpretable results not being reported, possibly over-inflating accuracy estimates:

Sensitivity and specificity estimates differed between the two studies, with lower sensitivity seen in the study which enrolled hospitalised patients only, included a higher proportion of HIV-infected patients, and used concentrated fluorochrome smears.

There was no significant difference in sensitivity or specificity between two-smear conventional microscopy and two-smear single specimen microscopy; however, heterogeneity (variability) was observed in both sensitivity and specificity in individual studies and since fewer than four studies were available no pooled accuracy estimates could be reliably generated.

Data were therefore excluded from subsequent assessment by the Expert Group.

### 3.1.7 Quality of evidence

Table 1 provides a summary of the accuracy data for conventional vs front-loaded approaches using microscopy.

Table 1. Summary of accuracy data on front-loaded approaches to case-finding by microscopy																	
APPROACH		Conventional				Front-loaded											
# Studies		7				7											
# Participants		7,308				7,308											
Pooled accuracy estimates from meta-analyses																	
<i>Two specimens and direct ZN</i>																	
Sensitivity										65% (95CI 62 - 69)				64% (95CI 59 - 69)			
Specificity										98% (95CI 97 - 99)				98% (95CI 97 - 99)			
consequence assuming 20% prevalence, with expected # per 1000																	
		TP	TN	FP	FN	TP	TN	FP	FN								
		130	784	16	70	128	784	16	72								
<i>Three specimens and direct ZN</i>																	
Sensitivity										68% (95CI 63 - 73)				71% (95CI 65 - 77)			
Specificity										99% (95CI 97 - 99)				98% (95CI 96 - 99)			
consequence assuming 20% prevalence, with expected # per 1000																	
										TP	TN	FP	FN	TP	TN	FP	FN
		136	792	8	64	142	784	16	58								
<i>Note: No statistically significant difference between two- and three-specimen strategy</i>																	
Accuracy estimates in subset of HIV-positive patients (one study, n = 586)																	
Sensitivity										50% (95CI 36 - 64)				66% (52 - 78)			
Specificity										98% (95CI 95 - 99)				95% (91 - 98)			
<i>Note: No statistically significant difference</i>																	
Accuracy estimates using front-loaded LED microscopy (one study, n = 2,303)																	
Sensitivity										72% (95CI 66 - 77)				68% (62 - 74)			
Specificity										94% (95CI 92 - 95)				95% (93 - 96)			
<i>Note: No statistically significant difference</i>																	

Factors affecting quality of evidence	
Design <sup>1</sup>	3 paired observational, 4 randomised controlled trials
Risk of bias (QUADAS) <sup>2</sup>	None
Directness (generalisability) <sup>3,4</sup>	Some uncertainty (-1 for patient-important outcomes)
Inconsistency	Low
Imprecision	Low
Publication/reporting bias	Unlikely

<sup>1</sup>All studies used culture as a reference standard and examined unprocessed (direct) smears using light microscopy with conventional ZN staining;

<sup>2</sup>All studies satisfied all 14 QUADAS quality requirements;

<sup>3</sup>Quality of evidence was downgraded in all systematic reviews for insufficient evidence on patient-important outcomes. False-positive results were judged to be less serious than false-negative results for public health impact (Expert Group opinion);

<sup>4</sup>All studies were conducted in a wide range of settings and appropriate patient groups. Many of the studies had been carried out in high HIV-prevalence settings, although limited data on HIV status of individual patients were available..

### 3.1.8 Balance of desirable and undesirable effects

- Concern was expressed about the loss of the morning specimen in a front-loaded approach, especially as the reference specimen for culture for those diagnostic centres where culture is routinely performed;
- The proportion of patients completing diagnostic evaluation was similar in a randomised control trial comparing front-loaded and conventional approaches; however, more data are needed from routine/programmatic settings where patient drop-out is common to assess this patient-important outcome more fully;
- A front-loaded approach will, at the very least, not be any worse than the conventional approach in terms of its ability to detect and start smear positive patients on treatment.

### 3.1.9 Values and preferences of patients

- No data were presented on values and preferences of patients, but the opinion and experience of selected Expert Group members suggested that (especially) poor patients have many difficulties with the conventional approach and may prefer a front-loaded approach which at least has the potential to reduce the time taken and patient costs incurred for a diagnosis to be established;
- On the other hand, selected members of the Expert Group raised concerns about the acceptability of a prolonged stay at health services while patients are waiting to produce the second specimen in a front-loaded approach, especially by employed patients. Concerns were also expressed about the risk of TB transmission in congregate settings and vulnerable populations (such as HIV-positive individuals, children, and pregnant women, especially where infection control measures are weak;

- Concerns were expressed on the impact of a front-loaded approach on laboratory work load and organization, and the need to ensure that specimens collected in a front-loaded approach be read and the results reported on the same day.

### **3.1.10 Cost and requirements**

- No data were presented, but selected members of the Expert Group were of the opinion that front-loading would reduce costs to both the health service and to patients;
- On the other hand, selected members of the Expert Group expressed concerns about the health service cost related to implementation of front-loading, notably retraining of health care and laboratory staff;

### **3.1.11 Research gaps identified**

Further research on the patient-important outcomes of a front-loaded approach to sputum collection is encouraged in the following areas:

- Patient preferences on front-loaded vs standard sputum collection approaches;
- Costs to patients and health services of front-loaded vs conventional sputum collection approaches;
- Patient drop-out during the diagnostic process comparing front-loading to conventional sputum collection approaches;
- The relative yield when two smears are prepared from the same sputum specimen.

These issues are best explored under programmatic conditions, preferably during phased implementation, so that comparisons can be made between sites implementing front-loading and sites still using conventional approaches.

## **FINAL RECOMMENDATION**

The Expert Group felt that there was sufficient generalisable evidence that front-loading is equivalent, in terms of diagnostic accuracy, to existing conventional case-finding approaches by microscopy, irrespective of whether two or three specimens are used. However, countries that may wish to switch to a front-loaded approach should do so through a carefully phased implementation plan to ensure that critical programmatic and operational issues are addressed.

Implementation should be preceded by a validation phase in each setting in which a front-loaded approach is considered, ensuring that the following programmatic issues are adequately addressed:

- Training requirements for at least the following health personnel cadres: staff responsible for requesting sputum smear microscopy, staff instructing patients on sputum collection and submission, laboratory staff, staff responsible for registering patients and initiating TB treatment;

- Alignment of sputum collection, microscopy reporting, and initiation of TB treatment as far as possible within existing human resource and laboratory work-load constraints. Front-loading has the potential to reduce costs for patients, but this potential can only be realised if results are issued and treatment initiated alongside the front-loading time-scale;
- Separation of patients producing sputum specimens from other non-coughing patient groups (especially those with HIV) to reduce the risks of TB transmission in health care settings. Adequate infection control practices and rapid triage of coughing patients in congregate settings and vulnerable populations are imperative;
- Monitoring of patient drop-out between laboratory and treatment registers, and monitoring of trends in case-detection and treatment outcomes are essential.

<b>OVERALL QUALITY OF EVIDENCE</b>	<b>MODERATE</b>
<b>STRENGTH OF RECOMMENDATION</b>	<b>STRONG, PROVIDED THAT PROGRAMMATIC CHALLENGES ARE SIMULTANEOUSLY ADDRESSED</b>  <b>WEAK, IF PROGRAMMATIC CHALLENGES ARE NOT SIMULTANEOUSLY ADDRESSED</b>

### **3.2 SPUTUM PROCESSING METHODS FOR IMPROVED SMEAR MICROSCOPY**

Classification of studies according to chemical and physical sputum processing methods identified four groups containing at least four studies (to allow pooled accuracy estimates to be done): Bleach was the most common agent (14 studies), followed by NALC-NaOH (8 studies) and NaOH alone (5 studies). All studies that used NALC-NaOH or NaOH alone physically processed specimens by centrifugation. The four groups identified by combining chemical and physical processing methods were 1) bleach centrifugation; 2) bleach sedimentation; 3) NALC-NaOH centrifugation; and 4) NaOH centrifugation alone. In addition to these four groups, data were synthesized separately for four studies that reported diagnostic accuracy estimates among confirmed HIV-infected patients.

Results are summarised below. Detailed methodology and findings are described in individual systematic review reports ([www.who.int/tb/dots/laboratory/policy](http://www.who.int/tb/dots/laboratory/policy))

#### **3.2.1 Bleach centrifugation**

Nine cross-sectional studies involving 3,923 participants were reviewed. Five (56%) studies performed bleach processing using a concentration of 5% or more, five (56%) studies performed centrifugation at high speed ( $\geq 2,500$  rpm or  $\geq 2,000g$ ), and seven (78%) studies examined smears using light microscopy after ZN staining. Six (67%) studies reported that smears were prepared and interpreted in the same laboratory and four (44%) studies reported that external quality assurance was in place.

No study met all QUADAS criteria assessed and only three (33%) studies adequately described patient/specimen selection. The majority of studies did, however, satisfy all of the other QUADAS criteria.

Sensitivity was inconsistent across studies for bleach centrifugation (range 44% - 73%;  $p < 0.001$ ) when compared to direct microscopy (range 31% - 72%;  $p < 0.001$ ). Pooled sensitivity was higher for bleach centrifugation (65%; 95CI 59 - 71) than for direct microscopy (56%; 95CI 49% - 63%). When sensitivity differences were pooled across studies, bleach centrifugation microscopy was 6% (95CI 3% - 10%;  $p = 0.001$ ) than direct microscopy.

Specificity was consistent for direct microscopy (range 95% - 100%;  $p = 0.06$ ) but more variable for bleach centrifugation microscopy (range 81% - 100%;  $p < 0.001$ ). Pooled specificity was high for both bleach centrifugation (96%; 95CI 93% - 98%) and for direct microscopy (98%; 95CI 97% - 99%). However, there was a small but statistically significant decrease in specificity with bleach centrifugation microscopy (-3%; 95CI -4% to -1%;  $p = 0.004$ ).

Compared to direct microscopy, bleach microscopy was 3% (95CI 1% - 6%;  $p = 0.02$ ) more sensitive in studies using low-speed centrifugation and 7% more sensitive (95CI 1% - 14%;  $p = 0.002$ ) in studies using high-speed centrifugation. However, specificity was significantly decreased with high-speed (-6%; 95CI -11% to -1%,  $p = 0.02$ ) but not with low speed centrifugation (-1%; 95CI -3% to +1%;  $p = 0.18$ ).

#### **3.2.2 Bleach sedimentation**

Five cross-sectional studies involving 2,307 participants were reviewed. Five (40%) performed bleach processing using a concentration of 5% or more, 3 (60%) studies performed overnight sedimentation, and all studies examined smears using light microscopy and ZN staining. All studies reported that smears were prepared and interpreted in the same laboratory and two (40%) studies reported that external quality assurance was in place. Three (60%) studies met all QUADAS criteria. Of the remaining two studies, one did not enrol ambulatory TB suspects, two did not describe

patient selection, and one did not report whether microscopy results were interpreted in a blinded fashion.

Sensitivity was consistent across studies for direct microscopy (range 49% - 51%) but not for bleach sedimentation microscopy (range 52% - 83%). Pooled sensitivity was higher for bleach sedimentation (63%; 95CI 51% - 74%) than for direct microscopy (50%; 95CI 47% - 53%). When sensitivity difference were pooled across studies, bleach sedimentation microscopy was 9% (95CI 4% - 14%) more sensitive than direct microscopy.

Specificity was consistent for direct microscopy (range 96% - 99%;  $p=0.36$ ) but was more variable for bleach sedimentation (range 86% - 99%;  $p<0.001$ ). Pooled specificity was high for both bleach sedimentation (96%; 95CI 91 - 99%) and for direct microscopy (98%; 95CI 97% - 99%).

Compared to direct microscopy, bleach microscopy was 2% (95CI 3% - 37%;  $p=0.02$ ) more sensitive in studies using overnight sedimentation. There was no significant difference in specificity with either short-term (-2%; 95CI -5% to 0%;  $p=0.05$ ) or overnight sedimentation (-3%; 95CI -6% to +1%;  $p=0.17$ ).

### **3.2.3 NALC-NaOH centrifugation**

Eight studies involving 2,785 participants were reviewed. All studies were cross-sectional in design, reported similar NALC-NaOH processing methods, and used high-speed centrifugation. Four (50%) examined smears using light microscopy and ZN staining. Seven (88%) studies reported that smears were prepared and interpreted in the same laboratory and one (13%) reported that external quality assurance was in place. No study met all QUADAS criteria. None reported enrolling ambulatory TB suspects, two (25%) clearly described patient selection, and five (63%) reported that microscopy results were interpreted in a blinded fashion.

Two studies were excluded when calculating pooled estimates of diagnostic accuracy because data to calculate specificity were not reported. Sensitivity was inconsistent across studies for NALC-NaOH centrifugation (range 52% - 93%;  $p<0.001$ ) and for direct microscopy (range 29% - 82%;  $p<0.001$ ). Pooled sensitivity was higher for NALC-NaOH centrifugation (78%; 95CI 62% - 89%) than for direct microscopy (55%; 95CI 47% - 62%). When sensitivity difference were pooled across studies, NALC-NaOH centrifugation microscopy was 19% (95CI 7% - 32%) more sensitive than direct microscopy.

Specificity was consistent for direct microscopy (range 79% - 100%;  $p=0.08$ ) but was more variable for NALC-NaOH centrifugation microscopy (range 32% - 100%;  $p<0.001$ ). Pooled specificity was high for both NALC-NaOH centrifugation (95%; 95CI 78 - 99%) and for direct microscopy (99%; 95CI 96% - 100%).

### **3.2.4 NaOH centrifugation**

Six studies involving 4,056 participants were reviewed. All studies were cross-sectional in design, and performed chemical processing with 4% NaOH. Four (67%) used high-speed centrifugation and five (83%) studies examined smears using light microscopy and ZN staining. All studies reported that smears were prepared and interpreted in the same laboratory and one (17%) reported that external quality assurance was in place. One study met all QUADAS criteria. Of the remaining five, three reported enrolling ambulatory TB suspects, two clearly described patient selection, and two reported that microscopy results were interpreted in a blinded fashion.

One study was excluded when calculating pooled estimates of diagnostic accuracy because data to calculate specificity were not reported. Sensitivity was inconsistent across studies for NaOH centrifugation (range 45% - 94%;  $p>0.001$ ) and for direct microscopy (range 47% - 80%;  $p>0.001$ ).



Pooled sensitivity was higher for NaOH centrifugation (78%; 95CI 61% - 89%) than for direct microscopy (65%; 95CI 52% - 75%). When sensitivity difference were pooled across studies, NaOH centrifugation microscopy was 8% (95CI 1% - 16%;  $p=0.03$ ) more sensitive than direct microscopy.

Specificity was consistent for NaOH centrifugation microscopy (range 95% - 99%;  $p=0.66$ ) and for direct microscopy (range 95% - 99%;  $p=0.08$ ). Pooled specificity was high for both NaOH centrifugation (99%; 95CI 98 - 99%) and for direct microscopy (99%; 95CI 98% - 99%). There was no significant difference in specificity between the two methods ( $p=0.53$ ).

### 3.2.5 Any processing method in specimens from HIV-infected individuals

Direct microscopy was compared to bleach centrifugation microscopy in three studies and with NALC-NaOH centrifugation in one study. Three studies examined smears using light microscopy and ZN staining. Three studies reported that smears were prepared and examined in the same laboratory and three studies reported that external quality assurance was in place. One study met all QUADAS criteria assessed. Of the remaining three studies, none reported enrolling ambulatory TB suspects, none clearly described patient selections, and two reported that microscopy results were interpreted in a blinded fashion.

One study was excluded when calculating pooled estimates of diagnostic accuracy because data to calculate specificity were not reported. Sensitivity was inconsistent across studies for processed microscopy (range 52% - 55%;  $p=0.88$ ) and for direct microscopy (range 47% - 51%;  $p=0.68$ ). Specificity was consistent for direct microscopy (range 99% - 100%;  $p=0.78$ ) but more variable for processed microscopy (range 89% - 99%;  $p=0.002$ ). Pooled estimates for sensitivity and specificity could not be calculated as fewer than four studies were available.

Data were therefore excluded from subsequent assessment by the Expert Group.

### 3.2.6 Quality of evidence

Table 1 provides a summary of the accuracy data for sputum processing methods to improve microscopy.

Table 1. Summary of accuracy data on sputum processing methods to improve microscopy									
METHOD		Bleach centrifugation				Direct microscopy			
# Studies		9				9			
# Participants		3,923				3,923			
Pooled accuracy estimates from meta-analyses									
Sensitivity		65% (95CI 59 - 71)				56% (95CI 49 - 63)			
Specificity		96% (95CI 93 - 98)				98% (95CI 97 - 99)			
consequence assuming 20% prevalence, with expected # per 1000		TP	TN	FP	FN	TP	TN	FP	FN
		130	768	32	70	112	784	16	88

METHOD	Bleach sedimentation	Direct microscopy																
# Studies	5	5																
# Participants	2,307	2,307																
Pooled accuracy estimates from meta-analyses																		
Sensitivity	63% (95CI 51 - 74)	50% (95CI 47 - 53)																
Specificity	96% (95CI 91 - 99)	98% (95CI 97 - 99)																
consequence assuming 20% prevalence, with expected # per 1000	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>126</td><td>768</td><td>32</td><td>74</td></tr></table>	TP	TN	FP	FN	126	768	32	74	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>100</td><td>784</td><td>16</td><td>100</td></tr></table>	TP	TN	FP	FN	100	784	16	100
TP	TN	FP	FN															
126	768	32	74															
TP	TN	FP	FN															
100	784	16	100															

METHOD	NALC-NaOH	Direct microscopy																
# Studies	6	6																
# Participants	2,785	2,785																
Pooled accuracy estimates from meta-analyses																		
Sensitivity	78% (95CI 62 - 89)	55% (95CI 47 - 62)																
Specificity	95% (95CI 78 - 99)	99% (95CI 96 - 100)																
consequence assuming 20% prevalence, with expected # per 1000	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>156</td><td>760</td><td>40</td><td>44</td></tr></table>	TP	TN	FP	FN	156	760	40	44	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>110</td><td>792</td><td>8</td><td>90</td></tr></table>	TP	TN	FP	FN	110	792	8	90
TP	TN	FP	FN															
156	760	40	44															
TP	TN	FP	FN															
110	792	8	90															

METHOD	NaOH	Direct microscopy																
# Studies	5	5																
# Participants	4,056	4,056																
Pooled accuracy estimates from meta-analyses																		
Sensitivity	78% (95CI 61 - 89)	65% (95CI 52 - 75)																
Specificity	99% (98CI 98 - 99)	99% (95CI 98 - 99)																
consequence assuming 20% prevalence, with expected # per 1000	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>156</td><td>792</td><td>8</td><td>44</td></tr></table>	TP	TN	FP	FN	156	792	8	44	<table><tr><td>TP</td><td>TN</td><td>FP</td><td>FN</td></tr><tr><td>130</td><td>792</td><td>8</td><td>70</td></tr></table>	TP	TN	FP	FN	130	792	8	70
TP	TN	FP	FN															
156	792	8	44															
TP	TN	FP	FN															
130	792	8	70															

<b>Factors affecting quality of evidence</b>	
<b>Bleach centrifugation</b>	
Design	9 cross-sectional
Risk of bias (QUADAS) <sup>1</sup>	Minor
Directness (generalisability) <sup>2,3</sup>	Limited (-1 for patient-important outcomes)
Inconsistency	Serious (-1)
Imprecision <sup>5</sup>	Moderate (-1)
Publication/reporting bias	Unlikely
OVERALL QUALITY	VERY LOW
<b>Bleach sedimentation</b>	
Design	5 cross-sectional
Risk of bias (QUADAS) <sup>1</sup>	Minor
Directness (generalisability) <sup>2,3</sup>	Limited (-1 for patient-important outcomes)
Inconsistency	Serious (-1)
Imprecision <sup>5</sup>	Moderate (-1)
Publication/reporting bias	Unlikely
OVERALL QUALITY	VERY LOW
<b>NALC-NaOH centrifugation</b>	
Design	8 cross-sectional, of which 2 excluded as data to calculate specificity not reported
Risk of bias (QUADAS) <sup>1</sup>	Serious (-1)
Directness (generalisability) <sup>2,3</sup>	Limited (-1 for patient-important outcomes)
Inconsistency	Serious (-1)
Imprecision <sup>5</sup>	High (-1)
Publication/reporting bias	Unlikely
OVERALL QUALITY	VERY LOW
<b>NaOH centrifugation</b>	
Design	6 cross-sectional, of which 1 excluded as data to calculate specificity not reported
Risk of bias (QUADAS) <sup>1</sup>	Serious (-1)
Directness (generalisability) <sup>2,3</sup>	Limited (-1 for patient-important outcomes)
Inconsistency	Serious (-1)
Imprecision <sup>5</sup>	High (-1)
Publication/reporting bias	Unlikely
OVERALL QUALITY	VERY LOW

<sup>1</sup>Some concern was expressed about the use of culture as a reference standard in settings where routine culture capacity is not available, which may have unfairly skewed results; this issue remains unresolved given the absence of a suitable replacement for culture as an internationally accepted reference standard. Accuracy estimates as calculated by the original systematic review methodology were therefore retained;

<sup>2</sup>Quality of evidence was downgraded in all systematic reviews for insufficient evidence on patient-important outcomes. False-positive results were judged to be less serious than false-negative results for public health impact (Expert Group opinion);

<sup>3</sup>Several of the studies had been carried out in high HIV-prevalence settings, although limited data on HIV status of individual patients were available. Several Expert Group members felt that the effect of sputum processing methods is mostly seen on low-positivity smears, but no specific evidence was presented;

<sup>4</sup>Wide confidence intervals, especially for sensitivity estimates, observed for both processed and direct microscopy.

Notes:

- A major limitation was considerable heterogeneity in diagnostic accuracy estimates for both direct and processed smear microscopy in most comparisons, largely due to variation in sputum processing methods, study design, study settings, and patient selection;
- For bleach centrifugation, some of the observed heterogeneity could be ascribed to centrifuge speed; however, for other processing methods specific sources of heterogeneity could not be determined;
- Due to the considerable heterogeneity, pooled accuracy estimates should be interpreted with caution; however, similar findings employing multiple different analyses supported the overall conclusions;
- In addition to inconsistent results across studies, the quality of evidence was downgraded due to limitations in study design, with at least one QUADAS criterion not satisfied by the majority of studies in every group.

### **3.2.7 Balance of desirable and undesirable effects**

The balance of effects was difficult to assess. The opinion of several Expert Group members was that false-negative results may have a relatively stronger *undesirable* effect (generating patient anxiety, uncertainty as to how to proceed, further testing required and negative consequences of not receiving appropriate treatment) than false-positive results. On this premise, diagnostic accuracy results would seem to favour sputum concentration methods over direct methods in general, resulting in a reduction of false-negative results in most studies.

### **3.2.8 Values and preferences of patients**

No data were presented and the opinion of the Expert Group was that patients would not express strong values and preferences about detailed technical laboratory procedures, and that none of the assessed methods would have likely impact on increased patient access to diagnostic services.

### **3.2.9 Cost and requirements**

No data were presented, but concern was raised about the biosafety risk of centrifugation methods at peripheral microscopy laboratory level, and the feasibility and cost (equipment, logistics) of implementing such methods on a large scale. In addition, some concern was expressed about the loss of specimens for culture when specimens are treated with bleach, the likely increase in turn-around times (especially for overnight sedimentation), and the implications for patient management.

### **3.2.10 Research gaps identified**

The Expert Group is aware of ongoing studies and felt that further research in this area should be reassessed once the results of these studies become available. It was also suggested that future updates of sputum processing methods be preceded by an Expert consultation to assess the value and use of culture as a reference standard.

**FINAL RECOMMENDATION**

The Expert Group felt that there was insufficient generalisable evidence that processed sputum specimens provide results that are superior to direct smear microscopy, given the large variations in study methods, study design, and results reported. Implementation of any of the assessed methods in programmatic settings is therefore not recommended. The Expert Group is aware of ongoing studies and felt that further research in this area should be reassessed once the results of these studies have been evaluated.

OVERALL QUALITY OF EVIDENCE	VERY LOW
STRENGTH OF RECOMMENDATION	STRONG




### **3.3 FLUORESCENT LIGHT EMITTING DIODE (LED) MICROSCOPY**

#### **3.3.1 Background**

Light emitting diode (LED) microscopy is a novel diagnostic tool developed primarily to provide resource-limited settings access to the benefits of fluorescence microscopy. Compared to conventional mercury vapour fluorescent microscopes, LED microscopes are less expensive, require less power and are able to run on batteries, the bulbs have a very long half-life and do not pose the risk of releasing potentially toxic products if broken, and are reported to perform equally well without a dark room. These qualities make LED microscopy feasible for use in resource-limited settings, having the potential to bring the benefits of fluorescent microscopy (improved sensitivity and efficiency) where needed most.

The first use of LED technology was seen when existing fluorescent microscopes were converted to LED light sources. Subsequently, several commercial LED products have become available on the market, as listed in Table 1. These include a stand-alone bright light-fluorescent hybrid model developed by Zeiss in collaboration with FIND (Primostar iLED), providing a high-quality all-in-one solution for laboratories aiming to upgrade their microscopy capacity, with preferential pricing having been negotiated for high-burden TB countries by FIND. Two stand-alone LED microscopes are also available on the market, smaller and built for maximum portability - these include the CyScope (Partec, Germany) and the FieldLab (Cytoscience, Switzerland). Two additional products (Lumin LW Scientific, USA and Paralens, QBC Diagnostics, USA) are LED-enabled objective lenses which can be swapped for a regular objective on an existing light microscope to confer epi-fluorescent capability. Another product, the FluoLED attachment (Fraen, Italy) requires installation into an existing light microscope and then provides full two-in-one light- and trans-fluorescent functionality.

**Table 1. Comparison of commercial light-emitting diode products currently available for TB diagnostics**

Table 1. Comparison of commercial light-emitting diode products currently available for TB diagnostics.								
Device	Manufacturer	Standalone microscope	Attachment	Light transmission	Battery powered	Weight (kg)	Cost (US\$)	Ref.
Primo Star iLED™ 	Carl Zeiss, Oberkochen, Germany	Yes	NA	Epifluorescent	Yes	9.5	4825 <sup>a</sup>	[101]
Lumin™ 	LW Scientific, Lawrenceville, GA, USA	No	Objective lens replacement (20, 40, 60 and 100× oil)	Epifluorescent	Yes	0.448	700–2000 <sup>b</sup>	[102]
ParaLens™ 	QBC™ Diagnostics, Philipsburg, PA, USA	No	Objective lens replacement (40, 60 and 100× oil)	Epifluorescent	Yes	1.27	995 <sup>c</sup>	[103]
FluoLED™ 	Fraen Corporation Srl, Settimo Milanese, Italy	No	Adaptor attached to base and filter installed on head of microscope	Transfluorescent	Yes	5	1977–3530 <sup>d</sup>	[104]
CyScope® 	Partec, Gorlitz, Germany	Yes	NA	Epifluorescent	Yes	2.7	2372–3699 <sup>e</sup>	[105]

<sup>a</sup>Quotes in currencies other than US dollars were converted using rates published 11 June 2009.  
<sup>b</sup>Special pricing available for high-burden countries: €1250.  
<sup>c</sup>Depending on options.  
<sup>d</sup>When purchased in quantity.  
<sup>e</sup>Depending on model and quantity of order.  
<sup>f</sup>Special pricing available for high-burden countries: US\$1398.  
 NA: Not applicable.  
 Images have been reproduced with the permission of the respective companies.

From: Minion, et al. 2009. *Expert Rev Med Devices* 6(4):341

### 3.3.2 Systematic review methodology

A systematic review was done with the following predetermined eligibility criteria for primary analyses: assessment of the diagnostic accuracy/performance characteristics of LED microscopy for the detection of mycobacteria in patient specimens, use of culture as reference standard, and adequate data to populate a diagnostic 2 by 2 table. Studies using alternate reference standards (eg. external rechecking of smears) were included and described separately, as were studies evaluating other characteristics such as time to read slides, cost-effectiveness, user assessment, and implementation issues such as training, and stain- or smear fading.

In addition to the accuracy estimates for LED vs conventional fluorescence microscopy (FM) and light microscopy (LM), the report included narrative sections on operational issues for four devices, ie. the Primostar iLED stand-alone unit, the Lumin and ParaLens objective lens attachments for routine light microscopes, and the FluoLED attachment installed into a light microscope. No evaluations for the two small handheld devices (CyScope and FieldLab) were available. Finally, a confidential report on the operational issues associated with the FIND Demonstration Project for Primo Star iLED had been made available to the Expert Group for scrutiny before the meeting.

The QUADAS criteria were used for study quality assessment. QUADAS criteria regarded as especially relevant to this systematic review included: i) blinded interpretation of test results with

reference results and vice versa; ii) complete verification of test results with the same reference standard; iii) recruitment of patients/specimens either consecutively or randomly; and iv) study design (cross-sectional vs case-control; prospective vs retrospective).

### 3.3.3 Study characteristics

Study characteristics are summarised in Table 2. Detailed methodology and findings are described in the systematic review report available at [www.who.int/tb/dots/laboratory/policy](http://www.who.int/tb/dots/laboratory/policy). The systematic review and meta-analysis included three published and nine unpublished studies, covering the available evidence for four commercially available LED devices for TB: Lumin (six studies), Primostar iLED (four studies), FluoLED (three studies), and Paralens (one study). Included in these were two head-to-head evaluations; ie. FluoLED vs Lumin; and Primostar iLED vs FluoLED vs Lumin. A single study used a conventional fluorescent microscope adapted for use with LED illumination.

Eight studies used mycobacterial culture as reference standard. The remaining four studies used a microscopic reference standard - two with external rechecking and two with conventional FM. Five studies each evaluated direct smears and concentrated smears; two studies reported data on direct and concentrated smears separately.

Different magnifications were used for screening of smears, with 400x being the most common (six studies) and 200x being the most common alternative magnification (four studies). A single study used 600x magnification and one study compared 400x with 200x.

Direct comparisons of LED with ZN were available from seven studies and six studies compared LED with conventional FM.

WHO EXPERT GROUP MEETING ON APPROACHES TO IMPROVE SPUTUM SMEAR MICROSCOPY FOR TUBERCULOSIS DIAGNOSIS; SEPT 7, 2009, GENEVA. CONTAINS UNPUBLISHED DATA. DO NOT CITE OR CIRCULATE.

Table 2. Study Characteristics (n=12)

Ref	Author	Year	Total N (Ref+/Ref-)	Country	LED Device	Reference	Comparison	Smear	Screening Magnification
(22)	Affolabi	unpublished	941/996	Benin	Lumin, FluoLED	rechecking	-	direct	200x
(23)	Cuevas	unpublished	1513/4999	Ethiopia, Nepal, Nigeria, Yemen*	Lumin	LI	ZN	conc	200x
(24)	FIND – Feasibility	unpublished	263/282	Thailand, Germany, Peru, Gambia*	iLED	LI	CFM	direct, conc	400x
(24)	FIND – Evaluation	unpublished	600/280	Thailand, Vietnam, India, Germany, Peru*	iLED	LI	ZN, CFM	direct	200x, 400x
(24)	FIND – Demonstration†	unpublished	1317/8229	multiple‡*	iLED	rechecking	ZN	direct	400x
(24)	FIND – Comparative	unpublished	205/277	Zambia, Uganda*	iLED, FluoLED, Lumin	LI	ZN, CFM	direct	400x
(25)	Kuhn	unpublished	20/5	USA/Bangladesh	ParaLens	CFM	-	conc	600x
(19)	Marais	2008	36/185	South Africa	Adapted CFM	MGIT, LI	ZN, CFM	conc	400x
(26)	Omar	unpublished	93/616	South Africa	Lumin	MGIT	CFM	conc	400x
(27)	Shenai	unpublished	635/267	India	Lumin	MGIT, LI	ZN	direct, conc	200x
(21)	Trusov	2009	199/508	Russia, Macedonia*	Lumin	LI	ZN, CFM	conc	400x
(20)	Van Deun	2008	100/361	Tanzania/ Thailand	FluoLED	CFM	-	direct	200x

†available data from all phases pooled (validation, implementation, continuation)

‡study sites: India, Vietnam, Cambodia, Thailand, Peru, Russia, Lesotho, Ethiopia, South Africa

\*study sites pooled

### 3.3.5 Study quality

Table 3 provides an overview of the key quality indicators for the included studies. All of these reported blinding of the evaluation of slides using LED microscopes. Nine studies reported complete verification using respective references standards while three used partial or differential verification.



Specimen recruitment was reported as prospective in all but one study, and sampling was reported as either consecutive or random in 8 of the 12 studies. Seven of the evaluations used a case-control study design and the remaining five used a cross-sectional design.

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**Table 3. Study Quality**

Characteristic	Frequency (n = 12 studies)
<b>Specimen Recruitment</b>	
- Prospective	11
- Unclear	1
<b>Study Design</b>	
- Cross-Sectional	5
- Case-Control	7
<b>Sampling</b>	
- Consecutive or Random	8
- Unclear	4
<b>Verification</b>	
- Complete	9
- Partial	3
<b>Blinded Interpretation</b>	
- Yes	12

### 3.3.6 Accuracy of LED when compared to reference standards

Table 4 provides a summary of the pooled estimates of sensitivity and specificity: Overall, when culture was used as reference standard, LED achieved 84% sensitivity (95CI 76% - 89%) and 98% specificity (95CI 85% - 97%). When a microscopic reference standard was used, overall sensitivity was 93% (95CI 85% - 97%) and overall specificity was 99% (95CI 98% - 99%).

Table 4 also indicate the results from sub-group analyses depending on whether direct or concentrated smears were used. In summary, there was a significant increase in sensitivity when direct smears were used (89%; 95CI 81% - 94%) compared to concentrated smears (73%; 95CI 69% - 76%) with culture as reference standard. This difference was even more pronounced in those studies where a microscopic reference standard was used, albeit from two studies only - one of the studies included a head-to-head comparison of direct and concentrated smears and found improved sensitivity and specificity using direct smears, while the second found no difference but noted that two of their four participating sites did find that concentrated smears had a lower sensitivity than direct smears.

Table 4. Pooled Estimates of LED Accuracy (against a reference standard) Using Bivariate Random Effects Models

Test (# arms)	Pooled Sensitivity (95% CI)	I <sup>2</sup> (p-value)	Pooled Specificity (95% CI)	I <sup>2</sup> (p-value)
<b>Culture Reference (n=13)</b>	83.6% (76.3, 89.0)	97.4% (p<0.0001)	98.2% (96.6, 99.0)	91.1% (p<0.0001)
Direct Smears only (n=7)	88.9%* (81.1, 93.7)	96.5% (p<0.0001)	98.3% (96.2, 99.3)	82.6% (p<0.0001)
Concentrated Smears only (n=6)	72.7%* (69.2, 76.0)	69.3% (p=0.006)	97.9% (94.8, 99.2)	93.9% (p<0.0001)
400x/600x Magnification (n=9)	84.1% (76.0, 89.8)	95.3% (p<0.0001)	99.0%* (98.0, 99.5)	67.4% (p=0.002)
200x Magnification (n=4)	82.1% (64.4, 92.1)	98.7% (p<0.0001)	94.4%* (91.5, 96.4)	80.3% (p=0.002)
<b>Microscopy Reference (n=6)</b>	92.7% (84.9, 96.7)	97.0% (p<0.0001)	98.5% (98.2, 98.8)	17.7% (p=0.30)
Direct Smears only (n=4)	93.6%* (88.8, 96.4)	97.5% (p<0.0001)	98.5% (98.1, 98.9)	42.4% (p=0.16)
Concentrated Smears only (n=2)†	78.0%* (69.0, 85.0)	91.2% (p=0.0008)	99.0% (98.0, 99.0)	0% (p=0.73)
400x/600x Magnification (n=3)†	95.0%* (95.0, 96.0)	96.6% (p<0.0001)	98.0% (98.0, 99.0)	0.0% (p=0.6)
200x Magnification (n=3)†	90.0%* (89.0, 91.0)	95.3% (p<0.0001)	99.0% (98.0, 99.0)	16.4% (p=0.3)

\*non-overlapping confidence intervals by subgroup

†too few studies to perform bivariate random effects pooling; univariate random effects pooling performed

### 3.3.7 Accuracy of LED compared to ZN microscopy

In individual studies (Table 5), LED sensitivity ranged from being 9% less sensitive to 24% more sensitive than direct ZN microscopy and LED specificity ranged from being 7% less specific to 1% more specific. Compared to ZN microscopy, pooled differences in sensitivity and specificity using random effect regression estimated LED sensitivity to be 6% (95CI 0.1% - 13%) greater than ZN and specificity to be 1% (95CI -3% - 1%) less than ZN.

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Table 5. Head to Head Comparisons of LED with ZN (n=8)

Ref	Author	Smear	Reference	Sample Size	LED		ZN		LED – ZN	
					Sensitivity	Specificity	Sensitivity	Specificity	Sensitivity	Specificity
(23)	Cuevas	conc	culture	6512	0.69	0.95	0.60	0.98	+9%	-3%
(24)	FIND – Evaluation†	direct	culture	880	0.96	1.00	0.91	1.00	+6%	0%
(24)	FIND – Demonstration‡	direct	microscopy	9546	0.93	0.99	0.78	0.99	+15%	0%
(24)	FIND – Comparison§	direct	culture	482	0.90	0.99	0.79	0.99	+11%	0%
(19)	Marais	conc	culture	221	0.85	0.99	0.61	0.99	+28%	0%
(27)	Shenai	conc	culture	903	0.74	0.89	0.74	0.96	1%	-7%
(27)	Shenai	direct	culture	904	0.76	0.94	0.85	0.93	-9%	+1%
(21)	Trusov	conc	culture	707	0.76	1.00	0.60	1.00	+16%	0%
Pooled Differences Using Random Effects Models					84.7% (73.6, 90.4)	98.8% (94.7, 99.7)	77.2% (67.6, 84.6)	98.8% (97.0, 99.5)	+6% (+0.1, +13)	-1% (-3, +1)
I <sup>2</sup> (p-value)					97.7% (p<0.0001)	94.1% (p<0.0001)	98.7% (p<0.0001)	89.2% (p<0.0001)	90.8% (p<0.001)	96.0% (p<0.001)

†LED used for LED data

‡subset of sites with head-to-head ZN comparison, not pooled with culture reference studies

§400x magnification used for LED data

### 3.3.8 Accuracy of LED compared to conventional FM microscopy

In individual studies (Table 6), LED sensitivity ranged from being 4% less sensitive to 16% more sensitive than FM and LED specificity ranged from being 1% less specific to 5% more specific. Compared to conventional FM, pooled differences estimated LED to be 5% (95CI 0% - 11%) more sensitive and 1% (95CI -0.7% - 3%) more specific than FM.

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Table 6. Head to Head Comparisons of LED with CFM (n=7)

Ref	Author	Smear	Reference	Sample Size	LED		CFM		LED – CFM	
					Sensitivity	Specificity	Sensitivity	Specificity	Sensitivity	Specificity
(24)	FIND - Feasibility	conc	culture	545	0.73	0.98	0.68	0.99	+5%	-1%
(24)	FIND – Feasibility	direct	culture	545	0.73	0.96	0.68	0.96	+5%	0%
(24)	FIND – Evaluation†	direct	culture	880	0.96	1.00	0.96	0.95	0%	+5%
(24)	FIND – Comparison‡	direct	culture	482	0.90	0.99	0.84	0.97	+6%	+2%
(19)	Marais	conc	culture	221	0.85	0.99	0.72	0.99	+13%	0%
(26)	Omar	conc	culture	709	0.67	0.98	0.71	0.99	-4%	-1%
(21)	Trusov	conc	culture	707	0.76	1.00	0.60	1.00	+16%	0%
Pooled Estimates Using					83.2%	99.2%	77.5%	98.5%	+5%	+1%
Random Effects Models					(72.3, 90.3)	(97.9, 99.7)	(64.2, 86.9)	(96.0, 99.4)	(0, +11)	(-0.7, +3)
I <sup>2</sup> (p-value)					96.4%	71.7%	97.3%	87.4%	73.5%	85.2%
					(p<0.0001)	(p=0.002)	(p<0.0001)	(p<0.0001)	(p=0.001)	(p<0.001)

†LED used for LED data

‡400x magnification used for LED data

### 3.3.9 Screening magnification

Subgroup analyses were performed to explore accuracy differences based on whether the screening magnification was 200x or higher (data not shown). Within the group of studies using culture as reference standard a lower screening magnification showed a significantly lower pooled specificity compared to studies using a higher screening magnification. This difference was not seen in studies using a microscopic reference standard but was observed in one head-to-head comparison of 200x vs 400x readings. A small increase in sensitivity also detected in studies using higher magnification.

### 3.3.10 Time to read slides

Six studies provided measures of the time needed to examine smears using LED. In total, 14 comparisons between LED and ZN were made and 7 between LED and FM, with varying proportions of smear-positive/smear-negative results, smear type, and screening magnification used. Using simple averages with equal weighting given to each study arm, the mean time saved compared to ZN microscopy was 46%. Considering estimates for smear-positive slides only, LED was 48% more efficient than ZN; considering only smear-negative slides, LED was 59% more efficient than ZN. Compared to FM, the time to read slides was approximately equal.

The FIND Demonstration Study measured the time to read slides one month after introduction of LED and again after three months. The reduction in reading time after one month was 20%, increasing to 45% after three months and showing that efficiency continued to increase with prolonged use.

In another measure of time to read slides, the FIND Evaluation Study recorded the sensitivity of reading smears for 30 seconds, one minute, 3 minutes and 5 minutes. Results indicated that >80% of positive slides were correctly identified by LED or FM within 30 seconds and that increasing the reading time from 3 minutes to 5 minutes did not significantly increase the yield. In contrast, when

using ZN stained slides, <50% of positive slides were correctly identified within 30 seconds and the full 5 minutes were required to maximise yield.

### **3.3.11 Cost estimates**

Equipment costs of the major commercial LED devices, as obtained from the respective companies, are provided in Table 1 above.

The FIND Demonstration Studies collected costing data for three participating settings (India, Lesotho, Peru). Taking into account equipment costs, staffing costs, chemicals and reagents, consumables, building and overhead costs, it was estimated that the average unit cost per test would be 10% to 12% lower for iLED compared to ZN. One important factor in this analysis was the time saving in using iLED (estimated to require 55% less reading time), which resulted in significant savings in staff costs. The conclusion from the FIND studies were that implementation of iLED technology would not require significant modifications to current budgets of national TB control programmes, except for the initial capital investment in equipment.

Previous cost estimates have shown that FM can be an effective alternative to ZN given the savings in labour despite higher upfront equipment costs. Considering the lower equipment cost for LED devices compared to FM and lower maintenance cost, LED technology can be considered a more cost-effective option to FM. Considering the time saved in reading and the resultant savings in staff costs, LED technology may also be a more cost-effective option in the long term than ZN microscopy.

### **3.3.12 Training requirements**

During the FIND Demonstration study, staff with experience in ZN microscopy but no experience in FM techniques were trained for one to five days before entering the first phase of the study. Accuracy estimates for three distinct phases were calculated as follows:

#### Validation phase (one month post-initial training):

Overall sensitivity: 94% (95CI 92% - 95%); Overall specificity: 98% (95CI 98% - 99%)

#### Implementation phase (six months following implementation):

Overall sensitivity: 97% (95CI 92% - 99%); Overall specificity: 98% 95CI 98% - 99%)

#### Continuation phase (based on data collected to date of report):

Overall sensitivity: 97% (95CI 92% - 99%); Overall specificity: 98% 95CI 98% - 99%)

Standardised proficiency testing was performed in the FIND studies and repeated at one month and three months. Performance targets (>95% accuracy, 100% acceptable staining quality, >80% proficiency) were required to be met at the end of the validation phase, before proceeding to implementation phase. These targets were met by 27 of 28 study sites, with the remaining site achieving this target one month later.

Feedback from the microscopists undergoing training in the FIND studies emphasised the importance of practical hands-on training, with the availability of a supervisor to assist with distinguishing acid-fast bacilli from artefacts. Most microscopists felt that five days of training was optimal for those experienced with ZN microscopy, and that at least 13 days of training would be required for those without experience.

Training issues were not addressed in most of the non-FIND studies; however, three studies that did not include extensive training and standardised proficiency testing noted the possible underperformance of LED upon introduction due to insufficient training of staff.

### **3.3.13 Head-to-head comparisons of LED devices**

Two studies included head-to-head evaluation of different LED devices. One study comparing the LW Scientific Lumin and Fraen FluoLED showed significantly more positive smears detected using the latter module with 200x magnification. This difference did not persist when 400x magnification was used. Users indicated a preference for the Fraen module citing easier focusing and better image quality.

In the FIND Comparison Study, all three LED devices (Zeiss iLED, Fraen FluoLED; LW Scientific Lumin) resulted in improved sensitivity over ZN and received positive feedback from users. Estimates of sensitivity gains compared to ZN resulted in +6% for iLED, +8% for FluoLED; and +4% for Lumin (statistically significant increase for FluoLED). Estimates for specificity gains compared to ZN resulted in +1% for iLED, -3% for FluoLED and +1% for Lumin (statistically significant decrease for FluoLED).

The time to examine slides was significantly less for all models compared to ZN, with the Lumin examination times higher than for the other two models (2.94 min/slide for Lumin vs 2.3 minutes/slide for iLED vs 2.38 min/slide for FluoLED. Users indicated a preference for iLED citing high quality optics, operational characteristics and ease of viewing in full light as advantages.

### **3.3.14 Staining methods**

All studies included in the systematic review used Auramine O/KMnO<sub>4</sub> staining.

A sub-study reported by FIND compared the performance and suitability of different commercial and in-house stains for use with FM. Users reported that all of the fluorochrome staining methods were easier to perform than ZN staining (likely due to the absence of a heating step). Experienced users preferred that Auramine O/KMnO<sub>4</sub> stain, and reading time was significantly shorter for both Auramine O/KMnO<sub>4</sub> and Auramine-Rhodamine/KMNO<sub>4</sub>; less experience users found it easier to focus and less tiring to read the stains with coloured backgrounds (Auramine/Methylene Blue and Auramine/Thiazine Red).

A separate evaluation of staining preference done in conjunction with the FIND Feasibility Study, users preferred Auramine O/KMnO<sub>4</sub> stain over Auramine-Rhodamine/KMNO<sub>4</sub> and Auramine/Methylene Blue.

### **3.3.15 Fading of fluorochrome-stained slides**

Two studies evaluated the potential of fading of fluorochrome stained smears during storage.

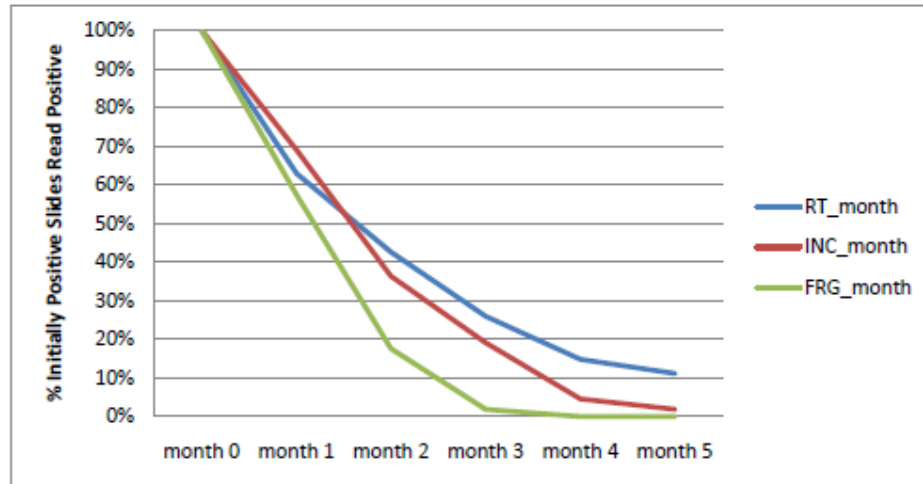
In a sub-study by FIND, six microscopy centres kept a set of 10 positive smears at room temperature (without air conditioning) and re-read them monthly for four months. None of the monthly readings changed from the initial positivity grading at months 1, 2 or 3 and a single centre reported misclassifying a single positive slide as negative during the month 4 reading. Qualitative assessments from all sites reported no impairment of reading at month 1 or 2, one site reported mild fading at month 3, and three sites reported impairment ranging from mild to significant by month 4.

A study performed in India stored sets of 120 slides in different environments and re-read them on a monthly basis for up to five months. Selected results are presented in Figure 6. Overall, the

proportion of positive slides that remained positive decreased to 63% at month 1, 43% at month 2, 26% at month 3, 15% at month 4 and 11% at month 5 for slides stored at air-conditioned room temperature. Slides stored in a humidified incubator faded faster than those at room temperature and, surprisingly, slides stored in a refrigerator showed the fastest fading.

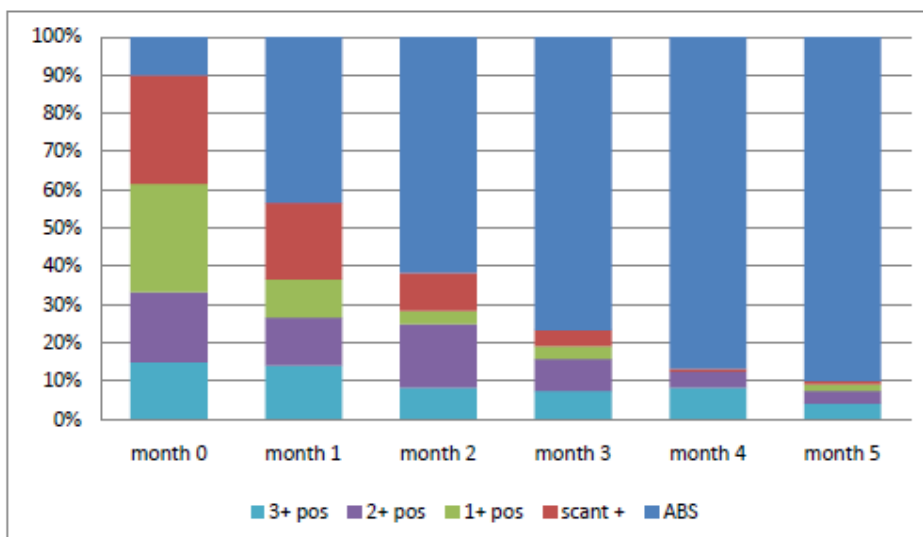
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Figure 6a. Fading of Auramine O/KMnO<sub>4</sub> Slides: Proportion of Positive Slides Re-read as Positive (n=120 at each storage condition)\*



\*RT\_month refers to storage at air conditioned room temperature (22°C), re-read monthly  
 INC\_month refers to storage in a humidified incubator (30°C), re-read monthly  
 FRG\_month refers to storage in a refrigerator (4°C), re-read monthly

Figure 6b. Fading of Auramine O/KMnO<sub>4</sub> Slides: Positivity Grading Over Time for Slides Stored at Room Temperature, 22°C (n=120)



(Source: Minion J, Shenai S, Vadwai V, Tipnis T, Rodriques C, Pai M, unpublished data).

### 3.3.16 Summary of principal findings

#### *Positive*

- All studies reported on sensitivity and specificity. Pooled estimates of accuracy found LED to have 84% sensitivity and 98% specificity when compared to culture, and 93% sensitivity and 99% specificity when compared to a microscopic reference;
- Direct comparisons estimated LED to have 6% greater sensitivity than ZN and 5% greater sensitivity than conventional FM, with not appreciable difference in specificity;
- Many studies included qualitative assessments on user-important characteristics and important outcomes relating to implementation, such as time to reading, cost-effectiveness, training and smear fading;
  - Timing data showed that LED has similar gains in efficiency to conventional FM (compared to ZN), requiring approximately 46% less time than ZN for smear examination;
  - Cost assessments predict improved cost-effectiveness of LED compared to ZN microscopy, with improved efficiency being a key quality;
  - Qualitative assessments of LED confirmed many touted advantages, including the ability to use LED without a dark room, durability and (in the case of attachment models) portability. User assessment in all field studies was reported as excellent;
- LED may provide a technology platform for other diagnostic services; eg. malaria and trypanosomiasis, reducing costs involved in providing integrated laboratory services;

#### *Negative*

- Considerable heterogeneity was found in many of the pooled accuracy estimates; however, this was not unexpected given the different products, diverse settings and study design used;
- The systematic review was limited by the lack of a common reference standard and lack of agreed and consistently applied methods for smear processing and screening magnification;
- Possible barriers to large-scale implementation of LED include training of laboratory staff unfamiliar with fluorescent microscopy and a reliable mechanism for quality control of the inherent unstable Auramine stain used;
  - Evidence from standardised training suggests that LED performance can be maximized within a period of one month;
  - Evidence regarding the effect of fluorochrome fading on the reproducibility of smear results over time suggests that current quality assurance programmes may have to be adapted;
- Some concerns were expressed over the potential cost implications of LED introduction on other diagnostic modalities, eg. light microscopy for urine/stool/blood examinations which will have to be retained at peripheral health laboratory level;
- No studies evaluated the impact of LED microscopy on patient-important outcomes;

### 3.3.17 Research gaps

This was not discussed in detail due to time constraints. However, as with the other two approaches to improve smear microscopy, further research on patient important outcomes of LED microscopy is

required, along with research into combining LED microscopy with front-loading of sputum collection and/or sputum processing to optimise case detection.

### 3.1.18 Final GRADE evaluation

Factors affecting quality of evidence	
Design	5 cross-sectional, 7 case-control
Risk of bias (QUADAS)	Minor
Directness (generalisability)	Limited (-1 for patient-important outcomes)
Inconsistency	Minor
Imprecision	Minor
Publication/reporting bias	Unlikely
OVERALL QUALITY	MODERATE

### FINAL RECOMMENDATION

The Expert Group felt that there was sufficient generalisable evidence that LED microscopy

- should replace conventional fluorescence microscopy;
- is a better alternative to ZN light microscopy in both high and low volume laboratories;

The switch to LED microscopy should be carried out through a carefully phased implementation plan using LED technologies that meet WHO specifications in countries able to address the following issues:

- Training requirements, especially for laboratory staff unfamiliar with FM techniques;
- Validation during the introductory phase;
- Monitoring of trends in case-detection and treatment outcomes.

WHO should develop the following to guide LED implementation plans:

- Specifications for approved LED technologies, including optics, light source, magnification;
- Recommendations for EQA of LED microscopy for TB diagnosis;
- A definitive case definition for a positive LED result.

OVERALL QUALITY OF EVIDENCE	MODERATE
STRENGTH OF RECOMMENDATION	STRONG

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