Case Study #1

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September 15, 2023

TB Intensive
September 13 – 15, 2023
Richmond, TX

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Jacquelyn Johnson-Minter, MD, MBA, MPH has the following disclosures to make:

- No conflict of interests
- No relevant financial relationships with any commercial companies pertaining to this educational activity

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Case Study
Highlighting Legal Aspects of Tuberculosis Management

TB Intensive
Houston, Texas
September 13th – 15th 2023

Jacquelyn Johnson-Minter, MD, MBA, MPH
Director & Local Health Authority Fort Bend County, Texas

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Patient Presentation

38 yo gentleman who initially presented to FBC TB through a referral from one of our local hospitals

- He arrived at the hospital ER with a history of a painful (but without draining or bleeding) neck mass that he noticed three weeks prior to presentation and a fever beginning 6 weeks prior to presentation.
- Pertinent positives include history of HIV diagnosed in 2019 treated with HAART, but none for the past 8 months.
- Pertinent ROS – in addition to fever, chills, fatigue, night sweats and non-pruritic rash
- Patient did self-manage with 1000mg acetaminophen as needed for the pain
- ER work up included a CT of the neck which revealed enlarged lymph nodes at C3, C4, and C5, and mediastinal lymphadenopathy, possible compression of Right vertebral artery, ENT consult/ID consult/CT Surgery consult

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ER Evaluation

Consultation in ER

Physical Exam – afebrile weighing 69.4 kg with a BMI of 26.6 – all other vitals were wnl

- Exam was remarkable for
  - leukoplakia of the oral mucosa,
  - Neck with right sided bulky lymphadenopathy, non tender to palpation, fluctuant and cystic with minimal blanching erythema and no induration
- all other exam unremarkable

Labs – elevated liver enzymes AST 192 ALT 182, all else wnl

Procedures –

- Flexible laryngoscopy was performed without anesthesia
  all normal findings, well tolerated by the patient
- Aspiration of neck mass performed under local anesthesia – 10cc of milky fluid, well tolerated by patient, cent for culture and cytology

Assessment and Plan: neoplastic vs infectious etiology for neck mass, admit for further evaluation including biopsy

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Hospital Course

Admission

Physical Exam –
- febrile during admission - maximum 102.3

Procedures –
- Abscess debridement – Culture and sensitivity
- IR – mediastinal LN
- Biopsy of neck mass

Labs – HIV viral load 178,000 CD4 150, QFT positive
Microbiology – C/S of abscess – staph species,
Lymph node aspirate x 3 - many AFBs, MTB PCR
Disposition: Discharged on Day 6 with pending labs to follow up with FBC Health Dept on RIPE and clarithromycin

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Public Health Response

Health Department Follow up
- Patient evaluated at home and DOT with RIPE started on day 3 after discharge
- Did not present for medical evaluation in clinic
- RIF resistance detected and reported – medications held
- Expert consultation obtained and TCID admission requested

Patient Response
- Phone conversation between patient and nurse case manager to explain findings and work up, patient stated he would be returning to his home country of Nicaragua to continue medical treatment near family and health care provider there.
- Explanation of isolation and process for release in US in addition to medical necessity and best treatment during initiation phase.
- OS stated that tickets had been purchased and he would be leaving.

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Do Not Board

Public Health Response

- TB Team alerts Health Authority
- DNB criteria reviewed

__X_ Infectious or likely to be infectious -OR- at risk of becoming infected with a communicable disease

AND

_x_ unaware of diagnosis; or has been advised regarding diagnosis and is non-adherent with public health recommendations; or there is a reason to believe the individual will become non-adherent; or unable to be located

OR

_x_ at risk of traveling on a commercial flight or if travelling internationally

OR

__ need to be place on DNB/LO list to respond to a public health outbreak or help enforce a public health order

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Coordinated Public Health Response

Public Health Response

TB team arranges a meeting with DSHS TB

Case presented – Do Not Board and potential Court Ordered Management

- Patient has a flight purchased
- Patient not planning wanting TCID admission

DSHS facilitates meeting with CDC for Do Not Board recommendation

- FBC presents case
- CDC agrees to support the DNB/LO request

Patient Actions

- TB Program manager discusses options with patient in his language
- Patient agrees not to fly to Nicaragua and remain in states for treatment
- Call received from TSA to quarantine station on day of flight that patient has tried to board flight without going through security
- Patient returns to apartment
- Concern that patient may try to leave by land – still not on any treatment regimen, has not had public health medical evaluation

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Court Ordered Management

Public Health Response

- TCID has approved admission but no beds available for at least one week.
- Concern that patient may try to leave by land – still not on any treatment regimen, has not had public health medical evaluation
- Court Ordered Management is only way to get immediate admission to TCID

Potential for Court Ordered Management is now a reality

- Documentation gathered by TB team
- County Attorney notified and process started
- DSHS central office legal counsel contacted to advise Fort Bend County Attorney through process of Court Ordered Management
- Documentation filed and signed by Health Authority
- Daily communication with TB program manager, patient becomes more comfortable with TCID admission

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The Rest of the Story

The Rest of the Story

- Patient admitted to Houston hospital for management while awaiting bed availability at TCID
- Organism found to be MDR – Resistant to Rifampin, INH, and Ethionamide
- Final diagnosis disseminated MDR tuberculosis with lymphadenitis
- Legal counsel advised to continue with Court Ordered Management process
- Patient was cooperative with management and transferred to TCID after approximately one month
- Patient was discharged from TCID after 4 months of in-patient treatment and returned to FBC for outpatient management

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Key Takeaways

- The potential for the need for control measures is present at every initial encounter
- Identifying high risk is essential to protect the public
- All parts of the TB team must cooperate swiftly
- Providing notice early allows all parties to be prepared
- Rarely used ≠ Never used
- **Control measures exist to help us end TB**

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