



Diagnosis & Medical Management of TB Disease

Lana Yamba, MD, MPH, CCRC

September 23, 2026

TB Nurse Case Management • September 23 – 25, 2026 • Edinburg, Texas



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Has the following disclosures to make:

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



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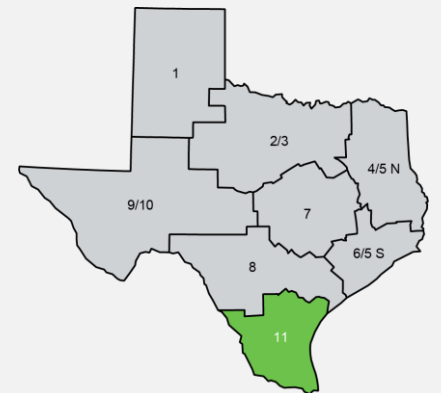
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Learning Objectives

- ❖ Identify the process for diagnosis of TB
- ❖ Discuss current recommendations for the medical management of active TB



Clinical Diagnosis



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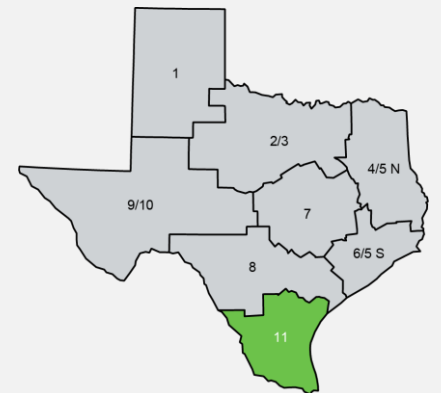
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Primary Tuberculosis

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- TB is divided into primary and post-primary (or reactivation)
- Most primary TB resolves spontaneously, but reactivation may occur without treatment

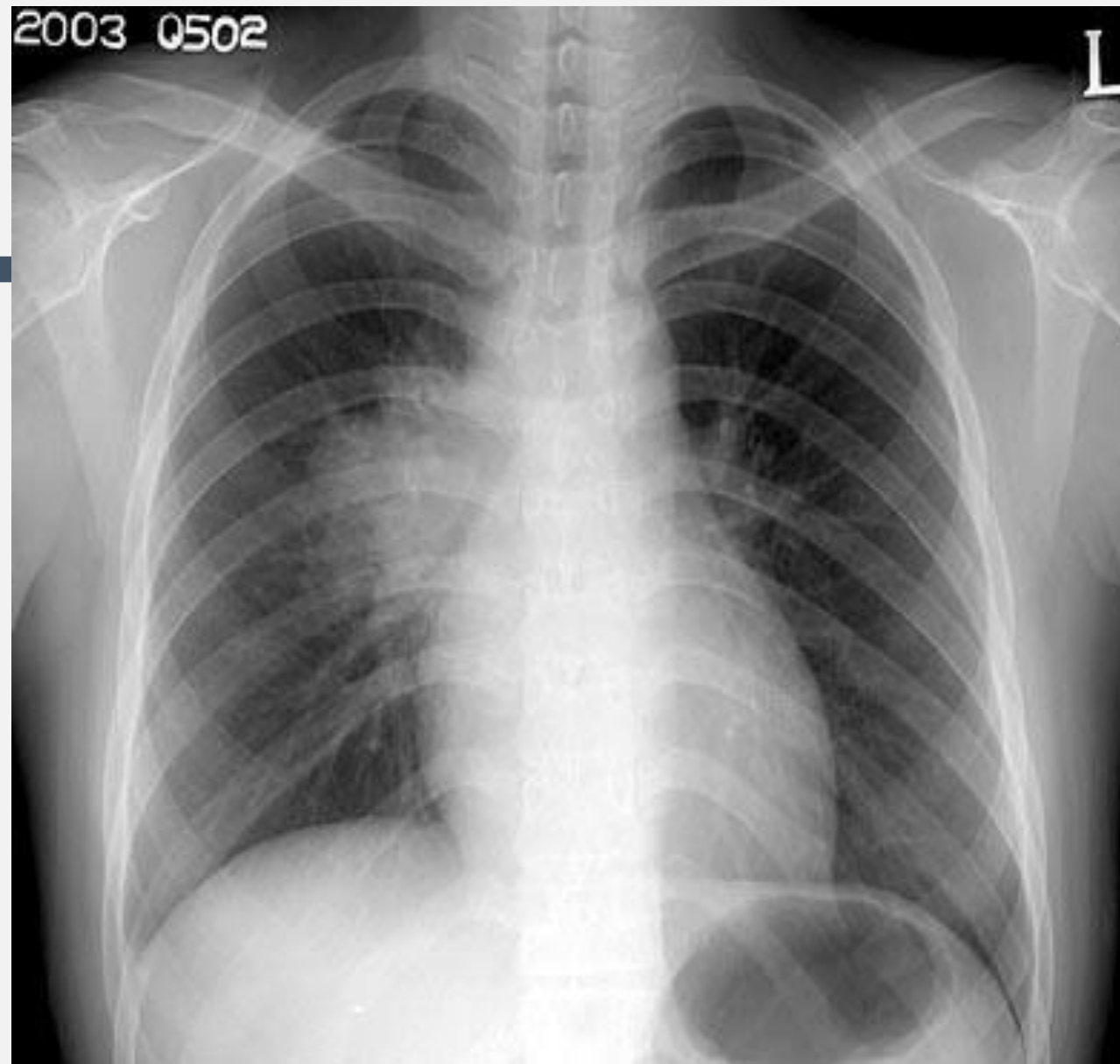


Primary Tuberculosis

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- **Most are asymptomatic; fever and nonproductive cough may occur**
- **Opacities are in middle and lower lungs**
 - Commonly unilateral
- **Lymph node enlargement often occurs, and may cause bronchial compression**



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Primary Tuberculosis

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- Pleural Effusion: Seen in up to 25% of those with primary TB.
- Often is the only manifestation.

Pleural TB

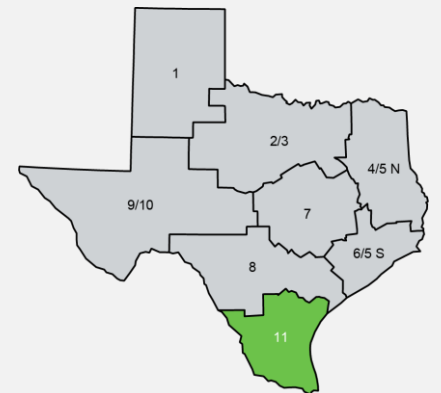


Primary Tuberculosis

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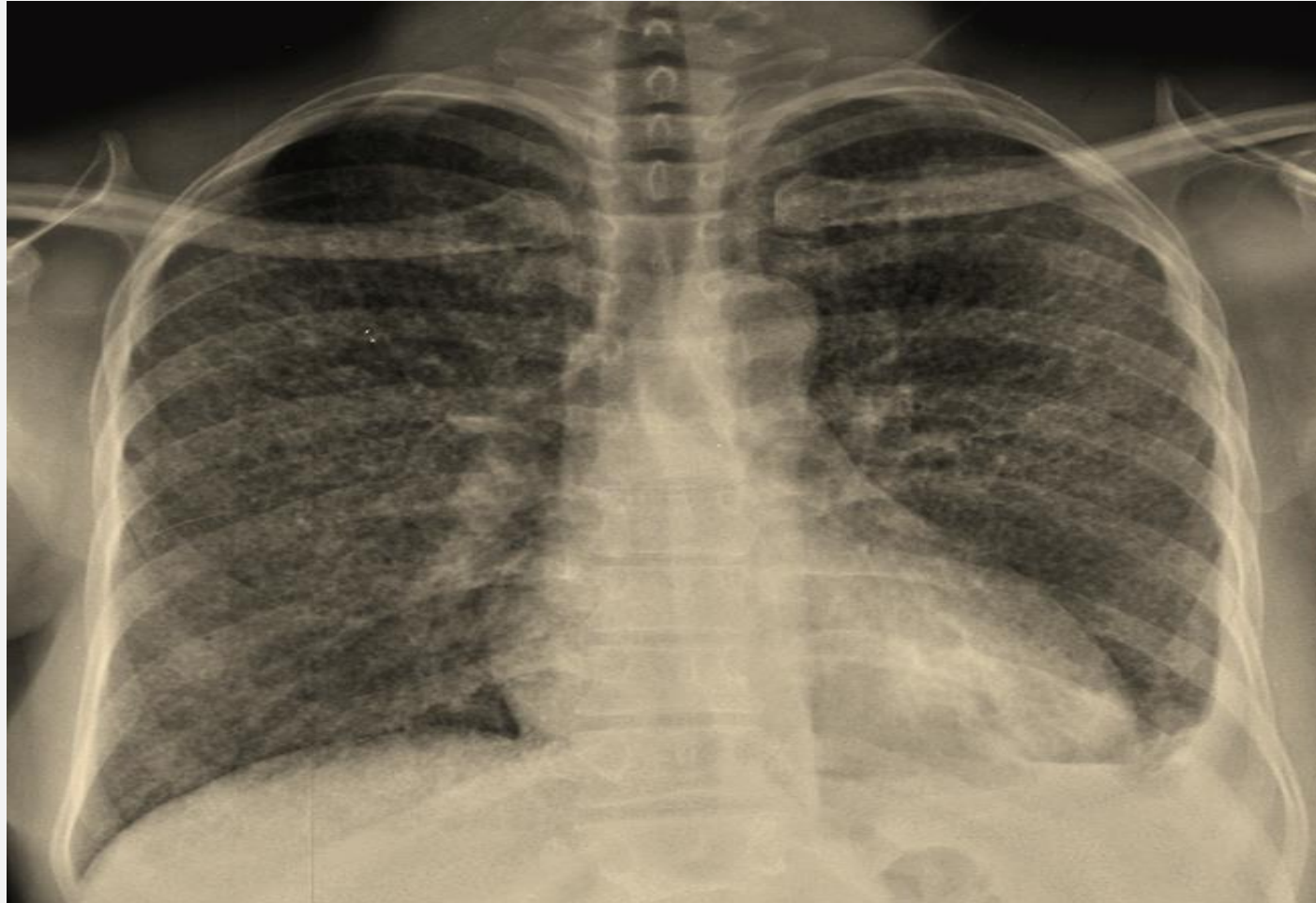
- The natural history of TB pleuritis is spontaneous resolution over 2 to 4 months
- May leave residual pleural thickening and calcification
- If not treated
 - High risk of reactivation
 - Rapid development of devastating disease in infants and immunocompromised persons



Primary Tuberculosis

- Miliary disease:
 - more commonly seen in the elderly, infants, and immunocompromised hosts.
 - Usually seen within 6 months of the initial exposure
- Evenly distributed diffuse small 2-3 mm nodules, with a slight lower lobe predominance

Miliary Tuberculosis



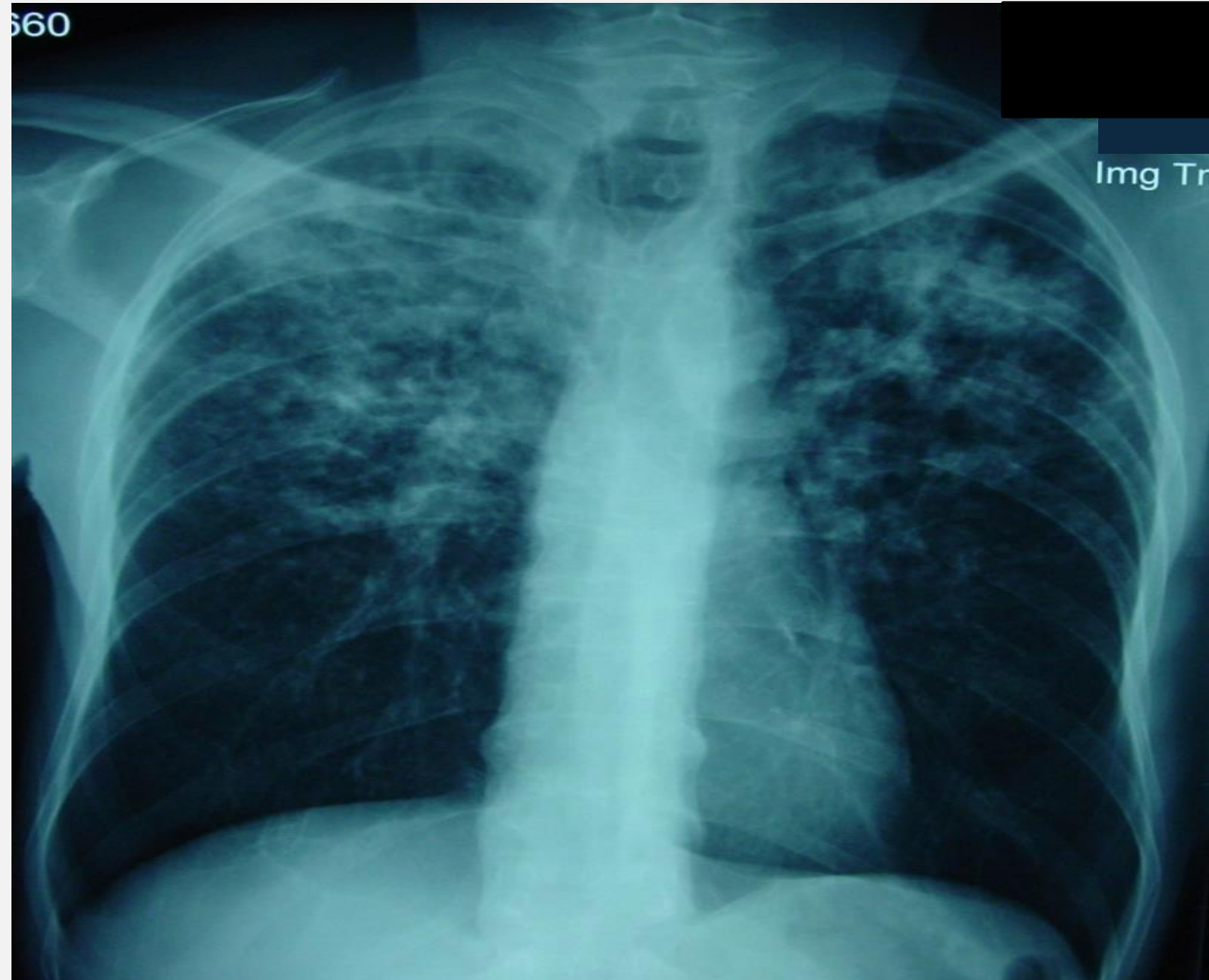
Post primary or reactivation tuberculosis

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- Post Primary TB is progressive
- Upper lobes predilection, cavitation and absence of lymphadenopathy
- Fibrosis and calcification are seen after healing

No Reactivation Tuberculosis



No CXR study shows findings specific for TB

Cavitary process are more likely to be TB

Common mimics of TB =

Non-tuberculous mycobacteria (NTM)

fungal infection

bacterial abscesses

necrotic neoplasm (especially lung neoplasm)

CXR - special situations

- Pregnant women who are highly suspected of having TB and are being evaluated for active disease should undergo a CXR without delay, even during the first trimester
- Patients suspected of extrapulmonary TB should have a CXR to R/O pulmonary TB



Yes! You can X-ray a pregnant patient!

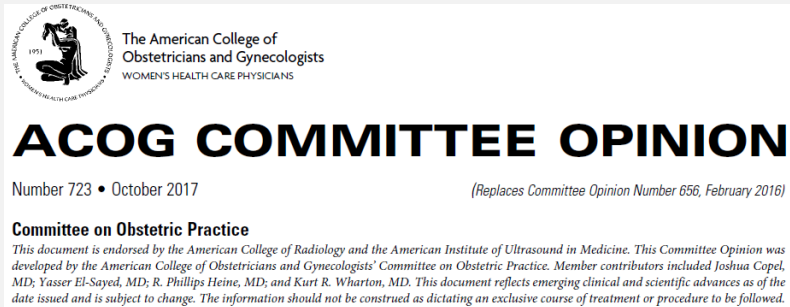


Table 2. Effects of Gestational Age and Radiation Dose on Radiation-Induced Teratogenesis ↵

Gestational Period	Effects	Estimated Threshold Dose*
Before implantation (0–2 weeks after fertilization)	Death of embryo or no consequence (all or none)	50–100 mGy
Organogenesis (2–8 weeks after fertilization)	Congenital anomalies (skeleton, eyes, genitals)	200 mGy
	Growth restriction	200–250 mGy
Fetal period	Effects	Estimated Threshold Dose*
8–15 weeks	Severe intellectual disability (high risk) [†]	60–310 mGy
	Intellectual deficit	25 IQ-point loss per 1,000 mGy
	Microcephaly	200 mGy
16–25 weeks	Severe intellectual disability (low risk)	250–280 mGy*

*Data based on results of animal studies, epidemiologic studies of survivors of the atomic bombings in Japan, and studies of groups exposed to radiation for medical reasons (eg, radiation therapy for carcinoma of the uterus).

[†]Because this is a period of rapid neuronal development and migration.

Modified from Patel SJ, Reede DL, Katz DS, Subramaniam R, Amorosa JK. Imaging the pregnant patient for nonobstetric conditions: algorithms and radiation dose considerations. *Radiographics* 2007;27:1705–22.

Table 3. Fetal Radiation Doses Associated With Common Radiologic Examinations ↵

Type of Examination	Fetal Dose* (mGy)
<i>Very low-dose examinations (<0.1 mGy)</i>	
Cervical spine radiography (anteroposterior and lateral views)	<0.001
Head or neck CT	0.001–0.01
Radiography of any extremity	<0.001
Mammography (two views)	0.001–0.01
Chest radiography (two views)	0.0005–0.01
<i>Low- to moderate-dose examinations (0.1–10 mGy)</i>	
Radiography	
Abdominal radiography	0.1–3.0
Lumbar spine radiography	1.0–10
Intravenous pyelography	5–10
Double-contrast barium enema	1.0–20
CT	
Chest CT or CT pulmonary angiography	0.01–0.66
Limited CT pelvimetry (single axial section through the femoral heads)	<1
Nuclear medicine	
Low-dose perfusion scintigraphy	0.1–0.5
Technetium-99m bone scintigraphy	4–5
Pulmonary digital subtraction angiography	0.5
<i>Higher-dose examinations (10–50 mGy)</i>	
Abdominal CT	1.3–35
Pelvic CT	10–50
¹⁸ F PET/CT whole-body scintigraphy	10–50

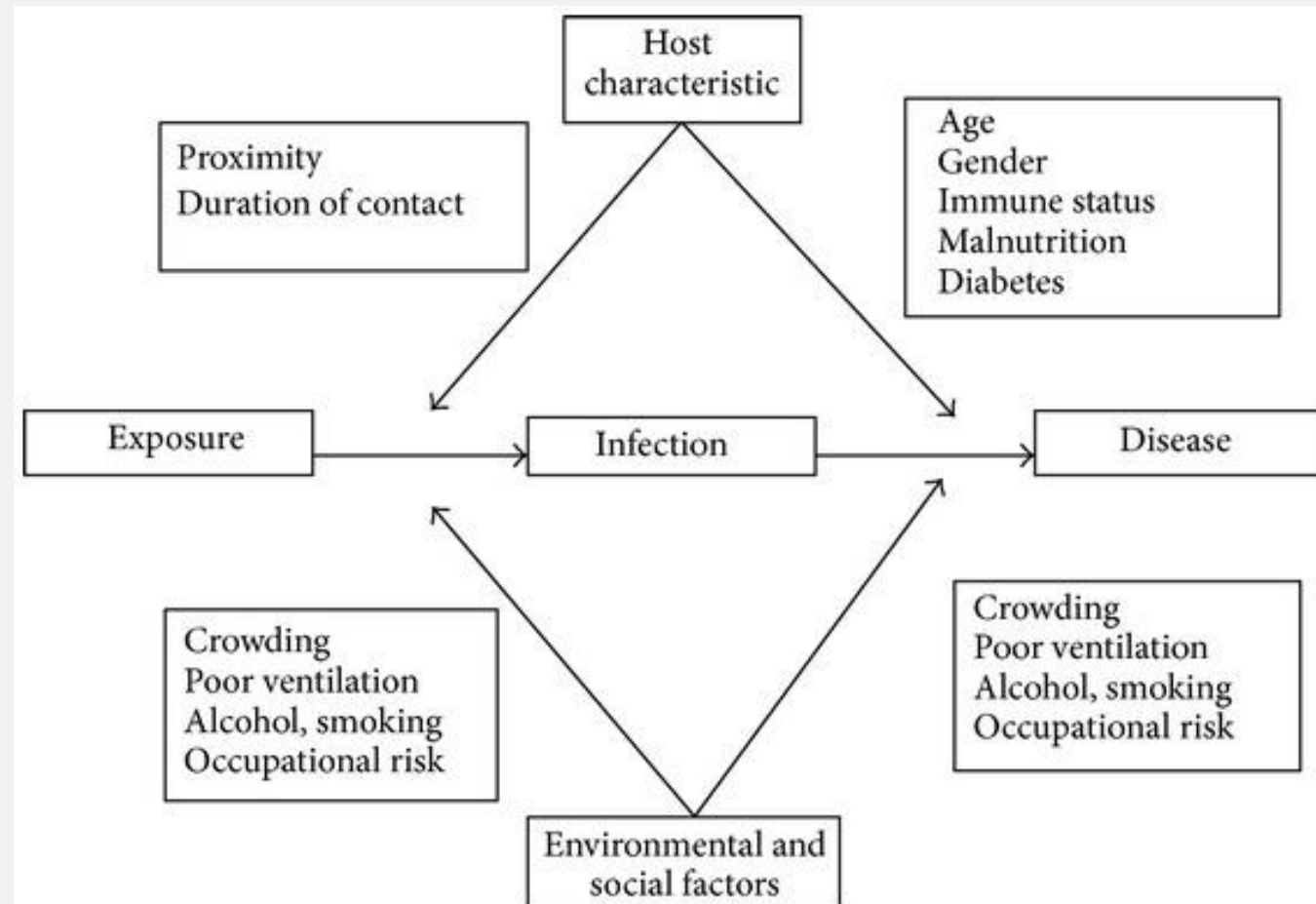
Assessing the Possible Risk

- EXPOSED
- LATENT TB INFECTION (LTBI)
- TB DISEASE



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Evaluation for TB

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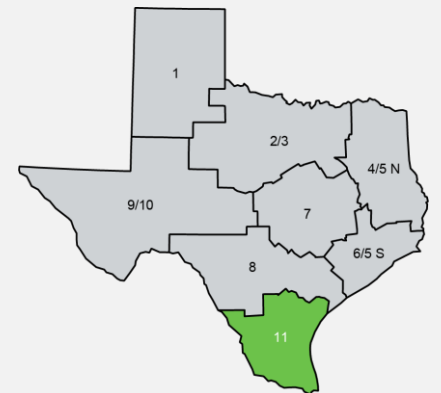
Medical (and social) history

Physical examination

Testing for TB infection

Chest radiograph

Bacteriologic or histologic exam

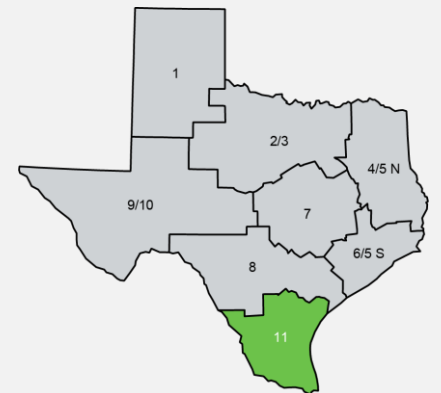


TB Evaluation

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- Patient History
 - Symptoms
 - History, co morbidities, demographics, family history
 - Hospital discharge information
- Physical examination
- Laboratory testing
 - Tuberculin Skin Test (TST) or Interferon Gamma Release Assays(IGRA)(QFT, Tspot)
 - CBC, LFTs, sputum smears/cultures, Tissue histology
- Radiologic evaluation
 - CXR, (CT, MRI)



Sites of TB Disease

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Lungs

Extrapulmonary:

Larynx

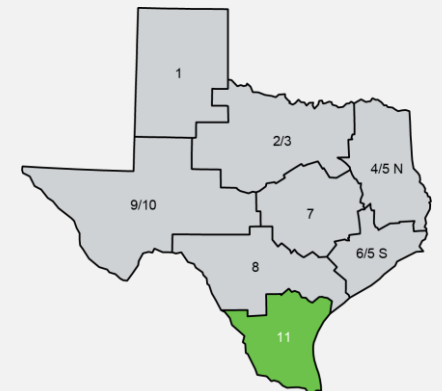
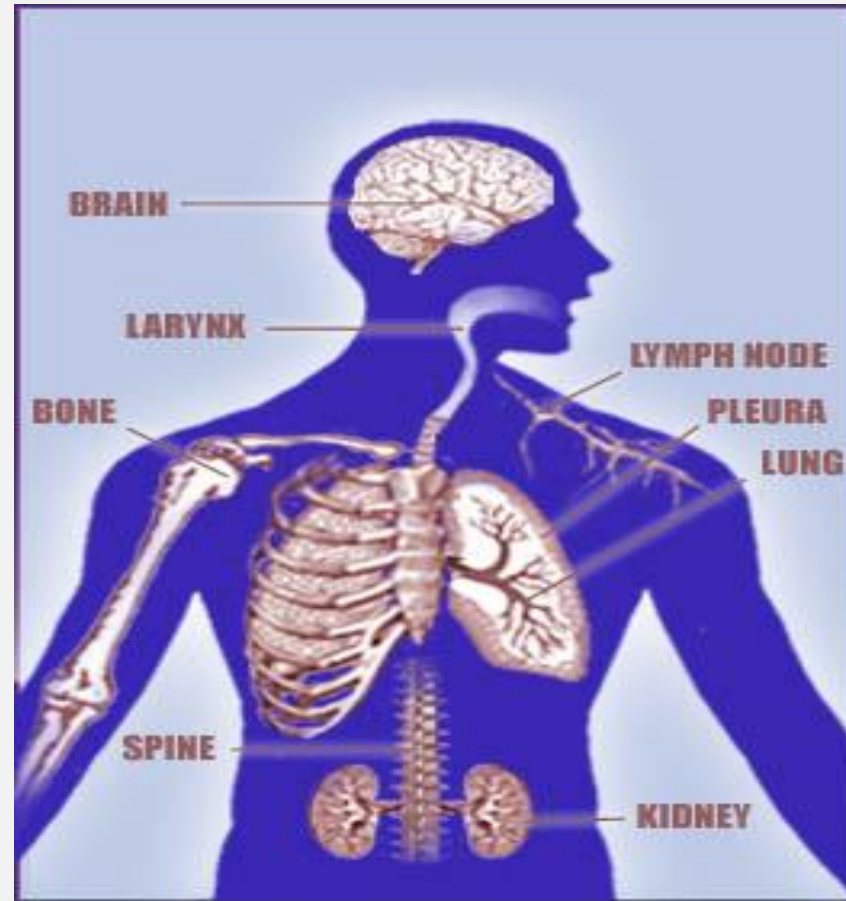
Pleural effusion

Kidneys

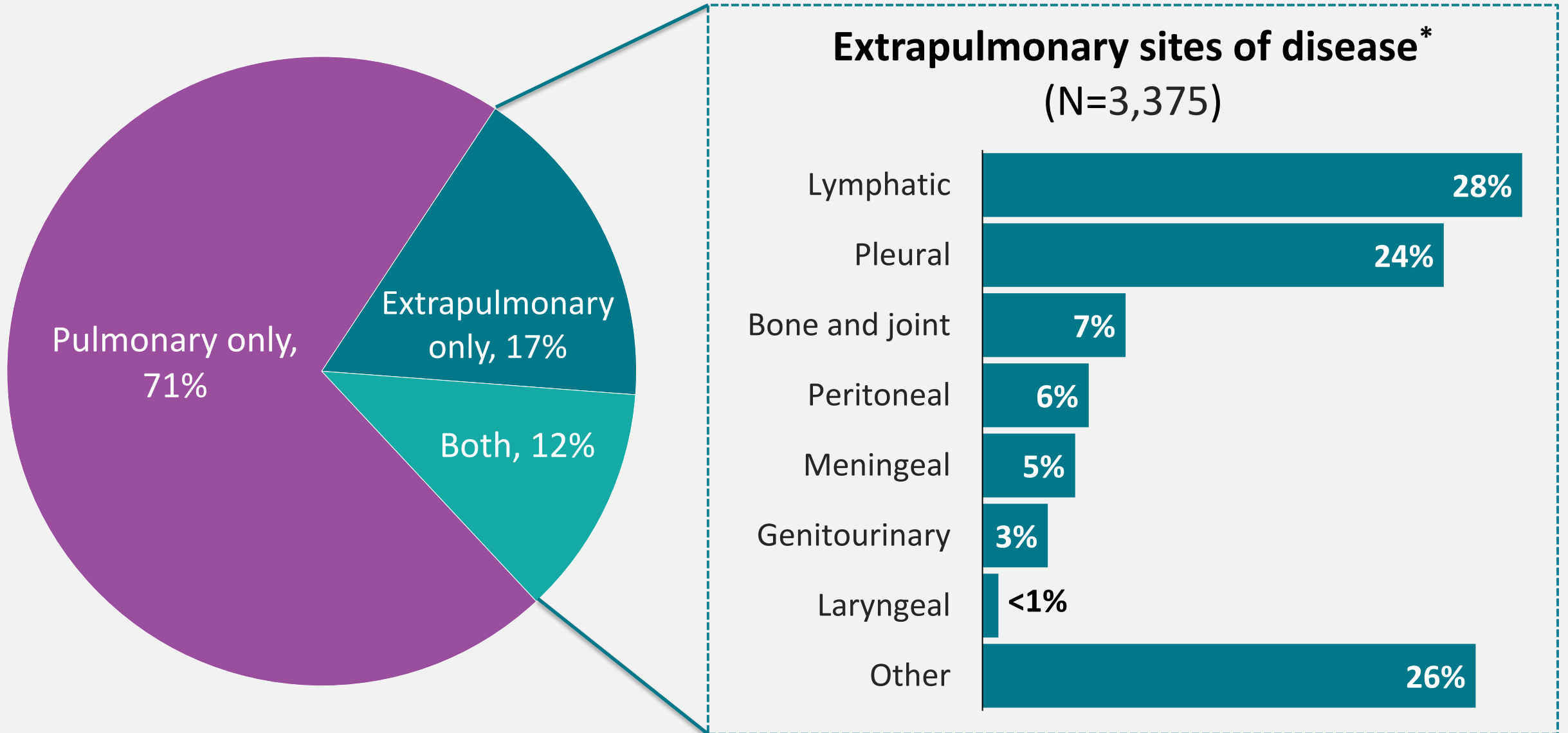
Lymphatics

Bones & joints

Miliary (disseminated)



Percentage of TB Cases by Site of Disease, United States, 2024



* Persons might have more than one extrapulmonary site of disease.

Signs & Symptoms Pulmonary TB

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Pulmonary Symptoms:

- Productive prolonged cough of over 3 weeks duration
- Chest pain
- Hemoptysis

Systemic Symptoms:

Fever

Chills

Night sweats

Appetite loss

Weight loss

Easy fatigability

Sputum Collection

- Collect sputum specimens if:
 - Abnormal CXR consistent with TB
 - Presence of respiratory symptoms even if normal CXR

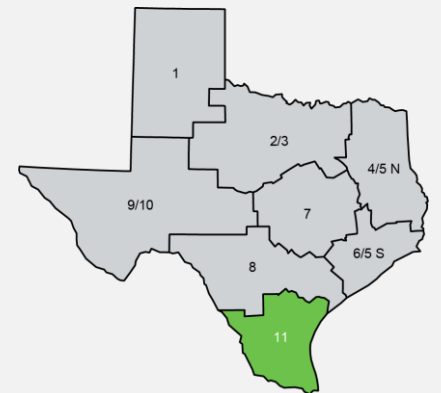


Mycobacterial Cultures

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- Three initial sputum cultures within 24 hours
 - At least one first morning
 - At least one observed
- Cultures should be obtained monthly until negative on two consecutive months
 - Determine length of therapy
 - Identify delayed response (+ at 3 months)
 - Identify treatment failure (+ at 4 months)



Bacteriologic and Histologic Examinations

Extrapulmonary Specimens

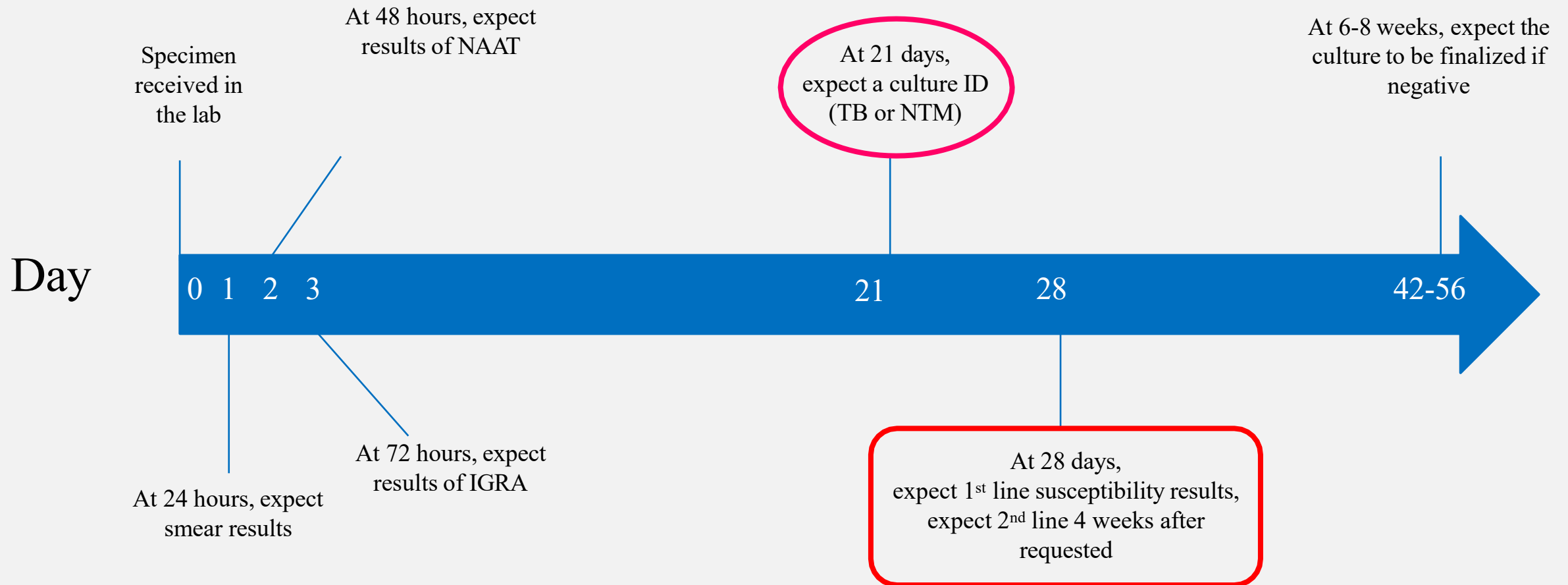
- Urine
- Cerebrospinal fluid *
- Pleural fluid *
- Pus
- Biopsy specimens

*recovery poor



**Do NOT collect
specimens in Formalin
or bacteriostatic saline!**

When should I consider my specimen delayed?



Chest Xray

- Obtain a CXR in
 - Every person with a newly positive TST or IGRA
 - Any person at risk of TB who has symptoms and no other obvious diagnosis
 - May be indicated in some asymptomatic, TST/IGRA negative contacts at increased risk
 - Children 4 years and younger
 - HIV infected
 - Immunosuppressed



Differentiating Between LTBI and Disease when the CXR is abnormal

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Abnormal CXR findings which could be consistent with LTBI

- Nodules/ Fibrotic lesions of old TB
- Calcified granuloma
- Pleural thickening
- Bronchiectasis



Management of TST + Persons With an Abnormal CXR and – AFB Smear

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- Isolated CXR with nodules and/or fibrotic lesions:
 - If no symptoms – **Wait!**
 - Collect sputum culture
 - Evaluate for symptoms
 - Repeat CXR
 - If CXR stable at 2 – 3 months and cultures are negative,
Treat as LTBI
- Isolated CXR with nodules and/or fibrotic lesions:
 - If patient has any signs or symptoms of TB disease:
 - **This person may have tuberculosis**
 - Start 4 drugs
 - Never start a single drug in a patient with possible active TB

Management of TB Disease



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Treatment Regimens for TB Disease

- **Initiation phase** of therapy
 - 8 weeks
 - INH, Rifampin and PZA +/-EMB
- **Continuation phase** of therapy
 - 16 weeks
 - INH and Rifampin



Treatment of Culture-Positive Drug Susceptible Pulmonary TB

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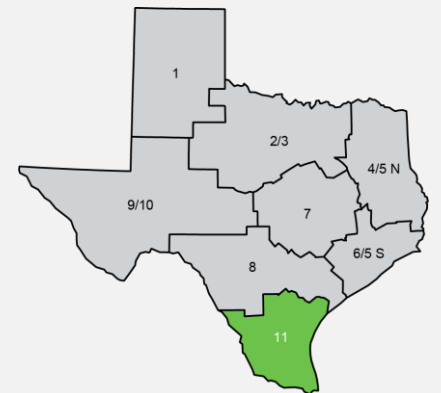
- General conclusions from the 2016 guidelines
 - 6 mo (26 wk) is the **MINIMUM** duration of RX
 - **6 mo regimens require rifampin and INH throughout and PZA for the first 2 months**

Treatment of Culture-Positive Drug Susceptible Pulmonary TB

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- General conclusions from the literature:
- **Without PZA** - minimum duration is **9 months**
- **Without rifampin** - minimum duration is **12 months (up to 18 months)**

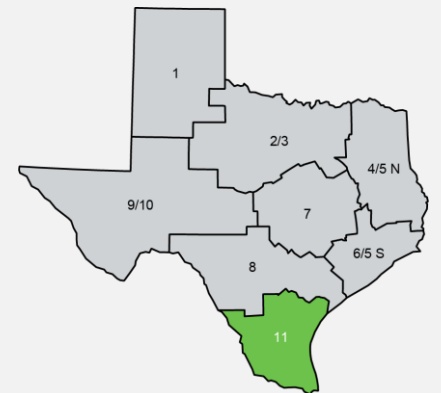


Treatment of Culture-Positive Drug Susceptible Pulmonary TB

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- General conclusions from the literature
 - 6 mo regimens are effective without INH (replace INH with a fluoroquinolone, continue EMB and PZA)
 - Intermittent regimens (2-3x/wk) are rarely warranted. If used:
 - **GIVEN by DOT ONLY**
 - Drug susceptible isolate
 - Regimen contains INH and rifampin



Treatment of Culture-Positive Drug Susceptible Pulmonary TB

Preferred Regimen (*HIV Uninfected*)

initial
phase

2 mo I,R,Z,E daily (56 doses, 8wks) **or**
2 mo I,R,Z,E 5x/wk (40 doses, 8wks) **then**

continuation
phase

4 mo - I,R daily (126 doses, 18 wks) **or**
4 mo - I,R 5x/wk (90 doses, 18 wks)



Treatment of Culture Positive Pulmonary Tuberculosis

Table 2. Drug Regimens for Microbiologically Confirmed Pulmonary Tuberculosis Caused by Drug-Susceptible Organisms

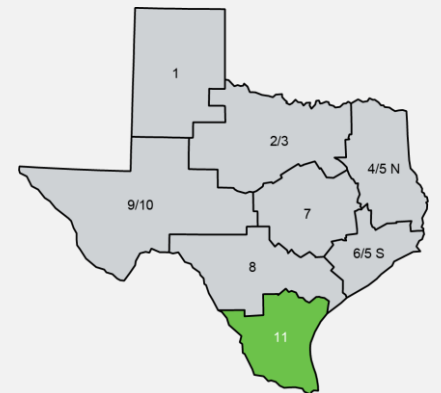
Regimen	Intensive Phase		Continuation Phase		Range of Total Doses	Comments ^{c,d}	Regimen Effectiveness
	Drug ^a	Interval and Dose ^b (Minimum Duration)	Drugs	Interval and Dose ^{b,c} (Minimum Duration)			
1	INH RIF PZA EMB	7 d/wk for 56 doses (8 wk), or 5 d/wk for 40 doses (8 wk)	INH RIF	7 d/wk for 126 doses (18 wk), or 5 d/wk for 90 doses (18 wk)	182–130	This is the preferred regimen for patients with newly diagnosed pulmonary tuberculosis.	 Greater Lesser
2	INH RIF PZA EMB	7 d/wk for 56 doses (8 wk), or 5 d/wk for 40 doses (8 wk)	INH RIF	3 times weekly for 54 doses (18 wk)	110–94	Preferred alternative regimen in situations in which more frequent DOT during continuation phase is difficult to achieve.	
3	INH RIF PZA EMB	3 times weekly for 24 doses (8 wk)	INH RIF	3 times weekly for 54 doses (18 wk)	78	Use regimen with caution in patients with HIV and/or cavitary disease. Missed doses can lead to treatment failure, relapse, and acquired drug resistance.	
4	INH RIF PZA EMB	7 d/wk for 14 doses then twice weekly for 12 doses ^e	INH RIF	Twice weekly for 36 doses (18 wk)	62	Do not use twice-weekly regimens in HIV-infected patients or patients with smear-positive and/or cavitary disease. If doses are missed, then therapy is equivalent to once weekly, which is inferior.	

Relapsed Tuberculosis

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- Circumstance in which a patient becomes and remains culture-negative while receiving antituberculosis drugs but at **some point, after completion of therapy**, either becomes culture-positive again or experiences clinical and radiographic deterioration consistent with TB disease



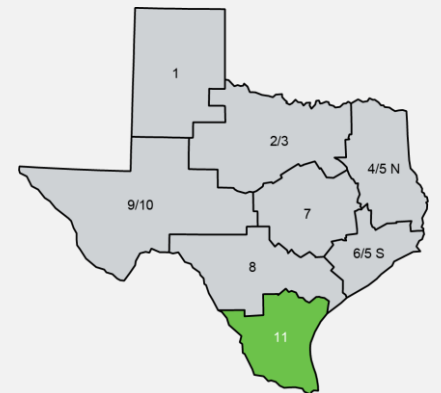
Relapsed Tuberculosis Management Strategies

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- Most relapses occur within the first 6 – 12 months after stopping therapy but some occur 5 or more years later
- Nearly all drug susceptible patients who were treated with a rifamycin and received DOT will relapse with drug susceptible organisms

Restart treatment with standard RIPE regimen



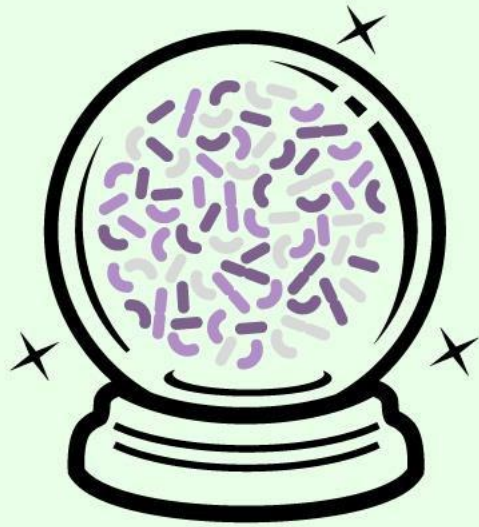
Patients at Risk of Relapse

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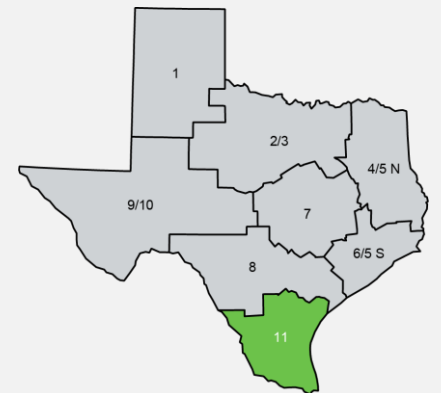
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A Clearer Crystal Ball

A Meta-Regression Model Predicts TB Relapse



- Who is more likely to have Relapse?
- What Can We Do Differently to Decrease the Risk?

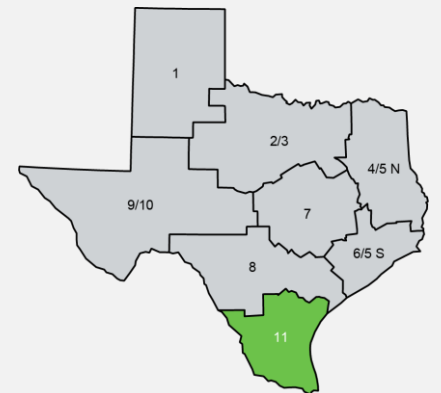


Medical Factors Associated With Relapse

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- Cavitory TB
- Extensive disease on CXR; bilateral infiltrates
- Positive 2 month culture
- Associated medical conditions
 - Diabetes
 - HIV
 - Malabsorption of TB drugs
- Underweight at diagnosis and failure to gain
 - Drug resistant disease
 - Prior treatment for tuberculosis

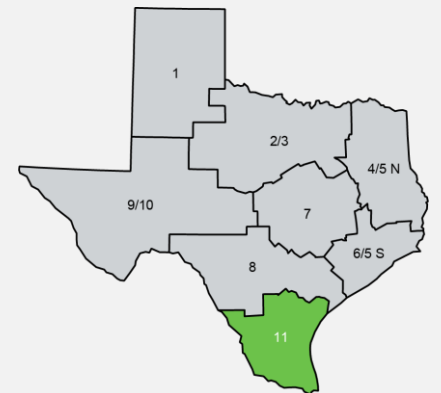


Treatment Factors Associated with Relapse of Tuberculosis

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- DOT
- Adherence
- Dosing intensity (Dose itself)
- Duration of therapy
 - Intensive phase
 - Continuation phase
 - Both
- Rifamycin containing regimen



Relapsed Tuberculosis Management Strategies

- **Suspect drug resistance if:**

- Patients treated with self administered therapy
- Patient was poorly adherent
- Patient deteriorates clinically or radiographically during initial weeks of treatment

- **Do molecular testing for drug resistance**

- Consider expanded regimen, especially if immune suppressed
 - Add at least 2 drugs (fluoroquinolone and an injectable)



Tailoring Treatment Regimens

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- **Prolong** continuation phase when:
 - Positive 2- month culture with cavitary disease
 - Extrapulmonary disease
 - Meningitis, bone and joint
 - Disseminated disease in children
- HIV TB in children and adolescents and **in adults not receiving HAART during TB treatment**



Treatment in Special Situations



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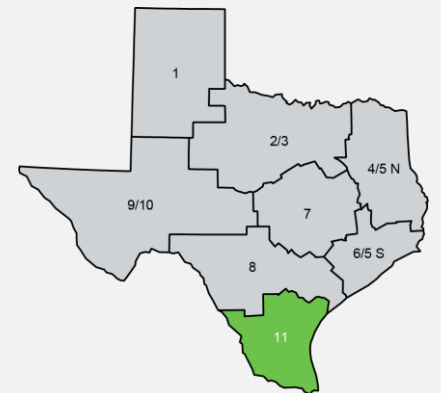
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“Delayed Response” Culture Positive at 3 Months

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- TB lab should **automatically repeat** susceptibility studies on last positive culture - check to be sure
- Assess adherence
- Consider serum drug levels
- Evaluate response to therapy
 - Clinically and radiographically
 - **By the time you know this it is 4 months into therapy!**



“Treatment Failure” Culture Positive at 4 Months

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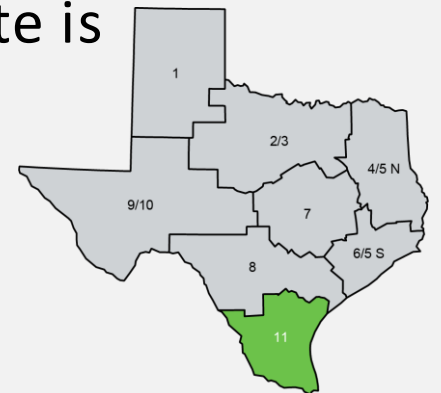
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Repeat susceptibility studies

- On last positive culture
- **And request on a “new sputum culture” now**
 - **Ask for molecular detection of drug resistance**
- Serum drug levels if not previously done
- Clinical evaluation

Augment therapy

- Add at least two and preferably three new drugs to which the isolate is likely to be susceptible
 - Even if no clinical or radiographic evidence of failure



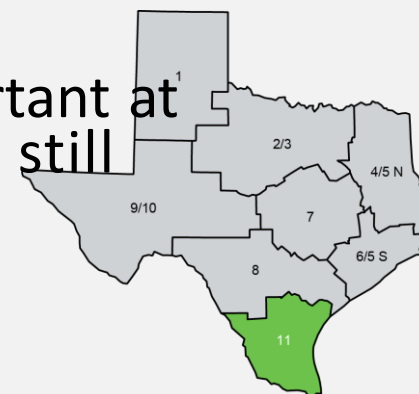
Active TB During Pregnancy

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- Diagnosis may be difficult
 - Respiratory symptoms common in late pregnancy
 - Reluctance to do a CXR
 - Extra-pulmonary disease is even more difficult
- Outcomes for BOTH mom and baby are improved with treatment during pregnancy
- Infection control is important at time of delivery if mom is still infectious



Active TB During Pregnancy

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Diagnosis:

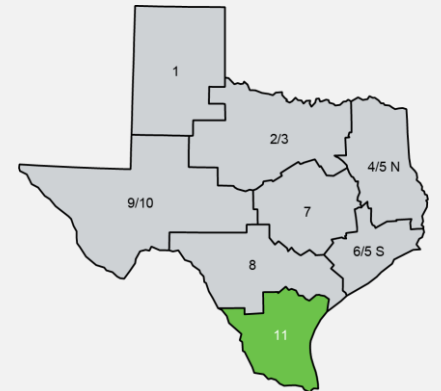
- If you are suspecting TB in a pregnant woman, shield the abdomen and get a CXR. You could be saving 2 lives

Treatment:

- INH, Rifampin, Ethambutol x 9 months
 - Stop Ethambutol if susceptible to INH and rifampin
- PZA is regarded as safe by most countries in world (only US and Australia don't). Discuss the benefits of treatment with the patient and strongly consider adding to the regimen

Follow carefully for hepatotoxicity

- During pregnancy
- Three months postpartum

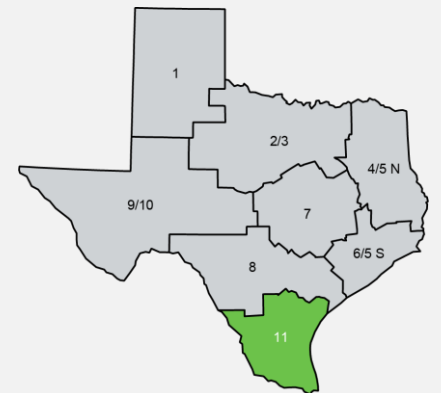


TB Drugs Cleared by the Kidneys

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- Ethambutol (EMB)
- Pyrazinamide (PZA)
- Levofloxacin
- Cycloserine
- Anything that is injected
 - Streptomycin
 - Amikacin
 - Capreomycin
 - Kanamycin



Treatment Regimen: Active TB with renal insufficiency

- Renal insufficiency counted at CrCl <30
- **Initial Phase** (first two months):
 - INH 300mg po daily
 - Rifampin 600mg po daily
 - Ethambutol 15-25mg/kg po *thrice weekly*
 - PZA 25-35mg/kg po *thrice weekly*
 - Vitamin B6 50mg daily
- **Continuation**
 - INH and Rifampin x 4 – 7 months
- **All doses should be given AFTER DIALYSIS**



Table 12. Dosing Recommendations for Adult Patients With Reduced Renal Function^a

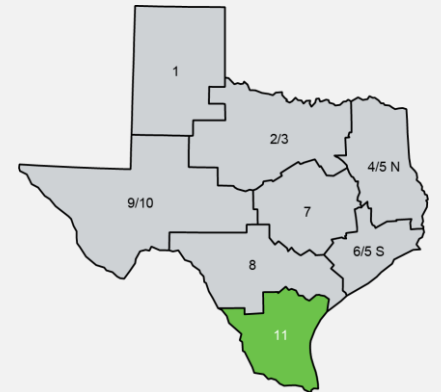
Drug	Change in Frequency?	Recommended Dose and Frequency for Patients With Creatinine Clearance <30 mL/min, or Patients Receiving Hemodialysis
Isoniazid	No	300 mg once daily, or 900 mg 3 times/wk
Rifampin	No	600 mg once daily, or 600 mg 3 times/wk
Pyrazinamide	Yes	25–35 mg/kg/dose 3 times/wk (not daily)
Ethambutol	Yes	20–25 mg/kg/dose 3 times/wk (not daily)
Levofloxacin	Yes	750–1000 mg/dose 3 times/wk (not daily)
Moxifloxacin	No	400 mg once daily
Cycloserine	Yes	250 mg once daily, or 500 mg/dose 3 times/wk ^b
Ethionamide	No	250–500 mg/dose daily
Para-amino salicylic acid	No	4 g/dose twice daily
Streptomycin	Yes	15 mg/kg/dose 2-3 times/wk (not daily)
Capreomycin	Yes	15 mg/kg/dose 2-3 times/wk (not daily)
Kanamycin	Yes	15 mg/kg/dose 2-3 times/wk (not daily)
Amikacin	Yes	15 mg/kg/dose 2-3 times/wk (not daily)

TB in the Elderly

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- Hepatotoxicity as well as other medication toxicities are more common
- Drug-drug interactions are more common
- May want to weigh the risk/benefit of using PZA

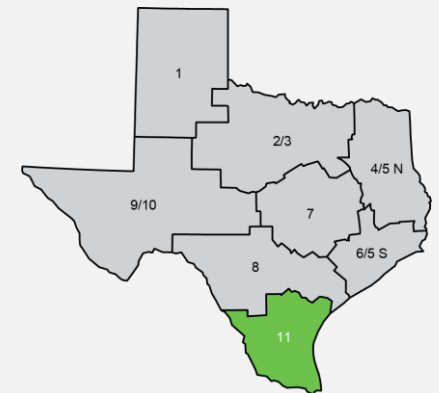


Mycobacterium bovis

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- Often disseminated disease that is highly associated with the abdomen (abdominal lymph nodes, abscesses, enteritis/colitis)
- Is more common along U.S./Mexico border
 - Non-pasteurized milk and cheese – a foodborne disease as well as respiratory
- Is associated with extra pulmonary disease and increased mortality
- **Resistant to PZA**, susceptible to INH, rifampin and EMB
 - Note: PZA monoresistance likely *M. bovis* or *M. kansasii*



Culture Negative TB

- A person who could have TB with positive TST or IGRA
 - Risk factors for TB
 - Abnormal CXR
 - Usually – clinical symptoms
- All cultures are negative
- Classify based on clinical and/or radiograph response treatment at 2 months
- **Clinical or CXR improvement – Culture Negative TB**
- Treatment recommendations are for RIPE x 2 months, then rifampin/INH for 2 more months
- Consider leaving all 4 drugs or at least INH/rifampin/EMB



Management of Treatment Interruptions

- Initial phase of therapy
 - <14 days –complete standard # of doses
 - >14 days – restart from the beginning
- Continuation phase
 - >80% doses by DOT – if initial smear negative, may stop
 - Repeat culture
 - >3 month interruption restart from beginning
 - <3 month interruption, culture positive, restart
 - <3 month interruption, culture negative, give an additional 4 months



4-month Rifapentine-moxifloxacin TB Treatment Regimen



Rectangular Snip

The 4-month TB treatment regimen consists of

- high-dose daily rifapentine (RPT) with
- moxifloxacin (MOX),
- isoniazid (INH), and
- pyrazinamide (PZA).

The 4-month rifapentine-moxifloxacin regimen has an intensive phase of 2 months, followed by a continuation phase of 2 months and 1 week (total 17 weeks for treatment).

Intensive Phase			Continuation Phase					
Drugs	Duration ^a	Frequency ^b	Drugs	Duration ^c	Frequency ^b	Total Doses	Comments ^{d,e}	Regimen Effectiveness
RPT MOX INH PZA	8 weeks	7 days/week for 56 doses	RPT MOX INH	9 weeks	7 days/week for 63 doses	119	Recommended for people ages 12 and older with body weight at or above 40 kg, with pulmonary TB caused by organisms that are not known or suspected to be drug-resistant, and who have no contraindications to this regimen.	The 4-month rifapentine-moxifloxacin TB treatment regimen is as effective as (noninferior to) the standard daily 6-month regimen in curing drug-susceptible TB disease.

Abbreviations: RPT= rifapentine; MOX= Moxifloxacin; INH = isoniazid; PZA = pyrazinamide

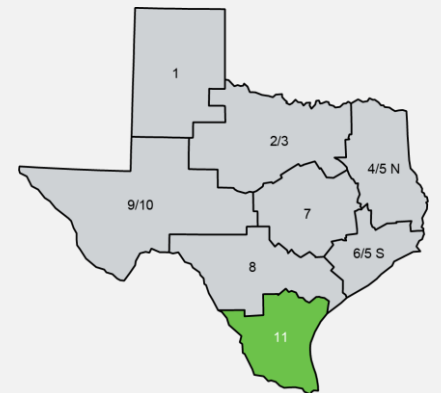


Potential Challenges

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- **Pill burden**
 - 1 INH, 8 rifapentine, 1 moxifloxacin, 1 pyridoxine (everybody gets these) + PZA for weight
- **Tolerability (versus safety, efficacy)**
- **Familiarity with the regimen**
 - Substitutions?
 - There is no guidance on substituting any of the drugs
 - EOT and they need more treatment?
 - There is no real guidance on how long to extend treatment
- **Drug shortages!**



Pill Burden

	Standard Regimen (HRZE) >75Kg	Short course regimen (HPMZ) >75Kg
Intensive Phase	8 weeks  Isoniazid Rifampin Pyrazinamide Ethambutol Vitamin B6	8 weeks  Isoniazid Rifapentine Moxifloxacin Pyrazinamide Vitamin B6
Continuation Phase	16-28 weeks  Isoniazid Rifampin Vitamin B6	9 weeks  Isoniazid Rifapentine Moxifloxacin Vitamin B6

Photos courtesy of George Lee, RN



CDC recommends the 4-month rifapentine-moxifloxacin regimen as an option for treating pulmonary TB disease caused by organisms that are not known or suspected to be drug-resistant for

- People who are 12 years and older
- People with a body weight at or above 40 kg
- People with [HIV](#) with CD4 counts at or above 100 cells/microliter (μL), who are receiving or planning to start efavirenz as part of their [antiretroviral therapy \(ART\)](#) regimen in the absence of any other known drug-drug interactions between antituberculosis and antiretroviral medications
- People who have no contraindications to this regimen
- People with a negative sputum culture who in the judgment of the clinician likely represent paucibacillary or low mycobacterial burden TB disease unless the person is included in one of the non-recommended groups listed below

Note: A 4-month regimen for smear-negative, culture-negative, noncavitary pulmonary TB disease exists in [the 2016 Treatment of Drug-Susceptible Tuberculosis Guidelines](#)  for the treatment of drug-susceptible TB disease and may also be used.

Four-month rifapentine-moxifloxacin tuberculosis (TB) treatment regimen:

Considerations for specific groups of people with TB disease

CDC recommends the 4-month rifapentine-moxifloxacin regimen as an option for treating drug-susceptible pulmonary TB disease for

- People who are 12 years and older
- People with a body weight at or above 40 kg
- People with [HIV](#) with CD4 counts at or above 100 cells/microliter (μL), who are receiving or planning to start efavirenz as part of their [antiretroviral therapy \(ART\)](#) regimen in the absence of any other known drug-drug interactions between antituberculosis and antiretroviral medications
- People who have no contraindications to this regimen
- People with a negative sputum culture who in the judgment of the clinician likely represent paucibacillary or low mycobacterial burden TB disease unless the person is included in one of the non-recommended groups listed below

Note: A 4-month regimen for smear-negative, culture-negative, noncavitary pulmonary TB disease exists in the [2016 CDC guidelines](#) for the treatment of drug-susceptible TB disease and may also be used.

CDC recommends that clinical consultation be obtained to determine if the 4-month rifapentine-moxifloxacin regimen is an acceptable treatment option for

- People at increased risk of *Mycobacterium tuberculosis* (M. tuberculosis) resistance to any drug in the 4-month regimen
- People who received more than 5 doses of TB treatment in the prior 6 months
- People who received more than 5 doses of latent TB infection treatment in the prior 6 months
- People who received more than 5 doses of treatment with any one or more of the following drugs for any reason (e.g., urinary tract infection, pneumonia) in the prior 30 days:
 - Isoniazid (INH), rifampin (RIF), rifabutin, rifapentine (RPT), pyrazinamide (PZA), or any fluoroquinolone
- People who have serum or plasma alanine aminotransferase or aspartate aminotransferase more than 3 times the upper limit of normal or total bilirubin more than 2.5 times the upper limit of normal, or with preexisting advanced liver disease
- People who have renal insufficiency or end-stage renal disease, or
- Serum or plasma creatinine level more than 2 times the upper limit of normal, or
- Plasma potassium level less than 3.5 milliequivalents per liter (mEq/L)
- People who have types of extrapulmonary TB that are likely to be paucibacillary, not pose a substantial risk of death or disability, and not require prolonged treatment (i.e., pleural or lymph node TB)
- People with a sputum specimen that is unable to be submitted for any M. tuberculosis resistance testing prior to initiating the 4-month treatment regimen

CDC does not recommend the 4-month rifapentine-moxifloxacin regimen for

- People who are younger than 12 years old
- People with a body weight below 40 kilograms (kg)
- People who are pregnant or breastfeeding
- People who have most types of suspected or documented extrapulmonary TB
- People who have a history of prolonged QT syndrome or concurrent use of one or more QT-prolonging medications (in addition to moxifloxacin (MOX))
- People who are receiving medications with known clinically relevant drug-drug interactions with INH, RPT, PZA, or MOX

Additional Resources:

Interim Guidance: 4-Month Rifapentine-Moxifloxacin Regimen for the Treatment of Drug-Susceptible Pulmonary Tuberculosis – United States, 2022. [MMWR Morbidity and Mortality Weekly Report](#), 2022. <https://www.cdc.gov/mmwr/immune/2022/mmwr/20220811a1.htm>

Frequently Asked Questions (FAQs) on a 4-month rifapentine-moxifloxacin TB treatment regimen: <https://www.cdc.gov/tb/topic/treatment/faq.htm>

Treatment for TB Disease: <https://www.cdc.gov/tb/topic/treatment/tb-disease.htm>

State TB Control Offices: <https://www.cdc.gov/tb/links/tb-offices.htm>

TB Centers of Excellence for Training, Education, and Medical Consultation: https://www.cdc.gov/tb/education/tb_coe/default.htm

[Considerations for the 4-month Rifapentine-moxifloxacin Regimen](#)  [PDF - 233 KB]



In Summary:

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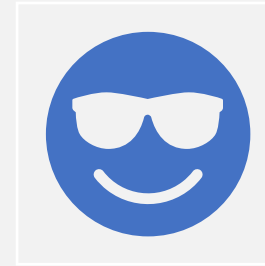
A Complete Assessment for the Diagnosis and Management of TB...



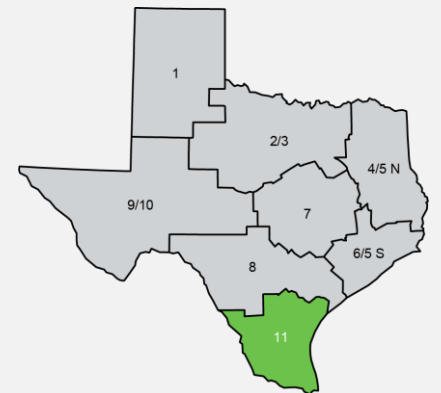
...Is Essential to Good
Patient Outcomes



and Public Health
Outcomes



Thank you!



Questions?



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