APPENDIX I. ACTIVE PULMONARY TB DIAGNOSTIC ALGORITHM FOR PRIMARY CARE

**Cough ≥ 3 weeks, or**
- Weight loss ≥ 3kg in past 2 months, or
- Fever ≥ 3 weeks, or
- Night sweats ≥ 3 weeks

Severe illness?
- HIV?
  - Consider hospitalization or specialty referral for urgent evaluation.

Stop TB evaluation.
- Re-evaluate if symptoms return later.

**Outpatient pulmonary TB evaluation:**
- Chest radiograph
- HIV serology
- TST or QFT*
- CBC, CMP
- Consider antimicrobial Rx (caution regarding FQNs)

Also, consider additional diagnoses consistent with the presenting syndrome: e.g., extrapulmonary TB, non-TB respiratory tract infections, other non-TB infections, malignancy, etc.

Illness improves on broad spectrum antimicrobials and follow-up imaging improved.

**Chest radiograph suggestive of active TB?**

Collect sputum for AFB x 3 and TB nucleic acid amplification x ≥ 1

Sputum AFB smear positive on ≥ 1 specimen or NAAT positive for TB nucleic acid

Isolate
- Initiate anti-TB therapy

Negative AFB smears and NAA
- Follow AFB cultures and meanwhile:

High suspicion still?

Refer for specialty evaluation or discuss with specialist regarding further evaluation and management

**CXR not suggestive of active TB**

Patient does not improve on empiric therapy or pre-treatment radiographic abnormality does not improve on follow-up

• Consider broad spectrum antimicrobials through primary care as empiric treatment for non-TB infection if not done already
  - If epidemiologic risk factors for TB, use non-FQN options

*Note: TST/QFT results provide supplemental, but not definitive information in the evaluation of patients with suspected TB. Sensitivity is 70-80% in HIV-negative patients, much lower in HIV-positive patients; specificity is even lower. A decision to test or treat for active disease should never hinge on TST/QFT results. TST and QFT are more useful in evaluating patients for latent or inactive TB.*