



PROTECTING YOUR WORKFORCE FROM
TUBERCULOSIS (TB)

HEALTH PROFESSIONALS
FACT SHEET 2

**IDENTIFYING SUSPECTS
AND DIAGNOSING TB**

For more information contact:

- Your local health department
- URC at TBinfo@urc-sa.com
- The National TB Control Programme at (012) 312 0106

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IDENTIFYING SUSPECTS AND DIAGNOSING TB

Rationale for prompt diagnosis

The systematic identification of adults with persistent cough of more than two weeks is the most cost effective way of early detection of TB. Employees with such a symptom should be encouraged to go to the nearest health facility for further testing. This reduces treatment delays and identifies infectious patients who are a risk to the community and to other staff.

TB can affect any part of the body, but the most common form of TB, is TB of the lungs, also called Pulmonary TB.

TB symptoms of the lungs:

- The most common symptom of pulmonary TB is a persistent cough for two weeks or more, usually with production of sputum.
- It may be accompanied by one or more of the following symptoms:

Weight loss, chest pain, tiredness, shortness of breath, fever, particularly with a rise in temperature in the evening, coughing up blood, loss of appetite, night sweats.

Careful diagnosis

The detection of TB cases requires two steps:

- Identifying TB suspects
In a workplace health centre, occupational health care worker or administrative staff would largely be

responsible for identifying persons with a persistent cough and referring them for further tests, usually a smear (sputum) examination. If an employee is identified as having the above symptoms he or she should not be discriminated against but encouraged to go for tests.

- Proceeding to diagnosis of TB among people identified as TB suspects - Every employee who has a cough for two weeks or more, with or without other symptoms, most probably will be asked to give two sputum samples examined for TB germs called Acid-fast bacillus (AFB). Sputum smear microscopy is the primary tool for diagnosing TB as it is more specific.

Employers with large workforces may have either on-site health facilities for TB diagnosis (sputum smear microscopy) or arrangements for referral of TB suspects for diagnosis. Many employers may directly refer TB suspects for diagnosis at the nearest health facility.

Since patients with active TB are the most infectious, they may be advised to refrain from working for the first two weeks of treatment; this will also give the patient an opportunity to rest.

After two weeks of treatment, most patients are no longer infectious. It is very important to elicit the history of previous anti-tuberculosis treatment to help define a case, to identify patients with increased risk of acquired drug resistance, to prescribe appropriate treatment, and for epidemiological monitoring.

People can also have the TB disease even though their sputum examination does not show TB germs (smear negative TB).

Presentation of TB in HIV-positive cases

Weight loss and fever are more common in HIV-positive patients with pulmonary tuberculosis. Cough is reported less frequently among HIV-positive TB cases, since there is less cavitation, inflammation, and endo-bronchial irritation because of impaired cellular immunity.

The main types of extra-pulmonary TB seen among HIV-positive patients are lymphadenopathy, pleural effusion, pericardial effusion, miliary TB, and tuberculosis bacteraemia.

Key pointers on the diagnosis of pulmonary TB:

- Sputum microscopy is the recommended diagnostic tool for patients suspected of having pulmonary TB.
- Two sputum samples should be examined under the microscope.
- Sputum samples should be examined as soon as possible and not later than a week after they are collected.
- No radiographic pattern is diagnostic of TB, although the classical hallmarks of the disease are cavitation, apical distribution, pulmonary fibrosis, shrinkage, and calcification.
- Further tests may be done such as chest x-ray and culture if one is HIV positive.