

**BY ORDER OF THE COMMANDER
59TH MEDICAL WING**

**59TH MEDICAL WING INSTRUCTION
48-107**



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Aerospace Medicine

***CONTROL OF COMMUNICABLE AND
OTHER REPORTABLE DISEASES***

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Program*, AFI 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*, and AFI 48-135, *Human Immunodeficiency Virus Program*. It delineates responsibilities and procedures for the management and reporting of communicable and other conditions of public health significance to include sexually transmitted infections (STIs), Human Immunodeficiency Virus, rabies, and tuberculosis. This instruction applies to all personnel assigned, attached, or on contract to the 59th Medical Wing (MDW). This instruction does not apply to the Air National Guard or Air Force Reserve. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule on the Air Force Portal available at <https://my.af.mil/afrims/afrims/afrims/rims.cfm>.

SUMMARY OF CHANGES

Added rabies post exposure prophylaxis table. A margin bar (|) indicates newly revised material.

Chapter 1

SEXUALLY TRANSMITTED INFECTIONS

1.1. Overview. The purpose of the Sexually Transmitted Infection (STI) Program is to detect, treat and provide education to patients infected with sexually transmitted infections in order to break the chain of infection and prevent complications and/or chronic disease. Sexually transmitted infections are identified in active duty and beneficiaries primarily through clinical encounters, whereas, female basic trainees are actively screened for Chlamydia and Gonococcal Infection (GC).

1.2. Responsibilities.

1.2.1. Healthcare providers will:

1.2.1.1. Diagnose and treat presumptive and confirmed STI CASES in accordance with the *Centers for Disease Control and Prevention Sexually Transmitted Infections Treatment Guidelines*, 2010 (or most recent version when superseded). <http://www.cdc.gov/std/treatment/default.htm>

1.2.1.2. Instruct patients to avoid intimate contact until 7 days after a single-dose regimen or after completion of a 7-day regimen for themselves AND for their contact(s).

1.2.1.3. Order initial Human Immunodeficiency Virus (HIV), Rapid Plasma Reagin, Chlamydia, Gonorrhea and Hepatitis B panel on all STIs.

1.2.1.4. Refer presumptive and confirmed STI patients immediately to Public Health for education and contact investigation in order to prevent re-infection. Notify by phone (pager 594-1950) and/or by faxing Wilford Hall Medical Center Form (WHMC) 3520, *Provider Reportable Condition*, worksheet to 671-6481.

1.2.1.5. Order 90-day HIV test for all STIs. For patients with confirmed Chlamydia or GC, order a 90-day follow-up test to ensure patient does not become reinfected.

1.2.1.6. For patients diagnosed with syphilis, consult with Infectious Disease at 916-5554 or page the on-call pager 513-6060, and report to Public Health 671-6481.

1.2.1.7. Treat STI CONTACTS presumptively in accordance with (IAW) Centers for Disease Control (CDC) guidelines and test for STI infection. <http://www.cdc.gov/std/treatment/default.htm>. Timely treatment of sex partners is essential for decreasing the risk for re-infecting the index patient. **Note:** As of 13 April 2007, Fluoroquinolones (ciprofloxacin, ofloxacin, or levofloxacin) are no longer recommended for the treatment of Gonococcal infections due to an increase in resistance.

1.2.2. The 559 AMDS Public Health (PH) flight will:

1.2.2.1. Conduct an epidemiological investigation to identify contacts of an STI case so that they can be treated presumptively and tested IAW the CDC's recommendations. Active duty contacts and beneficiaries are notified by PH and advised to seek immediate treatment; civilian contacts are forwarded to the San Antonio Metropolitan Health District for follow-up.

1.2.2.2. Educate patients on transmission, prevalence, and prevention of STIs in an effort to prevent re-infection. Instruct patients to avoid intimate contact until 7 days after a single-dose regimen or after completion of a 7-day regimen for themselves AND for their contact(s).

1.2.2.3. Conduct a quality review of the clinical management of STIs to ensure treatment is in accordance with the CDC's guidelines and appropriate laboratory tests are ordered. Refer discrepancies in clinical management to the STI consultant for resolution.

1.2.2.4. Conduct surveillance for STIs and other communicable diseases to identify cases that may not have been referred/reported. Maintain a database of STIs and conduct an annual program review to include a trend analysis. Present findings to the Aeromedical Council.

1.2.2.5. Report STIs in accordance with Air Force and State regulations and educate professional staff on program requirements such as follow-up testing requirements and current treatment guidelines and changes, and trends at least annually.

1.2.3. The 59 MDW Laboratory will:

1.2.3.1. Conduct testing in accordance with the College of American Pathologist guidelines and make results available to providers and Public Health.

1.2.3.2. Notifies PH of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the Tri-Service Reportable Events Guidelines and Case Definitions <http://www.afhsc.mil/reportableEvents>. Notifies PH of any unusual pattern of laboratory testing or significant increase in incidence of a disease.

1.2.4. STI Consultant will:

1.2.4.1. Serve by appointment of the 559th MDG/CC.

1.2.4.2. Provide clinical consultation for the STI program and interface with the Emergency Department, Primary Care, Chief of the Medical Staff and other providers on clinical issues.

1.2.5. The 59 MDW Chief of the Medical Staff (SGH) will:

1.2.5.1. Oversee the clinical peer review program for the management of STI patients.

Chapter 2

RABIES EXPOSURE CONTROL PROGRAM

2.1. Overview. To outline responsibilities and post-exposure procedures in order to prevent human rabies that may result from bite and non-bite exposures.

2.2. Responsibilities.

2.2.1. Healthcare providers will refer all potential rabies exposures to include scratches, bites, contact of saliva with mucous membranes or non-intact skin, etc to the 59 MDW emergency department for wound management, rabies risk assessment, and initiation of post-exposure prophylaxis (PEP) when indicated.

2.2.2. Treating Provider Will:

2.2.2.1. Clinically manage all potential rabies exposures (bite and non-bite) to include scratches, bites, contact of saliva with mucous membranes or non-intact skin, etc.

2.2.2.2. Render first aid to include cleansing the wound with soap and water due to the lipophilic nature of the rabies virus; when available, irrigates the wound with a virucidal agent such as a povidine-iodine solution.

2.2.2.3. Complete the DD Form 2341, *Report of Animal Bite - Potential Rabies Exposure*, Part I and II and assesses the risk for rabies exposure. Risk for rabies exposure is based on the type of animal involved, type of contact, circumstances of the exposure, health status of the animal, the animal's vaccination status, whether the animal is a stray and in the case of dogs and cats whether the animal is available for 10-day quarantine. Risk classifications are as follows:

2.2.2.3.1. Low Risk: Incident (bite, scratch, mucous membrane exposure) involves healthy dog or cat (not a stray) where the owner is known and the dog or cat is available for 10-day quarantine. Squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice, opossums, armadillos, and other rodents, rabbits, and hares are generally considered minimal risk (**Note:** these animals can carry rabies, though it is infrequent) unless there are unusual circumstances.

2.2.2.3.2. Moderate Risk: Incident (bite, scratch, mucous membrane exposure) involves dog or cat with bites or injuries to the face, head and neck, **OR** bites from dogs or cats too young for vaccination, **OR** bites from STRAY dogs or cats AVAILABLE for 10-day quarantine (**Note:** 10-day quarantine is only valid for dogs and cats).

2.2.2.3.3. High Risk: Incident (bite, scratch, mucous membrane exposure) involves a STRAY dog or cat NOT available for quarantine, **OR** a wild animal likely to carry rabies such as a bat, raccoon, skunk, fox, coyote, etc. **OR** an animal exhibiting signs of rabies. In incidents involving bats, PEP may be appropriate even in the absence of demonstrable bite, scratch, or mucous membrane exposure such as when a sleeping individual awakes to find a bat in their room, or an intoxicated individual or small child, or someone who otherwise can't give an accurate account, or if a bat flies up and brushes against an individual.

2.2.2.4. The provider may convene telephonically, the Rabies Advisory Board (Flight Surgeon, Base Veterinarian, PH) on Moderate or High Risk bites to discuss the need for PEP. Generally, the recommendation is to administer rabies post-exposure prophylaxis on all MODERATE (unless animal appears healthy and is available for 10-day quarantine) and HIGH RISK incidents as outlined in Table 2.1. If the provider deviates from this recommendation, he must clearly document WHY. The Human Diploid Cell Rabies Vaccine (HDCV) series can be stopped if the dog or cat is found to be healthy at the end of the 10-day quarantine or the animal's rabies test is negative.

Table 2.1. Rabies Post-exposure Prophylaxis (PEP) for Persons Not Previously Vaccinated.

Treatment	Regimen
RIG (Rabies Immunoglobulin)	Administer 20 IU/kg body weight. If anatomically feasible, the full dose should be infiltrated in and around the wounds and any remaining volume should be administered intramuscular (IM) in the gluteal muscle. Rabies Immune Globulin should not be administered in the same syringe as vaccine. Because RIG might partially suppress active production of antibody, no more than the recommended dose should be given. Note: Persons who have been previously vaccinated for rabies, such as veterinarians, do not require RIG, therefore consult CDC guidance for HCDV vaccination schedule
Vaccine	HDCV, Rabies Vaccine Adsorbed, or Purified Chick Embryo Cell Culture Rabies Vaccine 1.0 mL, IM (deltoid area for adults; anteriolateral thigh for infants and small children), one each on days 0, 3, 7, 14. Day 0 is the day the RIG and 1st dose of vaccine is given. Note: Vaccine should NEVER be given in the gluteal muscle as this may result in lower neutralizing antibody titers.

Table 2.2. Rabies Post-exposure Prophylaxis (PEP) for Persons Previously Vaccinated.

Treatment	Regimen
RIG (Rabies Immunoglobulin)	RIG should not be administered.
Vaccine	HDCV or Purified Chick Embryo Cell Culture Rabies Vaccine 1.0 mL, IM (deltoid area for adults), 1 each on days 0 and 3.
Note: For persons with immunosuppression, rabies PEP should be administered using all 5 doses of vaccine on days 0, 3, 7, 14, and 28.	

2.2.2.5. Provide patients the immunization schedule (Day 0 [the day the RIG and 1st vaccine dose is given], 3, 7, 14,) as outlined in current CDC guidelines, and instruct/direct patients to follow-up with appropriate clinics to complete HDCV series on weekdays and/or weekends/holidays.

2.2.2.6. Assess the tetanus status of the patient and administers booster doses as indicated.

2.2.2.7. Assess the risk for Dysgonic Fermentator-2 infection and administers antibiotics as indicated.

2.2.2.8. Provide a single point of contact (POC) to Public Health to correct and address discrepancies in completion of the DD Form 2341 and clinical management of patients.

2.2.2.9. Contact Civil Engineering Entomology at 671-3525 for animals involved in a bite that are loose on base and document contact on the DD Form 2341, block 20.b. (This can be accomplished by any admin support from the treating providers clinic.)

2.2.2.10. Document immunizations administered in the Air Force Complete Immunization Tracking Application (AFCITA). This can be accomplished by any admin support function from the treating providers clinic.

2.2.3. 59 MDG Public Health flight will:

2.2.3.1. Provide pre-numbered Animal Bite Forms (DD Form 2341) to the 59 MDW rabies program designee.

2.2.3.2. Conduct quality reviews of animal bite forms for accuracy. Return incomplete or inaccurate forms to 59 MDW designee for correction.

2.2.3.3. Monitor patients for who PEP was initiated to ensure RIG and HDCV were administered IAW with CDC guidelines or provider's documented treatment regimen.

2.2.3.4. Serves as a member of the Rabies Advisory Board.

2.2.3.5. Educate professional staff on program requirements and trends at least annually.

2.2.4. 59 MDW Immunizations Clinic will:

2.2.4.1. Administer rabies vaccine in accordance with the Centers for Disease Control and Prevention's recommended regimen.

2.2.4.2. Document series in the AFCITA and print a copy out for the patient. Provide the patient with a schedule of the series if not already provided.

2.2.4.3. Track patients to completion of post-exposure series.

2.2.4.4. Maintain RIG and HDCV inventory IAW historic usage rates.

2.2.5. Base Veterinarian will:

2.2.5.1. Pick up DD Form 2341s from the 59 MDW POC daily and fax a copy to PH.

2.2.5.2. Verify rabies vaccination status of dogs and cats.

2.2.5.3. Arrange the 10-day quarantine of dogs and cats involved in bite/non-bite exposures and verify the health status of the dog and cat at the end of quarantine. The 10-day quarantine starts at the time of the exposure.

2.2.5.4. Complete Part III of the DD Form 2341 and return the completed original to PH once the quarantine is complete.

2.2.5.5. Serve as a member of the Rabies Advisory Board and report rabies trends in animal species to the Aeromedical Council (AMC) annually or to PH to report to the AMC.

Chapter 3

MANAGEMENT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) PATIENTS

3.1. Overview. The purpose of this plan is to outline the nonclinical procedures in managing Human Immunodeficiency Virus positive active duty patients. Revisions in the program have occurred since AFI 48-135, *Human Immunodeficiency Program* was published in 2004 and are reflected below.

3.2. General. The medical evaluation and care of HIV positive patients is managed through the Division of Infectious Disease at Brooke Army Medical Center, Fort Sam Houston, Texas in cooperation with the Henry Jackson Foundation.

3.2.1. All active duty HIV positive individuals are evaluated at the United States Air Force HIV Medical Evaluation Unit (MEU), 59 MDOS/SGOMI, hereafter referred to as the HIV MEU and outlined in the 59MDWI 44-138, *Management of Human Immunodeficiency Virus (HIV) Cases*.

3.2.2. The HIV MEU will provide medical evaluation, staging of HIV disease, patient education and treatment recommendations.

3.3. Responsibilities.

3.3.1. Healthcare providers will:

3.3.1.1. Screen active duty Air Force for HIV biannually in conjunction with the Preventive Health Assessment and whenever clinically or operationally indicated. Basic trainees are screened upon arrival to Lackland (Week 0 of training) to identify individuals whose infections were not detected at the Military Entrance Processing Station. **Note:** HIV positives are also identified through the Blood Donor Center.

3.3.1.2. Notify PH immediately by phone (Pager 594-1950) and fax WHMC Form 3520, *Provider Reportable Condition* to 671-6481. **Note:** Notification of the patient is made in person by the HIV consultant. Patient notifications are NEVER made over the phone.

3.3.2. The 559 MDG Public Health Flight will:

3.3.2.1. Verify positive result through Armed Forces Health Longitudinal Technology Application (AHLTA) and by contacting the Air Force Institute of Operational Health (AFIOH) Lab as needed. AFIOH will Federal Express notifications of positive results to the Public Health Flight Commander.

3.3.2.2. Facilitate the notification of the patient and the issuing of the Preventive Medicine Order by the patient's commander.

3.3.2.3. Coordinate with the Air Force HIV Staff Physician (916-6022) assigned to the HIV MEU at Brooke Army Medical Center and arrange an appointment for an initial evaluation.

3.3.2.4. Report HIV positive serologies to State and Air Force.

3.3.3. 559 MDG HIV Consultant will:

3.3.3.1. Serve by appointment of the 559 MDG/CC.

3.3.3.2. Notify patients in person of HIV positive results, inform the patient of the significance of a positive test and address medical concerns.

3.3.3.3. For active duty patients, be present at the time the preventive medicine order is issued by commander to address questions.

3.3.4. Air Force HIV Staff Physician at the HIV MEU will:

3.3.4.1. Confirm the diagnosis and conduct a confidential patient epidemiologic interview, and initiate the contact notification process. This includes a blood donation “look back” process.

3.3.4.2. Conduct a medical evaluation of the patient and coordinate a mental health status screening for those undergoing an initial evaluation.

3.3.4.3. Ensure coordination to provide a nurse counselor who will provide education and risk reduction counseling.

3.3.4.4. Coordinate reevaluation visits for active duty.

3.3.5. The Primary Care Providers will: Initiate Duty Limiting Profile/Medical Evaluation Board for active duty patients diagnosed with HIV or patients with indeterminate HIV results in accordance with AFI 48-123, *Medical Examinations and Standard*. For Basic Military Trainees, follow paragraph A3.33.1 which states “Presence of Human Immunodeficiency Virus (HIV) or serologic evidence of infection (042) is disqualifying. Positive Enzyme-Linked Immunoabsorbent Assay test(s) for HIV with ambiguous or inconclusive results on Western Blot testing is disqualifying.”

3.3.5.1. Coordinate with the HIV MEU Staff Physician who provides narrative summaries in Medical Evaluation Board format and assures narrative summaries are entered into the patient’s electronic record.

Chapter 4

TUBERCULOSIS DETECTION AND CONTROL PROGRAM

4.1. Overview. The purpose of this plan is to outline procedures for the testing and treatment of latent tuberculosis in active duty Air Force personnel, military beneficiaries, basic trainees, civilians at Defense Language Institute (DLI), medical employees, and child care employees.

4.2. General. Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become exposed or infected; this is called latent TB infection. Exposure or TB infection is determined by the administration of a tuberculin skin test (TST).

4.2.1. Persons with latent TB have a 10% risk of developing active TB in their lifetime; 5% of the risk is during the first 2 years immediately following TST conversion, and the other 5% risk is during the rest of their lifetime. Identification and treatment of latent TB greatly reduces the likelihood of active TB, thereby preventing further infections. TST is conducted as follows:

4.2.1.1. Active duty Air Force personnel and military dependents are tested for TB based on exposure risk and clinical symptoms using a TST. Active duty personnel are required to have as a minimum a documented TST.

4.2.1.2. Medical personnel are tested IAW the Medical Employee Health Program.

4.2.1.3. Personnel working in base child care facilities are tested initially IAW the Department of Defense's (DoD) accrediting body for DoD Child Development Centers, the National Association for the Education of Young Children and whenever clinically indicated. (**Note:** Annual TST is not required for child care centers in Bexar County.) Personnel at DLI will receive testing annually and be tracked in the Air Force Complete Immunization Tracking Application.

4.2.1.4. Basic trainees are screened for tuberculosis upon arrival to Lackland Air Force Base.

4.3. Responsibilities.

4.3.1. The 59 MDW Immunization Clinic will:

4.3.1.1. Administer and read all TSTs. Routine surveillance testing is accomplished on personnel in accordance with AFI 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*.

4.3.1.2. Schedule follow-up appointments and brief patients on the importance of returning to have the TST read and result documented. **Note:** TSTs can only be documented as "negative" 48-72 hrs after test is administered. Negative tests not read within this time frame must be repeated on the opposite arm.

4.3.1.3. Enter all active duty, basic trainees and family members' TST results into the AFCITA and print a DD Form 2766C, *Adult Preventive and Chronic Care Flowsheet*

(*Continuation Sheet*), for the patient's hard copy medical record and for the patient's personal records. **Note:** Basic Military Trainees have a separate stand alone AFCITA used to track their immunizations.

4.3.1.4. Document the results of TSTs in the patient's shot record. Document tests assessed by a provider as "positive" to prevent repeat testing of individuals with Latent Tuberculosis Infection (LTBI).

4.3.1.5. Refers all persons with a reaction of greater than or equal to 5mm indurations to PH (with their shot records/medical record) for interview and counseling.

4.3.2. The 559th AMDS Public Health will:

4.3.2.1. Initiate AF Form 2453, *Tuberculosis Detection and Control Data*, for all patients referred with a 5mm or greater TST.

4.3.2.2. Conduct initial patient interview and education of patients with reactions of 5 mm or greater induration and refer patients to the healthcare provider for latent TB "positive" determination. Patients classified as "positive" by the provider will be assessed for LTBI treatment.

4.3.2.3. Ensure provider orders baseline chest x-ray test for patients with a positive TST result and document in the medical record. **Note:** If the patient is pregnant or suspects pregnancy, they do not receive an x-ray. It is the provider's clinical decision, but generally prior to initiating treatment for latent TB, baseline liver function (LFT's) tests are also ordered.

4.3.2.4. Re-enforce education regarding LTBI, signs and symptoms of active tuberculosis, treatment to include importance of strict adherence to treatment protocol, and potential side effects of isoniazid (INH) medication. Discuss the importance of notifying their provider of potential problems related to the INH (or other approved CDC treatment regimen) medication adherence, signs and symptoms of active TB, and potential medication side effects. Patients will be instructed to contact their provider prior to running out of their medication. Already addressed in section 4.3.3.5.

4.3.2.5. Enter patients into Preventive Health Assessment and Individual Medical Readiness so the provider can track monthly INH follow-up.

4.3.2.6. Notify the appropriate (military or civilian) public health authorities when patients requiring follow-up: permanent change of station (PCS), retire, or separate from military.

4.3.2.7. Conduct epidemiological investigations for active cases of TB in workplaces and TST conversion clusters.

4.3.2.8. Report active TB cases to Air Force and San Antonio Metropolitan Health District.

4.3.3. The 559 AMDS healthcare provider will:

4.3.3.1. Order baseline chest x-ray and alanine aminotransferase (ALT), HIV (unless documented HIV risk assessment indicates low risk) and aspartate aminotransferase (AST) as indicated. Baseline ALT and AST are indicated for persons infected with HIV, pregnant women, women in the immediate postpartum period (usually within 3 months of

delivery), persons with a history of liver disease, persons who use alcohol regularly, and those who have or are at risk for chronic liver disease.

4.3.3.2. Evaluate patients with a 5 mm or greater TST to determine if the skin test is “positive” based on their risk for infection and in accordance with Air Force and CDC guidelines. Determine the patient’s disease status (latent or active TB), initiate and document appropriate treatment IAW CDC guidelines.

4.3.3.3. Clearly document the rationale if patient is not started on medication (examples: liver disease, previous reaction to INH therapy, or suspended due to short-notice PCS, pregnancy, etc.). **Note:** PCS is not a valid reason to delay treatment unless there is insufficient time to evaluate the patient’s tolerance of the medication.

4.3.3.4. Document positive TST results and dates in the medical record, and the medication administered.

4.3.3.5. Monitor personnel on the TB Detection and Control Program monthly and schedule follow-up appointments and laboratory testing as necessary. Maintain a confidential log listing or other tracking system of pertinent patient information, dates for follow-up testing and results of laboratory tests. Ensure personnel on flying status are grounded for the first 7 days of treatment.

4.3.3.6. Conduct and document in the patient’s medical record monthly follow-ups to ensure appropriate documentation includes:

4.3.3.6.1. Patient’s adherence to treatment protocol.

4.3.3.6.2. Potential signs and symptoms of active tuberculosis.

4.3.3.6.3. Potential medication side effects. Research suggests evaluation for medical side effects is a better indicator of potential hepatotoxicity than reliance on liver function tests. In general, studies have shown that persons 35 years of age or older tend to develop hepatotoxicity at a greater frequency. Therefore, 59 MDW policy is to initially conduct monthly AST/ALT for persons 35 years of age or older to establish a trend in the patient’s LFTs and then either continue or stop testing at the clinician’s discretion. Educate patients to stop taking medication if they experience medication side effects and to immediately contact their provider to determine if treatment should continue.

4.3.3.7. Order INH medication refills. Ensure patients obtain medications from the Pharmacy.

4.3.3.8. Close out the AF Form 2453 when the patient completes or discontinues INH or other prophylaxis and notify PH. Send medical record and all documentation to PH for close out.

4.3.4. The 59 MDW Pharmacy will:

4.3.4.1. Issue patients their INH or accepted alternative medication in accordance with the primary care manager’s directions.

4.4. Treatment Considerations.

4.4.1. Treatment Choice:

4.4.1.1. INH continues to be the drug of choice for LTBI.

4.4.1.2. Other medications are recommended by the CDC for LTBI treatment, and should be considered if the patient was potentially exposed to multi-drug resistant TB or as clinically indicated by the provider. Additionally, approved research protocols may be used as alternative treatment regimens, when of benefit to the Air Force.

4.4.1.3. Medical contraindications to INH treatment include previous adverse reactions to INH treatment, acute hepatitis, and end-stage liver disease. Treatment is not contraindicated in patients who are HIV positive, pregnant, women immediately postpartum (within 3 months of delivery), history of chronic liver disease/infection (hepatitis B/C, alcoholic hepatitis, or cirrhosis), persons who use alcohol regularly, and persons at risk for chronic liver disease. However, these patients should receive baseline liver function testing and be monitored closely for INH side effects (monthly evaluations and routine laboratory monitoring—liver function testing).

4.4.2. Treatment Length for Latent Tuberculosis Infection (LTBI):

4.4.2.1. The current CDC Core Curriculum on Tuberculosis states the optimal course of treatment for LTBI is 9 months of INH.

4.4.2.2. Slight delays in completing treatment are acceptable, but not recommended. CDC doesn't recommend reinitiating treatment if the patient completes the 9-month course of INH (270 doses) therapy in 12 months. If the patient has a 2 month lapse in therapy their 9-month course will be re-started.

4.4.2.3. Provider must clearly document in the patient's medical record any variation in the recommended 9-month course of treatment to include reasons for the variation.

Chapter 5

OTHER REPORTABLE CONDITIONS

5.1. Purpose. To provide early identification and intervention for communicable diseases and other diseases/conditions of significance to the health of the public. To identify children living on and off base who are at risk for environmental lead exposure IAW CDC guidelines.

5.2. Responsibilities.

5.2.1. The 59 MDW Pediatrics will:

5.2.1.1. Conduct targeted blood lead screening of children beginning at 9-12 months of age and periodically between 24 months to 6 years of age using a risk assessment questionnaire.

5.2.1.1.1. Children with one or more lead-exposure risk factors will receive blood lead testing.

5.2.1.1.2. Refer all children with Blood Lead Levels (BLLs) of 10 ug/dl or greater to Public Health.

5.2.2. Healthcare Provider will:

5.2.2.1. Report cases of elevated blood lead levels, communicable diseases such as meningitis, West Nile Virus, and other diseases of public health and military significance to Public Health using the WHMC Form 3520, *Provider Reportable Condition Worksheet*, and when urgent reporting is required by contacting the PH Pager at 594-1950.

5.2.3. Public Health will:

5.2.3.1. Conduct community public health surveillance which includes chemical, biological, radiological, and nuclear terrorism and syndromic surveillance. Daily spool for reportable conditions, review Emergency Room logs, as well as review the Electronic Surveillance System for Early Notification of Community based Epidemics for warnings and alerts on specified syndromes and maintain surveillance tracking logs.

5.2.3.1.1. Inform chain of command, 59 MDG/CCs and Public Health Emergency Officer, providers on disease prevention, education and control programs for diseases/conditions of public health or military significance as necessary.

5.2.3.1.2. Establish program to evaluate risk of vector-borne and zoonotic disease in the local geographical area and establish a risk mitigation program.

5.2.3.2. Initiate a lead toxicity investigation for any confirmed pediatric BLLs greater than or equal to 10 ug/dL. Coordinate with Bioenvironmental Engineering for lead sampling of the facility based on epidemiological data IAW CDC and Occupational Safety and Health Administration guidelines.

5.2.3.3. Report BLLs greater than or equal to 10 ug/dL to AFIOH using Air Force Reportable Events Surveillance System.

5.2.3.4. Conduct an epidemiological investigation and implement prevention measures as outlined in the CDC guidelines and the *Control of Communicable Diseases Manual*.

5.2.4. The 59 MDW Laboratory:

5.2.4.1. Participate in the CDC Laboratory Response Network for Bioterrorism and Chemical Terrorism. Identify potential offensive biological and chemical agents and reports IAW CDC-DoD notification protocols.

5.2.4.2. During epidemiological and outbreak investigations, coordinate with PH on appropriate sample collection protocols, test availability and result reporting.

5.2.5. Public Health Emergency Officer and Alternate:

5.2.5.1. Serve by written appointment of the Installation Commander.

5.2.5.2. Verify the existence of cases suggesting a possible public health emergency and advise the installation commander of appropriate actions IAW DODD 6200.3, *Public Health Emergency Management Within the Department of Defense*, AFI 10-2603, *Emergency Health Powers of Air Force Installations* and the installation Disease Containment Plan.

HELEN HOOTSMANS, Colonel, MC, FS
Chief of the Medical Staff

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 44-108, *Infection Control Program*, 1 July 2000

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Abbreviations and Acronyms

AFCITA—Air Force Complete Immunization Tracking Application

AFIOH—Air Force Institute of Operational Health

AFPD—Air Force Policy Directive

AHLTA—Armed Forces Health Longitudinal Technology Application

ALT—Alanine Aminotransferase

AMC—Aeromedical Council

AST—Aspartate Aminotransferase
BLL—Blood Lead Levels
CDC—Centers for Disease Control
DLI—Defense Language Institute
DoD—Department of Defense
GC—Gonococcal Infection
HDCV—Human Diploid Cell Rabies Vaccine
HIV—Human Immunodeficiency Virus
IAW—In Accordance With
IM—Intramuscular
INH—Isoniazid
LFT—Liver Function Test
LTBI—Latent Tuberculosis Infection
MDW—Medical Wing
MDWI—Medical Wing Instruction
MEU—Medical Evaluation Unit
MMWR—Morbidity and Mortality Weekly Report
PCS—Permanent Change of Station
PEP—Post-Exposure Prophylaxis
PH—Public Health
POC—Point of Contact
RIG—Rabies Immune Globulin
RVA—Rabies Vaccine Adsorbed
STI—Sexually Transmitted Infections
TB—Tuberculosis
TST—Tuberculin Skin Test
WHMC—Wilford Hall Medical Center

Terms

Active Tuberculosis (TB)—Persons exposed to *Mycobacterium tuberculosis* (TB) as evidenced by a positive tuberculin skin test and are symptomatic and clinically ill. The possibility of Pulmonary TB should be considered in persons who have a productive cough, prolonged cough (duration of 3 weeks) chest pain, hemoptysis, and the systemic symptoms of TB including fever, chills, night sweats, appetite loss, weight loss, and easy fatigability. See the definition for latent tuberculosis below.

Latent Tuberculosis—Persons exposed to Mycobacterium TB as evidenced by a positive tuberculin skin test, but who are not sick or have symptoms of active TB disease are considered to have latent TB. Persons with latent TB infection are not infectious and cannot spread TB infection to others.