INH/ Isoniazid Shortage
Wisconsin Department of Health Services TB Program

Due to the shortage of INH, Wisconsin Department of Health Services TB program is immediately restricting the use of INH for all patients whose medications are paid for by the State of Wisconsin, so that the national supply needed to treat persons with active TB disease can be preserved.

Specifically:
   **FOR CASE TREATMENT:** No change is necessary at this time
   **FOR LTBI TREATMENT:** Medication provided ONLY for those patients with:
   - A positive IGRA (Quantiferon or T-Spot) – if US-born; or skin test – if foreign-born, **AND**
   - Risk factors for MTB infection **AND/OR**
   - Foreign-born **AND/OR**
   - Knew someone with TB disease.

The risk factors below are from CDC guidance, specifically [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e)

Suggested regimens are below the tables, including guidance for what to do with those who are already taking INH for a 9 month period.

**Risk factors for Mycobacterium tuberculosis infection**

- Persons at increased risk* for M. tuberculosis infection
- Close contacts of persons known or suspected to have active tuberculosis;
- Foreign-born persons from areas that have a high incidence of active tuberculosis (e.g., Africa, Asia, Eastern Europe, Latin America, and Russia);
- Persons who visit areas with a high prevalence of active tuberculosis, especially if visits are frequent or prolonged;
- Residents and employees of congregate settings whose clients are at increased risk for active tuberculosis (e.g., correctional facilities, long-term care facilities, and homeless shelters);
- Health-care workers who serve clients who are at increased risk for active tuberculosis;
- Populations defined locally as having an increased incidence of latent M. tuberculosis infection or active tuberculosis, possibly including medically underserved, low-income populations, or persons who abuse drugs or alcohol; and
- Infants, children, and adolescents exposed to adults who are at increased risk for latent M. tuberculosis infection or active tuberculosis.

*Persons with these characteristics have an increased risk for M. tuberculosis infection compared with persons without these characteristics.*
Risk factors for progression of infection to active tuberculosis

- Persons at increased risk* for progression of infection to active tuberculosis include
- Persons with human immunodeficiency virus (HIV) infection;†
- Infants and children aged <5 years;†
- Persons who are receiving immunosuppressive therapy such as tumor necrosis factor--alpha (TNF-α) antagonists, systemic corticosteroids equivalent to ≥15 mg of prednisone per day, or immune suppressive drug therapy following organ transplantation;†
- Persons who were recently infected with M. tuberculosis (within the past 2 years);
- Persons with a history of untreated or inadequately treated active tuberculosis, including persons with fibrotic changes on chest radiograph consistent with prior active tuberculosis;
- Persons with silicosis, diabetes mellitus, chronic renal failure, leukemia, lymphoma, or cancer of the head, neck, or lung;
- Persons who have had a gastrectomy or jejunoileal bypass;
- Persons who weigh <90% of their ideal body weight;
- Cigarette smokers and persons who abuse drugs or alcohol; and
- Populations defined locally as having an increased incidence of active tuberculosis, possibly including medically underserved or low-income populations.

Source: Based on CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. MMWR 2000;49(No. RR-6). * Persons with these characteristics have an increased risk for progression of infection to active tuberculosis compared with persons without these characteristics.
† Indicates persons at increased risk for a poor outcome (e.g., meningitis, disseminated disease, or death) if active tuberculosis occurs.
Suggested regimens for persons starting LTBI treatment, in order of preference:

1. Since only high-risk persons will be treated, we highly recommend the 12-week, directly-observed therapy. This is 9 pills (three INH tabs, 6 rifapentine capsules) once per week for 12 weeks. A number of people in WI, and across the country, have been treated with this regimen with very few side effects or people dropping out of treatment. Please contact the WI TB Program if you have questions about this regimen.

2. Rifampin 600 mg daily X 4 months. This is an alternate, although unproven by research, regimen which has been widely used, and is generally well-tolerated.

3. INH for 6 months; may be daily or twice weekly (twice weekly is usually 900 mg and MUST be DOT)

For persons already on INH daily regimen:

1. If began therapy within the past three months: switch to 12-week regimen.

2. If on therapy for more than three months, finish after 6 months of therapy. Therapy must NOT be shortened if patient is HIV+, and/or a child, and/or if there are fibrotic lesions on chest X-Ray (CXR).

3. If on therapy for more than 6 months and patient is NOT HIV+, a child, or has fibrotic lesions on CXR – may stop therapy. If meds have already been sent, please continue to use them, as if they are returned to the pharmacy, they will be destroyed.

4. If patient is HIV+ and/or a child and/or has fibrotic lesions on CXR: recommend either 12-week or rifampin regimens (12-week is not to be given to patient on anti-retroviral therapy).