



Indiana State Department of Health

Tuberculosis Control Program

2014 Annual Report

June 2, 2015

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I. Executive Summary

The mission of the Tuberculosis Control, Prevention and Elimination Program is to oversee, manage and facilitate activities that assure early identification and proper treatment of persons with tuberculosis; prevent transmission of *Mycobacterium tuberculosis* to others; increase the percentage of newly diagnosed infection cases that start and complete treatment; and provide education to both the public and health care workers.

In 2014, there were 108 new cases of tuberculosis (TB) reported to the Indiana State Department of Health, a 14.9 percent increase since 2013. However, there has been an overall 26.0 percent decrease in TB cases in Indiana over the last ten years, which continues the trend seen since 1956. Marion County continued to have the most cases of any jurisdiction, with 50 cases reported in 2014 and a total of 401 cases over the past ten years.

Disparities in TB continue to be seen among several populations, including by age group, race, ethnicity, gender, and foreign-born status. Among age groups, Hoosiers 65 years and older continue to have the highest TB rate, with 2.7 cases per 100,000 population in 2014. More than half of the cases in 2014 in Indiana (54.6%) were among foreign-born persons, which mirrors the disparity seen at the national level.

There are several established risk factors for TB, including HIV infection, homelessness, excess alcohol use and residence within a correctional facility. In 2014, HIV status was known among 87.4 percent of TB cases greater than or equal to 15 years of age, and 5.6 percent of all TB cases were HIV positive. Excess alcohol use was the most common measured risk factor, reported in 12.9 percent of all TB cases in Indiana.

Effective treatment of TB is essential to the control and elimination of the disease and several treatment related data measures are collected. In 2014, 94.3 percent of TB cases were started on the recommended initial therapy and 100 percent of cases in 2013 completed their therapy. There were two cases of multi-drug resistant TB in Indiana, a slight increase from 2013.

TB genotyping and contact investigation are used in TB control to help prevent additional cases. Nineteen new genotype clusters were identified in Indiana in 2014, while there were three ongoing outbreaks. In 2013, 97 percent of infectious TB cases had contacts identified, and 55 percent of those contacts were fully evaluated for infection and disease.

The vision of the Indiana State Department of Health's TB Control, Prevention and Elimination Program is: "A Tuberculosis-free Indiana." To achieve this vision, we will need continued collaboration between state and local health departments and continued efforts to find, diagnose, and effectively treat every case of TB in Indiana.

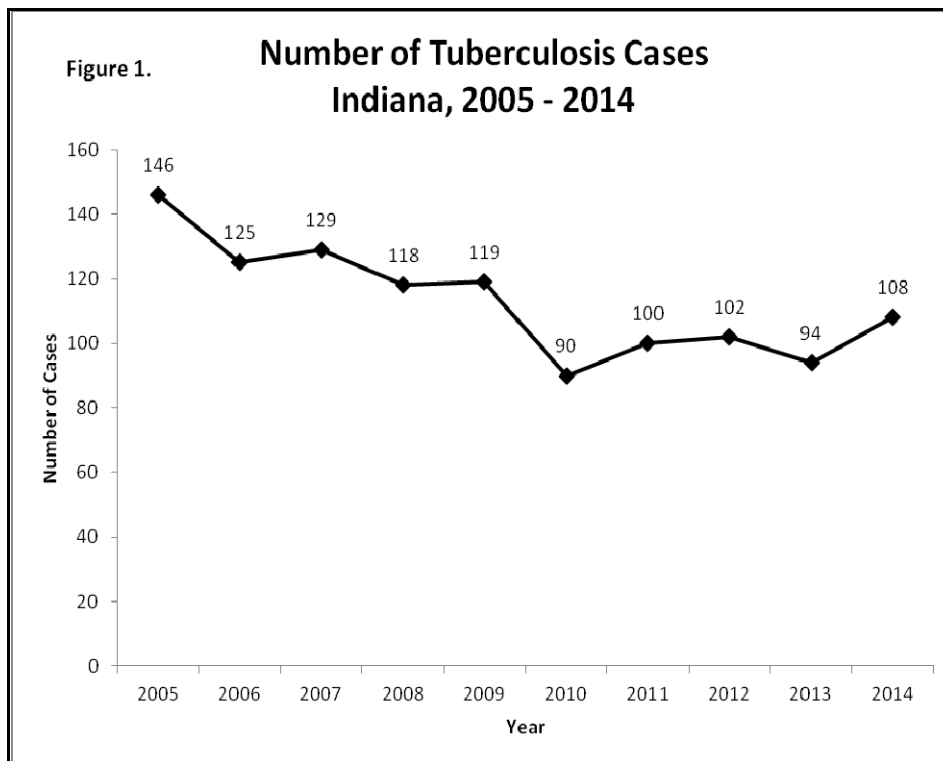
II. Summary Statistics

	Indiana		Program Goals
	2014	2013	2015
Number of Tuberculosis Cases	108	94	
Tuberculosis Case Rate per 100,000 Population	1.6	1.4	1.4
Number of Tuberculosis Deaths	4	3	
Laboratory Confirmation	80%	78%	
Pulmonary Site of Disease	67.6%	73.4%	
U.S. Born Incidence Rate	0.8	0.7	0.6
Foreign-Born Incidence Rate	19.2	16.9	16.0
White Incidence Rate	0.8	0.7	
Black Incidence Rate	3.8	3.2	
Asian Incidence Rate	24.9	28.4	25.0
Hispanic/Latino Incidence Rate	3.5	2.1	
Male Incidence Rate	2.0	2.0	
Female Incidence Rate	1.4	0.9	
Known HIV Status 25-44 Years of Age	97.6%	83.3%	88.0%
HIV Comorbidity	5.6%	2.1%	
Resident of Correctional Facility	4.6%	0.0%	
Homelessness	9.3%	10.6%	
Resident of Long-Term Care Facility	1.9%	3.2%	
Injecting Drug Use	3.7%	1.1%	
Non-Injecting Drug Use	6.5%	9.6%	
Excess Alcohol Use	12.0%	13.8%	
Initial Four Drug Therapy Regimen	94%	95.5%	97.0%
INH Resistance	8.3%	8.5%	
MDR	1.9%	0.0%	
Culture Conversion < 60 Days	72.7%	68.8%	72.0%
DOT Utilization	85.6% (2013)	80.8% (2012)	
Completion of Therapy <1 Year	96.1% (2013)	92.9% (2012)	95.0%

III. Tuberculosis in Indiana

Tuberculosis (TB) is an airborne disease caused by a group of bacteria called *Mycobacterium tuberculosis*. General symptoms may include a prolonged, productive cough, blood-tinged sputum, night sweats, fever, fatigue, and weight loss. TB usually affects the lungs (pulmonary TB) but can also affect other parts of the body such as the brain, kidneys or spine (extrapulmonary TB). TB bacteria are aerosolized when a person who has pulmonary TB or TB affecting the larynx coughs, sneezes, laughs, or sings; another person may become infected if they inhale the droplet nuclei that are formed. Individuals who become infected but do not become ill are considered to have latent TB infection (LTBI) and cannot transmit the infection to others. Approximately 10 percent of immunocompetent individuals with LTBI will progress to active disease at some point in their lives if they are not treated. Indiana requires reporting of all suspected cases and confirmed cases of TB. LTBI infection is not a reportable disease at the state level in Indiana at this time.

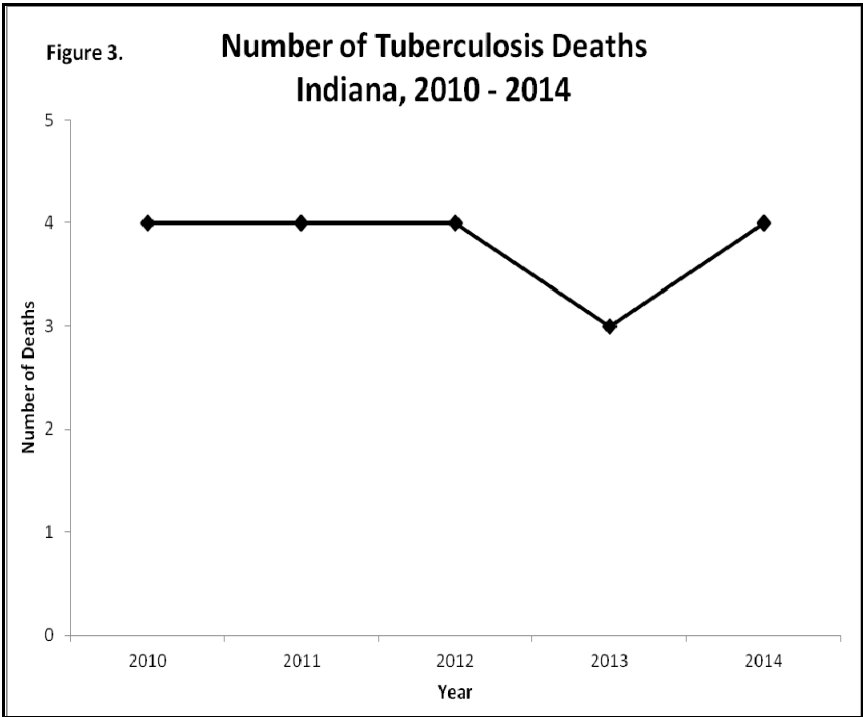
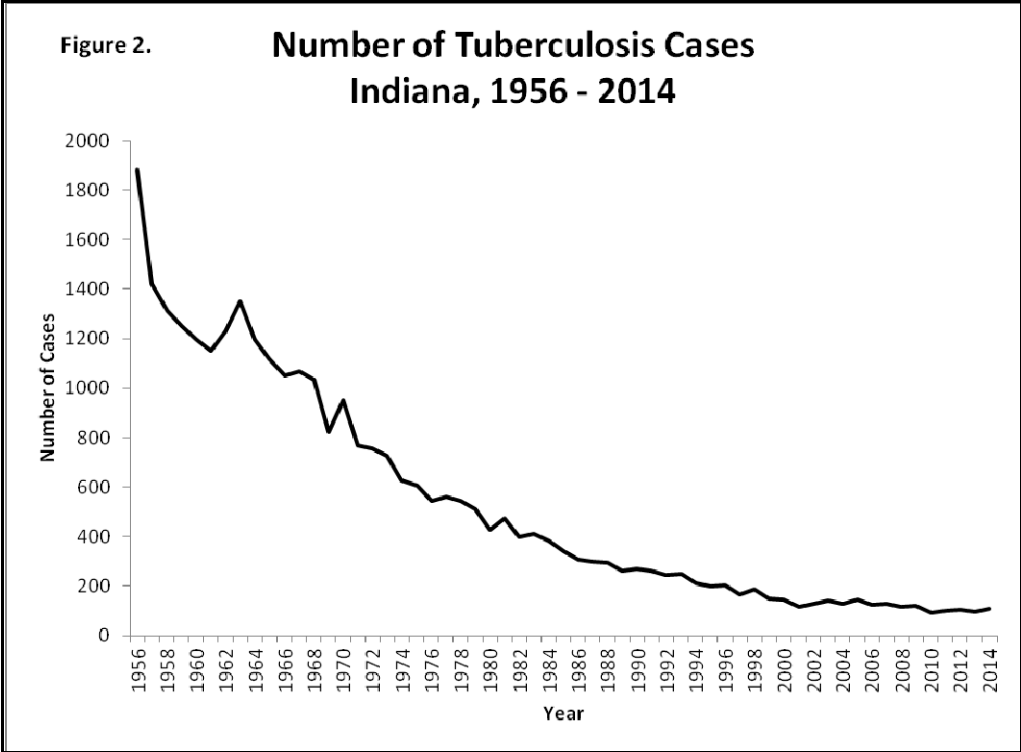
A. Burden & Trends



There were **108** reported cases of TB in Indiana in 2014 with an incidence rate of **1.6** per 100,000 population.

There has been an overall **26.0% decrease** in TB cases in Indiana in the last ten years.

The decrease seen in TB cases in the last ten years is in line with the downward historical trend seen in Indiana since 1956.



The number of TB related deaths in Indiana has remained stable in the last five years, with **four** deaths reported in 2014.

A diagnosis of TB is categorized as either laboratory, clinical, or provider diagnosis according to established criteria by the CDC shown below¹. Provider diagnosis is defined as a case that does not meet either laboratory or clinical case definitions but in which the provider believes there is sufficient evidence for a diagnosis of TB based upon the clinical evaluation.

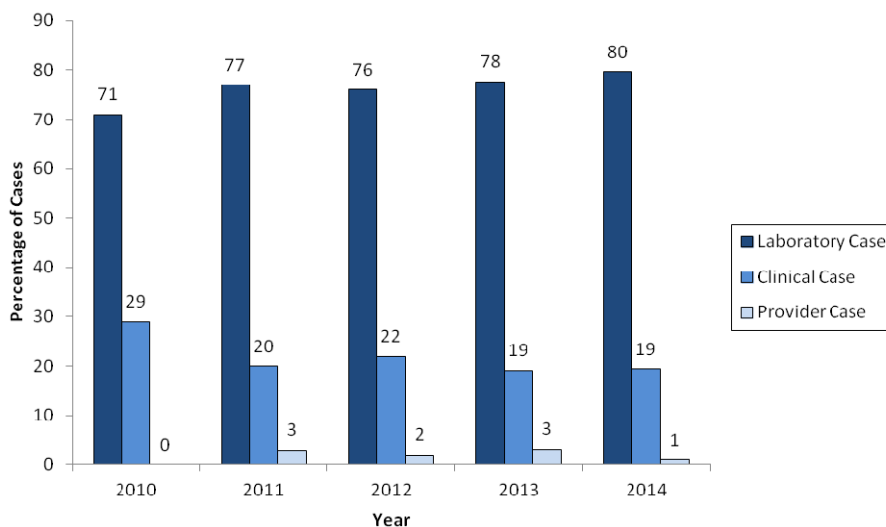
Laboratory Criteria

- Isolation of *M. tuberculosis* from a clinical specimen, OR
- Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification test, OR
- Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

Clinical Criteria

- A positive tuberculin skin test or positive interferon gamma release assay for *M. tuberculosis*
- Other signs and symptoms compatible with tuberculosis (TB) (e.g., abnormal chest radiograph, abnormal chest computerized tomography scan or other chest imaging study, or clinical evidence of current disease)
- Treatment with two or more anti-TB medications
- A completed diagnostic evaluation

Figure 4. **Percentage of Tuberculosis Cases by Case Definition
Indiana, 2010 - 2014**



In 2014, **80%** of TB cases in Indiana were laboratory confirmed (n = 86).

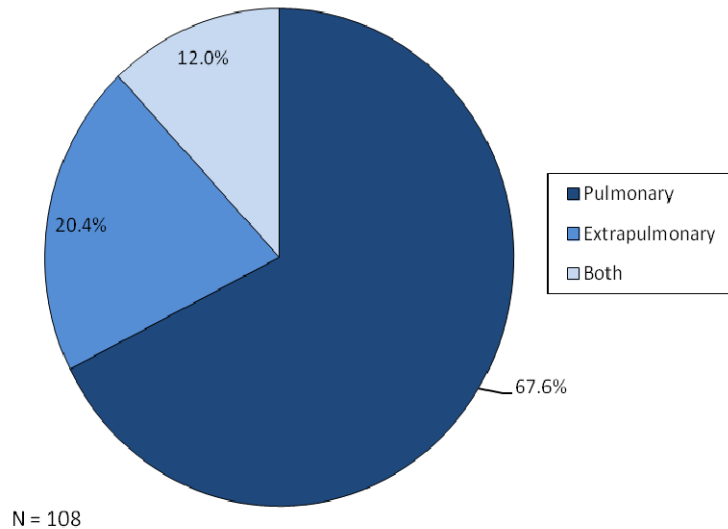
Over the last five years, the proportion of cases with laboratory confirmation has increased **9%**.

In 2014, **67.6%** of TB cases in Indiana were pulmonary (n = 73). This was a slight decrease from 2013 (73.4%).

Other sites of TB in Indiana in 2014 included:

- Eye & Ear Appendages
- Rectum
- Colon
- Lymphatic
- Pleural
- Meningeal
- Peritoneal
- Bone & Joints

Figure 5. **Tuberculosis Cases by Site of Disease Indiana, 2014**



Top Indiana Counties by Number of TB Cases 2014
(See Figure 6)

- 1) Marion County – 50 Cases
- 2) Hendricks County – 5 Cases

Top Indiana Counties by Number of TB Cases 2005-2014
(See Figure 7)

- 1) Marion County – 401 Cases
- 2) Allen County – 102 Cases
- 3) Lake County – 91 Cases
- 4) St. Joseph County – 39 Cases
- 5) Elkhart County – 37 Cases

In 2014, Marion County had **46.3%** of Indiana’s TB cases and only **14.2%** of Indiana’s population. This was an increase from 2013, when Marion County had 38.3% of Indiana’s TB cases.

Figure 6.

TB CASES 2014

Labeled by Cases Per County
(for counties with ≥ 5 cases)

Shaded by Number of
Cases per County

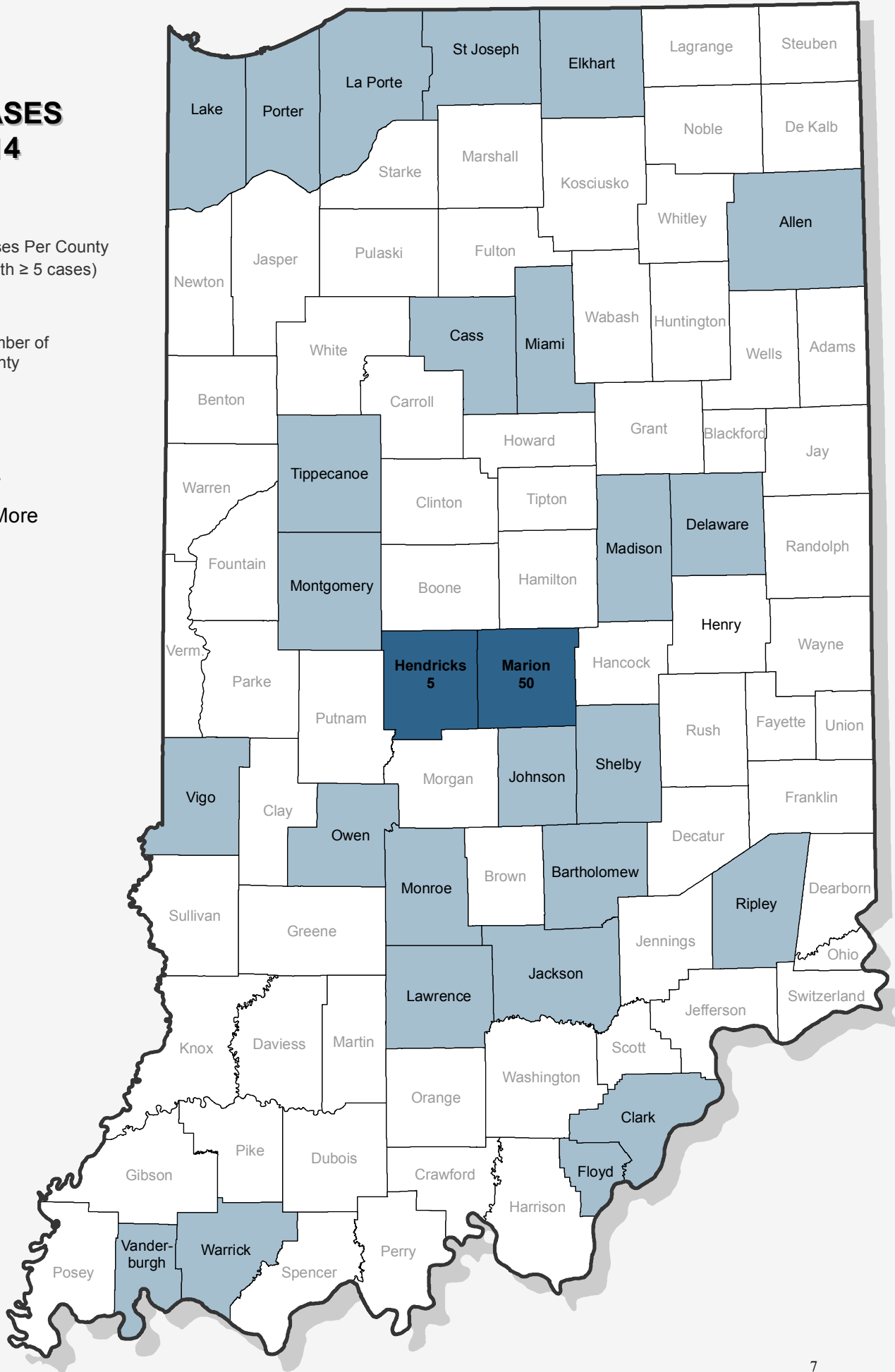
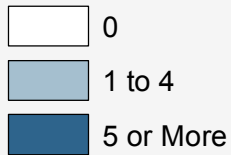


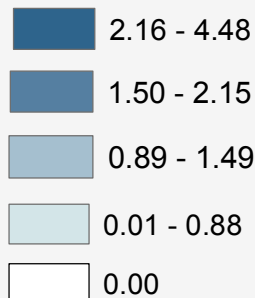
Figure 7.

TB CASES AND INCIDENCE RATES

**10-YEAR PERIOD:
2005 to 2014**

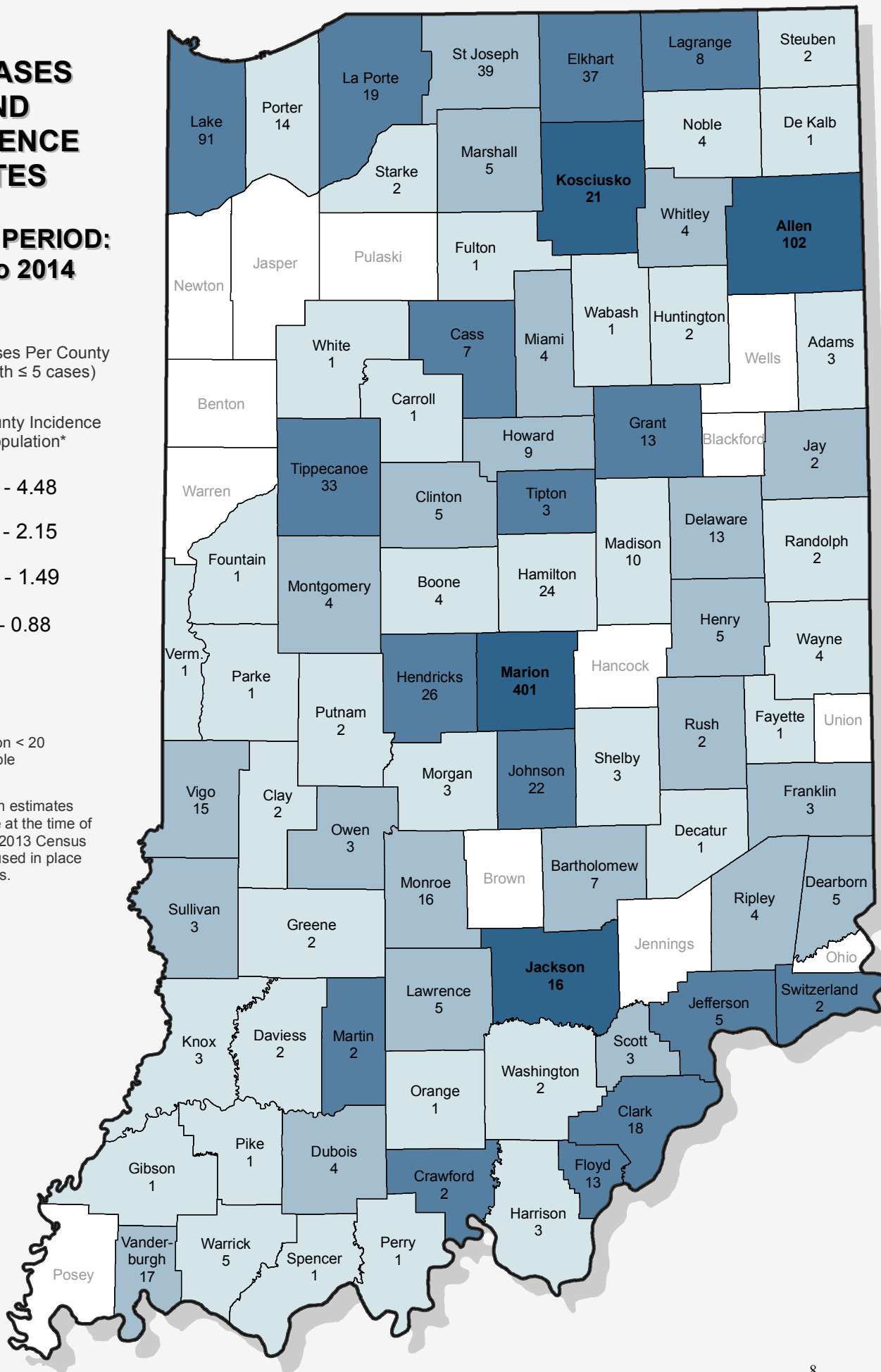
Labeled by Cases Per County
(for counties with ≤ 5 cases)

Shaded by County Incidence
Per 100,000 population*



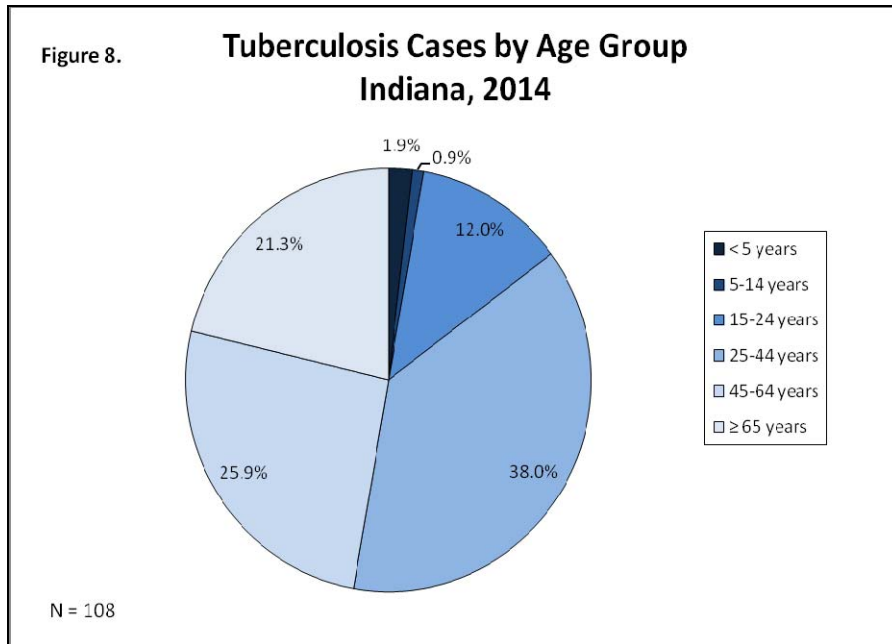
Rates based upon < 20 cases are unstable

* 2014 population estimates were unavailable at the time of publication. The 2013 Census estimates were used in place of 2014 estimates.



B. Demographics & Risk Factors

Despite prevention efforts, some groups of people are affected by TB more than others. The occurrence of TB at greater levels among certain population groups is called a health disparity. Differences may occur by gender, race or ethnicity, income, comorbid medical conditions, or geographic location².



In 2014, **85.2%** of Indiana's TB cases were adults aged 25 years or older (N = 92).

In 2014, adults aged 65 years and older made up **21.3%** of Indiana's TB cases, but only made up **13.3%** of the population.

Adults aged 65 years and older continue to have the highest rates of TB in Indiana with **2.7 cases per 100,000** populations in 2014.

The 2014 TB incidence rate for adults aged 25 to 44 years returned to 2012 levels after seeing a decrease during 2013.

Figure 9. Tuberculosis Case Rates by Age Group and Year Indiana, 2010 - 2014

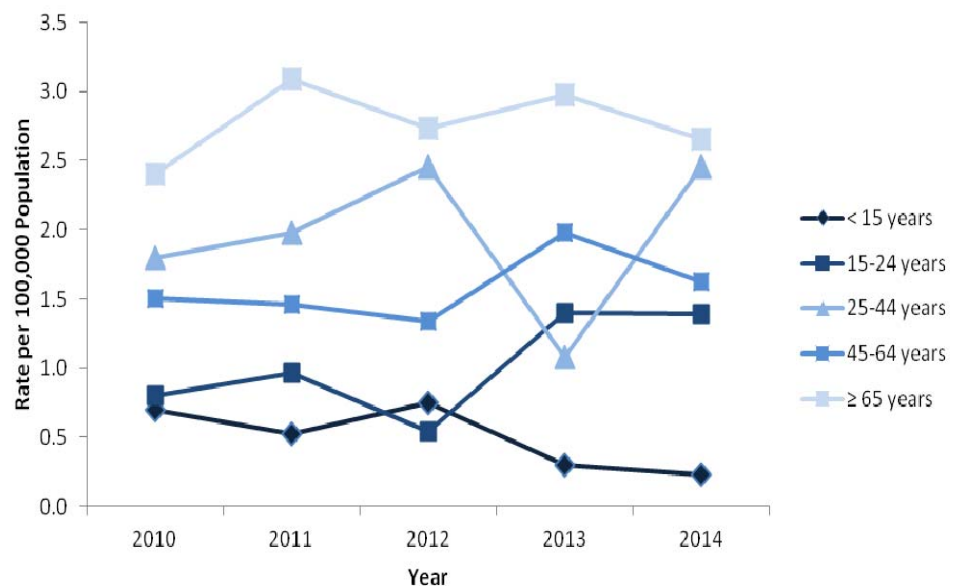
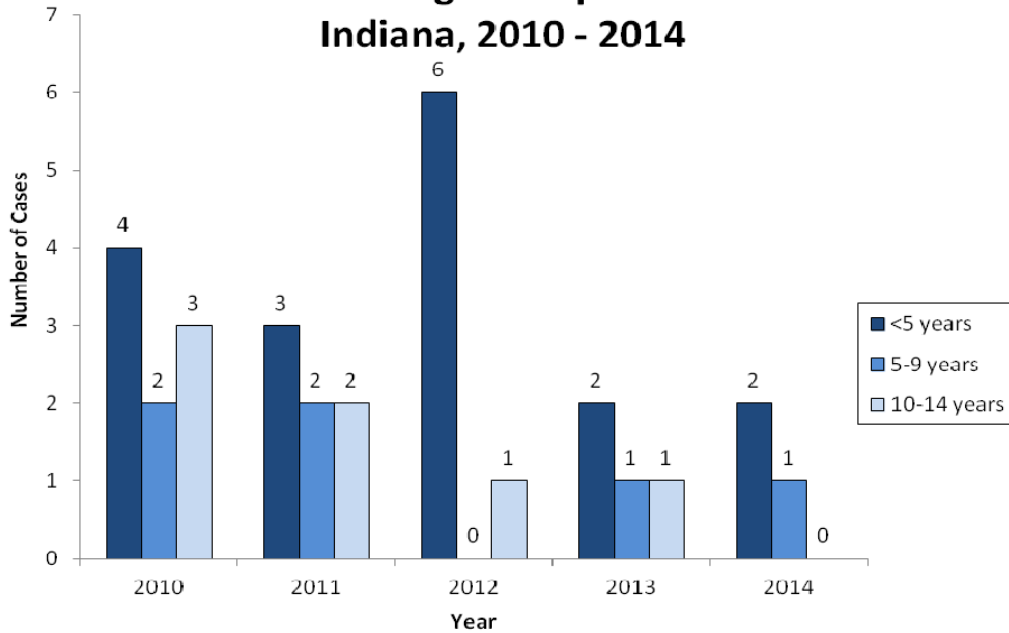


Figure 10. Number of Pediatric Tuberculosis Cases by Age Group



There were 3 pediatric TB cases (≤ 14 years) in Indiana in 2014, which was a slight decrease from 2013.

Pediatric TB is a public health problem of special significance because it is a marker for recent transmission of TB and is more likely to be life-threatening³.

In 2014, Asians made up **30.6%** of TB cases in Indiana, yet only make up **2.0%** of the population. All of the Asian cases were foreign-born.

There was also a disparity in the Black or African American population, who made up **23.1%** of TB cases in Indiana in 2014 but only **10.1%** of the population.

Figure 11. Tuberculosis Cases by Race Indiana, 2014

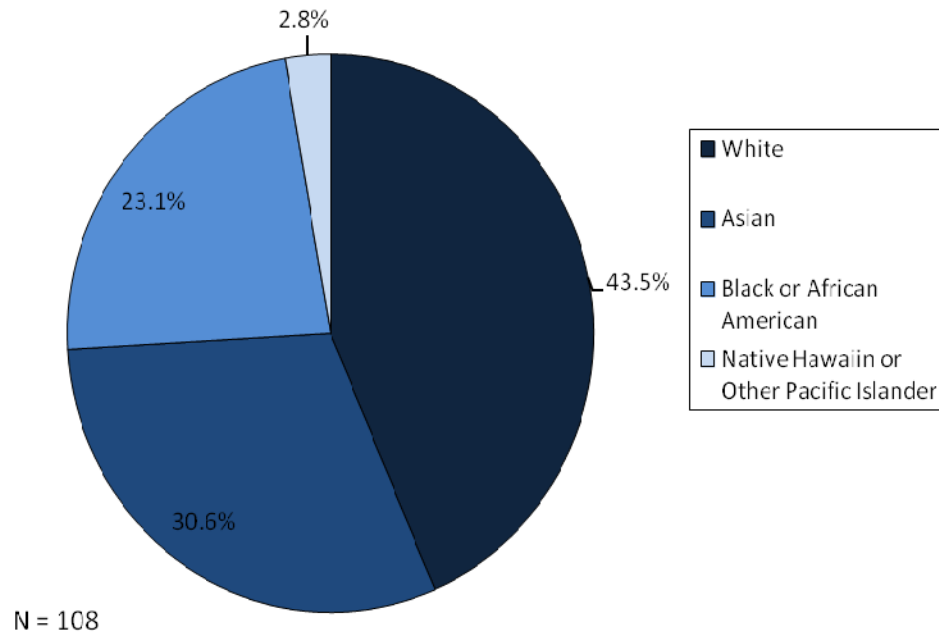
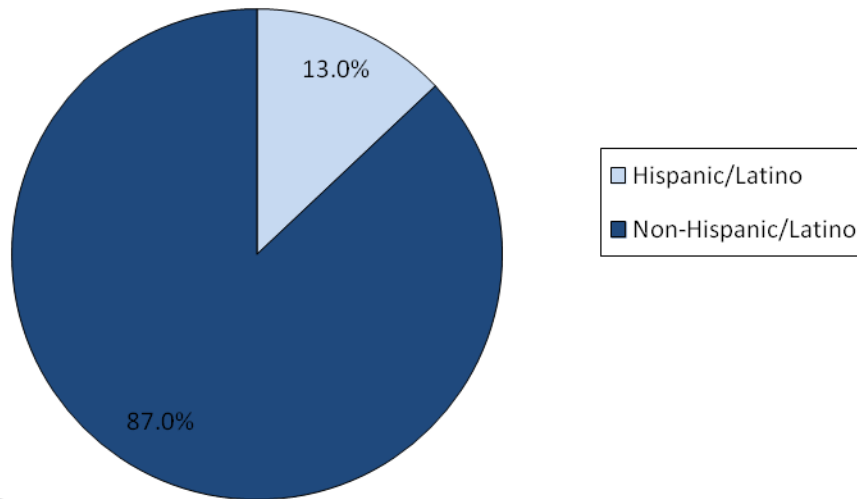
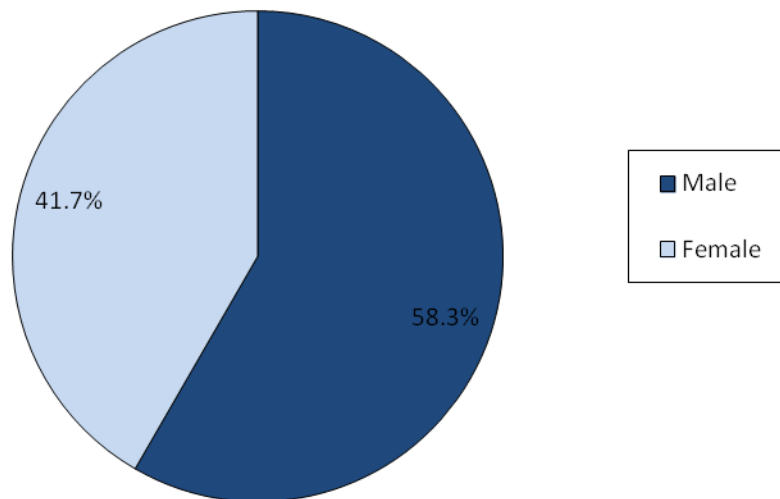


Figure 12. **Tuberculosis Cases by Ethnicity
Indiana, 2014**



In Indiana, **6.2%** of the population identifies as Hispanic/Latino, yet **13.0%** of TB cases in 2014 were seen in that population.

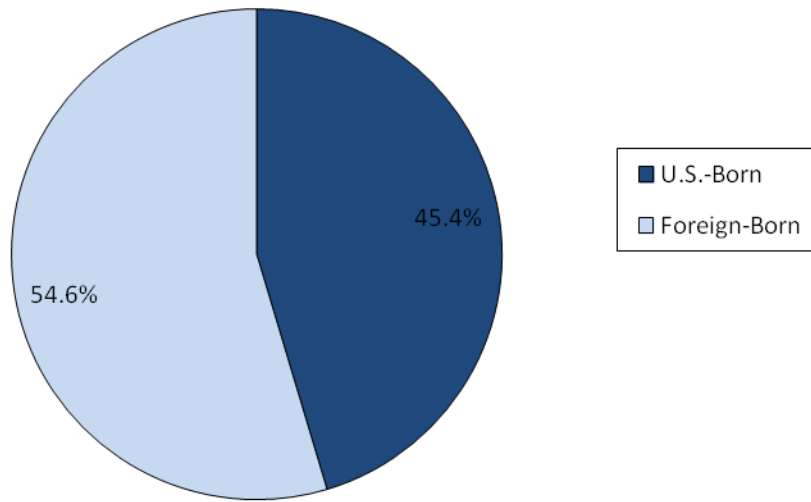
Figure 13. **Tuberculosis Cases by Gender
Indiana, 2014**



In 2014, males accounted for **58.3%** of TB cases in Indiana, which was a slight decrease from 2013 (67.0%).

Figure 14.

Tuberculosis Cases by U.S./Foreign Birth Indiana, 2014

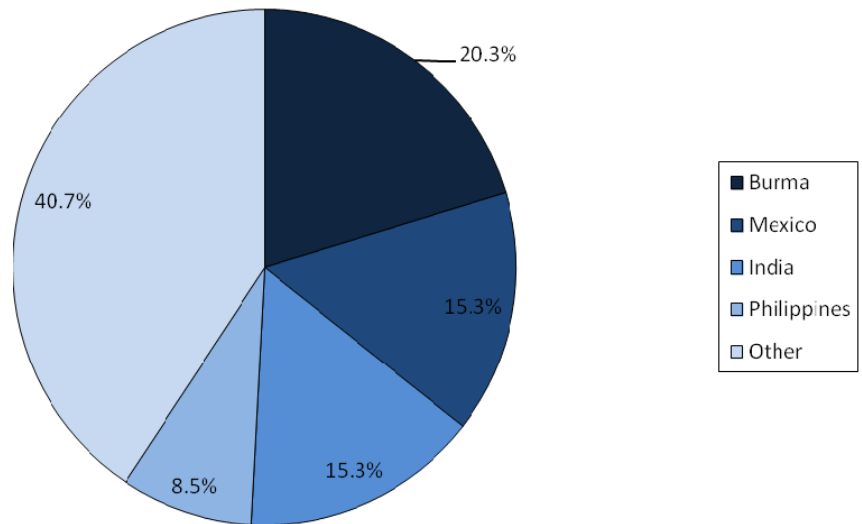


N = 108

In 2014, **54.6%** of TB cases in Indiana were foreign-born, which mirrors the disparity seen nationally (64.6% of TB cases in 2013).

Figure 15.

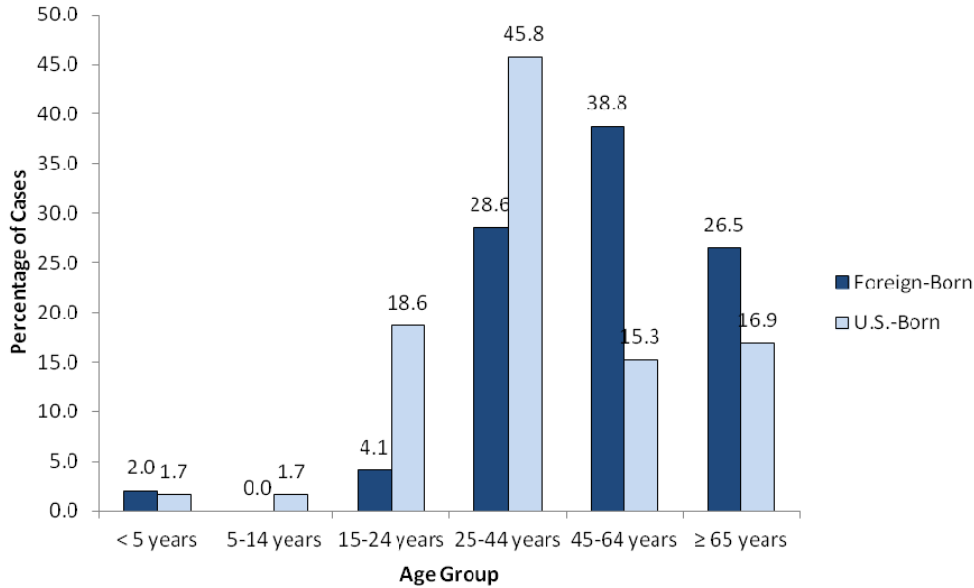
Percentage of Foreign-Born Tuberculosis Cases by Country of Birth, Indiana, 2014



Of the foreign-born TB cases in Indiana in 2014, **20.3%** of them were born in Burma (n=12).

Figure 16.

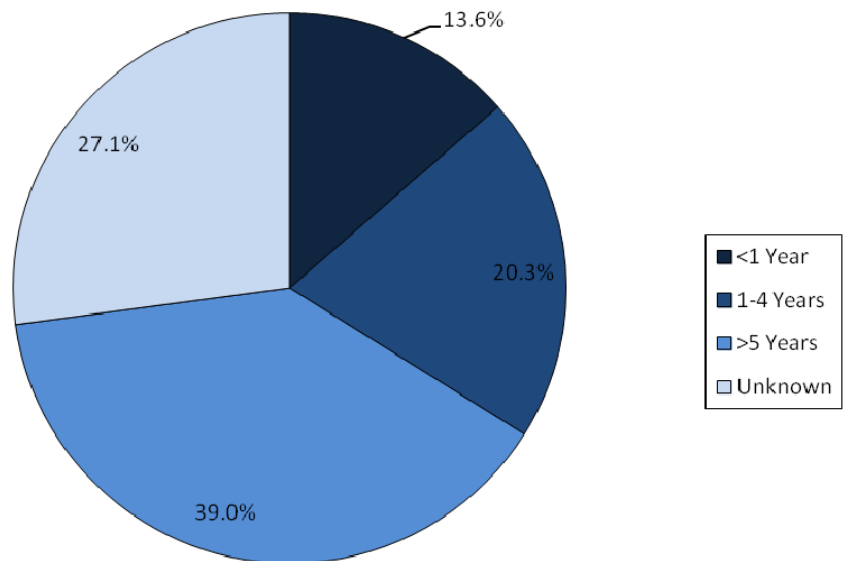
Percentage of Tuberculosis Cases by U.S./Foreign Birth and Age Group Indiana, 2014



Foreign-born and U.S.-born cases of TB in Indiana differed in regards to age, with a higher proportion of foreign-born cases falling in the 45-64 years and ≥ 65 years age groups then the U.S.-born cases.

Figure 17.

Percentage of Foreign-Born Tuberculosis Cases by Number of Years in U.S. Indiana, 2014



N = 59

Among the 59 foreign-born cases of TB in Indiana in 2014, **39.0%** of them had been in the U.S. for more than five years.

Someone with untreated latent TB infection and HIV infection is **much more** likely to develop TB disease during his or her lifetime than someone without HIV infection⁴.

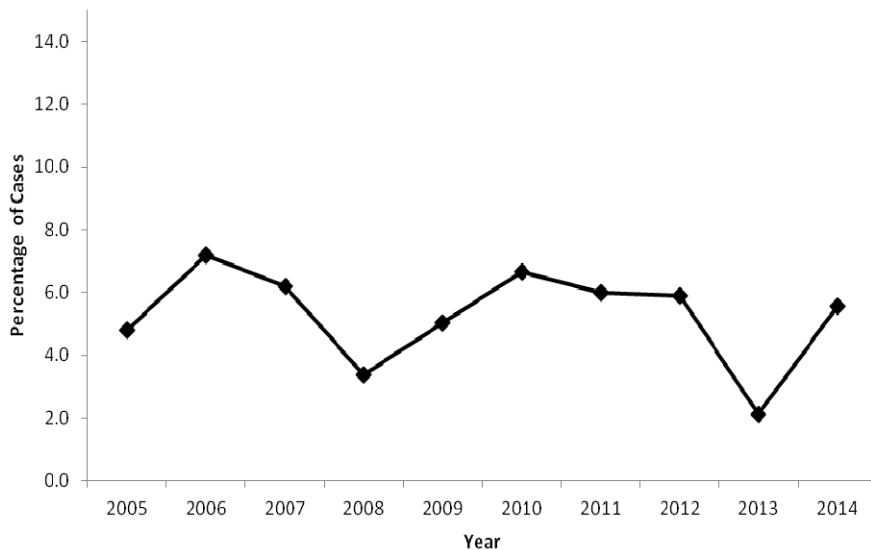
Among people with latent TB infection, HIV infection is the **strongest** known risk factor for progressing to TB disease⁴.

In 2014, **6.8%** of TB patients ≥ 15 years old were not offered HIV testing and **5.8%** refused testing. Among those 25-44 years old, only **2.4%** were not offered testing and no cases refused.

Percentage of TB Cases by HIV Testing Status & Age Group, Indiana, 2014		
HIV Testing Status	≥ 15 Years	25-44 Years
Test Results Known	87.4%	97.6%
Testing Not Offered	6.8%	2.4%
Refused Testing	5.8%	0.0%

Figure 18.

Percentage of Tuberculosis Cases with HIV Comorbidity Indiana, 2005 - 2014



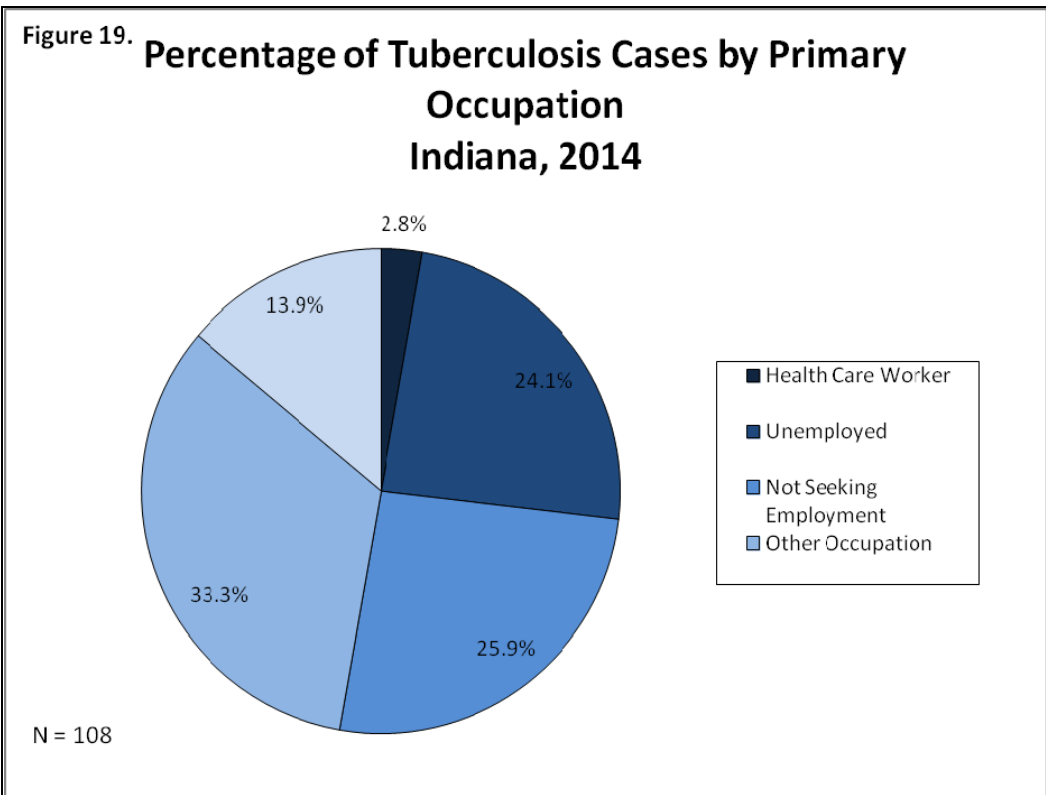
The proportion of TB cases in Indiana with HIV comorbidity increased in 2014 to **5.6%** from a low of 2.1% in 2013. Over the past ten years, the proportion of TB cases with HIV co-infection in Indiana has remained fairly stable.

Number & Percentage of TB Cases by Risk Factor Indiana, 2014		
Risk Factor	Number of Cases	Percent of Cases
Resident of Correctional Facility	5	4.6%
Homelessness	10	9.3%
Resident of Long-Term Care Facility	2	1.9%
Injecting Drug Use	4	3.7%
Non-Injecting Drug Use	7	6.5%
Excess Alcohol Use	13	12.0%

Among measured risk factors, the most common among TB cases in Indiana was excess alcohol use, at **12.0%** of cases in 2014.

Since 2013, the proportion of Indiana TB cases reporting residence at a correctional facility increased from 0% to **4.6%** in 2014.

In 2014, **24.1%** of Indiana's TB cases were unemployed, while unemployment in the general Indiana population was **9.6%**⁵. This was an increase from 2013, when 14.9% of TB cases in Indiana were unemployed.

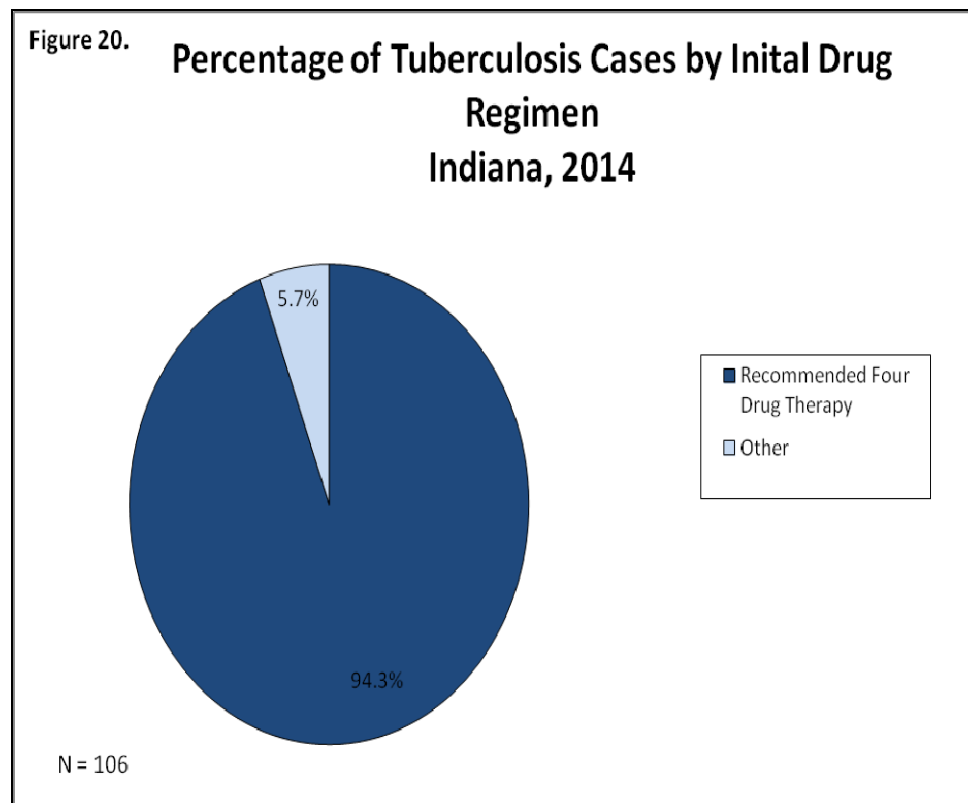


C. Treatment

TB disease can be treated by taking several drugs for six to nine months. There are 10 drugs currently approved by the U.S. Food and Drug Administration (FDA) for treating TB. Of the approved drugs, the first-line anti-TB agents that form the core of treatment regimens include:

- isoniazid (INH)
- rifampin (RIF)
- ethambutol (EMB)
- pyrazinamide (PZA)

It is very important that people who have TB disease finish the medicine, taking the drugs exactly as prescribed. If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the TB bacteria that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder and more expensive to treat⁶.



In 2014, **94.3%** of Indiana's TB cases were started on the recommended four drug initial drug therapy of INH, RIF, EMB, and PZA.

Of the 85 culture-positive TB cases in Indiana in 2014, drug susceptibility testing was performed on **100%** of the specimens submitted.

In 2014, there were **2** cases of multidrug resistant TB in Indiana, up from 0 cases in 2013.

Figure 21.

Percentage of Tuberculosis Cases by Drug Resistance, Indiana, 2010 - 2014

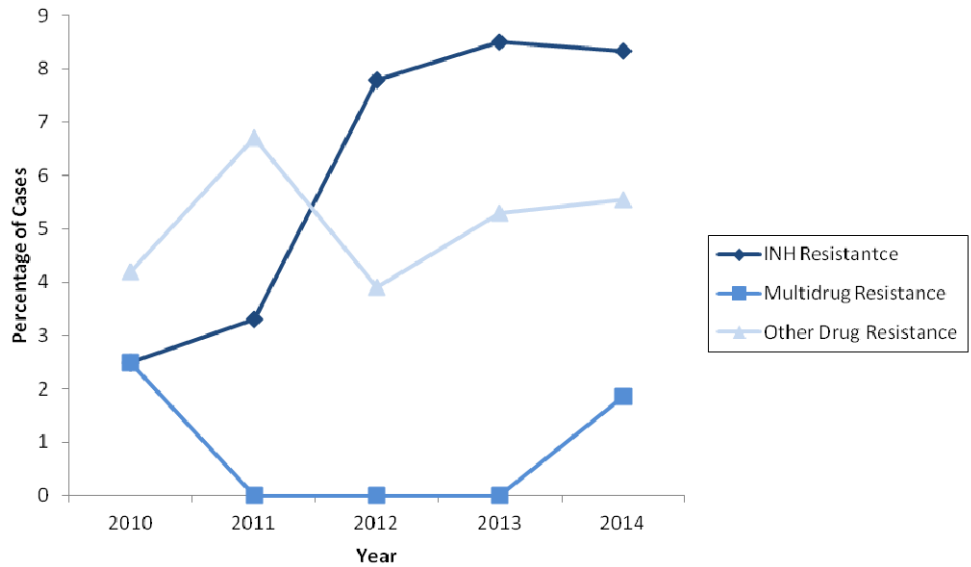
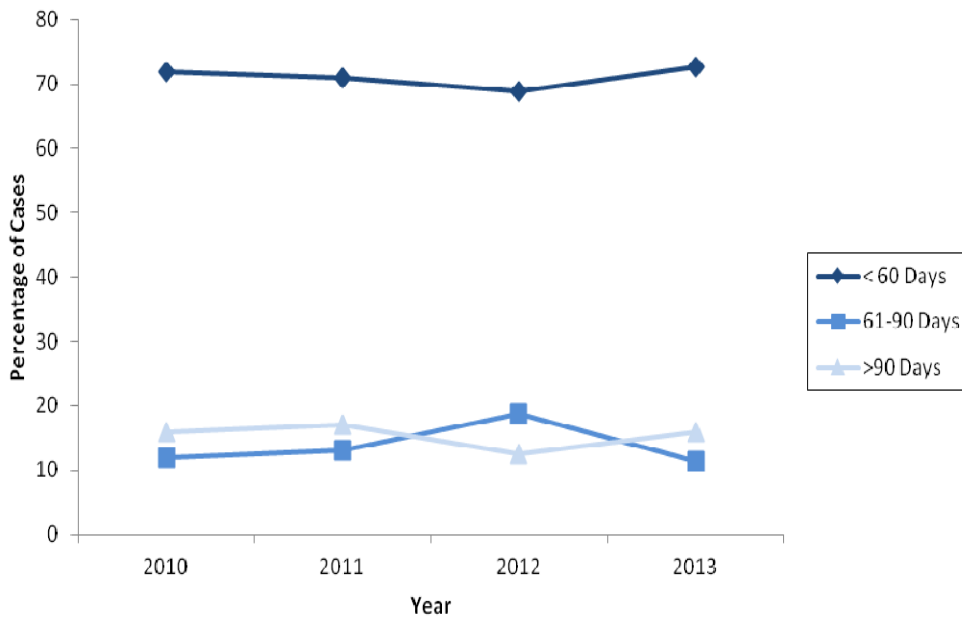


Figure 22.

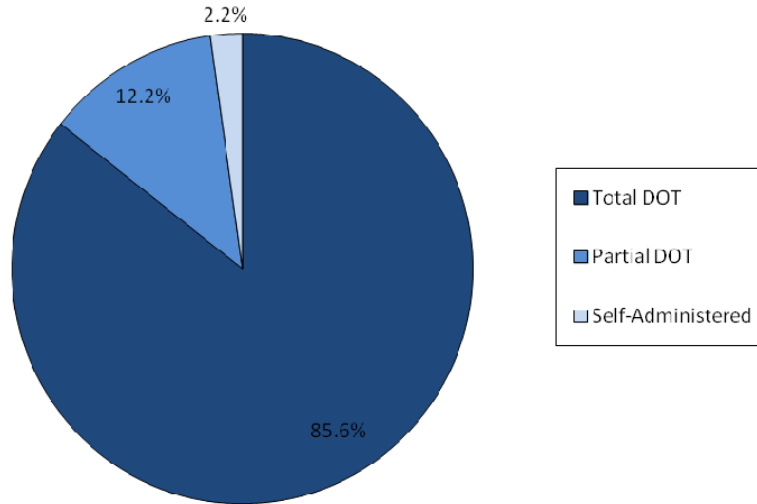
Percentage of Tuberculosis Cases that Culture Converted by Time to Conversion Indiana, 2009 - 2013



Sputum culture conversion (from positive to negative) data are collected to measure response to therapy and to determine length of treatment.

In 2013, culture conversion was reported for **93.6%** of eligible TB cases, with **72.7%** converting within the first 60 days of treatment.

Figure 23. **Tuberculosis Cases by Directly Observed Therapy Utilization
Indiana, 2013**

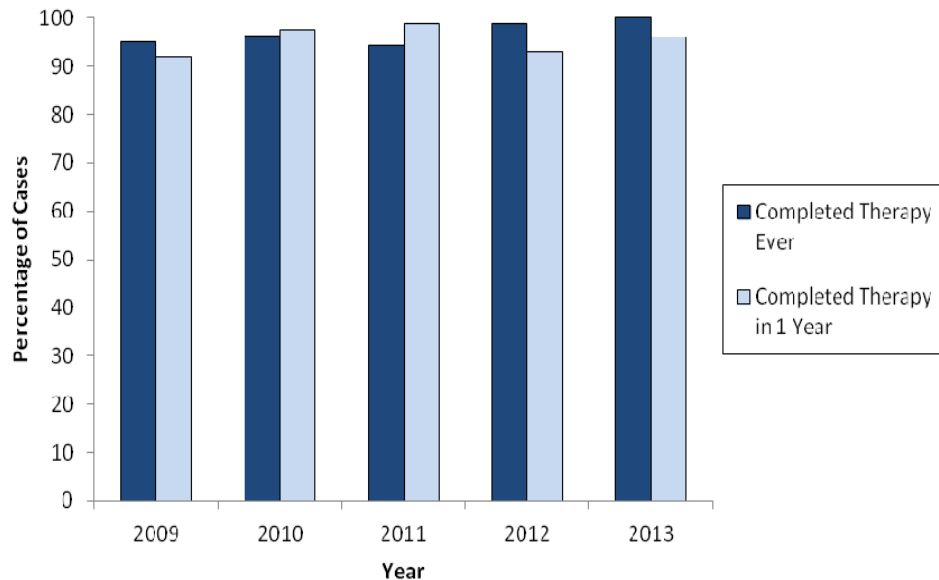


N=90

Directly observed therapy (DOT) is the most effective way to ensure a patient is complying with the prescribed treatment regimen and preventing acquired drug resistance.

In 2013, **85.6%** of Indiana TB Cases underwent total DOT, up from 80.8% in 2012.

Figure 24. **Tuberculosis Cases by Therapy Completion, Indiana, 2009 - 2013**



In 2013, **100%** of eligible Indiana TB cases completed therapy, with **96.1%** completing therapy within one year. This is an increase from 2012, when 92.9% of eligible TB cases completed therapy within one year.

D. Genotyping

TB genotyping is a laboratory-based approach used to analyze the genetic material (e.g., DNA) of *Mycobacterium tuberculosis*. Specific sections of the *M. tuberculosis* genome form distinct genetic patterns that help distinguish different strains of *M. tuberculosis*. TB genotyping results, when combined with epidemiologic data, help identify persons with TB disease involved in the same chain of recent transmission. In the same way, TB genotyping helps distinguish between persons whose TB disease is the result of TB infection that was acquired in the past, as compared to recently or newly acquired infection with development of TB disease.

When two or more *M. tuberculosis* isolates match by genotyping methods (i.e., same spoligotype and MIRU patterns), they are referred to as a genotype cluster. Patients who are members of the same genotype cluster are assumed to have the same strain, which may be a surrogate for recent transmission. However, genotyping information is only one piece of evidence used to determine transmission patterns. Genotyping information, epidemiologic linkages including spatial (geography) and temporal (time) associations, and drug susceptibility results (phenotype) can help distinguish recent transmission from activation of latent TB infection⁷.

Of the cases genotyped in 2014, **63.8%** were identified as part of a cluster in Indiana.

In 2014, **97.6 %** of culture-positive TB cases in Indiana were genotyped.

There were **19** new genotype clusters identified in IN in 2014.

There were **three** ongoing outbreaks in 2014.

E. Contact Investigations

Persons who have been exposed to a case of infectious TB disease are known as TB contacts. A TB contact investigation is a TB control strategy used to identify, find, and assess TB contacts and provide appropriate treatment for LTBI or TB disease, if needed. Effective contact investigations interrupt the spread of TB in communities and help prevent outbreaks of TB⁸. To help ensure contact investigations are being thoroughly completed, the CDC has set national objectives for contact investigation measures for programs to strive for.

2015 National Objectives & Indiana Contact Investigation Measures by Year 2009 - 2013						
Year	2009	2010	2011	2012	2013	2015 National Objective
Total Number of Cases	119	90	100	102	94	
Percentage of sputum AFB smear-positive TB cases with contacts identified	100%	97%	97%	90%*	97%*	100%
Percentage of contacts to sputum AFB smear-positive TB cases evaluated for infection and disease	54%	66%	83%	57%*	55%*	93%
Percentage of infected contacts who are started on treatment for latent TB that complete therapy	67%	70%	63%	52%*	44%*	79%

*Methodology used to calculate objectives was updated for 2012 and 2013

IV. Appendices

A. Data Sources & Methods

All TB data for Indiana was pulled from the Indiana State Department of Health's online database Statewide Investigation, Monitoring and Surveillance System (SWIMSS) and analyzed using SAS version 9.2. Historical data pre-dating SWIMSS (prior to 2009) was pulled from the prior TB Information Management database. All local health departments in Indiana are required to enter information regarding TB cases and their contact investigations into SWIMSS database, which is then used to transmit required information to the CDC through the Report of Verified Case of Tuberculosis (RVCT).

All population data presented and used to calculate rates within this report were obtained from the U.S. Census Bureau's American Community Survey. Population estimates used in 2014 rates are based on 2013 population estimates, as 2014 population had not been released at the time of publication.

The total number of TB cases is based on persons whose primary residence was in Indiana at the time of diagnosis and who were verified as having TB disease in the given year. Persons counted in another state and immigrants and refugees who are diagnosed and begin treatment abroad are excluded. Foreign visitors (i.e. students, tourists, etc.) and certain other categories of non-U.S. citizens who are diagnosed in Indiana but remain in the U.S. for less than 90 days of treatment are also excluded.

Cases counts less than five are suppressed at the county level to protect patient confidentiality.

Race is collected in five categories: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. Only those racial groups with TB cases within the given time period are shown in this report.

Data measures relating to treatment (initial drug regimen, culture conversion, DOT utilization, and therapy completion) exclude cases that were dead up diagnosis. The completion of therapy measure only includes cases for whom 12 months of treatment or less is recommended, who were alive at diagnosis, and who initiated treatment with one or more drugs. This excludes cases with any rifampin-resistant TB, meningeal TB, TB in bone or skeletal system, TB in the central nervous system, or children aged 14 or younger with disseminated TB. This also excludes cases who died or moved out of the U.S. within 366 days of initiating treatment.

B. Glossary

Acid-fast bacilli: Bacteria that retain certain dyes after being washed in an acid solution. *M. Tuberculosis* belongs to this group.

Clinical case confirmation: A clinical diagnosis is confirmed when all of the following criteria are met upon medical evaluation: (1) a positive tuberculin skin test (TST) or positive interferon-gamma release assay (IGRA) for *M. tuberculosis*, (2) other signs and symptoms compatible with TB (e.g., an abnormal chest x-ray or other clinical evidence of current disease), (3) current treatment with two or more anti-TB drugs, and (4) a completed diagnostic evaluation.

Cluster: A group of patients with LTBI or TB that is linked by epidemiologic, location, or genotyping data. A genotyping cluster is two or more cases with isolates that have an identical genotyping pattern.

Comorbid: The coexistence of two or more disease processes.

Contact: A person who has spent time with a person with infectious TB.

Culture: Growth of microorganisms in the laboratory performed for detection and identification of TB in sputum or other body fluids and tissues.

Culture conversion: Wherein sputum culture-positive results convert to sputum culture-negative.

Directly observed therapy (DOT): Adherence-enhancing strategy in which a health care worker or other trained person watches as a patient swallows each dose of medication. DOT is the standard care for all patients with TB disease and is a preferred option for patients treated for LTBI.

Extrapulmonary TB: TB disease in any part of the body other than the lungs. The presence of extrapulmonary disease does not exclude pulmonary TB disease.

Genotype: The DNA pattern of *Mycobacterium tuberculosis* used to discriminate different strains.

Interferon Gamma Release Assay (IGRA): Whole-blood tests that can aid in diagnosing TB by measuring a person's immune reactivity to *M. tuberculosis*.

Immunocompetent: Capable of developing an immune response; possessing a normal immune system.

Incidence: The extent or rate of occurrence, especially the number of new cases of a disease in a population over a period of time.

Laboratory case confirmation: Laboratory diagnosis is confirmed when: (1) Isolation of *M. tuberculosis* from a clinical specimen, or, (2) Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification test, or, (3) Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

Latent tuberculosis infection (LTBI): Infection with *M. tuberculosis* in which symptoms or signs of disease have not manifested.

MIRU: Distinguishes the *M. tuberculosis* strains by the difference in the number of copies of tandem repeats at specific regions, or loci, of the *M. tuberculosis* genome.

Mycobacterium tuberculosis: The namesake member organism of the *M. tuberculosis* complex and the most common causative agent of TB disease in humans. In certain instances, the species name refers to the entire *M. tuberculosis* complex, which includes *M. bovis* and *M. africanum*, *M. microti*, *M. canettii*, *M. caprae*, and *M. pinnipedii*.

Multi-drug resistance: Strains of *M. tuberculosis* that are resistant to at least isoniazid and rifampin.

Nucleic acid amplification test: A molecular technique used to detect a virus or bacterium, such as *M. tuberculosis*.

Outbreak: Unusually high occurrence of a disease or illness in a population or area. Three or more cases are required for an occurrence of TB to be classified as an outbreak.

Pulmonary TB: TB disease that occurs in the lungs.

Provider diagnosis case confirmation: In which a case does not meet criteria for laboratory nor clinical confirmation but the TB Program counts as a TB case based upon physician assessment and as determined by TB Medical Consultant and TB Controller.

Resistance: The ability of certain strains of mycobacteria, including *M. tuberculosis*, to grow and multiply in the presence of drugs that ordinarily kill or suppress them. Such strains are referred to as drug-resistant strains and cause drug resistant-TB disease.

Smear-positive: A positive test indicating the presence of TB bacteria in sputum done by smearing the sputum on a glass slide, staining it, and looking for bacteria.

Spoligotyping: Identifies the *M. tuberculosis* genotype based on presence or absence of spacer sequences found in a direct-repeat region of the *M. tuberculosis* genome where 43 identical sequences and 36 base pairs are interspersed by spacer sequences.

Sputum: Mucus containing secretions coughed up from inside the lungs. Sputum is different from saliva or nasal secretions, which are unsatisfactory for detecting TB disease.

Tuberculin skin test: A test done to detect TB infection by injecting liquid tuberculin under the skin and measuring the immune reaction.

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