

**Table 1. Interpretation of Strong and Weak (Conditional) Recommendations**

|               | Strong Recommendation                                                                                                                                                                                                                                                                                          | Weak (Conditional) Recommendation                                                                                                                                                                                                                                                                                      |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patients      | Most individuals in this situation would want the recommended course of action, and only a small proportion would not.                                                                                                                                                                                         | The majority of individuals in this situation would want the suggested course of action, but many would not.                                                                                                                                                                                                           |
| Clinicians    | Most individuals should receive the intervention. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator. Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences. | Recognize that different choices will be appropriate for individual patients and that you must help each patient arrive at a management decision consistent with his or her values and preferences. Decision aids may be useful in helping individuals to make decisions consistent with their values and preferences. |
| Policy makers | The recommendation can be adopted as policy in most situations.                                                                                                                                                                                                                                                | Policy-making will require substantial debate and involvement of various stakeholders.                                                                                                                                                                                                                                 |

acceptable alternative, especially in situations where an IGRA is not available, too costly, or too burdensome.

- There are insufficient data to recommend a preference for either a TST or an IGRA as the first-line diagnostic test in individuals 5 years or older who are likely to be infected with *Mtb*, who have a high risk of progression to disease, and in whom it has been determined that diagnostic testing for LTBI is warranted.
- Guidelines recommend that persons at low risk for *Mtb* infection and disease progression NOT be tested for *Mtb* infection. We concur with this recommendation. However, we also recognize that such testing may be obliged by law or credentialing bodies. If diagnostic testing for LTBI is performed in individuals who are unlikely to be infected with *Mtb* despite guidelines to the contrary:
  - We suggest performing an IGRA instead of a TST in individuals 5 years or older (*conditional recommendation, low-quality evidence*). Remarks: A TST is an acceptable alternative in settings where an IGRA is unavailable, too costly, or too burdensome.
  - We suggest a second diagnostic test if the initial test is positive in individuals 5 years or older (*conditional recommendation, very low-quality evidence*). Remarks: The confirmatory test may be either an IGRA or a TST. When such testing is performed, the person is considered infected only if both tests are positive.
- We suggest performing a TST rather than an IGRA in healthy children <5 years of age for whom it has been decided that diagnostic testing for LTBI is warranted

(*conditional recommendation, very low-quality evidence*).

Remarks: In situations in which an IGRA is deemed the preferred diagnostic test, some experts are willing to use IGRAs in children over 3 years of age.

- The preceding recommendations are summarized in [Figure 2](#). While both IGRA and TST testing provide evidence for infection with *Mtb*, they cannot distinguish active from latent TB. Therefore, the diagnosis of active TB must be excluded prior to embarking on treatment for LTBI. This is typically done by determining whether or not symptoms suggestive of TB disease are present, performing a chest radiograph and, if radiographic signs of active TB (eg, air-space opacities, pleural effusions, cavities, or changes on serial radiographs) are seen, then sampling is performed and the patient managed accordingly.

### Testing for TB Disease

- We recommend that acid-fast bacilli (AFB) smear microscopy be performed, rather than no AFB smear microscopy, in all patients suspected of having pulmonary TB (*strong recommendation, moderate-quality evidence*). Remarks: False-negative results are sufficiently common that a negative AFB smear result does not exclude pulmonary TB. Similarly, false-positive results are sufficiently common that a positive AFB smear result does not confirm pulmonary TB. Testing of 3 specimens is considered the normative practice in the United States and is strongly recommended by the Centers for Disease Control and Prevention and the National Tuberculosis Controllers Association in order to improve sensitivity given the pervasive issue of poor sample quality. Providers should request a sputum volume of at least 3 mL, but the optimal volume is 5–10 mL. Concentrated respiratory specimens and fluorescence microscopy are preferred.
- We suggest that both liquid and solid mycobacterial cultures be performed, rather than either culture method alone, for every specimen obtained from an individual with suspected TB disease (*conditional recommendation, low-quality evidence*). Remarks: The conditional qualifier applies to performance of both liquid and solid culture methods on all specimens. At least liquid culture should be done on all specimens as culture is the gold standard microbiologic test for the diagnosis of TB disease. The isolate recovered should be identified according to the Clinical and Laboratory Standards Institute guidelines and the American Society for Microbiology Manual of Clinical Microbiology.
- We suggest performing a diagnostic nucleic acid amplification test (NAAT), rather than not performing a NAAT, on the initial respiratory specimen from patients suspected of having pulmonary TB (*conditional recommendation, low-quality evidence*). Remarks: In AFB smear-positive