TUBERCULOSIS (INVESTIGATION AND MANAGEMENT FOLLOWING EXPOSURE IN PREGNANCY)

- Usually the result of:
- maternal history of TB in pregnancy
- baby exposed to a close (usually household) contact with sputum positive TB
- Effective management requires liaison between obstetric, neonatal, TB and paediatric ID teams

Risk factors for TB in newborn period

- Baby is at risk of acquiring TB if:
- mother received treatment for <2 weeks **or** treated for >2 weeks but sputum smear positive
- mother diagnosed with TB in postpartum period and/or after commencing breastfeeding
- close household contact has sputum positive TB

Congenital TB

- Acquired from transplacental spread or at birth
- Rare but potentially devastating infection with high mortality
- Characterised by primary focus in liver, hepatosplenomegaly and a miliary or disseminated picture including respiratory dissemination and TB meningitis

Neonatal TB

- Much more common than congenital infection
- Baby infected through respiratory route from infected mother or other close contact
- Baby highly susceptible to severe respiratory and disseminated disease including TB meningitis and miliary TB

IMMEDIATE MANAGEMENT

- If maternal infection fully treated before pregnancy give BCG
- If mother has TB in pregnancy:
- liaise with microbiology/TB specialist/paediatric ID consultant. Specialist may advise immediate anti-TB prophylaxis/treatment or investigations before treatment
- if no features of TB disease, start prophylaxis with rifampicin (R) and isoniazid (H)
- if RH resistance discuss with British Thoracic Society multi-drug resistant forum
- If mother had TB prophylaxis during pregnancy:
- examine babies at birth
- if no features of TB disease, give BCG

INVESTIGATIONS

- Gastric washings
- taken early morning pre-feed and transported in alkali medium for microscopy for acid fast bacilli, urgent PCR for M tuberculosis and mycobacterial culture
- liaise with microbiologist before sending
- Chest X-ray
- +/- CSF
- Maternal endometrial or placental samples may also be sent for TB testing

TREATMENT

- If baby has clinical signs, evidence of TB on chest X-ray or positive microbiology local specialist team will advise on treatment
- If baby well with normal investigations

- check renal and liver function
- start isoniazid
  - add pyridoxine 5 mg daily
  - do not give BCG as this will be affected by isoniazid treatment
  - check liver function again after 2 weeks
- Mother with active-phase TB can breastfeed once smear negative after appropriate treatment

FOLLOW-UP

- Will be done by local specialist team
- Neonatal team to prescribe sufficient discharge medication to last until first specialist review as GP does not prescribe this
- Mantoux or IGRA (interferon gamma release assay) at the end of prophylaxis – if negative, give BCG. **Do not** give BCG if either Mantoux or IGRA have been positive at any stage

PARENT INFORMATION LEAFLET FOR TB IN PREGNANCY AND FOR PROPHYLAXIS IN BABY

- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851854/RA_Pregnancy_TB_Patients.pdf