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4. Contact details of DTCOs and availability of microscopy centres

National Programme for Tuberculosis Control and Chest Diseases (NPTCCD) Contact details of DTCOs and District chest clinics				
District chest clinic	Office	DTCO	Tel. Number	Address
Ampara	063 - 2224165	Dr. Devika Wijetunge	077 - 7412092	District Chest Clinic, Near General Hospital, Kalmunai Road, Ampara
Anuradhapura	025 - 3852155	Dr. Deepthi Vaidyaratna	071 - 5451760	District Chest Clinic, Near St. Joseph's College, Bulankulama Disawa Mawatha, Anuradhapura
Badulla	055 - 2222483	Dr. Chinthika Dissanayake	071 - 4479511	District Chest Clinic, PGH Badulla
Batticaloa	065 - 2222678	Dr. Aranee Koneshwaran	071 - 8255308 077 - 3269488	District Chest Clinic, Hospital Road, Batticaloa
Colombo	011 - 2675274	Dr. Nayana De Silva	077 - 4839797	Central Chest Clinic, Baseline Road, Colombo 08
Colombo East	011 - 2549390	Dr. Sithara Rohana	071 - 8511601	Colombo East Base Hospital, Mulleriyawa New Town
Colombo South	011 - 2763261	Dr. Gihan Amarasinghe	071 - 4423852	Chest Clinic, Colombo South Teaching Hospital, Kalubowila
Galle	0 91 - 2234196	Dr. Iresha Samanmali	077 - 2914924	District Thaseem Chest Clinic, Wakwella Road, Galle
Gampaha	011 - 2960155	Dr. Kaushalya Rajapaksha	071 - 6850253	District Chest Clinic Gampaha, Chest Hospital Premises, Welisara
Hambantota	047 - 2220574	Dr. Sameera Ramanayake	077 - 3790795	District Chest Clinic, DGH Hambantota
Jaffna	021 - 2222494	Dr. R. Manivasakan	077 - 4933976	District Chest Clinic, No. 16, Clock Tower Road, Jaffna
Kalmunai	067 - 2260601	Dr. D. Mafaz	076 - 7225373	District Chest Clinic, BH Sammanturai
Kalutara	034 - 2222677	Dr. Niroshan Sampath	071 - 4391711	District Chest Clinic, DGH Kalutara, Nagoda
Kandy	081 - 2222071	Dr. Kavinda Amarasinghe	071 - 5601060	District Chest Clinic, Bogambara Rd, Kandy
Kegalle	035 - 2232431	Dr. Danoja Punyasoma	071 - 6673121	District Chest Clinic, Bulathkohupitiya Rd, Kegalle
Kilinochchi	021 - 2283709	Dr. K. Susidhiran	077 - 7252136	District Chest Clinic, DGH Kilinochchi
Kurunegala	037 - 2224439	Dr. S. Kulathilake	071 - 4971745	District Chest Clinic, Suwamedura, Puwakgala Junction, Kurunegala
Mannar	023 - 2232916	Dr. T.O. Tenny	076 - 8525666	District Chest Clinic, DGH Mannar
Matale	066 - 2224888	Dr. Senaka Rajagamuwa	071 - 4859250	District Chest Clinic, DGH Matale
Matara	041 - 2222134	Dr. Samitha Kadahettige	071 - 4336455	District Chest Clinic, No. 09, Rahula Cross Road, Matara
Monaragala	055 - 2276261	Dr. Susil Denagama	077 - 2551204	District Chest Clinic, DGH Monaragala
Mullativu	024 - 3248131	Dr. Thayaseelan	077 - 5025830	District Chest Clinic, DGH Mullativu
Nuwara Eliya	052 - 2051655	Dr. Senthuran	070 - 3773473	District Chest Clinic, DGH Nuwara Eliya
Polonnaruwa	027 - 2225570	Dr. Jeevani Samarasinghe	070 - 3073811	District Chest Clinic, DGH Polonnaruwa
Puttalam	032 - 2265361	Dr. Tharidu Weerasekara	077 - 9145319	District Chest Clinic, Colombo Road, Puttalam
Ratnapura	045 - 2222268	Dr. Buddhika Ranasinghe	071 - 4420802	District Chest Clinic, Hospital Road, Ratnapura
Trincomalee	026 - 2221026	Dr. T. Suresh Kumar	077 - 6014732	District Chest Clinic, DGH Trincomalee
Vavuniya	024 - 2221421	Dr. Chandra Kumar	077 - 7146765	District Chest Clinic, DGH Vavuniya



Snippets on Tuberculosis

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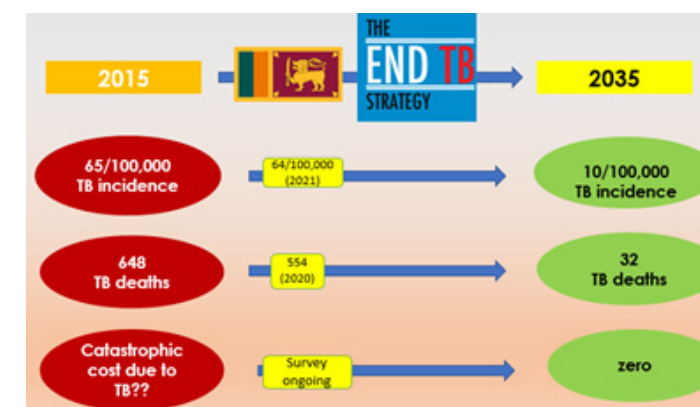
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1. Featuring article: Tuberculosis in Sri Lanka. Pathway to END TB.....

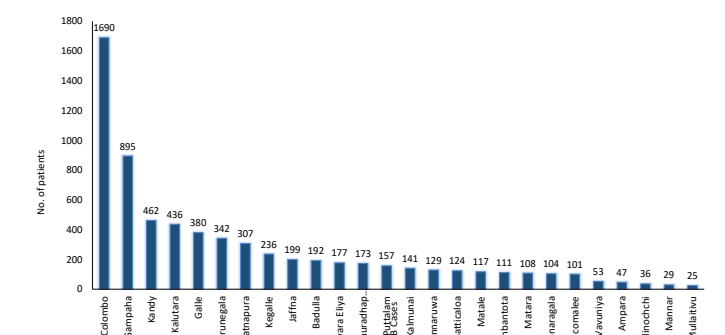
Tuberculosis (TB) reports the third highest incidence and second highest mortality among infectious diseases in Sri Lanka. According to current national programme goals of END TB, Sri Lanka should reach targets in reduced incidence and mortality for TB while maintaining zero levels of catastrophic cost due to TB by 2035 (Figure 1).

However, the latest estimates for TB incidence for Sri Lanka is 64/100,000 in 2021 while 602 TB deaths were reported in 2019. The catastrophic cost due to TB still remains to be estimated with the ongoing survey.

**Figure 1; End TB strategy of Sri Lanka**

Currently, annually around 8,000 – 9,000 diagnosed patients with TB are reported to the national programme with highest contributions from Colombo, Gampaha, Kandy and Kalutara districts respectively. During 2021, a total of 6,771 TB patients were reported with a similar district distribution (Figure 2). However, this figure is expected to be affected by the prevailing COVID 19 pandemic, suggesting missed TB patients in the community. Compared to 2021 for the year 2020, a total of 7,258 patients have been detected. This indicates nearly a 500 reduction of detected TB patients in 2021 while the number of patients' estimates remained the same (64/100,000). The patients' health

seeking behaviour and availability of investigations (sputum microscopy etc.) were affected during the 2020 -2021 period by the COVID pandemic. In addition, the COVID precautions such as use of face masks could have had a positive effect on reduced patient numbers.

**Figure 2; District wise distribution of TB cases 2021**

Since the third quarter of 2021, there was a positive reversal of detected number of TB patients per quarter (Q1 – 1,491, Q2 - 1,604, Q3 - 1,891). This trend is seen at the national level as well as in most of the districts indicating community and health services adaption to new normalcy. This trend needs to be strengthened further in the future through active involvement by the health care providers.

Although anyone can get TB, certain groups are at higher risk. These include, close contacts of TB patients, malnourished, immune suppressed (PLHIV, CKD patients, those on immune suppressive treatment etc.), people from congested settings (slum areas, estates, prisons, institutionalized etc.) and health care workers. The suspected TB patients (with cough >2weeks +/- SOB, chest pain, fever and night sweats, loss of appetite, loss of weight, fatigue and haemoptysis) need to be identified at the OPD, ward settings or GP encounters and directed for TB screening and diagnosis.

The Chest Xray is the mainstay of screening along with sputum examination (smear or Xpert/RIF) being the main diagnostic measures. The Xpert/RIF services are available in all districts free of charge and performed at District Chest Clinics or tertiary care hospitals.

2. Facts about management of patients with Tuberculosis

Classification of TB	
It is important to classify the cases of TB in order to determine the correct treatment regimen and the duration of treatment and for recording and reporting purposes.	
Site of TB disease	Pulmonary TB Extra pulmonary TB
Type of diagnosis	Bacteriologically confirmed Clinically diagnosed
History of previous TB treatment	New Relapse Treatment after failure Treatment after loss to follow up Other previously treated Unknown Previous TB Treatment History

Diagnosis of pulmonary TB
Any person who presents with symptoms or signs suggestive of TB, particularly, those who have cough for more than two weeks duration should be investigated for TB.

Investigations	
Sputum Microscopy	At least three sputum samples should be collected and examined by microscopy for Acid Fast Bacilli (AFB).
Xpert	Sample of sputum or any other sample can be examined. Better sensitivity and less time consuming. Resistance to Rifampicin also can be tested.
Chest X-ray	Chest X-ray has a limited role in the diagnosis of pulmonary TB.
Sputum culture for AFB	This is a more expensive method and needs at least 6-8 weeks to get the results.

Treatment of TB
The modern treatment strategy is based on standardized short course chemotherapy regimens and proper case management to ensure completion of treatment and cure.
Standard code for TB treatment regimens
There are four essential anti-TB drugs Isoniazid (H) Rifampicin (R) Pyrazinamide (Z) Ethambutol (E)
A TB treatment regimen consists of two phases:
Intensive phase: A combination of 4 drugs (available as a single tablet) are given at this phase to achieve rapid killing of actively multiplying bacillary population.
Continuation phase: Treated with fewer drugs for a comparatively longer time to eliminate persisting organisms which are responsible for relapses (given as a single tablet).

Multi drug Resistant Tuberculosis (MDR TB)
Emergence of drug resistant strains of the tubercle bacillus has become a major threat to control of TB worldwide .
MDR TB is defined as tuberculosis in patients whose infecting isolates are resistant in vitro to both isoniazid and rifampicin with or without resistance to other first line drugs.
The major causes for emergence of multi drug resistant forms are poor case management and poor compliance of patients to treatment.

Directly Observed treatment (DOT)
Directly Observed Treatment is one of the most important strategies in TB control.
This ensures the compliance of the patient to correct treatment regimen, that a TB patient takes the right anti- tuberculosis drugs, in the right doses at the right intervals without interruption and ensures that the patient completes the full course of treatment.
In DOTS strategy, patient swallows the tablets under the direct observation of a health worker or a trained volunteer.
It also helps to motivate the patient to continue treatment and provides opportunity for early detection of adverse effects.
Who will receive DOT?
All TB patients should be given daily DOT during the entire period of treatment, both in the intensive and continuation phases of the treatment.
This should be arranged or hospital based in the case of very ill patients or for those who are unable to attend daily for supervised treatment.
Who will be a DOT provider?
<ul style="list-style-type: none">• Health workers at state healthcare facilities• Field health care workers• General practitioners• Trained community volunteers• Community leaders

Monitoring of treatment
Bacteriological monitoring is done for pulmonary TB cases by examination of sputum smears at regular intervals during treatment.
Clinical monitoring by symptomatic improvement and weight gain especially in the case of extra pulmonary and sputum smear negative pulmonary TB.
Monitoring the drug intake during intensive phase and drug collection during the continuation phase by reviewing the treatment cards.

3. The role of GPs in detecting TB patients and referral pathways

The Role of General Practitioner in Control of TB

General Practitioners are among the first contacts for the majority of patients. Therefore, he or she should have a high index of alertness in order to identify TB suspects timely and to do the necessary investigations or refer them to the District Chest Clinic for investigations and further management. General Practitioners can also provide their service as DOT providers. As the caring physician or as the DOT provider, the GP will;

- Maintain a minimal volume of documents which is essential for proper management and follow up of TB patients.
- Refer patients under his/her care for follow-up sputum smears to Microscopy Centers or District Chest Clinics at regular intervals.
- Promptly refer patients who develop side effects to anti-TB drugs to the District Chest Clinic as early as possible.
- Refer patients who do not show satisfactory improvement (which may be suggestive of drug resistant TB or wrong diagnosis) to a Consultant Respiratory Physician or to the District Chest Clinic.
- Refer patients to relevant specialist in special situations such as pregnancy, HIV infection and children.
- Attempt to trace patients who interrupt (default) treatment even for a day and inform the DTCCO if it is unable to trace them and back on treatment.
- Assure confidentiality / professional secrecy of the information about the patient.
- Provide necessary advice to the patient or educate him regarding his health status.

