

**Health Protection Agency TB Programme Board
Lead: Prof. S. P. Borriello**

Tuberculosis

**Health Protection Agency Position Statement on the use of Interferon Gamma Release Assay (IGRA) tests for tuberculosis (TB)
Interferon Gamma Release Assay (IGRA) testing for tuberculosis (TB) - Questions & Answers (Q&As)**

November 2007 – December 2007

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General		<p>About the Faculty of Public Health The Faculty of Public Health is the leading professional body for public health specialists in the uK. It aims to promote and protect the health of the population, and improve health services by maintaining professional and educational standards, advocating on key public health issues, and providing practical information and guidance for public health professionals.</p> <p>This response was drafted B Smyth, CDSC Northern Ireland, on behalf of the Northern Ireland Affairs Committee of the Faculty of Public Health.</p>
1	1	This guidance is welcomed as the 2006 NICE guidance on use of interferon gamma was very limited acknowledging the evidence base at that time. Since then more evidence has become available though it is still incomplete and therefore this guidance should be regarding as interim.
	2	This documentation is also relevant to those providing occupational health services to healthcare workers
3	3	The rationale behind the HPA recommendations on inteferon gamma in the various clinical situations have not been adequately clarified. For example it is not recommended as a first line screen in contact tracing yet is recommended as a first line screen for new healthcare workers under certain circumstances.
	4	How is an inconclusive IGRA test defined? Is this test specific i.e. T Spot or Quantiferon Gold? Will the lab state the test is inconclusive?
	5	The recommendation that IGRA should not be used as a routine diagnostic test for active TB will be hard to police unless each request can only be sanctioned through a microbiologist.
	6	DH guidance on healthcare workers and serious communicable diseases recommends that new and re-entrant HCWs from high TB prevalence areas are recommended to have a TST even if there is evidence of prior BCG vaccination. It would be helpful to ensure there is no conflict between DH and HPA regarding screening of such HCWs as currently worded there will be confusion.
	7	A cost effectiveness analysis is required for use of IGRA. While laboratory costs of using IGRA may be high in it prevents the need, as per these recommendations, in certain situations for Mantoux testing and repeat patient visit for reading of the test. Thus it may be more cost effective for the patient and the NHS for greater use of IGRA tests and reduced reliance on skin testing. Does the use of IGRA need to go before the DH Rapid Review Panel?
	8	I agree with the recommendation to use IGRA testing as first line in screening healthcare workers – due to the large numbers, the logistics of arranging Mantoux clinics, readings and follow up and high DNA rates. I also agree that the importance of accurately detecting latently infected staff has real benefits for patient safety. It is also a matter of fact that as the BCG programme has halted in the UK (for whatever

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		reason), we will be getting larger and larger numbers of new healthcare workers who have never had a BCG – the IGRA will then be invaluable for our use.
Q&A document for HCWs		
	1	There should be an expanded paragraph about the “inconclusive or indeterminate” results and any subsequent action. What should be the minimum the time interval between IGRA tests in an individual? Is there an agreed laboratory range to define “indeterminate”