Tuberculosis (TB) is the leading cause of death from an infectious disease in women worldwide. In most low income countries twice as many cases of TB are reported among men than among women, a difference commonly attributed to biological and epidemiological characteristics as well as socioeconomic and cultural barriers in access to health care. The World Health Organization has encouraged gender specific comparisons in TB rates to determine whether women with TB are less likely than men with TB to be diagnosed, reported, and treated. A study was undertaken to identify gender based differences in patients with pulmonary TB and to use this information to improve TB control efforts.

Methods: Individuals with a cough for more than 2 weeks in southern Mexico were screened from March 1995 to April 2003. Clinical and mycobacteriological information (isolation, identification, drug susceptibility testing and IS6110 based genotyping, and spoligotyping) was collected from those with bacteriologically confirmed pulmonary TB. Patients were treated in accordance with official norms and followed to ascertain treatment outcome, retreatment, and vital status.

Results: 623 patients with pulmonary TB were enrolled. The male:female incidence rate ratio for overall, reactivated, and recently transmitted disease was 1.58 (95% CI 1.34 to 1.86), 1.64 (95% CI 1.36 to 1.98), and 1.41 (95% CI 1.01 to 1.96), respectively. Men were more likely than women to default from treatment (adjusted OR 3.30, 95% CI 1.46 to 7.43), to be retreated (hazard ratio (HR) 3.15, 95% CI 1.38 to 7.22), and to die from TB (HR 2.23, 95% CI 1.25 to 3.99).

Conclusions: Higher rates of transmitted and reactivated disease and poorer treatment outcomes among men are indicators of gender differentials in the diagnosis and treatment of pulmonary TB, and suggest specific strategies in endemic settings.
Written informed consent was obtained from each individual before enrolment. The study was approved by the institutional review boards of the Instituto Nacional de Salud Pública (INSP), the Instituto Nacional de Ciencias Médicas y de la Nutrición “Salvador Zubirán” (INCMNSZ), and Stanford University.

**Mycobacteriology and genotyping**  
Ziehl Neelsen staining, cultures for mycobacteria, species identification, and susceptibility testing were performed following standardised procedures. Genotypic analysis of *M* tuberculosis isolates was carried out using a standard insertion sequence IS6110 restriction fragment length polymorphism (RFLP) technique with computer assisted analysis of the patterns (Bioimage AQ-1 Analyzer and Molecular Fingerprinting Analyzer, version 2.0). Isolates with identical IS6110 genotype patterns with fewer than six hybridising bands were also analysed using spoligotyping as previously described. Because we were interested in assessing recent or ongoing transmission of *M* tuberculosis that rapidly progressed to disease, we established a 1 year period for defining clustering. Cases were considered “clustered” if two or more isolates from different patients were identified within 12 months of each other and had six or more IS6110 bands in an identical pattern, or fewer than six bands with identical IS6110 RFLP patterns and a spoligotype with the same spacer oligonucleotides. Pulmonary TB cases with a unique genotype pattern and the first case diagnosed in each cluster probably arose from the reactivation of a latent TB infection.

**Statistical analysis**  
To determine if women were less likely to undergo screening than men, we compared the proportion of women among screened individuals with the proportion of women in the general population. Of the 8195 individuals screened, 829 (10.1%) had AFB or *M* tuberculosis in at least one sputum sample and were retained based on the 1 year period for defining clustering. Cases were considered “clustered” if two or more isolates from different patients were identified within 12 months of each other and had six or more IS6110 bands in an identical pattern, or fewer than six bands with identical IS6110 RFLP patterns and a spoligotype with the same spacer oligonucleotides. Pulmonary TB cases with a unique genotype pattern and the first case diagnosed in each cluster probably arose from the reactivation of a latent TB infection.

**RESULTS**  
During the 8 year study period we screened 8195 individuals with a cough lasting ≥2 weeks, 4569 (55.7%) of whom were women. This proportion was larger than the proportion of women in the general population as measured by the 2000 census (n = 176 120, 47.7%, p < 0.0001). Age distribution of the group who presented with cough was similar to the general population. 86% of all those with a cough provided three sputum samples; the proportion of women who provided three samples (n = 3948, 86.4%) was slightly higher than the proportion of men (n = 3067, 84.6%, p = 0.03). Of all the individuals who were screened, 829 (10.1%) had AFB or *M* tuberculosis in at least one sputum sample and were diagnosed with pulmonary TB.

Mycobacteriological culture and genotyping results were obtained for 623 of the 829 TB patients (75.1%). Patients with an *M* tuberculosis genotype available were more likely than those who were unable to perform a genotype study to have >10 bacilli per oil immersion field in the sputum smear (257/623 (41.3%) vs 54/206 (26.2%), p = 0.001) and severe clinical symptoms such as fever (416/623 (66.8%) vs 115/206 (55.8%), p = 0.004) or initial weight loss (468/622 (75.2%) vs 139/206 (67.5%), p < 0.05).

**Table 1** Incidence and mortality rates of pulmonary TB by gender in Orizaba, Veracruz, 1995–2003

<table>
<thead>
<tr>
<th>Variables</th>
<th>Rate* in men</th>
<th>Rate* in women</th>
<th>Incidence rate ratio men:women (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incidence rates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clustered cases</td>
<td>7.54 (n = 67)</td>
<td>5.35 (n = 68)</td>
<td>1.41 (1.01 to 1.96)</td>
<td>0.03</td>
</tr>
<tr>
<td>Reactivated cases</td>
<td>24.25 (n = 280)</td>
<td>14.79 (n = 188)</td>
<td>1.64 (1.36 to 1.98)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total cases</td>
<td>31.79 (n = 367)</td>
<td>20.13 (n = 256)</td>
<td>1.58 (1.34 to 1.86)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Mortality rates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due to TB</td>
<td>3.20 (n = 37)</td>
<td>1.10 (n = 15)</td>
<td>2.91 (1.60 to 5.30)</td>
<td>0.0003</td>
</tr>
<tr>
<td>All cause mortality</td>
<td>7.61 (n = 88)</td>
<td>2.20 (n = 30)</td>
<td>3.46 (2.28 to 5.23)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*Per 100 000 person-years.  
†Clustering within 1 year of diagnosis.
Characteristics of clusters by gender

Of the 623 isolates of \( M \) tuberculosis, 155 (24.8%) were in clusters and 468 (75.1%) had a unique genotype. There were 43 different clusters, each with 2–19 isolates; 29 (67%) of index cases were male. Clusters with a female index case were not significantly larger (mean 3.8, median 2.5, range 2–9) than clusters initiated by men (mean 3.4, median 2.0, range 2–19, \( p = 0.53 \)). Similarly, there was no significant difference in the number of secondary cases by gender.

### Table 2  Characteristics of patients with pulmonary TB by gender, Orizaba, Veracruz, 1995–2003

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total</th>
<th>Men (( n = 367 ))</th>
<th>Women (( n = 256 ))</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) age (years)</td>
<td>44.3 (17.8)</td>
<td>45.19 (17.3)</td>
<td>43.12 (18.5)</td>
<td>0.15*</td>
</tr>
<tr>
<td>Any formal education, n (%)</td>
<td>505/620 (81.45)</td>
<td>313/365 (85.75)</td>
<td>192/255 (75.29)</td>
<td>0.001</td>
</tr>
<tr>
<td>Potable water available within the household, n (%)</td>
<td>246/606 (40.59)</td>
<td>157/375 (43.98)</td>
<td>89/249 (35.74)</td>
<td>0.04</td>
</tr>
<tr>
<td>Median (IQR) distance to nearest health centre (metres)</td>
<td>691.81 (436.94–1012.05)</td>
<td>868.93 (437.35–980.23)</td>
<td>705.47 (430.94–1211.67)</td>
<td>0.24†</td>
</tr>
<tr>
<td>Used alcohol, n (%)</td>
<td>285 (45.97)</td>
<td>255/365 (69.86)</td>
<td>30/255 (11.76)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Used tobacco, n (%)</td>
<td>149/620 (27.26)</td>
<td>150/365 (41.10)</td>
<td>19/255 (7.45)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Used illegal drug, n (%)</td>
<td>43/620 (6.94)</td>
<td>42/365 (11.51)</td>
<td>1/255 (0.39)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Homelessness or residence in shelters, n (%)</td>
<td>23/619 (3.72)</td>
<td>22/364 (6.04)</td>
<td>1/255 (0.39)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Previous imprisonment, n (%)</td>
<td>168/619 (27.14)</td>
<td>161/364 (44.11)</td>
<td>7/255 (2.76)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
| Mortality due to TB was higher in men (3.2 per 100 000 person-years) than in women (1.1 per 100 000 person-years, \( p = 0.0003; \) table 1).

### Table 3  Results of multivariate analysis of risk factors for default, retreatment, and death from TB among bacteriologically confirmed pulmonary TB patients, Orizaba Veracruz, 1995–2003

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Default</th>
<th>Retreatment</th>
<th>Death from TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) age (years)</td>
<td>3.30 (1.46 to 7.43)</td>
<td>3.15 (1.38 to 7.22)</td>
<td>2.23 (1.25 to 3.99)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>No formal education</td>
<td>3.85 (1.85 to 8.33)</td>
<td>&lt;0.001</td>
<td>–</td>
</tr>
<tr>
<td>No social security</td>
<td>4.54 (1.64 to 12.5)</td>
<td>0.003</td>
<td>–</td>
</tr>
<tr>
<td>Body mass index</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Weight loss</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Diabetes</td>
<td>–</td>
<td>1.83 (0.94 to 3.54)</td>
<td>0.073</td>
</tr>
<tr>
<td>HIV infection</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>MDR TB</td>
<td>4.96 (1.99 to 12.36)</td>
<td>0.001</td>
<td>2.84 (1.25 to 6.40)</td>
</tr>
<tr>
<td>Time interval between diagnosis and treatment (months)</td>
<td>2.87 (1.70–5.47)</td>
<td>2.90 (1.70–5.57)</td>
<td>2.78 (1.63–50)</td>
</tr>
<tr>
<td>Treatment default</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>
treatment outcomes by gender

Twelve patients refused treatment. Of 568 patients for whom treatment completion could be evaluated, 427 (75.2%) had initiated treatment within 10 days of diagnosis and 551 (97.0%) received directly observed therapy (DOTS). The treatment outcomes overall were as follows: 471 (82.9%) cured (419 (73.8%) of whom had bacteriological confirmation); 52 (9.2%) defaulted; 16 (2.8%) failed treatment; 17 (3.0%) died during treatment; and 12 (2.1%) transferred out of the study area. In the bivariate analysis, men were more likely than women to have a subsequent episode of TB and to require retreatment (p = 0.01, table 2). The Cox adjusted hazards ratio (HR) for retreatment, controlling for diabetes and drug resistance, was higher among men than among women (HR 3.15, 95% CI 1.38 to 7.22, p = 0.007; table 3).

One hundred and eighteen patients died during the study period; death was due to TB in 52 of these (44.1%). Of these 52 patients, three were untreated, 17 died during treatment, and 32 died after treatment. Four of the 12 patients who refused treatment, all of whom were men, died. The Cox adjusted hazards ratios for mortality from TB controlling for age, body mass index, weight loss, HIV infection, drug resistance, and treatment default was higher among men than among women (HR 2.23, 95% CI 1.25 to 3.99, p = 0.007; table 3). Men had lower survival rates when death due to TB (p = 0.05), death from other causes (p = 0.02), and death from all causes (p = 0.004) were assessed (fig 1).

Since alcohol use was more frequent among men, we evaluated models that included alcohol as an independent variable. Men were more likely to default, require retreatment, or die from TB when models were also adjusted by use of alcohol.

DISCUSSION

In this population based study conducted in a developing country with endemic rates of TB, we provide data indicating higher rates of bacteriologically proven pulmonary TB and more severe clinical consequences among men than women. By using molecular epidemiological techniques, we further determined that higher rates among men are the result of both reactivation of latent infection and of recent TB transmission. Public health strategies that aim to reduce TB will need to address both disease processes.

Data indicating higher TB rates for men, particularly when obtained from developing countries, have been highly controversial and have often been attributed to gender based differences in access to health care. Existing evidence indicates that the access to and use of healthcare services in Mexico is similar in men and women and, in fact, women use the health services more frequently than men. Although the women in our study came from lower socioeconomic groups than the men, these differences did not represent an obstacle for pulmonary TB screening, diagnosis, and treatment in the study area since such services are available free of charge through the public health sector in Mexico. The proportion of women who reported coughing for at least 2 weeks, provided sputum samples, and were screened for TB was greater than the proportion of men who were screened. There were no significant gender based differences in the distance to the nearest health centre and in the time interval between the onset of symptoms and the start of treatment, men were more likely than women to have a subsequent episode of TB and to require retreatment (p = 0.01, table 2). The Cox adjusted hazards ratio (HR) for retreatment, controlling for diabetes and drug resistance, was higher among men than among women (HR 3.15, 95% CI 1.38 to 7.22, p = 0.007; table 3).

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Since alcohol use was more frequent among men, we evaluated models that included alcohol as an independent variable. Men were more likely to default, require retreatment, or die from TB when models were also adjusted by use of alcohol.
also reported that women were more likely than men to access the healthcare services.  

Differences in TB rates have also been attributed to biological phenomena. It has been suggested that the propensity to develop disease after infection with *M. tuberculosis* (progression rate) may be greater in women of reproductive age than in men of the same age, whereas men have higher rates of progression when older.  

Co-morbid conditions such as HIV infection, diabetes, and cirrhosis could also affect the rate at which TB occurs, and their prevalence could vary by gender. We also note that men not only had higher rates of pulmonary TB, but also had more severe clinical symptoms when diagnosed with TB.  

The higher rates of pulmonary TB among the men in our study are partially explained by the local transmission dynamics, particularly in crowded, poorly ventilated or nosocomial settings. Men are more likely to report risk factors that have been associated with exposure to TB such as imprisonment or prior residence in a shelter. We previously described an outbreak of TB in the study area occurring in clandestine bars whose customers were mainly men.  

Men also reported more frequent use of alcohol and tobacco, behaviours that may influence the rate at which TB infection progresses to active disease. Evaluation of male gender and alcohol by logistic regression analyses and Cox models showed that men with TB are at a higher risk of a poor treatment outcome, independent of alcohol use.

There were significant differences in the outcomes of antituberculosis treatment between men and women. Although women just as likely as men to be treated with DOTS, men were more likely to default from treatment. The behaviour patterns of non-adherent male patients have been amply described. As has been reported previously, men were more likely than women to require retreatment, probably because of defaulting from treatment. The probability of death caused by TB among men more than doubled that of women when adjusted for variables known to be associated with mortality such as drug resistance and HIV infection. Men also had a higher probability of death due to other causes and of death due to all causes. This higher probability of death due to TB among men has been confirmed elsewhere.  

The conclusions that can be drawn from our study are limited by several potential biases. Determining the cause of death can be a complex process. In this study we used a combination of criteria (clinical, bacteriological, caregiver interview, and/or death certificate) to ascertain the cause of death which allowed us to estimate mortality rates. We have validated this method previously. The cause of death profile derived from interviewing a close caregiver or verbal autopsy has also been found to be useful by others. It should be noted that we studied only bacteriologically proven pulmonary TB cases. Our data may not be generalisable to patients with fewer bacilli and less severe symptomatology since our study population differed in bacilli concentrations and clinical manifestations from the total pulmonary TB cases. Finally, we only explored epidemiological and clinical information; other sociological and behavioural aspects which might determine gender differences were not included in our study. Nevertheless, our population based study allowed us to calculate unbiased pulmonary TB rates for men and women regardless of the complexity of other factors that were not considered.  

The results of our study support the need to devise and implement TB control strategies to block further TB transmission, including better case finding and confirmation that each TB patient is cured. Our data also show that increased screening and treatment of latent infection will be needed to decrease the incidence of reactivated disease.

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**Authors’ affiliations**

M-E Jiménez-Corona, L García-García, L Ferreyra-Reyes, B Cano-Arellano, S Canizales-Quintero, Instituto Nacional de Salud Pública (INSP), Cuernavaca Morelos, México  

K DeRiemer, Stanford University, Palo Alto, California, USA  

M Bobadilla-del-Valle, A Martínez-Gamboa, J Sifuentes-Osorno, A Ponce-de-León, Instituto Nacional de Ciencias Médicas y de Nutrición “Salvador Zubirán” (INCMNSZ) México, DF, México  

P M Small, Bill and Melinda Gates Foundation, Seattle, Washington, USA

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Competing interests: none.

**REFERENCES**


Gender differences in pulmonary TB

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LUNG ALERT

**Inhaled hypertonic saline reduces pulmonary exacerbations in cystic fibrosis**


Short term administration of hypertonic saline has been shown to improve lung function in cystic fibrosis. The authors conducted a double blind, parallel group trial over a 48 week period with 164 patients aged at least 6 years randomly assigned to either 7% (hypertonic) or 0.9% saline (control). A bronchodilator was administered before each inhalation of the study solution.

There was no significant difference between the two groups in the primary outcome measure—the rate of change in lung function. However, in the hypertonic saline group the absolute level of lung function, averaged over the period from 4 to 48 weeks after randomisation, was moderately higher than in the control group (p = 0.03): FEV₁ 3.2% (95% CI 0.1 to 6.2) higher; FVC 2.8% (95% CI 0.4 to 5.2) higher.

There were fewer pulmonary exacerbations (defined by signs and symptoms) in the hypertonic saline group than in the control group, with 2.74 exacerbations per participant in the control group and 1.32 in the hypertonic saline group (difference 1.42, 95% CI 0.86 to 1.99, p<0.001). Furthermore, 41% of the hypertonic saline group were exacerbation-free over 48 weeks compared with 16% of the control group (p<0.001). However, these differences were largely confined to the first 3 months of treatment and were paralleled by a decrease in compliance in patients over time.

This study suggests that hypertonic saline (preceded by a bronchodilator) may have potential as a long term intervention for cystic fibrosis.

A J Mackay

Senior House Officer, Royal Free Hospital, London, UK; malexmackay@hotmail.com

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Gender differentials of pulmonary tuberculosis transmission and reactivation in an endemic area


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