Avoid chemoprophylaxis in both cases, as it would seem a reasonable strategy to were positive. Based on this information, patients reported, neither of these tests would be classiﬁed as ‘low risk’ and thus not offered chemoprophylaxis if managed according to current BTS recommendations. The ethnic origin of the patient in case 1 is not stated by the authors but unless she is black African or from the Indian subcontinent, she would be classiﬁed as being at ‘low risk’ of having LTBI. The patient in case 2 is Moroccan so would be classiﬁed in ‘other ethnic group’ by the BTS guideline. In both cases, chemoprophylaxis would not have been recom- mended by the guideline. Recent data suggest that a proportion of patients deemed to be ‘low risk’ according to the BTS guideline may still have evidence of LTBI as deﬁned by either a positive tuberculin skin test (TST) or interferon γ release assay. However, in both of the patients reported, neither of these tests were positive. Based on this information, it would seem a reasonable strategy to avoid chemoprophylaxis in both cases, as the risks of therapy related hepatotoxicity theoretically outweigh the calculated risk of LTBI progression according to the tables contained in the BTS guideline. Both patients were managed in this way but subsequently developed active TB infection.

Based on current evidence, we would suggest that all patients are screened using a triple approach of risk calculation, TST and interferon γ release assay prior to commencement of TNF-α antagonist therapy, as highlighted by data from our study published in Thorax. However, we believe that the cases reported by Hoﬂand et al highlight a further area not addressed in the current BTS guideline and suggest that all patients being commenced on TNF-α antagonist therapy should also be carefully counselled to inform their rheumatology specialist if they plan to travel abroad with screening offered if travel has occurred to a TB-endemic area for more than 1 month (the two cases described were only away for 4–5 weeks). Indeed, the risk of developing active TB should be considered throughout the duration of TNF-α antagonist therapy and not solely prior to commencement. Any new guideline now needs to consider the additional factor of travel in addition to new contact with pulmonary TB.

We believe that data presented in our recent observational study and the cases presented by Hoﬂand et al provide a strong case for reconsideration of national guidelines for screening and monitoring of patients already on TNF-α antagonist therapy and who have a substantive travel history or new TB contact. These aspects should be speciﬁcally addressed in any future National Institute for Health and Care Excellence guidance.

References

Correspondence to Professor Onn Min Kon, Chest and Allergy Department, St Mary’s Hospital, Imperial College Healthcare NHS Trust, London W2 1NY, UK; Onn.Kon@imperial.nhs.uk

Contributors The overall content of the letter was overseen by OMK. The content was written by KM and AS and reviewed by MW.

Competing interests None.

Provenance and peer review Not commissioned; internally peer reviewed.


Received 27 August 2014
Accepted 16 September 2014
Published Online First 29 October 2014

http://dx.doi.org/10.1136/thoraxjnl-2012-202974

Thorax 2015;70:373.
do:10.1136/thoraxjnl-2014-206239