Consensus Statement on Research Definitions for Drug-Resistant Tuberculosis in Children

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Few children with drug-resistant (DR) tuberculosis (TB) are identified, diagnosed, and given an appropriate treatment. The few studies that have described this vulnerable population have used inconsistent definitions. The World Health Organization (WHO) definitions used for adults with DR-TB and for children with drug-susceptible TB are not always appropriate for children with DR-TB. The Sentinel Project on Pediatric Drug-Resistant Tuberculosis was formed in 2011 as a network of experts and stakeholders in childhood DR-TB. An early priority was to establish standardized definitions for key parameters in order to facilitate study comparisons and the development of an evidence base to guide future clinical management. This consensus statement proposes standardized definitions to be used in research. In particular, it suggests consistent terminology, as well as definitions for measures of exposure, drug resistance testing, previous episodes and treatment, certainty of diagnosis, site and severity of disease, adverse events, and treatment outcome.

Key words. Pediatric; Children; Tuberculosis; Drug-Resistance; Definition; Consensus

The World Health Organization (WHO) estimated that 630,000 cases of multidrug-resistant (MDR) tuberculosis (TB) occurred globally in 2010 [1]. MDR-TB is caused by Mycobacterium tuberculosis, which is resistant to the 2 most effective first-line medications: rifampin and isoniazid [2]. In high-burden settings, pediatric TB comprises 15%-20% of the total disease burden [3-4]; this equates to a global estimate of up to 100,000 children with MDR-TB. Children traditionally have been neglected by both healthcare systems and research [5]. This is especially true for children with drug-resistant (DR)-TB, with fewer than 500 children with MDR-TB described in the medical literature to date [6]. With the imminent roll-out of newer molecular diagnostic tests [7-8], more children will be identified both as confirmed DR-TB cases, as well as presumed TB cases that have been in contact with a DR-TB source case. The limited number of studies to date and challenges evident in data collection highlight the need for improved coordination and standardization of data to ensure the development of an evidence base to inform the management of these children.
The Sentinel Project on Pediatric Drug-Resistant Tuberculosis was formed in 2011 as a virtual community of experts and stakeholders who share the goal of preventing child deaths from DR-TB [9]. More than 200 researchers, healthcare providers, and advocates from over 40 countries are now collaborating in this global network. Task forces take on specific projects that seek to develop, deploy, and disseminate evidence-based strategies for improving the detection and treatment of children with DR-TB. One immediate priority for this network was to establish standardized definitions for key variables, terms, and outcomes, to facilitate study comparisons and research collaborations. The task force that developed this consensus statement has particular experience in carrying out research related to DR-TB in children. The proposed definitions were revised through meetings, conference calls, and written feedback to achieve clarity and consensus.

The current programmatic WHO definitions used to describe adults with DR-TB and children with drug-susceptible (DS) TB were considered to be inadequate for research studies of children with DR-TB. More rigorous definitions were required for use in research that records the epidemiology of exposure, infection and disease, as well as research into diagnosis, treatment, prevention, and outcome. Definitions were intended to be relevant for both prospective studies, in which comprehensive data can be collected, and for retrospective studies. The distinction between definitions used in clinical management, programmatic reporting, and research studies is complex; many research studies document clinical management or report programmatic data. Although we hope that the definitions suggested will strengthen programmatic reporting, this article proposes standardized consensus definitions intended for use in the research setting. These definitions are not intended for use by clinicians who make decisions regarding the management of children with DR-TB infection and disease.

**Terminology and Measures of Exposure**

To facilitate comparisons between different studies it is vital that key terms be standardized. Table 1 provides a summary of the suggested consensus definitions regarding epidemiologic terms, disease classification, type of treatment, and categories of drug resistance.

Exposure is a continuum, with no documented exposure at one extreme and extensive exposure at the other. Although any exposure to a DR-TB source case could potentially result in a child becoming infected, in reality this exposure must reach a significant threshold for the child to be deemed a contact. This necessitates the use of a binary definition. The issue is complex and incorporates elements of the infectiousness of the source case, the proximity and intensity of interaction between source case and contact, the daily duration of interaction, the length of exposure over time, as well as environmental factors such as air exchange [10-11]. Different definitions will provide different degrees of sensitivity and specificity, and it is important that definitions are consistent and well described. Recent interactions are more likely to result in disease in the child compared with interactions that took place more than 1 year ago [12-15].

This task force came to the consensus that a “DR-TB contact” should be defined as a child exposed to an infectious DR-TB source case who, in the last 12 months, had either slept in the same household or had daily interaction with the child [16]. We propose that, if possible, a set of 10 questions be answered to provide an exposure “score” (see Table 1), where the sum of binary responses valued at 0 (no) or 1 (yes) result in a contact score ranging from 0 to 10. This concept comprises 4 unique aspects of TB exposure, which provide a more precise and comprehensive description of the likely infection risk and correlates well with tests of *M tuberculosis* infection [11].

In the same way that exposure is a gradient, so too is the spectrum from exposure through infection to disease [17]. Despite this continuum, it is necessary to assign children into distinct categories for research studies. The terminology used in the literature for children who demonstrate immunological evidence of infection with *M tuberculosis*, in the absence of clinical symptoms, is confusing. Latent TB infection, latent TB, *M tuberculosis* infection, and TB infection have all been used. The word “tuberculosis” implies a disease state, and therefore we thought that TB infection should not be used for a well child. For children who have been recently infected by *M tuberculosis*, the use of the word latency is incongruous because it implies an established immunological equilibrium, which may not have been achieved. We suggest that a child with a positive immunological test (eg, tuberculin skin test or interferon-γ release assay) should be classified as having “*M tuberculosis* infection” to cover both recent and latent infection. This is consistent with other consensus definitions [18]. In order for a child to be classified as having “DR *M tuberculosis* infection,” the child must have a positive immunological test result as well as being a DR-TB contact. The terminology used for children with clinical, radiological, or microbiological pathology is similarly inconsistent across the published literature. “Active disease” is a term used widely to denote an ill child, but “inactive disease” was not felt to be a useful concept. For consistency, we suggest that the term “TB disease” be used.
### Table 1. Proposed Terminology for Drug-Resistant Tuberculosis in Children and the Assessment of Drug-Resistant Tuberculosis Exposure

<table>
<thead>
<tr>
<th><strong>Epidemiological terms</strong></th>
<th><strong>Recommended Term</strong></th>
<th><strong>Definitions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>DR-TB index case</td>
<td>The first identified, confirmed DR-TB case in a social group (e.g., a household) during an investigation or outbreak (which may be the child)</td>
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<tr>
<td>DR-TB source case</td>
<td>An infectious (sputum-smear microscopy or culture positive) DR-TB case who could have infected the contact</td>
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<tr>
<td>DR-TB contact</td>
<td>A child exposed to an infectious DR-TB source case who, in the last 12 months, had either slept in the same household or had daily interaction with the child [16]</td>
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<tr>
<td>DR-TB exposure score</td>
<td>Ten points to be used for exposure score [11]</td>
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<tr>
<td></td>
<td>• Is the source case the child’s mother?</td>
<td></td>
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<tr>
<td></td>
<td>• Is the source case the child’s primary caregiver?</td>
<td></td>
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<tr>
<td></td>
<td>• Does the source case sleep in the same bed as the child?</td>
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<tr>
<td></td>
<td>• Does the source case sleep in the same room as the child?</td>
<td></td>
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<tr>
<td></td>
<td>• Does the source case live in the same household as the child?</td>
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<tr>
<td></td>
<td>• Does the source case see the child every day?</td>
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<td></td>
<td>• Is the source case coughing?</td>
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<td></td>
<td>• Does the source case have pulmonary TB?</td>
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<td></td>
<td>• Is the source case sputum-smear microscopy positive?</td>
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<td></td>
<td>• Is there more than one source case in the child’s household?</td>
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</table>

#### Infection and disease

- **M tuberculosis infection**: A positive immunological test of infection (e.g., tuberculin skin test or interferon-γ release assay), in the absence of symptoms and physical signs (both acute and chronic) [18].
- **DR M tuberculosis infection**: A positive immunological test of infection, in the absence of symptoms and physical signs (both acute and chronic), but in combination with being a DR-TB contact.
- **TB disease**: Clinical, radiological, or microbiological pathology.
- **DR-TB disease**: Clinical, radiological, or microbiological pathology, in combination with diagnosis of confirmed, probable, or possible DR-TB disease (see Table 2).

#### Type of treatment

- **DR-TB treatment**: The treatment of DR-TB disease.
- **DR-TB preventive therapy**: Includes DR-TB pre-exposure (primary) prophylaxis, DR-TB post-exposure prophylaxis (including window prophylaxis), DR-TB secondary prophylaxis, and treatment of DR *M tuberculosis* infection.

#### Drug resistance categories

- **Monoresistant**: Resistance to a single TB drug.
- **Polyresistant**: Resistance to 2 or more TB drugs other than both rifampin and isoniazid.
- **MDR**: Resistant to at least both rifampin and isoniazid.
- **Pre-extensively DR**: MDR-TB with resistance to either a fluoroquinolone, or at least 1 of 3 injectable second-line TB drugs \(^b\), but not both.
- **Extensively DR**: MDR-TB with resistance to both a fluoroquinolone and at least 1 of 3 injectable second-line TB drugs \(^b\).
- **Primary resistance**: DR-TB that results from transmission of a DR *M tuberculosis* strain. This could be any of the after clinical situations in a child newly diagnosed with confirmed or probable DR-TB:
  - (a) *never treated*: a child without previous TB treatment who has not yet received any TB treatment; or
  - (b) *previously treated*: a child who was previously treated with first-line drugs who was either cured or completed that treatment regimen; or
  - (c) *currently receiving treatment*: a child who is receiving first-line drugs for presumed DS-TB disease.

#### Acquired resistance

A child previously diagnosed with confirmed DS-TB disease who developed DR-TB disease (or resistance to additional drugs) during TB treatment.

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**Abbreviations:** DR, drug-resistant; DS, drug-susceptible; MDR, multidrug-resistant; *M tuberculosis*, *Mycobacterium tuberculosis*; TB, tuberculosis.

\(^a\)Either of these 2 components will classify the child as being a DR-TB contact if occurring in the preceding 12 months.

\(^b\)Amikacin, kanamycin, capreomycin [2].
Terms used for the treatment given to those with TB disease include “curative treatment,” “disease treatment,” “anti-TB treatment,” and “TB treatment.” To avoid ambiguity, we suggest using the term “TB treatment.” In the existing literature, there is also inconsistency surrounding the terminology used to describe other forms of chemotherapy. Pre-exposure prophylaxis refers to treatment given to a child without known exposure to an infectious TB case. Postexposure (including window) prophylaxis refers to treatment given to a child after documented TB exposure. Treatment of latent TB infection refers to drugs given after a positive immunological test result indicating previous or current *M. tuberculosis* infection. Posttreatment prophylaxis refers to treatment given to a child after a course of TB treatment. For consistency, we suggest the use of the summative term “TB preventive therapy” to cover all of these circumstances.

**Definitions of Drug Resistance and Testing Methodology**

Although drug resistance is generally divided into the discrete categories of mono-, poly-, MDR-TB or extensively DR-TB [2] (see Table 1), it is more useful to view drug resistance as a continuum. For research into pediatric DR-TB, it is important to describe the precise drug-susceptibility test (DST) pattern. It is also important to record the DST pattern of the likely source case(s), rather than their DST category, when the child has been diagnosed presumptively.

Due to the wide variety of testing methodologies available to determine drug resistance, at a minimum, researchers should clearly state the laboratory techniques used in determining drug resistance. It should be documented to which drugs DST was performed and which techniques were used for each of the drugs. If DST is determined by phenotypic testing, the Clinical and Laboratory Standards Institute standards should be used [19]. It is anticipated that more DST will be carried out using genotypic methods in the future. More than 10 genotypic tests exist using nucleic acid amplification to determine drug resistance [20]. Some assays only determine whether the organism belongs to the *M. tuberculosis* complex and whether mutations in the *rpoB* gene are present (associated with rifampin resistance in >95% cases). The Xpert MTB/RIF assay (Cepheid, Sunnyvale, CA) is one such test, which is currently being rolled out widely [7]. If this test is used and the *rpoB* mutation result is positive, the sample should be recorded as having resistance to rifampin, because this test cannot confirm or rule out resistance to isoniazid. The frequency of rifampin-mono-resistant strains is increasing in some settings [21], and samples found to be rifampin-resistant should therefore not be assumed to also be resistant to isoniazid. Conversely, isoniazid-mono-resistant TB is common in many regions; if a sample is found not to have an *rpoB* gene mutation, it should not be assumed to be fully DS. Consequently, it is important to follow up results from nucleic acid amplification tests that only detect rifampin resistance with additional testing for isoniazid resistance.

The genotypic testing of resistance to isoniazid usually involves testing for mutations in the *inhA* promoter region and the *katG* gene [22]. A molecular line probe assay (e.g., GenoType MTBDRplus; Hain Lifescience, Nehren, Germany) is frequently used for this purpose. As well as recording the presence of genotypic resistance to isoniazid, it is desirable to also record the mutation conferring resistance, because this has clinical and epidemiological significance [23]. Other molecular tests are under development and in the future, genotypic testing to the second-line drugs is likely to become more widespread, because drug resistance to these agents is associated with known gene mutations [24].

**Certainty of Diagnosis of Disease**

When treating children for DR-TB disease, the decision is binary – the child is treated or not. For the clinician, this diagnosis is either confirmed or presumed. Either of these diagnoses may be sufficient for clinical management and for recording and reporting purposes. For research purposes, however, it is important to document the degree of certainty for both the diagnosis of TB and the diagnosis of drug resistance (see Table 2). For the diagnosis of TB disease in children, the WHO first proposed categories of suspect, probable, and confirmed TB for reporting and for research [25]. This classification has recently been refined by a National Institutes of Health expert panel, focusing specifically on intrathoracic disease [18]. For extrathoracic TB, a similar system should be adopted; one has been proposed for TB meningitis [26]. As with the definitions advised by Graham et al [18], at least 1 sign or symptom of TB is required for the research definition of TB disease. Children without clinical manifestations consistent with TB disease will therefore not meet the strict research criteria, even though in clinical practice a physician may initiate treatment.

A definition of “confirmed DR-TB disease” requires clinical evidence of TB disease together with the detection of *M. tuberculosis* from a specimen collected from the child with resistance demonstrated. We strongly support all specimens from children being submitted for culture and DST. A definition of “probable DR-TB disease” should be used when a diagnosis of probable TB disease has been made and the child is a DR-TB contact. Cases should be classified as “possible DR-TB disease” if a diagnosis of probable TB disease has been made and either the child...
fails adherent first-line TB treatment or has been exposed to a source case with risk factors for drug resistance (failed therapy, death, or default with no known DST).

**Previous Episodes and Treatment**

A distinction should be made between a previous episode of disease and any previous treatment given, because this will have implications both for research aimed at improving clinical management of individual patients and for research aimed at improving programmatic strategies. Definitions have been previously proposed for classifying patients who are newly diagnosed, previously treated with first-line drugs, and previously treated with second-line drugs [2]. However, no definitions have been proposed for a previous TB disease episode or for a previous DR-TB disease episode. We propose definitions to classify both of these types of disease episode (see Table 2). One recent study used a 6-month symptom-free period after the completion of at least 1 month of previous treatment as a pragmatic differentiator of disease episodes [27].

For a child newly diagnosed with confirmed or probable DR-TB disease, it is important to distinguish among several clinical scenarios. The first 3 scenarios are examples of transmitted or primary resistance, whereas the fourth is an example of acquired resistance (Table 1):

1. A child without previous TB treatment who has not yet received any TB treatment (primary resistance in a never treated child);
2. A child who was previously treated with first-line drugs who was either cured or completed that treatment regimen (primary resistance in a previously treated child);
3. A child who is currently receiving first-line drugs for presumed DS-TB disease (primary resistance in a child currently receiving treatment); and
4. A child previously diagnosed with confirmed DS-TB disease who developed DR-TB disease during treatment with first-line drugs.

Although clinically it is sensible to suspect the development of resistance in a child if treatment has been poorly adhered to or incorrectly prescribed or supplied, for this conclusion to be reached in a research context, it is necessary to have had an initial DS isolate. Most children with DR-TB disease, however, have transmitted resistance [28].

To document treatment delay, a standard definition of when the DR-TB episode began should be used to determine the interval from the assumed start of the disease episode to the start of DR-TB treatment. Published studies have defined a DR-TB episode as beginning (in the event that DR-TB was subsequently confirmed) at either the child’s initial documented presentation to the healthcare system, when a specimen was obtained that eventually confirmed DR-TB, or alternatively, when the child commenced TB treatment for the current episode, based on whichever was the first documented event [27].

**Site of Disease and Disease Severity**

Site and severity of disease can have an impact on the choice and duration of treatment as well as treatment outcome. Disease severity, for example, has been shown to correlate with bacterial yield in children and culture conversion [27, 29-30]. TB programs usually report disease site using ICD-10 codes [31], and this task force came to the consensus that these codes should be used for reporting disease site in children with DR-TB. Defining the severity of disease in children is challenging and existing approaches are limited. Radiological findings can be used to describe the spectrum of intrathoracic disease and can be an indicator of severity [32]. A recently proposed classification system divides different types of both intra- and extrathoracic childhood TB into severe and nonsevere disease based on known host-pathogen interaction and pathophysiology of disease [29]. Future studies need to ensure the accuracy of this classification system across pediatric TB populations. Furthermore, this classification system should be evaluated prospectively in children with DR-TB disease, because its correlation with treatment response, disease progression, and outcome is still unknown. Where possible, we propose that this classification should be used for research purposes.

**Adverse Events**

Second-line TB drugs are associated with increased risk of adverse events [33]. For research, it is important to determine the type of adverse event, the severity, the relationship to the medications being given, any action taken and any associated risk factors [34]. The Division of Microbiology and Infectious Diseases within the US National Institute of Allergy and Infectious Diseases has published tables to allow the grading of adverse events [35]. These tables are specific for children and we recommend their use for research on pediatric DR-TB. However, a number of adverse events that are frequently encountered in the treatment of children with DR-TB disease and DR M tuberculosis infection are not adequately covered in this classification system [36]. These include thyroid dysfunction, hearing loss, arthralgia, and arthritis. Proposed criteria for grading these adverse events are included in Table 3.

It is important to note the action taken when an adverse event occurs [37]. For each adverse event, we recommend that data be collected documenting whether any action was taken and, if so, what type. Where possible, other factors that may be associated with the adverse event should be recorded. These include comorbidities such as...
Table 2. Classification According to Previous Disease Episodes, Diagnostic Certainty, and Description of Drug-Resistant Tuberculosis Disease in Children

<table>
<thead>
<tr>
<th>Recommended Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Certainty of diagnosis of TB disease [18]</strong></td>
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<tr>
<td>Confirmed TB disease</td>
<td>At least 1 of the signs and symptoms suggestive of TB disease and microbiological confirmation of <em>M. tuberculosis</em></td>
</tr>
<tr>
<td>Probable TB disease</td>
<td>At least 1 of the signs and symptoms suggestive of TB disease and presence of 1 of the following: (a) a positive clinical response to TB treatment, (b) documented exposure to a source case with TB disease, or (c) immunological evidence of TB infection</td>
</tr>
<tr>
<td>Possible TB disease</td>
<td>At least 1 of the signs and symptoms suggestive of TB disease and either (a) a clinical response to TB treatment, documented exposure to a source case with TB disease or immunological evidence of TB infection, or (b) CR consistent with intrathoracic TB disease</td>
</tr>
</tbody>
</table>

| **Certainty of diagnosis of DR-TB disease** | |
| Confirmed DR-TB disease | At least 1 of the signs and symptoms suggestive of TB disease and detection of *M. tuberculosis* from the child with demonstration of genotypic or phenotypic resistance |
| Probable DR-TB disease | DR-TB contact and diagnosis of probable TB disease |
| Possible DR-TB disease | Diagnosis of probable TB disease together with either (a) contact of a source case with TB disease who has risk factors for drug resistance or (b) failure of first-line TB treatment |

| **Previous episodes and treatment** | |
| Previous TB disease episode | An episode of TB disease in which treatment was given for at least 1 month, after which there was a reported symptom-free period of ≥6 months before the start of the current DR-TB disease episode |
| DR-TB disease episode | If DR-TB disease is subsequently confirmed, a TB disease episode that began when the child is first documented to have presented to the healthcare system, when the specimen was obtained that eventually confirmed DR-TB disease, or when the child commenced any TB treatment, whichever is the first available documented event [27] |

| **Previously treated with first-line TB drugs** | Treatment for 1 month or more with any drug in Drug Group 1 [2] |
| **Previously treated with second-line TB drugs** | Treatment for 1 month or more with any drug in Drug Groups 2-5 [2] |

| **Site of TB and disease severity** | |
| ICD-10 code | Code to be recorded [31] |
| Severe disease | A clinical syndrome classified as uncontrolled, disseminated, or complicated [29] |
| Nonsevere disease | A clinical syndrome classified as controlled (limited), non-disseminated, and uncomplicated [29] |

Abbreviations: CR, chest radiograph; DR, drug-resistant; *M. tuberculosis*, *Mycobacterium tuberculosis*; TB, tuberculosis; WHO, World Health Organization.

*Persistent cough, weight loss, or failure to thrive; persistent unexplained fever; persistent unexplained lethargy or reduced playfulness; or the presence of any of the following in the neonate: pneumonia, unexplained hepatosplenomegaly, or sepsis-like illness [18].
*For extrathoracic TB disease, alternative appropriate radiological imaging should be substituted.
*Risk factors for DR-TB include: treatment failure, death during TB treatment, treatment default or nonadherence, previous treatment, exposure to a known DR-TB case, as well as having resided in or traveled to an area with high prevalence of DR-TB [2].
*Disseminate resulting in significant local or peripheral tissue damage and caseous necrosis.
*Drug resulting in infiltration or compression of adjacent bronchial, vascular, cardiac, nervous, or osseous tissue, resulting in functional impairment. Often involves severe sequelae, with the exceptions of peripheral lymph node disease, pleural effusion without emphysema, and skin disease.
human immunodeficiency virus infection (HIV), diabetes, and asthma, as well as the nutritional status and the type and severity of TB disease.

**Disease Outcome**

Adult guidelines typically use microbiological parameters to determine response to treatment. The outcome definitions currently recommended by WHO for adults with DR-TB disease were first proposed by an expert consensus group for use in the analysis of retrospective data. Cure was defined as “five consecutive negative cultures from samples collected at least 30 days apart in the final 12 months of treatment” [2, 38]. For children with DS-TB disease, cure has been defined as a child who is “sputum smear-negative in the last month of treatment and at least one previous occasion” [39]. This task force reasoned that neither of these definitions was appropriate for children with DR-TB disease. Instead, we propose to define “cure” as the completion of treatment, with attainment of clinical (resolution of symptoms and physical signs), radiological (improvement of imaging abnormalities), and microbiological (conversion of cultures) criteria (Table 4).

Because only a relatively small proportion of children will have a confirmed diagnosis at the beginning of their treatment [40-42], and because microbiological investigations are frequently not repeated during follow-up, the majority of children will not fulfill the definition for cure. We chose to define “probable cure” as the presence of the same constellation of features, but without the microbiological component. The proposed definitions for treatment outcome are described in detail in Table 4. One consideration in using this approach relates to the natural history of TB: in some patients, disease involutes without treatment [15]. However, it is impossible to predict which children will respond in this manner and if the research terminology is consistently applied across settings to facilitate comparisons, this should not undermine the value of such definitions.

Treatment response can be divided into clinical, radiological, and microbiological responses. A key component of clinical response is nutritional status, with poor status being a risk for both the development of TB disease as well as poor treatment outcome [43-46]. Nutritional variables that require monitoring, at a minimum, include height and weight. These parameters should be assessed at treatment initiation and then monthly and should then be plotted on standardized growth charts (see Table 4). We propose that an improvement in nutritional status (ie, resolution of failure to thrive) should be included among the criteria used to define “probable cure.” Radiological improvement encompasses partial or complete resolution of chest radiographic features. However, it is important to consider that
<table>
<thead>
<tr>
<th>Treatment outcome</th>
<th>Recommended Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cure</td>
<td>Completion of prescribed treatment(^a) with attainment of clinical (resolution of symptoms and physical signs(^b)), radiological (improvement of imaging abnormalities(^c)), and microbiological (conversion of cultures(^d)) criteria.</td>
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<tr>
<td>Probable cure</td>
<td>Completion of prescribed treatment(^a) with attainment of clinical(^b) and radiological(^c) improvement.</td>
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<tr>
<td>Treatment completed</td>
<td>Completion of prescribed treatment(^a)</td>
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<tr>
<td>Default</td>
<td>Treatment interruption for 2 months or more</td>
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<td>Primary default</td>
<td>Never started on DR-TB treatment</td>
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<tr>
<td>Death</td>
<td>Death for any reason while on DR-TB treatment</td>
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<tr>
<td>Primary death</td>
<td>Death before starting DR-TB treatment</td>
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<tr>
<td>Treatment failure</td>
<td>Ongoing sputum culture positivity, or does not meet criteria for both clinical(^b) and radiological(^c) improvement, after more than 6 months of the child receiving an appropriate DR-TB regimen (with adherence &gt;80%) in the absence of IRIS.</td>
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</table>

**Abbreviations:** DR, drug-resistant; IRIS, immune reconstitution inflammatory syndrome; TB, tuberculosis.

\(^a\)Treatment completion criterion: The duration of prescribed DR-TB treatment will vary according to the study setting and may vary based on the drug-resistance profile and the clinical severity.

\(^b\)Clinical criterion: Resolution of all acute and chronic clinical manifestations (symptoms and physical signs) of TB disease, including both those that are constitutional and those that are specific to the affected anatomical sites. Constitutional manifestations: TB can cause decreased activity level, decreased appetite, failure to thrive, fever, and night sweats. The resolution of failure to thrive should be objectively demonstrated by a weight gain equal or greater than that required to follow the child’s baseline weight-for-age percentile (on the WHO Child Growth Chart [53–54]) over the treatment period. For consistency, we suggest use of the current (pretreatment) percentile, because predisease measurements may not be available in all children. Manifestations specific to the affected anatomical site(s): TB has myriad manifestations given that necrotic lymph node infiltration into contiguous structures and lymphohematogenous spread of *Mycobacterium tuberculosis* can lead to disease in virtually any tissue of the body. An exhaustive list of manifestations is therefore not possible. The following is a list of examples of common tuberculous clinical syndromes, organized by organ systems: pulmonary/pleural (eg, pneumonia; pleural effusion); cardiovascular (eg, pericarditis; vasculitis); digestive (eg, enteritis; pancreatitis; hepatitis); urinary (eg, nephritis); endocrine (eg, adrenal insufficiency; thyroiditis); hematologic (eg, anemia); lymphatic (eg, lymphadenitis; splenic abscess); nervous (eg, meningitis; parenchymal granuloma); musculoskeletal (eg, arthritis; osteomyelitis); integumentary (eg, nodular skin disease); and reproductive (eg, salpingitis; tubo-ovarian mass; epididymitis). All manifestations of persisting disease activity should be resolved by the completion of TB treatment. However, manifestations associated with sequelae (ie, secondary complications after healing of TB disease) such as permanent lung scarring (eg, bronchiectasis), neurological deficits (eg, cognitive impairment; cranial nerve palsy), and joint/bone deformities (eg, gibbus) should be excluded from this criterion.

\(^c\)Radiological criterion: Improvement of imaging abnormalities of all of the following: (a) lymph nodes (after effective DR-TB treatment, the enlarged lymph nodes of the majority of children will have normalized in size; however, a small minority may have mildly enlarged lymph nodes or have developed calcifications); (b) lung parenchyma (after effective DR-TB treatment, the parenchymal lesions of the majority of children will have resolved; however, a minority may only present improvement [reduction in size and/or intensity of lesions], or have developed calcifications or fibrotic lesions); and (c) pleural space (after effective DR-TB treatment, the pleural lesions of the majority of children will have resolved; however, some may have residual pleural thickening or calcifications).

\(^d\)Microbiological criterion: In those children with bacteriologically confirmed disease, at least 3 consecutive negative mycobacterial cultures of respiratory specimens (eg, sputum; gastric aspirate/lavage) during the treatment course, with at least 1 in the last 12 months of treatment, and no positive cultures during the minimum length of treatment after culture conversion.
some children with HIV infection who are started on antiretroviral therapy may experience a radiological deterioration despite clinical improvement due to immune reconstitution inflammatory syndrome (IRIS) [47-49]. Nevertheless, this phenomenon is unlikely to influence classification of final disease outcome, because IRIS typically presents early in the treatment course and resolves before final outcome is determined.

We propose that other treatment outcomes which should be recorded are primary death and primary default. The first term would apply in a child who is diagnosed with DR-TB disease but dies before receiving DR-TB treatment; the second term would apply in a child who refuses treatment or is not given treatment or is lost to follow-up before DR-TB treatment is initiated. Finally, for the purpose of assigning classification of final disease outcome, we propose that the outcome of treatment failure be assigned if a child has had ongoing sputum culture positivity or does not meet criteria for both clinical and radiological improvement (Table 4), after more than 6 months of receiving an appropriate DR-TB treatment regimen in the absence of IRIS. It should be noted that this definition is intended for research use such as analyzing outcomes in treatment cohorts, and it is not intended to guide clinical decisions about individual patients. More research is needed to identify the optimal durations of the intensive and continuation phases for children with DR-TB, as well as to identify optimal cutoffs for assigning final treatment outcomes specifically for children with DR-TB.

CONCLUSIONS

Currently, there is a concerning paucity of data regarding childhood DR-TB and inconsistent use of classifications for cases, treatment, and outcome. More pediatric studies are urgently needed. Overall, the study of children with DR-TB requires similar approaches to research in adults. However, many existing adult tools require adaptation for the specific requirements of studies of childhood DR-TB. The standard definitions and terminology proposed here will allow improvements in data collection for clinical research and reporting of study findings, thereby facilitating comparison across different settings and populations, as well as promoting a stronger evidence base for policymakers and guideline development.

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