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CD Summary

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Tuberculosis Disease in Oregon: A new era emerges

Increase in TB disease cases

Oregon's tuberculosis (TB) incidence has been rising since 2020, reflecting a nationwide trend of increasing incidence. In 2025, the Oregon Health Authority (OHA) TB Program confirmed 100 new TB cases, corresponding to a preliminary incidence rate of 2.3 cases per 100,000 population. This represents the highest annual case count since 2005, and the highest incidence rate since 2010. The 2025 total is 13 cases higher than 2024, when 87 cases were reported (2.0 per 100,000). The factors driving this uptick of TB cases are not yet known. Contact investigation and molecular surveillance data do not suggest increased local transmission or outbreaks. While most cases occurred in metropolitan areas, people were diagnosed with TB disease throughout the state, including in frontier counties. Despite recent increases, Oregon TB incidence remains below the 2024 U.S. rate of 3.1 per 100,000.

Known as the great mimicker, TB is often mistaken for other respiratory illnesses such as pneumonia. This misdiagnosis can delay treatment, leading to severe lung damage or even death. During 2024 and 2025, eight people died of TB disease in Oregon. Delays in diagnosis also increase the risk of TB transmission to household members and the community. *Think. Test. Treat TB* is a CDC public health campaign to raise TB awareness among providers. World TB Day on March 24 is another good opportunity to remind your colleagues about the importance of early detection and treatment.

Assessing for TB risk factors is essential

The primary risk factors for TB exposure include being born in or traveling to TB endemic countries, substance use, and living or working in congregate settings such as shelters or correctional facilities. Immunocompromised conditions, uncontrolled diabetes, kidney disease, age less than 5, and use of immunosuppressive medications (e.g., steroids, tumor necrosis alpha inhibitors) increase the risk of progression to active TB disease after infection occurs.[1]

Symptoms of TB disease

Symptoms of pulmonary TB disease in adults include chronic cough, weight loss, fever and night sweats. TB disease, however, can occur in any part of the body. Symptoms of extrapulmonary disease depend upon the organ or body part involved (e.g., lymph node swelling, meningitis, vision loss, pain or swelling in affected joint). People who have extrapulmonary TB also often have constitutional symptoms such as fevers and extensive weight loss. Unless the person has risk factors for TB, symptoms are most likely related to another disease such as pneumonia or non-tuberculosis mycobacterium (e.g., *M. avium*).

Diagnosing TB disease

For patients who have a risk factor for TB infection and symptoms consistent with pulmonary TB, perform a physical exam and obtain a chest x-ray (CXR). CXR results which could indicate TB disease include cavities (likely highly infectious), infiltrates, pleural effusions, patchy consolidation, or poorly defined linear and nodular opacities. TB disease often occurs in the upper lobes. To learn more about CXR interpretation, review Tuberculosis Radiology Practice Cases from the Curry International TB Center.

In very young children, signs and symptoms of TB disease may be subtle. Children are often identified as having TB disease as part of the contact investigation of an adult case. Symptoms may include cough, fevers and failure to thrive. Typical CXR findings include hilar lymphadenopathy. Seek-

ing consultation through Curry International TB Center or a pediatric infectious disease specialist is strongly advised.

If an adult CXR is indicative of TB, collect 3 sputum samples taken at least 8 hours apart. One sample should be collected in the morning. Order smear and culture for MTB on all three and PCR or GeneXpert on at least one sputum.[2]

Public health's role when a person is diagnosed with TB disease

Both the lab and medical provider are required to report TB disease within one day of identification to the patient's county of residence when TB disease is confirmed. Medical providers should also report if the patient is started on 4-drug TB treatment or if pathology results indicate TB. Latent TB infection is not reportable in Oregon.[3]

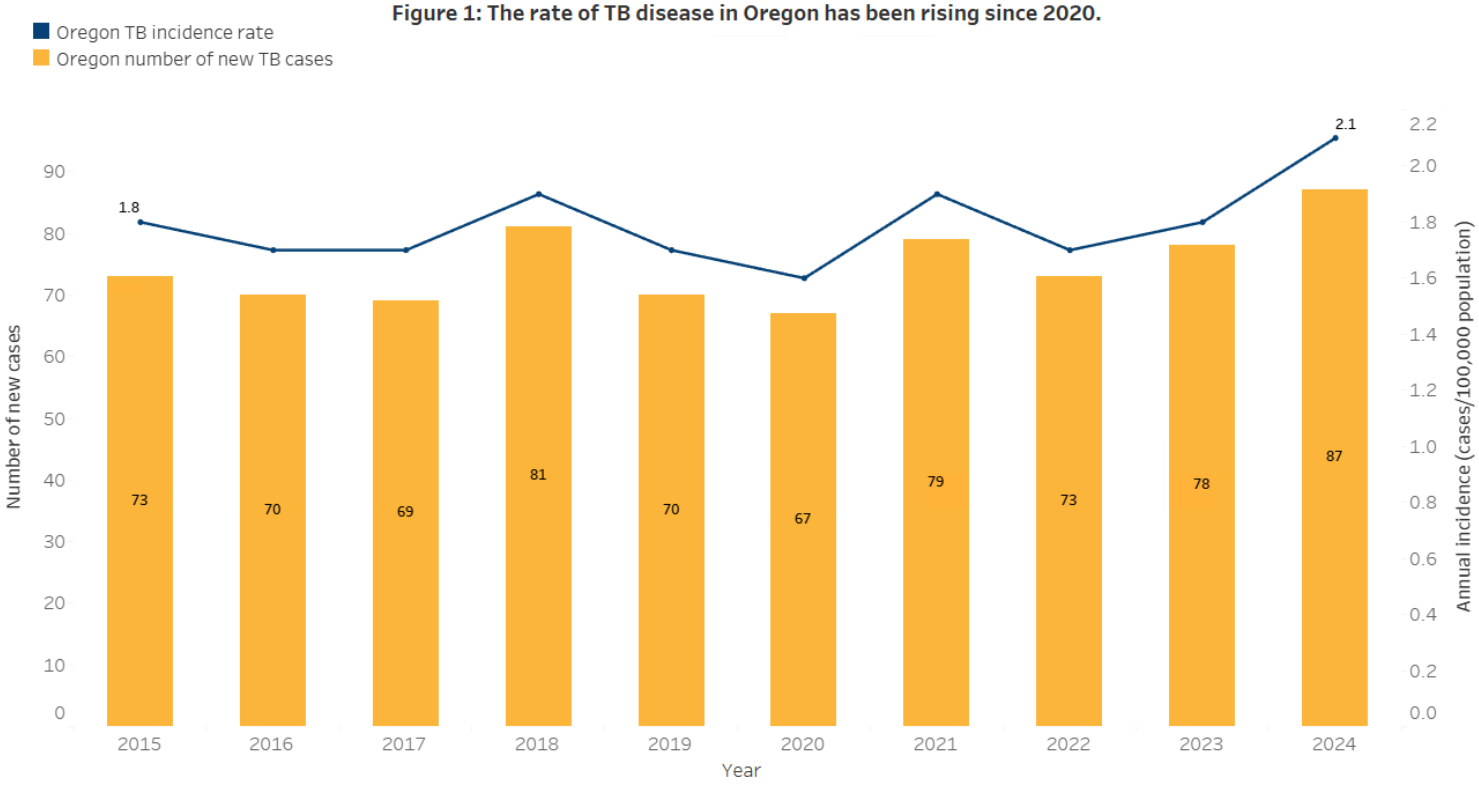
After receiving a report, the role of public health is to help prevent transmission and remove barriers to care for patients. When a person is diagnosed with pulmonary TB disease, public health requires them to stay at home. The duration of home isolation depends on the extent of disease, but most people in Oregon are released from community isolation after five days of TB treatment. Public health ensures the person can stay at home by providing assistance with rent and other life necessities during TB treatment. Public health will also initiate directly observed therapy (DOT). The patient is observed taking their TB medications on weekdays. Finally, a case manager is assigned to the patient to conduct a contact investigation and make certain TB treatment goes according to plan. Due to the nature of the disease and burden to the patient, public health aims to remove barriers to care by providing TB medications and testing for contacts of the case at no cost to patients.

Collaboration between medical providers and public health is essential when caring for TB patients. Unexpected complications such as side effects, hospice care or non-adherence require a team approach to get the patient through the 6–9 months it usually takes to cure TB disease.

Treatment for latent TB infection is highly encouraged, especially for contacts

People with latent TB infection (LTBI) harbor inactive TB bacteria, are asymptomatic, and are not infectious. Contacts of people with TB disease and people with TB risk factors should be screened for LTBI with an interferon

Figure 1: The rate of TB disease in Oregon has been rising since 2020.



gamma release assay (IGRA) or tuberculin skin test (TST) and, if positive, a CXR should be obtained. The risk of LTBI progression to active TB disease is highest during the first two years after initial exposure. Therefore, most patients with LTBI, especially contacts, should be offered treatment with a short-course regimen (e.g., 4 months daily rifampin, 12 dose once weekly isoniazid plus rifapentine, or 3 months daily isoniazid/rifampin). Check carefully for any drug interactions with rifampin and rifapentine before starting treatment.[4]

For more information

Despite the increase in TB cases, the disease is still relatively rare in Oregon. For clinical consultations, contact your local public health department or the OHA TB Program at 503-358-8516 or TB@odhsoha.oregon.gov. The OHA TB Program Website has patient education in multiple languages and many other resources. Additionally, consultations are available through the Curry International TB Center by calling 877-390-6682 or email currytbcenter@ucsf.edu.

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