Infliximab also is approved for Crohn’s disease, and etanercept is approved for specific other arthritides and for psoriasis. Use of these agents has been associated with other life-threatening infectious diseases besides TB, including candidiasis, histoplasmosis, aspergillosis, and listeriosis.1 TNF-α antagonists often are used in conjunction with other immunosuppressive therapies, particularly glucocorticoids and methotrexate. Whether the increased rates of TB or other infectious diseases are caused by interactions among these therapies is unknown.

Diagnosing LTBI in candidates for TNF-α antagonist therapy is challenging (Box). For patients who undergo treatment for LTBI, the optimal time for starting TNF-α antagonist therapy is undetermined. Some experts advocate postponing therapy until LTBI treatment is complete. However, this delay might be impractical.1,6 The risk for TB relapse in patients previously cured of TB disease and subsequently treated with TNF-α antagonists is unknown.

If active TB disease develops during TNF-α antagonist therapy, the TNF-α antagonist should be discontinued, at least until the anti-TB regimen has been started and the patient’s condition has improved. The optimal time for resuming TNF-α antagonist therapy is undetermined. Outcomes with other immunosuppressive agents during the treatment of TB disease have been variable. Use of glucocorticosteroids during the treatment of TB disease is considered safe,7 and studies of TB disease in organ transplant recipients suggest that survival is not decreased by the use of cyclosporine or azathioprine.8 Etanercept, administered in a phase-1 clinical trial along with a standard initial anti-TB regimen, did not delay the resolution of TB disease markers in a group of patients coinfected with human immunodeficiency virus in comparison with historical controls; adverse effects were not detected.9 However, use of anti–T-cell agents in transplant recipients with TB disease is associated with increased mortality; whether this increased mortality is because of the suppression of immune response or the dysfunction of the transplanted organ is unclear.8

Practitioners who prescribe TNF-α antagonists should educate their patients about the symptoms of TB disease, with added emphasis on extrapulmonary symptoms, which can include fever, malaise, or development of a mass. A patient with symptoms should undergo diagnostic testing for TB. In addition to following local reporting requirements, health-care providers should report TB cases associated with TNF-α antagonists to FDA’s MedWatch system (available at http://www.fda.gov/medwatch).

Ongoing clinical trials are using both approved and experimental TNF-α antagonists in the treatment of additional conditions.1 Novel therapies that inhibit other related inflammatory cytokines are under development. As the use of these blocking agents expands, associated cases of TB might increase. Vigilance for TB in association with these agents is critical to early recognition and successful treatment.


REFERENCES

9 available

Availability of Revised Guidelines for Identifying and Managing Jaundice in Newborns

MMWR. 2004;53:590-591

The American Academy of Pediatrics has published revised guidelines for identifying and managing jaundice in newborns. Jaundice is caused by an increase in serum bilirubin concentration (i.e., hyperbilirubinemia) and makes the skin appear yellow. Excessive hyperbilirubinemia can lead to permanent brain damage (i.e., kernicterus).1 The revised guidelines were developed to promote greater uniformity and consistency of care for all newborns. Four key recommendations were emphasized for physicians:

- Perform a systematic assessment of all infants before their discharge from the birth hospital. This assessment will determine their risk for severe jaundice and can be performed by measuring the total serum bilirubin or transcutaneous bilirubin levels, or assessing risk factors, or both.2
- Provide appropriate follow-up based on the time of discharge. A follow-up visit should be scheduled within 3-5 days of an infant’s birth, when the bilirubin level is likely to be highest.
- Promote and support successful breastfeeding practices. Encourage breastfeeding at least 8-12 times a day in the first days of an infant’s life. Effective breastfeeding can reduce substantially the risk for hyperbilirubinemia.
- Provide parents with written and oral information about the risks associated with jaundice in newborns. Information about jaundice in newborns is available at http://www.aap.org/family/jaundicefaq.htm.

CDC supports the use of these guidelines for eliminating kernicterus and hyperbilirubinemia. In 2001, CDC reported an increase of kernicterus cases in the United States2 and encouraged systematic assessment of bilirubin levels in newborns before their discharge from the birth hospital, along with proper follow-up care, lactation support, and parent education about jaundice. Additional information about kernicterus is available at http://www.cdc.gov/ncbddd/dd/kernicterus.htm. Information about the revised guidelines is available at http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;114/1/297.

REFERENCES