A study on the assessment of retreatment tuberculosis patients attending the DOTS centre in Sikkim, India from 2002-2010

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Abstract

Background: Sikkim, India has maintained the global targets of 70% detection and 85% cure of the new smear positive cases since 2003; however, the rate of retreatment cases have become a matter of concern. An accurate analysis of the retreatment cases and their treatment outcome is needed to ascertain the strengths and weaknesses in the management of retreatment.

Methods: Diagnosis, classification, chemotherapy and outcomes following treatment were noted. Treatment details were updated regularly and the patient's final outcome was recorded at the end of their treatment. Annual notification and treatment outcome analysis was conducted for retreatment cases as a whole as well as for each sub-category of retreatment independently. The Chi square test was used to assess the statistical significance of each rate ratio. A statistical test was considered significant when the P value was <0.005.

Results and discussion: Overall relapse cases (63.8%) were the most common; followed by failure cases (20.8%) and treatment after default cases (15.2%). Overall cohort analysis of retreatment cases shows treatment cure rate of 62.4% and treatment failure of 22.1%. Stratified cohort analysis highlights treatment cure rate of 70.4% and 34.1% among relapses and failures. The treatment failure rate for failures was 45.2%, strongly suggesting multi drug resistance (MDR); this highlights the need to implement measures to reduce the number of failures. Among the treatment after default the default rate was 6.7%; strict treatment adherence and positive patient's attitude and behaviour towards the disease is the main solution to avoid defaulting.

Conclusion: In the retreatment category relapse cases were the most common retreatment category however these patients were more likely to be cured with the Category II retreatment regimen; patients who failed the Category I treatment were most likely to wound up as failures on the Category II retreatment regimen, and first time defaulters had a significant risk of defaulting from the Category II retreatment regimen. Controlling the need for retreatment is the best known strategy, apart from this continuous monitoring, adherence and treatment completion is essential in order to improve tuberculosis control.

Keywords: Retreatment category, failure, relapse, treatment after default and tuberculosis

Introduction

Tuberculosis (TB) remains a worldwide healthcare concern and is a major health problem in Sikkim, India. Based on the findings and recommendation of the 1992 review Committee of National Tuberculosis Programme (NTP), Government of India revised its strategy and introduced Revised National Tuberculosis Control Programme (RNTCP) in October 1993. Sikkim is a small hilly north eastern state of India. It is fully covered under RNTCP from 1st March 2002. With the implementation of RNTCP; Sikkim has had a progressive increase and maintained the global targets of 85% cure of new smear positive patients and detection of at least 70% of the new smear positive cases since 2003 [1], these indicators are tantamount with good programme performance however, the treatment outcome of patients on retreatment has remained unchanged over the years; the treatment failure of the failure group has increased from 40.8% in 2009 to 50% in 2010, similarly the treatment failure in default group has increased from 15.6% in 2009 to 22.4% in 2010 [2,3], hence, the study aims to find out the effectiveness of the DOTS program by analyzing the retreatment category and their treatment outcome. According to the recommendations of the World Health Organization (WHO), patients with recurrent tuberculosis are defined as retreatment cases and are eligible for the standardized category II treatment regimen [4]. An accurate analysis of all the information recorded on the treatment outcome of retreatment cases is needed to identify strengths and weaknesses in the management of retreatment cases and to discuss possible measures for improving tuberculosis care in this group of patients. Under the RNTCP, the percentage of smear positive retreatment cases out of all smear positive cases is 24% [5]. According to the RNTCP data for 2009, the cure rate among the retreatment group was 64%, mortality rate 7.8%, failure rate 5.6% and default rate about 14.1% [2]. Despite of the differences in the outcomes of the retreatment category, they are however, treated with the same regimen under the program. Outcome after retreatment is normally worse and costly because of the cost of extended treatment and second line drugs and emergence of drug resistance. The objective of the study was to describe and discuss notification and treatment outcome data of retreatment cases that underwent category II treatment regimen during the period 2002-2010 in Sikkim, India. Cohort analysis were performed on the group of
re-treatment cases as a whole as well on each sub-category of re-treatment cases independently.

Materials and methods

Sikkim is administratively divided into 4 districts, 5 TB units, 20 Designated Microscopy Centres, and 698 DOTS centres. According to the national guidelines, TB patients receiving the category II treatment regimen are registered and monitored in three different sub-categories, namely.

Relapse

A TB patient who was declared cured or treatment completed by a physician, but who reports back to the health service and is now found to be sputum smear-positive.

Treatment after default

A TB patient who received anti-tuberculosis treatment for one month or more from any source and returns to treatment after having defaulted, i.e., not taken anti-TB drugs consecutively for two months or more, and is found to be sputum smear-positive.

Failure

Any TB patient who is smear-positive at 5 months or more after starting treatment. These case definitions did not change over the study period. All smear positive confirmed pulmonary tuberculosis patients who were given the category II treatment regimen from 2002 to 2010 in the RNTCP of Sikkim were enrolled in this retrospective study. A standardized retreatment regimen was used consisting of isoniazid (H), rifampicin (R), pyrazinamide (Z) ethambutol (E) and streptomycin (S) \([2H, R, Z, E, S]+1H, R, Z, E, S+5H, R, E, S]\). The number before the letters refer to the number of months of treatment and the subscript after the letters refers to the number of doses per week. Diagnosis, classification and chemotherapy were performed according to the RNTCP guidelines [6], and outcomes following treatment were noted. The records of all patients who receive anti-tubercular treatment are kept in the tuberculosis register at the tuberculosis unit (TU). Treatment details were updated regularly and the patients’ final outcome was recorded at the end of their treatment. The TU compiles information about all TB patients entered in the unit register. The TU prepares report for case detection and treatment outcome quarterly and submits the report to the district tuberculosis officer (DTO), who is responsible for compiling the reports from all the units and submits them, to the state tuberculosis officer (STO). STO compiles reports from all districts and submits them to the central TB division.

Annual notification and treatment outcome analysis was conducted for re-treatment cases as a whole as well as for each sub-category of re-treatment independently for the years 2002-2010. Rate ratios were used to assess the differences in treatment outcome between re-treatment sub-categories. The Chi square test was used to assess the statistical significance of each rate ratio. A statistical test was considered significant when \(P\) was <0.005.

As the study was anonymous and retrospective data analysis, no ethical approval was sought except the administrative clearance was obtained from the state TB cell, Government of Sikkim, state task force (RNTCP) and PhD review committees of Sikkim Manipal University, India.

Results

During the study from 2002 to 2010 in all the four districts of Sikkim; a total of 6827 cases were registered for pulmonary tuberculosis. Out of these cases, 6051(88.6%) were cured; 205(3%) had died; 399(5.8%) had failed; 124(1.8%) had defaulted and 48(0.7%) were lost to follow up. A total of 1855 pulmonary tuberculosis patients were put on Category II re-treatment regime (1185 relapse cases, 387 failures and 283 treatment after default). The total re-treatment rate of Sikkim is 1855(27.1%). Over the years, we observed that relapse cases 1185(63.8%) were found to be the most common in the re-treatment category; followed by failure cases 387(20.8%) and treatment after default cases 283(15.2%). The overall cohort analysis which presents annual treatment outcomes of re-treatment cases considered as a whole, shows treatment cure rate of 62.4% (range 57.7%-65.9%), treatment failure of 22.1% (range 15.4%-27.1%), mortality rate of 8.71% (range 6.5%-14.1%) and default rate of 4.3% (range 3.0%-6.5%) (Figure 1). However, stratified cohort analysis highlights relevant differences between the three sub-categories of re-treatment cases. Among relapses, the treatment success rate was 835(70.4%) and the treatment failure rate was 185(15.6%). Among patients who failed the category I treatment regimen, the treatment success rate was only 132(34.1%); while the treatment failure rate was 175(45.2%) and the mortality rate was 50(12.9%). Among those who interrupted one course of treatment and then received the category II treatment regimen the treatment success rate was 190(67.1%) and the default rate was 19(6.7%) (Table 1). The comparison of treatment outcome between the sub-categories shows that treatment success rates are significantly higher among the relapse cases than among patients who failed category I (\(P<0.005\)) and among those who defaulted from one previous course of anti-tuberculosis treatment (\(P<0.005\)) in all the years. Failure rates are also significantly and consistently higher in patients who failed category I treatment than in default cases (\(P<0.005\) but in two years), while no clear differences can be demonstrated with relapse cases. Default rates was not found to be significant in patients who defaulted from one previous course of anti-tuberculosis treatment compared to those who failed category I treatment and for those who relapsed, it was found to be significant only in two years (Table 2).

Discussion

Retreatment cases represent a serious threat to TB control in many settings, and could significantly undermine the overall
success of the DOTS strategy. This article presents an analysis of outcome of anti-tuberculosis treatment of patients who underwent the category II regimen. In our study, the rate of relapse, treatment failure and default cases were 63.8%, 20.8% and 15.2% respectively. We observed that the largest group who had received previous RNTCP treatment was relapse cases. Chandrasekar and Mehra have also found higher relapse rates in their studies [7,8]. It is also to be mentioned that RNTCP does not follow up on patients for any period of time after successful completion of treatment to determine whether they relapse or not [9]. Similar results have been observed in several other settings such as Korea, Nicaragua and some provinces of China [10-12].

The overall cohort analysis shows conflicting results between the years, Sikkim has shown cure rate of 62.4% among the retreatment category and are always associated with higher failure rate of 22.1% and death rate of 8.7%. The chances of high failure rate will have an utmost impact on the

Table 1. Rates of treatment success, failure and default by subcategory of retreatment cases in Sikkim, 2002-2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>Relapse (n)</th>
<th>Success (%)</th>
<th>Treatment Failure (%)</th>
<th>Default (%)</th>
<th>Failure (n)</th>
<th>Success (%)</th>
<th>Treatment Failure (%)</th>
<th>Default (%)</th>
<th>Total (n)</th>
<th>Success (%)</th>
<th>Treatment Failure (%)</th>
<th>Default (%)</th>
</tr>
</thead>
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<tr>
<td>2002</td>
<td>47</td>
<td>70.2</td>
<td>14.8</td>
<td>2.1</td>
<td>11</td>
<td>45.4</td>
<td>45.4</td>
<td>-</td>
<td>27</td>
<td>55.5</td>
<td>18.5</td>
<td>7.4</td>
</tr>
<tr>
<td>2003</td>
<td>111</td>
<td>71.1</td>
<td>12.6</td>
<td>5.4</td>
<td>32</td>
<td>28.1</td>
<td>53.1</td>
<td>6.2</td>
<td>51</td>
<td>78.4</td>
<td>13.7</td>
<td>-</td>
</tr>
<tr>
<td>2004</td>
<td>111</td>
<td>65.7</td>
<td>20.7</td>
<td>5.4</td>
<td>38</td>
<td>52.6</td>
<td>26.3</td>
<td>5.2</td>
<td>30</td>
<td>66.6</td>
<td>20.0</td>
<td>6.6</td>
</tr>
<tr>
<td>2005</td>
<td>169</td>
<td>78.1</td>
<td>11.2</td>
<td>2.9</td>
<td>42</td>
<td>45.2</td>
<td>40.4</td>
<td>4.7</td>
<td>29</td>
<td>75.8</td>
<td>3.4</td>
<td>10.3</td>
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<tr>
<td>2006</td>
<td>144</td>
<td>69.4</td>
<td>14.5</td>
<td>5.5</td>
<td>48</td>
<td>37.5</td>
<td>43.7</td>
<td>4.1</td>
<td>22</td>
<td>77.2</td>
<td>-</td>
<td>18.1</td>
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<tr>
<td>2007</td>
<td>144</td>
<td>68.7</td>
<td>15.2</td>
<td>2.7</td>
<td>58</td>
<td>22.4</td>
<td>58.6</td>
<td>5.1</td>
<td>25</td>
<td>76.0</td>
<td>12.0</td>
<td>-</td>
</tr>
<tr>
<td>2008</td>
<td>152</td>
<td>73.0</td>
<td>19.7</td>
<td>1.3</td>
<td>44</td>
<td>20.4</td>
<td>56.8</td>
<td>6.8</td>
<td>29</td>
<td>62.0</td>
<td>20.6</td>
<td>10.3</td>
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<tr>
<td>2009</td>
<td>157</td>
<td>67.5</td>
<td>19.7</td>
<td>4.4</td>
<td>51</td>
<td>35.2</td>
<td>39.2</td>
<td>3.9</td>
<td>37</td>
<td>51.3</td>
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<td>8.1</td>
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<tr>
<td>2010</td>
<td>150</td>
<td>68.0</td>
<td>22.6</td>
<td>4.0</td>
<td>63</td>
<td>33.3</td>
<td>41.2</td>
<td>3.1</td>
<td>33</td>
<td>60.6</td>
<td>15.1</td>
<td>6.0</td>
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</table>

Table 2. Rate ratios of treatment success, treatments failure and default across retreatment categories in Sikkim, 2002-2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>Relapse/Failure</th>
<th>Relapse/Treatment after default</th>
<th>Failure/Relapse</th>
<th>Failure/Treatment after default</th>
<th>Treatment after default / Relapse</th>
<th>Treatment after default / Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>38.3*</td>
<td>12.0*</td>
<td>0.16</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>2003</td>
<td>108.2*</td>
<td>24.2*</td>
<td>0.25</td>
<td>6.75*</td>
<td>8.33*</td>
<td>1.00</td>
</tr>
<tr>
<td>2004</td>
<td>58.1*</td>
<td>58.1*</td>
<td>8.72*</td>
<td>1.125</td>
<td>2.25</td>
<td>0.00</td>
</tr>
<tr>
<td>2005</td>
<td>166.1*</td>
<td>154.2*</td>
<td>0.05</td>
<td>25.0*</td>
<td>0.25</td>
<td>0.00</td>
</tr>
<tr>
<td>2006</td>
<td>111.2*</td>
<td>114.9*</td>
<td>0.00</td>
<td>38.0*</td>
<td>1.50</td>
<td>0.33</td>
</tr>
<tr>
<td>2007</td>
<td>129.0*</td>
<td>105.7*</td>
<td>4.32*</td>
<td>48.6*</td>
<td>4.50*</td>
<td>2.66</td>
</tr>
<tr>
<td>2008</td>
<td>170.0*</td>
<td>131.2*</td>
<td>0.58</td>
<td>20.9*</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>2009</td>
<td>122.0*</td>
<td>118.3*</td>
<td>3.92*</td>
<td>8.64*</td>
<td>1.8</td>
<td>0.00</td>
</tr>
<tr>
<td>2010</td>
<td>104.0*</td>
<td>107.5*</td>
<td>1.63</td>
<td>25.8*</td>
<td>2.25</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*Statistically significant (P<0.05)
morbidity and mortality of tuberculosis in the state, causing to be a matter of grave concern. This analysis highlights the need to manage and implement measures to reduce the number of failures. However, the low default rate of 4.3% determines good supervision of the committed workers of RNTCP by improving the case holding, better performance and effective management of the programme.

On further analysis of treatment outcome by subcategory of retreatment shows good cure rate among the relapse cases and default cases (70.1% and 67%), however, lower that the national data of 74% and 68% respectively [13]. Mukherjee [14] have reported (76.35%) of their relapse patient put on category II therapy as having a positive outcome. Hence, patients who relapse after receiving a single course of antituberculosis treatment are more likely to be cured with category II retreatment regimen. But this was not the case for failure cases which had worse treatment outcome. The treatment failure was found to be very high in all the three categories (above 10%) throughout the years. Similar results have been reported under RNTCP from all over the country with a failure rate of 15.5% for failure group as compared to relapse group 4.8% [5]. This has already been observed in several studies that have shown that failures are significantly associated with multi drug resistance (MDR) [15-16]. In these categories of patients, the standard retreatment regimen is inadequate and should be assessed for drug resistant tuberculosis and then ultimately make the most of the second line drugs [17-18].

It is a known fact that patients who interrupt their first course of treatment have a significant and consistently higher probability of interrupting a retreatment regimen compared to other cases. In our study we also observed that the frequency of defaulting was more in default cases (13.8%) than in failure cases (4.34%) and relapse cases (3.74%), though the figure was lower than the national data (18%) [4]. For these particular cases, treatment adherence is the main solution, apart from this patient’s attitude and behaviour towards the disease is also a major factor influencing treatment adherence. There can be many reasons for a patient not co-operating with the treatment. Other risk factors have been described as lack of health knowledge; distance to treatment centre, patient’s economic status [19-20]. Migration due to one’s work as been the main cause of defaulting among the tuberculosis patients in Sikkim [21]. Studies have shown most defaulters tend to discontinue their treatment again; hence exploring the risk factors for defaulting may help the programme by setting up health education, counseling of the patients, better tracking system of the patients and treatment adherence should be strongly emphasized to them.

Conclusion
Persistent monitoring of treatment outcomes of relapse, failure and default cases is crucial for improving TB control. The analysis has shown that in Sikkim: relapse cases were the most common retreatment category; patients who relapse after receiving a single course of anti-tuberculosis treatment were more likely to be cured with the Category II retreatment regimen; patients who failed the Category I treatment have a high risk of also failing on the Category II retreatment regimen, and patients who default from a first anti-tuberculosis treatment regimen have a significant risk of also defaulting from the Category II retreatment regimen. Hence, our national TB program should be designed on guidelines where failure cases are prevented from failing again and default cases from defaulting again. Controlling the need for retreatment is the best known strategy in the first place, apart from this continuous monitoring, adherence to treatment and treatment completion is essential to review the tuberculosis control programme in order to improve tuberculosis control.

Competing interests
The authors declare that they have no competing interests.

Authors’ contributions
Karma G. Dolma conceived, designed, acquired data, analyzed & interpreted, statistical analysis & drafted the manuscript. Peggy Dadul, Tsering Laden & Lalita Singhig acquired data, supervision, critical revision of data. Luna Adhikari conceived & designed, supervision, critical revision. J. Mahanta designed, analyzed & interpreted, supervision & critical revision for important intellectual content.

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