

**American College of Radiology  
ACR Appropriateness Criteria®  
Imaging of Possible Tuberculosis**

**Variant: 1 Suspect active tuberculosis.**

Procedure	Appropriateness Category	Relative Radiation Level
Radiography chest	Usually Appropriate	☢
CT chest without IV contrast	Usually Appropriate	☢☢☢
CT chest with IV contrast	May Be Appropriate	☢☢☢
MRI chest without and with IV contrast	Usually Not Appropriate	○
MRI chest without IV contrast	Usually Not Appropriate	○
CT chest without and with IV contrast	Usually Not Appropriate	☢☢☢

**Variant: 2 Newly positive PPD or IGRA OR positive PPD or IGRA with unknown prior status.  
No clinical symptoms.**

Procedure	Appropriateness Category	Relative Radiation Level
Radiography chest	Usually Appropriate	☢
CT chest with IV contrast	May Be Appropriate	☢☢☢
MRI chest without and with IV contrast	Usually Not Appropriate	○
MRI chest without IV contrast	Usually Not Appropriate	○
CT chest without and with IV contrast	Usually Not Appropriate	☢☢☢
CT chest without IV contrast	Usually Not Appropriate	☢☢☢

**Variant: 3 PPD not available. Placement in group home or skilled nursing facility. No clinical symptoms.**

Procedure	Appropriateness Category	Relative Radiation Level
Radiography chest	Usually Appropriate	☢
MRI chest without and with IV contrast	Usually Not Appropriate	○
MRI chest without IV contrast	Usually Not Appropriate	○
CT chest with IV contrast	Usually Not Appropriate	☢☢☢
CT chest without and with IV contrast	Usually Not Appropriate	☢☢☢
CT chest without IV contrast	Usually Not Appropriate	☢☢☢

James G. Ravenel, MD<sup>a</sup>, Jonathan H. Chung, MD<sup>b</sup>, Jeanne B. Ackman, MD<sup>c</sup>, Patricia M. de Groot, MD<sup>d</sup>, Geoffrey B. Johnson, MD, PhD<sup>e</sup>, Clinton Jokerst, MD<sup>f</sup>, Fabien Maldonado, MD<sup>g</sup>, Barbara L. McComb, MD<sup>h</sup>, Robert M. Steiner, MD<sup>i</sup>, Tan-Lucien H. Mohammed, MD<sup>j</sup>

**Summary of Literature Review**

**Introduction/Background**

Pulmonary tuberculosis (TB) predominantly results from the transmission of aerosolized mycobacterium TB to susceptible hosts [1]. In the vast majority of cases, this results in subclinical

disease with the immune system isolating the organism. In this setting, a person has latent TB and does not pose a risk to the community at large. The development of active infection within 1 year following exposure is termed primary TB and is classically described as a lobar pneumonia and/or mediastinal and hilar adenopathy. This pattern is most often seen in children and severely immunocompromised individuals. If active infection develops later than 1 year after initial exposure, it is considered to be reactivation TB, often presenting with apical posterior upper-lobe or superior-segment lower-lobe fibrocavitary disease and endobronchial spread through the airways.

With modern molecular techniques it has been shown that radiographic patterns of primary and reactivation TB overlap, and thus the preferred terminology for TB infection is active TB [2]. The important public health issue is that both primary and reactivation TB present a risk of exposing the general population to TB infection.

A high level of suspicion should be maintained in immunocompromised hosts, particularly those with AIDS, as imaging manifestations may not fit a classic primary or reactivation pattern; instead, these patients may present with mediastinal lymphadenopathy alone or a deceptively normal chest radiograph.

## **Overview of Imaging Modalities**

### **Chest radiograph**

The chest radiograph is usually the first study performed in patients suspected of having TB. Although frontal and lateral radiographs are often performed in this setting, it has been shown that the lateral radiograph does not improve the detection of findings related to TB [3]. In those with signs or symptoms of disease, the radiographic pattern of upper-lobe or superior-segment lower-lobe fibrocavitary disease in the appropriate clinical setting is sufficient to warrant respiratory isolation and sputum culture for definitive diagnosis. Using radiographs in combination with clinical evaluation results in a high sensitivity for the diagnosis but a relatively low specificity for both latent [4] and active TB [5]. In addition, radiographs may reveal ancillary findings of TB such as pleural effusion or spondylitis. For immunocompromised hosts, particularly those with a low CD4 count, computed tomography (CT) should be considered.

### **Computed tomography**

The major advantage of CT is increasing the specificity of the diagnosis of TB; therefore, CT is often not necessary in the acute setting, particularly when the disease is already suspected and appropriate precautions and testing are already underway. CT may be able to better show distinct findings such as cavitation or endobronchial spread with tree-in-bud nodules and may be helpful in cases in which the chest radiograph does not show "classic" findings of TB [6]. CT findings can also be helpful in predicting acid-fast bacilli smear positivity [7-9]. Even in acid-fast bacilli smear-negative patients, CT may suggest the risk that a patient will be TB culture positive when findings consistent with active TB are present [10]. CT may be of value in the severely immunocompromised patient with a normal or near-normal radiograph by revealing abnormal lymph nodes or subtle parenchymal disease. Finally, CT may also have a role in identifying patients with latent TB who will be at risk for reactivation disease [4,11].

### **Magnetic resonance imaging**

Only 1 study has been performed evaluating magnetic resonance imaging (MRI) for suspected TB.

In this study the accuracy of MRI was similar to CT in describing findings related to culture-positive patients [12]. Inferential data regarding the value of MRI can also be derived from its role in cystic fibrosis and the observation in other settings that MRI correlates well with CT for parenchymal findings including bronchiectasis, cavitation, and tree-in-bud nodules [13]. Although MRI is technically feasible and described in the literature, MRI has not been specifically evaluated as a primary imaging modality for patients with suspected or proven TB.

#### Nuclear scintigraphy

Several nuclear radiopharmaceuticals have been employed for the purpose of evaluating possible TB, particularly for differentiating active from inactive tuberculomas and distinguishing tuberculomas from neoplasms. In small studies, Tc-99m methoxyisobutylisonitrile has shown higher activity over background in active tuberculomas compared with inactive tuberculomas [14,15]. Similarly, metabolic activity measured by fluorine-18-2-fluoro-2-deoxy-D-glucose positron emission tomography (FDG-PET) is higher in active tuberculomas. Dual-time-point FDG-PET imaging (1 and 2 hours postinjection) can also help differentiate active tuberculomas from neoplasms, owing to the longer retention of FDG in benign lesions [16]. Gallium 67 has been used to follow patients for disease activity and correlates with the number of organisms on sputum smears [17]. Evidence for the use of nuclear imaging to diagnose active TB is limited to either small single-site studies or several small studies, and the impact on clinical practice and patient care at this time is minimal.

### **Discussion of Procedures by Variant**

#### **Variant 1: Suspect active tuberculosis.**

The initial suspicion of active TB should be made based on clinical symptoms and demographics. Those at particular risk include those in close contact with patients having active TB, spending time in a TB-endemic country, or working/spending time in sites where TB is more prevalent, such as prisons, homeless shelters, and long-term care facilities. Those who are immunocompromised are at particular risk. Included in this category are also individuals with a newly positive purified protein derivative (PPD) skin test or a positive interferon-gamma release assay (IGRA) and who have symptoms that could be related to active TB. Clinical symptoms of active TB may include unexplained weight loss, night sweats, fever, prolonged cough, hemoptysis, and fatigue.

#### **Variant 1: Suspect active tuberculosis.**

##### **A. Chest radiography**

Identified individuals should undergo chest radiography as the initial test. Chest radiographs have been shown to have a high sensitivity for detecting manifestations of active TB [5]. Chest radiography has a high sensitivity but relatively poor specificity owing to the overlap of findings with nontuberculous pulmonary infection. The yield of chest radiographs in high-risk patients ranges from 1% to 7%, although it is not clear how many of these cases would have been suspected based on clinical symptoms alone [18,19].

In particular, lobar pneumonia with associated hilar and/or mediastinal adenopathy or cavitory air space disease involving the apical posterior segments of the upper lobe or superior segment of the lower lobe should raise particular concern [20]. When a chest radiograph confirms the clinical suspicion of active TB, it is sufficient to warrant respiratory isolation pending sputum cultures. However, in patients who are immunocompromised, particularly those with AIDS and very low CD4 counts, chest radiographs may be deceptively normal.

## **Variant 1: Suspect active tuberculosis.**

### **B. Computed tomography**

The role of CT remains less clear, but it should be considered for those with equivocal chest radiographic findings and may be efficacious in excluding active TB owing to its higher specificity. High-risk acid-fast bacilli smear–negative patients may also benefit from CT. AIDS patients with low CD4 counts and those taking anti–tumor necrosis factor medications have sufficient risk to warrant CT in the setting of high clinical suspicion for active TB and an unrevealing chest radiograph.

## **Variant 1: Suspect active tuberculosis.**

### **C. Magnetic resonance imaging**

MRI is a reasonable consideration for use in select patients for whom there is a desire to avoid ionizing radiation.

## **Variant 2: Newly positive PPD or IGRA OR positive PPD or IGRA with unknown prior status. No clinical symptoms.**

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### **A. Chest radiography**

One key principal of PPD testing is application in those at high risk for developing latent TB infection. This may include those who work in settings where contact with active TB is possible and those coming from regions where TB is endemic. Although screening of low-risk individuals is discouraged, it is recommended for those whose future activity will place them at high risk for exposure or reactivation. The rationale behind performing chest radiography following a positive PPD is to distinguish latent TB from active TB, as these are managed differently. However, in patients without clinical symptoms the yield of radiographs for active TB (that would change management) is negligible [21]. Furthermore, parenchymal findings of latent TB are relatively poor predictors of future reactivation. If a chest radiograph is performed, a frontal view is sufficient [3].

## **Variant 2: Newly positive PPD or IGRA OR positive PPD or IGRA with unknown prior status. No clinical symptoms.**

### **B. Computed tomography**

CT should be reserved for the rare case in which a chest radiograph may be equivocal for active TB and cases for which knowledge of latent TB abnormalities may inform future care, such as patients undergoing solid organ transplantation and biologic therapy for rheumatologic disease [4,11].

## **Variant 2: Newly positive PPD or IGRA OR positive PPD or IGRA with unknown prior status. No clinical symptoms.**

### **C. Magnetic resonance imaging**

Like CT, there is a very limited role for MRI, although it may be considered when cross-sectional imaging is deemed necessary in a patient for whom there is a desire to avoid ionizing radiation.

## **Variant 3: PPD not available. Placement in group home or skilled nursing facility. No clinical symptoms.**

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### **A. Chest radiography**

Low-risk screening also frequently occurs in patients being transferred to correctional institutions,

group homes, and skilled nursing facilities. Because of time constraints related to placing and interpreting a PPD, chest radiography has emerged as a surrogate measure. A meta-analysis of homeless populations suggests that using chest radiography as a screening measure is sufficient and can lead in some cases to a decline in the incidence of TB over time [19]. This study, however, did not compare chest radiography screening to other screening strategies in terms of efficacy. Screening procedures vary from one prison site to another. There does not appear to be a large discrepancy in TB incidence regardless of screening technique (symptom survey, PPD, or chest radiograph) [22]. There is no evidence regarding the performance of routine radiography in low-risk patients who did not receive other TB screening before transfer to a group home or nursing facility.

**Variant 3: PPD not available. Placement in group home or skilled nursing facility. No clinical symptoms.**

**B. Computed tomography**

CT should be reserved for the rare case in which a chest radiograph is equivocal for active TB and more definitive testing such as sputum culture is impractical.

**Variant 3: PPD not available. Placement in group home or skilled nursing facility. No clinical symptoms.**

**C. Magnetic resonance imaging**

Like CT, there is a very limited role for MRI, although it might be considered when cross-sectional imaging is deemed necessary in a patient for whom there is a desire to avoid ionizing radiation.

**Summary of Highlights**

- Chest radiography is the first recommended test in patients with suspected tuberculosis.
- Chest radiography is generally appropriate for patients with new evidence of exposure or at high risk for development of tuberculosis, although it may be of low yield in patients who have no clinical symptoms.
- Chest CT is appropriate when tuberculosis is suspected and radiography is nonrevealing or nondiagnostic.

**Supporting Documents**

The evidence table, literature search, and appendix for this topic are available at <https://acsearch.acr.org/list>. The appendix includes the strength of evidence assessment and the final rating round tabulations for each recommendation.

For additional information on the Appropriateness Criteria methodology and other supporting documents, please go to the ACR website at <https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Appropriateness-Criteria>.

**Appropriateness Category Names and Definitions**






Appropriateness Category Name	Appropriateness Rating	Appropriateness Category Definition
Usually Appropriate	7, 8, or 9	The imaging procedure or treatment is indicated in the specified clinical scenarios at a favorable risk-

		benefit ratio for patients.
May Be Appropriate	4, 5, or 6	The imaging procedure or treatment may be indicated in the specified clinical scenarios as an alternative to imaging procedures or treatments with a more favorable risk-benefit ratio, or the risk-benefit ratio for patients is equivocal.
May Be Appropriate (Disagreement)	5	The individual ratings are too dispersed from the panel median. The different label provides transparency regarding the panel's recommendation. "May be appropriate" is the rating category and a rating of 5 is assigned.
Usually Not Appropriate	1, 2, or 3	The imaging procedure or treatment is unlikely to be indicated in the specified clinical scenarios, or the risk-benefit ratio for patients is likely to be unfavorable.

### Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Patients in the pediatric age group are at inherently higher risk from exposure, because of both organ sensitivity and longer life expectancy (relevant to the long latency that appears to accompany radiation exposure). For these reasons, the RRL dose estimate ranges for pediatric examinations are lower as compared with those specified for adults (see Table below). Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

### Relative Radiation Level Designations

Relative Radiation Level*	Adult Effective Dose Estimate Range	Pediatric Effective Dose Estimate Range
0	0 mSv	0 mSv
	<0.1 mSv	<0.03 mSv
	0.1-1 mSv	0.03-0.3 mSv
	1-10 mSv	0.3-3 mSv
	10-30 mSv	3-10 mSv
	30-100 mSv	10-30 mSv

\*RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a number of factors (e.g., region of the body exposed to ionizing radiation, the imaging guidance that is used). The RRLs for these examinations are designated as "Varies."

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## Disclaimer

The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

<sup>a</sup>Medical University of South Carolina, Charleston, South Carolina. <sup>b</sup>Panel Vice-Chair, National Jewish Health, Denver, Colorado. <sup>c</sup>Massachusetts General Hospital and Harvard Medical School, Boston, Massachusetts. <sup>d</sup>The University of Texas MD Anderson Cancer Center, Houston, Texas. <sup>e</sup>Mayo Clinic, Rochester, Minnesota; Commission on Nuclear Medicine and Molecular Imaging. <sup>f</sup>Mayo Clinic, Phoenix, Arizona. <sup>g</sup>Vanderbilt University Medical Center, Nashville, Tennessee; American College of Chest Physicians. <sup>h</sup>Mayo Clinic, Jacksonville, Florida. <sup>i</sup>Columbia University Medical Center New York and Temple University Health System, Philadelphia, Pennsylvania. <sup>j</sup>Specialty Chair, University of Florida College of Medicine, Gainesville, Florida.