UCSF Health

Last updated 3/19/26

Archbishop Riordan High School Tuberculosis (TB) Outbreak Response FAQs (UCSF)

The following are frequently asked questions regarding the Archbishop Riordan High School (ARHS) TB outbreak. Due to the extent of the outbreak, SFDPH is relying on community clinicians to help screen all students and staff of Archbishop Riordan High School for TB. Clinicians who would like to stay informed as the situation evolves can visit the SFDPH website for periodic updates.

UCSF Hospital Epidemiology and Infection Prevention has put together a TB exposure algorithm to help clinicians screen patients for TB. Please note that the algorithm is updated frequently as the outbreak evolves; for the most up-to-date version, use the link above to access the algorithm through the HEIP website (do not print and post this algorithm).

What is *Mycobacteria tuberculosis (TB)*?

A slow-growing bacteria that can cause infection in both the respiratory tract, and less commonly in other parts of the body and has the potential for severe disease in patients who are untreated.

How is TB transmitted?

It is spread through the air when a person with active TB in their lungs or airways coughs, speaks or breathes near others. Exposure to TB typically occurs during prolonged face-to-face contact with an untreated patient with pulmonary TB.

What are common TB symptoms?

The most common symptoms associated with TB include cough lasting > 3 weeks, coughing up blood (hemoptysis), fever, fatigue, unintentional weight loss, night sweats or concerns about appropriate growth and development in children.

Are patients with TB exposure infectious?

Although these Archbishop Riordan High School students are exposed to TB, it does not mean they are infected. The additional TB screening these patients are having will determine if they are infected with TB and if they are, whether they have latent TB infection (which is not contagious) or active TB disease (contagious).

What is the difference between latent TB infection and active TB disease?

Patients with latent TB infection are not infectious to others and generally do not have symptoms and do not feel sick; however, latent TB infection should be identified and treated in a timely way to prevent progression to active TB disease.

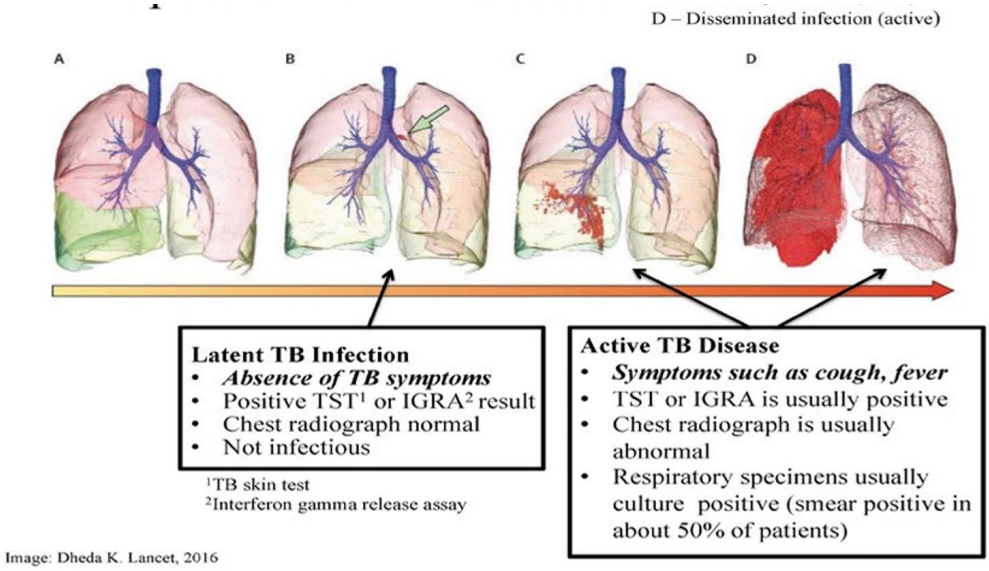


Image: Dheda K. Lancet, 2016

What TB screening is appropriate for someone who has been exposed to TB?

Follow the UCSF Hospital Epidemiology and Infection Prevention TB exposure algorithm. Please note that the algorithm is updated frequently as the outbreak evolves; for the most up-to-date version, use the link above to access the algorithm through the HEIP website (do not print and post this algorithm).

When should I be concerned about active pulmonary TB disease?

If the exposed patient has TB symptoms and/or a chest X-ray with abnormalities that can be seen with TB, they need additional evaluation for active TB disease.
Please contact Hospital Epidemiology and Infection Prevention immediately so that the patient can have a 'TB Airborne Isolation' flag added to their chart and follow the additional workflow steps outlined below and in the UCSF Hospital Epidemiology and Infection Prevention has put together a TB exposure algorithm. If a clinician feels that a symptomatic patient's symptoms might be due to TB, please contact both Hospital Epidemiology and Infection Prevention and Report TB to the San Francisco Department of Public Health | SF.gov

My patient was born in a TB-endemic country and received the BCG vaccine (TB vaccine). Do I still need to screen them?

Patients who have a history of receiving the BCG vaccine as an infant are still at risk for TB infection and disease. The BCG vaccine does not interfere with the QuantiFERON test; a positive QuantiFERON test in this patient should not be dismissed as a false positive test and the patient should have a 2-view CXR.

My patient/patient's caregivers are asking if they can receive the TB vaccine in response to this outbreak. How do I respond?

The TB vaccine is not available in the United States and is not used for outbreak response. The TB vaccine is given to infants in other countries where TB is common to prevent severe disease (such as TB meningitis, disseminated TB).

Patients who were born outside of the US and received the TB vaccine as an infant are still at risk for developing TB and should be screened with QuantiFERON and/or 2-view CXR based on exposure risk.

My patient does not attend ARHS but has attended events there/has contacts with individuals at ARHS. Do they need to be screened?

Pending further guidance from SFDPH, the risk to the general public remains low and only ARHS students/staff should be screened due to this high school TB outbreak.

Please share this SFDPH Information for the General Public alert with your patients.

Other patients can have other TB risk factors like international travel or other known TB exposures and should be assessed and if indicated, screened as per regular clinical care workflows.

What workflow should office staff follow for patients with concern for active TB disease, including those with a 'TB Airborne Isolation' flag?

Contact UCSF HEIP for placement of 'TB Airborne Isolation' flag to your patient's chart.

If you have access to an Airborne Infection Isolation Room (AIIR), please use it to evaluate the patient, place an Airborne Isolation sign, and follow associated workflows including a fit-tested N95 respirator or higher level of respiratory protection.

If an AIIR is not available:

1) Schedule visits for the last appointment of the day.
2) Ask patient and if applicable, the accompanying caretaker, to wear a *surgical mask* that covers the nose/mouth throughout the visit; they do not need an N95 respirator.
3) Room the patient right away in an individual room (patient should not be in the waiting room).
4) Keep the door closed for the duration of the visit, except for entry/exit and post the **Airborne Isolation sign.**
5) Healthcare personnel should wear a fit-tested N95 respirator or higher level of respiratory protection.
6) Ask patient and if applicable, the accompanying caretaker, to follow a direct path of travel when leaving the clinic/area.

7) Leave the room empty for at least 1 hour after the patient/accompanying caretaker leaves. If healthcare personnel need to enter the room during this hour, they should wear a fit-tested N95 respiratory or higher level of respiratory protection.

If active TB disease is ruled out, contact HEIP to remove the flag from the patient's chart.

Do patients with concerns for active TB disease due to compatible signs and symptoms and/or an abnormal CXR need to wear an N95 respirator when they are being evaluated in-person?

These patients and their caregivers (if applicable) should be wearing a surgical mask that covers their nose and mouth. An N95 respirator is not recommended. Household contacts of a patient with active TB disease should also wear a surgical mask.

Healthcare providers caring for these patients should be wearing an N95 respirator that they have been fit tested to wear or a higher level of protection (e.g., PAPR).

See above for additional workflow steps that need to be followed in the care of these patients.

What workflow should be followed if a patient connected to the ARHS TB outbreak does not have symptoms concerning for TB and does not have an abnormal CXR?

These patients can be cared for using Standard Precautions.

What if an asymptomatic exposed patient has a positive QuantiFERON and needs a 2-view CXR?

If the exposed patient does not have any symptoms concerning for TB they can be cared for using Standard Precautions.

If the exposed patient has symptoms concerning for TB, please contact HEIP as per above and follow the workflow needed for patients with a 'TB Airborne Isolation' flag.

How long does it take from exposure to a positive QuantiFERON?

It can take up to 8-10 weeks for a TB-infected person to develop a positive QuantiFERON. SFDPH recommends screening patients every 8-10 weeks until the outbreak has resolved in order to identify patients who have been infected but whose QuantiFERON has not yet become positive.

My patient who had a negative QuantiFERON on their initial screening now has a positive QuantiFERON during rescreening. How do I proceed?

Patients who "convert" during the outbreak (test positive during rescreening after testing negative during the initial phase of screening) need to have a 2-view CXR performed within 48-72 hours in order to be cleared to return to school. Latent TB treatment can be started soon after but the CXR should be done in a timely manner to determine whether they have active or latent TB.

Are there special considerations for my immunocompromised patient from ARHS whose initial QuantiFERON was negative and is now due for their repeat QuantiFERON?

Continue to perform symptom review, a focused lymph node exam, and chest X-ray in addition to repeat QuantiFERON (if prior testing was negative) each time the patient is screened.

Where can I learn more about TB including latent TB infection (LTBI) therapy in children?

Here is a link to an SFDPH clinician pediatric latent TB treatment webinar that took place on February 5, 2026.

Once I start my patient on LTBI treatment, how often should they be evaluated for new symptoms?

Ideally, patients on LTBI treatment should be evaluated monthly for new symptoms, adverse events and adherence to treatment.

What is considered "acceptable adherence" to LTBI treatment? What if my patient misses a few doses?

While full adherence is ideal, acceptable adherence is defined as:

- Rifampin daily x 4 months- patients should be taking 6/7 doses (≥85%) per week and complete all 120 doses within 6 months

  OR

- 3HP x 12 weeks (INH and rifapentine once weekly) - patients should take a minimum of 11 doses within 16 weeks total

  OR

  Isoniazid (INH) daily x 6-9 months (for patients unable to take a rifamycin drug)- patients should take 6/7 doses per week and must complete 180 doses within 9 months total.

Link to dosing for the above regimens:

- https://www.cdc.gov/tb/hcp/treatment/latent-tuberculosis-infection.html
- https://www.cdc.gov/mmwr/volumes/69/rr/rr6901a1.htm?s_cid=rr6901a1_w#T1_down

What are potential drug-drug interactions that I need to consider for a patient who is on LTBI treatment?

Rifampin and rifapentine (both rifamycin drugs) have interactions with many other medications; please check with your pharmacist if your patient is taking other chronic medications.

Patients who are taking a rifamycin as part of their LTBI treatment (either rifampin or 3HP) should be reminded that efficacy of hormonal contraception will be decreased, and barrier contraception is strongly recommended.

Should I expect updates and changes to the TB screening recommendations related to this TB outbreak?

Yes, there will be changes in the SFDPH recommendations as the outbreak investigation proceeds. UCSF will continue to update their TB outbreak response tools to align with SFDPH recommendations.

For more information, refer to the SFDPH website.

Where can I find more information?

-UCSF Hospital Epidemiology and Infection Prevention has put together a TB exposure algorithm and UCSF TB Resources
-SFDPH Health Advisory Updates