*Philadelphia Department of Public Health*
**Division of Disease Control**

DONALD F. SCHWARZ, MD, MPH
*Deputy Mayor, Health & Opportunity*
*Health Commissioner*

NAN FEYLER, JD, MPH
*Chief of Staff*

CAROLINE C. JOHNSON, MD
*Director, Division of Disease Control*

# *Health Advisory*

## National Shortage of Isoniazid (INH)
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On December 21st 2012, the CDC's Division of Tuberculosis Elimination reported in the MMWR [MMWR 61(50):1029] on a national shortage of 300 mg tablets of the antituberculosis medication isoniazid (INH) . On January 15th 2013, shortages of 100 mg tablets of INH were also reported. INH is one of the most important drugs used to treat tuberculosis disease and latent tuberculosis infection. Shortages of INH may require that tuberculosis patients be treated with alternate drug regimens, alternate dosing schedules, and/or increased tablet numbers. All of these changes have the potential to impact patient compliance and treatment success rates, and to promote emergence of drug-resistance, if treatment choices are not made astutely.

Currently, there are three U.S. suppliers of INH: Teva (888-838-2872), Sandoz (609-627-8500), and VersaPharm (800-548-0700). Each manufacturer is reporting different timeframes for product availability, so distributors may need to check with each manufacturer to locate supplies. The US Food and Drug Administration (FDA) reports that INH availability may be limited for at least several months to come. Find up-to-date information on INH availability at *http://www.fda.gov/drugs/drugsafety/drugshortages/default.htm.*

**When INH is not available, the Philadelphia Dept. of Public Health (PDPH) recommends the following treatment options:**

*For Adults with Latent Tuberculosis Infection*

- Rifampin 600 mg once daily x 4 months
- If patient is intolerant of rifampin, or has a contraindication to rifampin (sensitivity, potential drug interaction), consult with the Medical Director of PDPH Tuberculosis Control Program (PDPH TB Control) for specific drug recommendations (215-685-6873).
- For HIV-positive patients, consider ruling out pulmonary tuberculosis with sputum cultures before treating with rifampin for latent tuberculosis infection --this would avoid inadvertent monotherapy of tuberculosis.

*For Adults with Suspect or Confirmed Active Tuberculosis Infection*

- Initiate therapy with ethambutol, pyrazinamide (PZA), and rifampin. If disease is extensive or severe, consider adding a fluoroquinolone, such as levofloxacin or moxifloxacin.
- If drug resistance is a concern, consult with the Medical Director of PDPH TB Control (215-685-6873) who will advise on addition of secondary anti-tuberculous drugs, pending availability of susceptibility test results.

*For Pediatric Patients with Latent Tuberculosis Infection*

- Age 12 yrs or older, use rifampin once daily, 12-17 mg/kg/dose (max 600mg per day) for 4 months.
- Age < 12 yrs, use rifampin once daily, 12-17 mg/kg/dose (max 600 mg per day) for 6 months.
- If patient is intolerant of rifampin, or has a contraindication to rifampin (sensitivity, potential drug interaction), consult with the Pediatric Infectious Disease Specialist in PDPH TB Control for specific drug recommendations (215-685-6873).

*For Pediatric Patients with Suspect or Confirmed Active Tuberculosis Infection*

- Consult with Pediatric Infectious Disease Specialist in PDPH TB Control (215-685-6873) for recommendations.

*For HIV positive patients who are on HAART, rifabutin is a suitable alternative to rifampin because it is a less potent inducer of cytochrome P450 enzymes and has fewer drug interactions. The dosage of rifabutin and co-administered HAART drugs may need to be adjusted for certain combinations.