1. When speaking about false positivity with Interferon gamma release assays (IGRAs), you're referring to QuantiFERON (QFT) results (greater than 0.35). However, are providers considering moving towards T-spots, which tend to be more accurate and have lower rates of false positives?
    a. I have no information that there is a movement in this direction, although it would not be unreasonable.

2. Pulmonary TB is highly contagious via air droplet. Is ocular TB contagious via direct contact with the exudate from the infected eye?
    a. Ocular TB would be considered contagious via direct contact from eye exudates only for providers working with the patients and that too, in close contact.
    b. Ocular TB would not be expected to spread from person-person from just sitting next to the patient.

3. Do you recommend 4 drug therapy throughout, or are you comfortable d/c PZA at end of initiation phase?
    a. Ocular TB, like other forms of TB does not require a 4-drug therapy for the entire duration of the course, typically 6 months.
    b. Treatment is initiated with the standard RIPE regimen (Rifampin/Isoniazid/Pyrazinamide/Ethambutol) for a 4-month duration. At the 2-month mark, the regimen is de-escalated to only Rifampin and Isonazid.

4. Any incidence of "conversion" during treatment- meaning any incidence of conversion to "Pulmonary TB???
    a. If there were no Pulmonary TB symptoms and screening chest imaging at the onset of treatment for Ocular TB was NEGATIVE for any signs of active TB, then we would not expect "conversion" of a LATENT TB pulmonary focus to occur while on appropriate RIPE therapy. RIPE therapy would treat active TB anyway.

5. What contributed to treatment failure?
    a. I presume the question refers to the clinical case patient. He is still undergoing treatment for Ocular TB and is responding well in terms of resolution of uveitis (although how much of the good response could be attributed to topical steroids is up for debate).

6. Directly observed therapy (DOT) while on RIPE?
    a. Not necessary, if the patient is reliable and because the public health risks with Ocular TB are not the same as for active Pulmonary TB. The Department of Public Health does follow up weekly with our patient by phone.

7. You mentioned evidence of uveitis resolving after treatment, but what was the outcome of his symptoms? Did it all improve as well?
    a. Yes, his ocular symptoms also resolved within 1 mo of being on topical steroids + RIPE (although how much of the good response could be attributed to topical steroids is up for debate).

8. I have a new patient with recurring scleritis since 2021 that has not been responsive to treatment (oral, topical, and injectable). She was tested for autoimmune diseases as well as TB with an IGRA. IGRA was positive, all other testing negative. No history of known TB exposure or any TB signs/symptoms. CT of chest did show calcified nodules in RUL. What are the chances she has ocular TB?
    a. Ocular TB is definitely a concern here.
    b. Have other infectious and autoimmune diseases been ruled out adequately?
    c. Is it possible for ocular samples for culture/ AFB PCR AND histopath?
    d. How positive was IGRA?
    e. Recommend referral to an Infectious Disease provider and an experienced ophthalmologist.

9. What percentage of ocular TB cases are generally bacteriologically confirmed?
    a. less than 5%

10. Why are some of the diagnoses bold in your causes slide?
    a. Because these are the commonest differentials diagnoses that should be considered when working up ocular Tb.