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### **Research Article**

# **Tuberculosis Knowledge and its Complications among the Patients in a Teaching Hospital**

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#### Abstract

Tuberculosis (TB) is an infectious disease which is transmitted by air. This disease damages the lungs and other organs in the human body. It is one of the leading causes of morbidity and mortality despite the fact that it can be cured with adequate treatment. The entry of multidrug resistant tuberculosis (MDR-TB) or extensively drug resistant (XDR-TB) is biggest challenges in our effort to control the disease and drugs complications. A cross-sectional study was conducted to assess TB related knowledge, its complications and control among the patients from the Pulmonology department of Owaisi Hospital and Research Center- HYD. The research shows that maximum number of patients [59%] was unsure about the severe complications of TB disease and their drugs whereas patients did not adhere to the treatment and discontinue it half-way, this become the prime reasons for the gap between treatment and control, thereby no adherence treatment could have severe consequences of diseases and might lead to death. Knowledge about pulmonary complication and duration of treatment has to be emphasized.

**Keywords:** Pulmonary Complication; Patient's Perception; Treatment; Prevention and Control

#### Introduction

After human immunodeficiency virus (HIV) Tuberculosis (TB) is one of the leading causes of the disease worldwide [1-3]. The Latest World Health Organization (WHO) Report shows that there were 9.0 Million new TB cases and 1.5 Million tuberculosis deaths, [6-10]. The spread of the TB disease by Mycobacterium tuberculosis occurs by air in the form of sneeze, talk, cough, spit etc. transmission of the disease occurs only after continues exposure patients with active TB [11-13]. In some patients the sign and symptoms of the disease does not appear for many years and TB bacteria a remains dormant. The diseases get effect only if the immune system becomes weakened by Diabetes, HIV infection, Malignancy, Kidney disease, immunosuppressive agent [14-19].

Active or pulmonary tuberculosis (TB) can cause permanent lung damage when it is not diagnosed and treated early [12]. Untreated active disease can also spread to other organs of the body where it leads to serious or life-threatening complications. Complications of TB arise due to late detection, identification and irregular treatment. These complications can vary from mild to severe health problems that may also cause death [20-26]. Few complications of the disease are listed like permanent lung damage, Meningitis, bone and joint complications, cardiac problems and liver or renal inflammation. [28-32]

Due to Multidrug resistance, some of the TB programs were not successful. Drug resistance in MDR-TB or XDR-TB is a human-made problem. [33-35] Lack of awareness, incomplete or inappropriate treatment and bad quality of medicines has led to the present situation of TB prevalence [36-37]. The early detection and proper treatment of TB using combination of drug therapies

for 6-9 months can make the patient noninfectious and finally cure the disease [38-39]. However, in countries like India proper assessment of the TB has not been done. This study is done to assess the patient's perception on TB complication and drug regimen [40-44].

#### Method

A cross-sectional survey was done to assess TB-related knowledge, its complications, and control among the participants from the outpatient Pulmonology department of Owaisi Hospital and Research Center-HYD

Participants: The data collection is done with help of a questionnaire which contains two different parts that is 1) Knowledge on TB disease, 2) Complication and control of TB. The study includes 1006 patients from the out-patients from Pulmonology department which were previously diagnosed for tuberculosis. The

182

184

patient's response in the survey study was assessed on perception of TB disease, its complications and control.

#### Discussion

The study reveals significant variations in the genders male and female. Male are better informed the causes, transmission of TB, its complication and Control. Maximum patients were unsure about the sever complication of TB and drugs. The result of this study also indicates that intolerance of Anti-tuberculosis drugs due to side effect is still a serious problem in patients. The incidence rate of hepatic dysfunction was found to be the most frequent side effect. Whereas minor ocular and gastrointestinal complications were reported, Rifampicin and ionize were the most causative agent of heptotoxicity. Of all the participants 62% of the patients stated that they didn't have idea of properly maintain the medical records for their treatment of the disease, This is the main root cause, where TB not under control

262

290

#### Results

no

Unsure

Response	Male ( N= 744)		Female (N= 262 )		Total Participants N=1006	
	Freq	%	Freq	%	Freq	%
yes	470	-63%	121	-46%	591	-59%
no	274	-37%	141	-54%	415	-41%

D	Male (1	N= 744)	Female (	(N=262)	Total Participants N		
Response	( N=	744)	(N=	262)	Total Partici           N=           7%           454	006	
yes	378	-51%	72	-27%	454		

-24%

-25%

 Table 1: Do you know, Tb disease is one of the leading cause of death.

6	107	
Table 2	: Is Tuberculosis cont	agious?

83

-32%

-41%

Response	Male		Fen	nale	Total Participants	
	( N= 744)		(N= 262 )		N=1006	
YES	228	-31%	69	-26%	297	-30%
NO	98	-13%	14	-6%	112	-11%
UNSURE	418	-56%	179	-68%	597	-59%

Table 3: Do you know that TB can cause severe complications?

Response	Male(N=744)		Female	(N=262)	Total Participants N=1006	
	Freq	%	Freq	%	Freq	%
Yes	528	-71%	182	-69%	710	-70%
No	130	-17%	59	-23%	189	-19%
Unsure	86	-12%	21	-8%	107	-11%

Table: 4: Is medication important in controlling TB?

=1006

-45% -26%

-29%

	Male		Fen	nale	Total Participants	
Response	( N= 744)		(N= 262)		Total Participants	
	Freq	%	Freq	%	Freq	%
Yes	88	-12%	29	-11%	109	-11%
No	362	-49%	159	-61%	529	-52%
Unsure	294	-40%	74	-28%	368	-37%

Table 5: Do you know the side effects caused by drug used in treatment of TB?

	Male		Female		- Total Participants	
Response	( N= 744)		(N=262)			
	Freq	%	Freq	%	Freq	%
Sever Consequences of disease	469	-63%	176	-67%	645	-64%
Relapse of disease	162	-22%	57	-22%	219	-22%
Don't Know	113	-15%	29	-11%	142	-14%

Table 6: What could be the consequences of incomplete or inappropriate treatment?

	Male ( N= 744)		<b>Female</b> (N= 262 )		- Total Participants	
Response						
	Freq	%	Freq	%	Freq	%
yes	252	-34%	133	-51%	385	-38%
no	492	-66%	129	-49%	621	-62%

Response	Male		Fen	nale	Total Participants	
	( N= 744)		(N=262)		(N=1006)	
	Freq	%	Freq	%	Freq	%
Yes	65	-9%	18	-7%	83	-8%
No	476	-64%	187	-71%	663	-66%
Unsure	203	-27%	57	-22%	260	-26%

Table 8: Do you know what are Multidrug resistance tuberculosis (MDR-TB)?

	Male		Fen	nale	Total Participants	
Response	( N= 744)		(N=262)		(N=1006)	
	Freq	%	Freq	%	Freq	%
Yes	350	-48%	72	-29%	426	-42%
No	390	-52%	190	-71%	580	-58%

Table 9: After getting a positive TB test, have you completed given treatment?

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• The above statistical analysis shows that, maximum (59%) were unsure that the severe complication of Tuberculosis. Participants both (male & female) were unaware about treatment and side effects of the given medicine.

pants did not adhere to the treatment and discontinue it half way. This becomes the prime reason for the gap between the treatment and its adherence.

- 90% of total participants scared when they had cough with blood and sought immediate treatment. 45% of total partici-
- 58% of total participants' belief that TB is a short lived infectious disease and curable. In Contrast to this 28% total of participant had opposite-ve thought; they told that TB is not at

all curable completely.

• 30% of total participant thought that 1 or 2 months treatment are sufficient to control TB disease.

#### Conclusion

According to this study analysis, it was clear that patients do not have clear knowledge regarding the tuberculosis and its complications with respective to drug and disease. Perfect management of active tuberculosis treatment includes the initiation and the completion of anti-tuberculosis therapy with minimal complication and reduce side effect of anti-tuberculosis drug by closer monitoring of Adverse Drug Reaction (ADR). MDR-TB can be diminished by identifying the drug resistance and by treating the disease with the second line anti-tuberculosis drugs in proper regiment in relapse cases. Thereby inappropriate or incomplete treatment could lead to severe consequences and may leads to death of the patient. Knowledge about pulmonary complication and duration of treatment has to be focused.

#### References

- Nyangulu DS, Harries AD, Kang ombe C, Yadidi AE, Chokani K, et al. (1997) Tuberculosis in a prison population in Malawi. The Lancet 350: 1284-1287.
- Abebe DS, Bjune G, Ameni C, Biffa D, Abebe F (2011) Prevalence of pulmonary tuberculosis and associated risk factors in Eastern Ethiopian prisons. Int J Tuberc Lung Dis 15: 668–673.
- Banu S, Hossain A, Uddin MKM, Reaj MU, Ahmed T, et al.(2010) Pulmonary Tuberculosis and drug resistance in Dhaka central jail, the largest prison in Bangladesh. PLoS ONE 5.
- Getahun H, Gunneberg C, Sculier D, Verster A, Raviglione M (2012) Tuberculosis and HIV in people who inject drugs: evidence for action for tuberculosis, HIV, prison and harm reduction services. Curr Opin HIV AIDS 7: 345–353.
- Shah S, Mujeeb S, Mirza A, Nabi K, Siddiqui Q (2003) Prevalence of pulmonary tuberculosis in Karachi juvenile jail, Pakistan. East Mediterr Health J 9: 667–674.
- 6. World Health Organization, Global Tuberculosis Report 2014.
- 7. World Health Organization, "Drug-resistant TB surveillance & response supplement," Global Tuberculosis Report, 2014.
- Streicher EM, M<sup>-</sup>uller B, Chihota V (2012) Emergence and treatment of multidrug resistant (MDR) and extensively drug-resistant (XDR) tuberculosis in South Africa. Infect Genet Evol 12: 686–694.
- Andrews JR, Shah NS Weissman D, Moll AP, Friedl G, et al.(2010) Predictors of multidrug-and extensively drug-resistant tuberculosis in a high HIV prevalence community. PLoS ONE 5.
- World Health Organization, Multidrug and Extensively Drug-Resistant TB (M/XDR-TB): 2010 Global Report on Surveillanc and Response, World Health Organization, Geneva, Switzerland, 2010.
- 11. Tessema B, Muche A, Bekele A, Reissig D, Emmrich F, et al.( 2009)

Treatment outcome of tuberculosis patients at Gondar University Teaching Hospital, Northwest Ethiopia. A five-year retrospective study. BMC Public Health 9.

- Hamusse SD, Demissie M, Teshome D, Lindtjørn B (2014) Fifteenyear trend in treatment outcomes among patients with pulmonary smear-positive tuberculosis and its determinants in Arsi Zone Central Ethiopia. Global Health Action 7.
- Shingadia D and Seddon JA (2014) Epidemiology and disease burden of tuberculosis in children a global perspective. Infection and Drug Resistance 7: 153–165.
- 14. World Health Organization, Tuberculosis (2015)
- World Health Organization, (2009) WHO Policy on TB Infection Control in Health-Care Facilities, Congregate Settings and Households, WHO/ HTM/TB/2009.419, World Health Organization, Geneva, Switzerland.
- Lawn SD and Wilkinson R (2006) Extensively drug resistant tuberculosis. British Medical Journal 333: 559–560.
- 17. Revised National Tuberculosis Control Programme Training Manual for Mycobacterium tuberculosis Culture and Drug Susceptibility Testing, Central Tuberculosis Division, New Delhi, India, 2009.
- Kumar VG, Urs TA, Ranganath RR (2011) MPT 64Antigen detection for rapid confirmation of M tuberculosis isolates. BMC Research Notes 4.
- Sethi S, Mewara A, Dhatwalia SA, Singh H, Yadav R, et al. (2013) Prevalence of multidrug resistance in Mycobacterium tuberculosis isolates from HIV seropositive and seronegative patients with pulmonary tuberculosis in north India. Bio Med Central Infectious Disease 13.
- Paramasivan CN, Bhaskaran K, Venkataraman P, Chandrasekaran V,Narayanan PR (2000) Surveillance of drug resistance in tuberculosis in the state of Tamil Nadu. Indian Journal of Tuberculosis 47: 27–33.
- Trivedi SS and Desai SG (1988) Primary anti-tuberculosis drug resistance and acquired Rifampicin resistance in Gujarat, India. Tubercle 69: 37–42.
- Rawat J, Sindhwani G, Dua R (2009) Five-year trend of acquired antitubercular drug resistance in patients attending a tertiary care hospital at Dehradun (Uttarakhand). Lung India 26: 106–108.
- Jain NK, Chopra KK, Prasad G (1992) Initial and acquired Isoniazid and Rifampicin resistance to M. tuberculosis and its implications for treatment. Indian Journal of Tuberculosis 39: 121–124.
- Vijay S, Balasangameshwara VH, Jagannatha PS, Saroja VN, Shivashankar B, et al.(2002) Re-treatment outcome of smear positive tuberculosis cases under DOTs in Bangalore city. Indian Journal of Tuberculosis 49: 195–204.
- 25. Paramasivan CN, Venkataraman R, Chandrasekaran V, Bhat S, Narayanan RR (2002) Surveillance of drug resistance in tuberculosis in two districts of South India. Int J Tuberc Lung Dis 6: 479–484.
- Gopi PG, Vallishayee RS, Appegowda BN, Paramasivan CN, Ranganatha S,et al.(1997) A tuberculosis prevalence survey based on symptoms questioning and sputum examination. Indian Journal of Tuberculosis 44:171–180.
- 27. Singla R, Sharma SK, Mohan A, Makharia G, Sreenivas V, et al. ( 2010) Evaluation of risk factors for anti-tuberculosis treatment induced

hepatotoxicity. Indian J Med Res 132: 81-86.

- Marra F, Marra CA, Bruchet N, Richardson K, Moadebi S, et al.(2007) Adverse drug reactions associated with first-line anti-tuberculosis drug regimens. Int J Tuberc Lung Dis 11: 868–875.
- Javadi MR, Shalviri G, Gholami K, Salamzadeh J, Maghooli G, et al.(2007) Adverse reactions of anti-tuberculosis drugs in hospitalized patients: incidence, severity and risk factors. Pharmacoepidemiol Drug Saf 16:1104–1110.
- Qureshi W, Hassan G, Kadri SM, Khan GQ, Samuel B, et al.(2007) Hyperuricemia and arthralgias during pyrazinamide therapy in patients with pulmonary tuberculosis. Lab Med 38: 495-497.
- SharmaSK, Balamurugan A, Saha PK, Pandey RM, Mehra NK, (2002) Evaluation of clinical and immunogenetic risk factors for the development of hepatotoxicity during antituberculosis treatment. The Am J Respir Crit Care Med. 66: 916–919.
- Jasmer RM, Saukkonen JJ, Blumberg HM (2002) et al. Shortcourse rifampin and pyrazinamide compared with isoniazid for latent tuberculosis infection: amulticenter clinical trial. Annals of Internal Medicine137: 640–647.
- Gandhi NR, Nunn P, Dheda K, Schaaf HS, Zignol M, et al.(2010) Multidrug-resistant and extensively drug-resistant tuberculosis: a threat to global control of tuberculosis. The Lancet 6736: 1–14.
- Goyal M, Saunders NA, van Embden JD (1997) Differentiation of Mycobacterium tuberculosis isolates by spoligotyping and IS6110 restriction fragment length polymorphism. J Clin Microbiol 35: 647–665.
- Gandhi NR, Shah NS, Andrews JR, Vella V, Moll AP, et al. (2010) HIV coinfectionin multidrug- and extensively drug-resistant tuberculosis results in high early mortality. Am J Respir Crit Care Med 181: 80–86.

- Kim SJ (2005) Drug-susceptibility testing in tuberculosis: methods and reliability of results. Eur Respir J 25: 564–569.
- Jain A, Dixit P, Prasad R (2012) Pre-XDR & XDR in MDR and Ofloxacin and Kanamycin resistance in non-MDR Mycobacterium tuberculosis isolates. Journal of Tuberculosis 92: 404–406.
- Bhatter P, Chatterjee A, Mistry N (2012) Mycobacterium tuberculosis Beijing epidemics: a race against mutations? Tuberculosis 92:92–94.
- Veen J, Raviglione M, Rieder HL, Migliori GB, Graf P, et al.(1998) Standardized tuberculosis treatment outcome monitoring in Europe. Eur Respir J 12: 505–510.
- Salami AK and Oluboyo PO (2002) Hospital prevalence of pulmonary tuberculosis and co-infection with human immunodeficiency virus in llorin: a review of nine years (1991–1999). West Afr J Med 21: 24-27.
- Malhotra R, Taneja DK, Dhingra VK, Rajpal S, Mehra M (2002) Awareness regarding tuburculosis in a rural population of Delhi. Indian Journal of Community Medicine 27: 62–68.
- 42. Ali SS, Rabbani F, Siddiqui UN, Zaidi AH, Sophie A, et al.(2003) Tuberculosis: do we know enough? A study of patients and their families in an out-patient hospital setting in Karachi, Pakistan. Int J Tuberc Lung Dis 7: 1052–1058.
- Yadav SP, Mathur ML, Dixit AK (2006) Knowledge and attitude towards tuberculosis among sandstone quarry workers in desert parts of Rajasthan. Indian J Tuberc 53: 187–195.