**Cross-cutting issues**

**Missing/unknown dates**

* If day is missing/unknown but month and year are known, use "01" for the day. For example:
  + Patient birth year (1980), month (February) and day unknown: 01/Feb/1980.
* If day and month are missing/unknown but the year is known, use "01" for the day and "July" for month. For example:
  + Patient birth year (1980), month and day unknown: 01/Jul/1980.

**General aspects for different types of patients**

**Situation 1:** The patient is starting a new regimen that contains new drugs. In this situation, when the patient starts the new regimen, the previous treatment should be closed and the appropriate outcome should be recorded.

* For example:
  + The patient relapsed after receiving a full course of standard MDR regimen and is not currently taking any treatment. A new regimen including new TB drugs is planned.
  + The patient's prior regimen was stopped because of multiple positive sputum cultures, and has not taken any anti-TB treatment for three months. A new regimen including new TB drugs is planned.
  + The patient is persistently sputum culture positive while receiving a standard MDR regimen and the decision has been made to change to a new regimen that includes new TB drugs.
* Important points regarding forms:
  + **Treatment start date** is the date that the new treatment regimen is started.
  + **Baseline Assessment** **Form** should use the case definition and data at the time of the start date of the new treatment regimen.
  + **Active Medication Log** should capture all anti-TB drugs and regimen changes from the start of the new treatment regimen.
  + **Bacteriology Form** should capture all sputum culture results from the start of the new treatment regimen.
  + **Hospital Admission Form** should be filled out if the patient is hospitalized at the time of starting the new treatment regimen. The "Date of hospital admission" is the real date that the patient was hospitalized, even if it is before the "Treatment start date".

**Situation 2:** If an empiric regimen for a duration longer than a month is being changed due to the results of a baseline DST (i.e. the treatment is "adapted" to the baseline DST results), the previous treatment should be closed and the outcome should be recorded as "Treatment adapted".

* For example:
  + The patient was originally started on an empiric MDR regimen, and DST was sent at the same time. Several months later, the result of the baseline DST shows pre-XDR or XDR-TB, requiring strengthening of the empiric regimen with new TB drugs. This strengthening of the regimen should be considered a new treatment regimen.
* Important points regarding forms:
  + **Treatment start date** is the date that new drugs are included as a part of the new regimen.
  + **Baseline Assessment** **Form** should use the case definition and data at the time of the treatment start date. In the TB History section of this form, the previous treatment should be given an outcome of "Treatment adapted". In the Case Definition section, the WHO category should be marked as, "Other previously treated patients".
  + **Active Medication Log** should capture all anti-TB drugs and regimen changes from the start of the new treatment regimen (start date of new TB drugs).
  + **Bacteriology Form** should capture all sputum culture results from the start of the new treatment regimen.
  + **Hospital Admission Form** should be filled out if the patient is hospitalized at the time of starting the new treatment regimen. The "Date of hospital admission" is the real date that the patient was hospitalized, even if it is before the "Treatment start date".

**Situation 3:** If the regimen is being changed due to adverse events (e.g. replacement of kanamycin with bedaquiline) but the patient is culture negative and does not fulfill the definition of failure, this is not considered a new treatment, but rather a continuation of the original treatment.

* N.B. If the patient fulfills the definition of failure (e.g. is smear- or culture-positive), then the previous treatment course should be given an outcome of "failure". This is described in Situation 1.
* Important points regarding forms:
  + **Treatment start date** is the start date of the original regimen and NOT the date that the regimen was changed by the substitution of a new TB drugs.
  + **Baseline Assessment Form** should use the case definition and data at the time of the start date of the original regimen (e.g. the regimen with kanamycin).
  + **Active Medication Log** should capture all anti-TB drugs and regimen changes since the original regimen was started (e.g. the regimen with kanamycin).
  + **Bacteriology Form** should capture all sputum culture results from the original treatment start date.
  + **Hospital Admission Form** should be filled out if the patient is hospitalized at the time of starting the new treatment regimen. The "Date of hospital admission" is the real date that the patient was hospitalized.