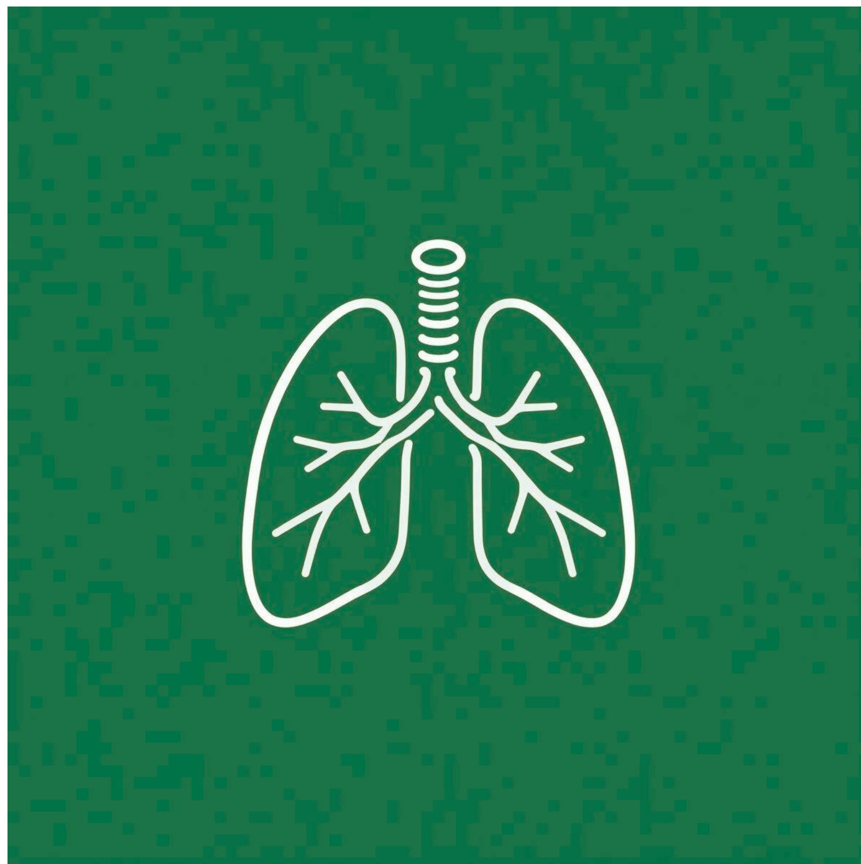
British Thoracic Society

BTS MDR-TB Clinical Advice Service Annual Report 2025



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EXECUTIVE SUMMARY

The BTS MDR-TB Clinical Advice Service was launched in January 2018 with the intention of fulfilling three key objectives: Facilitating the provision of expert advice on the treatment and monitoring of multidrug-resistant tuberculosis (MDR-TB); increasing the understanding of drug toxicity patterns across the UK and providing a formal gatekeeping function for the use of specially commissioned and novel drugs.

Provision of expert advice to clinicians

See Overview 1 (page 11): Service Activity in Numbers

The Service facilitates the provision of advice on a case-by-case basis. From 01 January 2025 to 31 December 2025 our panel of expert Clinical Service Advisers (CSAs) advised on a total 328 cases, of which 245 were new cases. 35% of the total case discussions were reported as known or suspected MDR/XDR-TB. Many other cases involved sensitive TB that was functionally MDR due to toxicity which are currently not counted under these categorisations.

Clinical Service Advisers provided 1,304 written advice messages to clinicians in this period, often within hours of a case being posted. Monthly teleconference multidisciplinary team (MDT) meetings are also used to discuss cases, and 65% of all new cases referred to the Service in 2025 had at least one MDT discussion. Treating clinicians and/or colleagues are invited to dial in to provide extra detail and ask additional questions. Interested observers from trainees and the wider TB community are also invited to dial in to the monthly virtual MDT meetings.

Gatekeeping function – specialised commissioned and novel drugs

See Overview 2 (page 21: Specialised Commissioned and Novel Drugs)

The Service has continued to provide an independent review and consensus on supporting Blueteq applications for the use of bedaquiline and delamanid. From June 2024[4] this function widened to include pretomanid when prescribed as part of the new preferred treatment options (BPaL/BPaLM) for patients with suspected, functional, or confirmed RR-TB, MDR-TB or pre-XDR TB. In the reporting period, 69% of cases that have had one or more of these drugs recommended were either MDR or suspected MDR-TB.

Impact of the Clinical Advice Service

Expert clinical advice on the treatment and monitoring of cases of MDR-TB (and similar infections) or complex functionally resistant TB has a direct and immediate impact on patient care. These cases are increasingly complex, and the impact of prompt, expert clinical, microbiological, and public health advice is correspondingly increasingly important. Case referrals to the Service saw a 9% increase in the 12-month period ending 31 December 2025 over the same period in 2024. The largest increase by clinician-reported disease category was recorded in the number of Complex sensitive TB (122% increase) and Complex TB (45% increase). The number of MDR-TB cases remained around level with 62 referrals over 65 in 2024.

The BTS MDR-TB Clinical Advice Service forms a crucial resource supporting the care of patients both directly and indirectly. Wider implications of the Service include facilitating ongoing training and development of the TB workforce.

The Service makes an essential contribution to promoting education for both referring clinicians and CAS advisors, through knowledge exchange and shared clinical experience of treating MDR-TB. We have recorded 65 person-hours of clinician involvement in MDTs over 2025 (for their own cases). However, we have not quantified the time many clinicians remain in the MDT after their own case has been discussed, which is common.

The MDTs also serve an important role supporting the training of Higher Specialty Trainees in Respiratory Medicine and Infectious Diseases. Over the reporting period, we recorded 258 person-hours of trainee/observer involvement. In October, for the second year running, a Webinar replicating one of the monthly MDT meetings with live case discussion of three cases was held. A total of 131 people attended the webinar and a recording was made available from the BTS website.

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FOREWORD

My first year as chair of the MDR-TB Clinical Advice Service coincided with confirmation that provisional data reports were showing tuberculosis (TB) infections in England to have risen by (13%) in 2024. Meaning that, at 9.5 per 100,000 people, numbers were fast approaching the WHO threshold for continued classification as a low incidence country (10 per 100,000). Of relevance to this Service, we have again seen case referral numbers rise possibly reflecting the UKHSA numbers but also in no small part due to the recognition amongst clinician-colleagues that this is known as a reliable source of robust, consensus advice and support.

The MDR-TB CAS Advisers, form an MDT team that includes respiratory and infectious disease physicians, paediatricians, microbiologists, public health consultants, pharmacists and TB nurses all volunteering their time and knowledge. It's a privilege to be part of these discussions and we are all constantly learning from each other when considering some very complex TB cases. Recruitment of new advisers takes place each summer and the post is held for a 3-year term.

The MDR-TB Clinical Advice Service continued the extension of its educational offer to trainees by staging a second, MDT webinar featuring simulated discussion around 3 TB cases. The webinar was well attended with over 130 colleagues joining and submitting questions to the live discussion. The recording is still available on the British Thoracic Society website.

Dr Martin Dedicoat
Chair, BTS MDR-TB Clinical Advice Service Steering Group

The BTS Board is proud to continue its support for this unrivalled service which, via its team of specialist advisers, offers access to prompt, collaborative, expert advice. Clinicians around the UK faced with the most challenging TB cases, can receive reassurance on diagnosis and on management within hours of posting on the web forum.

This 2025 report shows that case referral numbers again increased perhaps unsurprisingly against a landscape of rising TB numbers in England, halting more than a decade of declining incidence. The value of the MDR-TB Clinical Advice Service is recognised in the RNOH/GIRFT Report (pub. March 2025) as 'of great benefit to clinicians.' This value is equally recognised by the 840 plus NHS professionals who have registered with CAS since its inception in 2018.

Again, personally and on behalf of the BTS Board, I'd like to express thanks to the Clinical Service Advisers who so generously volunteer their time, expertise and care to ultimately help improve outcomes for TB patients.

Dr Richard Russell
Chair, BTS Board of Trustees (2024-2027)

BTS MDR-TB Clinical Advice Service Steering Group Membership 2025:

Dr Martin Dedicoat	Chair
Professor Gerry Davies	BTS Consultant member
Dr Pranabashis Haldar	BTS Consultant member
Professor Onn Min Kon	BTS Consultant member
Dr Heinke Kunst	BTS Consultant member
Dr Toby Capstick	Consultant Pharmacist
Dr Suzi Coles	UK Health Security Agency representative
Professor Marc Lipman	British HIV Association (BHIVA) representative
Dr Padmasayee Papineni	British Infection Association (BIA) representative
Dr Felicity Perrin	Chair of the BTS TB Specialist Advisory Group (SAG)
Dr Esther Robinson	National Mycobacterial Reference Service (NMRS) representative
Ms Adele Mackin Mr Jeff Featherstone/Felicity Dormo Mr Stephen Hindle	NHSE (Corresponding member) NHSE (Corresponding member) from April 2024 NHSE (Corresponding member) from April 2024
Mr Mohammad Shadab	Lay representative
BTS Head Office Staff:	
Miss Sally Welham	BTS Chief Executive
Mr Miguel Souto	BTS Head of Clinical Programmes
Miss Suzanne Howard	BTS MDR-TB CAS Coordinator

ACKNOWLEDGEMENTS

The BTS MDR-TB Clinical Advice Service received initial part-funding from Public Health England (PHE) for the year 2017/18. Confirmation of support to the continued operation of the Service was received from NHS England for the years 2025-2029. This support is gratefully acknowledged.

We would also like to acknowledge the Clinical Service Advisers who generously volunteer their time and expertise, without which the Clinical Advice Service would not be able to run. A full list of the Clinical Service Advisers who have supported the Service in 2025 is included on page 22.

If you would like to know more about the BTS MDR-TB Clinical Advice Service, please visit the BTS website at: https://www.brit-thoracic.org.uk/quality-improvement/lung-disease-registries/bts-mdr-tb-clinical-advice-service/

HISTORY

The BTS MDR-TB Clinical Advice Service launched in January 2018, building on the longstanding work of the previous MDR-TB Forum.

INTRODUCTION

The management of MDR-TB is more complex and associated with more adverse effects than standard TB treatment. The complexity of cases is broad, and a substantial proportion of patients have health, social or economic circumstances that confound their treatment and contribute to poor outcomes. The cost of treating MDR-TB is extremely high (at least 10 times that of drug sensitive TB), in part due to prolonged isolation in hospital and costly alternative anti-mycobacterial drugs.

There are four primary routes through which the Service works to help improve patient care:

- **Facilitating the provision of advice to clinicians**
  After written patient consent is obtained, clinicians may post their case to the Clinical Advice Service. Cases posted are reviewed and once approved by the Service administrator, the panel of expert Clinical Service Advisers (CSAs) are notified that a new case has been posted to the Service. The CSAs can review the anonymised case details, providing prompt advice on treatment and offer continued monitoring through the website.

  Additional support is provided via formal and structured, monthly, virtual multidisciplinary team meetings (MDTs). Treating clinicians are strongly encouraged to attend, providing an opportunity for real-time discussion with CSAs to reach an informed consensus for optimising patient care.

- **Providing an expert opinion on the use of specialised commissioned and novel drugs**
  One role of the panel of CSAs is to consider the appropriateness of the use of specialised commissioned and novel drugs. When clinicians make an Individual Funding Request (IFR), the CSAs advise on the appropriateness of this. When bedaquiline, delamanid or pretomanid funding is requested through the Blueteq system, applicants are asked to confirm discussion in a regional MDT and hence the MDR CAS provides this resource with real-time responses and monthly, virtual, MDTs. The national TB plan now advocates that all MDR cases are discussed with the MDR CAS. A minimum of three CSAs must approve the proposed regimen containing any of these drugs.

- **Supporting research**
  All patients whose cases are discussed must give consent for their data to be processed for that purpose. Separately, patients are advised that their anonymised data may be used for the purpose of research, unless they choose to opt out. Researchers from external organisations may apply to access pseudonymised data held by BTS.

- **Increasing knowledge and understanding of drug toxicity patterns**
  In addition to providing clinicians with the tools needed to make the best clinical decisions for their patients, the intention is for the Service to support care across the UK by improving the understanding of drug toxicity patterns.

Who can participate in the BTS MDR-TB CAS and how many are doing so now?

The BTS MDR-TB Clinical Advice Service is open to all secondary and tertiary care institutions in England, Scotland, Wales, and Northern Ireland, as well as the island territories (Crown Dependencies). At the end of December 2025, 844 clinicians had registered to use the Service, and cases had been entered from a total of 191 sites across the UK. From January 2018 to December 2025, 1,254 cases have been registered of which 1,149 cases had been discussed through the Service.

Clinicians may bring cases of consenting patients with confirmed or suspected drug-resistant tuberculosis, as well as other complex tuberculosis or mycobacterial infections, to the Service for discussion. Data entry for individual patient records is divided into three sections:

- Patient demographic information (age, gender, comorbidities, etc).
- Clinical features at the time the case is first brought to the Service.
- Follow-up information from subsequent clinic visits.

Service Ethics Approval, Information Governance and Data security

New ethical approval for the British Thoracic Society Multidrug Resistant Clinical Advice Service Database (22/LO/0698) was granted by the London – South East Research Ethics Committee (REC) in November 2022. This continues the 2017 REC approval stating that patient consent must be obtained before any patient information is entered into the BTS MDR-TB CAS. Information for patients and copies of the dataset are available on the BTS website at:
https://www.brit-thoracic.org.uk/quality-improvement/lung-disease-registries/bts-mdr-tb-clinical-advice-service/

All patient identifiable data (e.g. name, date of birth) are encrypted at the point of entry and visible only to the hospital team in the centre responsible for treating the patient. The British Thoracic Society Information Governance Policy and associated data security policy documents are available on the BTS website at: https://www.brit-thoracic.org.uk/about-us/governance-documents-and-policies/

Availability of advice through the MDR-TB CAS

The British Thoracic Society created the platform on which the MDR-TB Clinical Advice Service is provided to facilitate discussion between health care professionals in relation to individual patient cases of confirmed or suspected MDR-TB plus other complex TB/mycobacterium infections.

Neither the British Thoracic Society nor the MDR-TB Clinical Advice Service has any clinical responsibility or accountability for the patients that are discussed. The posting facility and reports provided are intended to support the clinician and to this end they are provided with a variety of experienced opinions and discussions to inform optimal clinical decision making, and this does not constitute medical advice from BTS. It remains the responsibility of the referring healthcare professionals involved in the Service to make decisions appropriate to the circumstances of each patient in consultation with the patient and or their guardian/carer.

Notes on data and percentages/denominators

Throughout this report figures are displayed as percentages and as exact figures (of the format *numerator/denominator*). When reading this report please be aware that:

- Denominators in this report always exclude cases where no response was entered.
- Unless otherwise stated, denominators in this report exclude cases where the saved response was ‘not known’ or ‘not recorded’.
- Percentage figures may be rounded to the nearest whole number throughout this report. This means rounding errors may lead to some total percentages adding up to, for example, 101%.

PART 1 – The Impact of the BTS MDR-TB CAS

The BTS MDR-TB Clinical Advice Service has a number of real-world benefits.

- **Directly supporting clinicians with advice**, the Service has significant impacts on the TB workforce:

> *Many thanks to the whole team for providing rapid and extremely helpful responses. It is extremely reassuring to have expert and friendly advice so readily at hand, as well as the excellent educational opportunity of sitting in on the MDT. Thank you, Deb.*
>
> Dr Deborah Ellames
> Consultant Respiratory Physician
> Leeds Teaching Hospitals

- **Supporting UK MDR-TB experts** by fostering closer ties among the expert community across the UK. The panel of expert advisers also includes a mix of new and more senior advisers, identifying and supporting the development of MDR-TB experts.
    - When treating clinicians dial in to discuss their own cases, they often remain on the call to observe other case discussions.
    - Clinical Service Advisers have described the MDTs as a unique opportunity for them to discuss a range of complex cases, and to learn from colleagues across a range of specialist areas.

- **Supporting and developing trainees** by providing the opportunity to observe expert national multidisciplinary discussions, increasing, and maintaining clinical expertise. The monthly virtual MDTs, which facilitate real-time discussion of individual cases, also have another important dimension: education of the TB workforce. The educational offer was expanded in 2024 and 2025 to include a Webinar simulation of a live MDT.

The BTS MDR-TB CAS across the UK

The BTS MDR-TB Clinical Advice Service was developed with the intention of supporting clinicians in the treatment and monitoring of patients across all four nations of the UK and the island territories (Crown Dependencies).

Since the launch of the Service in January 2018 clinicians have submitted cases of MDR-TB (and similar infections) to the BTS MDR-TB Clinical Advice Service from hospitals across England, Scotland, Wales, Northern Ireland, and the Isle of Man.

Cases of MDR-TB are more commonly treated in major cities, such as London and Birmingham. The geographical distribution of cases submitted to the CAS highlights the importance of sharing local expertise and experience nationally.

Overview 1: 2025 Service Activity in Numbers

This overview provides a summary of the activities of the Service for the reporting period ending 31 December 2025. Clinicians bring cases to the service and can gain immediate advice by posting their query to the online forum; in addition, around 14 cases will be invited to one of the monthly virtual MDTs.

Figure 3 shows the increase in numbers of new cases brought to the BTS MDR-TB Clinical Advice Service, over time, for all categories of disease (including NTM and complex sensitive TB). The number of cases received by the service has seen year on year growth from 2020 onward. Figure 4 shows cases over time by the main TB disease categories. Of this annual number, in 2025, 245 clinicians sought advice via the online forum and of this 16.7% (41/245) were MDR-TB or Suspected MDR-TB reported disease categories.

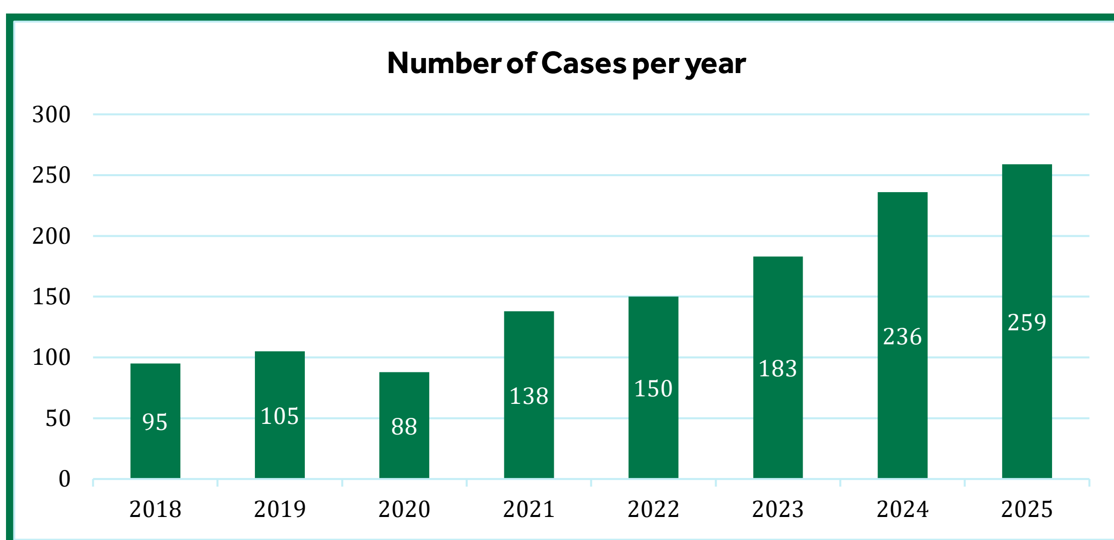


Figure 3: Cases referred to the MDR Clinical Advisory Service over time

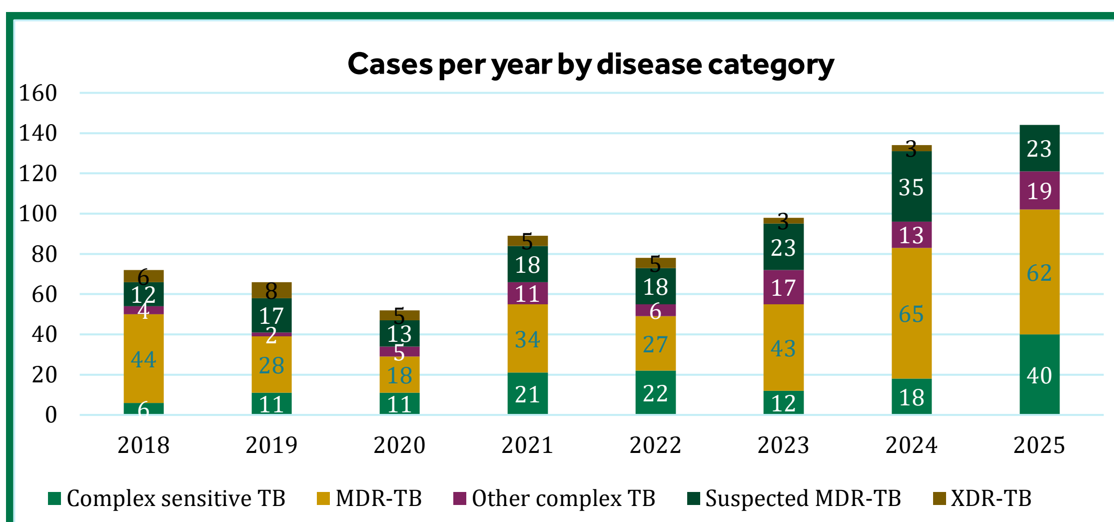


Figure 4: Cases in the MDR Clinical Advisory Service by disease category over time

844 clinicians are registered on the Clinical Advice Service

From a total of **191** hospitals across all four nations of the UK, and the Isle of Man

54

Expert Clinical Service Advisers

- Respiratory medicine
- Pharmacy
- Paediatrics
- Infectious diseases
- TB nursing
- Public health
- Microbiology

291

Cases discussed on the forum by our panel of expert advisers

1,304

Individual messages from expert Clinical Service Advisers to clinicians who have posted cases on the forum. These messages are separate to the MDT discussions, and initial responses are often received within minutes.

Discussion is a key element in identifying the best approach to treatment and monitoring for each individual case.

Monthly virtual MDT meetings
195 case discussions held on 178 cases

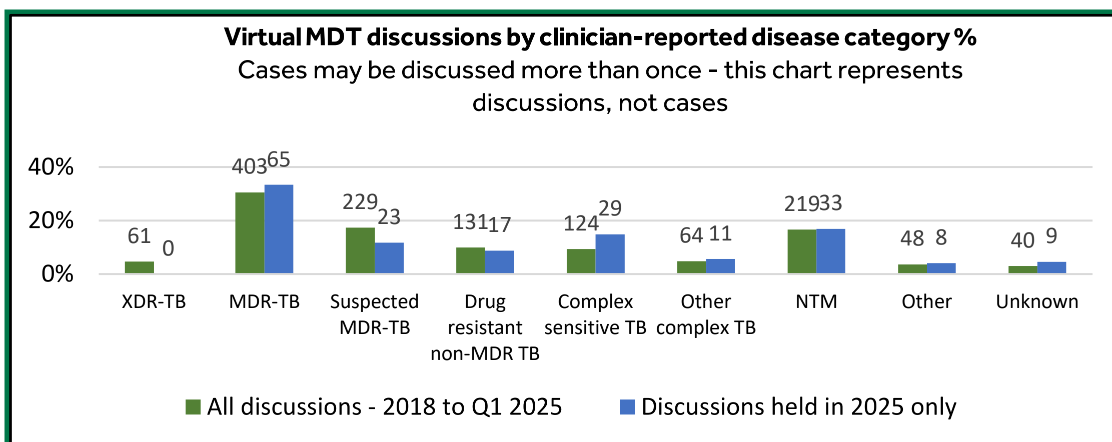


Figure 5: Number of virtual MDT case discussions by clinician reported disease category

MDT **2025** ***CASE DISCUSSIONS***

0 XDR-TB

65 MDR-TB

23 Suspected MDR-TB

17 Drug Resistant non-MDR-TB

NTM **33**

Other/Unknown **17**

Other complex TB **11**

Complex sensitive TB **29**

Of all **new** cases referred to the CAS in 2025 were discussed in at least one virtual MDT

Of cases the **new** cases discussed at virtual MDT were **MDR-TB or Suspected MDR-TB**

12 Virtual MDTs were held, with a mean of 16 cases discussed per meeting. Cases may be discussed at MDT as often as needed.

36
Hours of **MDT** discussion, with one MDT every month

65
Person-hours of **clinician MDT involvement.** Estimated as 20 minutes per case. Many clinicians stay on the call longer for personal learning.

.

792
Person-hours of **adviser MDT involvement.** Our expert advisers gave their time, knowledge and experience voluntarily

258
Person-hours of **trainee / observer MDT involvement**

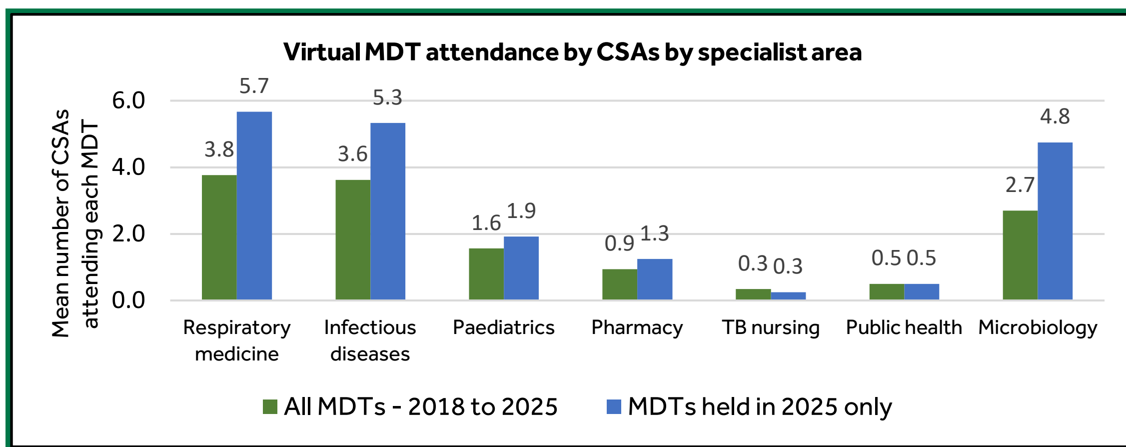
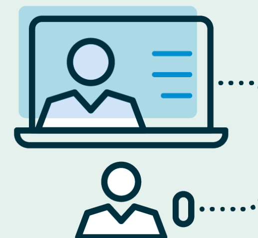


Figure 6: CSA attendance at virtual MDTs by specialist area

MDT WEBINAR: October 2025

- **131** Trainees/professionals attended
- **72** Trainees/professionals downloaded /viewed the recording



As well as the provision of expert advice, the Clinical Advice Service aims to offer support for the education and training of sub-specialty trainees. Spaces are therefore made available at the monthly MDTs for trainees who wish to observe the live case discussions.

To broaden this offer further, in 2024, a free, one-off webinar was proposed which would replicate one of the virtual, MDTs.

This objective was achieved in 2024 and, following positive feedback, the MDR-TB CAS Steering Group decided to repeat the offer in 2025 with the following changes:

- Part of the 'welcome' slide deck would include a list of useful definitions including: MDR-TB; XDR-TB; pre-XDR-TB and RR-TB.
- Bookings page would include link to WHO guidelines on tuberculosis and care.
- Timing would change to lunchtime (90mins)

PART 2 – Multi and Extensively Drug-Resistant Tuberculosis (MDR AND XDR-TB)

This section of the report deals with cases reviewed from January 2025 to the end of December 2025, initially categorised by the clinician as being either XDR-TB, MDR-TB or suspected MDR-TB.

The World Health Organisation (WHO) definitions, as of January 2021[1]:

Pre-XDR-TB: TB caused by Mycobacterium tuberculosis(M.tuberculosis) strains that fulfil the definition of MDR/RR-TB and which are also resistant to any fluoroquinolone*

XDR-TB: TB caused by Mycobacterium tuberculosis (M. tuberculosis) strains that fulfil the definition of MDR/RR-TB and which are also resistant to any fluoroquinolone and at least one additional Group A drug*

*The fluoroquinolones include levofloxacin and moxifloxacin as they are the fluoroquinolones currently recommended by WHO for inclusion in longer regimens. The Group A drugs are currently levofloxacin or moxifloxacin, bedaquiline and linezolid, therefore XDR-TB is MDR/RR-TB that is resistant to a fluoroquinolone and at least one of bedaquiline or linezolid (or both). The Group A drugs may change in the future; therefore the terminology Group A is appropriate here and it will apply to any Group A drugs in the future.

In 2025, **35** centres have contributed cases classified by the treating clinician as either XDR, MDR or suspected MDR-TB to the BTS MDR-TB Clinical Advice Service:

65 patient demographic records

65 complete clinical/diagnosis records

5 follow-up records representing 3 unique patients.

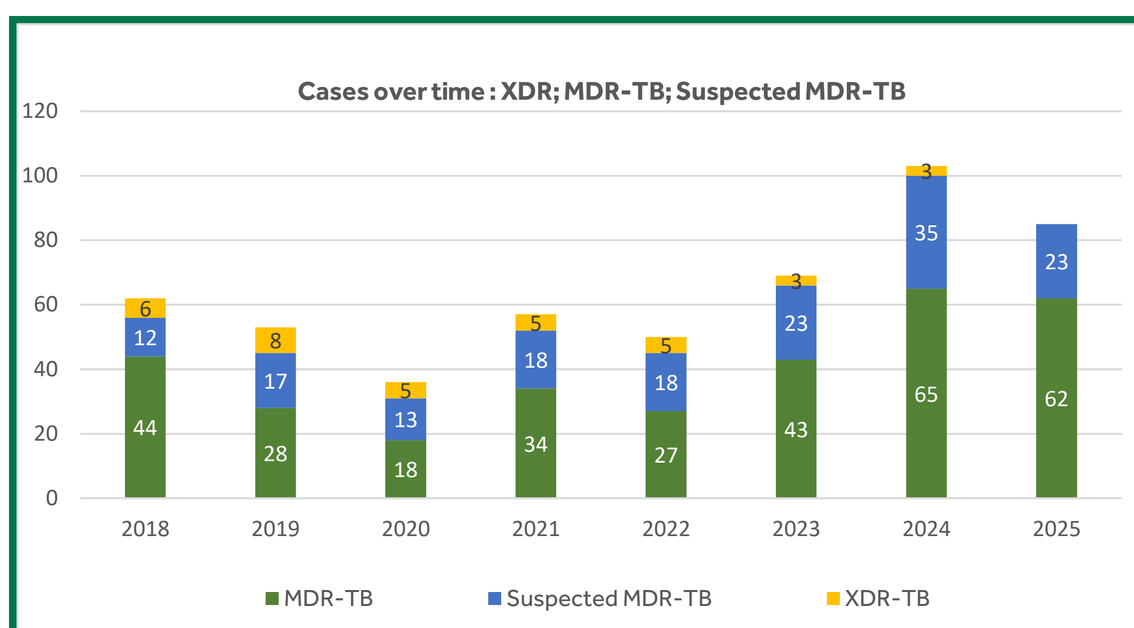


Figure 7: Case number totals over time for clinician reported XDR-TB, MDR-TB and Suspected MDR-

2.1 THE 2025 XDR, MDR-TB and Suspected MDR-TB PATIENT COHORT

There was a slight weight of male (64%) to female (36%) patients, and the majority were of South Asian (46%), White (23.8%), or Black African (20.6%) ethnicity.

The mean age of patients at the time their case was first discussed on the CAS was 35.5 (± *12.4*), with ages ranging from <6 months to 80 years. More than half of patients (66%) were aged 20–39 years.

Under half of patients (47.7%, 21/44) had recorded clinical risk factors. Where present the most common were smoking (52.4%, and Diabetes (28.6%). Around 10% of cases reported Immunosuppression of which 50% recorded biological therapy (anti TNFα) as the cause. One case of immunosuppression was due to HIV co-infection (overall 3% of the population had HIV co-infection).

The majority (91.1%, 51/56) of patients had no listed social risk factors. Of those who did the most common were alcohol addiction (40%) and 40% with prison history (> 5 years ago). Drug use was reported in around 20% of cases. Where drug use was a known risk factor patients were still actively using drugs.

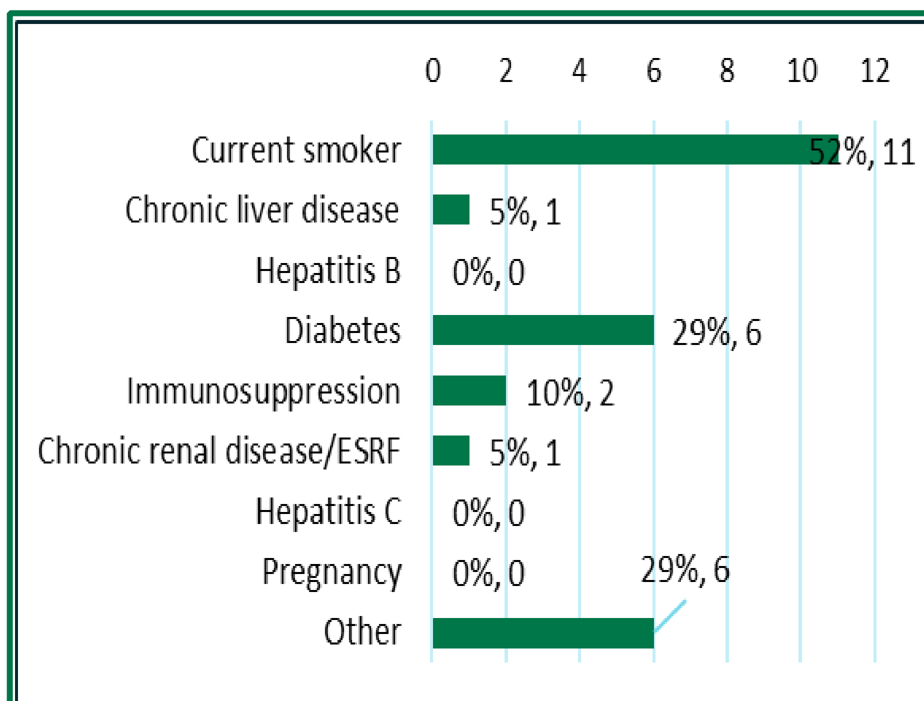


Figure 8: Clinical risk factors at first discussion (Total records:34)
Clinical risk factors recorded for all patients with known or suspected MDR-TB .

Overall, occupation reported for categories where the risk of exposure to TB may be elevated numbers were low with 79% reporting occupation as either 'other' or 'none'. Healthcare workers accounted for around 10% (10.3%) of reported cases and education 8.6% of cases.

2.2 CLINICAL/DIAGNOSTIC DATA

Weight loss (57%), cough (55%), fever (41%), night sweats (30%) and fatigue (27%), were the most commonly reported symptoms. Overall, 13% (7/56) of screened patients were reported to be asymptomatic. The majority of patients (72%) experienced symptoms for between one and six months before their case was entered into the Service and 13% experienced symptoms a year or more before presentation.

Excluding sputa, where smear samples were obtained the most commonly reported techniques were bronchoalveolar lavage (BAL) /endobronchial washing 8/65 cases (1.5%) and lymph node aspirate 5/65 cases.

Overall, 71% of cases had pulmonary involvement, with extra-thoracic and intra-thoracic lymph node involvement (19% and 22%) and pleural disease (7%) also frequently reported.

Within the reporting period, 13/65 patients were known to have a previous diagnosis of TB. Of these, 17% involved active TB. Resistance was known in 87.5% of source cases.

Key Figures

Key points

- **71%** of cases had pulmonary involvement
- **13%** of patients asymptomatic
- **17%** previously diagnosed with active TB
- **71%** required contact tracing
- **49%** had therapy observed in some way (e.g. DOT/VOT)

Contact tracing was required in 70.9% (39/55) of cases, while contact tracing requirements were unreported in 15% (8/55) of cases. Therapy was directly observed (DOT) in 17.6% (9/51) and video observed (VOT) in 31.4% (16/51) of cases. Therapy was self-administered (SAT) in 39.2% (20/51) of cases.

2.3 DRUG RESISTANCE

Local molecular laboratory capacity was responsible for 87% of cases (40/46) of initial MTB identification by PCR, with rpoB mutation representing rifampicin resistance present in 95% of cases where known (39/41).

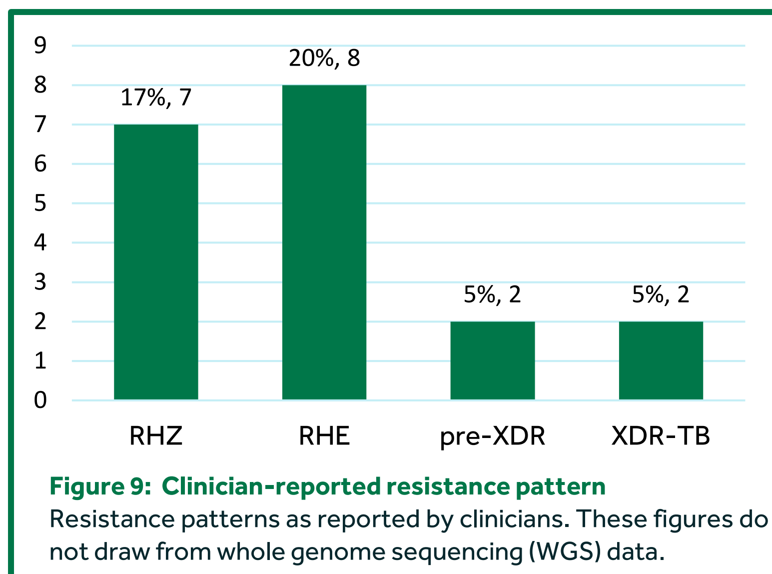


Figure 9: Clinician-reported resistance pattern
Resistance patterns as reported by clinicians. These figures do not draw from whole genome sequencing (WGS) data.

Of the 41 patients known or suspected MDR-TB (as described by the treating clinician), 17% (7/41) were specifically reported as resistant to each of rifampicin (R), isoniazid (H), and pyrazinamide (Z), and 20% (8/41) to R, H and Ethambutol (E).

Using the 2021 World Health Organisation (WHO) definitions [1], 5% (2/41) of cases would be considered to meet the definition of pre-XDR TB, and 5% (2/41) of cases met the definition for full XDR-TB.

PART 3 – Complex Sensitive TB, complex and Drug Resistant Non-MDR TB

This section of the report deals with cases reviewed from January to the end of December 2025, initially categorised by the clinician as being either complex sensitive TB, drug resistant non-MDR TB or other complex TB. The cases included in this section were contributed by 44 different centres.

53 patient demographic records

53 complete clinical/diagnosis records

5 follow-up records representing 4 unique patients.

3.1 THE COMPLEX SENSITIVE/RESISTANT NON-MDR TB PATIENT COHORT

Patients were almost equally reported as male (53.8%, 28/52) and female (46.2%, 24/52), and the majority were of either South Asian (55.3%) or White (26.4%), and 8% Black African ethnicity.

The mean age of patients at the time their case was first discussed on the CAS was 42.7 (± *20*), with ages ranging from 3 to 85. Nearly half of patients (43%) were aged 20 – 39.

Over half of patients (62.2%, 23/37) had listed clinical risk factors. Where present the most common was immune-suppression (30.4%). Cases where immunosuppression was a factor, biological therapy (anti TNFα) was the cause in 29% of cases. No cases of immune-suppression were reported as due to HIV co-infection. Smoking was reported in 26% of cases, chronic renal disease in 13% of cases and diabetes in 17.4% of cases.

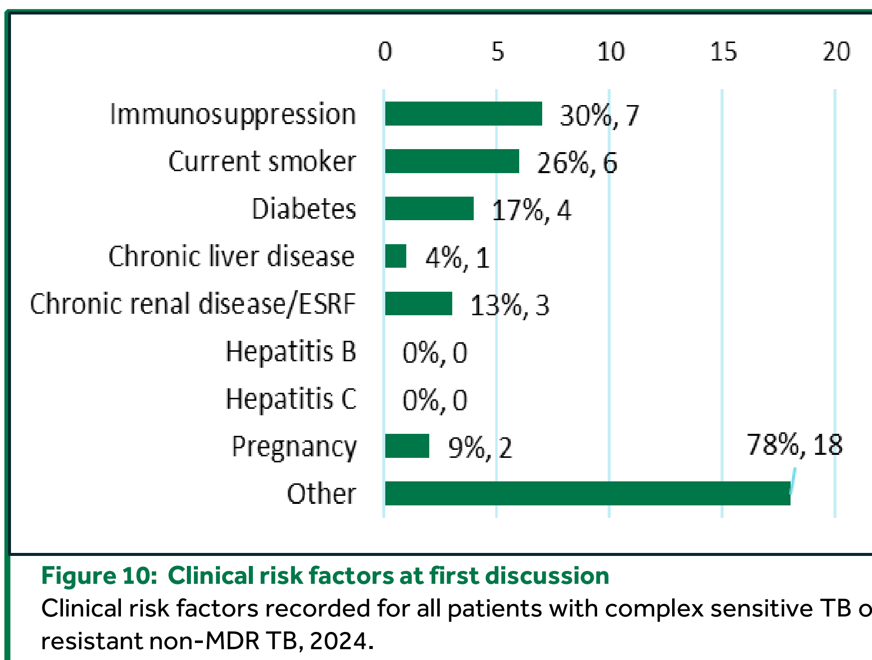


Figure 10: Clinical risk factors at first discussion
Clinical risk factors recorded for all patients with complex sensitive TB or resistant non-MDR TB, 2024.

Only 11.4% (5/44) of patients listed with a social risk factor and in 40% of cases (2/44) the risk was reported alcohol addiction and 40% reported homelessness.

Overall, 28.6% (14/49) of the cases discussed between January and December 2025 involved a patient who was known not to be in work. Occupation categories where the risk of exposure to TB may be expected to be elevated were healthcare (8.2% of cases), and education (14.3%).

3.2 CLINICAL/DIAGNOSTIC DATA

Cough (46%), weight loss (46%), night sweats 38%) fever (31%), and lymph node swelling (31%) were the most commonly reported symptoms. Half of patients (66%) experienced symptoms for between one and six months before their case was entered into the Service, with 25% of patients experiencing symptoms for a year or more.

Excluding sputa, where smear samples were obtained, techniques reported were bronchoalveolar lavage (BAL) /endobronchial washing 1.5% (5/53 cases) and lymph node aspirate 1.2% (4/53 cases).

Overall, 54% of cases reported intra-thoracic lymph node involvement, 38% of cases had pulmonary involvement, and 38% extra-thoracic lymph node involvement.

Overall, only one patient was 4.2% known to have a previous diagnosis of Active TB and none Latent TB.

Contact tracing was reported as required in 30.8% (4/13) of cases. Therapy was self-administered (SAT) in 90% (10/11) of cases, 9% of cases were VOT.

Key Figures

- **46%** Cough and weight loss most common reported symptoms
- **54%** had intra-thoracic lymph node involvement
- **38**% had pulmonary involvement
- **4.2%** previously diagnosed with Active TB *(0% Latent TB)*
- **90%** therapy was self-administered (SAT)

PART 4 – Specialised Commissioned and Novel Drugs

NHS England's commissioning policy statement (pub. 26 June 2024) confirming BPaL/BPaLM as the preferred treatment option for all eligible patients with suspected, functional, or confirmed RR-TB, MDR-TB or pre-XDR TB. NHSE also approved extended (> 6months) and/or sequential and/or concomitant use of bedaquiline and delaminid for those same defined patient groups plus patients with XDR-TB (Pub. 28 June 2024). NHS England has commissioned use in patients who meet the following criteria:

- Treatment agreed following discussion with the MDT of the MDR-TB treatment centre or the regional MDT in conjunction with an MDR-TB treatment centre; treatment of children must also be agreed after discussion with a Paediatric Infectious Diseases Centre.
- The patient must be managed with directly or video observed therapy.
- The treatment regimen must be designed according to current WHO recommendations[2], based on known resistance patterns and tolerance to individual drugs.

The BTS MDR-TB Clinical Advice Service can be considered as providing the function of a regional/national MDT to consider support of Blueteq applications for the use of these drugs.

The information presented here relates to individual patient treatment history at first entry. Data on the panel supporting the prescription (or continuing use of) bedaquiline or delamanid is based on the outcome of virtual MDT case discussion meetings and on support through consensus reached outside MDT discussion.

Of the cases registered with the BTS MDR-TB CAS in 2025, 31.8% (78/245) involved a clinician requesting support for novel drug regimen. Of these, requests for only bedaquiline were 7.7% (6/78) or only delamanid (1.3% 1/78). Bedaquiline and Pretomanid were requested as part of BPaL or BPaLM regimen in 90% (70/78) of cases.

Overall, the panel approved or supported a regimen / drug request in 96.2% (75/78) of all cases. BPaL (1/5) / BPaLM(4/5) was recommended in 5 cases by CAS in the absence of any clinician request.

A full breakdown of support for the use of bedaquiline and/or delamanid by disease category is included in Overview 2 below.

Key Figures

- The panel supported using Bdq and/or Dlm in **100%** of cases where requests were made, and **5%** (4/80) of cases were known or suspected XDR/MDR-TB
- Bedaquiline approval was requested and approved in 5/6 cases compared to in 17 out of 21 requests/cases in 2024.
- Bedaquiline use, as part of BPaL/BPaLM regimen featured in in over **89.9%** (70/78) of cases seeking approval/support.
- Overall, over **96%** of requests for novel drugs were approved

Overview 2: Specialised Commissioned and Novel Drugs

The BTS MDR-TB Clinical Advice Service provides an important gatekeeping function for the use of specialised commissioned and novel drug therapies, conducting independent reviews and providing consensus on whether to support use (or continued use beyond 24 weeks) of bedaquiline and delamanid.

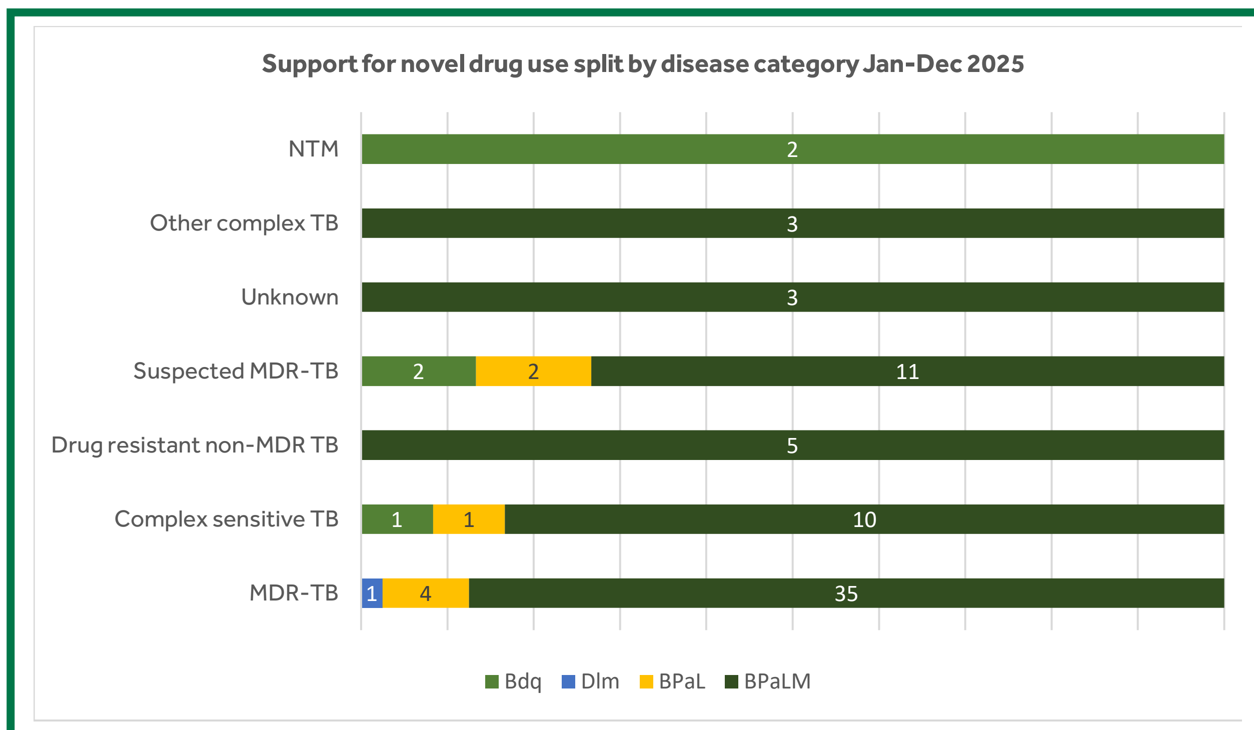


Figure 10: Support for novel drugs

This figure (Figure 10) shows the absolute numbers of cases discussed during this reporting period, as reported at entry to the Service. Further analysis is required to determine the eventual categorisation of cases reported as suspected MDR-TB.

The proportion of cases where the panel supported the use of one or more novel drug treatments is high with 96% being approved (69% of cases reported to have known or suspected XDR/MDR-TB. These data highlight the essential role of expert discussion in case management.

These figures may be artificially low, as cases where advisers indicated conditional support (e.g. dependent on pending sensitivity results, or on the loss of another drug) have not been counted.

	Bedaquiline only	BPaLM (inc BPaL)	Delamanid only	Not requested/supported
XDR-TB	0% (0/0)	0% (0/0)	0% (0/0)	0% (0/0)
MDR-TB	0% (0/54)	72.2% (39/54)	1.9% (1/54)	25.9% (14/54)
Suspected MDR-TB	13.3% (2/15)	86 % (13/15)	0% (0/15)	0% 0/15)
Resistant non-MDR	0% (0/5)	100% (5/5)	0% (0/5)	0% (0/5)
Complex sensitive TB	8.3% (1/12)	91.7% (11/12)	0% (0/12)	0% (0/12)
NTM	100% (2/2)	0% (0/2)	0% (0/2)	0 % (0/2)
Other	0% (0/3)	100% (3/3)	0% (0/3)	0% (0/3)
Unknown	0% (0/3)	100% (3/3)	0% (0/3)	0% (0/3)

CLINICAL SERVICE ADVISERS

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Dr Maddalena Cerrone
Miss Aneeka Chavda
Ms Christabelle Chen
Dr Meg Coleman
Dr Suzi Coles
Dr David Connell
Professor Gerry Davies

Dr Martin Dedicoat
Dr Devesh Dhasmana
Professor Francis Drobniewski
Dr Laura Ferreras Antolin
Professor Andres Floto
Dr Louis Grandjean
Dr Guy Hagan
Dr Pranabashis Haldar
Dr Dominic Heining
Ms Hanna Kaur
Professor Onn Min Kon
Dr Heinke Kunst
Dr Ian Laurenson
Dr Patrick Lillie
Professor Marc Lipman
Miss Vikki Lloyd
Dr Jim Macfarlane
Dr Kavina Manalan
Dr Andrew McCallum
Dr Ellen Mekonnen

Dr James Millard
Dr Olga Moncayo
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Further information on the work of the British Thoracic Society can be found on the following websites:

British Thoracic Society (BTS)

BTS MDR-TB Clinical Advice Service

Respiratory Futures