Supplemental Digital Content 1A. Pediatric TB score chart developed by the IDAI[2]

	Score			
	0	**1**	**2**	**3**
Household contact	Not clear	-	By family report; smear (-)/ not known	Smear (+)
Tuberculin skin test	Negative	-	-	Positive (>10 mm or >5 mm if immunosuppressed)
Nutritional status	-	BW/H <90% or BW/A <80%	Severe malnutrition (BW/A <60%)	-
Fever of unknown origin	-	≥2 weeks	-	-
Chronic cough	-	≥3 weeks	-	-
Lymphadenopathy (cervical, axillary, inguinal)	-	≥1 cm, amount >1, pain (-)	-	-
Joint swelling (hip, knee, vertebral, phalangeal)	-	Swelling (+)	-	-
Chest X-ray	Normal/ not clear	Suggestive TB	-	-

IDAI: Ikatan Dokter Anak Indonesia (Indonesian pediatric society); BW: body weight; H: height; A: age.

To diagnose TB using the IDAI scoring system, there are several aspects that should be considered: (1) A child is diagnosed with TB and treated with anti-TB drugs if total score ≥6; (2) Chest X-ray is not considered to be the main diagnostic tool; (3) Prolonged fever and cough are relevant as TB symptoms if no response to an adequate therapy; (4) If total score <6 with a negative tuberculin skin test (TST) and no close contact history, the patient should be observed for the next 2-4 weeks. Then, if clinical characteristics of TB occur during follow-up, re-evaluate for TB or other possible diagnoses; (5) A child with a total score of 6 consisting of positive bacillary TB close contact and positive TST induration but without any sign and symptom of TB, should be closely observed for clinical prognosis over 2-4 weeks and treated with isoniazid prophylaxis; (6) Isoniazid prophylaxis is prescribed for patients with a total score <6 when smear-positive TB close contact confirmed; (7) A child with a total score of 5 consisting of smear-positive TB close contact and two other clinical TB symptoms, in a health facility where TST is not available, the diagnosis for TB may be enforced, and the child should be closely monitored for the first two months of TB-therapy; (8) In a health facility where TST and chest radiography are not available, the diagnosis can be established when a total score ≥6; (9) If clinical improvement is observed during 2-4 weeks monitoring, the treatment is allowed to continue. If there is no clinical improvement after treatment with anti-TB drugs, patients should be assessed for other possible causes such as misdiagnosis, comorbidity, drug resistance TB and low medication adherence.[1]

Supplemental Digital Content 1B. The daily drug doses of isoniazid, rifampicin, pyrazinamide and ethambutol for children based on the IDAI in accordance with the WHO[1,2]

	Dose and range (mg/kg body weight)	Maximum (mg)
Isoniazid (H)	10 (7-15)	300
Rifampicin (R)	15 (10-20)	600
Pyrazinamide (Z)	35 (30-40)	2000
Ethambutol (E)	20 (15-25)	1000

IDAI: Ikatan Dokter Anak Indonesia (Indonesian pediatric society); WHO: World Health Organization. All patients were followed up based on DOTS (directly observed treatment, short-course) as recommended by the WHO.

References for Supplemental Digital Content:

1. Rahajoe NN, Setyanto DB, Kaswandani N, et al. Petunjuk teknis manajemen TB anak (*National guideline on the management of tuberculosis in children*). Jakarta: Kemenkes RI; 2013.
2. WHO. 2014. Guidance for national tuberculosis programmes on the management of tuberculosis in children (2nd ed). Available at: http://www.who.int/tb/publications/childtb_guidelines/en/