

Health Update

Date: November 5, 2009
From: Spokane Regional Health District Epidemiology
To: Spokane County Health Care Providers
Subject: This Week's H1N1 Information Update

Please ensure that this information is shared with the appropriate personnel in your facility. Thank you.

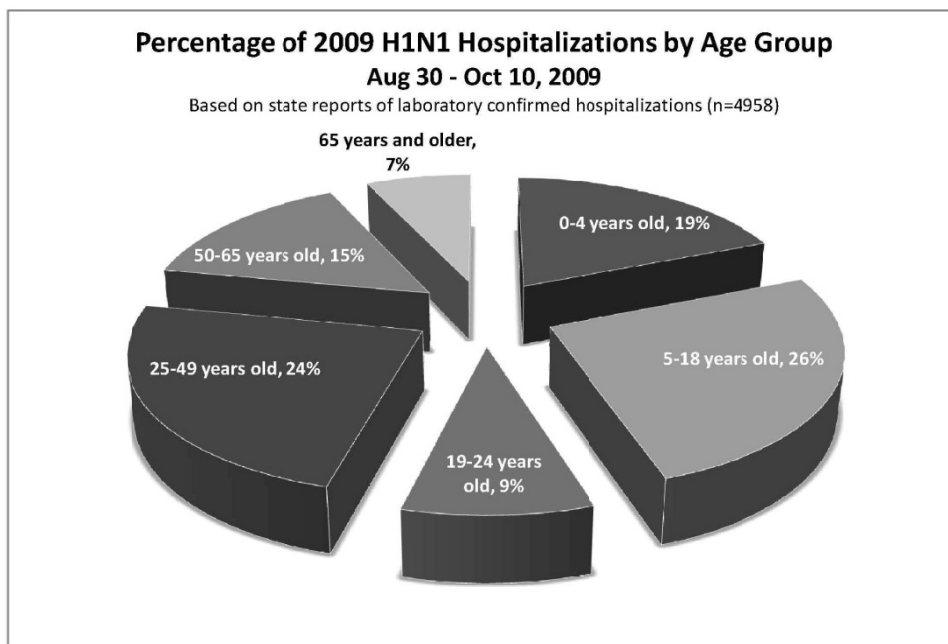
The weekly Update will now be distributed on Wednesdays, as that is the day statewide data is available.

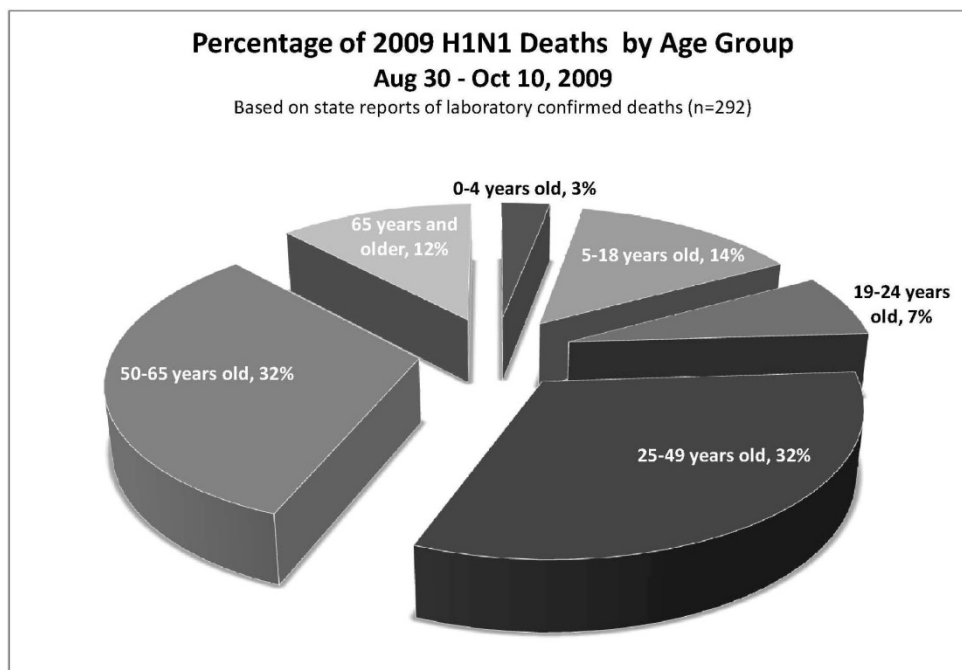
Summary Data for:

Nation Week 42 (October 18-24, 2009)

- All subtyped influenza A viruses reported to CDC were 2009 influenza A (H1N1) viruses.
- The proportion of outpatient visits for influenza-like illness (ILI) was above the national baseline. Forty-eight states reported geographically widespread influenza activity.
- The proportion of deaths attributed to pneumonia and influenza (P&I) was above the epidemic threshold.
- Twenty-two influenza-associated pediatric deaths were reported. Nineteen of these deaths were associated with 2009 influenza A (H1N1) virus infection and three were associated with an influenza A virus for which the subtype was undetermined.

Newly available information on nationwide hospitalizations and deaths is displayed below:



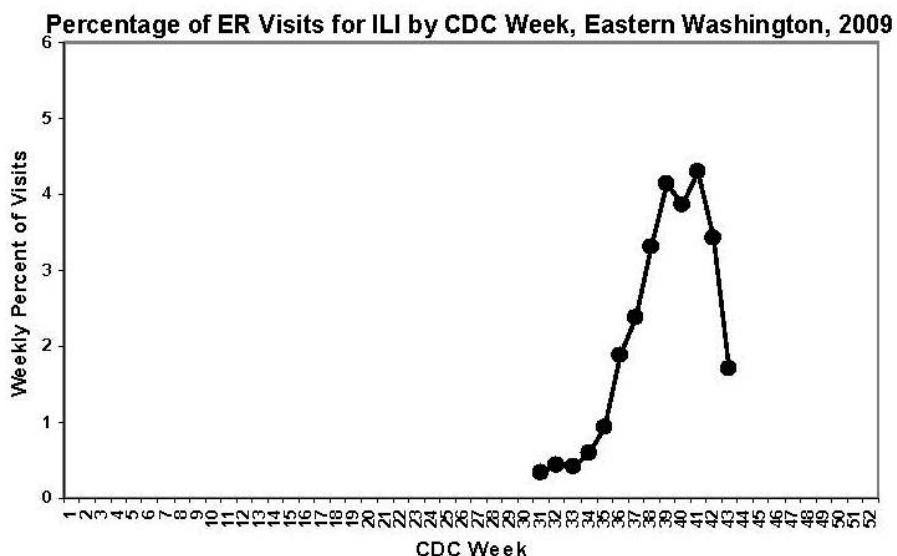


According to Emerging Infections Program (EIP) data collected from April 15 through October 27, 2009, 32% of people hospitalized with 2009 H1N1 had asthma.

State/Local Week 43 (October 25-31, 2009)

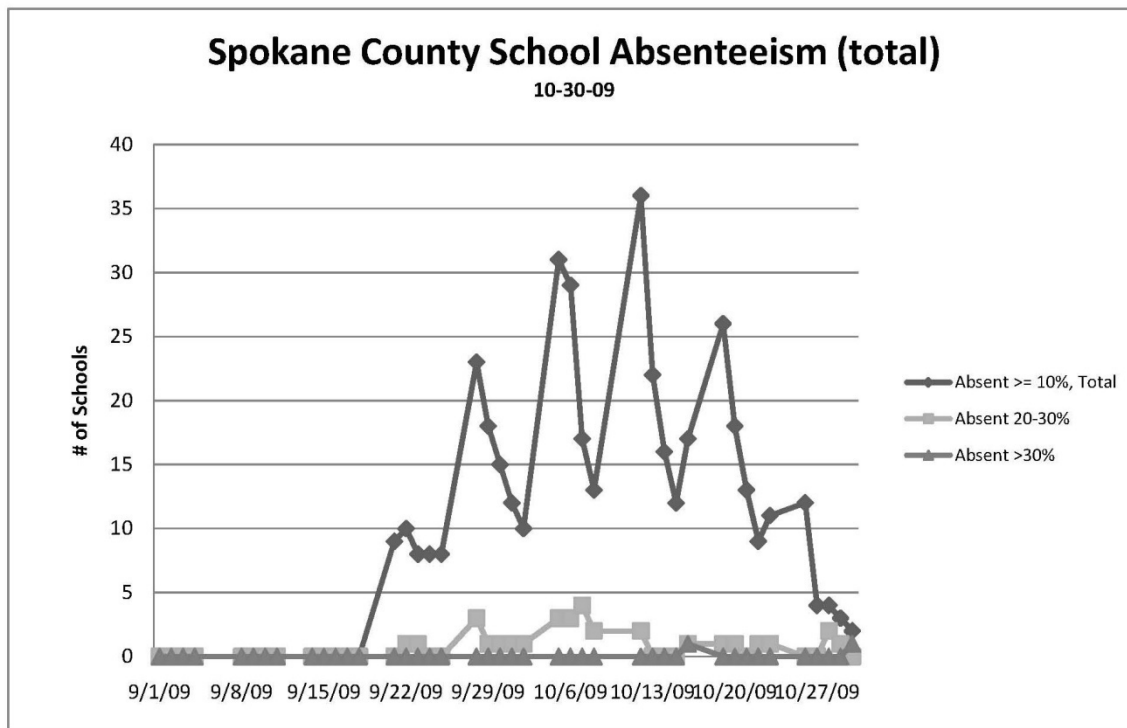
- The number of hospitalized and fatal influenza cases reported to the Department of Health (DOH) was approximately the same as the previous week (214 cases in week 42 vs. 202 cases in week 43).
- No influenza-associated pediatric deaths were reported in Washington.
- DOH received one report of a hospitalized patient with confirmed seasonal [not 2009] H1N1. This patient acquired the infection in another country.
- Influenza activity remains high in both western and eastern Washington. In western Washington, influenza activity continues to increase but may be starting to level off. Influenza activity is decreasing in eastern Washington.
- Twelve sentinel providers in Washington reported data to CDC. Of 2381 patient visits, 219 patients (9.2%) met the case definition for influenza-like illness (ILI; defined as fever $\geq 100^{\circ}$ F AND cough and/or sore throat [in the absence of other known cause]). Most patients seen for ILI during week 43 were under 25 years old.
- During September 19–October 31, DOH received reports of 736 hospitalized and 19 fatal cases of laboratory-confirmed influenza. Of these cases, 327 reside east and 428 reside west of the Cascade Mountains.

Health Information Exchange Data: This syndromic surveillance system collects data from 12 emergency departments (ED) in Eastern Washington. ILI is derived from chief complaint.



School Absenteeism:

Because not all people with influenza-like illnesses are tested, we use school absenteeism as one indicator of flu activity levels in the community. Because not all people with influenza-like illnesses are tested, we use school absenteeism as one indicator of flu activity levels in the community.)



Note: Absenteeism rates include full and partial days of absence for any reason, including appointments, field trips, and any kind of illness. Data for most recent days may not be complete due to delayed reporting from schools.

ANTIVIRALS:

On October 16, 2009 the CDC updated guidance for the use of Antiviral Medication in the treatment and prevention of influenza (www.cdc.gov/h1n1flu/recommendations.htm). Antiviral medications can reduce the severity and duration of influenza illness and can reduce the risk of influenza-related complications, including severe illness and death. Most healthy people who develop an illness consistent with uncomplicated influenza, or persons who appear to be recovering from influenza, do not need antiviral medications for treatment or prophylaxis. Antiviral medication is recommended for the following:

1. **Recommended:** all patients hospitalized with suspected or confirmed influenza
2. **Recommended:** persons with warning symptoms (dyspnea) or signs (tachypnea, oxygen desaturation) of lower respiratory involvement
3. **Generally recommended:** persons at risk for complications with confirmed or suspected influenza, including:
 - Children under 5 years old
 - Pregnant women and women up to 2 weeks postpartum (including after pregnancy loss)
 - Adults over 65 years of age
 - Persons under 19 years of age on long-term aspirin therapy
 - Persons with chronic predisposing conditions or immunosuppression

Other treatment considerations:

1. Clinical judgment is always important.
2. Recommendations apply to persons with confirmed or suspected influenza.
3. Treatment should not be delayed to establish the diagnosis
4. The rapid tests show sensitivity of only 10%-70%.
5. Patients at high risk for complications might be given prescriptions for antivirals to fill after telephone consultation.

6. More than 99% of seasonal influenza A (H1N1) strains were resistant to oseltamivir in the 2008-2009 flu season, but few of those strains have been detected since April 2009. Therefore, the recommendation stands to use oseltamivir or zanamivir until national surveillance data shows a need for an alternative strategy.

Post exposure Prophylaxis

Consideration for antiviral prophylaxis should generally be reserved for people at higher risk for influenza-related complications who have had contact with someone likely to have been infectious with influenza. Consider oseltamivir or zanamivir prophylaxis in the following circumstances:

1. In persons at high risk for complications with exposure.*
2. In health care workers or emergency medical service workers with exposure.*
3. To control outbreaks in closed or semi-closed settings, such as nursing homes and correctional institutions.

*Unprotected exposure no longer than 48 hours after contact with a person with confirmed, probable, or suspected H1N1 or seasonal flu during the contagious period (defined as 1 day before symptoms until 7 days after onset of illness)

Early treatment after exposure is an alternative strategy to postexposure prophylaxis. This would involve giving patients prescriptions for oseltamivir or zanamivir to take promptly after the onset of symptoms after consulting with their health care provider. Antiviral prophylaxis is not recommended for healthy children or adults exposed in community, school, camp, or similar settings.

VACCINE:

Important Points about H1N1 Vaccine

- All influenza vaccine preparations in the United States for the 2009-2010 season contain residual egg protein and none contain adjuvant.
- Children 6 months to 9 years of age who are given influenza A (H1N1) vaccine should receive 2 doses separated by 4 weeks; persons 10 years of age and older should receive 1 dose.
- The influenza A (H1N1) vaccines are made according to the same standards for seasonal influenza vaccines and have the same age group indications, precautions, and contraindications as vaccines that are FDA-approved for seasonal flu.
- Clinical trials have been conducted with influenza A (H1N1) vaccines using the same methods used to test the safety and efficacy of seasonal flu vaccines.
- There is minimal evidence of significant antigenic change since the first characterization of the virus in April 2009, indicating that the virus continues to be well matched with the vaccine strain.
- Live attenuated influenza vaccine (LAIV) can be given to nearly all healthy, non-pregnant health care workers, including those who come in contact with newborn infants (even those in neonatal intensive care), pregnant women, persons with a solid organ transplant, persons receiving chemotherapy (except in preparation for a bone marrow transplant), people with diabetes, people with asthma taking corticosteroids and persons with HIV/AIDS.
- The only healthy, non-pregnant health care providers under 50 years of age who should not get LAIV are those who provide medical care for patients who require special environments in the hospital because they are profoundly immunocompromised (e.g., those who work in bone marrow transplant units).

Information on local vaccine availability is regularly updated on our website, www.srhd.org or on our recorded information lines, 324-1495 for H1N1, or 324-1643 for seasonal.

NEW CDC RESOURCES:

CDC has set up a [24/7 phone line \(404-368-2133\)](tel:404-368-2133) to provide clinical consultation on critically ill pregnant women with suspected or confirmed influenza. CDC has asked that this line not be used for other pregnancy flu-related questions.

Antiviral Resistance Testing

In addition to performing antiviral resistance testing for surveillance purposes, CDC provides antiviral resistance testing for clinical care on a limited case by case basis. For information regarding antiviral testing for clinical purposes, please see the attached CDC-developed fact sheet and algorithm. According to this algorithm, antiviral testing for clinical purposes should primarily be reserved for the following patients:

- 1) Patients with either a severe immunocompromising condition or patients in an ICU with no signs of clinical recovery despite a 5 day course of antiviral therapy, and documentation of persistent influenza A positive diagnostic tests.
- 2) Patients who develop laboratory confirmed influenza while on antiviral prophylaxis and who are recommended for antiviral therapy (hospitalized or at high-risk of complications).

Oct 22 '09 For APHL

Interim Algorithm for Requests for Antiviral Resistance Testing by CDC for Clinical Care

