



THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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nyc.gov/health

2005 New York City Department of Health and Mental Hygiene Health Advisory # 43: Influenza Update

- **Influenza Advisory**
 - Influenza vaccine distribution is expected to continue into January 2006 with more doses being available compared to last year. Vaccination should begin as soon as providers have vaccine and should continue into early 2006.
 - If unable to obtain vaccine, requests for vaccine can be placed through DOHMH at <http://www.nyc.gov/html/doh/html/imm/fluhome.shtml> or by calling 1-866-NYC-DOH1.
 - Four laboratory-confirmed influenza infections have been reported in NYC to date this season. There is no evidence of widespread influenza activity.
 - DOHMH requests that pediatric providers report suspected or confirmed influenza-related deaths in children < 18 years of age.

- **H5N1 Avian Influenza Advisory**
 - Highly pathogenic avian influenza (H5N1) activity continues in both birds and humans in Asia. Avian influenza activity has also been found in birds in parts of Europe; no human cases have been reported there.
 - DOHMH reminds providers to remain alert and report any suspected H5N1 avian influenza cases among travelers returning from currently affected countries. Providers should obtain a travel history from ALL patients with severe respiratory illness (e.g., pneumonia or ARDS) requiring hospitalization.
 - Personal stockpiles of influenza antiviral medications are not recommended.

Please distribute to staff in the Departments of Critical Care, Emergency Medicine, Family Practice, Geriatrics, Internal Medicine, Infectious Disease, Infection Control, Pediatrics, Pulmonary Medicine and Laboratory Medicine

November 10, 2005

Dear Colleagues,

With recent reports of the first laboratory-confirmed influenza infections in New York City this season, the New York City Department of Health and Mental Hygiene (DOHMH) would like to remind providers of the importance of influenza vaccination, especially in persons at high risk of complications secondary to influenza infection and of the need to report: 1) nosocomial outbreaks of febrile respiratory disease, 2) suspected or confirmed influenza-related deaths in children aged < 18 years, and 3) suspected cases of avian influenza among travelers returning from affected countries.

1) Influenza vaccine should be in sufficient supply this season, and vaccination should begin as soon as providers have vaccine: This year, more influenza vaccine will be available compared to last year;

Categories of urgency levels for NYC DOHMH Broadcast Notification System:

Health Alert: conveys the highest level of importance; warrants immediate action or attention

Health Advisory: provides important information for a specific incident or situation; may not require immediate action

Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action

total production is estimated to range between 71 and 97 million doses. Despite the shortage of vaccine last year, an estimated 3 million doses of vaccine went unused. There are three manufacturers of inactivated influenza vaccine: Sanofi Pasteur (formerly Aventis), GlaxoSmithKline (licensed for use in the U.S. market in August 2005), and Chiron. MedImmune manufactures a live, attenuated intranasal vaccine (FluMist®). Influenza vaccine distribution began in September and is expected to continue through January. Many facilities and providers may have only received a partial shipment or they may not yet have received any vaccine. Providers in need of vaccine should first check with their supplier. If unable to obtain vaccine, requests for vaccine can be placed through DOHMH at <http://www.nyc.gov/html/doh/html/imm/fluhome.shtml> or by calling 1-866-NYC-DOH1. Updates on vaccine supply can be found at <http://www.cdc.gov/flu/professionals/vaccination/>.

Sanofi Pasteur has preservative-free 0.25 ml pre-filled syringes for use in children 6 – 35 months still available for purchase. FluMist® is available for purchase from MedImmune and is encouraged for use in healthy persons 5–49 years of age including health care workers (except those who work in settings requiring protective isolation such as bone marrow transplant units) and household contacts of high risk individuals. Influenza vaccine is available for Vaccines For Children providers through the usual procedures.

DOHMH recommends that influenza vaccination proceed as soon as a provider receives vaccine; there are currently no restrictions on vaccine use. Although the optimal time to vaccinate against influenza is October and November, vaccination should continue as vaccine is received and into early 2006.

Strategies to improve inpatient and outpatient influenza vaccination rates should be implemented. Use of standing orders has been demonstrated to significantly increase coverage among patients and should be considered the standard of care. Increased efforts should be undertaken to ensure that hospital and clinic staff are vaccinated; vaccination of staff has been shown to improve patient safety and decrease work absenteeism by approximately half. If employees decline influenza vaccination, they should sign a refusal form acknowledging your commitment to staff vaccination. Go to <http://www.nfid.org/publications/calltoaction.pdf> for information on strategies to promote influenza vaccination among health care workers.

Additional information on influenza prevention and control and influenza vaccination recommendations is available at <http://www.nyc.gov/html/doh/downloads/pdf/chi/chi24-6.pdf>. For more information about standing orders, sample refusal forms, and additional resources to promote influenza vaccination, go to <http://www.nyc.gov/html/doh/html/imm/immpinfo.shtml> or call the Bureau of Immunization at 212-676-2259.

2) Only sporadic evidence of influenza in New York City so far this season

To date, four cases of laboratory-confirmed influenza have been reported this season. The first was influenza A, confirmed by culture, occurring in an 8-year-old female from Brooklyn. The second case was influenza B, confirmed by rapid test, in 10-week old female from the Bronx. The third was influenza A, diagnosed by rapid test, and occurred in Brooklyn in an 8-day-old baby who recovered and was discharged from the hospital. The fourth was influenza A, diagnosed by rapid test, occurring in a 48-year-old Queens resident. There have been no reported institutional influenza outbreaks, and the DOHMH's syndromic surveillance systems do not show any evidence of widespread influenza-like activity. As of early November 2005, there have been only a few reports of laboratory-confirmed influenza A or B nationally, which is normal for this time of year.

3) Surveillance for pediatric influenza-associated deaths

Influenza is a major vaccine-preventable cause of death among children. A significant number of recently described pediatric influenza-associated deaths occurred in previously healthy children aged 2 years of age or older, a group not currently recommended to receive annual influenza vaccination. More complete

data are needed to better define the burden of severe influenza in children and to develop appropriate strategies for prevention of pediatric influenza-associated mortality.

Suspected or confirmed influenza-associated death in a child less than 18 years of age is a reportable condition in New York City. A suspected or confirmed influenza-associated death is defined as one either resulting from a clinically compatible illness or confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. Laboratory testing for influenza A and B viral infection may be performed on pre- or post-mortem clinical specimens. DOHMH can advise on appropriate laboratory testing and can facilitate referral of specimens, including autopsy tissues, to reference laboratories. Providers should report any case of suspected influenza-associated death occurring in a child less than 18 years of age to both the DOHMH (see below) and the New York City Office of the Chief Medical Examiner at 212-447-2030 or to a hospital pathologist for autopsy evaluation.

4) H5N1 influenza: International Surveillance Update and Reporting Criteria in NYC

The extensive geographic spread of highly pathogenic avian (H5N1) influenza in wild and domesticated birds continues in Asia, and reports of H5N1 infection in birds have also recently occurred in Russia and parts of Europe. However, there have been no confirmed human infections of avian influenza outside of Asia (> 120 cases have been reported from Vietnam, Thailand, Cambodia and Indonesia to date). Almost all human infections of avian influenza have resulted from contact with infected poultry (i.e., chickens, ducks, or other domesticated birds), and human-to-human transmission of avian influenza has been very limited to date. Until an avian influenza strain emerges that can be transmitted efficiently from person to person, human H5N1 infection will not have demonstrated pandemic potential.

Air travel can facilitate global spread of emerging infections, and NYC acute care and outpatient facilities must remain alert for any recent traveler who presents with severe respiratory illness. **To rapidly detect the importation of influenza A (H5N1) into NYC, DOHMH requests that providers remain vigilant for severe respiratory disease in travelers within 10 days of returning from countries with recently confirmed H5N1 infections in poultry or humans.** (Currently, this includes Cambodia, China, Vietnam, Indonesia, Japan, Kazakhstan, Romania, Russia, Thailand, and Turkey.)

Interim Surveillance Criteria for Influenza A (H5N1): Febrile respiratory illnesses are one of the most common indications for medical evaluation, especially during the winter season. Since human cases of H5N1 influenza would be unlikely to occur in New York City, in the absence of increased evidence of human to human transmission in affected countries abroad, please only report suspect cases who meet the following clinical and epidemiologic criteria:

1. Hospitalized patients with:

- Unexplained, radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternative diagnosis has not been established, **AND**
- Travel to a country with documented H5N1 avian influenza in poultry and/or humans (currently including parts of Asia and Europe) within 10 days from onset of symptoms. Ongoing updates on countries affected by avian influenza may be found at websites listed below.

2. Hospitalized or ambulatory patients with milder illness meeting the criteria below (testing to be considered on a case-by-case basis):

- Documented temperature of >38°C (>100.4°F) and one or more of the following respiratory symptoms: cough, sore throat, or shortness of breath (dyspnea), **AND**

- History of direct contact with either (a) live domestic poultry or carcasses, or poultry feces (e.g., visited a live poultry farm, household raising poultry, or bird market) or (b) a known or suspected human case of influenza A (H5N1) in an affected country within 10 days of symptom onset.

Patients meeting these clinical and epidemiologic criteria should be placed in a separate room away from other patients and cared for using standard and droplet infection control precautions pending further evaluation. DOHMH should be notified as soon as possible and will provide further guidance on clinical management, including arranging diagnostic testing and transportation of specimens to appropriate reference laboratories. Diagnostic specimens (e.g., nasopharyngeal swabs or aspirates) should not be sent for routine viral culture until H5N1 influenza is ruled out. These interim guidelines may change in the future depending on updates in federal guidance or on changing epidemiologic features of avian influenza in humans.

To ensure that individuals meeting the above criteria are rapidly identified, it is recommended that acute and primary care facilities institute routine screening for travel history among all patients with suspected pneumonia or severe respiratory infections at the time of triage or on initial medical evaluation. Please note that the list of countries affected by H5N1 will likely change. Monitoring the following websites is recommended for the most up-to-date information on current avian influenza activity worldwide:

Centers for Disease Control and Prevention: <http://www.cdc.gov/flu/avian/>
 World Health Organization: http://www.who.int/csr/disease/avian_influenza/en/
 World Organization for Animal Health <http://www.oie.int>

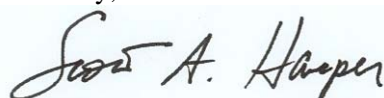
REPORTING SUSPECTED FATAL PEDIATRIC INFLUENZA CASES OR SUSPECTED CASES OF AVIAN INFLUENZA TO DOHMH:

- **During business hours, call the Bureau of Communicable Disease at 212-788-9830.**
- **At all other times call the Poison Control Center at 212-764-7667 or 1-800-222-1222.**

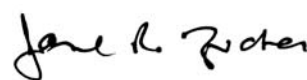
5) DOHMH does not recommend stockpiling of oseltamivir (Tamiflu®) or other influenza antivirals: There is currently no sustained, efficient transmission of avian influenza viruses from person-to-person occurring anywhere in the world. It is recommended that individuals NOT acquire or maintain personal stockpiles of oseltamivir (Tamiflu®). Providers should not provide prescriptions to patients for this purpose since doing so might lead to a decrease in the already limited supply of antivirals and might foster resistance to both human and avian influenza viruses if the drugs were used improperly. In addition, it is unclear how persons with personal stockpiles would know when to initiate therapy or what would constitute an effective regimen. However, influenza antiviral medications should continue to be used for prophylaxis and treatment of human influenza this season, especially in persons deemed at high risk for serious complications secondary to influenza infection.

As always, we appreciate the cooperation of the medical community in New York City and will update you with further information when it becomes available.

Sincerely,



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