

2009-2010 Influenza Season Update #2

To: Healthcare Providers, Hospital Emergency Departments, Clinical Laboratories,
Infection Control Practitioners, Pharmacists, Dental Health Professionals
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– Please Distribute Widely –

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Epidemiology & Surveillance Update

In Vermont:

- Vermont Department of Health Laboratory: Of 65 specimens analyzed between Oct. 4 and Oct. 10, 10 isolates were confirmed as influenza A. All were subtyped as 2009 H1N1 influenza A.
- Influenza-like illness activity (ILI) in Vermont is now classified as *regional*.
- Respiratory syndrome and ILI visits to seven hospitals and one walk-in clinic we monitor have increased since Labor Day, still within expected ranges for this time of year.

The Health Department reports weekly on Vermont flu activity at our website:
www.HealthVermont.gov. Choose “The Flu” at the top of our home page.

National and regional flu surveillance data reported to the Centers for Disease Control & Prevention (CDC) is available at: www.cdc.gov/flu/weekly/ Between Sept. 27 and Oct. 3 flu activity increased nationally. As of Oct. 3:

- 37 states reported *widespread* influenza activity.
- 99% of all subtyped influenza A viruses have been identified as 2009 H1N1.
- Resistance to oseltamivir remains below 1%.
- *Update*: The proportion of deaths from pneumonia and flu is now at the epidemic threshold.
- 11 children died from 2009 H1N1 influenza-associated illnesses between Aug. 23 and Sept. 26. Bacterial infections were noted in 37.5% of patients who had culture specimens collected from normally sterile sites.
- *Staphylococcus aureus* was the most commonly identified organism.
- 8 of 14 of these *S. aureus* isolates were resistant to methicillin.

Seasonal Flu Vaccine Supply

The national effort to provide sufficient 2009 H1N1 vaccine is complicating production and delivery of seasonal flu vaccine. We have learned from both CDC and vaccine manufacturers that the scheduled delivery for remaining doses of seasonal flu vaccine will not be as early as originally anticipated. Seasonal flu vaccine delivery delays – and shortfalls at some locations – have resulted in some clinics being postponed or cancelled. Some provider practice sites are also experiencing this.

We know that as of Oct. 5, more than 76,000 adult and pediatric doses of seasonal flu vaccine have been shipped to Vermont. Deliveries are expected to continue despite delays. Most of the remaining seasonal flu vaccine ordered is expected to be delivered during October and into November. As in past years, availability of seasonal vaccine should expand as the season progresses.

Providers looking to order additional vaccine are encouraged to use any supplies that they have now, and continue to look for additional flu vaccine for purchase in the coming weeks. Prioritizing use of available vaccine according to current seasonal flu vaccination guidelines is encouraged. See seasonal flu guidance at: <http://healthvermont.gov/prevent/flu/index.aspx>

To assist providers in finding flu vaccine available for purchase, the National Influenza Vaccine Summit supports IVATS, the Influenza Vaccine Availability Tracking System, which provides information about vaccine manufacturers and distributors with vaccine available for purchase. IVATS can be found at: <http://www.preventinfluenza.org/ivats/>. The information in IVATS is updated throughout the influenza vaccination season.

As always, the Health Department will publicize flu vaccination clinics that are open to the public on our website. Go to www.HealthVermont.gov, then choose the clinic finder at the top of the home page.

2009 H1N1 Influenza Vaccination

To date, nearly 16,000 doses of 2009 H1N1 vaccine have been shipped to hospitals and primary care practices in the state. Recipients include all 16 hospitals, 49 primary care providers, 7 colleges and 6 Visiting Nurse or Home Health agencies. Of the initial 3,900 doses of Live Attenuated Influenza Vaccine for the new 2009 H1N1, over 630 doses have been administered to patients and health care providers. Wider distribution of new shipments and re-supply to existing recipients is planned as new deliveries arrive. Future deliveries will include both LAIV as well as injectable vaccine formulations. Please use CDC's Advisory Committee on Immunization Practices (ACIP) recommendations to administer vaccine first to those identified to be at greatest risk for serious illness:

- Pregnant women
- Household contacts and caregivers of children younger than 6 months
- Health care workers and EMS personnel
- Anyone age 6 months through 24 years old
- Adults age 25 through 64 with medical conditions that put them at higher risk of serious complications from influenza

School-based vaccination clinics are due to begin in late October. **Please note:** We encourage providers to offer vaccine to anyone age 6 months to 24 years old, even if the child or young adult attends a school that will be holding H1N1 vaccination clinics. We expect to be able to send the list of participating schools, with a health advisory about vaccinating school-age children, by Oct. 16.

Public vaccination clinics for the same groups at higher risk of complications (listed above) will begin in November. As more vaccine is available in the coming months, it will be offered to people beyond the groups identified above.

You can still enroll as a participating provider. Call the Health Department's Immunization Program at 802-863-7638.

Live Attenuated Influenza Vaccine (LAIV) & Health Care Personnel

The 2009 H1N1 LAIV is indicated for healthy, non-pregnant 2- to 49-year-olds, including many health care providers. Questions about LAIV use with EMS personnel who have contact with immunocompromised persons have been received.

From CDC's Frequently Asked Questions on this topic - 10.08.09:

http://www.cdc.gov/h1n1flu/vaccination/nasalspray_qa.htm

LAIV is a good option for most health care providers who are healthy, younger than 50 years, and not pregnant. However, health care providers should not get LAIV if they are providing medical care for patients who require special protected environments in the hospital because they are severely immunocompromised (e.g., those who work in bone marrow transplant units).

Although no immunocompromised patient has been shown to be harmed by use of LAIV among health care workers, the recommendation against the use of LAIV in health care workers with this type of patient contact is intended as an extra precaution for fragile immunocompromised patients.

Health care workers with this type of patient contact can get LAIV, but if they do, they should wait seven days after being vaccinated before returning to duties that include care of severely immunocompromised patients in special environments.

Below is a link to a report about the status of LAIV in the U.S. See the safety profile section for specific information on shedding and spread of LAIV to contacts:

www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2710797

You may also be interested in the current Healthcare Infection Control Practices Advisory Committee (HICPAC) isolation guidelines: www.cdc.gov/ncidod/dhqp/gl_isolation.html These guidelines detail "Protective Environment" precautions indicated for stem cell transplant recipients during times of greater risk for acquiring infections.

A reminder that any health care provider who chooses to work while ill: The Health Department strongly discourages anyone with flu-like illness, including those employed in health care, to stay home until at least 24 hours after their fever ends, without the use of fever-reducing medications.

Adverse Event Reporting after Vaccination

As a health care provider, you can help monitor the safety of vaccines by promptly and accurately reporting any clinically significant adverse event that occurs following vaccination to the Vaccine Adverse Event Reporting System (VAERS). Clinically significant adverse events are those events that are of concern to you or your vaccinated patients or their caregivers. Report clinically significant adverse events after vaccination, whether or not you administered the vaccine, and even if you are not sure if the vaccine caused the adverse event.

Contact the Health Department with questions about, or reports of, vaccine-associated adverse events, 802-863-7240 or by visiting the online VAERS site: <http://vaers.hhs.gov/index>

Antiviral Stockpile Guidance

Last spring, the Vermont Department of Health sent a portion of its antiviral stockpile to hospitals. This occurred during the rapid emergence and spread of the new flu, and out of a concern about the potential for high mortality. A 1918-like pandemic has not emerged at present, but this was one of the planning assumptions that led to the creation of the antiviral stockpile and planning for its use.

The stockpile is comprised not of one large holding, but of both state-held and federally-held drugs in amounts that, in total, would provide treatment courses to approximately 25 percent of each state's population. Last spring, Vermont received a portion of its federal allocation, as did other states and territories. After receipt, some states pushed drugs they'd received out widely, others held all drugs back in warehouses and monitored for shortages they might use their stockpile assets to fill, and still others placed portions of their stockpile closer to likely points of use, e.g. hospitals. This last method was Vermont's strategy: the Health Department placed 25 percent of the federally-supplied drugs we received at the state's hospitals to assure access for treatment of ill patients, in the event that demand overwhelmed the usual supply chain. We are fortunate that such demand did not occur, and only a handful of antivirals from the stockpile were used.

Use of the antiviral stockpile is authorized if, in the hospitals' best judgment, this is the best use of these assets. An example would be if the usual sources of antivirals could not meet demand.

Note that the Health Department may not be able to get additional antivirals from federal sources, so we discourage use of state stockpile unless clearly indicated, and in a setting where usual sources are insufficient. Providers dispensing state stockpile antivirals also must report such use to the Health Department—reporting is not needed if usual antiviral sources are used. We recognize this additional bureaucratic burden, but we are required to report to CDC how our stockpile allocations are used, and we must collect this information from providers and dispensers. Therefore, to reduce the risk of our state stockpile running low without clear ability to re-supply (which some states are experiencing) and to reduce reporting burdens on prescribers, dispensers and the health department, we discourage use of state stockpile antivirals when usual sources are sufficient to meet demand.

Providers can find current guidance at:
www.cdc.gov/h1n1flu/recommendations.htm