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Stephen A. Harriman, Commissioner

Influenza and Long Term Care Facilities

In the United States, influenza typically occurs between October and April, with peak activity between late December and early March. Influenza is a particular concern in long term care facilities. Because of their age and health condition, residents of long term care facilities are at increased risk for developing severe complications or even death due to influenza. In addition, influenza can spread easily in these settings, where many susceptible people live close to each other. When an influenza outbreak occurs in a long term care facility, more than half of the residents can be infected.

The Connecticut Department of Public Health recently conducted a survey of long term care facilities in Connecticut related to influenza and pneumococcal vaccination coverage levels. This survey was helpful in monitoring progress in Connecticut towards achievement of the US Public Health Service Healthy People 2000 goals of 80% influenza and pneumococcal vaccination coverage among residents of long term care facilities. Overall influenza vaccination coverage levels were good, with 70% of facilities meeting the Healthy People 2000 objective of 80% coverage. Facilities not requiring yearly consent for influenza vaccination had higher influenza vaccination coverage levels than those requiring yearly consent. Overall pneumococcal vaccination coverage levels were not as good, with only 31% of responding facilities meeting the US Public Health Service Healthy People 2000 objective of 80% coverage. Facilities that offered pneumococcal vaccination to all newly admitted residents who had not been previously vaccinated had higher pneumococcal vaccination coverage levels than those that did not.

In This Issue

Influenza and Long Term Care Facilities	21
Respiratory Disease Outbreaks in Health Care Facilities	21
New VRSA Reporting	23
STD Treatment Guidelines	23

During the winter months, respiratory illnesses due to viruses other than influenza are also common. Long term care facilities should have a system for monitoring the incidence of respiratory illness among residents and staff. Facilities should also have plans for controlling outbreaks of respiratory illness. Because respiratory outbreaks due to influenza can be particularly severe, and because special measures for controlling influenza outbreaks are most effective if implemented early, facilities should be prepared to quickly identify and manage outbreaks that are due to influenza. The following recommendations are intended to aid facilities in preventing and managing respiratory outbreaks in general, and influenza outbreaks in particular.

Respiratory Disease Outbreaks in Health Care Facilities

Advance Preparations

1. Encourage all residents and staff to receive an annual influenza vaccination according to ACIP guidelines (1).
2. Throughout the influenza season (October-April), offer the current influenza vaccination to all newly admitted residents who have not yet received it.

3. Encourage residents to receive pneumococcal vaccination according to ACIP guidelines (2).
4. Keep influenza and pneumococcal vaccination records available and up to date.
5. Establish a plan for management of respiratory outbreaks, including use of antiviral medication if warranted.
6. Obtain viral collection kits so they will be readily available if influenza testing is needed. Viral collection kits for influenza testing (throat swabs) can be obtained free of charge from the State Laboratory (860-509-8501).

Recognizing a Respiratory Outbreak

1. Identify a respiratory outbreak when respiratory illness occurs in more residents or staff than expected.
2. When an outbreak is identified:
   - Notify the medical director of the facility
   - Develop and maintain a line list of cases including name, location (wing/floor, room number), age, sex, date of symptom onset, major underlying medical conditions, symptoms, temperature, influenza and pneumococcal vaccination status, hospitalization, chest x-ray results, laboratory results (including influenza testing results), date of personal physician notification, and interventions and treatments implemented.

Control Measures for Respiratory Outbreaks

1. Confine symptomatic patients to their rooms if possible. If this is not possible, restrict them to the affected unit. Do not allow them to have access to the rest of the facility.
2. Ensure that ill employees do not work.
3. Discontinue "floating" of personnel where possible (have employees work consistently in only one area).
4. When transfers occur, notify the receiving facility of the outbreak.
5. Provide in-service training sessions for all staff. In-service training sessions should be specifically related to the duties of each employee group.
6. Notify visitors that a respiratory illness is occurring in the facility.

Reporting a Respiratory Outbreak

1. When a respiratory outbreak is identified, immediately notify the following agencies by phone (state regulations require reporting of all institutional outbreaks of any type):
   - Health Systems Regulation, DPH- phone (860) 509-7400, fax (860) 509-7543
   - Epidemiology Program, DPH- phone (860) 509-7994
   - Local Health Department for your town
   - Have your line list available when reporting the outbreak. This will facilitate answering some of the questions you will be asked.

Identifying Respiratory Outbreaks due to Influenza

1. Influenza should be suspected if a high proportion of affected residents or staff have fever (≥100°F oral or ≥101°F rectal) along with cough, sore throat or nasal congestion. If influenza is suspected, the medical director should ensure that specimens (naso-pharyngeal wash or swab, or throat swab) are obtained from at least six residents or staff with recent onset of symptoms (ideally within 48 hours of symptom onset).
2. Specimens should be submitted to an appropriate laboratory and tested by both rapid antigen detection and viral culture. Rapid antigen tests are very specific (95%-100%) and allow for prompt identification of influenza A. However, a rapid antigen test should be supplemented with viral culture because the sensitivity of the test may be only 50-75%. Both tests are available through the State Laboratory (free of charge from October 1, 1998 through March 31, 1999). If desired, two swabs can be collected, one for testing at a local laboratory and the other to be sent to the State Laboratory.

   When submitting specimens to the State Laboratory for influenza testing, write on the requisition form in section #1 that the specimen is for "Flu Study". This labeling must be present for the testing to be done

free of charge. If you have questions about submitting specimens, call the Virology Section of the State Laboratory at (860) 509-8553.

Control Measures for Respiratory Outbreaks due to Influenza

1. The measures listed above should be implemented for all respiratory outbreaks including influenza outbreaks.
2. For clusters or outbreaks identified as being due to influenza (one or more specimens positive for influenza by rapid antigen test or culture), also consider the following additional control measures:
   - Re-offer influenza vaccine to unvaccinated persons, including staff.
   - For clusters or outbreaks due to influenza A, use amantadine or rimantadine in accordance with Centers for Disease Control and Prevention guidelines and with appropriate physician orders (1).
   - Notify visitors that influenza is occurring in the facility.

References

1. CDC. Prevention and control of Influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1998;47(No. RR-6).
2. CDC. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1997;46(No. RR-8).

New VRSA Reporting

In January 1998, vancomycin-nonsusceptible *Staphylococcus aureus* was made reportable in Connecticut and laboratories that had suspect isolates were required to send them to the State Laboratory for confirmation.

In August 1998, at the request of the Centers for Disease Control and Prevention (CDC), in August we expanded the reporting requirement on a voluntary basis, and requested that all isolates with intermediate or reduced susceptibility to vancomycin and teicoplanin glycopeptides (minimum inhibitory concentration [MIC] $\geq$ 4 µg/mL) be reported to the state Department of Public Health (DPH) and that all such isolates which met CDC testing criteria be sent to the State Laboratory for confirmation. These categories include: vancomycin (or glycopeptide) intermediate-*S. aureus* (GISA) and *S. aureus* with reduced susceptibility to vancomycin (SARSV) along with vancomycin (or Glycopeptide) resistant-*S. aureus* (GRSA).

Antimicrobial resistance is increasingly a national concern, being found in a variety of healthcare settings. Of particular public health concern is the emergence of *S. aureus* with intermediate levels of resistance to vancomycin (1). As of August 1998, four such patients had been reported to the CDC. The Hospital Infections Program at the CDC has recommended that all staphylococci possibly resistant to glycopeptides (MIC $\geq$ 4 µg/mL) be sent to the CDC. (1)

Patients with staphylococcal infections with reduced susceptibility to vancomycin may have extremely limited clinical treatment options. Isolates with reduced susceptibility are needed for researchers to better understand the emerging mechanisms of resistance to aid in drug discovery and examination of treatment options. In addition, clinical outcome and laboratory information needs to be systematically reviewed to ensure that susceptibility data based on MICs are clinically relevant and that risk factors for the acquisition or development of infection are identified.

All SARSV, GISA, and GRSA suspect isolates meeting the CDC testing criteria should be immediately reported to the DPH and sent to the State Laboratory.

Please contact Dr. Zygmunt Dembek at the Epidemiology Program (860-509-7994) should any questions about antimicrobial-resistant *S. aureus* reporting arise.

Reference:

1. CDC. Update: Staphylococcus aureus with reduced susceptibility to vancomycin -- United States, 1997. *MMWR* 1997;46:813-815.

Connecticut Department
of Public Health
410 Capitol Ave., MS11EPI
P.O. Box 340308
Hartford, CT 06134-0308

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In This Issue... | Respiratory Outbreaks, VRSA Reporting, STD Treatment

New Guidelines for Treatment of Sexually Transmitted Diseases

The Centers for Disease Control and Prevention (CDC) has released a publication entitled *1998 Guidelines for Treatment of Sexually Transmitted Diseases* (1).

Advances since the last guidelines, published in 1993, include:

- Highly effective single-dose oral therapies for almost all common curable STDs;
- Improved treatments for herpes and human papilloma virus (HPV);
- A simple urine test making it much easier to diagnose and treat chlamydia in clinical and non-clinical settings;
- Recommendations to vaccinate all sexually active youth for hepatitis A and B; and
- Improved treatments for STDs in pregnancy to produce fewer side effects and to reduce the number of infants born prematurely.

The guidelines include diagnosis and treatment information for all common STDs, and are organized by syndrome -- STDs characterized by genital ulcers, by urethritis and cervicitis, and by vaginal discharge. They also include recommendations for STD prevention, as well as special considerations for women, adolescents and infants.

The guidelines are available for download at the CDC website:
http://www.cdc.gov/epo/mmwr/mmwr_rr.html.

Copies of *guidelines* can also be obtained by contacting: The Connecticut Department of Public Health, STD Control Program, 410 Capitol Avenue, Mail Stop #11STD, P. O. Box 340308, Hartford, CT 06134-0308; Phone 860-509-7920 or Fax 860-509-7743.

Reference:

1. CDC. 1998 Guidelines for treatment of sexually transmitted diseases. MMWR 1998;47(No. RR-1).

Division of Infectious Diseases

James L. Hadler, MD, MPH
State Epidemiologist

AIDS Epidemiology (860) 509-7900
Epidemiology (860) 509-7994
Immunizations (860) 509-7929
Pulmonary Diseases (860) 509-7722
Sexually Transmitted
Diseases (STD) (860) 509-7920

Connecticut Epidemiologist

Editor: Matthew L. Cartter, MD, MPH

Assistant Editor: Starr-Hope Ertel