



Influenza Testing

Isolation and identification of circulating influenza virus strains is an important part of the Connecticut Department of Public Health's (DPH) influenza surveillance system. The DPH encourages physicians to submit throat swabs from patients with a typical influenza syndrome (abrupt onset of fever, myalgia, and cough) to the DPH Laboratory for virus isolation. Specimens should be collected no later than 3 days after onset of symptoms and sent immediately to the DPH Laboratory, on wet ice if possible.

Throat swab collection kits (VRCs) may be obtained by calling the DPH Laboratory at 860-509-8501. Health care providers can submit specimens for influenza testing **at no charge** from **October 1, 2000 through March 31, 2001**. Please check "**181 V Influenza surveillance**" on the new microbiology test requisition form. Please provide all other necessary information as well. If you have any questions on specimen collection, handling, or transport, please contact the Virology Unit at 860-509-8553.

Updated Recommendations From the Advisory Committee on Immunization Practices in Response to Delays in Supply of Influenza Vaccine for 2000-01 Season

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References omitted

Edited to include erratum correction

On July 14, the Centers for Disease Control and Prevention (CDC) reported a substantial delay in the availability of a proportion of influenza vaccine for the 2000--01 season and the possibility of a vaccine shortage. Since then, resolution of

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manufacturing problems and improved yields of the influenza A (H3N2) vaccine component have averted a shortage. Although safe and effective influenza vaccine will be available in similar quantities as last year, much of the vaccine will be distributed later in the season than usual. This update provides information on the influenza vaccine supply situation and updated influenza vaccination recommendations by the Advisory Committee on Immunization Practices (ACIP) for the 2000--01 influenza season.

For the 1999-2000 influenza season, approximately 77 million doses of vaccine were distributed, of which 3 million doses were returned. On the basis of information provided by manufacturers, distribution of approximately 75 million doses is anticipated for the 2000--01 season, including 9 million doses that the CDC has contracted with Aventis Pasteur (Swiftwater, Pennsylvania) to produce. Most vaccine doses usually become available to providers by October, with 99% of distributed doses available before December; this year, approximately 18 million doses are expected to be distributed in December.

The optimal time to administer influenza vaccine is October through mid-November to assure that vaccination occurs before there is substantial influenza activity. In any influenza season, vaccine should continue to be offered after November to persons at high risk for influenza complications; this will be particularly important in this season in which vaccine delivery is delayed. The effectiveness of this approach is supported by surveillance data from the past 18 years,

indicating that seasonal activity peaked four times in December, four times in January, seven times in February, and three times in March.

Vaccination of persons aged ≥ 65 years substantially reduces influenza morbidity and mortality. For each additional million elderly persons vaccinated, the CDC estimates that approximately 900 deaths and 1300 hospitalizations would be averted during the average influenza season (CDC, unpublished data, 2000). The health impact of individual seasons can vary widely on the basis of the size of the susceptible population, the prevalence of influenza infections, the type and strain of the predominating virus(es), and the match between the vaccine strains and those circulating in the community. The primary goal of influenza vaccination is to prevent severe illness and death from influenza infection and its complications. Although the severity of influenza seasons varies, an annual average of approximately 20,000 deaths and 110,000 pneumonia and influenza (P&I) hospitalizations result from influenza infections. More than 18,000 (>90%) of these deaths and approximately 48,000 of the P&I hospitalizations per year occur among persons aged ≥ 65 years who are at highest risk for influenza-related complications.

Because of the potential health impact of delayed influenza vaccine availability, the CDC and the ACIP updated recommendations for the 2000--01 season. The goal of these recommendations is to minimize the adverse health impact of delays on high-risk persons. Minimizing the adverse impact on this group will require an effective response by the private and public sectors, including actions that have not been undertaken during past seasons.

Updated ACIP Recommendations for the 2000--01 Influenza Season

Persons at high risk for complications from influenza are:

1. persons aged ≥ 65 years;
2. residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
3. children and adults who have chronic disorders of the pulmonary or cardiovascular systems, including asthma;
4. children and adults who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal

dysfunction, hemoglobinopathies, or immunosuppression (e.g., caused by medications or human immunodeficiency virus);

5. persons aged 6 months--18 years who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza; and
 6. women who will be in the second or third trimester of pregnancy during the influenza season.
- When influenza vaccine becomes available, vaccination efforts should be focused on persons at high risk for complications associated with influenza disease and on health-care workers who care for these persons.
 - Temporary shortages because of delayed or partial shipments may require decisions on how to prioritize use of vaccine available early in the season among high-risk persons and health-care workers; such decisions are best made by those familiar with the local situation. Vaccine available early in the season should be used to maximize protection of high-risk persons. Because vaccine supplies are expected to increase substantially in November and December, plans should be made to continue vaccination of high-risk persons and health-care workers into December and later.
 - Mass vaccination campaigns should be scheduled later in the season as availability of vaccine is assured. Based on projected vaccine distribution, in most areas campaigns will be scheduled in November or later. Efforts should be made to increase participation by high-risk persons and their household contacts, but other persons should not be turned away.
 - Groups implementing mass vaccination efforts should seek to enhance coverage among those at greatest risk for complications of influenza and their household contacts. Strategies for targeting mass vaccination efforts at high-risk persons include 1) targeting announcements in publications and other media focused toward the elderly and those with high-risk medical conditions; 2) establishing liaisons with community groups representing the elderly

and those with chronic diseases; and 3) offering vaccination to elderly relatives of persons in the workplace and employees.

- Special efforts should be made in December and later to vaccinate persons aged 50--64 years, including those who are not at high risk and are not household contacts of high-risk persons. Persons in this age group with high-risk conditions should be vaccinated along with other high-risk persons. However, special efforts to vaccinate healthy persons in this age group should begin in December and continue as long as vaccine is available.
- Vaccination efforts for all groups should continue into December and later as long as influenza vaccine is available. Production of influenza vaccine will continue through December, and providers should plan for how vaccine provided late in the season can be used effectively. Providers who administer all of their available influenza vaccine supply early in the season and who still have unvaccinated high-risk patients should order additional vaccine that will become available in December. To minimize wastage of influenza vaccine, providers whose initial vaccine orders are delayed or partially filled should not seek replacement vaccine from other manufacturers or distributors unless use of all vaccine doses ordered can be assured during the 2000--01 season.
- Pneumococcal vaccines are recommended by the ACIP for many of the same high-risk persons for whom influenza vaccine is recommended. Assuring pneumococcal vaccination of high-risk persons in accordance with the ACIP recommendations early in the season will confer substantial protection from a major complication of influenza (pneumococcal pneumonia).
- Annual influenza vaccination provides an opportunity to review the pneumococcal vaccination status of persons for whom pneumococcal vaccination is recommended by the ACIP. This season, pneumococcal vaccine should be administered when indicated even if influenza vaccine is not yet available. Providers should emphasize to patients or their caregivers that pneumococcal vaccination is not a substitute for influenza vaccination and that patients need to return for influenza vaccine when it is available.

Role of Health-Care Organizations and Health-Care Providers

The ACIP encourages health-care organizations and providers to undertake special efforts to maximize influenza vaccine coverage among high-risk persons. Health-care organizations and medical providers that can identify elderly and high-risk patients from computerized administrative databases or clinical records should evaluate their capacity to send reminders directly to these patients. Reminder-recall systems have been proven effective in increasing vaccination coverage and are recommended by the Task Force on Community Preventive Services. In addition, the ACIP recommends use of standing orders in long-term-care facilities and other settings (e.g., inpatient and outpatient facilities, managed-care organizations, assisted-living facilities, correctional facilities, adult workplaces, and home health-care agencies) to ensure the administration of recommended vaccinations for adults, including influenza vaccine. Assuring that elderly and high-risk patients receive vaccine before hospital discharge throughout the influenza season will provide protection for a large number of high-risk persons.

Role of State and Local Health Departments

State and local health departments can play a critical role in promoting vaccination of high-risk persons and in promoting ongoing vaccination through December and later. Because only a small proportion of influenza vaccine is delivered by the public sector, the greatest impact may be achieved through the formation of coalitions that include community and provider organizations to promote the strategies recommended by the ACIP. Key coalition partners include professional societies, Health Care Financing Administration peer review organizations that have an existing focus on influenza vaccination through the National Pneumonia Project, and community groups that focus on high-risk populations. Many states already may have an active coalition for adult vaccination that could serve as a focus for state and local efforts. Health departments also can play a key role in disseminating timely and accurate local information on influenza activity and communicating local availability of vaccine to high-risk groups and monitoring and promoting vaccination of residents of long-term-care facilities.

In This Issue...

Free Flu Testing, Updated ACIP Recommendations for Flu Vaccine Delay

Update on Use of Influenza Vaccine in Children

Early vaccination of young children with high-risk conditions is a priority because two doses of vaccine administered at least 1 month apart are recommended for children aged <9 years who are receiving influenza vaccine for the first time. Two influenza vaccines (Flushield™, Wyeth Laboratories, Inc. [Marietta, Pennsylvania], and Fluzone® split, Aventis Pasteur, Inc.) are licensed and recommended for use in high-risk children aged ≥6 months. One other influenza vaccine, Fluvirin™ (Medeva Pharma Ltd., Leatherhead, England), is labeled in the United States for use only in persons aged ≥4 years because its efficacy in younger persons has not been demonstrated. Because Fluvirin™ is not indicated for children aged 6 months--3 years, providers should use other approved influenza vaccines for vaccination of children in this age group.

The CDC will provide information material to assist state health departments and other organizations in their communication and education efforts. This material and updates on the influenza vaccine

supply will be posted on the CDC's World-Wide Web site, <http://www.cdc.gov/nip>. Additional information and assistance can be obtained by contacting the CDC's National Immunization Program by e-mail, nipinfo@cdc.gov, or the National Immunization Information Hotline, telephone (800) 232-2522.

[For complete article with references go to: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4939a3.htm>]

**To find out where you can get a FLU SHOT
Call the
American Lung Association
of Connecticut
1-888-NO TO FLU
(1-888-668-6358) Toll Free**

**Monday through Friday during October,
November, and early December
(through Dec. 15th).
9:00 a.m. to 4:00 p.m.**

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