

This is an official
CDC HEALTH ADVISORY

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Dear Colleagues,

Flu activity is increasing in Oregon. Preliminary data from last week indicate that 4.1% of ED visits were due to influenza-like illness (ILI), and 12 influenza or ILI outbreaks were reported. With that in mind, please review the attached antiviral treatment guidance from CDC and forward it as needed. Unlike the rest of the country where influenza A/H3 is the dominant strain, in Oregon 66% of influenza-associated hospitalizations are due to Influenza A, of which 70% of subtyped strains are A/H1N1. This does not change the current guidance on influenza treatment.

Since many of the flu outbreaks reported in Oregon have occurred in long-term care facilities, we would also like to highlight the guidance for antiviral prophylaxis during confirmed flu outbreaks in institutional settings:

Special Considerations for Institutional Settings

Use of antiviral chemoprophylaxis to control outbreaks among high-risk persons in institutional settings, such as long-term care facilities, is recommended.

- An influenza outbreak is likely when at least two residents are ill within 72 hours, and at least one has laboratory confirmed influenza. When influenza viruses are circulating in the community, even one positive laboratory result in conjunction with other compatible illnesses on the unit indicates that an outbreak of influenza is likely occurring.
- When influenza is identified as a cause of a respiratory disease outbreak among nursing home residents, use of antiviral medications for chemoprophylaxis is recommended for all non-ill residents (regardless of whether they have received influenza vaccination). Antiviral chemoprophylaxis is meant for residents who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza, to prevent transmission.
- Antiviral chemoprophylaxis can also be offered to unvaccinated health care personnel during confirmed influenza outbreaks. For newly-vaccinated staff, antiviral chemoprophylaxis can be offered for up to two weeks (the time needed for antibody development) following influenza vaccination. Chemoprophylaxis can also be offered for all employees, regardless of their influenza vaccination status, if the outbreak is caused by a strain of influenza virus that is not well-matched by the vaccine. As noted above, an emphasis on close monitoring for signs and symptoms of influenza, and initiation of early antiviral treatment is an alternative to chemoprophylaxis for health care personnel.
- For institutional outbreak management, antiviral chemoprophylaxis should be administered for a minimum of two weeks, and continue for at least seven days after the last known case was identified.

Seasonal Influenza A(H3N2) Activity and Antiviral Treatment of Patients with Influenza

Summary

The Centers for Disease Control and Prevention (CDC) is providing: 1) a notice about increased influenza A(H3N2) activity and its clinical implications; 2) a summary of influenza antiviral drug treatment recommendations; 3) an update about approved treatment drugs and supply this season; and 4) background information for patients about influenza treatment.

Background

In the United States (U.S.), influenza activity has increased significantly over recent weeks with influenza A(H3N2) viruses predominating so far this season. In the past, A(H3N2) virus-predominant influenza seasons have been associated with more hospitalizations and deaths in persons aged 65 years and older and young children compared to other age groups. In addition, influenza vaccine effectiveness (VE) in general has been lower against A(H3N2) viruses than against influenza A(H1N1)pdm09 or influenza B viruses. Last season, VE against circulating influenza A(H3N2) viruses was estimated to be 32% in the U.S. CDC expects that VE could be similar this season, should the same A(H3N2) viruses continue to predominate. For this reason, in addition to influenza vaccination for prevention of influenza, the use of antiviral medications for treatment of influenza becomes even more important than usual. The neuraminidase inhibitor (NAI) antiviral medications are most effective in treating influenza and reducing complications when treatment is started early. Evidence from previous influenza seasons suggests that NAI antivirals are underutilized in outpatients and hospitalized patients with influenza who are recommended for treatment.

This CDC Health Advisory is being issued to—

- 1) Remind clinicians that influenza should be high on their list of possible diagnoses for ill patients because influenza activity is increasing nationwide, and
- 2) Advise clinicians that all hospitalized patients and all high-risk patients (either hospitalized or outpatient) with suspected influenza should be treated as soon as possible with a neuraminidase inhibitor antiviral. While antiviral drugs work best when treatment is started within 2 days of illness onset, clinical benefit has been observed even when treatment is initiated later.

Recommendations

1. CDC Antiviral Recommendations for the 2017–2018 Season

CDC recommends antiviral medications for treatment of influenza as an important adjunct to annual influenza vaccination. Treatment with neuraminidase inhibitors has been shown to have clinical and public health benefit in reducing illness and severe outcomes of influenza based on evidence from randomized controlled trials, meta-analyses of randomized controlled trials, and observational studies during past influenza seasons and during the 2009 H1N1 pandemic.^{[i],[ii],[iii],[iv],[v],[vi]}

2. All Hospitalized, Severely Ill, and High-Risk Patients with Suspected or Confirmed Influenza Should Be Treated with Antivirals

Any patient with suspected or confirmed influenza in the following categories should be treated as soon as possible with a neuraminidase inhibitor:

- 1) Any patient who is hospitalized—treatment is recommended for all hospitalized patients;
- 2) Any patient who has severe, complicated, or progressive illness—this may include outpatients with severe or prolonged progressive symptoms or who develop complications such as pneumonia but who are not hospitalized;
- 3) Any patient who is at higher risk for influenza complications but not hospitalized. Patients in this group include—
 - children younger than 2 years (although all children younger than 5 years are considered at higher risk for complications from influenza, the highest risk is for those younger than 2 years)
 - adults aged 65 years and older
 - persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematological (including sickle cell disease), and metabolic disorders (including diabetes mellitus), or neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)
 - people with immunosuppression, including that caused by medications or by HIV infection
 - women who are pregnant or postpartum (within 2 weeks after delivery)
 - people aged younger than 19 years who are receiving long-term aspirin therapy
 - American Indians/Alaska Natives
 - people with extreme obesity (i.e., body-mass index is equal to or greater than 40)
 - residents of nursing homes and other chronic-care facilities

3. Timing of Treatment and Implications for Patient Evaluation, Treatment, and Testing

Clinical benefit is greatest when antiviral treatment is administered as early as possible after illness onset. Therefore, antiviral treatment should be started as soon as possible after illness onset and **should not be delayed** even for a few hours to wait for the results of testing. Ideally, treatment should be initiated within 48 hours of symptom onset. **However, antiviral treatment initiated later than 48 hours after illness onset can still be beneficial for some patients.**

A very large observational study of more than 29,000 hospitalized influenza patients reported that while the greatest clinical benefit was found when antiviral treatment was initiated within 48 hours of illness onset, starting antiviral treatment more than 2 days after onset had survival benefit in adults versus no treatment.⁶ Also, a randomized, placebo-controlled study suggested clinical benefit when oseltamivir was initiated 72 hours after illness onset among febrile children with uncomplicated influenza.^[vii] Clinical judgment, on the basis of the patient's disease severity and progression, age, underlying medical conditions, likelihood of influenza, and time since onset of symptoms, is important when making antiviral treatment decisions for outpatients, particularly those who are not at increased risk for influenza complications.

Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza.** Therefore, empiric antiviral treatment should generally be initiated as soon as possible when there is known influenza activity in the community. A history of current season influenza vaccination does not exclude a diagnosis of influenza in an ill child or adult. During influenza season especially, high-risk patients should be advised to call their provider promptly if they have symptoms of influenza. It may be useful for providers to implement phone triage lines to enable

high-risk patients to discuss symptoms over the phone. To facilitate early initiation of treatment, when feasible, an antiviral prescription can be provided without testing and before an office visit.

4. Influenza Testing

Information to assist clinicians about influenza testing decisions is available at <https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm>. The most accurate influenza tests are molecular assays. Rapid molecular assays are available in clinical settings that can detect influenza virus nucleic acids in respiratory specimens in 15-30 minutes with high sensitivity and specificity. Other approved molecular assays can yield results in 60-80 minutes or in several hours with very high sensitivity and specificity.

For hospitalized patients with suspected influenza, molecular assays are recommended. Information on influenza molecular assays is available at <https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm>. Rapid influenza diagnostic tests (RIDTs) with an analyzer device can detect influenza A and B viral nucleoprotein antigens in respiratory specimens in 10-15 minutes with moderate sensitivity, and RIDTs without an analyzer device have low to moderate sensitivity compared with reverse transcription-polymerase chain reaction (RT-PCR).

Proper interpretation of influenza testing results is important to guide optimal management of influenza patients. An algorithm to assist clinicians in interpreting the results of influenza testing when influenza viruses ARE circulating in the community is available at <https://www.cdc.gov/flu/professionals/diagnosis/algorithm-results-circulating.htm>. **Clinicians should be aware that a negative RIDT result does not exclude a diagnosis of influenza in a patient with suspected influenza when there is influenza activity in the community.** Other factors such as the quality of the specimen, the source of the specimen in the respiratory tract, and the timing of specimen collection in relationship to illness onset, may also affect test results.

5. Antivirals in Non-High Risk Patients with Uncomplicated Influenza

Neuraminidase inhibitors can benefit other individuals with influenza. While current guidance focuses on antiviral treatment of those with severe illness or at high risk of complications from influenza, antiviral treatment may be prescribed on the basis of clinical judgment for any previously healthy (non-high risk) outpatient with suspected or confirmed influenza who presents within 2 days after illness onset.

Neuraminidase inhibitors can reduce the duration of uncomplicated influenza illness by approximately 1 day when started within 2 days after illness onset in otherwise healthy persons. It is possible that antiviral treatment started after 48 hours may offer some benefit.⁷

6. Antiviral Medications

Three prescription neuraminidase inhibitor antiviral medications are approved by the U.S. Food and Drug Administration (FDA) and are recommended for use in the U.S. during the 2017–2018 influenza season: oseltamivir (available as a generic version or under the trade name Tamiflu®), zanamivir (Relenza®), and peramivir (Rapivab®).

- Oral oseltamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons aged 2 weeks and older, and for chemoprophylaxis to prevent influenza in people 1 year of age and older. Although not part of the FDA-approved indications, use of oral oseltamivir for treatment of influenza in infants younger than 14 days old, and for chemoprophylaxis in infants 3 months to 1 year of age, is recommended by CDC and the American Academy of Pediatrics. Due to limited data, use of oseltamivir for chemoprophylaxis is not recommended in children younger than 3 months unless the situation is judged critical. CDC recommends oseltamivir treatment as soon as possible for hospitalized patients with suspected or confirmed influenza, high-risk outpatients with suspected or confirmed influenza, and those with progressive disease.

- Inhaled zanamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons 7 years and older and for prevention of influenza in persons 5 years and older. Inhaled zanamivir is not recommended for treatment of influenza in hospitalized patients due to limited data.
- Intravenous peramivir is FDA-approved for the treatment of acute uncomplicated influenza within 2 days of illness onset in persons aged 2 years and older.

Adamantanes (rimantadine and amantadine) are not currently recommended for antiviral treatment or chemoprophylaxis of influenza A because of high levels of resistance among circulating influenza A viruses.

There are no current national shortages of neuraminidase inhibitors (i.e., oseltamivir, zanamivir and peramivir), and manufacturers report they expect to meet projected seasonal demands. If there is difficulty locating oseltamivir for oral suspension, as there has been in some previous seasons, oral suspension can be compounded by a pharmacy from oseltamivir capsules. However, this compounded suspension should not be used for convenience or when oseltamivir oral suspension is commercially available.

More information about compounding an oral suspension from oseltamivir 75 mg capsules can be found at https://www.gene.com/download/pdf/tamiflu_prescribing.pdf

Additional Considerations for Clinicians

- **Bacterial Infections:** Antibiotics are not effective against influenza virus infection, and early diagnosis of influenza can reduce the inappropriate use of antibiotics if bacterial co-infection is not suspected. However, because certain bacterial infections can produce symptoms similar to influenza and bacterial infections can occur as a complication of influenza, bacterial infections should be considered and appropriately treated, if suspected. In addition, because pneumococcal infections are a serious complication of influenza infection, current pneumococcal vaccine recommendations for adults 65 years of age or older, as well as adults and children at increased risk for invasive pneumococcal disease due to chronic underlying medical conditions, should be followed (see <http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm> and <http://www.cdc.gov/vaccines/vpd-vac/pneumo/vacc-in-short.htm> for further information).
- **Adverse Events and Antiviral Use:** The most common adverse events associated with oral oseltamivir include a slightly increased risk of nausea and vomiting as compared to placebo, with nausea occurring in 10% of adults with influenza who received oseltamivir and 6% of people who received placebo in controlled clinical trials (3% and 4%, respectively, in children), and vomiting occurring in 9% of adults with influenza who received oseltamivir and 3% of people who received placebo in controlled clinical trials (15% and 9%, respectively, in children). These symptoms are generally transient and can be mitigated if oseltamivir is taken with food. Adverse events for inhaled zanamivir were not increased as compared to placebo in clinical trials, but cases of bronchospasm have been reported during post marketing; inhaled zanamivir is not recommended for persons with underlying airways disease (e.g., asthma or chronic obstructive pulmonary diseases). For people who received peramivir intravenously or intramuscularly in clinical trials, the most common adverse event was diarrhea, occurring in 8% versus 7% in people who received placebo.

Resources for Patient Education

Results from unpublished CDC qualitative research shows that most people interviewed were not aware that drugs to treat influenza illness are available. A fact sheet for patients is available at <http://www.cdc.gov/flu/antivirals/whatyoushould.htm>.

Note the following important background information for patients:

- If you get the flu, antiviral drugs are a treatment option.
- It is very important that antiviral drugs are used early to treat hospitalized patients, people with severe flu illness, and people who are at high risk for flu complications because of their age, severity of illness, or underlying medical conditions.
- If you have severe illness or are at high risk of serious flu complications, you may be treated with flu antiviral drugs if you get the flu.
- If you have a high-risk condition, treatment with an antiviral drug can mean the difference between having milder illness instead of very serious illness that could result in a hospital stay.
- Other people also may be treated with antiviral drugs by their doctor this season. Most otherwise-healthy people who get the flu, however, do not need to be treated with antiviral drugs.
- Studies show that flu antiviral drugs work best for treatment when they are started within 2 days of getting sick. However, starting antivirals later can still be helpful for some people.
- If your health care provider thinks you have the flu, your health care provider may prescribe antiviral drugs. A test for flu is not necessary.
- Antibiotics are not effective against the flu. Using antibiotics inappropriately can lead to antibiotic resistance and may expose patients to unwanted side effects of the drug.
- Other practices that may help decrease the spread of influenza include respiratory hygiene, cough etiquette, social distancing (e.g., staying home from work and school when ill, staying away from people who are sick) and hand washing.

Additional Resources

- Summary of Influenza Antiviral Treatment Recommendations for Clinicians:
<http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>
- Clinical Description and Lab Diagnosis of Influenza:
<http://www.cdc.gov/flu/professionals/diagnosis/index.htm>
- Guidance for Clinicians on the Use of RT-PCR and Other Molecular Assays for Diagnosis of Influenza Virus Infection:
<http://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm>
- Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities:
<http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>
- Influenza Virus Testing in Investigational Outbreaks in Institutional or Other Closed Settings:
<https://www.cdc.gov/flu/professionals/diagnosis/guide-virus-diagnostic-tests.htm>
- FDA Influenza (Flu) Antiviral Drugs and Related Information (including package inserts):
<http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm100228.htm>

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