

Editorials

Influenza Management Guide 2010-2011

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Last year, the new strain of influenza we now know as 2009 pandemic influenza A (H1N1) hit the United States and worldwide. Vaccine makers scrambled to manufacture adequate supplies; however, a temporary lack of sufficient vaccines required prioritization among patient groups to ensure that the most vulnerable would have first access to the limited supply. The 2010-2011 influenza vaccine will again target the 2009 H1N1 strain, as well as other common strains of seasonal influenza: H3N2 influenza A and influenza B. Expected to be in adequate supply this year, the vaccine is recommended for all patients older than six months. The live intranasal vaccine continues to be contraindicated for some patient groups, including pregnant women, immunosuppressed patients, patients younger than two years or older than 50 years, and some patients with chronic medical conditions, such as asthma. For these patients, the inactivated injectable vaccine can be used instead.

Appropriate and expedited triaging in health care settings will be an important preventive step to minimize exposures and disease spread through the community. Vaccination of all health care workers will be an essential preventive measure. Additional practice interventions, such as telephone consultation, can help minimize elective office visits by affected patients. Telephone triage can assess severity of symptoms and identify patients at risk of complications who would benefit from expedited access to antiviral medications, which can then be prescribed by telephone or fax. This approach provides timely access to treatment while reducing waiting room exposures. Conversely, if telephone triage identifies concerning symptoms that would require outpatient or emergency department evaluation, this can be arranged and expedited. Once in the office, a patient with influenza-like symptoms should be triaged appropriately. This

may involve masking, using designated waiting areas and examination rooms to minimize exposure to other patients, and posting visual alerts and reminders for hand and cough hygiene.

Will 2009 H1N1 be the predominant virus in circulation again this year, or will the other seasonal strains dominate as they have this summer in some regions of the world? Will the impact of 2009 H1N1 be as severe as last season, now that the population has substantial experience with the virus or the vaccine? The answers to these questions will unfold over time.

When indicated to treat disease and to prevent the spread of virus, antiviral medications are an important component of management. The 2009 H1N1 influenza virus throughout the 2009-2010 season remained sensitive to the neuraminidase inhibitors oseltamivir (Tamiflu) and zanamivir (Relenza), with only rare oseltamivir resistance; however, it maintained complete resistance to the adamantanes, rimantadine (Flumadine) and amantadine (Symmetrel). Previous years' seasonal influenza viruses, conversely, had a reverse sensitivity profile that remained almost entirely resistant to oseltamivir and sensitive to adamantanes.

Because questions remain about which viral strain will predominate this season, antiviral drug recommendations are not yet established. At the National HIV/AIDS Clinicians' Consultation Center (Warmline; 800-933-3413), based at San Francisco General Hospital, University of California, San Francisco, Department of Family and Community Medicine, we are following the trends closely via updates from the Centers for Disease Control and Prevention (<http://www.cdc.gov/flu>) and will continually revise our Influenza Management Guide this season (<http://www.nccc.ucsf.edu>).

Although initially developed to address questions about treating influenza in persons with human immunodeficiency virus infection, the guide remains applicable to primary care physicians for prevention and management of all patients presenting with  influenza-like illness (*Online Tables A and B*).

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