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## A QUICK GUIDE FOR SAN FRANCISCO CLINICIANS

### Avian Influenza (June 2015)

#### SITUATION

Outside the USA, highly pathogenic avian influenza A viruses have caused severe and fatal human infections. Since 2003, over 800 **H5N1** cases have been reported in numerous countries, predominantly Egypt, Indonesia, Vietnam, Cambodia, Thailand, and China. Since 2013, over 500 **H7N9** cases have been reported, all originating in eastern China or Taiwan. Several human cases have been imported to Canada but none to the USA. All confirmed cases to date have had respiratory disease, and most have reported contact with poultry. There has been no sustained human-to-human transmission.

In the USA, since 2014 multiple outbreaks of highly pathogenic avian influenza A have occurred in poultry, mainly involving **H5** strains (H5N2 and H5N8), and affecting 40 million birds in 20 states, including California. Large flocks are undergoing quarantine and culling and no vaccine is yet available. Transmission to humans has not yet occurred, but although the risk is considered low, human cases could occur in the future.

#### CLINICIAN RESPONSE

##### CONSIDER AVIAN INFLUENZA IN PATIENTS WITH:

New-onset severe respiratory illness leading to hospitalization or death **AND** a history of either:

- (a) Recent international travel to an area with human H5N1 or H7N9 avian influenza illness (for a list of H5N1 countries - [who.int/influenza/human\\_animal\\_interface/H5N1\\_cumulative\\_table\\_archives/en/](http://who.int/influenza/human_animal_interface/H5N1_cumulative_table_archives/en/)), **OR**
- (b) Close contact to a human or bird case of avian influenza virus within the last 10 days

**AVIAN INFLUENZA SHOULD ALSO BE CONSIDERED IN:** persons with respiratory illness who have had contact in the USA with potentially-infected birds, their organs or their secretions. For more information concerning the approach to potential bird exposures in the USA, see [emergency.cdc.gov/han/han00378.asp](http://emergency.cdc.gov/han/han00378.asp).

**IMMEDIATELY REPORT ALL SUSPECTED CASES TO:** SFDPH Communicable Disease Control Unit (CDCU) 24/7 telephone: 415-554-2830 (after-hours, follow instructions to page the on-call MD) **AND** to your Infection Control Professional (ICP—check your institution’s directory). Action will be taken promptly by CDCU and ICPs to prevent additional cases and to coordinate laboratory testing.

**IMPLEMENT APPROPRIATE INFECTION CONTROL PRECAUTIONS.** The infectious period for avian influenza is assumed to be from 1 day before symptom onset until resolution of illness. Place hospitalized suspected, probable, and confirmed cases in a negative-pressure isolation room with **airborne, contact and standard precautions, including eye protection**. Those not requiring hospitalization should be isolated at home. For more information on infection control, see: [www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm](http://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm).

**COORDINATE DIAGNOSTIC TESTING with CDCU:** After consultation with CDCU, send specimens to SFDPH Public Health Laboratory (SFPHL) using the lab form available at [sfdcp.org/influenzareporting.html](http://sfdcp.org/influenzareporting.html). **Polymerase chain reaction (PCR) testing is coordinated by SFPHL.**

Laboratories should NOT attempt to perform viral culture on specimens from patients with suspected or laboratory-confirmed novel influenza infection. Avian influenza viruses may be unsubtypeable by standard methods and reagents available in clinical labs. **Submit multiple specimens** to increase yield, including both upper and lower respiratory tract specimens. Use only synthetic fiber swabs with plastic shafts. In those with pneumonia or ARDS, lower respiratory specimens are best.

**TREAT WITH ANTIVIRAL MEDICATION.** Oseltamivir 75 mg PO BID for 5 days is recommended for all hospitalized patients or outpatients. Do not delay treatment while waiting for laboratory results. IV zanamivir may be available for patients who are not responding to or cannot tolerate or absorb oral oseltamivir. For more info see: [cdc.gov/flu/professionals/antivirals/intravenous-antivirals.htm](http://cdc.gov/flu/professionals/antivirals/intravenous-antivirals.htm).

**WORK WITH CDCU TO IDENTIFY CLOSE CONTACTS AND FACILITATE PROPHYLAXIS:** Post-exposure prophylaxis (PEP) consists of 2 daily doses of oseltamivir (all ages) or inhaled zanamivir (age  $\geq 7$  years with no underlying airway disease). The duration is 10 days if exposure is ongoing, or 5 days if not. The decision to initiate PEP with asymptomatic close contacts should be based on clinical judgment, with consideration given to the type of exposure and to whether the close contact is at high risk for complications from influenza. PEP should be considered for healthcare personnel with higher-risk exposures.

#### **ADDITIONAL INFORMATION**

<http://cdph.ca.gov/programs/cder/Pages/H7N9.aspx>

<http://cdc.gov/flu/avianflu/healthprofessionals.htm>

<http://cdc.gov/flu/avianflu/hpai/hpai-background-clinical-illness.htm>

[http://who.int/influenza/human\\_animal\\_interface/influenza\\_h7n9/en/](http://who.int/influenza/human_animal_interface/influenza_h7n9/en/)