Interim Guidance for Ambulatory Care of Influenza-Like Illness in the context of H1N1 influenza virus

This guidance document is being provided by the Public Health Agency of Canada in response to the outbreak from the pandemic H1N1 2009 virus. Please note that this document replaces previous guidance with respect to Interim Guidance for Clinicians in Ambulatory Care Settings. It is based on current, available scientific evidence about this emerging disease, and is subject to review and change as new information becomes available. The following guidance should be read in conjunction with relevant provincial and territorial guidance documents. The Public Health Agency of Canada will be posting regular updates and related documents at www.phac-aspc.gc.ca.

Introduction

The 2009 pandemic H1N1 virus continues to circulate in Canada and around the world. Recent evidence suggests it has an incubation period of 7 days and a period of infectivity of 7 days – both longer than seasonal influenza. To date, the 2009 H1N1 flu virus has spread almost exclusively in the community setting. It generally causes a mild disease with a mortality rate in Canada of approximately 3/1000 cases. The need for vigilance remains, and there is a risk that a more virulent form of this virus could arise. This guidance has been developed for clinicians to manage patients presenting with cough and fever in the context of pandemic H1N1 and other respiratory pathogens. These guidelines highlight the need for infection prevention and control measures, targeted assessment and laboratory testing, and ongoing collaboration with public health.

INFECTION PREVENTION AND CONTROL

Initial triage

All patients who present to a primary care setting should be screened for fever and respiratory symptoms. This includes passive screening (e.g. posters that alert patients to report cough and fever) and/or active screening (e.g. reception staff asking about fever and respiratory symptoms).

Infection prevention and control for patient

Patients who report fever and respiratory symptoms should be instructed to:

1. clean their hands with 60-90% alcohol-based hand rub (or soap and water),
2. don a surgical mask, and
3. be seated at least 2 metres (6 feet) away from others. If this is not possible in the waiting room setting, they should be placed immediately in an examining room.

Routine practices and contact precautions for clinicians
Before a clinical assessment:

1. perform hand hygiene,
2. put on gloves; wear a gown only when there is a risk of clothing or skin contamination, and
3. wear a surgical mask and eye protection (goggles or face shield) to protect yourself from droplet contamination. An N95 respirator is recommended when there is a risk of aerosol transmission[1] , such as during an aerosol-generating medical procedure.

During **a clinical assessment:**

1. ensure coughing patients continue to wear a surgical mask over his/her nose and mouth. If a nasopharyngeal swab is indicated, the mask can be temporarily lowered to expose the nose while still covering the mouth to provide protection if the patient coughs.

After a clinical assessment:

1. remove eye or face protection first, then remove mask by the straps (do not touch mask)
2. perform hand hygiene
3. ensure surfaces that have been touched by the patient or that are within droplet range are cleaned with a hospital-grade disinfectant.

CLINICAL ASSESSMENT

Clinical assessment of ILI in the context of H1N1 and other viruses of concern requires ongoing knowledge of what respiratory viruses are circulating in the community. This should be made available from local/regional public health authorities.

History

Patient's symptoms that meet the definition for ILI include acute onset of respiratory illness with fever and cough and **one or more of the following:** sore throat, arthralgia, myalgia, or prostration (with the caveat that young children and elderly may not present with fever). Take a routine travel history. Although it may not be relevant for the pandemic H1N1, it remains a best practice and could be significant for H5N1 virus (e.g., a patient coming from Egypt or Vietnam with a contact history). Ask about contact with ill people; it may reveal an unusual cluster of cases (such as a school outbreak) that would increase the possibility of infection with the H1N1 flu virus. An occupational history is relevant in the case of laboratory personnel who work directly with influenza or other respiratory viruses, and health care workers exposed to patients linked to a community or health care facility outbreak. Finally, it is especially important to screen for conditions that place patients at risk of complications from influenza. Based on seasonal influenza[2] and early epidemiologic data this includes:

- chronic health conditions (including cardiac disease, pulmonary disorders (especially asthma), diabetes mellitus and other metabolic diseases, cancer, immunodeficiency, immunosuppression, renal disease, anemia or hemoglobinopathy, conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration, and children on long term acetylsalicylic acid therapy),
- children 6-23 months of age, and
- healthy pregnant women (the risk being higher during the 3rd trimester than the 2nd)

It appears people over 65 are not as vulnerable to pandemic H1N1 as seasonal influenza.

LABORATORY BEST PRACTICES

Collection of a nasopharyngeal (NP) swab for viral diagnosis is appropriate when clinically indicated, such as for patients who may require hospitalization (severe ILI), have atypical presentations, or a history of contact with severe ILI. Throat and nasal swabs are acceptable by some laboratories but are generally not recommended. Decisions to test for viruses may be affected by epidemiological factors (e.g., sudden onset of cough and fever in the summer may warrant a test but not in the middle of flu season). Patients without nasal symptoms and fever should not be tested. Ensure that both the specimen and the requisition are clearly labelled and the exposure history and clinical symptoms are noted on the laboratory requisition. Point of care tests are not recommended due to their low sensitivity (i.e. high false negative rate).

COLLABORATION WITH PUBLIC HEALTH

Clinicians should report any respiratory infections of concern, such as severe disease or unusual clusters of illness, to local public health authorities. Surveillance of H1N1 flu virus and any other respiratory viruses of concern will be addressed through the enhanced FluWatch program (http://www.phac-aspc.gc.ca/fluwatch/) which includes laboratory testing by sentinel physicians in the community.

CLINICAL MANAGEMENT

For otherwise healthy patients with no underlying medical conditions, the basic therapy is supportive. Routine advice includes staying at home for 24 hours after resolution of symptoms **or** for 7 days if pandemic H1N1 is suspected. Review good respiratory and hand hygiene practices. Recommend reassessment if symptoms worsen; there have been occassional cases of healthy people with no risk factors becoming very ill from pandemic H1N1 virus. For pregnant women and people with other high risk conditions, antivirals are indicated. If household contacts of patients have high risk conditions, they should be advised to seek medical assessment at the first indication of ILI symptoms to begin early treatment.

References and resources:

1. Council of Canadian Academies. *Influenza Transmission and the Role of Personal Protective Equipment Respiratory Equipment: An Assessment of the Evidence.* Ottawa, Canada. 2007. 254-265. See: http://www.scienceadvice.ca/documents/(2007-12-19)_Influenza_PPRE_Final_Report.pdf PDF

2. National Advisory Committee on Immunization (NACI) Statement on Influenza Vaccination for the 2008-2009 Season. Canada Communicable Disease Report. 2008 Vol 34; ACS-3 pg 6-7. See: http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/08vol34/acs-3/index-eng.php

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