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Communicable Disease and Epidemiology News

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2008-2009 Influenza Season Update

Influenza Surveillance

Influenza activity is currently low both locally and nationally. Flu season typically begins in fall, peaks in February, and continues through March. Patients should be vaccinated at this time and throughout the season as long as vaccine is available.

Throughout the season, Public Health posts weekly influenza surveillance updates on-line at:
www.kingcounty.gov/healthservices/health/communicable/immunization/fluactivity.

Influenza Vaccine Recommendations

Trivalent influenza vaccine is available as injectable inactivated (TIV) and live attenuated intranasal vaccine (LAIV) formulations. **This season's vaccine protects against three new virus strains** (A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Florida/4/2006-like antigens) and is anticipated to be well-matched to circulating viruses

Highlights from this year's ACIP recommendations for influenza immunization include:

- **Annual vaccination of all children aged 5-18 years is recommended, with a continued focus on children at high risk for influenza-related complications.**
- **Annual vaccination of all children aged 6 months-4 years (59 months) and older children with conditions that place them at increased risk for complications from influenza should continue.**
- **Either TIV or LAIV can be used when vaccinating healthy persons aged 2-49 years.** (see below)

Antiviral Drug Treatment and Prophylaxis

When started within the first two days of symptoms, influenza antiviral medication can reduce illness severity and shorten duration of illness. Limited data suggest that influenza antiviral medications may also prevent serious influenza-related complications (e.g., pneumonia or exacerbation of chronic diseases).

Antiviral medications are also 70% to 90% effective in preventing influenza and are useful adjuncts to vaccination in certain settings.

Amantadine and rimantadine are NOT recommended for antiviral treatment or prophylaxis because of high levels of resistance among influenza A strains worldwide. Last season in the US, 99% of H3N2 and 10% of H1N1 isolates were resistant. These drugs have no activity against influenza B.

Approximately 10% of influenza A (H1N1) viruses, no A (H3N2) viruses, and no influenza B viruses were resistant to oseltamivir last season in the United States. The overall percentage of influenza A and B viruses resistant to oseltamivir nationally was less than 5%.

Because the vast majority of influenza virus strains remain sensitive to oseltamivir, and resistance levels to other antiviral medications remain high, oseltamivir or zanamivir continue to be the recommended antivirals for treatment of influenza.

Influenza Vaccine Supply

Approximately 146 million doses of influenza vaccine are expected to be available from currently licensed manufacturers in the U.S. for use during the 2008-09 influenza season. This will be the most flu vaccine ever distributed in the U.S. during a single influenza season.

Influenza and MRSA Infections – A Perfect Storm?

Over the past few years an increasing number of reports have been published describing severe cases of MRSA pneumonia complicating influenza infection in young healthy people. One troubling feature of the reports is that the MRSA pneumonia appears to develop concomitantly with the influenza infections, not as a secondary infection.

A CDC Health Advisory in Jan. 2008 recommended that health care providers should:

- Test persons hospitalized with respiratory illness for influenza, including those with suspected community-acquired pneumonia.
- Be alerted to the possibility of bacterial co-infection among children with influenza, and request bacterial cultures if children are severely ill or when community-acquired pneumonia is suspected.
- Be aware of the prevalence of methicillin-resistant *S. aureas* strains in their communities when choosing empiric therapy for patients with suspected influenza-related pneumonia.
- Report deaths among children associated with laboratory-confirmed influenza to Public Health by calling 206-296-4774.

Although the exact relationship between MRSA pneumonia and influenza is yet to be defined, these reports provide another reason to assure that all persons for whom influenza vaccination is recommended get vaccinated.

FAQs About Influenza Vaccination

Q: Who can receive FluMist, the live-attenuated intranasally administered influenza vaccine (LAIV)?

A: FluMist is an excellent option for vaccination of healthy, non-pregnant persons aged 2-49 years, including health care workers. Possible advantages of LAIV include its potential to induce a broad mucosal and systemic immune response, its ease of administration, and the acceptability of an intranasal rather than intramuscular route of administration.

Q: Can persons receive LAIV (FluMist) if they care for, or have contact with someone who is immune compromised?

A: A person should not receive LAIV if he or she is in contact with someone with a severely weakened immune system *being cared for in a protective environment* (for example, a hematopoietic stem cell transplant patient requiring protective isolation). However, LAIV may be given to those who have contact with people with lesser degrees of immunosuppression (for example, diabetic patients, persons with asthma on corticosteroid therapy, or HIV infected persons).

Q: How late in the season should I continue to offer influenza vaccine?

A: Influenza vaccine should be administered as soon as it is available in the influenza season and vaccination should continue throughout the season as long as vaccine is available. Nationally and in Washington State, flu season generally peaks in February, and a significant proportion of cases occur from March through early spring. It is important to continue offering your patients flu vaccine even after influenza activity has peaked and for the duration of the seasonal epidemic.

For complete CDC/ACIP recommendations on influenza vaccine and antiviral drug use, please see: www.cdc.gov/flu/professionals/index.htm

New Public Health Website

King County has a new website and our addresses have changed. The new addresses are:

- **Public Health main page:**www.kingcounty.gov/health
- **Communicable Disease Epidemiology & Immunization Section main page:**
www.kingcounty.gov/health/cd
- **Immunization Program page:**
www.kingcounty.gov/health/immunization

King County and Public Health made these changes to make the web site more user-friendly, reliable, and easier to manage. Unfortunately, our old web page addresses will not re-direct to the equivalent web page on the new web site. Instead, you will be re-directed to our new main web page address [through the end of 2008](http://www.kingcounty.gov/health). You can use our search engine or categorical directory to find the page you want on the new site, and then add a bookmark when you find it.

Starting in 2009, all of the links to the previous Public Health website will no longer work at all. If you have web links or printed materials that include our old address, please update them before the end of the year.

We apologize for any inconvenience and hope you find the new website a relevant and comprehensive source for current and accurate health information for our community. As always, we welcome your feedback on ways we can improve. Please email questions or suggestions by clicking the CONTACT link at the top of the web page.

<u>Disease Reporting</u>	
AIDS/HIV.....	(206) 296-4645
STDs.....	(206) 744-3954
TB	(206) 744-4579
All Other Notifiable Communicable Diseases (24 hours a day)	(206) 296-4774
Automated reporting line for conditions not immediately notifiable.....	(206) 296-4782
<u>Hotlines</u>	
Communicable Disease	(206) 296-4949
HIV/STD.....	(206) 205-STD5

Reported Cases of Selected Diseases, Seattle & King County 2008

	Cases Reported in September		Cases Reported Through September	
	2008	2007	2008	2007
Campylobacteriosis	23	27	245	188
Cryptosporidiosis	4	9	31	36
Chlamydial infections	483	502	4,456	4,242
Enterohemorrhagic <i>E. coli</i> (non-O157)	1	2	3	6
<i>E. coli</i> O157: H7	11	8	30	32
Giardiasis	12	17	86	111
Gonorrhea	105	131	1009	1128
<i>Haemophilus influenzae</i> (cases <6 years of age)	0	0	2	2
Hepatitis A	1	0	15	10
Hepatitis B (acute)	2	4	28	21
Hepatitis B (chronic)	72	72	679	626
Hepatitis C (acute)	0	0	10	5
Hepatitis C (chronic, confirmed/probable)	156	108	1,110	1,023
Hepatitis C (chronic, possible)	41	23	272	225
Herpes, genital (primary)	45	44	403	474
HIV and AIDS (new diagnoses only)	20	37	270	328
Measles	0	0	0	1
Meningococcal Disease	1	0	5	5
Mumps	0	3	1	7
Pertussis	6	16	58	61
Rubella	0	0	0	0
Rubella, congenital	0	0	0	0
Salmonellosis	22	19	166	194
Shigellosis	6	7	37	44
Syphilis	11	8	162	114
Syphilis, congenital	0	0	0	0
Syphilis, late	5	1	62	55
Tuberculosis	11	28	82	112

The *EPI-LOG* is available in alternate formats upon request.