



OB Right News!

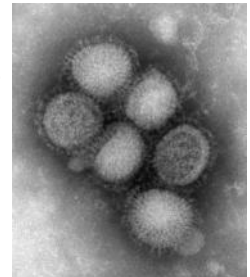
Weekly H1N1 Update

Volume 2, Issue 4

October 5, 2009

Our H1N1 Plan this Week

Several other clinical aids are moving to completion and may be live this coming week. Two Representatives from the WHCEC H1N1 Subcommittee met with a house wide group of clinicians tasked with building order sets for use by providers in the EPIC system.



Order sets have been designed and are currently in build phase:

- Adult H1N1 Order Set. This is an admission order set designed for the "other" side of the house and may be used for pregnant patients at less than 18 weeks gestation
- Maternal H1N1 Order Set. This order set is designed for use in the population of 18 weeks or greater gestation. It is a stand alone order set that does not include routine admission orders because of the many and varied order sets that exist for the many and varied obstetric patient.
- Newborn H1N1 Order Set. This order set is designed for use in the newborn population. It is a stand alone order set that does not include routine admission orders because of the already existing order sets used for the population

Changes to Clinical Management Week of October 5, 2009

EPIC Order Sets sent to Design & Build Team
Clinical Management Recommendations Unchanged

Visiting

Our Corporate leadership is working to gain consensus with other healthcare organizations in the region insofar as the visiting policy is concerned. Work continues behind the scenes to ready signage, press announcements and educational handouts so that we are ready to implement the policy.

Look for additional information to be forthcoming. In the interim, you may direct questions regarding the care of our population to Diana Behling at djcassel@sentara.com or by paging 475-6191

Our goal is to reduce morbidity and prevent mortality of women and infant patients exposed to or infected with H1N1 influenza.



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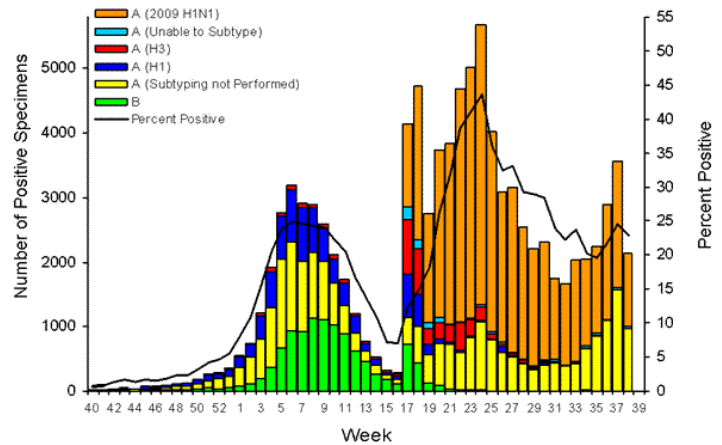
CDC Update Week 38 September 20-26, 2009



During week 38 (September 20-26, 2009), influenza activity increased in the U.S.

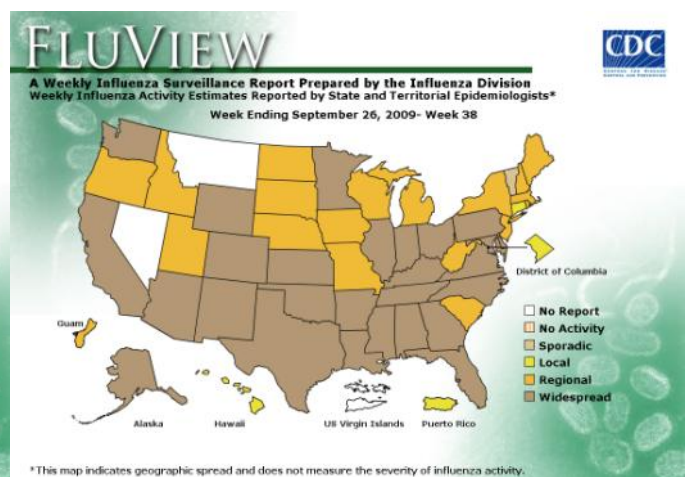
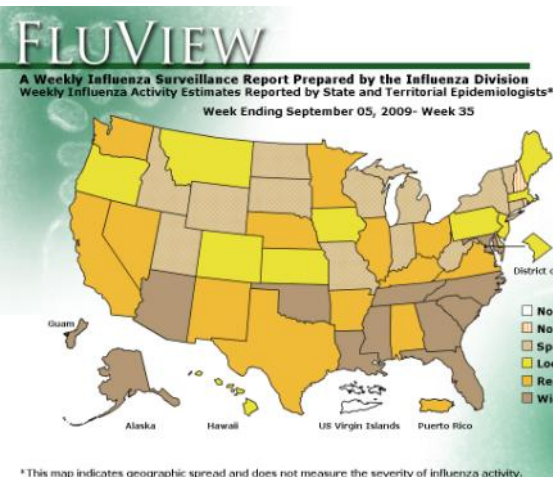
- Nationwide during week 38, 4.2% of patient visits reported through the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) were due to influenza-like illness (ILI). This percentage is above the national baseline of 2.4%. 2,126 (22.8%) specimens tested by U.S. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories and reported to CDC/Influenza Division were positive for influenza.
- 99% of all subtyped influenza A viruses being reported to CDC were 2009 influenza A (H1N1) viruses.
- The proportion of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold.
- **Eleven influenza-associated pediatric deaths were reported and all eleven were associated with 2009 influenza A (H1N1) virus infection.**
- The proportion of outpatient visits for influenza-like illness (ILI) was above the national baseline. Regions 2 through 10 reported ILI above region-specific baseline levels; only Region 1 was below its region-specific baseline.
- Twenty-seven states reported geographically widespread influenza activity, Guam and 18 states reported regional influenza activity, two states, the District of Columbia, and Puerto Rico reported local influenza activity, one state reported sporadic influenza activity, and the U.S. Virgin Islands and two states did not report.

Influenza Positive Tests Reported to CDC by U.S. WHO/NREVSS Collaborating Laboratories, National Summary, 2008-09



The 2009-10 influenza season officially began October 4, 2009.

FLUVIEW Comparison Week Ending September 5 v. Week Ending September 26





Article Review

H1N1 Influenza in Pregnancy: Cause for Concern

Saleeby, Erin MD, MPH; Chapman, Jocelyn MD; Morse, Jessica MD, MPH; Bryant, Allison MD, MPH
Obstetrics & Gynecology: October 2009 - Volume 114 - Issue 4 - pp 885-891

A recently published article in Obstetrics & Gynecology underscores the urgency of early triage and intervention with antivirals to promote the best possible outcomes in our pregnant patients.

“Patients were noted to follow either a rapidly progressive disease course and become critically ill within 24–48 hours of admission, or to exhibit a milder disease process with a stable course. This report adds to a growing body of data that supports the notion that pregnant women may be both more susceptible to and exhibit more severe symptoms with H1N1 influenza than is seen in non-pregnant patients.”

Some key points:

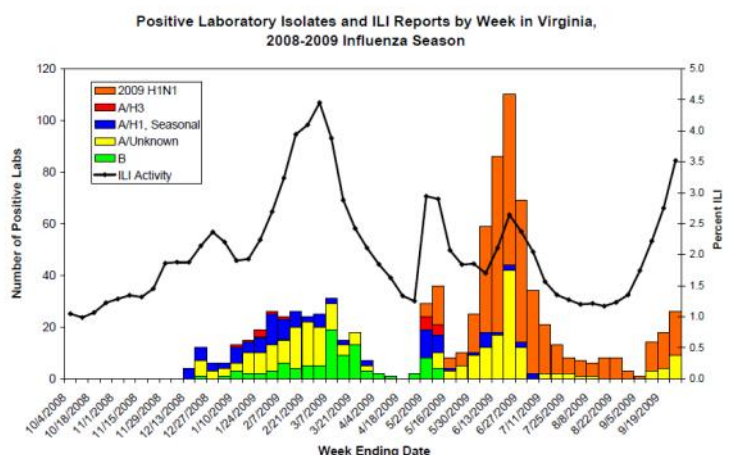
- Due to the varied reliability of testing results, there should be an increased index of suspicion for H1N1 influenza in women with influenza-like illness in pregnancy, even with negative rapid antigen or direct fluorescence antibody testing
- Patients with influenza-like illness in pregnancy should be diagnosed and treated presumptively on the basis of symptoms alone
- To support early triage and intervention and minimize illness and transmission, telephone triage may be helpful in the office setting for patients without comorbidities
- Any patient who is high risk, lives in a group setting, or has poor access to care and follow-up should be evaluated in person
- Given the potential for rapidly worsening disease, close follow-up of patients is recommended. The practitioner prescribing treatment should plan to contact patients on treatment within the first 24 hours of therapy to evaluate response
- Risk factors for severe disease have included obesity, low socioeconomic status, active or past tobacco use, third-trimester gestation, and underlying cardiac disease
- Observed complications included adult respiratory distress syndrome, superimposed bacterial pneumonia, renal failure, pulmonary embolus, and maternal death
- These authors pose the possibility of an increased Tamiflu dosing regimen of 150mg BID for ten days, for patients presenting with or developing severe disease, for instance acutely ill patients requiring assisted ventilation

Despite recommendations that antiviral drugs be started as soon as flu symptoms appear, many pregnant women are not treated soon enough.

Delays ranged from 6 to 15 days from the time that symptoms started, and 2 to 14 days from the time the women were seen by a doctor.

Not one of the six pregnant and relatively healthy women who died received medication within 48 hours of the onset of her illness.

Jamieson DJ, Honein MA, Rasmussen SA, Williams JL, Swerdlow DL, Biggerstaff MS, et al. H1N1 2009 influenza virus infection during pregnancy in the USA. Lancet 2009 Jul



H1N1 Vaccine and Guillain-Barre Syndrome: Talking Points for Providers Dispel Myth, Maximize Vaccination

In our region, flu activity has risen rapidly, currently matching rates of disease typical for the height of flu season in midwinter. The coming availability of the H1N1 vaccine is somewhat of a good news bad news situation. Good news... the opportunity to prevent illness and transmission of the virus. Bad news...the many urban legends surrounding vaccines in general and H1N1 in particular. What is key is that as many pregnant women as possible get vaccinated.

Recent stories in the mainstream media highlight the scope of our challenge.. One report puts the chance of a pregnant woman dying from H1N1 at greater than the chance of a heart patient dying during triple bypass surgery. Only 1 in 6 pregnant women get the seasonal flu vaccine, a rate far lower than any adult group for whom it is recommended, making the case for H1N1 vaccination may be an uphill battle.

According to the CDC, there have been approximately 700 reported cases of H1N1 in pregnant women since April. Of these, 100 women have required admission to an intensive care unit and 28 have died. In other words, 1 out of every 25 pregnant women who contracted H1N1 died of it. By any standard, that is an appalling death rate.

Vaccine and GBS

One widely publicized issue with vaccination is belief that it causes Guillain-Barre Syndrome.

- GBS occurs worldwide at an annual incidence of 1-2 cases per 100,000.
- Men are 1.5 times more likely than women to develop GBS.
- Applying this rate to the population of Virginia, we would expect 80-160 new GBS cases annually.

The risk of GBS following novel H1N1 influenza vaccination is unknown, but there is no evidence to suggest that

the risk will be higher than for the seasonal influenza vaccine. A risk profile similar to seasonal influenza vaccine means that at worst, one in 1 million vaccinated may develop GBS.

The benefits of novel H1N1 influenza vaccination will likely far exceed the risks. Although common sense prevention measures are also important, vaccination is the best means of preventing the flu and curbing its spread. Forgoing vaccination risks overburdening the healthcare delivery system and puts the most vulnerable populations at unnecessary risk. It is worth noting that the highest incidence of hospitalization to date has been among children less than 4 years of age.⁶

GBS has many causes, including infection from the influenza virus. The majority of GBS cases follow GI and respiratory infections, and the risk of developing GBS from the flu is likely to be higher than the risk of developing GBS from receiving the vaccine.

Lead by example. Nothing will allay the fears of your patients like hearing that you and your staff have been or will be vaccinated. Healthcare workers and emergency medical services personnel are among the priority groups for early novel H1N1 influenza vaccination.⁷

It is important to remember that influenza infection itself may trigger GBS.

Accessed

at: [http://](http://www.vdh.state.va.us/epidemiology/DiseasePrevention/H1N1/pdf/09-30-09%20GBS%20Fact%20Sheet%20Final.pdf)

www.vdh.state.va.us/epidemiology/DiseasePrevention/H1N1/pdf/09-30-09%20GBS%20Fact%20Sheet%20Final.pdf

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See also: http://www.nytimes.com/2009/09/29/health/views/29essa.html?_r=1 Pregnancy Is No Time to Refuse a Flu Shot



EVMS
Eastern Virginia Medical School



Clinical information is current as of compilation date, 092809 as it applies to the women and infant populations. The likelihood of changes to clinical recommendation is ever present as the pandemic situation is a dynamic event. Further updates will come in the form of email, newsletter or other form of instant communication. Questions or concerns may be directed to:

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Basic Tenets of Our HINI OB Right Plan:

- Influenza screening for all patients presenting to L&D
- Initiate antiviral therapy ASAP.
- Assess for worsening condition
- Place in a private room on standard/droplet precautions with eye protection.
- Maternal-Infant separation until mom has received anti-virals for 48 hours, her fever has resolved and she can control her cough.
- No children 18 or under, including siblings, will be allowed into the Women and Infant's areas
- Breast pumping is encouraged for confirmed HINI moms

Women & Infants HINI Flu Sub-Committee

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Julie Limauro RN
Sherry MacDonald RN, LC
Beth Ruello RN



Basic Tenets of Our Patient Safety Program:

- Use applicable evidence and published standards and guidelines
- When a clinical choice is presented choose patient safety over production.