

Influenza Clinical Pathway in the Time of COVID-19

Ambulatory, ED and Inpatient

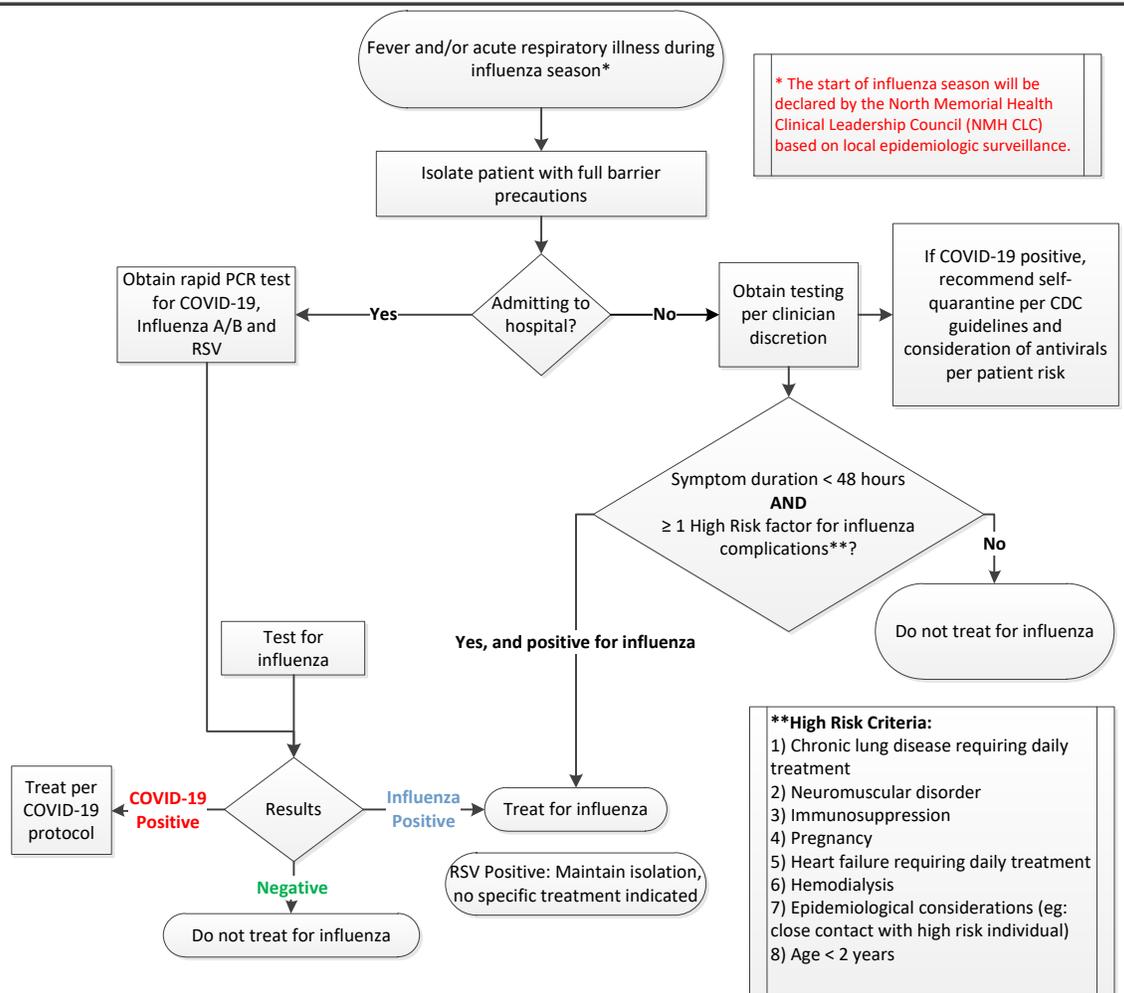
November 2022 – Version 3.0

Influenza is a highly contagious respiratory virus that infects humans. The spectrum of disease ranges from mild to severe, and some cases can be fatal. Influenza is best prevented by vaccination and avoidance of ill contacts.

When suspected or diagnosed, influenza treatment has a very limited impact on disease symptom duration (shortening length of illness by approximately 1 day); close contacts and family members may also be less likely to contract the disease, if the ill patient is treated. Current data does not suggest that influenza treatment affects mortality or need for hospitalization.

The following is our recommendation for an approach to patients with suspected influenza. This has been updated to account for appropriate testing and isolation practices during the COVID-19 pandemic.

ED and Inpatient Testing Guidance



Medication Options:

Oseltamivir (Tamiflu®) - PREFERRED

Treatment (5 days)
If younger than 1 yr old:

- 3 mg/kg/dose twice daily

 If 1 yr or older, dose varies by child's weight:

- ≤ 15 kg, the dose is 30 mg twice a day
- > 15 to 23 kg, the dose is 45 mg twice a day
- > 23 to 40 kg, the dose is 60 mg twice a day
- > 40 kg, the dose is 75 mg twice a day

Zanamivir4 (Relenza®)

(FDA approved and recommended for use in children 7 yrs or older)
Treatment (5 days)

- 10 mg (two 5-mg inhalations) twice daily

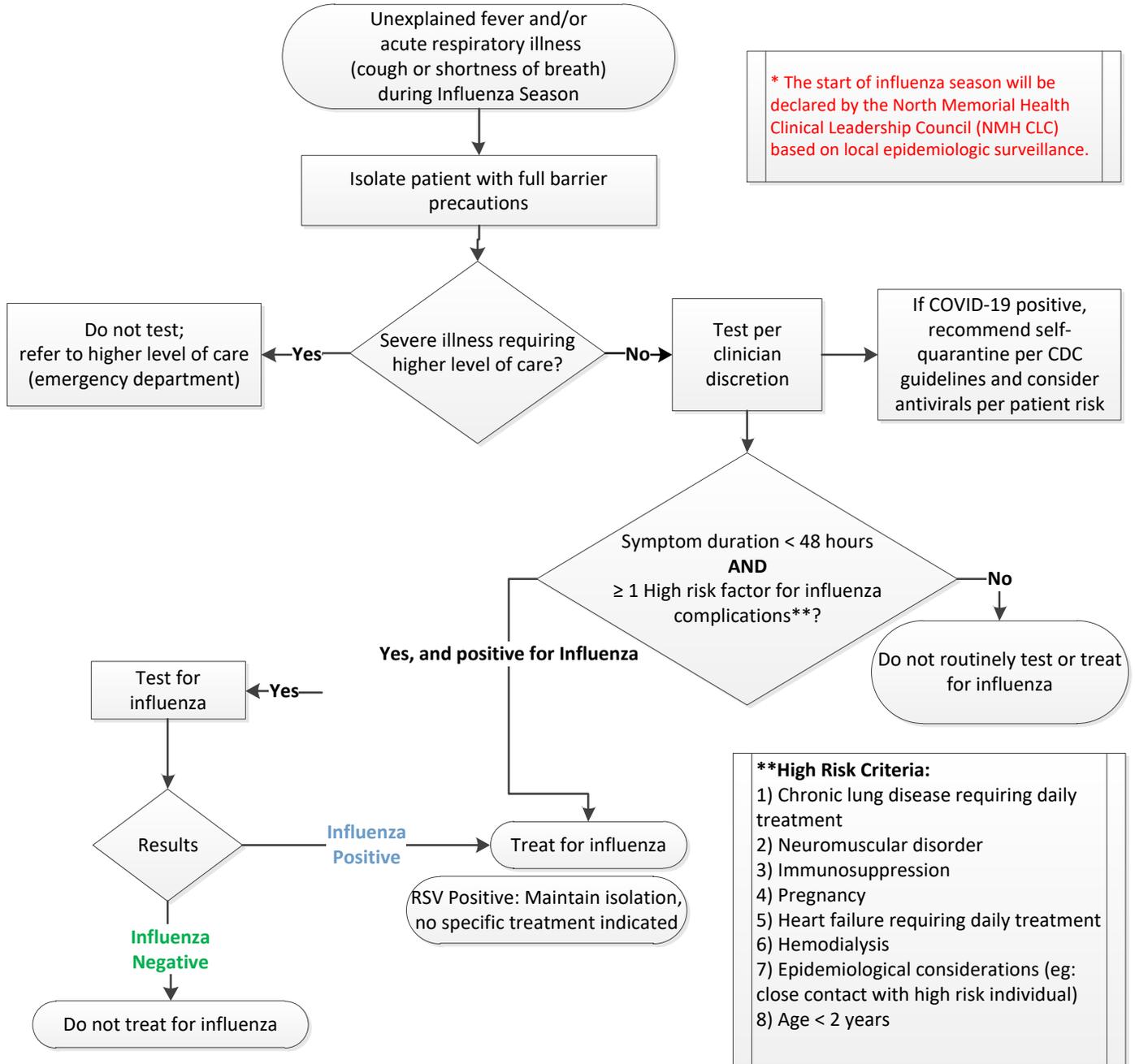


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Frequently Asked Questions:

1. Why are we returning to discretionary testing for ambulatory patients?

Thankfully, the supply chain shortages that necessitated judicious use of tests have been largely alleviated, and we are happy to be able to return to provider and customer-directed testing. We continue to require PUI testing for admissions to protect team members and other customers.

2. Why are we only recommending testing for outpatients only if symptoms have been present for fewer than 48 hours?

Existing evidence suggests that antiviral therapy has a modest impact on disease duration, only when started early in disease. Treatment after 48 hours has not been shown to result in any patient-oriented benefit, particularly in outpatient populations. This is supported by the IDSA and CDC.

3. Why are we only recommending outpatient therapy for high-risk groups?

These specific patient groups are the likeliest to experience complications related to influenza. Antiviral therapy is not without downsides (cost and adverse effects). In conjunction with professional recommendations for the IDSA and CDC, we are advising that routine testing/treatment be reserved for specific patient groups. Otherwise, healthy patients are unlikely to experience any significant benefit from antiviral treatment.

4. May I test or treat patients outside of these recommendations if there are extenuating circumstances?

Yes. As always, you should use your clinical judgment; this is intended as a guideline for most patient care situations.

5. How about RSV, when should I test?

We are recommending that all admitted PUIs undergo RSV testing, in order to prevent transmission to other hospitalized customers and team members. On the ambulatory side, we recommend testing if it will impact disposition or management (e.g. in daycare attendees).

References:

1. Antiviral Agents for the Treatment and Chemoprophylaxis of Influenza; Recommendations of the Advisory Committee on Immunization Practices (ACIP). Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, January 21, 2011, 60 (1): 1-26.
2. Harper SA, Bradley JS, Englund JA, File TM, Gravenstein S, et al. Seasonal Influenza in Adults and Children—Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management: Clinical Practice Guidelines of the Infectious Diseases Society of America. Clin Infect Dis (2009) 48 (8): 1003—1032.
3. Lansbury L, et al. Co-infections in people with COVID-19: a systematic review and meta-analysis. Journal of Infection. 2020.
4. Rubin R, et a. What Happens When COVID-19 Collides With Flu Season? JAMA. 2020.
5. WHO Guidelines for Pharmacological Management of Pandemic Influenza A (H1N1) 2009 and other Influenza Viruses. World Health Organization, February 2010. Available at: http://www.who.int/csr/resources/publications/swineflu/h1n1_guidelines_pharmaceutical_mngt.pdf?ua=1



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INFLUENZA WORKGROUP FOR THE ACUTE MEDICINE CLINICAL PRACTICE COUNCIL

This team represents expertise in Influenza. If you would like further information, please contact the lead for the Acute Medicine Clinical Practice Council, Cameron Berg, MD — Cameron.Berg@NorthMemorial.com.

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Revision History

This document is active and further recommendations are forthcoming. It will be updated as additions develop.

Revision	Description of Changes	Approvals	Date
1.0	Initial Document	Acute Medicine CPC	1-27-2017
2.0	Updates to pathway to include covid-19 protocol	Acute Medicine CPC	10-21-2020
3.0	Updates to pathway to include RSV guidance and consolidated ED/IP and Ambulatory guidance into one document	Acute Medicine CPC	11-9-2022