

Weekly Influenza Update

April 10, 2008

MEASLES ALERT (see bottom)

Clinical Case Definition for Measles

- Generalized rash lasting 3 or more days
- Temperature > 38.3oC or > 101oF
- Cough, or coryza, or conjunctivitis

Wisconsin: Influenza activity continues to decline in Wisconsin. Based on historical trends, about 6.4% of cases are yet to occur. The prevalence of influenza-like illness [fever of 100oF or higher and either cough or sore throat] in Wisconsin's primary care patients has fallen to an estimated 1.8%. 15.0% of last week's primary care patients had acute respiratory infections.

CLINICAL NOTES:

Diagnosis

- PPV of rapid influenza tests is fair, NPV is good

Prevention

- it is reasonable to stop providing routine immunization at this time
- the estimated vaccine match is 48% for North Central US

Treatment

- antivirals must be started within 36-48 hours of first symptoms to be effective in outpatient setting
- antivirals may be effective well past 48 hours for hospitalized patients
- NOTE: 9.2 % of H1N1 viruses exhibit a mutation that confirms resistance to oseltamivir

Other

- Parainfluenza virus 3 is being detected in low number
- RSV prevalence is low
- rotavirus isolation has been relatively low this season

Across the U.S.:

As of March 29, 33,347 positive surveillance cultures have been recorded in the United States. 17.7% of respiratory specimens during week 13 (March 23-29) were positive for influenza.

-75.0% of isolates have been type A

27.7% of all sub-typed A viruses have been H1N1 (69% are similar to vaccine strain; 31% show somewhat reduced reactivity)

72.3% of A viruses have been H3N2 (23% are similar to vaccine strain; 69% are A/Brisbane with reduced reactivity; 8% have reduced reactivity) -25.0% of isolates have been type B (4% are similar to the vaccine strain; 1% have reduced reactivity; 95% belong to a different strain type)

-8.5% of deaths during week 13 (March 23-29) were due to pneumonia or influenza [well above the epidemic threshold of 7.0%].

-59 pediatric influenza deaths has been reported to CDC this season, including 2 from Wisconsin

Global News [from the WHO]: The Ministry of Health and Population of Egypt has announced a new human case of avian influenza A(H5N1) virus infection. The case is a 19-year-old male who developed symptoms on 30 March was hospitalized on 31 March and died on 4 April. Investigations into the source of his infection indicate a history of contact with sick and dead poultry.

Since 2003, there have been 379 laboratory-confirmed cases of Avian influenza (A-H5N1). The cases been confined to Laos, Viet Nam, Thailand, Indonesia, Cambodia, the People's Republic of China, Turkey, Iraq, Azerbaijan, Egypt, Djibouti, Nigeria, Myanmar and Pakistan. There have been 239 associated deaths (case fatality rate= 63.1%). There is enhanced avian influenza surveillance in Wisconsin. Contact Tom Haupt at the Wisconsin Division of Public Health (608-266-5326) prior to submitting specimens for fee-exempt testing for patients with influenza-like illness returning from Southeast Asia within 10 days.

Other Observations: Measles Alert from the Wisconsin Division of Public Health

A positive case of measles has been reported in an unimmunized 23 month old child from Milwaukee County. The symptom onset was on March 26, 2008 and rash onset on March 27, 2008. The Measles IgM was positive on a serology specimen drawn on April 3, 2008. No known source has been identified and there had been no out-of-state travel during the probable source period. Day care and other close contacts are being followed. There was no known travel of the case outside of Milwaukee County during the child's infectious period. The next generation of cases would be expected to occur in the period of April 7 - April 13, 2008.

As this child has had no out of state travel, has no known source of infection and the fact that cases of measles are occurring in other parts of the United States health care professionals are asked to maintain a high index of suspicion of measles in patients presenting with rash/fever illnesses. Patients that present with such symptoms should be taken immediately to negative pressure isolation rooms for diagnosis. If phone contact is made ahead of any visit steps should be taken to isolate the patient upon arrival to the health care facility. On any suspect case seen please submit an acute blood specimen for confirmation. In addition, nasopharyngeal and throat swabs and a urine sample (in that order of importance) should be submitted to the State Laboratory of Hygiene for genotyping. The immunization status of any accompanying family member should be reviewed and MMR vaccine offered when applicable. Health care providers should inform the local health department immediately of any suspect cases, do not wait for laboratory confirmation.

Health care providers should take this opportunity to review the immunization/immune status for measles for all staff that may have patient contact. We will be sending out a synopsis of the immunization recommendations for the general population in a later communication.

Please contact the Immunization Program if there are questions, concerns or comments.

Daniel Hopfensperger, Manager - WI Immunization Program

1 W. Wilson St., P.O. Box 2659

Madison, WI 53701-2659

Ph # 608-266-1339

Fax # 608-267-9493

E-Mail hopfedj@dhfs.state.wi.us

Jonathan L. Temte, MD/PhD
AAFP Liaison to ACIP
Associate Professor
Department of Family Medicine
University of Wisconsin
777 South Mills Street
Madison, Wisconsin 53715

Telephone: 608-263-3111

Fax: 608-263-6663

email: Jon.Temte@fammed.wisc.edu