Persisting right through the summer, the once “novel” and now “pandemic” H1N1 influenza strain has made a mockery of the notion of an influenza “season.” With the arrival of autumnal breezes—and perhaps more importantly, the reunion of children in schools—we expect increases in casualties in the coming months. Pandemic H1N1, coupled with the likely return of more familiar influenza strains, makes preparation for the upcoming flu season especially important. This issue of the CD Summary reviews the emerging epidemiology of pandemic H1N1 and offers guidance about testing, treatment, infection control, and prevention of influenza in the coming fall and winter.

NEW REPORTING LAW
As of September 1, 2009, an emergency Oregon Administrative Rule mandates reporting by physicians, labs, and medical facilities of all patients hospitalized with laboratory-confirmed influenza to the local health department for the county in which the patient resides. Please include patient name, home address, phone number, date of birth, sex, and date of hospital admission; race and ethnicity would be appreciated as well.

EPIDEMIOLOGY OF PANDEMIC H1N1
On April 15, CDC confirmed pandemic H1N1 influenza in a US patient. The apparently promiscuous virus, which has genetic sequences in common with North American avian flu, human seasonal flu, and both Eurasian and North American swine flu, had spread to all 50 states by mid-June. The World Health Organization declared a pandemic on June 11, 2009.

In Oregon, as of August 19, 2009, there have been 92 hospitalizations of people with confirmed pandemic H1N1 and 11 deaths. The severity of illness continues to be similar to that seen with seasonal influenza, with the rate of hospitalization among confirmed cases in Oregon measuring in the 10%–15% range. Compared with seasonal strains, the pandemic virus has been more likely to cause illness among school-age children and less likely to affect persons >65 years of age (Figure).

Hospitalizations with laboratory-confirmed influenza, by age group and strain, US Emerging Infections Program.

VACCINATE!
Immunization is the most effective means of minimizing illness and death from influenza. This year we’ll have two vaccines: one for the usual “seasonal” strains, and one for pandemic H1N1. Persons ≥9 years of age need but a single dose of seasonal vaccine; but for immunity to the pandemic strain—which none of us have hitherto “seen” immunologically—two doses, spaced three weeks apart, will probably be required.

Healthcare workers attract patients with influenza and are therefore high priorities for receipt of both pandemic and seasonal vaccines; if you want to stay healthy and in business throughout the season, get yourself vaccinated, and offer the same at no cost to your staff, as soon as vaccine is available.

Vaccine against seasonal influenza should arrive in early fall; start using it as soon as it arrives, and keep using it as long as influenza is circulating. The groups advised to receive it are the same as for last year’s vaccine.

The vaccine against pandemic H1N1 will lag a bit: at press time, CDC is guessing that, nationally, perhaps 45 million doses of this new vaccine will be available by mid-October, with an additional 20 million doses becoming available each week thereafter. Priority groups for this vaccine are listed in the Table.

Priority groups for pandemic H1N1 vaccination

- pregnant women
- household contacts/caregivers for children <6 months of age
- healthcare and emergency medical services personnel
- all persons 6 months–24 years of age, and
- persons aged 25–64 years with health conditions that put them at higher risk of complications*

RESPIRATORY HYGIENE
Stress to both staff and patients the importance of hand hygiene and cough etiquette in stemming the spread of respiratory viruses. Make surgical masks available to patients with influenza-like illness (have pe-
DHS

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