

Influenza Vaccination Recommendations: 2001-02

The reduction from four to three manufacturers of influenza vaccine caused significant delays in vaccine availability for the 2000-01 influenza vaccination season. The three remaining manufacturers continue to expand their production facilities. While the total volume of vaccine available for the 2001-02 season is expected to exceed levels from the previous 2 years, the shipment of some vaccine supplies is expected to be delayed. The Minnesota Department of Health (MDH) has developed a plan to assure vaccination of persons in high priority categories. The plan, which was adopted by both the Minnesota Coalition on Adult

Immunization and the MDH Immunization Practices Task Force, has been distributed to all private medical clinics, public health agencies, nursing homes, hospitals, pharmacies, health plans, vaccine vendors that supply facilities in Minnesota, large employers, and others. This is the second year in which MDH has requested medical and health care providers to conduct their influenza vaccination activities according to a strategic plan. Because influenza vaccination programs are provided in many different settings, the cooperation of all is necessary.

The complete plan, presented below,

calls for this year's major vaccination efforts to begin in mid-October, with each of the first 4 weeks highlighting a different aspect of the campaign (Table 1). Retail sites (e.g., food stores and drug stores) will begin their clinics during the week of October 22 and will target only high-priority persons during that week. To facilitate these efforts, a poster presenting the following messages to help persons determine their priority for influenza vaccination is being distributed:

- Influenza vaccination services should be prioritized to reach persons that will experience serious morbidity and death if they develop disease.
- It is never too late to get vaccinated, even if influenza is already in the community.

The role of local public health agencies (LPHA) is to assure the availability of influenza vaccination services in the community, especially for those for whom influenza disease may result in serious complications, by coordinating activities in their jurisdictions, including:

- Determine if all clinics and/or facilities in their area have adequate vaccine supplies to vaccinate persons in priority categories 1 and
- continued...**

Health Care Providers Wanted for Sentinel Influenza Surveillance

The Minnesota Department of Health (MDH), in cooperation with the Centers for Disease Control and Prevention, is recruiting primary health care providers in family practice, internal medicine, and pediatrics to serve as sentinel providers as a part of MDH's influenza surveillance activities. Nineteen sentinel providers (M.D., D.O., Nurse Practitioner, or Physician Assistant) are needed statewide. In addition to long-term care facility- and school-based surveillance systems, sentinel health care providers provide valuable information about influenza activity in the general public. In addition, these providers play a critical role in early detection, characterization, and control of disease in the event of a public health crisis, such as pandemic influenza. From October to April, sentinel sites

report weekly the number of patients in four age categories (0-4, 5-24, 25-64 and >64 years) presenting with influenza-like illness and the total number of patients seen for any reason. Reporting can be done via e-mail, toll-free telephone call, or facsimile. Sentinel sites collect specimens for viral culture and strain subtyping from three patients each at the beginning, middle, and end of the influenza season. Specimen collection kits, shipping, and laboratory testing are provided by MDH free of charge. Sentinel providers receive a free year's subscription to the *Morbidity and Mortality Weekly Report* (MMWR) and free attendance at the MDH Emerging Infections in Clinical Practice Conference. For more information, contact Shelly Feaver at (612) 676-5414 or (toll-free) 1-877-676-5414.

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- 2 (Table 2), and
- If any clinic or facility lacks sufficient vaccine to meet the demand, attempt to locate additional resources in their community (e.g., vaccine, clinic services, etc.).

Medical clinics, long-term care facilities, and others providing vaccination services are asked to follow the following procedures:

- If you do not have sufficient vaccine for persons in priority categories 1

- and 2 (Table 2) and are part of a health system, contact your parent company to determine if you can acquire vaccine from within the health system, and
- Contact the LPHA in your area if you do not have sufficient vaccine for persons in priority categories 1 and 2 (Table 2) or if you have vaccine remaining after vaccinating persons in categories 1 and 2.

For information on influenza vaccine

recommendations from the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices, a copy of the federal vaccine information statement in English and other languages, consumer informational materials, dates and locations of mass vaccination clinics, updates on vaccine availability, and links to the CDC's influenza web site, visit the MDH web site (<http://www.health.state.mn.us/immunize>).

Table 1. Timeline for Influenza Vaccination Efforts in 2001-02

Time Period	Activity and Targeted Group
October 15, or earlier if vaccine is available (and ongoing)	<u>Clinic-based and other approaches that target persons at high risk:</u> Beginning in mid-October or as soon as vaccine is available, private medical clinics should start routine vaccination of high-risk persons and their direct care givers (priority categories 1 and 2 in Table 2) when patients are seen at their primary medical clinic for routine care, are hospitalized, or are seen in home care. Programs that provide vaccine to high-risk persons in long-term care facilities or senior centers also should begin at this time. No retail-based, other community-based, or worksite clinics should be held during this time.
October 22 (and ongoing)	<u>Community- or retail-based approaches that target high-risk persons:</u> Vaccination of high-risk persons and their direct care givers (priority categories 1 and 2 in Table 2) should begin in retail-based and other community-based settings (e.g., churches, public health agencies, etc.). During this week, all clinics should target only high-risk persons and their direct caregivers.
October 29 (and ongoing)	<u>Other community- or retail-based clinics:</u> Vaccination of the general, otherwise healthy public may begin. Vaccination of persons at high risk and their caregivers should continue.
November 5 (and ongoing)	<u>Worksite-based approaches:</u> Vaccination programs and other campaigns directed to employer groups that serve predominantly healthy persons <65 years of age may begin. Vaccination of high-risk persons in all settings should continue.

Table 2. Risk Categories for Use in Setting Influenza Vaccination Priorities

<p>Category 1 Groups at highest risk for influenza-related complications, including:</p> <ul style="list-style-type: none"> persons 65 years of age or older; residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions; adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma; adults and children who required regular medical follow-up or hospitalization during the prior year due to chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications); 	<ul style="list-style-type: none"> children and adolescents (6 months to 18 years of age) who are receiving long-term aspirin therapy that might put them at risk for developing Reye syndrome after influenza; and women who will be in the second or third trimester of pregnancy during the influenza season. <p>Category 2 Persons who provide direct care to persons in category 1, including:</p> <ul style="list-style-type: none"> physicians, nurses, and other staff in hospital or outpatient settings who provide direct patient care; employees of nursing homes or chronic-care facilities who have direct contact with patients or residents; employees who provide direct care at assisted living facilities or other residences for persons in high-risk groups; 	<ul style="list-style-type: none"> providers of home care to people at high risk (e.g., visiting nurses and volunteer workers); and household contacts (including children) of high-risk persons. <p>Category 3 Otherwise healthy persons 6 months of age or older who wish to reduce their likelihood of becoming ill with influenza, such as:</p> <ul style="list-style-type: none"> students and other persons in institutional settings (e.g., college students in dormitories); health care employees who do not provide direct patient care; persons who provide essential community services; healthy persons in the workplace; and others.
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Catch the Latest on Appropriate Antibiotic Use!

The Minnesota Antibiotic Resistance Collaborative (MARC), Wisconsin Antibiotic Resistance Network (WARN), and the Centers for Disease Control and Prevention are hosting a satellite conference on Thursday, November 15, 2001, 12 noon to 1 p.m., on "Adult Respiratory Illness and Antibiotics: Management Strategies to Promote Appropriate Use." Ralph Gonzales, M.D., M.S.P.H., from the University of California at San Francisco, will be the keynote speaker. Dr. Gonzales, a nationally renowned expert on appropri-

ate antibiotic use, chaired the national panel that published "Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults," in the March 20, 2001 issue of *Annals of Internal Medicine*.

This free program is approved for AMA/PRA Category 1 CME credit, AAFP Prescribed credit, and nursing contact hours. It will be broadcast live from the Marshfield Clinic and can be viewed at numerous sites throughout Minnesota.

As cold and influenza season approaches, this is a fantastic opportunity to review current treatment recommendations for adult respiratory illness and learn effective patient communication strategies to promote appropriate antibiotic use. The program will include a question and answer session.

You can register on-line at <http://www.wismed.org> or by calling the Minnesota Department of Health at (612) 676-5414 or 1-877-676-5414.

Hepatotoxicity Associated with Rifampin/Pyrazinamide -- Revised Recommendations for Treatment of Latent Tuberculosis Infection

In June 2000, the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC) issued new guidelines which included a 2-month regimen of rifampin and pyrazinamide (RIF-PZA) as an acceptable alternative to isoniazid (INH) for treatment of latent tuberculosis infection (LTBI).¹ Recommendations for use of RIF-PZA were based on clinical trials conducted among HIV-infected persons.

The number of patients treated for LTBI with either RIF-PZA or INH during the past year is unknown; therefore, the risk of hepatotoxicity associated with each regimen cannot be compared. However, the number of recent reports of severe liver injury among non-HIV infected persons treated with RIF-PZA has been unexpectedly high. In April, CDC reported one fatal and one severe case of hepatotoxicity associated with RIF-PZA; this report emphasized clinical monitoring for liver injury and other adverse effects in patients receiving treatment for LTBI and introduced surveillance measures to monitor and assess the safety of the RIF-PZA regimen.² Most recently, the August 31, 2001 issue of the *Morbidity and Mortality Weekly Report*³ outlined results of CDC's investigation of 21 HIV-negative patients who were hospitalized with severe liver injury associated with the RIF-PZA regimen for treatment of LTBI; 16 patients recovered and five died. Based on these findings, CDC and ATS, with endorsement of the Infectious Diseases Society of America, have issued updated recommendations for use of

RIF-PZA for treatment of LTBI.³ The revised recommendations include the following changes:

- In most instances, 9 months of daily INH is the preferred treatment for LTBI in persons not infected with HIV; 4 months of daily rifampin is an acceptable alternative. The 2-month RIF-PZA regimen may be useful for patients who are unlikely to complete a longer course of treatment and who can be monitored closely.
- Although available data do not suggest excessive risk of severe hepatotoxicity associated with RIF-PZA treatment for LTBI among HIV-infected persons, it may be prudent to use 9 months of daily INH to LTBI in this population as well when completion of treatment can be assured.
- The 2-month RIF-PZA regimen for treatment of LTBI should be used with caution, particularly in patients taking other potentially hepatotoxic medications and those with alcoholism. RIF-PZA is not recommended for persons with underlying liver disease or those who have experienced INH-associated hepatotoxicity.
- Persons being considered for treatment with RIF-PZA should be informed of the potential risk of liver injury (as well as the benefits of treatment of LTBI) and asked whether they have had liver disease or adverse effects from prior treatment with INH.
- The PZA dosage in the RIF-PZA regimen for treatment of LTBI should be <20 mg/kg/day and a maximum

of 2 gm/day.

- Patients' serum aminotransferase (AST or ALT) and bilirubin should be measured at baseline and at weeks 2, 4, and 6 of treatment with RIF-PZA. Treatment should be stopped and not resumed in the event of 1) AST/ALT greater than five times the upper limit of normal range in an asymptomatic person, or 2) AST/ALT greater than the normal range when accompanied by symptoms of hepatitis or a serum bilirubin above the normal range.
- Patients receiving RIF-PZA should be assessed in person by a health care provider at 2, 4, and 6 weeks of treatment for adherence, tolerance, and adverse effects and at 8 weeks to document completion of treatment. In order to facilitate periodic clinical assessment, patients should be given no more than a 2-week supply of RIF-PZA at a time. At each visit, a health care provider conversant in the patient's language should instruct the patient to stop taking RIF-PZA immediately and to seek medical consultation if symptoms of hepatitis develop. Provider continuity is important for effective monitoring.

These revised recommendations apply only to the RIF-PZA regimen for the treatment of LTBI and do not pertain to treatment of active TB disease. Because sporadic cases of severe liver injury associated with INH occur as well, patients taking INH for treatment of LTBI also should continue to be **continued...**

monitored as previously recommended. CDC continues to collect reports of severe hepatotoxicity associated with any regimen for treatment of LTBI; health care providers should report such cases to CDC at (404) 639-8116. Despite the cautions outlined in these updated guidelines, it is important to recognize that most patients tolerate treatment for LTBI well, and treating LTBI is an important part of TB prevention and control efforts.

Recent surveillance efforts and data at

the Minnesota Department of Health (MDH) indicate that very few persons have received the 2-month RIF-PZA regimen for treatment of LTBI in Minnesota. MDH has received no reports of any patient statewide who has experienced liver injury associated with this regimen. In accordance with the revised national recommendations, the MDH TB Prevention and Control program will update its guidelines for treatment of LTBI in Minnesota. These materials (and other TB-related information) are available at [http://](http://www.health.state.mn.us/tb)

www.health.state.mn.us/tb or by calling (612) 676-5414 or 1-877-676-5414.

References

1. CDC and ATS. Am J Respir Crit Care Med 2000;161:1376-1395. (<http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/rr4906a1.htm>).
2. CDC. MMWR 2001;50(15). (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5015a3.htm>).
3. CDC. MMWR 2001;50(34). (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5034a1.htm>).

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