

CDC H1N1 Transcript for Thursday June 18, 2009

Operator: I would like to remind you your lines are on hold unless you press star-1 to ask a question. I'll now turn the meeting over to Joe Quimby. Thank you, sir, you may begin.

Joe Quimby: Good afternoon. And thank you all for joining us today. With me to speak with you are two doctors – Dr. Daniel Jernigan, the Deputy Director of the Influenza Division at the Centers for Disease Control and Prevention here in Atlanta and also Dr. Michael Bell, the Associate Director for Infection Control here at the Centers for Disease Control and Prevention. First up will be Dr. Dan Jernigan.

Dan Jernigan: As the summer is approaching, influenza season has normally ended by now. However, the novel H1N1 influenza transmission continues in the United States, but is very significantly from region to region. The percent of flu viruses we're detecting here at CDC in our laboratory are predominantly the H1N1 novel strain, but 89% of those that we're seeing are the novel H1N1 strain. The overall proportion of patients seen in the ambulatory setting that is outpatients that are going in for influenza-like illness, that proportion is now below the national baseline. But there are two areas of the country that continue to see increased numbers of patients in the clinic with influenza-like illness. And both of those are in the northeast part of the United States. There continues to be some activity reported by our state health departments of influenza activity in 17 states. Some of them are reporting widespread activity like we might see during the regular flu season. The U.S. will likely continue to see influenza activity through the summer, and at this point we're anticipating that we will see the novel H1N1 continue with activity probably all the way into our flu season in the fall and winter. The amount of activity we expect to be low, and then pick up later. In terms of the numbers of infections that have been laboratory confirmed as H1N1, there are now more than 17,800 of those in the United States, including around 1,600 that have been hospitalized and 44 that have died. As we have been saying all along, these numbers are likely an underestimate of the number of cases that are out there. There are some surveys that indicate that the amount of disease in the areas that are having activity with H1N1 is perhaps around 7% of the population reporting symptoms due to influenza-like illness. The virus continues to impact mostly younger people. So far it is not causing significant illness and death in the elderly like we would see with seasonal influenza. And the symptoms that are being reported are consistent with influenza, that being predominantly fever, cough, some shortness of breath, fatigue and chills. There is some vomiting and diarrhea that have been associated with cases of this infection. Everyone needs to be alert to the symptoms of the illness, and especially if you have underlying conditions, such as asthma, diabetes and heart disease. For those folks, they need to be vigilant about their symptoms and consult their doctors or health care providers early if they develop flu-like symptoms. All of the evidence so far indicates that antiviral drugs still work. The inhibitors work particularly well. And we are recommending that they be used in high-risk patients that are sick and also in those being hospitalized and those that have severe illness.

From a global perspective, the W.H.O. is now reporting nearly 40,000 laboratory confirmed cases of novel H1N1 in 88 countries, and reporting 167 deaths. We are watching the southern hemisphere very closely and are engaged with many partners there to improve and expand systems to track the virus in how it's behaving through the flu season. We're working closely with W.H.O., and with ministries of health to identify from the laboratory standpoint, and also from disease in the community. The world health organization declared phase 6 last week. We are continuing the monitoring that we had started previously in the preparation for the return of increased activity in the fall in the United States.

With regard to the vaccine, we're continuing to work with manufacturers as they prepare these vaccine candidates for development of vaccine later in this summer. As I said before, children have been most affected with novel H1N1, schools were clearly a site where transmission was occurring, and likewise, over the summer camps -- the summer camps are now affected with flu in campers. So far there are a number of

outbreaks that have been identified in different states. They're affecting mostly adults, teenagers and children, mostly children, though. This is not unexpected, unfortunately, and it follows a pattern we saw with the disease in children in schools over the past few months. The CDC has posted on the website guidance for summer camp H1N1 disease. Those generally are that if your child is ill, they should not go to camp until seven days after their onset of their illness, or four days after their illness stops. We ask for camp staff to look for influenza-like symptoms in children and separate those children. It's important also that aspirin is not used in children with influenza-like illness because of complications that can occur. And parents need to be prepared that if their child is going to camp, there's a potential that they may be asked to come and pick up their child if they develop influenza at the camp.

What I'd like to do now is hand over to Dr. Michael Bell to describe novel H1N1 virus infections among health care personnel that appeared in the MMWR this week.

Mike Bell: Thanks, Dan. This is Mike Bell. I'm going to be telling you a little bit about the MMWR that's scheduled for release on June 19th, tomorrow, on H1N1 among health care personnel. The report covers health care personnel detected up to May 13th. This is a snapshot of what we knew up until that time. At that time there were 48 health care personnel that were identified with novel H1N1 of whom we were able to find detailed information for 26. Of those 26, half of them had exposure that were traced back to either the general community or else were unknown. The remaining half were probably related to the health care setting. And these include at least one case in which the exposure was to another ill health care provider.

The assessment of other clusters is currently ongoing, so we will be having a follow-up report in the coming weeks to update those numbers with what we learned from the other clusters. Of the 26 that are described in this report, two individuals were hospitalized. One of whom had some underlying medical conditions. Neither of the hospitalized health care personnel required intensive care and neither of them died. The other point that's made in this report is related to the infection control measures that are used to prevent exposure of health care personnel to influenza. Probably the single most important thing is that infectious patients be identified at the front door. Whether these patients are coming in through the emergency department or the ambulatory care clinic, identifying them up front is essential so health care personnel know that they should be doing the things that we recommend; that consistent application of precautions is important to make sure that there isn't occupational exposure.

The current recommendations include using a single patient room for infectious individuals and have them cover their cough. And use respirators, gloves, eye protection when they're in the patient with a patient with probable H1N1. As always, careful attention to hand hygiene is part of standard precautions that continue to be recommended. For novel H1N1 we currently also recommend that special procedures that might generate a fine aerosol be performed in a special room with negative pressure air handling so other parts of the hospital aren't exposed to potentially infectious material. Let me stop there and hand it back to Joe.

Joe Quimby: Thank you very much, Dr. Bell and Dr. Jernigan. We'll now turn over the telebriefing for questions and answers. Operator?

Operator: Thank you. At this time if you'd like to ask a question, press star-1 on your touch tone phone. Maggie Fox from Reuters, your line is open.

Maggie Fox: I would like to ask about vaccinating health care personnel. I know we don't have a specific one for H1N1 vaccinations. Will this be the case with H1N1 and does the report today sort of illustrate why that's important?

Mike Bell: This is Mike Bell. Let me comment from the perspective from the vaccination in general. I think health care personnel should be vaccinated annually. I think an important concern to keep in mind is that an infectious health care provider can come into the hospital early in the course of their disease, and spread potentially dangerous infection to very vulnerable individuals in hospital settings. So vaccination protects not only the health care provider, but also that health provider's patient.

Operator: The next is from Helen Branswell, Canadian Press.

Helen Branswell: Thanks very much. This is a question not about the health care, the MMWR, but about swine flu in general. Earlier in the outbreak, Dr. Cox was saying that people over 60 were probably -- probably had from previous exposures from H1N1 viruses that were more similar to swine flu than the contemporary viruses. Is the thinking on that, has the thinking on that changed? I heard from clinicians that they think it has to do with the immune response of younger people, that younger people are having more severe disease because of their immune response. I'm wondering if CDC has a position on this at this point?

Dan Jernigan: Thanks, Helen. A couple of things in that, I think one, is that the protection that might be afforded from past exposures, the second is the manifestation of disease in a host. And so from the protection standpoint, the sir oh logic indication is that those who are older may have been exposed to viruses that are more similar to one is now the novel H1N1. And therefore, they may be less likely to either manifest disease or to become infected. In terms of the younger individuals, the severity of disease, it may be that the severity of the disease is due to the robust immune response of younger individuals. But at this point we don't have any specific information to tease that out. But I would say that the serology supports the notion that there may be protection among older individuals and the severity of the disease mainly in Mexico City that the response in the younger may be responsible for the severity.

Joe Quimby: Thank you, doctor. Next question, please?

Operator: The next is from Jon Cohen with Science Magazine. Your line is open.

Jon Cohen: Thank you for taking my call. Dr. Jernigan, you said there might be as many as 100,000 Americans infected. With the finding that 7% had influenza-like illness in affected communities, that extrapolates to 20 million Americans. Could you give an estimate that's more up to date than the 100,000?

Dan Jernigan: Well, the 100,000, as you know, is a rough generalization to try to give a sense of the magnitude of infections that might be there relative to the numbers of laboratory confirmed that we actually had. And so as you can see, in some areas, where there have been a lot of transmissions, like New York City, they're finding maybe around 7% of the community was infected, or had influenza-like illness. There's some other parts of the U.S. where some of our preliminary data suggests the same thing. I think it would be inaccurate to try and take an attack rate of 7% or an area that's highly affected and apply that to the U.S. population. Because as we all know, the amount of disease is different in different parts of the U.S. And so clearly there are hundreds of thousands of cases that have occurred in the U.S. We are working to get a very good estimate of that. But at this point, it would be incorrect to take that percent and apply it to the U.S.

Joe Quimby: Thank you, doctor. Next question, please?

Operator: The next is from Mike Stobbe with the Associated Press. Your line is open.

Mike Stobbe: Hi. Thanks for taking my call. Actually, two questions. First, I think you said earlier in the call that CDC's expecting that the novel swine flu virus that we'll see cases through the summer and well into the fall and even winter. Did I get that right? And why do you think that? Could you explain a little

more? The second question has to do with the higher cases in the northeast. I was wondering if you could quantify that, how many more, or how many times more cases are you seeing up there?

Dan Jernigan: The amount of disease in the northeast that we were referring to is based on a system that looks at people coming into the clinic. And so what we see from our sentinel providers there in the northeast is that they are seeing a number of people coming into their clinic that have influenza-like illness as a percent of the total people that they see in their clinics, those numbers are above what they would see in the regular influenza season. And so they're above baseline. That's a rough indicator, it's not an enumerated indicator of disease. And so that's how we monitor influenza syndromically, rather than by specific laboratory confirmed cases. What was your first question?

Joe Quimby: Doctor, I believe Mike's first question had to do with the expectations of --

Dan Jernigan: Oh, yeah, throughout the summer, yeah. So there are a couple things. One is that we normally don't do the type of surveillance that we do right now during the summer. We have systems that continue to monitor for viruses through the summer. And we find very low levels of influenza. And in the past we've attributed that to influenza that has been introduced from the southern hemisphere, or might be in small pockets of disease in the U.S. But generally during the summer, very low levels of activity. The fact that we're seeing ongoing transmission now indicates there is something different. And we believe that that may have to do with the complete lack of immunity to this particular virus among those that are most likely affected. And those are children. The areas of the country that are most affected, some of them have very high population densities, like Boston and New York. So that may be a contributor as well. Plus the temperature in that part of the country is cooler, and we know that influenza appears to like the cooler times of the year for making transmission for effective.

Joe Quimby: Thank you, doctor. Next question, please, operator?

Operator: The next is from Beth Galvin from Fox TV in Atlanta.

Beth Galvin: Thank you for taking our call. I was just wondering on the camp issue, what would your advice be right now to nervous parents who are getting ready to send their kids off to camp? What are you telling the camps? Should the children be immediately sent home if they develop influenza-like illness or can they just be isolated and go on with camp activities?

Dan Jernigan: This is a complicated issue. Because there are different kinds of camps, different settings, different capabilities for health care provision, et cetera, at different camps. A lot of that is going to depend on the setting. And a lot of that depends on the interactions between that camp and the local health department. We've requested that camps work closely with their local health departments so that they understand about testing, and about availability of those jurisdictions to assist if they need any, in terms of guidance and specifying it to the situation. There is also a lot of information in our website with the -- from the American Camp Association, where they have provided some specific guidance that camps can go to and get directly from that association as well as from what we have posted on there. At this point we are recommending the same thing in camps that we have recommended in schools, and that is that if you have influenza-like illness that is suggestive or is likely to be the novel H1N1, that they -- those individuals be removed for seven days, or for 24 hours after the last symptom, if that's longer. That therefore for a week long camp will create issues for that child where it would probably be best for that child to go home. And so that's where parents, I think, need to be aware of the potential, they can talk with their pediatricians beforehand but our expectations is that we want to try and stop transmission as much as possible but also we want kids to get the appropriate care and sometimes that means that they need to come home.

Joe Quimby: Thank you, Beth. Operator, next question.

Operator: Our next question comes from Michelle Marill with Hospital Employee Health Newsletter, your line is open.

Michelle Marill: Um, thank you very much for taking, I have two questions, um, regarding the information on health care personnel. Um, the first is that you know that there has been substantial debate about whether surgical masks and respirators are the appropriate form of protection and I'm wondering if you think that confusion could have lead to mixed messages to health care workers cause clearly they are not consistently using their personal protective equipment or why you think it might be that they are not and um, the second question is the issue of eye protection. I notice of all the personal protective equipment, I don't think any of them have used eye protection. Is that a viable method of actually contracting influenza? And how significant is that that they were not using eye protection?

Mike Bell: Michelle, thanks for those questions. Let me deal with the eye protection thing first. The recommendation to protect your eyes from splashes is part of standard precaution. Anytime health care personnel think they might be in the line of infectious substance, they are recommended to protect their eyes, because it is a potential portal of entry. We don't have specific data for this particular strain of flu. So out of caution, we recommend if there's a possibility of having someone cough in your face, that your eyes are protected as well.

The other you bring up, whether it's best to use a mask or respiratory, that's currently under debate. There's actually a working group of our advisory committee that's deliberating on this right now. And will be providing additional information to CDC based on that in the coming weeks. I think your question about whether that can contribute to confusion and whether it's confusion that's keeping health care personnel from using protective equipment is an interesting question. I think that's certainly a possibility. But I think what I said at the beginning is also a major contributor. I mentioned that there are additional clusters that are currently being assessed. And as we look through this information, one of the patterns that we're beginning to see is that health care facilities are not promptly identifying potentially infectious patients. When these patients are in a regular setting, without any indication that health care personnel are supposed to wear a mask or respirator or what have you, there's no way to expect those personnel to do this consistently. That identification of potentially infectious patient's first step is absolutely essential for this to work.

I think while we're on the topic, I'll also throw out there that we're beginning to see a pattern of health care personnel-to-health care personnel transmission in some of the clusters, which is also concerning, because it gets to the issue of people showing up to work sick. As much as people want to do their very best, and come, you know, contribute to the work, even when they're feeling bad, I think it's very important that health care personnel understand that if they're ill, especially during an epidemic of influenza like this, they need to stay home. That has secondary implications. I mean, on the beneficial side it means you won't be spreading infection to your colleagues and further affecting the health care provider community. But more importantly, you're also not going to be spreading infections to patients who can be much more fragile, as we said. This also means that health care facilities need to have appropriate leave policies in place, and health care personnel need to understand that they won't be penalized for using sick leave appropriately. Likewise, facilities use a large number of contractors, and those contractors also need to have appropriate sick leave policies.

Joe Quimby: Thank you, doctor. Operator, next question, please?

Operator: The next is from Donald McNeil with The New York Times, your line is open.

Don McNeil: Hi. This is a follow-up to that question for Mike bell. The MMWR this week has a paragraph, additional messages aimed at reinforcing controls are needed that implies that the CDC has found there have been real failures in infection control. I guess you sort of outlined them, failure to identify patients when they first come in, failure to make sure the health care workers don't come to work sick. Is the CDC going to do more than basically print this sentence and make recommendations? Are you going to do anything to press states to enforce regulations, press for new policies from hospitals, press for an absolute policy that sick patients be identified, something like that? How tough can it get?

Mike Bell: I don't know. From the enforcement and regulatory perspective, I'm afraid I'm not the person to ask. So I would defer to people who know better. I do think that greater attention to those topics is very important. And I think we've been lucky that this first wave that we've seen so far has not been of the lethality that some people feared early on. I think it's been a very helpful learning experience. And those lessons do need to be applied so that if something were to come around, we'll actually be prepared to deal with it safely. You know, education and reinforcement are part of this, making sure that everybody understands what they need to do, and when they need to do it. But the oversight and enforcement piece I think, you know, you have a very good point. And there certainly may be some of that. But I'm not the person to ask, unfortunately.

Joe Quimby: Thank you, doctor. Next question, please?

Operator: The next is from Mike Estrel of the Wall Street Journal.

Mike Estrel: Thank you for taking my question. I wanted to ask, I realize there's probably no real hard data, but do you have any estimates on how much more H1N1 has spread in health care environments since may 13th? And also I just want to understand, are you recommending that health care personnel, all of them get Tamiflu, or is it at this point selective and might that change at some point?

Mike Bell: So in terms of what we've seen since may 13th, we're up to, I believe, 81 individuals with some relationship to health care delivery who have been identified as having novel H1N1. As I said, we don't have detailed information on all of those yet, and that's actually under way. I won't say much more about that. I guess it is fair to say that if the, you know, shift from 48 to 81 since may 13th does not represent a sudden increase, or an alarming change in pattern, we are not seeing anything that would indicate that health care personnel are overly represented amongst the recognized cases in this country. With respect to the second part, Tamiflu, there isn't a routine recommendation right now for all health care personnel to receive Tamiflu. We do, you know, follow the current recommendation from the influenza division with regard to prophylaxis of individuals exposed. And I don't know of any change to that recommendation at this point.

Joe Quimby: Thank you, doctor. Next question, please? Operator, we have time for two more questions.

Operator: The next is from Emma Hitt with MedScape.

Emma Hitt: Thank you for taking my question. The first question is try to get a sense, what proportion of hospitalized patients and those who have died do not have underlying health conditions? So what is the chance a completely healthy person will require, you know, intensive care or may even die from H1N1? And also, do you have a sense that health care practitioners are clear about the use of Tamiflu, and do you believe guidelines are being followed with respect to antiviral use?

Dan Jernigan: Let me start with the antiviral part. What we can tell you just from the individuals that have been assessed so far is there are some side effects related to Tamiflu use, specifically nausea and diarrhea, that have been problematic. Individuals have either declined altogether when offered, or have stopped their

prophylactic treatment early because of those symptoms. So I think, you know, it is potentially a challenging medication to take. And the uptake has been mixed. I think the first part of the question was whether normal, healthy individuals are being affected?

Dan Jernigan: Your question is, what numbers of individuals that are hospitalized have underlying diseases, and ~~about 40% or so~~ about 70% (this is the corrected percent of hospitalized patients with underlying health conditions) have some kind of underlying disease. The most predominant of that is asthma. The second being diabetes. Immunocompromised status, either through cancer chemotherapy or other compromising conditions is about 13%. And chronic underlying heart disease. The things that we see normally as underlying diseases that are associated with increased influenza risk are the same that we're seeing with H1N1.

Joe Quimby: Operator, thank you. Our last question, please?

Operator: Thank you. The next is from Bob Roos from CIDRAP News, your line is open.

Bob Roos: Thanks for taking my question. Just wondering what you're seeing in the data from the southern hemisphere so far? Are the H1N1 crowding out other seasonal flu viruses? Or can you tell at this point?

Dan Jernigan: This is an excellent question. And it's one that we look forward to seeing and understanding. The type of testing that's occurring in different parts of the southern hemisphere varies. There are some places that tend to focus just on testing with -- for the novel H1N1. The centers for disease control has provided to over 250 labs globally now kits for detecting the novel H1N1, and also the ability to detect some other kinds of influenza. What we're finding is that because of the numbers of cases for some of these laboratories, they are testing just for H1N1. So in some places it looks like the percentage is predominantly, even in the 90% area, that it is the novel H1N1. What we need to know is are they adequately doing a sample that would allow us to say what's really the breakdown of the different sub types of influenza. In some places that have been doing influenza survey for a long time, they are also seeing predominance of the H1N1 novel strain. But they're also seeing some of the seasonal H1N1s and the seasonal H-3s and 2s and Bs. There is a potential for this fall that we might have multiple sub types circulating. In the past with pandemic strains that has been a replacement. In 1918, 1957, 1968. But right now, we don't have enough information to say that there is a replacement occurring. And at this point we are expecting at least planning that there will be multiple sub types that are circulating at the same time this fall.

Joe Quimby: Dr. Jernigan, Dr. Bell, thank you very much for being with us today. All of you on the call, thank you as well. Have a great day. This now concludes our briefing.