



Health Update:

Influenza and Respiratory Illness 2021 – 22

December 8, 2021

This Health Update is designed to help San Francisco clinicians prepare for the upcoming influenza season, which generally occurs during the period from November through April.

Situation: Seasonal influenza cases have begun to appear sporadically in California and in San Francisco, and flu disease activity may increase in the coming months. See [SFDPH flu dashboard](#) and [statewide flu surveillance reports](#). Influenza activity nationally is still low overall; however, according to CDC, an increase of influenza A(H3N2) viruses has been detected in recent weeks, with most of these infections occurring in young adults.

This year, the influenza season will again occur while COVID-19 is circulating, raising the risk that increased morbidity and mortality resulting from both flu and COVID-19 could strain healthcare resources. There remains uncertainty regarding the potential course of this year's flu season, and thus it is important to prepare for the co-circulation of influenza and COVID-19 and make every effort to prevent a severe flu season, starting with ensuring widespread influenza vaccination.

Also of note, the California Department of Public Health (CDPH) is reporting [early occurrence of high respiratory syncytial virus \(RSV\) activity](#) this year, with RSV detections still on the rise as we enter December.

Summary of Actions Requested of San Francisco Clinicians

1. **Instruct all patients with influenza symptoms to self-isolate and obtain SARS-CoV-2 diagnostic testing.** Influenza and COVID-19 illness are unlikely to be distinguishable based on clinical symptoms alone.
2. **Test for influenza routinely in:**
 - **Patients with acute respiratory illness who are hospitalized** or being evaluated for hospital admission
 - **Patients with influenza symptoms who reside in long-term care facilities**
3. **Test for influenza in other persons with influenza symptoms when it will influence clinical management or infection control decisions.** This approach is unchanged from prior years. For asymptomatic persons, SFDPH does not recommend influenza testing.
4. **Consider testing for RSV** in patients with compatible symptoms, particularly in groups at risk for higher morbidity and mortality such as young children and residents of long-term care facilities.



5. **Review and implement [COVID-19 infection control precautions](#)**, as well as influenza precautions, in patients with influenza symptoms.
6. **Report** influenza and other acute respiratory outbreaks, suspected cases of novel or variant influenza, influenza-associated deaths in children aged 0 – 17 years, and RSV-associated deaths in children aged 0 – 4 years, according to the reporting guidance below.
7. **Initiate antiviral treatment** as soon as possible for any patient with suspected or confirmed influenza who is hospitalized, has severe, complicated, or progressive illness, or is at [higher risk for influenza complications](#); do not wait for results of influenza or SARS-CoV-2 testing.
8. **Prescribe antiviral chemoprophylaxis** to persons at higher risk for influenza complications who have been exposed to influenza, especially those in congregate settings.
9. **Encourage and administer annual influenza vaccine** to everyone aged ≥ 6 months, as [recommended by CDC](#). This year, while COVID-19 is co-circulating, influenza vaccination will reduce strain on our healthcare system. Vaccination is particularly important for individuals at high risk of influenza complications and for health care workers.
10. **Administer pneumococcal vaccination** with pneumococcal conjugate vaccine (Pneumovax) and and/or Pneumovax23[®] [as recommended](#) by CDC; please be aware that in October 2021 the CDC created new recommendations for the use of pneumococcal conjugate vaccines Pneumovax15 and Pneumovax20 which will become official once published (check [here](#)).
11. **Administer COVID-19 vaccination** according to [CDC recommendations](#).

SARS-CoV-2 Testing in Patients with Influenza Symptoms

With the exception of anosmia and ageusia (loss of smell and taste, respectively), symptoms associated with COVID-19 overlap with those of influenza. Fever, chills, myalgia, headache, sore throat, cough, shortness of breath, rhinorrhea or nasal congestion, nausea, diarrhea, and vomiting are common to both illnesses.

During the 2021-22 flu season, patients with one or more of the above symptoms could have influenza or COVID-19 (or even both) and at present we lack prediction tools to guide clinicians in making the diagnosis based on clinical presentation alone.

Therefore, to identify cases of COVID-19 and prevent further community transmission of COVID-19, SFPD recommends that **all individuals experiencing symptoms that could represent either influenza or COVID-19 symptoms, should be immediately isolated, and tested as soon as possible for SARS-CoV-2**. Influenza testing may be added if results would change clinical management, or for infection control decisions (see [CDC testing guidance](#)).



Influenza Testing in Patients with Influenza Symptoms

The Centers for Disease Control and Prevention (CDC) recommendations for influenza testing in symptomatic patients differ based on the context of care, and the patient's presentation.

- Patients with [acute respiratory illness being evaluated for hospital admission](#) or [already hospitalized](#) should **routinely** be tested with a nucleic acid detection assay for influenza A/B.
- For patients with [acute respiratory illness in the outpatient setting who do not require hospitalization](#), **influenza testing is indicated when it will influence clinical management or infection control decisions.**
- [Residents of long-term care facilities](#) with signs and symptoms of acute respiratory illness or influenza-like illness should be **routinely** tested for influenza.

Persons meeting clinical criteria for influenza testing should also be tested for SARS-CoV-2.

Also, clinicians should keep in mind that SARS-CoV-2 and influenza infection can co-occur, though the frequency at which this occurs is currently unknown. Therefore, a positive SARS-CoV-2 test result without influenza testing does not preclude influenza virus infection, and a positive influenza test result without SARS-CoV-2 testing does not preclude SARS-CoV-2 infection.

Conversely, a negative SARS-CoV-2 test does not implicate influenza as the etiology of a patient's symptoms, and a negative influenza test does not implicate SARS-CoV-2 as the diagnosis.

Influenza Testing in Asymptomatic Individuals is not Recommended

SFDPH does not recommend influenza testing in asymptomatic individuals. Even if recommendations exist for testing certain asymptomatic individuals for SARS-CoV-2 infection – for example close contacts of known COVID-19 cases or residents and healthcare staff at long-term care facilities -- these recommendations do not extend to testing for influenza.

There is no current CDC or CDPH recommendation to test asymptomatic individuals in congregate or long-term care settings for influenza.

Laboratory Testing for Influenza

When influenza is suspected and antivirals are indicated, treatment with antiviral therapy should not be delayed pending test results.

Laboratory testing for influenza with reverse-transcription polymerase chain reaction (RT-PCR) is the preferred testing method when there is strong clinical suspicion of influenza, even if the rapid test is negative. Influenza RT-PCR is readily available at hospital and commercial laboratories and is particularly encouraged:

- For hospitalized, intensive care, and fatal cases of influenza or influenza-like illness.
- During acute respiratory outbreaks in skilled nursing facilities, and



- In persons with influenza symptoms whose history of travel or contacts suggests concern for variant or novel influenza.

Rapid Influenza Diagnostic Testing (RIDT) can be useful but has limitations. Rapid influenza tests vary in specificity and range in sensitivity from 50-70%. False positives are common when influenza prevalence is low, and false negatives can occur when influenza prevalence is high. To minimize false negative results: collect respiratory specimens for RIDT within 3-4 days of illness onset and consider confirmatory testing with RT-PCR, particularly if an RIDT result is negative during a period of high community influenza activity. The [CDC algorithm](#) may be helpful for interpreting results of influenza testing during periods of community influenza transmission.

The San Francisco Public Health Laboratory (SFPHL) currently offers the following testing options:

- Combined SARS-CoV-2 testing **and** Influenza A/B testing by RT-PCR multiplex assay, or
- SARS-CoV-2 testing alone via RT-PCR

The order form and instructions for specimen submission can be found at the [SFPHL website](#).

Infection Control Precautions for Influenza in Healthcare Settings

CDC has issued guidance on [Prevention Strategies for Seasonal Influenza in Healthcare Settings](#).

- Influenza viruses are thought to spread person-to-person mainly via droplet transmission, but indirect contact via hand transfer from virus-contaminated surfaces or objects to mucosal surfaces of the face (nose, mouth) may also occur. All respiratory secretions and bodily fluids of patients with influenza are potentially infectious. Airborne transmission via infectious aerosols may occur but is primarily thought to occur in the vicinity of the infected patient and not over longer distances.
- Therefore, infection control precautions for lab-confirmed influenza only (when patient is not on COVID-19 transmission-based precautions) include standard and droplet precautions, with airborne precautions generally recommended (if feasible) only when aerosol-generating procedures on patients with suspected or confirmed influenza cannot be postponed.

Additionally, CDPH has issued [Recommendations for the Prevention and Control of Influenza in California Skilled Nursing Facilities during the COVID-19 Pandemic](#).

In general, infection control precautions for influenza are less stringent than for COVID-19, and therefore healthcare settings will be able to control influenza transmission by following [COVID-19 precautions](#). SF healthcare providers must also follow Best Practices mandated by the SF Health Officer related to controlling spread of COVID-19. See:

- [Health Orders](#) specifically the Safer-Return-Together order
- [Health Directives](#) specifically the Isolation and Quarantine Directives



Influenza Reporting:

By phone (415) 554 – 2830 / By fax (415) 554 – 2848. See www.sfcddcp.org/influenzareporting

PLEASE REPORT:

All [outbreaks](#) of influenza or acute respiratory illness, whether occurring in health care institutions (e.g., hospitals, long-term care, rehab) or in congregate settings (e.g., schools, assisted living, correctional facilities) (*report by phone within 24 hours*).

- See recommendations checklist and other resources at www.sfcddcp.org/longtermcare.

Fatal laboratory-confirmed influenza-associated cases aged 0 – 17 years (*report within 7 days*).

- Complete a case history form (www.sfcddcp.org/influenzareporting).
- SFDPH may request that retained specimens from fatal cases be sent to CDPH for viral culture, strain typing and antiviral resistance testing.

Fatal respiratory syncytial virus (RSV)-associated cases aged 0 – 4 years (*report within 7 days*).

Novel or variant influenza (*report immediately by phone if suspected*).

- Novel influenza (“bird flu” e.g., A/H5N1 and A/H7N9 viruses) is characterized by ILI severe enough to require inpatient medical care in a person with recent (within 10 days of illness onset): (a) close contact with a confirmed or suspected case of human infection with a novel influenza virus; OR (b) travel to areas where a novel virus has been detected in humans or animals; OR (c) working with a novel influenza virus in a lab.
- Variant influenza (“swine flu”) is caused by an influenza A virus that normally circulates in pigs and can occur sporadically in humans, most commonly among people who have direct or frequent contact with pigs.
- Visit the [CDPH influenza page](#); see Quick Sheets for Novel Influenza and Variant Influenza.

Influenza Antiviral Treatment and Chemoprophylaxis

CDC has updated its [influenza antiviral medication guidance for 2021-22](#), addressing both treatment and chemoprophylaxis. Key points are summarized below.

Treatment Recommendations: Antiviral treatment is recommended as soon as possible for any patient with suspected or confirmed influenza who is (a) hospitalized, (b) has severe, complicated, or progressive illness, or (c) is at [higher risk for influenza complications](#).

While testing can help distinguish between influenza virus infection and SARS-CoV-2 infection, for patients in the priority groups above, clinicians should not wait for the results of influenza testing or SARS-CoV-2 testing to initiate empiric antiviral treatment.



Clinicians can consider early empiric antiviral treatment of non-high-risk outpatients with suspected influenza based upon clinical judgment if treatment can be initiated within 48 hours of illness onset.

Chemoprophylaxis Recommendations: Oral oseltamivir or inhaled zanamivir are 70 – 90% effective in preventing influenza and are useful adjuncts to vaccination. Chemoprophylaxis is recommended to be initiated as soon as possible but no later than 48 hours after exposure to influenza in certain situations, such as:

- People at high risk of influenza complications during the first two weeks following vaccination, before they would be expected to develop vaccine-based immunity.
- People at high risk of influenza complications who cannot receive influenza vaccine due to a contraindication.
- People with severe immune deficiencies or others who might not respond to influenza vaccination, such as people receiving immunosuppressive medications.
- Among exposed residents of institutions such as nursing homes, regardless of whether they have received influenza vaccine. Chemoprophylaxis should also be considered for unvaccinated institutional staff.

Patients receiving antiviral chemoprophylaxis should be encouraged to seek medical evaluation promptly if they develop a febrile respiratory illness that might indicate influenza.

Antiviral chemoprophylaxis with oseltamivir or zanamivir should be taken daily for the duration of potential exposure to a person with influenza and continue for 7 days after the last known exposure. In addition, for institutional outbreaks, the minimum duration of chemoprophylaxis is 14 days. Baloxavir is approved for post-exposure prophylaxis (single dose) of influenza in persons age 12 years and up.

Seasonal Influenza Vaccination

Please continue to ensure seasonal influenza vaccination for all patients age 6 months and older who do not have a contraindication to receiving flu vaccine.

See our [Health Update for SF Providers: Flu Vaccination Vaccinations](#) (9/21/2021).

Our SFDPH [FAQ on flu vaccination during COVID-19](#) offers guidance updated for 2021-22:

- Vaccination of persons in isolation or quarantine for COVID-19
- Vaccination of persons getting tested at COVID-19 testing locations
- Vaccination of persons with mild vs. moderate-to-severe acute illness
- SARS-CoV-2 testing of persons with systemic symptoms following flu vaccination
- Co-administration of flu and COVID-19 vaccines



Pneumococcal Vaccination

Pneumococcal vaccines protect against invasive pneumococcal disease caused by vaccine serotypes, which can include pneumonia caused by *Streptococcus pneumoniae*.

Two new pneumococcal conjugate vaccines (PCV) were recently FDA-approved for persons aged 18 years and older: 20-valent PCV (Prevnar20[®], Pfizer) and 15-Valent PCV (Vaxneuvance[®], Merck). Detailed recommendations for use of these new vaccines are forthcoming from CDC. Until the new recommendations are published, clinicians may continue to follow [current CDC guidance](#):

13-valent Pneumococcal Conjugate Vaccine (Prevnar13[®]) is recommended for:

- All infants, routinely, prior to age 15 months (4-dose series)
- Children ages 2-5 years with an incomplete Prevar13 series
- Children ages 6-18 years with a [high-risk condition](#) and no prior Prevnar13 doses
- Adults ages 19+ years with a [high-risk condition](#) and no prior Prevnar13 doses
- Healthy adults ages 65+ years with no prior Prevnar13 doses, based on [shared clinical decision-making](#) with the provider

23-valent Pneumococcal Polysaccharide Vaccine (Pneumovax23[®]) is recommended for:

- Children ages 2-18 years with a [high-risk condition](#)
- Adults ages 19-64 years with a [high-risk condition](#)
- Adults ages 65+ years, routinely

COVID-19 Vaccination

Guidelines for COVID-19 vaccination are frequently modified; please visit CDC's [Interim Recommendations for Use of COVID-19 Vaccines](#) for comprehensive and updated information.

Additional Resources

- [SFDPH flu pages](#) with links for patients, providers, and facilities
- SFDPH COVID-19 [guidance for providers](#), [Health Orders](#) and [Health Directives](#)

The public can call 311 for basic information about COVID-19, flu, and flu vaccination in SF.

Program Contact Information:

Communicable Disease Control Unit
Disease Prevention and Control Branch, Population Health Division
Tel: (415) 554-2830
Email cdcontrol@sfdph.org
Fax (415) 554-2848
<https://www.sfdcp.org/>