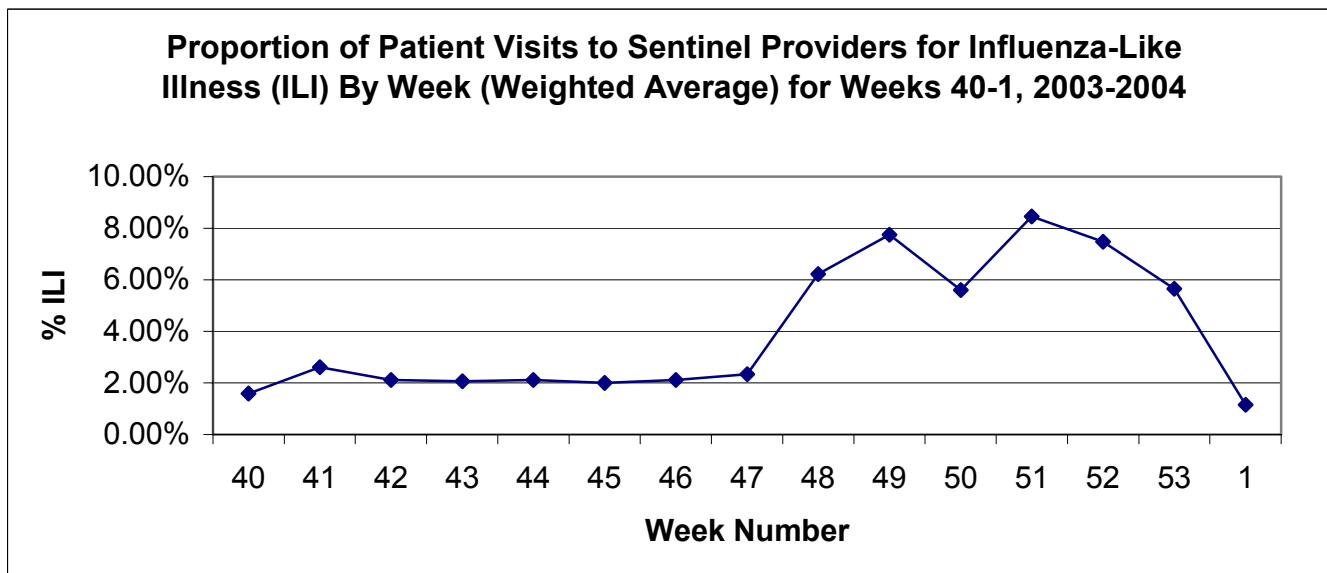


**Date:** January 16, 2004  
**To:** Health Care Provider  
**From:** Salena Savarda, BS, Surveillance Coordinator  
**Subject:** Influenza Report for Week 1 (January 4-10, 2004)

Forty-five cases of Influenza-like illness (ILI) were reported during week 1. **Criteria for inclusion as a case of ILI are fever  $\geq 100^{\circ}\text{F}$  ( $37.8^{\circ}\text{C}$ ) and cough or sore throat.** The proportion of patient visits to sentinel providers for ILI was **1.15%** (weighted average), which is lower than the national baseline of 2.5%. The percentage of deaths attributed to pneumonia and influenza (P&I) in Las Vegas was **7.84%**. The national P&I mortality for week 1 was 10.2%, which exceeds the epidemic threshold of 8.1%. The proportion of ILI cases by week in Clark County for weeks 40-1 of the 2003-2004 surveillance season is presented in the following figure.



Two hundred and six confirmed cases of influenza have been reported to the Office of Epidemiology (OOE) to date this season in Clark County. One hundred and seventy-five of these cases were confirmed by an influenza rapid test. Sixty of these were results of a type of test which differentiates between influenza A & B, and all results were reported as influenza A except for one which was reported as influenza B. Thirty-one cases were confirmed by viral culture and were all typed as influenza A. Twenty-three of these thirty-one isolates were subtyped as influenza A (H3N2). Subtyping on the remaining eight isolates is still pending. One isolate was antigenically characterized by the Centers for Disease Control and Prevention (CDC) as influenza A/Korea/770/2002-Like (H3N2). No new reports of influenza-related deaths have been confirmed by the OOE.

Influenza A (H5N1) viruses normally circulate among wild birds, but can infect poultry and rarely have infected people in the past. Earlier this week, Japan reported the deaths of 6,000 chickens on a single farm in the western part of Honshu due to influenza A (H5N1) virus infection, although no human cases of infection with the avian influenza virus have been reported in this outbreak. Since the end of October 2003, three persons (2 children and 1 adult) in Hong Kong and Vietnam, have been confirmed to have avian influenza A (H5N1). In Vietnam, eleven children were admitted to hospitals in Hanoi from surrounding provinces for severe respiratory illness. Twelve of the patients, including 11 children and

one adult, have died. Further details about the reported cases of influenza A (H5N1) in Vietnam can be accessed at the World Health Organization (WHO) web site [www.who.int/en/](http://www.who.int/en/).

In Hong Kong in 1997, H5N1 caused disease in 18 persons, of whom 6 died. During this outbreak, transmission of the virus to people occurred primarily from direct contact with birds. Efficient, sustained transmission of the virus from person to person did not occur. Approximately 1.4 million chickens were destroyed in Hong Kong to remove the source of the virus. In 2003, two residents of Hong Kong who traveled to China developed influenza A (H5N1) virus infections and one of them died. During December 2003, an outbreak of avian influenza A (H5N1) was reported among poultry in South Korea.

At this time, CDC recommends enhanced surveillance efforts by state and local health departments, hospitals, and clinicians to identify patients who have been hospitalized with unexplained pneumonia, ARDS, or severe respiratory illness AND who have traveled to Vietnam, South Korea, and Japan within 10 days from onset of symptoms. The OOE has an ample supply of viral transport media for viral culturing. Healthcare providers wishing to evaluate a patient with risk factors for influenza A (H5N1) should contact the OOE at (702)383-1378 to obtain an influenza test kit.

### **SARS Update**

On January 13, 2004, the Chinese Ministry of Health and WHO reported a new suspect SARS case in a 35-year-old man living in Guangdong Province, China. This case is the third recent report of suspected or confirmed SARS in patients in southern China. No link has been established at present between the confirmed case and the two recent suspect SARS cases, and the source of exposure for all three cases is unclear. In light of these reports, the CDC is recommending that U.S. physicians maintain a greater index of suspicion for SARS in patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome (ARDS) AND who have a history of travel to Guangdong Province (or close contact with an ill person with a history of recent travel to Guangdong Province) in the 10 days before onset of symptoms.

Since there is considerable potential for the clinical presentation and travel history of persons with either SARS or influenza A (H5N1) infection to overlap, influenza A infection should be considered in the differential diagnosis when evaluating a potential SARS patient. To serve as a quick reference guide, the OOE has updated the poster (attached) that was previously distributed, which outlines the risk factors to be considered when evaluating patients with severe acute respiratory illness for SARS or influenza A (H5N1). The guidelines for diagnostic testing of those patients at high risk for SARS can be accessed at the following website <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>. The most current information on SARS can be accessed at the Centers for Disease Control and Prevention website at <http://www.cdc.gov/ncidod/sars/>

**Reference:** Centers for Disease Control and Prevention. <http://www.cdc.gov/flu/weekly/> January 14, 2004.

Centers for Disease Control and Prevention. <http://www.cdc.gov/ncidod/diseases/flu/avian-influenza.htm>

This newsletter is also posted on the Clark County Health District webpage for health care practitioners. See [http://www.cchd.org/physician/physician\\_only.htm](http://www.cchd.org/physician/physician_only.htm) for this and other health and bioterrorism related information.

Each year from October through May, the Centers for Disease Control provide weekly updates on U.S. influenza activity. The information is online at: <http://www.cdc.gov/flu/weekly/>

Health care providers wishing to participate in the ongoing Clark County Health District Influenza Surveillance Program should contact Salena Savarda, Surveillance Coordinator, at (702) 383-1378

# CLINICAL DETECTION OF SARS OR INFLUENZA A(H5N1)

SARS or Avian Influenza diagnosis should be based on possible exposure as well as clinical illness. Consider SARS or Influenza A(H5N1) in the differential diagnosis for all hospitalized cases with *CXR-confirmed pneumonia of unknown etiology*.

## Ask the following questions to assess SARS or Avian Influenza exposure risk

- “Have you traveled to SARS affected areas\* within the last 10 days?”
- “Have you traveled to Influenza A(H5N1) affected areas\* within the last 10 days?”
- “Have you been in close contact with persons who have recently traveled to these areas\*?”
- “Are you employed as a health care worker with direct patient contact?”
- “Do you have close contacts who have been told they have pneumonia?”

# YES?

If a patient with CXR-confirmed pneumonia answers “yes” to any of these questions:

- For Influenza: institute droplet precautions
- For SARS: institute airborne precautions
- Notify the Office of Epidemiology at 383-1378 (24 hours).

Revised 1/28/04

\* The most current list of SARS and Influenza affected areas can be found on the Clark County Health District’s website at [http://www.cchd.org/physician/physician\\_only.htm](http://www.cchd.org/physician/physician_only.htm)