

## Response to questions from September 10<sup>th</sup> Flu Teleconference

(These are responses to questions that were not answered during the teleconference.)

Q. What is the efficacy of the H1N1 vaccine?

A. **The effectiveness of the flu vaccine is based on the health status of the person receiving the vaccine as well as how good of a “match” the vaccine is to circulating flu strains. CDC monitors the effectiveness of the vaccine every year and will be doing the same for the H1N1 vaccine. Clinical trial data show that one dose of the vaccine induces a strong immune response in adults while 2 doses are needed in children under age 10.**

Q. Can H1N1 vaccine be given with seasonal flu vaccine – what is the timeframe?

A. **Inactivated H1N1 vaccine and inactivated seasonal flu vaccine can be given at the same time or at any interval (at different sites). One inactivated vaccine and one live vaccine can be given at the same time or at any interval. Live H1N1 vaccine and live seasonal flu vaccine should not be given at the same time; they should be separated by a minimum of 28 days.**

Q. Like the seasonal flu vaccine should the H1N1 vaccine be administered every year from now on?

A. **If the H1N1 strain continues to cause disease, it will likely be included in the seasonal flu vaccine in subsequent years.**

Q. Who should **not** receive the **injectable** H1N1 vaccine?

A.

- **People who have a severe allergy to chicken eggs;**
- **People who have had a severe reaction to an influenza vaccination;**
- **People who developed Guillain-Barré syndrome (GBS) within 6 weeks of getting an influenza vaccine previously;**
- **Children younger than 6 months of age (influenza vaccine is not approved for this age group);**
- **People who have a moderate-to-severe illness with a fever (they should wait until they recover to get vaccinated).**

Q. Who should **not** receive the **live** virus H1N1 vaccine?

A.

- **People younger than 2 years of age;**
- **Pregnant women;**
- **People 50 years of age and older;**
- **People with a medical condition that places them at higher risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system;**
- **Children younger than 5 years old with a history of recurrent wheezing;**
- **Children or adolescents receiving aspirin therapy;**
- **People who have had Guillain-Barré syndrome (GBS) within 6 weeks of getting a flu vaccine;**
- **People who have a severe allergy to chicken eggs or who are allergic to any of the nasal spray vaccine components.**

Q. Is a previous history of Guillain Barré or family history of GBS a contraindication to vaccination against H1N1?

**A. A previous history of Guillain-Barré syndrome (GBS) within 6 weeks of getting an influenza vaccine is a contraindication to vaccination against H1N1, but family history is not a contraindication.**

Q. What is the estimated turnaround time for H1N1 testing at the DPH lab?

**A. Turnaround time is currently a couple of days but will likely increase with increased testing requests. Testing for H1N1 at the DPH lab is currently only being offered for hospitalized patients and hospital-based healthcare workers with influenza-like illness (ILI). Testing for other patients, if wanted by a provider, should be done through commercial laboratories in the state.**

Q. Does the Rapid Influenza Test have a high specificity? If a patient tests positive, is this a confirmation?

**A. The sensitivities of rapid influenza diagnostic tests (RIDTs) and direct immunofluorescence assays (DFAs) are lower than real-time reverse transcriptase polymerase chain reaction (rRT-PCR) tests and viral culture. Sensitivities for the RIDTs have ranged widely from 10-70% in the current outbreak. A negative RIDT or DFA result does not rule out influenza virus infection. Further, these tests cannot distinguish between 2009 H1N1 and seasonal H1N1 or H3N2 influenza A viruses.**

Q. Vaccinating in the schools is a great idea if the five top priority groups can get the vaccine, which means that all kids can get vaccinated. If there are problems with supply and there will be a need to stratify by risk group, how will schools be able to do this?

Q. Is there any plan to vaccinate kids in schools, and is there thought about who would staff these clinics? Many schools have only one RN, would there be any thought to reaching out for RN volunteers in the community to help?

**A. Schools interested in conducting H1N1 vaccination programs should coordinate with their respective Mass Dispensing Areas to address vaccine supply, staffing and other issues. A previous teleconference on school-based flu clinics was presented this past March and presentations from the teleconference may be accessed on the DPH website by clicking on “Programs and Services” then “T” for teleconferences.**

Q. If we have a baby delivered to an H1N1-positive mother in our nursery, do we need to isolate the baby from other non-exposed infants?

Q. If mom arrives in labor to our Pregnancy and Birth Center with suspected H1N1 signs and symptoms, does the baby need to be isolated immediately after birth from the mother? If so, how long and when is direct breastfeeding of the newborn allowed? In our level II SCN may the exposed family members of the suspected H1N1 mother be allowed to visit in the SCN?

**A. CDC has issued guidance regarding the management of pregnant women with influenza-like illness during labor and delivery and their newborn infants. This can be found at <http://www.cdc.gov/h1n1flu/guidance/obstetric.htm>.**

Q. In view of OB patients being high risk, should they be triaged to treatment based on phone interview/classic flu symptoms without bringing them in for office evaluation?

**A. As with other patients at increased risk for flu complications, pregnant women should be counseled about the signs and symptoms of influenza-like illness and instructed to call their provider immediately if symptoms develop so that severity of illness can be assessed and to allow for timely access to antiviral medications.**

Q. Can you give some information on pregnancy and lactation?

**A. Pregnant women and breastfeeding mothers should be given both seasonal flu and 2009 H1N1 influenza vaccines. Breastfeeding is fully compatible with flu vaccination, and preventing maternal**

**infection provides secondary protection to the infant. Maternal vaccination is especially important for infants less than 6 months old, who are ineligible for vaccination. In addition, transfer of vaccination-related antibodies by breastfeeding further reduces the infant's chances of getting sick with the flu.**

Q. Could the decreased incidence in those over 65 be related to the fact that they were less likely to travel to resort areas at the time of the outbreak and also were less likely to be closely exposed to those infected who returned to schools and infected the other students at school?

**A. Laboratory tests on blood samples indicate that older people likely have some pre-existing immunity to the 2009 H1N1 flu virus and this may explain the decreased incidence of H1N1 flu in persons older than 65 years.**