Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

Volume 15. Number 4. May 2019 • Page 1 of 2

Influenza Update

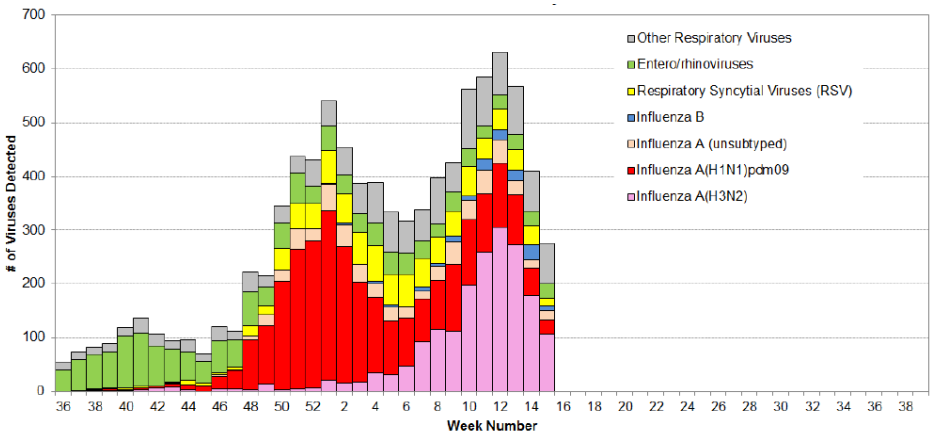
Most surveillance indicators suggest that the late-season wave of influenza A (H3N2) is subsiding, although influenza activity remains elevated above historical averages for this time of the year.

Among influenza viruses typed since week 40, virtually all have been influenza A. Influenza A(H1N1)pdm09 viruses predominated from October to mid-February, and have accounted for just over 60% of subtyped A viruses since season start. However, since week 7, A(H3N2) viruses have comprised a greater share of influenza A detections, accounting for 80% of subtyped A viruses in week 15.

Two laboratory-confirmed long-term care facility (LTCF) outbreaks of influenza A(H3N2) were reported in week 15, a decrease from week 14 (n=7) and in comparison to the peak number observed in weeks 10 and 12 (n=11).

Updated vaccine effectiveness (VE) estimates from the Canadian Sentinel Practitioner Surveillance Network (SPSN) suggest the 2018-19 northern hemisphere influenza vaccine has provided little or no protection against A(H3N2) viruses, particularly among working-age adults. These findings reinforce the importance of adjunct protective measures while the A(H3N2) epidemic is ongoing.

Published last week in *Eurosurveillance*, SPSN investigators also report that children under 10 years of age were more affected during the primary 2018-19 influenza A(H1N1)pdm09 epidemic compared to prior seasonal epidemics in Canada. The full report, which explores the potential reasons for this surveillance signal, can be read here.

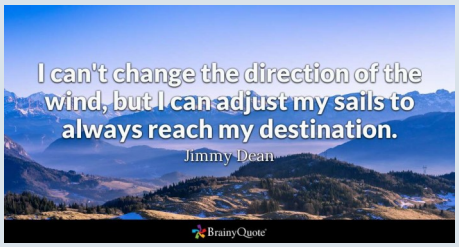


*Results are subject to change as more data become available, particularly for the most recent reporting weeks.
Source: BCCDC Public Health Laboratory (PHDRW); Data are current to April 17, 2019.

Source: BC Centre for Disease Control Influenza Surveillance Bulletin: Report No. 20, Week 15 April 7 to April 13, 2019

Inside this Issue:

Notable Quotable:



Contacts:

Dr. Sandra Allison, Chief MHO
Ph: 250-565-7424; Cell: 250-612-2582
sandra.allison@northernhealth.ca

Dr. Rakel Kling, Interim MHO-Northwest HSDA
Ph: 250-631-4261; Cell: 250-641-1758
rakel.kling@northernhealth.ca

Dr. Andrew Gray, MHO-Northern Interior HSDA
Ph: 250-565-7461 Cell: 778-349-4398
andrew.gray@northernhealth.ca

Dr. Jong Kim, MHO-Northeast HSDA
Ph: 250-261-7235 Cell: 250-793-3751
jong.kim@northernhealth.ca

Dr. Ronald Chapman, MHO and VP Medicine
Ph: 250-649-7653; Cell: 250-961-3234
ronald.chapman@northernhealth.ca

After hours calls to UHNBC Switchboard 250-565-2000 and ask for the MHO on-call

northern health
the northern way of caring

Measles Information

The intent of this memo is to clarify the current risk of measles faced by physicians and other health care workers (HCW) in NH, and priority actions recommended at this time.

The overall risk of measles for people in Northern Health remains low.
While it is possible that a traveler may import measles to the region, roughly 90% of people in BC are immune to measles. Any transmission is expected to be very limited.

Groups at higher risk, who should be targeted for immunization in the short term, are as follows:

- Exposed susceptible contacts of measles cases (if any)
- Non-immune individuals planning travel to areas with active measles outbreaks
- Routine childhood immunizations at 12 months and 4-6 years
- K-12 students, in BC's school-age measles immunization catch-up campaign

Most physicians and other health care workers (HCW) are not at high risk in the short term, and do not need urgent immunization.

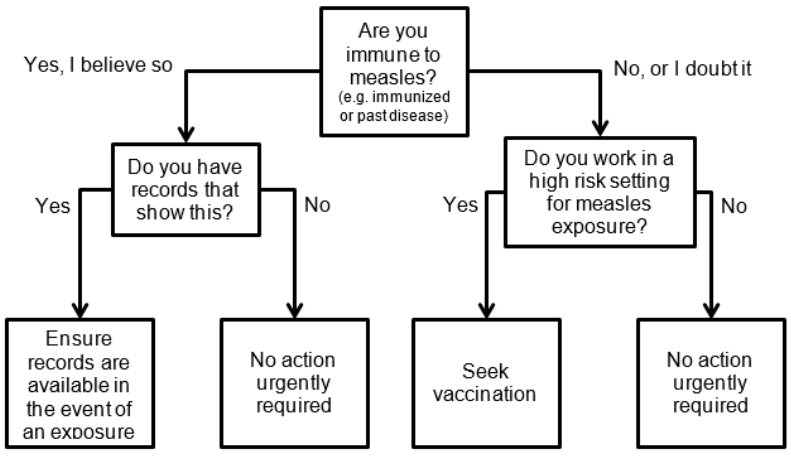
- A HCW who does not have access to their immunization records, but believes they have received all recommended vaccines, or has had measles, is likely immune and **does not need to be urgently re-immunized** at this time.
- In the rare event that a HCW is exposed to measles while airborne precautions are not in place, if no record of immunity is available, urgent serological testing will be requested. This will prove immunity in most cases, and exclusion from work will be unnecessary.
- Exposed HCWs will be considered **immune** if they were born before 1957, have had measles disease in the past, or have had one dose of measles vaccine. One dose provides 95% protection, and two doses provides 99% protection.
- Temporary exclusion from work is possible if a non-immune, unprotected HCW is exposed to measles. This is expected to be **very rare**.

In the short term, HCW vaccination should be targeted towards those who have specific reason to believe they have received zero doses of measles vaccine and have never had measles disease, who work in a high risk setting (acute/urgent care) or have other special circumstances that place them at significant risk of unprotected measles exposure. Few HCWs in BC meet these criteria (likely <5%).

Blood tests for measles immunity (serology) are not recommended, except in the event of a recent verified exposure.

For further information
- The latest provincial measles updates (BCCDC)
- NH's measles information page on ourNH (NH intranet)
- Workplace Health and Safety measles fact sheet for staff (NH intranet)
- Tips for locating immunization records (immunizeBC.ca)

Relevant guidelines
- BC guideline on measles control (BCCDC)
- BC guideline for use of measles vaccine (BCCDC)
- BC guideline regarding measles exposure among health care workers (PICNet)



Submitted by: Andrew Gray, Northern Interior Medical Health Officer

New Infant Formula Resource

Perinatal Services BC (PSBC) and the Ministry of Health have released a new resource entitled Infant Formula: What You Need to Know. This resource was adapted from an Ontario resource with the same name. A PSBC webpage provides additional information and related resources: Infant Formula Resource.

Content

- This resource addresses a significant need, as there is little detailed information on formula use in other provincial parent resources, such as Baby's Best Chance.
- This comprehensive booklet includes unbiased information and best practices about safe preparation, transportation, and storage of infant formula, as well as responsive, cue-based feeding.
- Its content aligns with the recommendations in *Chapter 2: Human Milk Substitutes* of the Northern Health (NH) Infant-Toddler Nutrition Guidelines for Health Professionals.

Alignment with the Baby-Friendly Initiative

- This resource aligns with the principles of Baby-Friendly Initiative (BFI), which supports all mothers, families, and caregivers to effectively feed their infants.
- NH has a Perinatal Program goal to support implementation of the BFI Ten Steps and WHO Code Outcome Indicators, as outlined in the NH Clinical Practice Standard Baby-Friendly Initiative (BFI): Protect, Promote, and Support Breastfeeding.
- BFI protects, promotes, and supports breastfeeding, and also supports individual families regarding the safe preparation and responsive use of human milk substitutes.
- Provincial work is underway to develop additional health professional resources to support informed/shared decision making regarding infant feeding.

Intended Use

- To avoid violations of BFI and to prevent unintended harm to families, it is important that this resource is used as intended.
- This resource is intended to support **one-on-one conversations** between health care providers and families with healthy, term infants who have made an informed decision to use infant formula.
- This booklet should be provided in its entirety - single pages should not be photocopied.
- **This resource is not for all families. As such, care should be taken that it is not put on public display; not used in group settings; and not added to standard prenatal or postpartum information packages.**

Access

- This booklet can be accessed electronically via the PSBC website: Infant formula resource.
- The province has provided a limited number of print copies to NH, which have been distributed to primary and community care teams and maternity care facilities.
- Additional print copies can be ordered from NH Document Source (order # 21101).

Suggested Actions

With your patients:

NH staff and physician partners are encouraged to use the Infant Formula: What You Need to Know booklet as the standard resource to support families who have made an informed decision to use infant formula.

- After having a supportive conversation with individual families, and ensuring their questions are answered, provide the family with a hardcopy of the booklet.
- Depending on the family, these conversations might happen in the prenatal period, or at any point in the infant's first year of life.

In your clinic:

Consider replacing any older educational resources in your office, related to infant formula, with this new PSBC booklet. This resource complements other existing resources that support families to safely and effectively feed their infants, including:

- HealthLink BC resources (short 1-2 page resources):
  - Breastfeeding (BC Health File #70)
    - Feeding Your Baby Formula: Before You Start (BC Health File #69a)
    - Feeding Your Baby Formula: Safely Making and Storing Formula (BC Health File #69b)
- Baby's Best Chance – available at local health units or online
- Toddler's First Steps – available at local health units or online

For More Information

If you have any questions, please contact either:

- Vanessa Salmons, Executive Lead, Perinatal Program, at Vanessa.Salmons@northernhealth.ca
- Lise Luppens, Population Health Dietitian; Regional Lead, Early Years Nutrition at Lise.Luppens@northernhealth.ca.

Submitted by:
- Dr. Kim Jong, Northeast Medical Health Officer
- Vanessa Salmons, Executive Lead, Perinatal Program
- Lise Luppens, Population Health Dietitian, Regional Lead, Early Years Nutrition

AMS Topic of the Month-Managing Uncomplicated skin and soft tissue infections-Preventing Hospital Admissions

Skin and soft tissue infections are a common reason for physician office and emergency department visits. Depending on the severity at presentation initiation of oral therapy may not be desirable and a few days of intravenous therapy prior to conversion to oral therapy may be required. In attempts to reduce the number of admissions, physicians often turn to outpatient administration of IV antimicrobials.

Previous practices in NH for outpatient IV management of uncomplicated skin and soft tissue infections (uSSTI) relied on the use of cefazolin plus oral probenecid. In 2011, probenecid was removed from the Canadian Market. At that time, ceftriaxone replaced cefazolin plus probenecid in the outpatient setting for uSSTI. This is not an ideal practice because ceftriaxone has suboptimal activity against S. aureus, has a higher risk for developing *C. difficile* infection and provides unnecessary gram negative coverage promoting antimicrobial resistance.

Probenecid (a uricosuric agent that inhibits kidney tubular secretion of cefazolin) given orally prior to a once daily dose of cefazolin 2g IV has been shown to increase serum concentrations and extend the half-life of cefazolin in a manner that achieves clinical resolution of cellulitis and related soft tissue infections compared to treatment with ceftriaxone 2g IV daily. Prescribing cefazolin 2g IV q24h plus probenecid 1g PO daily **(given 10 to 30 min prior to cefazolin)** in outpatient treatment settings for uSSTI will minimize use of ceftriaxone for uSSTI in outpatient treatment settings. However there will still be situations that warrant use of ceftriaxone in the outpatient setting (e.g. complicated infections such as: bone and joint infection, endocarditis, moderate/severe diabetic foot ulcers and animal bites)

NH is now able to obtain a compounded product through a Canadian manufacturer in Quebec. These capsules are not available via community pharmacies (manufacturer will only sell to hospital pharmacies), therefore NH facilities are required to provide patients with this oral medication daily (when patient returns for cefazolin dose).

Probenecid is contraindicated in patients with renal dysfunction and should not be used in patients with a creatinine clearance (CrCl) of less than 30 mL/min. Patients with CrCl of less than 30 mL/min could be treated with cefazolin at a reduced frequency (see below).

Creatinine Clearance (mL/min)	Cefazolin dosing
10 – 30	Cefazolin 2 g IV q 12h (no probenecid)
Less than 10	Cefazolin 2g IV q 24h (no probenecid)
Hemodialysis	Cefazolin 2 g IV after dialysis 3 x/week (no probenecid)

Points for practice
Use of cefazolin + probenecid for uSSTI allows sparing of ceftriaxone for more complicated infections and allows for convenient daily dosing for outpatients
Assess response to initial antibiotic therapy at 3 days and consider conversion to oral therapy if appropriate
Keep in mind that an increased redness/extension of cellulitis may occur after initiation of antibiotic therapy (due to release of toxins from bacteria) therefore NOT a reliable marker of clinical status if otherwise improving

See NH's IV Antimicrobial Therapy for Outpatients and Home IV order set.

Other topic: Pneumonia
Are you looking for some online learning about pneumonia? Northern Health's AMS program has created a new course on the learning hub, consisting of 3 separate modules (a. community-acquired pneumonia, b. hospital-acquired and ventilator-associated pneumonia and c. aspiration pneumonia). Once logged into the learning hub search for course title: NHA - AMS - Pneumonia. Each module will take approx. 20 to 30 minutes and includes a quiz and simple evaluation for future improvements. Your feedback will be reviewed!

Visit the NH Antimicrobial Stewardship program's pages on the NH physicians' website or OurNH for links to AMS information and resources.

Submitted by: Ryan Doerksen, Interim Antimicrobial Stewardship Program Coordinator