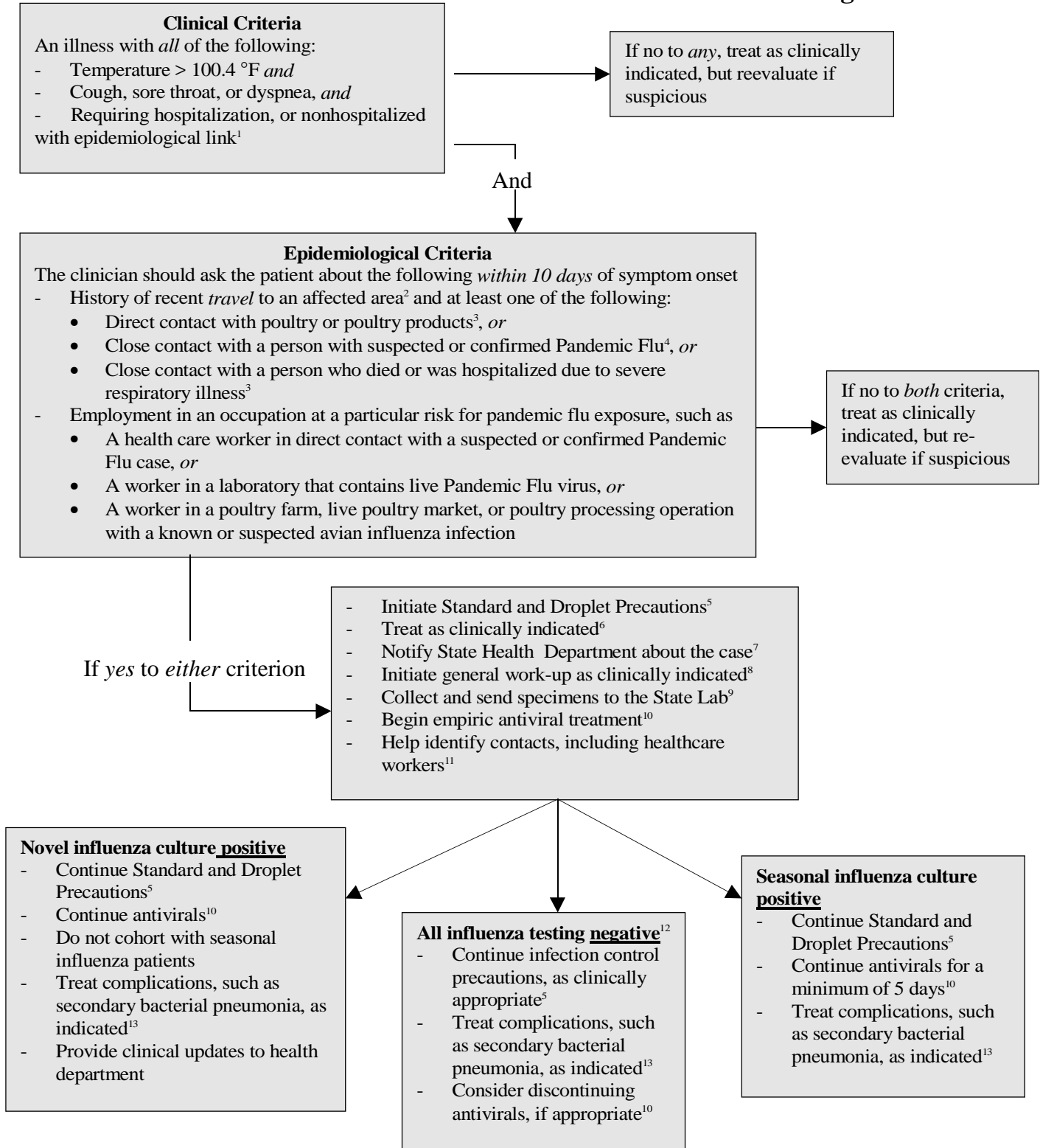


Clinical Guidelines

Maine Pre-pandemic Maine LEVEL I (Alert)

Case Detection and Clinical Management Figure 1



Footnotes to Figure 1:

1. Further evaluation and diagnostic testing should also be considered for outpatients with strong epidemiological risk factors and mild or moderate illness.
2. Updated information on areas where novel influenza virus transmission is suspected or documented is available on the WHO website (http://www.who.int/csr/disease/avian_influenza/country/en/index.html).
3. For persons who live in or visit affected areas, close contact includes touching live poultry (well-appearing, sick or dead) or touching or consuming uncooked poultry products, including blood. For animal or market workers, it includes touching surfaces contaminated with bird feces. In recent years, most instances of human infection with a novel influenza A virus having pandemic potential, including influenza A (H5N1), are thought to have occurred through direct transmission from domestic poultry. A small number of cases are also thought to have occurred through limited person-to-person transmission or consumption of uncooked poultry products. Transmission of novel influenza viruses from other infected animal populations or by contact with fecal contaminated surfaces remains a possibility. These guidelines will be updated as needed if alternate sources of novel influenza viruses are suspected or confirmed.
4. Close contact includes direct physical contact, or approach within 3 feet of a person with suspected or confirmed novel influenza.
5. Standard and Droplet Precautions (see appendix E)
6. Hospitalization should be based on all clinical factors, including the potential for infectiousness and the ability to practice adequate infection control. If hospitalization is not clinically warranted, and treatment and infection control is feasible in the home, the patient may be managed as an outpatient. The patient and his or her household should be provided with Home Quarantine and Self-Help information. The patient and close contacts should be monitored for illness by local public health department staff.
7. Guidance on how to report suspected cases of novel influenza to the Maine CDC is provided in Surveillance Plan (1-800-851-5821).
8. The general work-up should be guided by clinical indications. Depending on the clinical presentation and the patient's underlying health status, initial diagnostic testing might include:
 - Pulse oximetry
 - Chest radiograph
 - Complete blood count (CBC) with differential
 - Blood cultures
 - Sputum (in adults), tracheal aspirate, pleural effusion aspirate (if pleural effusion is present) Gram stain and culture
 - Antibiotic susceptibility testing (encouraged for all bacterial isolates)
 - Multivalent immunofluorescent antibody testing or PCR of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A

- and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
- In adults with radiographic evidence of pneumonia, *Legionella* and pneumococcal urinary antigen testing
 - If clinicians have access to rapid and reliable testing (e.g., PCR) for *M. pneumoniae* and *C. pneumoniae*, adults and children <5 yrs. with radiographic pneumonia should be tested.
 - Comprehensive serum chemistry panel, if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected.
9. Guidelines for novel influenza virus testing as per Maine State CDC. All of the following respiratory specimens should be collected for novel influenza A virus testing: nasopharyngeal swab; nasal swab, wash, or aspirate; throat swab; and tracheal aspirate (for intubated patients), stored at 4° C (39°F) in viral transport media; and acute and convalescent serum samples.
10. Strategies for the use of antiviral drugs are provided in **Pandemic Influenza Medication Plan**.
11. Guidelines for the management of contacts in a healthcare setting are provided in **Occupational Health Plan**.
12. Given the unknown sensitivity of tests for novel influenza viruses, interpretation of negative results should be tailored to the individual patient in consultation with the state health department. Novel influenza directed management might need to be continued, depending on the strength of clinical and epidemiological suspicion. Antiviral therapy and isolation precautions for novel influenza may be discontinued on the basis of an alternative diagnosis. The following criteria may be considered for this evaluation:
- Absence of strong epidemiological link to known cases of novel influenza
 - Alternative diagnosis confirmed using a test with a high positive-predictive value
 - Clinical manifestations explained by the alternative diagnosis.

Clinical Guidelines

Maine Levels II & III

(Evidence of pandemic flu in the United States)

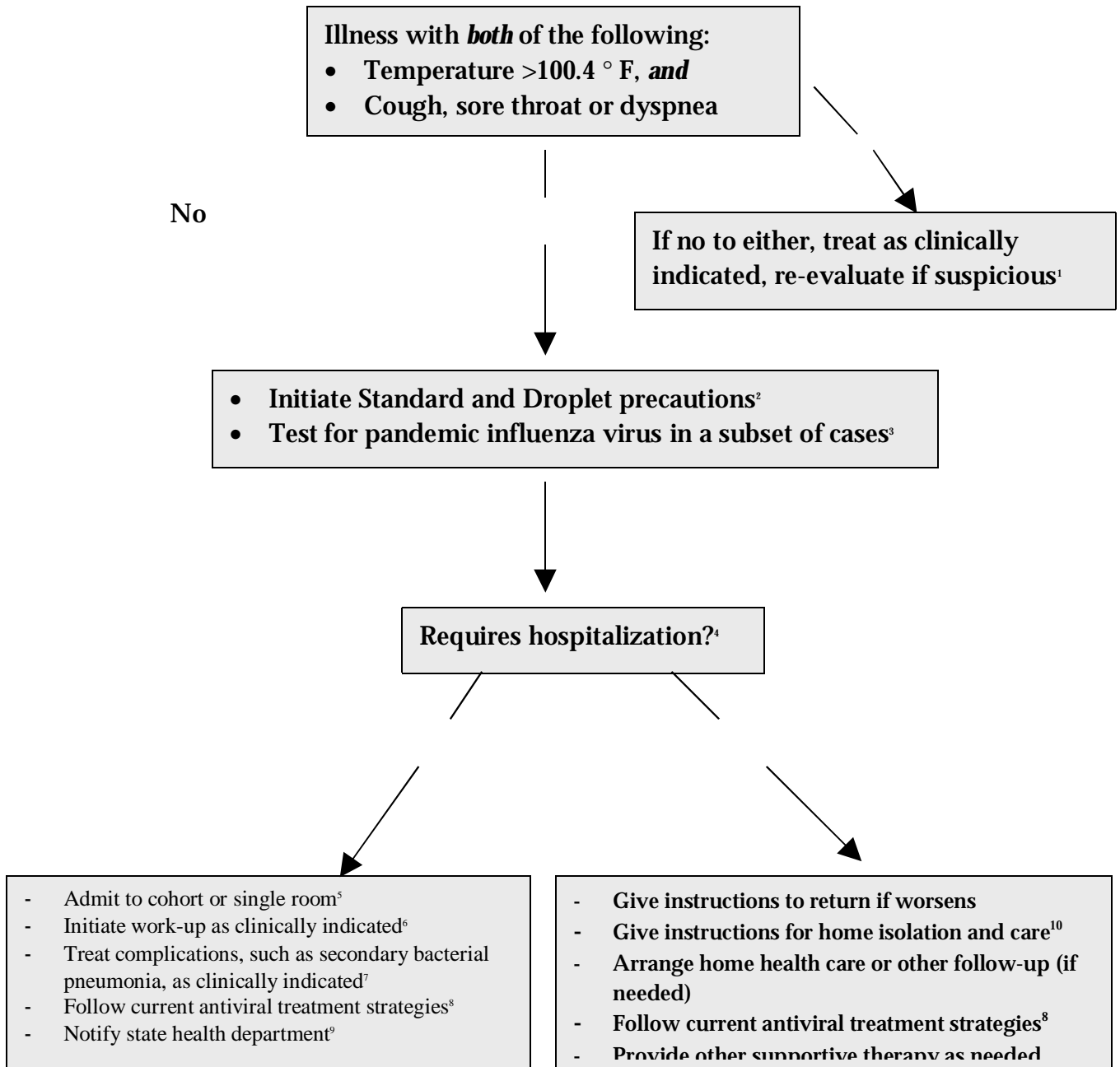
Maine Levels II & III

(Evidence of pandemic flu in local area)

Maine Level IV

(Increased and sustained transmission in the general population)

**Case Detection and
Clinical Management
Figure 2**



Footnotes to Figure 2:

1. Antiviral therapy and isolation precautions for pandemic influenza should be discontinued on the basis of an alternative diagnosis only when both the following criteria are met:
 - Alternative diagnosis confirmed using a test with a high positive-predictive value, and
 - Clinical manifestations entirely explained by the alternative diagnosis
2. Standard and Droplet Precautions (see appendix E).
3. See guidance from the state on laboratory testing during the Pandemic Period.

Generally, specimens

should include respiratory samples (e.g., nasopharyngeal wash/aspirate; nasopharyngeal, nasal or oropharyngeal swabs, or tracheal aspirates) stored at 4°C in viral transport media.

Routine laboratory confirmation of clinical diagnoses will be unnecessary as pandemic activity becomes widespread in a community. CDC will continue to work with state health laboratories to conduct virologic surveillance to monitor antigenic changes and antiviral resistance in the pandemic virus strains throughout the Pandemic Period.

4. The decision to hospitalize should be based on a clinical assessment of the patient and the availability of hospital beds and personnel.
5. Guidelines on cohorting can be found in **Facility Access, Triage, and Admission Plan**. Laboratory confirmation of influenza infection is recommended when possible before cohorting patients.
6. The general work-up should be guided by clinical indications. Depending on the clinical presentation and the patient's underlying health status, initial diagnostic testing might include:
 - Pulse oximetry
 - Chest radiograph
 - Complete blood count (CBC) with differential
 - Blood cultures
 - Sputum (in adults) or tracheal aspirate Gram stain and culture
 - Antibiotic susceptibility testing (encouraged for all bacterial isolates)
 - Multivalent immunofluorescent antibody testing of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
 - In adults with radiographic evidence of pneumonia, *Legionella* and pneumococcal urinary antigen testing
 - If clinicians have access to rapid and reliable testing (e.g., PCR) for *M. pneumoniae* and *C. pneumoniae*, adults and children <5 yrs. with radiographic pneumonia should be tested.

- Comprehensive serum chemistry panel, if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected
7. Strategies for the use of antiviral drugs are provided in **Pandemic Influenza Medication Plan**.
 8. Guidance on the reporting of pandemic influenza cases is provided in **Surveillance Plan**.
 9. Patients with mild disease should be provided with FCHN home-care kits, including standardized instructions on home management of fever and dehydration, pain relief, and recognition of deterioration in status. Patients should also receive information on infection control measures to follow at home. Patients cared for at home should be separated from other household members as much as possible. All household members should carefully follow recommendations for hand hygiene, and tissues used by the ill patient should be placed in a bag and disposed of with other household waste. Infection within the household may be minimized if a primary caregiver is designated; ideally, someone who does not have an underlying condition that places them at increased risk of severe influenza disease. Although no studies have assessed the use of masks at home to decrease the spread of infection, using a surgical or procedure mask by the patient or caregiver during interactions may be beneficial. Separation of eating utensils for use by a patient with influenza is not necessary, as long as they are washed with warm water and soap.