Low level mix of influenza viruses detected in BC

Summary

During week 5 (January 30 – February 5, 2011), influenza surveillance indicators in BC (sentinel physician ILI rate and MSP influenza visits) were consistent with those of the previous reporting week, remaining below historic levels for this time of year. At the BC Public Health Microbiology & Reference Laboratory, 190 respiratory specimens were tested. Influenza was detected in 34 (18%) specimens: pandemic influenza A/H1N1 in 13 (7%), A/H3N2 in 6 (3%), unsubtyped influenza A in 6 (3%), and influenza B in 9 (5%) specimens. Of 190 specimens tested, other respiratory viruses detected included 14 (7%) RSV, 19 (10%) rhino/enterovirus and 17 (9%) coronavirus.

For your information, an updated influenza antiviral guidance document entitled “The Use of Antiviral Drugs for Influenza: Guidance for Practitioners, 2010-11” has been posted on the Association of Medical Microbiology and Infectious Disease, Canada (AMMI Canada) website available at the following link: www.ammi.ca/index.php. This document is also available on the Public Health Agency of Canada FightFlu.ca website at: www.fightflu.ca/health_professionals-eng.html

Report disseminated February 10, 2011
Contributors: Samson Chan, Lisan Kwindt, Naveed Janjua, Danuta Skowronski
Sentinel Physicians

During week 5, ~0.5% of patients presenting to sentinel physicians had ILI, which is similar to the previous week and still below the expected range for this time of year. Fifty-four percent (25/46) of sentinel physician sites have reported to-date for week 5.

BC Children’s Hospital Emergency Room

The percentage of BC Children’s Hospital ER visits attributed to “fever and cough” or flu-like illness decreased from 10.5% in week 4 to 8.4% towards the end of week 5.
Medical Services Plan
Influenza illness as a proportion of all submitted BC Medical Services Plan (MSP) claims is also similar to the previous week in most regions, being at or above 10-year medians provincially and in Vancouver Coastal, Fraser, Vancouver Island and Interior (where evidence of recent increase is observed) while remaining below the 10-year median in Northern HA. To better reveal current low-level trends, the ~9% peak in MSP claims of late October/early November 2009 is not shown in the graphs below (consult earlier bulletins).

*Influenza Illness Claims* British Columbia

![Influenza Illness Claims Graph](image)

* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).

Data provided by Population Health Surveillance and Epidemiology, Ministry of Health Services

**Notes:**
- MSP week beginning 13 Feb 2010 corresponds to sentinel ILI week 7.
- Data current to Feb 08, 2011

Northern

![Northern Influenza Illness Claims Graph](image)
One hundred and ninety respiratory specimens were tested at the BC Public Health Microbiology & Reference Laboratory in week 5. Influenza was detected in 34 (18%) submitted specimens. Thirteen of these (7% of submitted specimens) were pandemic A/H1N1, 6 (3%) were A/H3N2, 6 (3%) were unsubtyped A, and 9 (5%) were type B. There were sporadic detections of influenza A/H3N2 viruses from Fraser, Vancouver Coastal, and Vancouver Island Health Authorities. Pandemic A/H1N1 was detected sporadically from all HAs except Northern. Influenza B was sporadically detected from all HAs. During this week, of 190 specimens tested for other respiratory viruses, 19 (10%) were positive for rhino/enterovirus, 14 (7%) were for RSV, and 17 (9%) for coronavirus. Other respiratory viruses were also sporadically detected.

During week 5, BC Children’s and Women’s Health Centre Laboratory tested 76 respiratory specimens. One (1%) was positive for influenza A and 1 (1%) was positive for type B. Twenty seven specimens (35.5%) were positive for RSV.

Data provided by Virology Department at Children’s & Women’s Health Centre of BC
**ILI Outbreaks**

During week 5, eighteen new ILI school outbreaks were reported from schools in Interior (12), Fraser (5), and Northern (1). One specimen from the school outbreak in Northern was lab-confirmed to be Influenza B positive. Other outbreaks were not tested for respiratory viruses. In week 5, an ILI outbreak was identified in a correctional facility in Interior HA. Lab testing confirmed pandemic A/H1N1.

**Number of Influenza and Influenza-Like Illness (ILI) Outbreaks Reported, Compared to Current Sentinel ILI Rate and Average Sentinel ILI Rate for past 19 years, per Week, British Columbia, 2010-2011 season**

* Facility influenza outbreak defined as 2 or more ILI cases within 7-day period, with at least one case laboratory-confirmed as influenza.

† School ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.

**CANADA**

**FluWatch**

During week 4 ending January 29, 2011, influenza activity in Canada appeared to have peaked in most regions across the country. The influenza-like illness (ILI) consultation rate remained within the expected range for this time of year. One thousand one hundred and fifty-five specimens (17.7% in week 3) tested positive for influenza, a slight decrease from the previous week (20.8%): 380 A/H3N2, 658 unsubtyped influenza A, 55 pandemic H1N1, and 62 influenza B. Specimens were reported from all provinces; influenza A activity was mainly concentrated in ON, QC, AB, and NB. During week 4, 24 new paediatric hospitalizations and 26 new adult hospitalizations related to influenza were reported through IMPACT and CNISP networks. This is a decrease over previous weeks. In Ontario, during week 4, 463 influenza laboratory confirmed cases were detected with 16.5% positivity; a decrease from the previous week. The overall ILI consultation rate has decreased from 55/1,000 patient visits in Week 3 to 42/1,000 patient visits in Week 4. In Quebec during week 3, 545 (22%) tested specimens were positive for influenza. www.phac-aspc.gc.ca/fluwatch/

**National Microbiology Laboratory (NML): Strain Characterization**

Between September 1, 2010 and February 3, 2011, one hundred and eighty-three influenza isolates were collected from provincial and hospital labs and characterized at the NML as follows:

- **121 A/Perth/16/2009 (H3N2)-like** ‡ from QC, ON, MN, SK, AB & BC;
- **34 A/California/07/2009 (H1N1)-like** * from QC, ON, AB & BC;
- **27 B/Brisbane/60/2008 (Victoria lineage)-like** † from QC, ON, SK, AB & BC;
- **1 B/Florida/04/2006-like (Yamagata lineage)-like** ‡ from BC

* indicates a strain match to the recommended H1N1 component of the 2010-11 northern hemisphere trivalent influenza vaccine

‡ indicates a strain match to the recommended influenza B component of the 2008-2009 northern hemisphere trivalent influenza vaccine
NML: Antiviral Resistance

Drug susceptibility testing at the NML between September 1, 2010 and February 3, 2011 indicated that all but one A/H3N2 and all pandemic H1N1 isolates were resistant to amantadine. All the isolates (107 A/H3N2, 31 pandemic H1N1, 26 type B) tested for zanamivir and oseltamivir resistance showed susceptibility.

INTERNATIONAL

Northern Hemisphere: During week 4 ending January 29, 2011, influenza activity had increased in the United States [www.cdc.gov/flu/weekly/](http://www.cdc.gov/flu/weekly/). Two thousand and forty-four specimens (out of 6,209, or 32.9%) tested positive for influenza in week 4: 423 pandemic H1N1, 718 A/H3, 530 unsubtyped influenza A, and 373 type B. The proportion of ILINet physician visits for ILI was 4.0%, which was above the national baseline of 2.5%. The CDC further reported that the proportion of deaths attributed to pneumonia and influenza was above the epidemic threshold in the USA.

The WHO report for week 5 is pending. As of January 28, influenza activity continues to increase in Europe, particularly in the West. The United Kingdom reported that flu activity has peaked and the number of severe cases is now declining. In many other countries of Western Continental Europe such as Denmark and France, significant numbers of severe and fatal cases of influenza are now reported. Of the samples tested from sentinel sites across Europe, 43% were positive for influenza. Overall in Europe, pandemic H1N1 remains the dominant strain, co-circulating with A/H3N2 and type B. In North Africa and the Middle East, influenza activity appears to have peaked, though Morocco, Pakistan, and Tunisia reported increased activity. Pandemic H1N1 is the predominant strain in this area. Influenza activity has peaked in Egypt in late December or early January. In North Asia (including Mongolia, northern China, the Republic of Korea, and Japan), influenza activity has recently peaked and is now declining. Influenza activity was associated with A/H3N2 in Mongolia and northern China, but had peaked in late December when number of pandemic H1N1 cases began to be detected. Japan had earlier detections of A/H3N2 but pandemic H1N1 has become the predominant virus. The Republic of Korea reported mainly pandemic H1N1 circulation.


Avian Influenza: As of February 9, 2011, one new human case of A/H5N1 was reported. A 5-year-old female with exposure to sick poultry developed symptoms on January 29, was hospitalized on February 3, and died 12 hours following admission. More details and a complete tally of A/H5N1 detections can be found at the links below:

www.who.int/csr/disease/avian_influenza/en/

WHO Recommendations for 2010-11 Northern Hemisphere Influenza Vaccine

On February 18, 2010 the WHO announced the recommended strain components for the 2010-11 Northern Hemisphere trivalent influenza vaccine:

- A/California/7/2009 (H1N1)-like virus
- A/Perth/16/2009 (H3N2)-like virus
- B/Brisbane/60/2008 (Victoria lineage)-like virus

A/California/7/2009 (H1N1) was the recommended component for pandemic H1N1 vaccines produced and administered in 2009-10. The recommended H3N2 virus has changed from the previous year’s vaccine (A/Perth/16/2008), while the recommended B virus remains unchanged (B/Brisbane/60/2008). For further details, see: www.who.int/csr/disease/influenza/recommendations2010_11north/en/index.html
BRITISH COLUMBIA INFLUENZA SURVEILLANCE BULLETIN
2010-11: Number 12, Week 5
January 30 to February 5, 2011

Contact Us:
Epidemiology Services : BC Centre for Disease Control (BCCDC)
655 W. 12th Ave, Vancouver BC V5Z 4R4. Tel: (604) 707-2510 / Fax: (604) 707-2516. InfluenzaFieldEpi@bccdc.ca

List of Acronyms
ACF: Acute Care Facility
AI: Avian Influenza
FHA: Fraser Health Authority
HBoV: Human bocavirus
HMPV: Human metapneumovirus
HSDA: Health Service Delivery Area
IHA: Interior Health Authority
ILI: Influenza-Like Illness
LTCF: Long Term Care Facility
MSP: BC Medical Services Plan
NHA: Northern Health Authority
NML: National Microbiological Laboratory
pH1N1: Pandemic H1N1 influenza
RSV: Respiratory syncytial virus
VCHA: Vancouver Coastal Health Authority
VIHA: Vancouver Island Health Authority
WHO: World Health Organization

Web Sites
1. Influenza Web Sites
Canada – Flu Watch: www.phac-aspc.gc.ca/fluwatch/
Washington State Flu Updates: www.doh.wa.gov/FLUNews/
USA Weekly Surveillance reports: www.cdc.gov/flu/weekly/
European Influenza Surveillance Scheme: www.eiss.org
WHO – Global Influenza Programme: www.who.int/csr/disease/influenza/mission/
WHO – Weekly Epidemiological Record: www.who.int/wer/en/
Influenza Centre (Australia): www.influenzacentre.org/

2. Avian Influenza Web Sites
World Organization for Animal Health: www.oie.int/eng/en_index.htm

3. This Report On-line: www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm
Influenza-Like Illness (ILI) Outbreak Summary Report Form

Please complete and email to ilioutbreak@bccdc.ca or fax to (604) 707-2516

ILI: Acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia, or prostration which could be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

Schools and work site outbreak: greater than 10% absenteeism on any day, most likely due to ILI.

Residential institutions (facilities) outbreak: two or more cases of ILI within a seven-day period.

SECTION A: Reporting Information

Person Reporting: ______________________  Title: _____________________________
Contact Phone: ______________________  Email: ____________________________
Health Authority: ______________________  HSDA: ____________________________
Full Facility Name: __________________________________________________________

Is this report:  □ First Notification (complete section B below; Section D if available)
□ Update (complete section C below; Section D if available)
□ Outbreak Over (complete section C below; Section D if available)

SECTION B: First Notification

Type of facility:  □ LTCF  □ Acute Care Hospital  □ Senior’s Residence
(if ward or wing, please specify name/number: ______________________)
□ Workplace  □ School (grades:_______)  □ Other (_________)

Date of onset of first case of ILI (dd/mm/yyyy): ___________/_______/_______

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<th>Numbers to date</th>
<th>Residents/Students</th>
<th>Staff</th>
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<td>Total</td>
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<td>With ILI</td>
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<td>Died</td>
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SECTION C: Update AND Outbreak Declared Over

Date of onset for most recent case of ILI (dd/mm/yyyy): ___________/_______/_______
If over, date outbreak declared over (dd/mm/yyyy): ___________/_______/_______

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SECTION D: Laboratory Information

Specimen(s) submitted?  □ Yes (location: _______________)  □ No  □ Don’t know
If yes, organism identified?  □ Yes (specify: _______________)  □ No  □ Don’t know