

# British Columbia Influenza Surveillance Bulletin

Influenza Season 2018-19, Number 6, Week 50

December 9 to December 15, 2018

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## Increased influenza activity continues in BC with A(H1N1)pdm09 predominance

During week 50, influenza activity remains elevated in BC, with ongoing A(H1N1)pdm09 predominance.

In week 50, 34% of specimens tested by laboratories in BC were positive for influenza, a further increase from recent prior weeks. Among influenza viruses typed at the BCCDC PHL since week 40, virtually all have been influenza A and, among those subtyped, just under 90% have been A(H1N1)pdm09.

Children less than 10 years of age and non-elderly adults comprise 80% of all A(H1N1)pdm09 detections to date, with children in particular disproportionately involved. Conversely, elderly adults are overrepresented among A(H3N2) detections in BC, accounting for three-quarters of detections thus far.

Since our last bulletin in week 49, no further outbreaks in long term care facilities (LTCF) have been reported (Since week 40, there have been a total of 3 lab-confirmed LTCF outbreaks this season (two attributable to A(H3N2), one of unknown subtype). In contrast, between weeks 40 and 50 of the A(H3N2) dominant 2016-17 and 2017-18 seasons, 16 and 10 lab-confirmed LTCF outbreaks, respectively, had been reported. The lower number to date this season is consistent with fewer LTCF outbreaks expected during seasons of dominant A(H1N1)pdm09 compared to dominant A(H3N2) circulation.

Please note that this will be the last bulletin of the 2018 calendar year. Reporting will resume in the New Year.

Prepared by BCCDC Influenza & Emerging Respiratory Pathogens Team

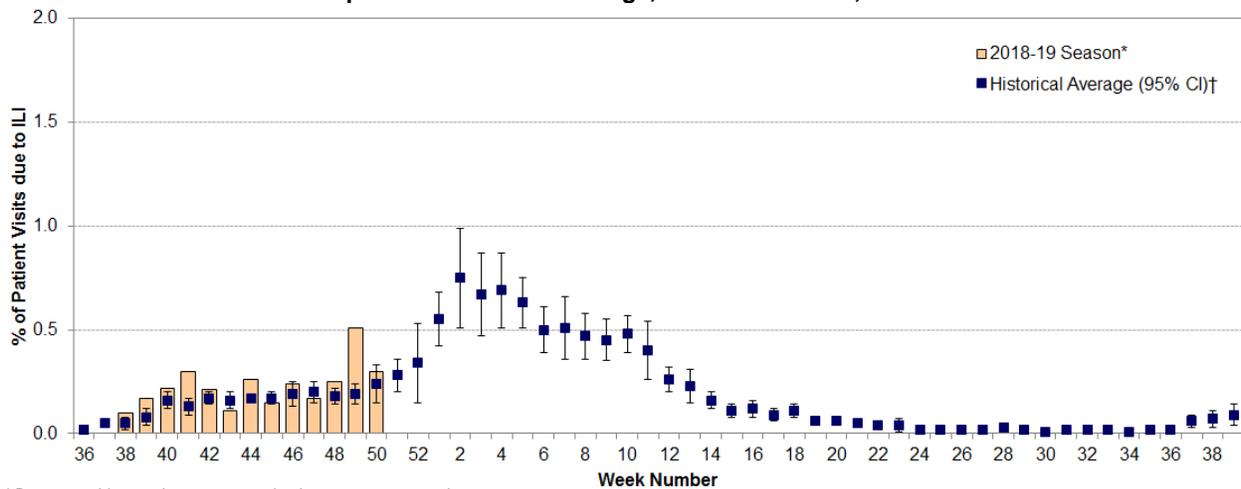
Report Disseminated: December 20, 2018

## British Columbia

### Sentinel Physicians

In week 50, influenza-like illness (ILI) rates among patients presenting to sentinel sites returned to expected levels for this stage of the season, down from the unusually elevated rate observed in week 49 (**Figure 1**). Rates are subject to change as reporting becomes more complete. Twenty (74%) of sentinel sites have reported data for week 50.

**Figure 1: Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2018-19**



\* Data are subject to change as reporting becomes more complete.

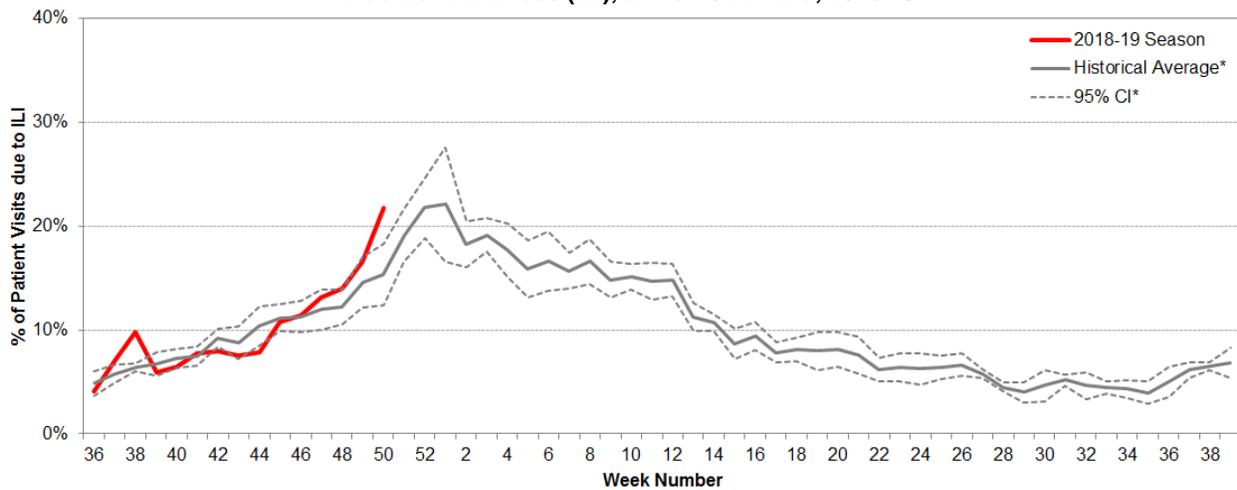
† 10-year historical average for 2018-19 season based on 2005-06 to 2017-2018 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

Please note: the previously circulated bulletin (for week 49) had inadvertently omitted the week 49 rate – this was subsequently corrected in the on-line posting and is correctly specified in the current bulletin.

### BC Children’s Hospital Emergency Room

In week 50, the proportion of visits to BC Children’s Hospital Emergency Room (ER) attributed to ILI continued to increase and exceeded the upper 95% confidence interval for the historical average of the past 5 seasons (**Figure 2**).

**Figure 2: Percent of patients presenting to BC Children’s Hospital ER attributed to influenza-like illness (ILI), British Columbia, 2018-19**

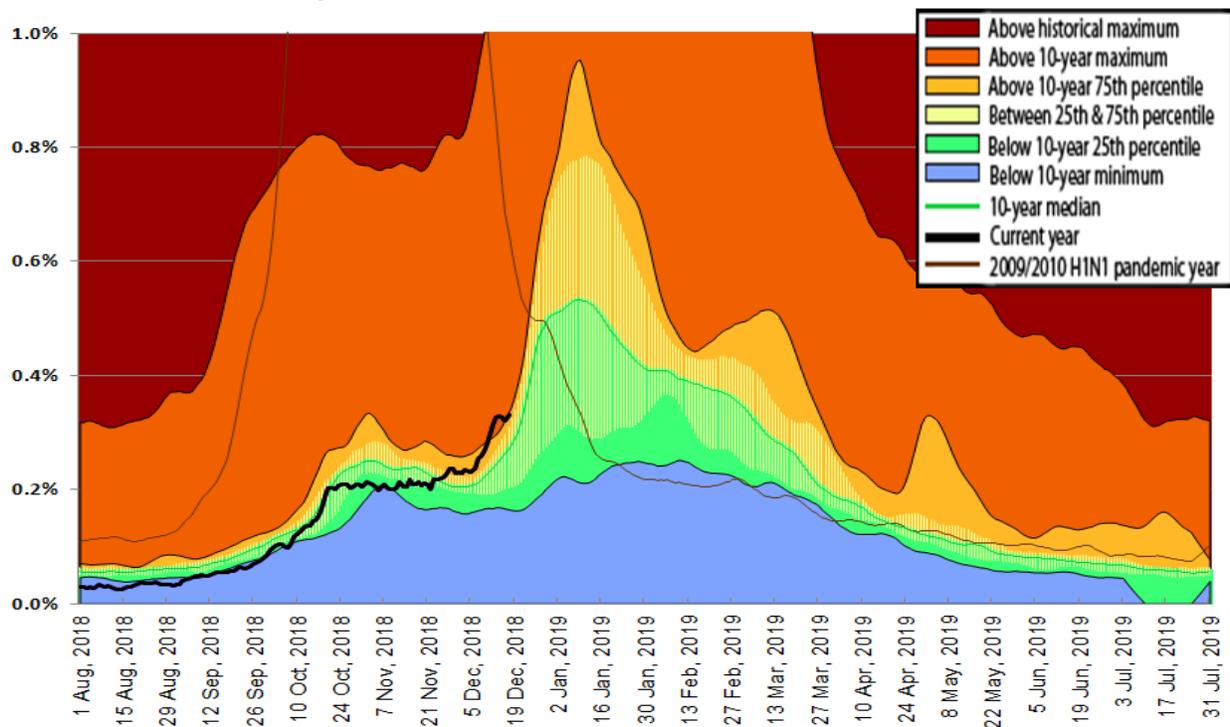


Source: BCCCH Admitting, Discharge, Transfer database (ADT). Data includes records with a triage chief complaint of "flu" or "influenza" or "fever/cough."  
\* 5-year historical average for 2018-19 season based on 2012-13 to 2017-18 seasons; CI=confidence interval.

## Medical Services Plan

In week 50, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims remains elevated and is currently just below the 10-year maximum for this time of year overall for the province (**Figure 3**). Some regional variation has been observed, with the proportion of II claims exceeding the 10-year maximum in the Interior and on Vancouver Island (**Figure 4**).

**Figure 3: Service claims submitted to MSP for influenza illness (II)\* as a proportion of all submitted general practitioner service claims, British Columbia, 2018-19**

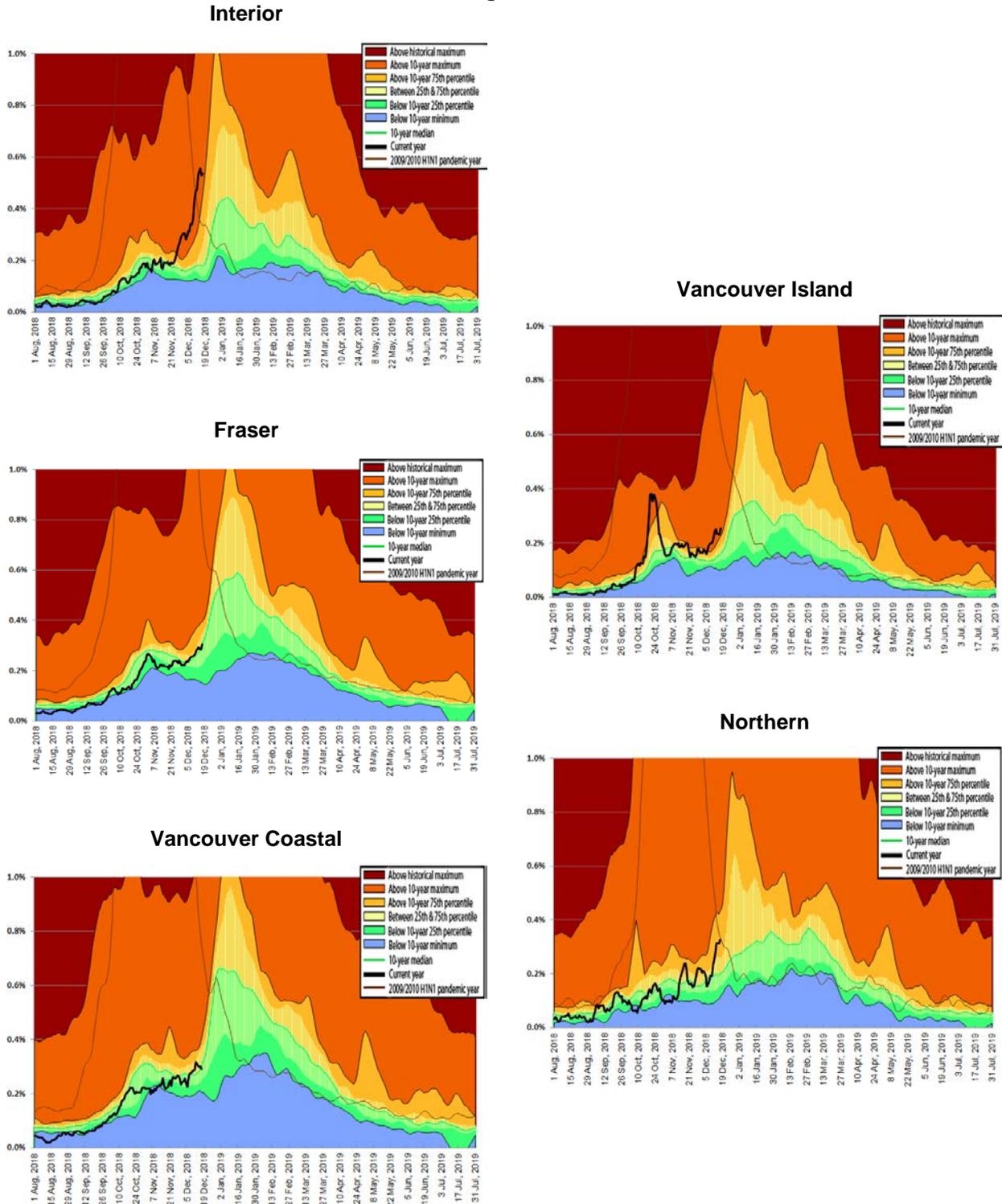


\* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).

Data for the period August 1, 2009 to July 31, 2010 have been excluded from the 10-year median calculation due to atypical seasonality during the 2009/2010 H1N1 pandemic year. MSP data beginning August 1, 2018 corresponds to sentinel ILI week 31; data are current to December 18, 2018.

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

Figure 4



## British Columbia Laboratory Reports

In recognition of expanded influenza testing by additional laboratories across British Columbia, this section of the bulletin now includes respiratory specimens tested at sites beyond the BCCDC Public Health Laboratory (PHL) in deriving the test-positivity indicator. This change was implemented in the last two bulletins (issued weeks 47 and 49) and represents a change from prior bulletins. Type and subtype distribution will continue to be derived from the BCCDC PHL.

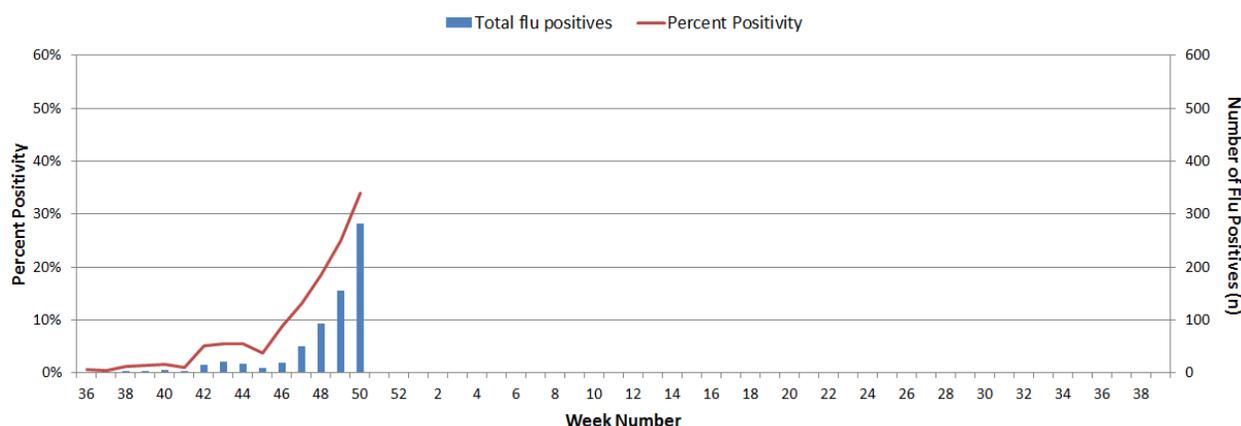
Cumulatively, during the 2018-19 season (since week 40, starting October 1, 2018), 677/4534 (15%) specimens tested positive for influenza at participating laboratories across British Columbia (BC) (as submitted to FluWatch). In week 50, 283/835 (34%) specimens tested positive for influenza at these laboratories, representing a continued increase over previous weeks (**Figure 5**).

Cumulatively, during the 2018-19 season (since week 40, starting October 1, 2018), 507 patients tested positive for influenza at the BC Centre for Disease Control (BCCDC) Public Health Laboratory (PHL), of which 505 (99.6%) were typed as influenza A [49 (10%) A(H3N2), 344 (68%) A(H1N1)pdm09, 112 (22%) subtype unknown] and 2 (0.4%) as influenza B. Among influenza A viruses subtyped, therefore, 344/393 (88%) were A(H1N1)pdm09. Of 142 typed influenza viruses in week 50, all were influenza A. Among these influenza A viruses, 2 (1%) were identified as A(H3N2), 56 (40%) as A(H1N1)pdm09, and for 84 (59%) subtype was unknown. Thus, in week 50, 56/58 (97%) influenza A viruses subtyped were A(H1N1)pdm09 indicating its continued predominance over A(H3N2) contribution (**Figure 6**).

Since week 40, approximately half (48%) of A(H1N1)pdm09 detections were among adults 20-64 years of age and 32% were among children  $\leq 9$  years old, with lesser involvement of those 10-19 years (4%) or among elderly adults (16%). Children under 10 are therefore disproportionately represented among A(H1N1)pdm09 detections in BC (comprising about 10% of the BC population overall). Conversely, the majority (75%) of A(H3N2) detections were among elderly adults, and 19% among adults 50-64 years of age, with lesser involvement of adults 20-49 years (4%), or those 10-19 years (2%) and with none to date among children  $\leq 9$  years (**Figures 7 and 8**). Elderly adults are therefore overrepresented among A(H3N2) detections in BC (comprising less than 20% of the population but 75% of A(H3N2) detections)<sup>1</sup>.

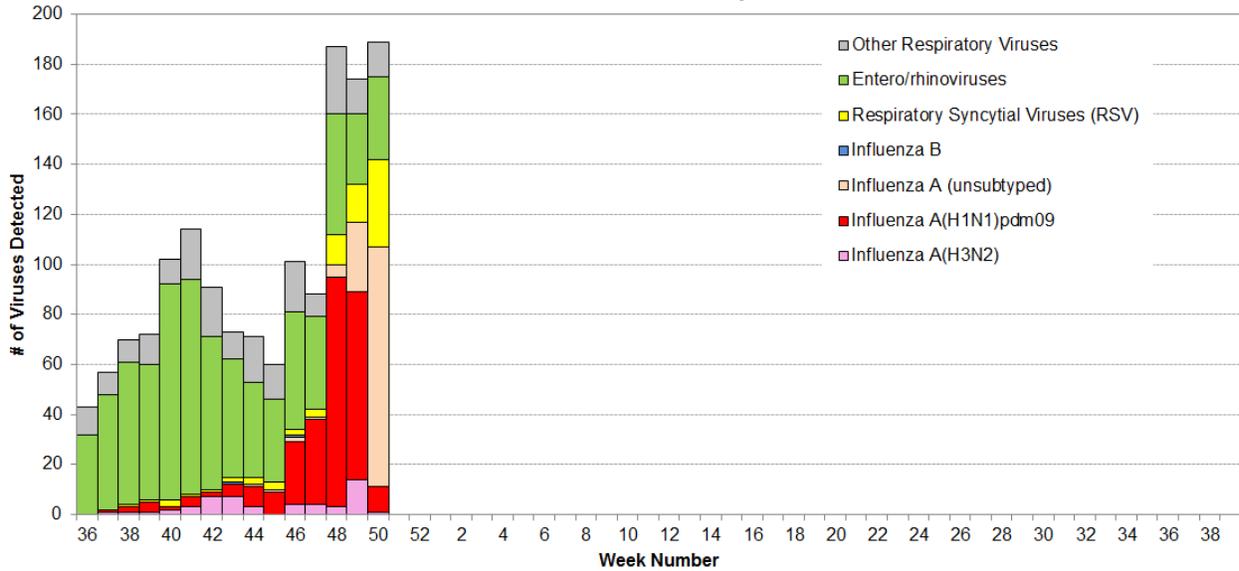
Enteroviruses (n=39) were the most commonly detected other respiratory virus (excluding influenza) at the BCCDC in week 50 (**Figure 6**).

**Figure 5: Flu positivity derived from influenza specimens submitted to participating laboratories across BC, 2018-19**



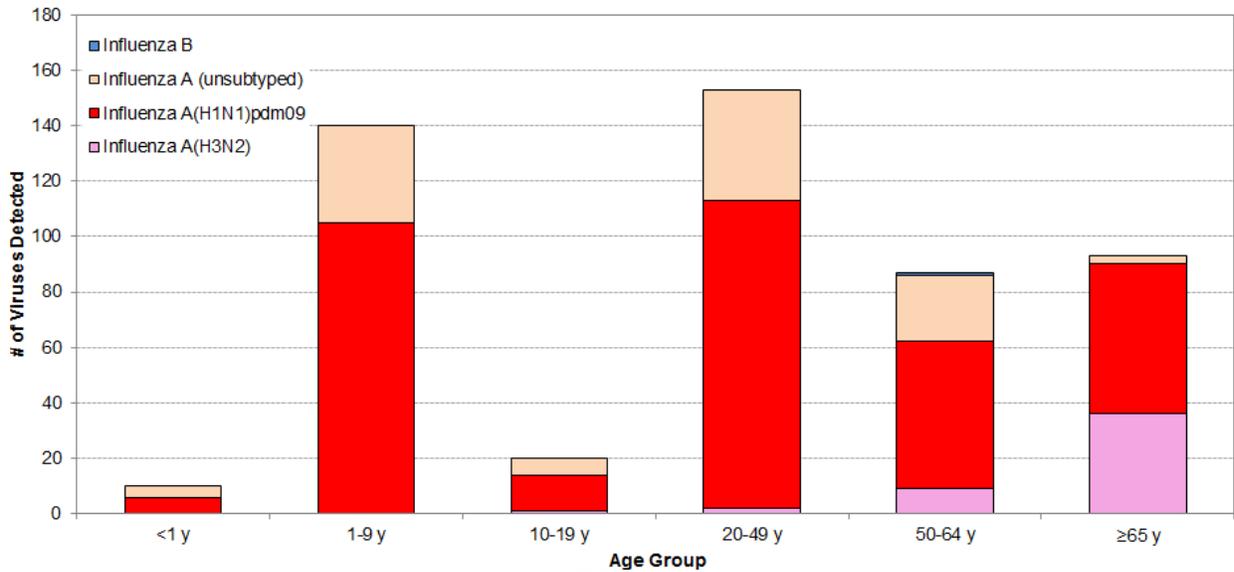
<sup>1</sup> Government of British Columbia, BC Stats. Population Estimates 2017. URL: <https://www.bcstats.gov.bc.ca/apps/PopulationEstimates.aspx>. Date accessed: December 13, 2018.

**Figure 6: Influenza and other virus detections among respiratory specimens submitted to BCCDC Public Health Laboratory, 2018-19<sup>1</sup>**



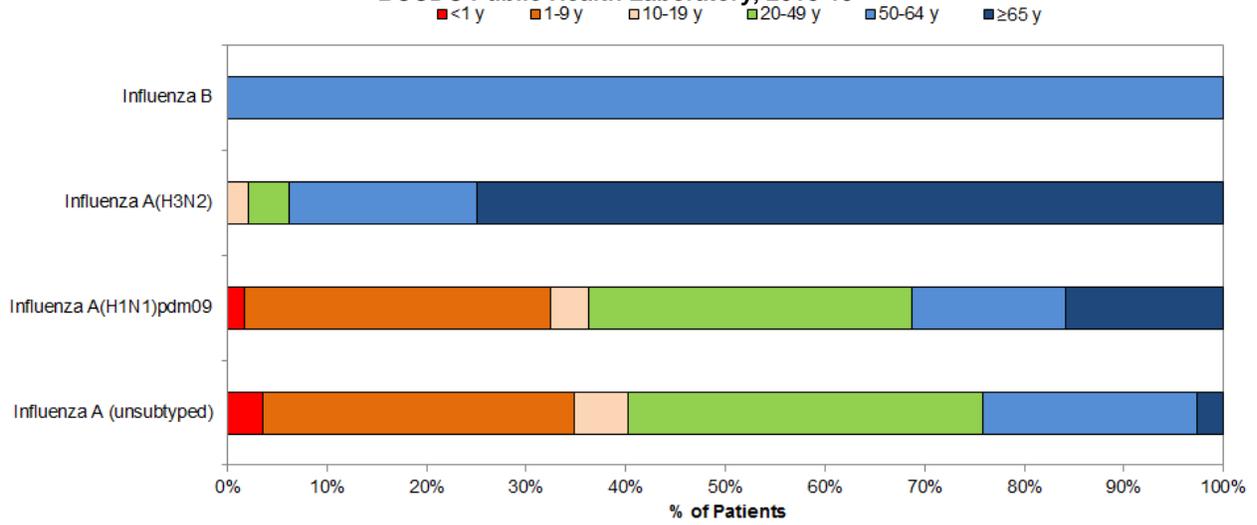
<sup>1</sup>This graph is shown for the purposes of relative subtype distribution. Absolute numbers will change as data become more complete.  
Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 19, 2018.

**Figure 7: Cumulative number (since week 40) of influenza detections by type, subtype, and age group, BCCDC Public Health Laboratory, 2018-19**



Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 19, 2018; figure includes cumulative influenza detections for specimens collected since week 40.

**Figure 8: Age distribution of influenza detections (cumulative since week 40),  
BCCDC Public Health Laboratory, 2018-19**

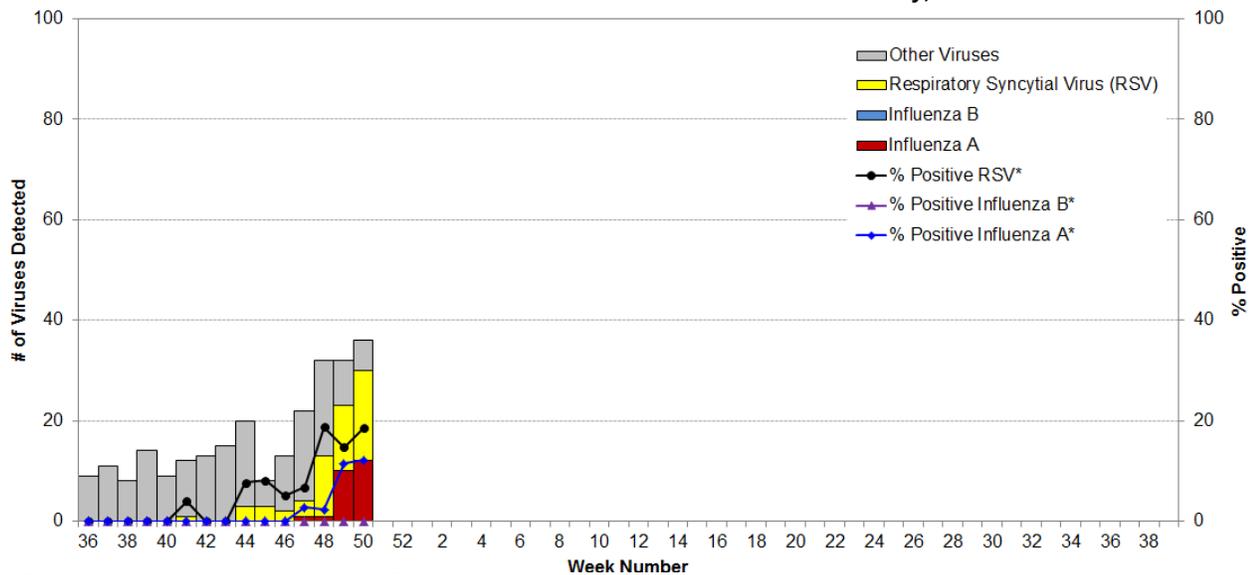


Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 19, 2018; figure includes cumulative influenza detections for specimens collected since week 40.

BC Children's and Women's Health Centre Laboratory

In week 50, 99 tests for influenza and 97 tests for respiratory syncytial virus (RSV) were conducted at the BC Children's and Women's Health Centre laboratory. Of these, 12 were positive for influenza A (not subtyped), 0 for influenza B, and 18 were positive for RSV. Influenza A test positivity was comparable in week 50 compared to week 49 (12% both weeks); respiratory syncytial virus (RSV) test positivity increased slightly (15% vs 19% in weeks 49 and 50, respectively). In week 50, RSV was the most commonly detected respiratory virus overall (**Figure 9**).

**Figure 9: Influenza and other virus detections among respiratory specimens submitted to BC Children's and Women's Health Centre Laboratory, 2018-19**



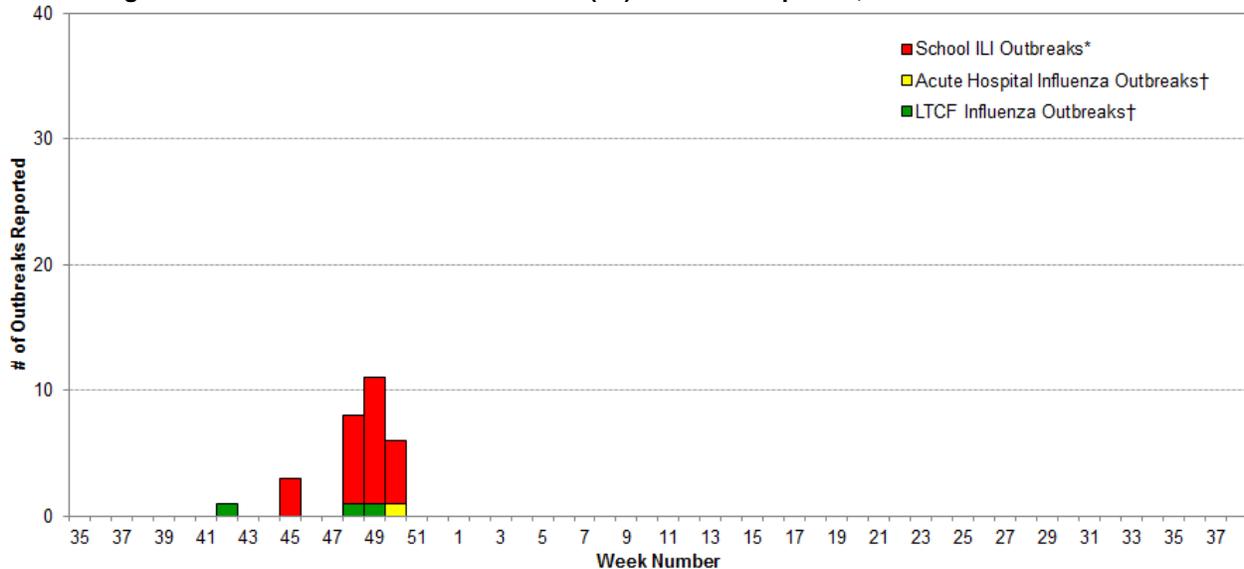
\* Positive rates were calculated using aggregate data. The denominators for each rate represent the total number of tests; multiple tests may be performed for a single specimen and/or patient.

### Influenza-like Illness (ILI) Outbreaks

One laboratory-confirmed influenza A (subtype unknown) acute care facility outbreak and five school ILI outbreaks were reported in week 50. Since week 40, a total of 3 long-term care facility (LTCF) (two A(H3N2) and one subtype unknown) and 25 school ILI outbreaks have been reported (**Figures 10 and 11**).

By way of comparison, between weeks 40 and 50 of the 2016-17 and 2017-18 seasons, 16 and 10 lab-confirmed LTCF outbreaks, respectively, had been reported.

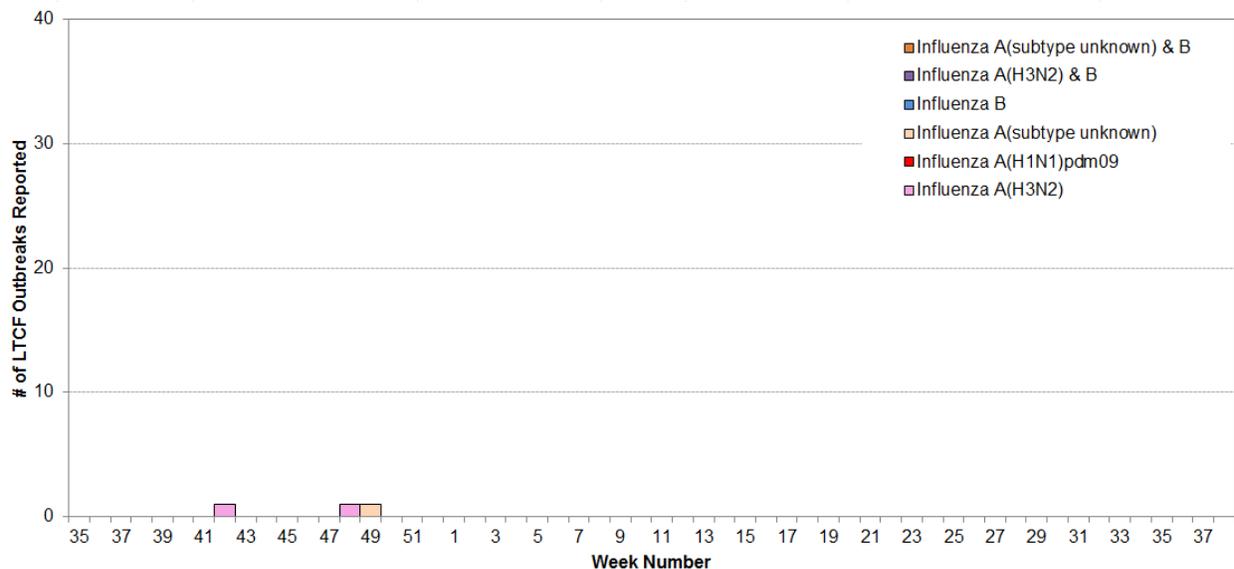
**Figure 10: Number of influenza-like illness (ILI) outbreaks reported, British Columbia 2018-19**



\* School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI. Onset

† Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one laboratory-confirmed case of influenza.

**Figure 11: Number of influenza outbreaks by type/subtype in long-term care facilities (LTCF), British Columbia 2018-19†**



† Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one laboratory-confirmed case of influenza.

## Emerging Respiratory Viruses

### **US outbreak of acute flaccid myelitis (AFM) – possibly associated with enterovirus D68 (EV-D68) - continues to grow**

Since September, the US CDC has reported an increase in paediatric cases of acute flaccid myelitis (AFM), a subset of acute flaccid paralysis (AFP) (often referred to as “polio-like illness” in the media). As of December 14<sup>th</sup> 2018, the CDC has confirmed 165 cases of AFM across 36 states – predominantly affecting children under 5 years of age. A further 155 reports are currently under investigation. Patients have presented with neurological features, specifically single or multi-limb weakness, with most requiring hospitalization. More than 90% of AFM cases reported a mild respiratory illness or fever - consistent with a viral infection - in the weeks preceding symptom onset. AFM has a variety of possible causes, including non-polio enterovirus infection. Among 71 confirmed cases tested, just over half (54%) tested positive for enterovirus or rhinovirus at the time of AFM diagnosis (37% for enterovirus D68 (EV-D68), 29% for enterovirus A71 (EV-A71)); however, a clear and consistent etiology has not yet been identified.

The number of confirmed cases has surpassed that of the previous high in 2016 (when 149 confirmed cases were detected in the US), and continues to increase. These reports indicate that 2018 represents another biennial peak, similar to that observed during EV-D68 epidemics in 2014 and 2016. The latter EV-D68 epidemics were noteworthy for including cases with severe respiratory manifestations (less prominently noted in 2018); however, neurological complications were also identified. Accordingly, the US CDC has escalated its response by establishing an AFM task force to aid investigation efforts.

Whilst low-level EV-D68 activity has been detected in BC, as may be expected at this time of the year, to date, we are not aware of any confirmed EV-D68 cases with neurological manifestations. Elsewhere in Canada, a possible uptick in reports of AFP has been noted; however, thus far, the number of confirmed cases falls within the annual expected range. The number of cases of sudden onset muscle weakness in children reported to the Public Health Agency of Canada in 2018 can be found at the link below.

Additional information is available from the following sources:

US CDC AFM webpage: <https://www.cdc.gov/acute-flaccid-myelitis/index.html>

US CDC factsheet on EV-D68: <https://www.cdc.gov/non-polio-enterovirus/about/ev-d68.html>

PHAC information sheet on AFM in Canada: <https://www.canada.ca/en/public-health/services/diseases/acute-flaccid-myelitis.html>

A summary of the 2014 experience in BC was published in Euro Surveillance, available from: <https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2015.20.43.30047>

## National

### **FluWatch (week 49, December 2 to December 8, 2018)**

At the national level, influenza activity continued to increase in week 49. Influenza A is the most common influenza virus circulating in Canada, and the majority of detections continue to be A(H1N1)pdm09. The percentage of laboratory tests positive for influenza increased from 18.1% in week 48, to 19.3% in week 49. To date, the majority of lab confirmations and hospitalizations have been among individuals less than 65 years of age. Details are available at: <https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance/weekly-influenza-reports.html>.

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

From September 1, 2018 to December 20, 2018, the National Microbiology Laboratory (NML) has antigenically characterized 240 influenza viruses [5 A(H3N2), 221 A(H1N1)pdm09, and 14 B(Yamagata lineage)] received from Canadian laboratories.

Influenza A(H3N2): The 5 influenza A(H3N2) viruses were considered antigenically similar to A/Singapore/INFIMH-16-0019/2016, the WHO-recommended A(H3N2) component of the 2018-19 northern hemisphere influenza vaccine. Two of the characterized viruses belonged to genetic group 3C.2a1; sequencing is pending for the remaining 3 viruses.

Influenza A(H1N1)pdm09: All of the 221 A(H1N1)pdm09 viruses characterized were antigenically similar to the A/Michigan/45/2015 virus: the WHO-recommended influenza A(H1N1) component of the 2018-19 northern hemisphere influenza vaccine.

Influenza B: The 14 influenza B viruses characterized were antigenically similar to the B/Phuket/3073/2013 virus, which belongs to the B Yamagata lineage: the WHO-recommended influenza B component of the 2018-19 northern hemisphere *quadrivalent* influenza vaccine. Of note, the WHO-recommended influenza B component of the *trivalent* vaccine is a B/Colorado/06/2017-like virus of the B Victoria lineage.

### **National Microbiology Laboratory (NML): Antiviral Resistance**

From September 1, 2018 to December 20, 2018, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing.

Amantadine: Of the 221 influenza viruses [26 A(H3N2) and 195 A(H1N1)pdm09] tested against amantadine, all were resistant.

Oseltamivir: Of the 262 influenza viruses [28 A(H3N2), 220 A(H1N1)pdm09, and 14 B] tested against oseltamivir, all were sensitive.

Zanamivir: Of the 261 influenza viruses [28 A(H3N2), 220 A(H1N1)pdm09, and 13 B] tested against zanamivir, all were sensitive.

## International

### **USA (week 49, December 2 to December 8, 2018)**

During week 49, influenza activity remained slightly elevated in the United States. Since September 30, 2018, the most frequently identified influenza subtype reported by public health laboratories has been influenza A(H1N1)pdm09. The proportion of deaths attributed to pneumonia and influenza remained below the system-specific epidemic threshold. One influenza-associated pediatric death was reported during week 49. The proportion of outpatient visits for ILI remained at 2.2%, which is at the national baseline of 2.2%. The US CDC has posted a summary of influenza activity in the US and elsewhere for week 49, available at:

<https://www.cdc.gov/flu/weekly/index.htm>

### **WHO (December 10, 2018, based on data up to November 25, 2018)**

In the temperate zone of the northern hemisphere, influenza detections continued to increase, but still remained low overall. Some countries in Southern and South-East Asia reported increased influenza activity. Influenza activity in the temperate zones of the southern hemisphere has returned to inter-seasonal levels. Worldwide, influenza A(H1N1)pdm09 viruses have predominated.

From November 12 to November 25, 2018, the WHO GISRS laboratories tested more than 118,399 specimens. Of these, 6,596 were positive for influenza viruses, of which 5,995 (90.9%) were typed as influenza A and 601 (9.1%) as influenza B. Of the subtyped influenza A viruses, 3,019 (85.5%) were A(H1N1)pdm09 and 511 (14.5%) were A(H3N2). Of the characterized influenza B viruses, 39 (38.6%) belonged to the B(Yamagata) lineage and 62 (61.4%) to the B(Victoria) lineage.

The full report is available at: [www.who.int/influenza/surveillance\\_monitoring/updates/en/](http://www.who.int/influenza/surveillance_monitoring/updates/en/).

## WHO Recommendations for Influenza Vaccines

### **WHO Recommendations for 2018-19 Northern Hemisphere Influenza Vaccine**

On February 22, 2018, the WHO announced the recommended strain components for the 2018-19 northern hemisphere trivalent influenza vaccine (TIV)\*:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus; †
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage) ‡.

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

\* Recommended strains represent a change for two of the three components used for the 2017-18 northern hemisphere TIV

† Recommended strain represents a change from the 2017-18 season vaccine which contained an A/Hong Kong/4801/2014 (H3N2)-like virus

‡ Recommended strain represents a change from the 2017-18 season vaccine which contained a B/Brisbane/60/2008-like virus.

For further details: [http://www.who.int/influenza/vaccines/virus/recommendations/2018\\_19\\_north/en/](http://www.who.int/influenza/vaccines/virus/recommendations/2018_19_north/en/)

### **WHO Recommendations for the 2019 Southern Hemisphere Influenza Vaccine**

On September 27, 2018, the WHO announced recommended strain components for the 2019 southern hemisphere trivalent influenza vaccine (TIV):\*

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Switzerland/8060/2017 (H3N2)-like virus; ‡
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage).§

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

\* Recommended strains represent a change for two of the three components used for the 2018 southern hemisphere TIV.

‡ Recommended strain represents a change from the 2018 season vaccine which contained an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus

§ Recommended strain for the influenza B component represents a lineage-level change from a B(Yamagata)-lineage virus in the 2018 vaccine to a B(Victoria)-lineage virus in the 2019 vaccine.

For further details: [http://www.who.int/influenza/vaccines/virus/recommendations/2019\\_south/en/](http://www.who.int/influenza/vaccines/virus/recommendations/2019_south/en/)

## Additional Information

### **Explanatory Note:**

The surveillance period for the 2018-19 influenza season is defined starting in week 40. Weeks 36-39 of the 2017-18 season are shown on graphs for comparison purposes.

### **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

**A(H1N1)pdm09:** Pandemic H1N1 influenza (2009)

**RSV:** Respiratory syncytial virus

**VCHA:** Vancouver Coastal Health Authority

**VIHA:** Vancouver Island Health Authority

**WHO:** World Health Organization

### **Current AMMI Canada Guidelines on the Use of Antiviral Drugs for Influenza:**

[www.ammi.ca/?ID=122&Language=ENG](http://www.ammi.ca/?ID=122&Language=ENG)

### **Web Sites:**

BCCDC Emerging Respiratory Pathogen Updates:

[www.bccdc.ca/health-professionals/data-reports/emerging-respiratory-virus-updates](http://www.bccdc.ca/health-professionals/data-reports/emerging-respiratory-virus-updates)

### **Influenza Web Sites**

Canada – Influenza surveillance (FluWatch): <https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance.html>

Washington State Flu Updates: <http://www.doh.wa.gov/portals/1/documents/5100/420-100-fluupdate.pdf>

USA Weekly Surveillance Reports: [www.cdc.gov/flu/weekly/](http://www.cdc.gov/flu/weekly/)

Joint ECDC – WHO/Europe weekly influenza update (Flu News Europe): [flunewseurope.org](http://flunewseurope.org)

WHO – Weekly Epidemiological Record: [www.who.int/wer/en/](http://www.who.int/wer/en/)

WHO Collaborating Centre for Reference and Research on Influenza (Australia): [www.influenzacentre.org/](http://www.influenzacentre.org/)

Australian Influenza Report:

[www.health.gov.au/internet/main/publishing.nsf/content/cda-surveil-ozflu-flucurr.htm](http://www.health.gov.au/internet/main/publishing.nsf/content/cda-surveil-ozflu-flucurr.htm)

New Zealand Influenza Surveillance Reports: [www.surv.esr.cri.nz/virology/influenza\\_weekly\\_update.php](http://www.surv.esr.cri.nz/virology/influenza_weekly_update.php)

### **Avian Influenza Web Sites**

WHO – Influenza at the Human-Animal Interface: [www.who.int/csr/disease/avian\\_influenza/en/](http://www.who.int/csr/disease/avian_influenza/en/)

World Organization for Animal Health: [www.oie.int/eng/en\\_index.htm](http://www.oie.int/eng/en_index.htm)

### **Contact Us:**

Tel: (604) 707-2510

Fax: (604) 707-2516

Email: [InfluenzaFieldEpi@bccdc.ca](mailto:InfluenzaFieldEpi@bccdc.ca)

Communicable Disease Prevention and Control Services (CDPACS)

BC Centre for Disease Control

655 West 12<sup>th</sup> Ave, Vancouver BC V5Z 4R4

Online: [www.bccdc.ca/health-professionals/data-reports/influenza-surveillance-reports](http://www.bccdc.ca/health-professionals/data-reports/influenza-surveillance-reports)

Link to fillable Facility Outbreak Report Form: [http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Epid/Influenza%20and%20Respiratory/OutbreakReportForm\\_2018.pdf](http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Epid/Influenza%20and%20Respiratory/OutbreakReportForm_2018.pdf)

[http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Epid/Influenza%20and%20Respiratory/OutbreakReportForm\\_2018.pdf](http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Epid/Influenza%20and%20Respiratory/OutbreakReportForm_2018.pdf)

# Influenza-Like Illness (ILI) Outbreak Summary Report Form

Please complete and email to [ilioutbreak@bccdc.ca](mailto:ilioutbreak@bccdc.ca)

**Note: This form is for provincial surveillance purposes.  
 Please notify your local health unit per local guidelines/requirements.**

**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.

<b>A</b>	<b><u>Reporting Information</u></b>	
	Person Reporting:	Title:
	Contact Phone:	Email:
	Health Authority:	HSDA:
	Full Facility Name:	
	Is this report:	First Notification ( <i>complete section B below; section D if available</i> ) Outbreak Over ( <i>complete section C and section D below</i> )
	Report Date (dd/mm/yyyy):	

<b>B</b>	<b><u>First Notification</u></b>	
	Type of facility*:	Long Term Care Facilities, Nursing Homes      Acute Care Facility Other Setting:
	<i>If ward or wing, please specify name/number:</i>	
	Date of onset of first case of ILI (dd/mm/yyyy):	
	Date outbreak declared (dd/mm/yyyy):	
	<small>*Long Term Care Facilities, Nursing Homes: Facilities that provide living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping or other residential care facilities where provincial/territorial public health is responsible for outbreak management under provincial legislation; <b>Acute Care Facility:</b> Publicly funded facilities providing medical and/or surgical treatment and acute nursing care for sick or injured people, through inpatient services. (i.e. hospitals including inpatient rehabilitation and mental facilities); <b>Other Setting:</b> Any locations not otherwise specified here in which outbreaks of influenza or ILI may occur (e.g. retirement homes, assisted living or hospice settings, private hospitals/clinics, correctional facilities, colleges/universities, adult education centres, shelters, group homes, and workplaces).</small>	

<b>C</b>	<b><u>Outbreak Declared Over</u></b>										
	Date of onset for last case of ILI (dd/mm/yyyy):										
	Date outbreak declared over (dd/mm/yyyy):										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Numbers to date</th> <th style="width: 50%;">Residents</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><b>Total</b></td> <td></td> </tr> <tr> <td style="text-align: center;"><b>With ILI</b></td> <td></td> </tr> <tr> <td style="text-align: center;"><b>Hospitalized*</b></td> <td></td> </tr> <tr> <td style="text-align: center;"><b>Died*</b></td> <td></td> </tr> </tbody> </table>		Numbers to date	Residents	<b>Total</b>		<b>With ILI</b>		<b>Hospitalized*</b>		<b>Died*</b>
Numbers to date	Residents										
<b>Total</b>											
<b>With ILI</b>											
<b>Hospitalized*</b>											
<b>Died*</b>											
<small>*suspected to be linked to case of ILI</small>											

<b>D</b>	<b><u>Laboratory Information</u></b>			
	Specimen(s) submitted?	<input type="checkbox"/> Yes (location: _____ )	No	<input type="checkbox"/> Don't know
	If yes, organism identified?	Yes	No	Don't know
	<b>Please specify organism/subtype:</b>	Influenza A (subtype: _____ )	Influenza B	
		Parainfluenza      Enterovirus      Coronavirus      RSV HMPV                  Adenovirus      Other:		