What About the Flu?
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Although the United States and much of the world have been concentrating most of our attention on COVID-19, which has infected more than 33,404 people in the US with 400 deaths at the time of this publication,1,2 we are also in the middle of the 2019-2020 influenza season that began on September 29, 2019, and will end on September 26, 2020.3 During this flu season, there have been over 32 million cases of influenza reported thus far and 19,000 flu-related deaths.4 There have been 125 pediatric deaths related to influenza/pneumonia and, although, the hospitalization rate for children and young adults has been similar to previous flu seasons, rates are higher in children who are younger than age 4 years (92/100,000 children) as compared to previous seasons.4 So far, most of the pediatric deaths (96 of 149) have been associated with influenza B viruses with overall rates of influenza A and B infections equal.4 The efficacy of the flu vaccine is felt to be 55% this season, which is comparable to previous seasons.4 As stated in the American Academy of Pediatrics (AAP) News article, the recommendation is for “everyone 6 months and older to get vaccinated” and patients with risk factors who have developed flu should be treated with antiviral medications.4

The AAP recommendations for treating children who have influenza with antiviral medication are readily accessible.5 Here is a summary of the recommendations for children when antiviral medication should be considered:

• Any hospitalized child with suspected or confirmed influenza disease regardless of the duration of their symptoms
• Any child with severe, complicated, and/or progressive illness attributable to influenza, inpatient or outpatient, regardless of the duration of symptoms
• Any child with influenza infection who is at high risk for complications of influenza, regardless of duration of symptoms

There are also recommendations when antiviral medication may be considered:

• Any previously healthy child who is symptomatic being seen as an outpatient with suspected or confirmed influenza infection when therapy may begin within 48 hours of illness onset
• Children with suspected or confirmed influenza infection whose siblings or household contacts either are younger than age 6 months or have a high-risk condition that predisposed them for complications of influenza

Providers should minimize antiviral treatment for patients who do not have influenza infection.

The Centers for Disease Control and Prevention6 recommends the following for patients who have risk factors and cannot receive the influenza vaccine:

• Chemoprophylaxis is recommended in patients who are at high risk for complications of influenza and the vaccine is contraindicated
• For children at high risk for complications of influenza during the 2 weeks after inactivated influenza vaccination (IIV)
• For unvaccinated family members who have close exposure to unvaccinated children who are at high risk or to unvaccinated infants and toddlers younger than age 24 months
• For control of influenza outbreaks for unvaccinated staff and children in closed institutional setting with children who are at high risk (eg, extended care facilities)
• As a supplement to IIV vaccination for children at high risk, includi-
ing children who are immunocompromised
• As a postexposure antiviral chemoprophylaxis for family members and close contacts of a person who is infected
• For children at high risk of complications and their family members and close contacts

This editorial is meant to provide some perspective as to the impact of the flu on pediatric patients and to reference some practical resources in making clinical decisions about the care of our patients.

REFERENCES