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Irish College of General Practitioners

H1N1 " SWINE FLU"

Up-date

Dear Colleague

Many of us thinking about "Swine flu", whether health care professional or the general public, will fall into either of 2 mindsets: scepticism and disbelief on the one hand ("it's all exagerated"), or apprehension and foreboding ("we won't be able to cope")on the other. Being human, we will even shift between one and the other sometimes! Reading the guidance documents can easily provoke these same reactions, and it is important that we keep a sensible perspective.

Every day as GPs we deal with uncertainty, make judgement calls and deal with a complex number of unique variables in every presenting consultation, bringing them to a sensible and satisfactory outcome just about every time. We filter and refine the presented symptoms and signs to decide how sick is this child, how serious is this problem, what is the best solution here?

We must not forget amongst the myriads of algorithms and advice that the same skills and judgements apply in dealing with patients who may have "swine flu".

Algorithms and guidance documents are just that: structures and information to help us make the right decisions for the individual patient we are caring for, while remembering in these circumstances that there are also implications for other members of society, our other patients and even ourselves. They should be used in an informed and considered way and no-one expects a skilled and experienced doctor to follow them mindlessly. Circumstances will arise where a rigid application of a guide will be inappropriate or impossible, and we will have to do the best we can just as we do every day. Advice is available where necessary from colleagues in GP and Public Health, from the HPSC website and others. Do not suspend your intelligence and judgement, but equally please do not casually disregard the guidance offered.

At present the evidence is that relatively little swine flu is circulating in Ireland, although of course it is likely that much of it has gone (and may continue to go) undiagnosed. The absolute level of this activity is measured by our colleagues working in the Sentinel practices. At some point in the weeks or months ahead this will accelerate dramatically as we have seen it do in Britain. In the meantime there will be a steady trickle of cases mixed in with a larger number of unassorted respiratory illness presenting to us. When it becomes more prevalent we will quickly get more familiar with its various guises.

Could it be 'flu?

In the first place when dealing with a person with an acute febrile illness we have to consider if this could be Swine flu, while remembering that all the other causes we are used to dealing with are still prevalent, and possibly even more likely. When making or suspecting this diagnosis and disregarding the other possibilities, the next question is probably

What are we going to do about it?

In reality if they are not too sick, not in an at risk group and don't have vulnerable household contacts then your usual flu advice applies, infection control measures, symptomatic and supportive treatment, expectant management and watch out for the unlikely possibility of significant deterioration. Remember when patients are asking for Tamiflu outside the recommendations that any drug has its side effects, and the cure might be worse than the disease.

For those who are particularly ill, have risk factors or if they live with someone who is pregnant, severely obese or asthmatic (and yes that is a fair few people!), more active management is required. This includes assessing the severity of their illness , the prescription of Tamiflu, treating their co-morbidities or complications as clinically indicated in addition to the other measures.

Identifying the really sick patient is something most of us probably do instinctively. Small babies and the elderly are always particularly hard to read, but this disease also kills a small minority of healthy young people. Trust your instincts: Features such as confusion, hypotension, respiratory distress or marked dehydration need to be treated with respect and probably warrant referral. Remember to notify ambulance staff and to follow the local advice about accessing hospital services in these cases.

What about swabbing?

Because of the low level of illness in the community, we are presently advised to continue swabbing cases whom we commence on anti-virals. This is because we want to avoid over-treating people who are unlikely to have the illness, or giving prophylaxis unnecessarily. Once the incidence reaches a defined threshold this will cease: in other words when it really gets going we will depend entirely on the clinical diagnosis. Up to now these swabs were done in a very controlled way, individually sanctioned and couriered up and down the country for rapid assessment. The reality is that the urgency and control is not so acute at this stage, so they may be sent by post (as the sentinel practices do) or through local laboratories with a corresponding prolongation of the time before a result is ready. (The ideal timescales and storage conditions for samples are just that: ideal but not essential it seems). Laboratory capacity is a finite resource and we need to use our discretion in each case, patients will have to understand that it is not possible to test everyone who wants to be tested. Clinical judgement should be used: for example if the delay is likely to be long, the clinical suspicion high and the close contact is particularly vulnerable you might consider giving the prophylaxis anyway. Equally we should not start anti-viral treatment or prophylaxis lightly.

What about masks?

Donning masks again might remind you of the first faltering time you "scrubbed in", when the operation was nearly finished before you had mastered the art of donning your gloves to sister's satisfaction! It's all fairly sensible once you understand what you're doing, and accept that no infection control is 100% effective short of living in a bubble. These measures are to protect ourselves and our patients from infection, and the death of our British colleague Dr Day from this disease should prompt us to act prudently without being hysterical. The reality is that many but not all of us will probably catch it at some stage (even if we are not working) , and we should take proportional measures to protect ourselves. Remember how simple it all was by the time you scrubbed into your 10th emergency section?

Hand hygiene (for doctors, patients, staff and contacts) remains the single most effective measure.

Housecalls & infection control in the surgery:

Most of us dread the thought of a huge demand for housecalls, having seen them decline significantly in recent decades. They are usually inefficient, sometimes difficult but occasionally necessary. Most of us do home visits when the patient genuinely cannot come to the surgery, or occasionally when it suits ourselves. The suggestion that all of these possible cases can or should be seen by home visits is probably not sustainable for any prolonged period of time. Certainly there will be those who are just too sick to come to the surgery, however there will be many who seek our services who are not so ill, but whom we need to see (the not-too-sick partner of a pregnant woman for example). Telephone diagnosis and prescribing may be appropriate sometimes, but unless we are going to do detailed telephone triage and assessment on every person with a febrile illness and respiratory symptoms, we will have to make some arrangement for seeing these cases in an infection-controlled way in the surgery. Mainly we want to avoid mixing possible 'flu cases with non-flu cases (or indeed other possible flu cases who turn out not to be 'flu). This generally requires a separation in time or in space, and basic hygiene measures between patients and afterwards. Sometimes it will just be easier to do the house-call, and every doctor and practice will do what works best for them at that given point in time.

Tissues, bins and hand hygiene for patients and staff need to be available.

What about when I get sick?

If you get sick with swine 'flu you should stop seeing patients immediately, and not return to seeing patients for 7 days (according to the current advice). You should consult your own doctor and take their guidance. You could of course do telephone advice or non clinical work if well enough to do so. You should be managed with anti-virals if appropriate. Clinical discretion about swabbing should be exercised. People who have had the disease should be immune thereafter.

What about vaccines?

The normal *seasonal* flu vaccine will be available for at risk groups in the usual way in the autumn. This should be given as normal, but will not protect significantly against "swine flu". Expect increased demand nevertheless, and make sure you and your staff avail of it as appropriate.

The *pandemic* vaccine will be available later in 2009. It requires 2 doses to be effective, and it is expected that it will be offered to the entire population on a phased basis managed by the HSE. This

is a massive undertaking, and production limitations mean that it will take several months to complete.

What is the College doing?

The College has been making representations, suggestions and comments on much of the planning and advice which has issued, and is working to make the relevant information available to GPs generally through the HPSC website. We recognise that it is not perfect, and we will address the deficiencies in a prioritised way. The rapidly evolving situation makes web-based communications ideal for this purpose, although we know that not all doctors have easy access to this resource.

The College welcomes feedback, suggestions and even criticisms which will help to plan future developments. An email address for this purpose will be issued early next week. It may not be possible to respond individually to all inquiries, but all comments will be noted and help inform our actions and advice. It is intended to up-date on a weekly basis.