

State of Wyoming



Department of Health

Wyoming Influenza Summary Report 2012-2013 Season

Thomas O. Forslund
Director

July 2013

**State of Wyoming
Department of Health**

**Wyoming Influenza Summary Report
2012-2013 Season**

Wyoming Influenza Summary Report is published by the
Public Health Division
Wendy E. Braund, MD, MPH, MEd, FACPM
State Health Officer and Senior Administrator

Additional information and copies may be obtained from:
Reginald C. McClinton
Infectious Disease Epidemiology Unit
Wyoming Department of Health
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
307-777-8640
307-777-5573
reginald.mcclinton@wyo.gov

WYOMING INFLUENZA SUMMARY REPORT, 2012-2013 SEASON (September 30, 2012 – May 18, 2013)

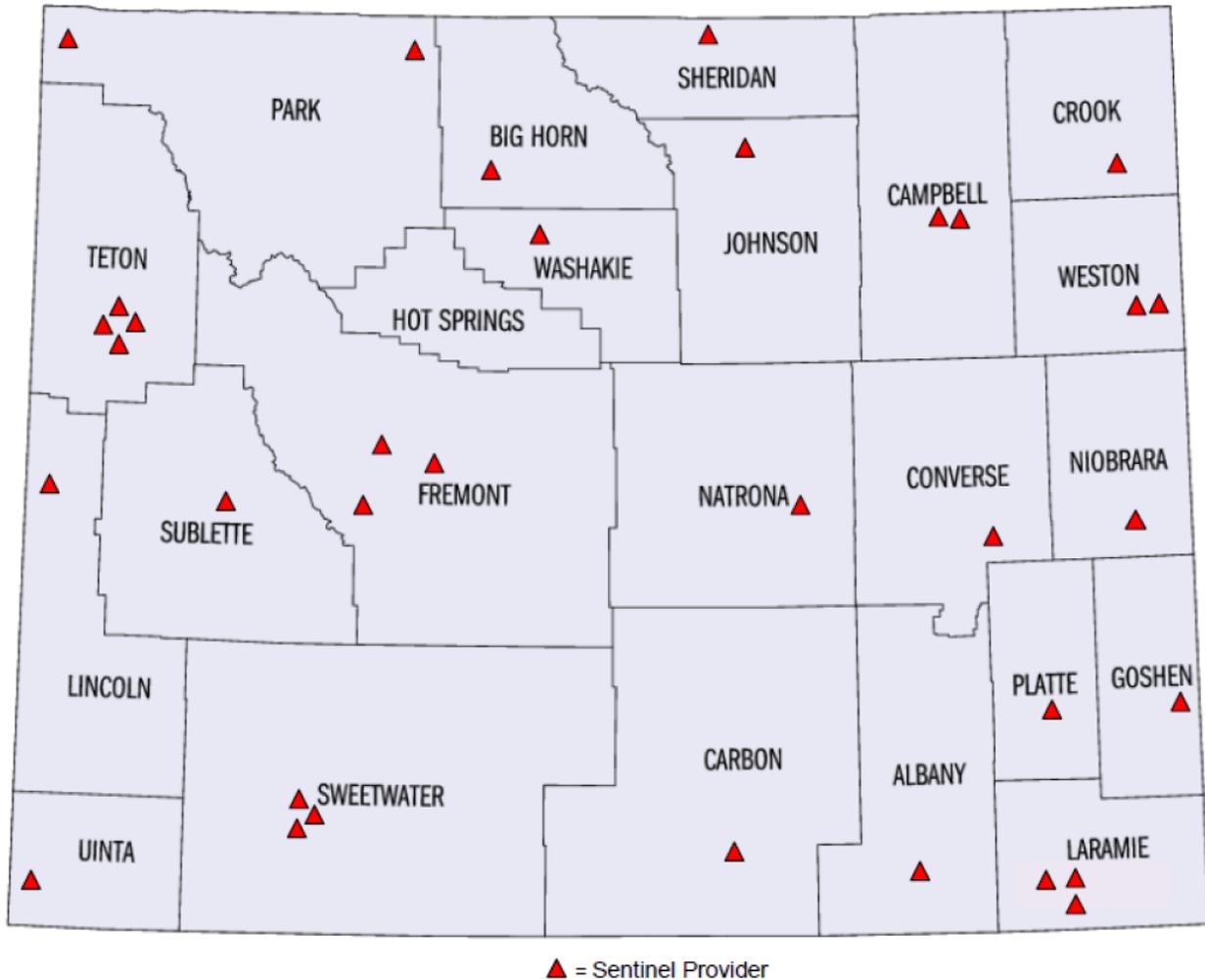
SYNOPSIS

Influenza activity during the 2012-2013 influenza season was moderately severe, as determined by the number of deaths resulting from pneumonia and influenza, the number of reported cases of laboratory-confirmed influenza, and the percentage of visits to outpatient clinics or hospitals for influenza-like illness (ILI) during the influenza season. Early in the influenza season, low levels of influenza activity were reported in Northern Wyoming. The number of cases reported and the percentage of outpatient visits for ILI began to significantly increase in November 2012. The number of reported cases in Wyoming peaked the week ending December 22, 2012 (MMWR Week 51). In addition, the number of positive influenza specimens and the percentage of positive samples reported by the Wyoming Public Health Laboratory (WPHL) peaked the same week. However, reports of ILI activity by Wyoming's network of influenza sentinel providers/ILINet providers peaked the following week, ending December 29, 2012 (MMWR Week 52). Activity throughout the state remained elevated until early March 2013. For the remainder of the season, Wyoming experienced low levels of influenza activity.

SURVEILLANCE AND THE INFLUENZA SENTINEL PROVIDER NETWORK

Influenza is a reportable disease in the State of Wyoming. The Wyoming Department of Health (WDH) receives reports of rapid influenza diagnostic tests (RIDT), direct fluorescent antibody (DFA), indirect fluorescent antibody (IFA), polymerase chain reaction (PCR) and laboratory cell cultures from various physicians, clinics, hospitals, and laboratories from across the state and the nation. The surveillance program relies on these sectors to test and report all positive results. In addition, Wyoming has a network of influenza sentinel providers located across the state. An influenza sentinel provider, or ILINet provider, conducts surveillance for ILI in collaboration with the WDH and the Centers for Disease Control and Prevention (CDC). Reports are submitted each week, even when no influenza activity is observed by the influenza sentinel providers. In addition, the influenza sentinel providers collect specimens from a small number of patients with ILI. The samples are sent to the WPHL for influenza testing. This information often provides public health officials the earliest identification of circulating virus types, subtypes, and strains during the influenza season. The map below indicates the locations of the healthcare providers enrolled in the ILINet Provider - Influenza Surveillance Program during the 2012-2013 influenza season.

**MAP 1: WYOMING'S NETWORK OF INFLUENZA SENTINEL PROVIDERS
2012-2013 INFLUENZA SEASON**



Thirty-four influenza sentinel providers were enrolled during the 2012-2013 influenza season. A major goal of the Infectious Disease Epidemiology Unit is to recruit and maintain influenza sentinel providers from every county in the state, including various municipalities and types of practices within each county. This season, ILINet providers were enrolled in 22 of Wyoming's 23 counties. Data from the influenza sentinel providers are critical for monitoring the impact of influenza and in combination with other influenza surveillance data, can be used to guide prevention and control activities, vaccine strain selection, and patient care. Providers of any specialty (e.g., family practice, internal medicine, pediatrics, infectious diseases) in any type of practice (e.g., private practice, public health clinic, urgent care center, emergency room, university student health center) are eligible to be sentinel providers. The sentinel provider program involves two major components: weekly ILI reporting and laboratory specimen collection.

The first component, weekly ILI reporting, consists of recording and reporting summary data (total number of patient visits for any reason and the number of patient visits for ILI by age group) each week to CDC via the Influenza-like Illness Surveillance Network (ILINet) website. The influenza sentinel provider program, also known as the ILINet provider program, consists of more than 3,000 healthcare providers in all 50 states and several United States Territories. The program provides public health officials with a source of outpatient illness surveillance during the influenza season. The ILI case definition used for national surveillance is (1) a fever ($\geq 100.0^{\circ}$ F or 37.8° C) and (2) a cough and/or sore throat in the absence of a known cause other than influenza. The ILI case definition is not designed to capture only influenza cases, but it is designed to capture patients with an influenza-like illness. Therefore, some patients will meet the ILI case definition and not actually have the disease of influenza. Reports were submitted through the ILINet website weekly beginning October 1, 2012 (MMWR Week 40); the reports will continue until September 28, 2013 (MMWR Week 39). Some of the influenza sentinel providers discontinued reporting on May 18, 2013 (MMWR Week 20). Historically, the twentieth week of the year marks the end of the influenza season. However, in recent years, CDC requested that influenza sentinel providers continue to report throughout the summer. Year-round influenza surveillance provides a baseline level of influenza activity; this process develops the annual epidemic thresholds.

The second component, laboratory specimen collection, involves collecting specimens from a small number of patients with ILI each influenza season. The specimens are sent to the WPHL for specialized influenza testing. The WPHL performs reverse transcriptase – polymerase chain reaction (RT-PCR). In addition, subsets of the specimens that are submitted to the WPHL are forwarded to CDC for influenza culture testing. This testing often provides the earliest identification of circulating virus types, subtypes, and strains in a season. During a typical influenza season, laboratory and epidemiology officials will utilize the influenza sentinel provider program as a major part of influenza surveillance for the WDH. In addition, the WPHL is a World Health Organization (WHO) Collaborating Laboratory. As a WHO Collaborating Laboratory, the WPHL reports the total number of respiratory specimens tested and the number of positive influenza specimens to CDC each week. The participating influenza sentinel providers are offered summaries of state and national influenza data, free subscriptions to CDC's Morbidity and Mortality Weekly Report, and Emerging Infectious Diseases Journal, and viral isolation test kits for free influenza testing at the WPHL. Finally, the most important consideration is the data provided by sentinel providers are critical for protecting the public's health. For more information on the Influenza Sentinel Surveillance Network, or if you are interested in becoming a sentinel provider, please contact the Infectious Disease Epidemiology Unit at (307) 777-8640.

REPORTED CASES

This season 3,931 laboratory-confirmed influenza cases (RIDT, DFA, PCR, and laboratory cultures) were reported from every county in Wyoming. The first positive cases for the 2012-2013 influenza season were reported the week ending October 6, 2012 (MMWR Week 40). Reporting of influenza peaked the week ending December 22, 2012 (MMWR Week 51), when 502 cases were reported. In comparison, during the 2011-2012 influenza season, reporting of influenza peaked the week ending March 17, 2012 (MMWR Week 11), when 152 cases were reported. Table 1 displays the number of cases reported by week. Although all positive laboratory tests for influenza are required to be reported to the WDH, not all providers report these results. Additionally, many ill persons do not seek medical care or are not tested for the disease during a medical visit. Therefore, comparing reported cases of influenza from year-to-year or week-to-week may not be valid as many factors influence both testing and reporting.

**CHART 1: REPORTED CASES OF INFLUENZA (RAPID AND CULTURE TEST POSITIVE)
WYOMING, (2008-2009 to 2012-2013)**

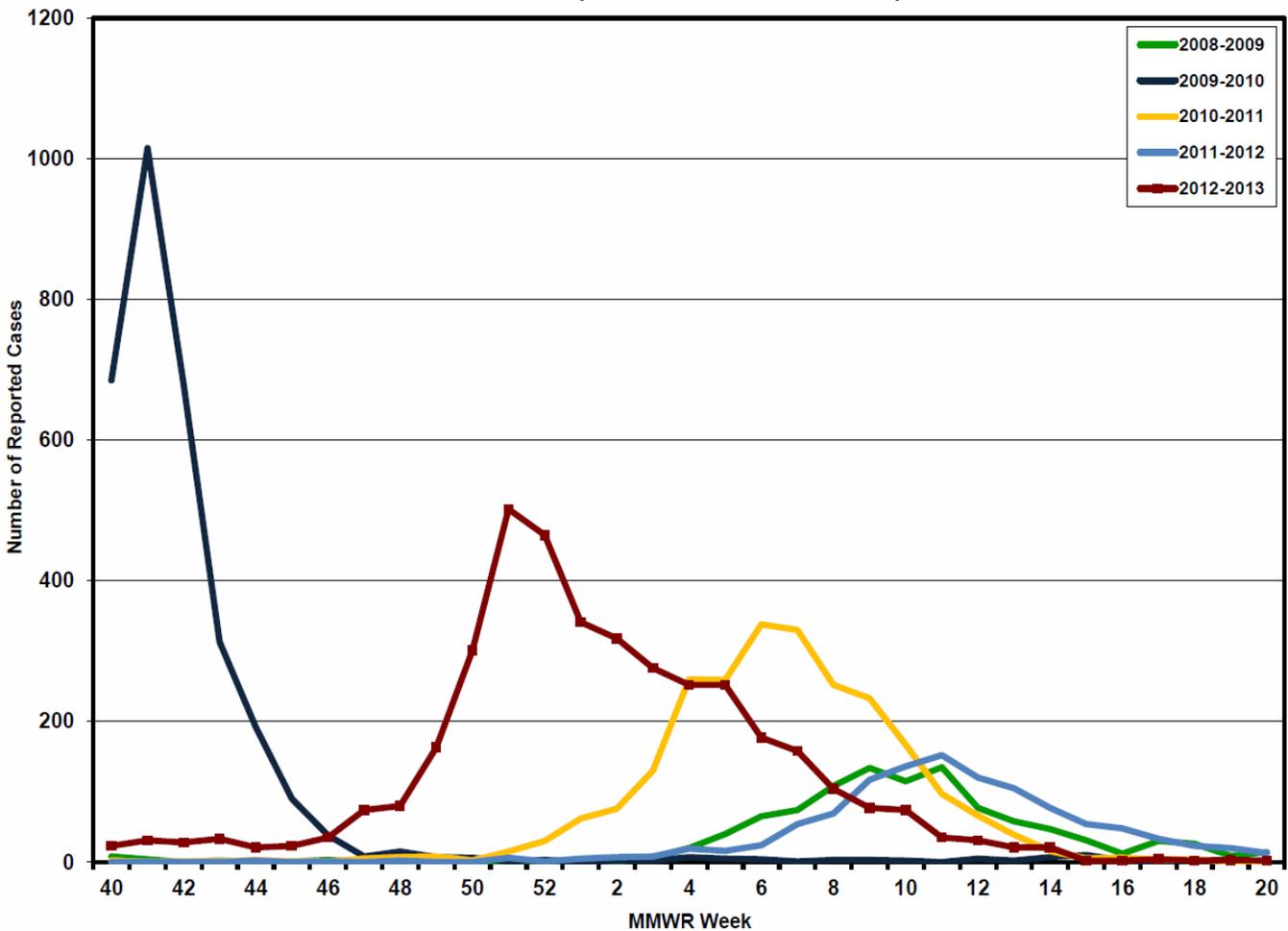


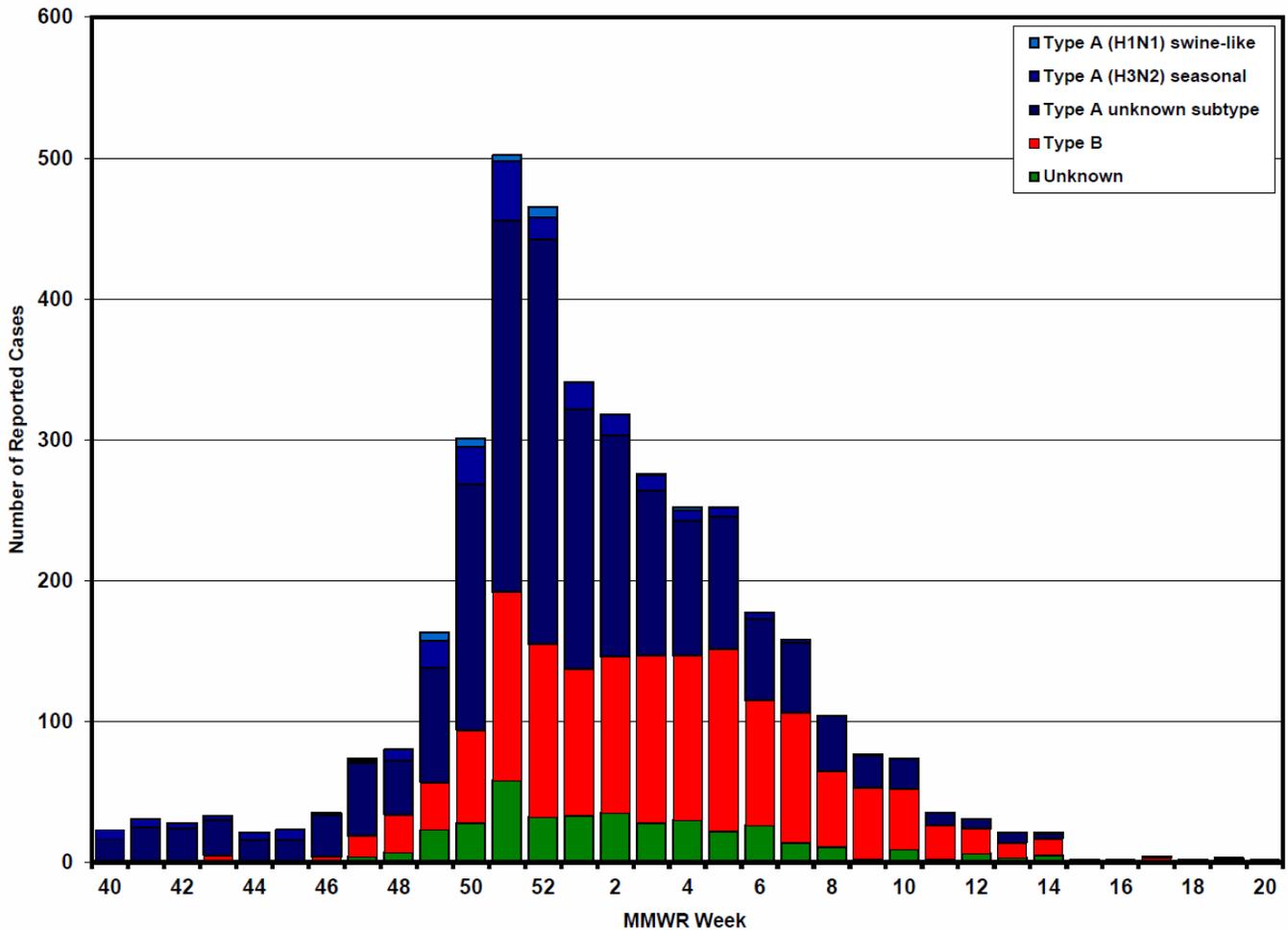
TABLE 1: REPORTED CASES OF INFLUENZA; WYOMING, 2012-2013 SEASON

Week Ending	Number	County	Number	Age	Number
06-Oct	23	Albany	108	0-4	894
13-Oct	31	Big Horn	85	5-10	995
20-Oct	28	Campbell	495	11-19	552
27-Oct	33	Carbon	62	20-39	664
03-Nov	21	Converse	119	40-59	487
10-Nov	23	Crook	53	60+	339
17-Nov	35	Fremont	394	Unknown	0
24-Nov	74	Goshen	118	Total	3931
01-Dec	80	Hot Springs	14		
08-Dec	163	Johnson	30	Gender	Number
15-Dec	301	Laramie	620	Male	1935
22-Dec	502	Lincoln	58	Female	1996
29-Dec	465	Natrona	534	Unknown	0
05-Jan	341	Niobrara	5	Total	3931
12-Jan	318	Park	163		
19-Jan	276	Platte	47	Type	Number
26-Jan	252	Sheridan	238	A	2155
02-Feb	252	Sublette	76	B	1392
09-Feb	177	Sweetwater	328	Unknown	384
16-Feb	158	Teton	126	Total	3931
23-Feb	104	Uinta	136		
02-Mar	77	Washakie	98		
09-Mar	74	Weston	24		
16-Mar	35	Unknown	0		
23-Mar	31	Total	3931		
30-Mar	21				
06-Apr	21				
13-Apr	2				
20-Apr	2				
27-Apr	4				
04-May	2				
11-May	3				
18-May	2				
Total	3931				

LABORATORY DATA

Of the 3,931 reported cases, 2,155 (54.8%) were type A, 1,392 (35.4%) were type B, and 384 (9.8%) were an unknown type of influenza. Three hundred fifty-seven of these cases were confirmed by PCR at the WPHL. An additional eighty-seven cases were confirmed by PCR at other laboratories. One case was confirmed by DFA; two cases were confirmed by laboratory culture; and the remaining 3,489 cases were confirmed by rapid test only. During the 2012-2013 influenza season, the WPHL tested a total of 691 specimens for influenza virus and 357 (51.7%) were positive. The first positive PCR confirmed specimen by WPHL was tested during the week ending October 13, 2012 (MMWR Week 41), and the last positive specimen was tested during the week ending May 11, 2013 (MMWR Week 19). Among the 357 positive influenza specimens tested at the State’s public health laboratory, 218 (61.1%) were Influenza A (H3N2); 13 (3.6%) were 2009 Influenza A (H1N1) viruses; 125 (35.0%) were Influenza B viruses; and one (0.3%) was a dual infection with influenza A (H3N2) and influenza B (see chart 2 below).

**CHART 2: REPORTED CASES OF INFLUENZA BY VIRUS TYPE
WYOMING, 2012 - 2013 SEASON**



On a national level, WHO and the National Respiratory and Enteric Virus Surveillance System collaborating laboratories tested a total of 309,913 specimens for influenza viruses during the 2012-2013 influenza season and 73,130 (23.5%) were positive. Among the 73,130 influenza viruses, 51,675 (70.7%) were influenza A viruses and 21,455 (29.3%) were influenza B viruses. Thirty-four thousand nine hundred twenty-two (67.6%) of the 51,675 influenza A viruses have been subtyped: 33,423 (95.7%) were influenza A (H3N2) viruses and 1,497 (4.3%) were 2009 influenza A (H1N1) viruses. Additionally, two infections with an influenza A (H3N2) variant virus (H3N2v) were reported. During the 2012-2013 influenza season, 2009 influenza A (H1N1), influenza A (H3N2), variant influenza A (H3N2v), and influenza B viruses co-circulated in the United States. Overall, seasonal influenza A (H3N2) viruses were the most commonly reported influenza virus type and subtype throughout most of the influenza season. Specifically, influenza A (H3N2) viruses were predominant in the U.S. Department of Health and Human Services (DHHS) Region 8 during the weeks leading up to Wyoming's influenza peak. The State of Wyoming is located within DHHS Region 8. Although influenza A (H3N2) viruses predominated, influenza B viruses also circulated widely. However, the relative proportion of each type and subtype of influenza virus varied by region and week. The proportion of influenza B viruses reported was highest later in the season. Influenza B viruses were more common in DHHS Region 4 and Region 8 compared to other regions; also, influenza B viruses predominated the second half of Wyoming's influenza season.

Most of the influenza viruses sent to CDC for further characterization were antigenically similar to one of the components of the 2011-2012 Northern Hemisphere vaccine. As of May 18, 2013, CDC antigenically characterized 2,452 influenza viruses collected by United States laboratories since October 1, 2012. Two hundred forty-nine of the 252 2009 influenza A (H1N1) viruses were characterized as A/California/7/2009-like, the 2009 influenza A (H1N1) component of the 2012-2013 influenza vaccine for the Northern Hemisphere. Three 2009 influenza A (H1N1) viruses showed reduced titers with antiserum produced against A/California/7/2009. One thousand three hundred nineteen of the 1,324 influenza A (H3N2) viruses were characterized as A/Victoria/361/2011-like, the influenza A (H3N2) component of the 2012-2013 influenza vaccine for the Northern Hemisphere. Five of the 1,324 viruses tested showed reduced titers with antiserum produced against A/Victoria/361/2011-like. Five hundred eighty-one of the 876 influenza B viruses belong to the B/Wisconsin/1/2010-like, the recommended influenza B component for the 2012-2013 Northern Hemisphere influenza vaccine. The B/Wisconsin/1/2010-like viruses belong to the Yamagata lineage of viruses. The remaining 295 of the 876 influenza B viruses were identified as belonging to B/Victoria lineage of the viruses. Overall, the 2012-2013 influenza vaccine matched the circulating strains of influenza virus in the United States.

VACCINE EFFECTIVENESS

The influenza viruses selected for seasonal influenza vaccines are chosen each year based on information gathered over the previous influenza season. Researchers study the strains of the viruses that are infecting humans and how they are changing. Circulating influenza strains and information on disease trends are gathered by 141 National Influenza Centers (NIC) in 111 countries. The combined data is analyzed by the four WHO Collaborating Centers for Reference and Research on Influenza. Based on this information, experts forecast which viruses are likely to circulate the following influenza season, and WHO recommends specific virus strains that can be used to make the vaccine. The recommendation for vaccines produced for the Northern Hemisphere is made by WHO in February each year. Each country can then use the recommendations made by WHO to assist with national decisions about what viruses to use in influenza vaccines for their country. In the United States, an advisory committee convened by the Food and Drug Administration (FDA) makes the final decision about vaccine strains in February. Manufacturers grow vaccine strains based on these recommendations. How well the influenza vaccine works each year depends on how closely related, or matched, the viruses in the vaccine are to the influenza viruses circulating that season.

Vaccine effectiveness also varies depending on how well a vaccinated person responds to the vaccine in terms of producing protective antibody, and how successful vaccination programs are at vaccinating people in advance of the season. A good match is said to occur when the viruses in the vaccine and the viruses circulating among people during a given influenza season are closely related and the antibodies produced by the vaccine are able to provide protection against infection. In years when the vaccine strains and the virus strains are well-matched, the vaccine can reduce the chances of becoming infected with influenza by 70%-90% in healthy adults. Influenza viruses constantly change as the virus replicates. Influenza viruses often change from one season to the next or even change within the course of an influenza season. When influenza viruses change, they may no longer closely match viruses used to make that season's vaccine, thus making the vaccine less effective. In the United States, annual vaccination against seasonal influenza is recommended for all persons aged 6 months and older. Each season since the 2004-2005 influenza season, CDC conducts studies to estimate how well the seasonal influenza vaccine protects against influenza-associated medical visits. An early season estimate was conducted on the 2012-2013 influenza season because of the high levels of early season influenza activity. Subsequently, a number of studies looking at the effectiveness of the 2012-2013 influenza vaccine have been published.

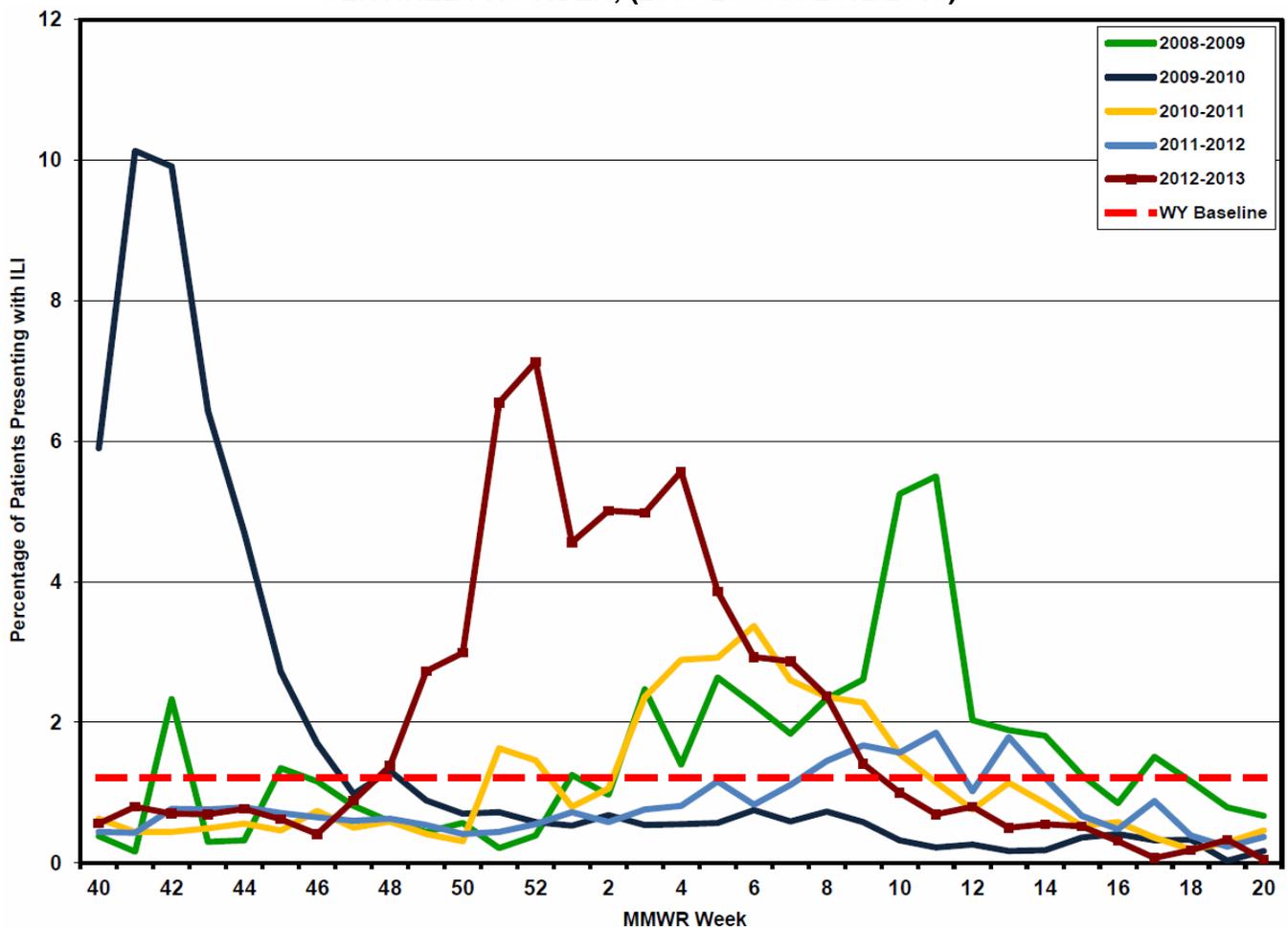
In late June 2013, CDC presented updated interim vaccine effectiveness estimates for the 2012-2013 influenza season during the Advisory Committee on Immunization Practices (ACIP) meeting in Atlanta. The estimates represent the final number of U.S. Influenza Vaccine Effectiveness Network enrollees from the 2012-2013 influenza season; however, some of the information is pending and thus the estimates are interim estimates. Overall, the estimated vaccine effectiveness against influenza A and influenza B was 52%. The estimates do not include adjustment for chronic medical conditions and vaccine type. This estimate is lower but similar to early (62%; 95% confidence intervals [CI] = 51% to 71%) and mid-season (56%; 95% CI: 46% to 63%) interim estimates. The adjusted vaccine effectiveness against laboratory-confirmed influenza A (H3N2) was 44% (95% CI: 35% to 52%) and the vaccine effectiveness against laboratory-confirmed influenza B viruses from both lineages was similar: 64% (95% CI: 56% to 71%) vaccine effectiveness for the B/Yamagata lineage and 56% (95% CI: 42% to 67%) for the B/Victoria lineage. Thus vaccination with the 2012-2013 influenza season vaccine reduced the risk of influenza-associated medical visits from influenza A (H3N2) by approximately one half and from influenza B by approximately two thirds for most of the population.

The results of most of the published studies were consistent in that they indicate that vaccination provided only moderate protection against influenza illness across most age groups. The two exceptions to this were vaccine effectiveness against influenza A (H3N2) viruses among people 65 years and older (19%; 95% CI: -36% to 52%) and children aged 9-17 years (24%; 95% CI: -17% to 50%). It is unclear why lower vaccine effectiveness estimates were detected in these age groups. In general, vaccine effectiveness estimates for adults 65 years and older have been lower than estimates in younger adults, but estimates have varied between years, studies, and by virus types. According to CDC, one possible explanation for these findings is that some older adults did not mount an effective immune response to the influenza A (H3N2) component of this season's vaccine. Additionally, CDC cautions that there are important factors affecting how well the vaccine works; specifically, vaccine match, the health, and age of the person being vaccinated. Nonetheless, the findings should not discourage future vaccination by persons 65 years and older, who are at greater risk for more severe cases and complications from influenza. The benefits of the influenza vaccine may vary in this age group from year-to-year; however, the vaccine is the best way to protect this especially vulnerable population each year. The vaccine effectiveness results in adults 65 years and older and children aged 9-17 years highlight the importance of continued efforts to develop more effective vaccines. Additionally, CDC is taking a closer look at both groups to determine why lower vaccine effectiveness against the influenza A (H3N2) component of the influenza vaccine occurred during the 2012-2013 influenza season.

OUTPATIENT INFLUENZA-LIKE ILLNESS (ILI) REPORTS FROM WYOMING SENTINEL SITES

Information on patient visits to healthcare providers for ILI symptoms is collected through CDC's ILINet website. Each week, ILINet providers reported the total number of patients seen and the number of those patients with ILI by age group. Influenza-like illness morbidity reported by Wyoming sentinel providers started the influenza season, MMWR Week 40, below the baseline level (0 - 1.21%); ILI activity among the influenza sentinel providers remained below the baseline until the week ending November 24, 2012 (MMWR Week 47). The peak percentage of patient visits for ILI was 7.13%, which occurred the week ending December 29, 2012 (MMWR Week 52). However, the number of cases and the number of PCR positive specimens reported by the WPHL peaked the previous week; December 22, 2013 (MMWR Week 51). Additionally, ILI activity among the ILINet providers remained above the baseline until the week ending March 9, 2013 (MMWR Week 10). In comparison, during the 2011-2012 influenza season the peak percentage of patient visits for ILI was 1.85%, which occurred the week ending March 17, 2012 (MMWR Week 11).

CHART 3: WEEKLY INFLUENZA-LIKE ILLNESS (ILI) REPORTING BY WYOMING SENTINEL PROVIDER, (2008-2009 to 2012-2013)



ANTIVIRAL AGENTS FOR INFLUENZA

The FDA recommended two antiviral drugs for use against influenza during the 2012-2013 influenza season: zanamivir and oseltamivir. An overview of the indications, administration, and use of antiviral medications is presented in Table 2. Zanamivir and oseltamivir are in a class of medication known as neuraminidase inhibitors. They are active against both influenza A and B viruses. Antiviral resistance to oseltamivir and zanamivir among circulating influenza viruses is currently low. Additionally, antiviral resistance can emerge during or even after treatment of certain patients with influenza. For example, this has been known to occur in patients that are immunosuppressed. Clinical trials and observational data show that early antiviral treatment can shorten the duration of fever and illness symptoms, and may reduce the risk of complications from influenza and shorten the duration of hospitalization. Clinical benefit is greatest when antiviral treatment is administered early, especially within 48 hours of influenza illness onset. For additional information on antiviral medications during the 2012-2013 influenza season, please visit: <http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>.

TABLE 2: RECOMMENDED DOSAGE AND SCHEDULE OF INFLUENZA ANTIVIRAL MEDICATIONS FOR TREATMENT AND CHEMOPROPHYLAXIS, 2012-2013 SEASON

Antiviral Agent	Activity Against	Use	FDA Approved For	Not Recommended for Use in	Adverse Events
Oseltamivir (Tamiflu®)	Influenza A and B	Treatment	2 weeks and older	N/A	Adverse events: nausea, vomiting. Sporadic, transient neuropsychiatric events (self-injury or delirium) mainly reported among Japanese adolescents and adults.
		Chemoprophylaxis	1 year and older	N/A	
Zanamivir (Relenza®)	Influenza A and B	Treatment	7 years and older	People with underlying respiratory disease (e.g., asthma or COPD)	Allergic reactions: oropharyngeal or facial edema. Adverse events: diarrhea, nausea, sinusitis, nasal signs and symptoms, bronchitis, cough, headache, dizziness, and ear, nose and throat infections.
		Chemoprophylaxis	5 years and older	People with underlying respiratory disease (e.g., asthma or COPD)	

NOVEL INFLUENZA A VIRUSES

Influenza viruses in swine do not normally infect humans. However, sporadic human infections with swine influenza viruses that usually circulate in pigs and not in people have occurred. When this happens, these viruses are called variant viruses. Most commonly, human infections with variant viruses occur in people with exposure to infected pigs. Since August 2011, a number of United States residents were infected with influenza A variant viruses. Public health investigations revealed human infections with these viruses following contact with swine, as well as limited human-to-human transmission. A notable increase in cases of H3N2 variant (H3N2v) virus infection has been identified since the summer of 2012. However, the virus has been circulating among pigs in the United States since 2011. The reports of influenza A (H3N2v) continued into the 2012-2013 influenza season. According to CDC, the majority of H3N2v cases have been in children, although some adults have been infected, and linked to recent direct or indirect exposure to pigs. Almost all of the H3N2v cases reported in 2012 have been epidemiologically linked to agricultural fairs, either through exhibiting pigs or walking through a swine barn. By the end of the 2012-2013 influenza season, CDC received reports on 321 cases of H3N2v viruses since 2011.

During the 2012-2013 influenza season human infections with a novel avian influenza A (H7N9) virus were reported in China. The virus was also detected in birds within China. Global attention focused on the novel virus because of the increasing number of cases and the high mortality rate associated with infections of the novel avian virus. Clinically, some of the cases had mild illness; however, most patients had severe respiratory illness and some people have died. The human cases of H7N9 infections were isolated to China; the new H7N9 virus has not been detected in people or birds in the United States. Available evidence indicates that most people were infected with the disease after exposure to birds or to environments that might be contaminated with bird flu virus; for example, a live bird market. Human infections with avian influenza viruses are rare but occur occasionally, most commonly after exposure to infected birds (bird-to-human spread). There is no evidence of sustained human-to-human transmission of the H7N9 virus. As of July 2013, WHO has received reports on 131 cases of H7N9 with 36 deaths. Public health officials are continuing to monitor and investigate the outbreak.

COMPOSITION OF THE 2013-2014 VACCINE

Influenza vaccines are designed to protect against three influenza viruses that public health experts predict will be the most common during the upcoming season. Three kinds of influenza viruses commonly circulate among people today: Influenza A (H1N1) viruses, influenza A (H3N2) viruses, and influenza B viruses. Each year, one influenza virus from each of the three circulating viruses is used to produce the seasonal influenza vaccine. The WHO has recommended the vaccine virus strains for the 2013-2014 Northern Hemisphere trivalent influenza vaccine. The FDA - Vaccines and Related Biological Products Advisory Committee (VRBPAC) agreed with the recommendations for the U.S. influenza vaccine supply. Both agencies recommend that the vaccine contain A/California/7/2009-like (2009 H1N1), an A (H3N2) virus antigenically like the cell-propagated, or cell-grown, virus A/Victoria/361/2011 (A/Texas/50/2012), and a B/Massachusetts/2/2012-like (B/Yamagata lineage) virus.

It is recommended that quadrivalent vaccines containing an additional influenza B virus contain a B/Brisbane/60/2008-like (B/Victoria lineage) virus in addition to the viruses recommended for the trivalent vaccines. These recommendations were based on global influenza virus surveillance data related to epidemiology and antigenic characteristics, serological responses to 2012-2013 seasonal vaccines, and the availability of candidate strains and reagents. The recommendations from WHO and FDA changed the influenza A (H3N2) and influenza B virus components of the 2013-2014 Northern Hemisphere influenza vaccine formulation from the 2012-2013 influenza vaccine formulation. This recommendation was based on global influenza virus surveillance data related to epidemiology and antigenic characteristics, serological responses to 2012-2013 trivalent seasonal vaccine, and the availability of candidate strains and reagents.

REPORTED INFLUENZA-ASSOCIATED DEATHS

Influenza-associated deaths are reportable in the state of Wyoming. This season, 14 seasonal influenza-associated deaths were reported to the WDH. This was the highest number of influenza mortality reported to the state in the past ten years. The median age was 86 years, and 85.7% of the deaths were 65 years of age or older. This season, no pediatric deaths were reported. Twelve of the 14 influenza-associated deaths occurred in individuals aged 65 years or older. The remaining two influenza-associated deaths occurred in individuals under the age of 65 years. Thirteen of the 14 deaths occurred during 2013; however, all of the deaths occurred after the influenza peak that occurred the week ending December 22, 2012 (MMWR Week 51). The deaths were associated with both influenza A and influenza B infections.

REPORTING REMINDER

All of the following are reportable to the Wyoming Department of Health: laboratory confirmed cases of influenza, influenza-associated deaths; an unusual incidence of influenza-like illness; and outbreaks or unusual clusters of influenza or influenza-like illness in schools, long-term care facility/nursing homes, and other institutions. A report is required by state statute from both the attending health care provider/hospital and any laboratory performing diagnostic testing. Reports can be faxed to our secure fax line at (307) 777-5573 or can be made by phone to (307) 777-8640. In addition, WDH requests that hospitals submit respiratory specimens to the WPHL on all hospitalized patients with ILI or clinical suspicion of influenza regardless of the results of the rapid influenza diagnostics test.