Chief Medical Officer for Scotland

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The Scottish Government
Riaghaltas na h-Alba

Dear Colleagues

Seasonal Influenza: Use of Antivirals 2022-23

1. Recent intelligence provided by Public Health Scotland (PHS) of increases in laboratory-confirmed influenza incidence and test swab positivity in general practices (GPs) now suggests sustained community-level influenza transmission in Scotland. This may lead to an increase in numbers of people presenting at GPs with influenza-like illness who are likely to be infected with the influenza virus. PHS also has confirmed influenza outbreaks in a few care homes, hospitals, and other closed settings. See the PHS weekly respiratory report for current levels of circulating respiratory conditions in Scotland.

2. Based on PHS's intelligence, **antiviral medicines (specifically oseltamivir and zanamivir) can now be prescribed to treat influenza where clinically indicated, and in particular, among those vulnerable to severe disease or presenting with severe infection/symptoms.** Antiviral use may help to prevent infection following exposure and, amongst those with infection, to lessen symptoms, shorten the period of illness and reduce the risk of complications that otherwise might lead to hospitalisation or death. Antiviral medicines are not a substitute for vaccination, which remains the most effective way of preventing influenza illness.

Testing

3. Clinical diagnosis of influenza is challenging given its similarity in presentation to COVID-19. This situation complicates recommendations for antiviral use based on clinical-epidemiologic evidence alone. As such, virological testing should be increasingly considered to guide case management and outbreak response, especially in closed settings (e.g., care homes) and among at-risk populations.

From the Chief Medical Officer for Scotland
Chief Pharmaceutical Officer
Professor Sir Gregor Smith
Professor Alison Strath

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Addresses

For action
Chief Executives, NHS Boards
Medical Directors, NHS Boards
Directors of Public Health, NHS Boards
Directors of Nursing & Midwifery, NHSBoards
Directors of Pharmacy
General Practitioners
Practice Managers
Practice Nurses
Health Visitors
Immunisation Coordinators
CPHMs
Scottish Prison Service
Scottish Ambulance Service
Consultant Obstetricians
Occupational Health Leads

For information
Chairs, NHS Boards
Infectious Disease Consultants
Consultant Paediatricians
Consultant Physicians
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4. UK Health Security Agency (UKHSA) guidance on influenza testing can be found here (Please see "Recommendations on testing for COVID-19 and influenza to guide the use of neuraminidase inhibitors (NAIs)" as in Table 1 and on p.7 of the UKHSA guidance).

5. Laboratories are requested to refer positive influenza samples to the West of Scotland Specialist Virology Centre (WoSSVC) for sequencing, especially from severe cases, suspected outbreaks, vaccine failures or where co-infections with other respiratory viruses are detected.

6. GP practices that are taking part in the CARI (Community Acute Respiratory Infection) sentinel surveillance programme have been provided with bespoke, multiplex test kits which allow detection by the laboratory of a range of respiratory pathogens in patients who present with flu-like symptoms. These are returned directly to WoSSVC. Please contact phs.cari@phs.scot for more information on how to become a sentinel GP practice.

Treatment of suspected or confirmed influenza

7. UK Health Security Agency (UKHSA) guidance on antiviral use for influenza can be found here:

> Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza (publishing.service.gov.uk).

Advice contained in the PHS Addendum also should be reviewed as per below:

> PHS external guidance addendum: for UKHSA 'Guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza' - version 1

8. A summary algorithm for prescribing antiviral treatment for influenza from the UKHSA guidance is included in Annex A. Details in chapter 2 of the UKHSA guidance are also provided for treatment of adults and children with uncomplicated/complicated influenza (including severely immunosuppressed); dosage in patients with renal dysfunction; treatment of oseltamivir-resistant influenza; management of influenza in critical care; and other licensed and unlicensed treatments.

9. Some influenza types are associated with a greater risk of developing oseltamivir resistance (in general, influenza A(H1N1)pdm09 is considered to have a higher risk compared to A(H3N2) and influenza B). The risk of resistance is greatest in people who are severely immunosuppressed.

10. It is still too early to predict what will be the dominant virus for the 2022/23 season. Both influenza A(H1N1)pdm09 and A(H3N2) strains have been co-circulating in Scotland. The most recent information on the dominant circulating strain of influenza is reported in the PHS weekly respiratory report.

11. Regarding treatment of influenza in the context of co-circulation of COVID-19:

- there are no data to indicate any adverse impact of initiating NAIs in patients with COVID-19;
- COVID-19 is not a contraindication to prescribing influenza antivirals where prompt initiation for suspected or confirmed influenza is required; and
- there are no data to support prescribing of influenza antivirals for the treatment of COVID-19.

Post exposure prophylaxis

12. Details in the UKHSA guidance are included on National Institute for Health and Care Excellence (NICE) guidance on antiviral use for prophylaxis of persons in at-risk groups following exposure to a person in the same household or residential setting with influenza-like illness when influenza is circulating in the community. Local Health Protection Teams are advised to carry out a risk assessment to determine whether to initiate post-exposure prophylaxis or not.

13. NICE guidance provides advice regarding prescription of antivirals, and this guidance should be read in conjunction with UKHSA guidance. The full NICE guidance on the use of antivirals can be accessed at:

https://www.nice.org.uk/guidance/ta168 for treatment; and
https://www.nice.org.uk/guidance/ta158 for prophylaxis.

Conclusion

14. Based on evidence provided by PHS about recent increases in influenza transmission, antiviral use in the community should now be considered. When PHS indicates that influenza levels have reduced, they again will advise to cease the use of antivirals in the community.

15. The relevant directions under NHS Circular PCA(M)(2010)22 remain in force (available at: SE Health Department NHS, MEL (scot.nhs.uk)) and this means clinicians are still able to prescribe antivirals for any individuals, including those not in recognised risk groups and children under one year of age.

16. It is expected that the use of antivirals for the general population would only be used if the clinician feels the individual is at serious risk of developing complications or has developed these complications. Patients in the general population presenting with mild to moderate flu-like symptoms should be advised to take paracetamol and fluids and to seek further assistance should their condition deteriorate.

Prescriptions – Advice for Prescribers for Endorsing Prescriptions

17. Prescribers are reminded to endorse all prescriptions for antivirals with the reference “SLS”. Pharmacists can only dispense antivirals at NHS expense if this endorsement is made by the prescriber.

Access to Antivirals

18. The normal route for prescribing antiviral medication will be through GP10. Community pharmacies are advised to review their stock levels of antivirals via their wholesalers in response to local demand. Directors of Pharmacy should make sufficient supplies of antivirals available to local Out of Hours services.

19. In the event of any national shortages of antiviral medicines further advice regarding the use of the national stockpile will be issued.

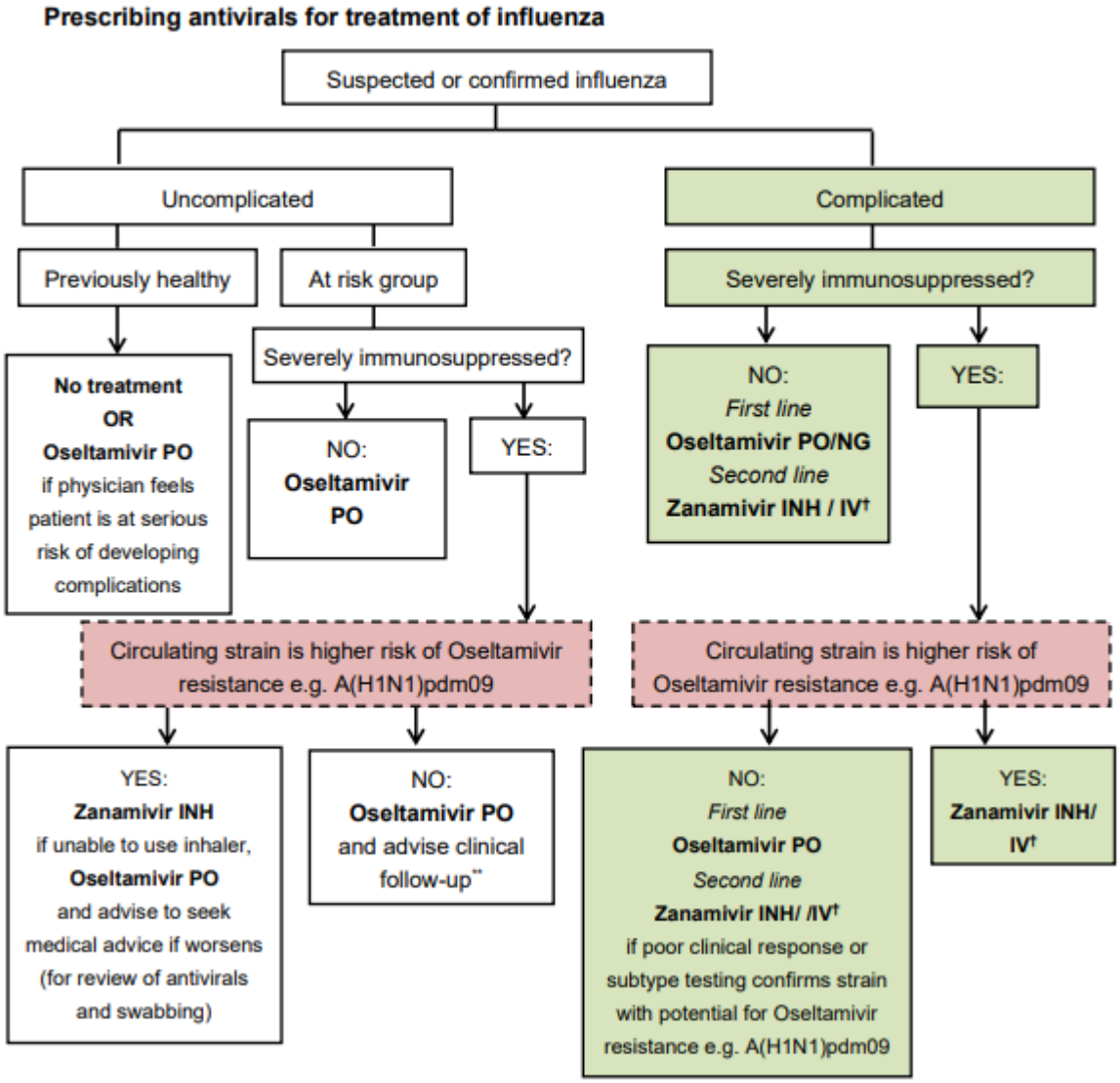
Yours sincerely,

Gregor Smith *Alison Strath*

Professor Sir Gregor Smith
Chief Medical Officer for Scotland

Professor Alison Strath
Chief Pharmaceutical Officer

Summary algorithm for prescribing antiviral treatment for influenza (**UKHSA Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza**)



*As of week-ending 13th November 2022, Both A(H1N1)pdm09 and A(H3N2) are co-circulating in Scotland. Further information on the dominant circulating strain of influenza is reported in the **PHS weekly respiratory report.**

Table: Recommendations on the use of COVID-19 and influenza diagnostic tests when considering NAI initiation in at-risk patients (adapted from UKHSA **Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza**)

	Indication in eligible at-risk patient group	CMO has notified GPs that flu is circulating	NAI initiation and testing for detection of COVID-19 (SARS-CoV-2) and/or influenza
1	Treatment: the person presents with complicated influenza-like illness, typically requiring hospitalisation.	Year round	If point of care tests (POCTs) for COVID-19 and influenza are unavailable, consider prompt NAI initiation prior to virological testing. Local or national surveillance may help inform this. Reassess indication for NAI once test results are available
2a	Treatment: the person presents with an (uncomplicated) influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms as per licensed indications.	No CMO notification of influenza circulation	NAI use should usually be guided by influenza diagnostic tests. COVID-19 testing should be done if influenza is clinically suspected unless this has been specifically discounted. If the patient has onset during a virologically-confirmed influenza outbreak in a closed setting then this would be indication for empirical initiation of NAI.
2b	Treatment: the person presents with an (uncomplicated) influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms.	CMO has notified GPs that flu is circulating	COVID-19 testing should be done if influenza is clinically suspected unless this has been specifically discounted. Negative results for COVID-19 would usually be an indication for NAIs (in the absence of testing for other respiratory viruses) based on clinicalepidemiological probability. COVID-19 point of care testing with a lateral flow device may be used to inform antiviral use but is not a substitute for COVID-19 PCR testing in patients with relevant symptoms. If POCTs are unavailable, NAI should be started promptly without awaiting results of PCR testing if the clinician considers influenza to be highly probable (such as symptom onset following close contact with a confirmed influenza case). If available, testing for influenza should be undertaken alongside COVID-19 testing but is not required for NAI initiation.

	Indication in eligible at-risk patient group	CMO has notified GPs that flu is circulating	NAI initiation and testing for detection of COVID-19 (SARS-CoV-2) and/or influenza
3a	Post-exposure prophylaxis, where: (i) The person has been exposed to an influenza-like illness and is able to begin prophylaxis within the timescale specified in the marketing authorisations of the individual drugs (within 36 hours of contact with an index case for zanamivir and within 48 hours of contact with an index case for oseltamivir); and (ii) the person has not been effectively protected by vaccination.	No CMO notification of influenza circulation.	NAI use should usually be guided by influenza testing of the index case(s). COVID-19 testing of the index case(s) should be done if influenza is clinically suspected unless this has been specifically discounted.
3b	Post-exposure prophylaxis, where: (i) The person has been exposed to an influenza-like illness and is able to begin prophylaxis within the timescale specified in the marketing authorisations of the individual drugs (within 36 hours of contact with an index case for zanamivir and within 48 hours of contact with an index case for oseltamivir); and (ii) the person has not been effectively protected by vaccination.	CMO has notified GPs that flu is circulating.	COVID-19 testing of the index case should be done if influenza is clinically suspected in the index case(s) unless this has been specifically discounted. Negative results for COVID-19 would usually be an indication for NAIs (in the absence of testing for other respiratory viruses). COVID-19 point of care testing with a lateral flow device may be used to inform antiviral use but is not a substitute for COVID-19 PCR testing in patients with relevant symptoms. If available, testing for influenza in the index case(s) should be undertaken alongside COVID-19 testing but is not required for NAI initiation.

Notes for Table

Suspected or confirmed COVID-19 is not a contraindication to NAI initiation where suspected or confirmed influenza is part of the differential diagnosis.

An episode of COVID-19 may result in prolonged detection of SARS-CoV-2 by RT-PCR such that a positive COVID-19 PCR result in such a patient does not exclude that recent onset symptoms are due to influenza or another respiratory virus.

For empirically-initiated NAI treatment clinicians may continue with NAI where there is strong clinical suspicion despite a negative influenza result, guided by factors such as an epidemiological link to a case, high community incidence of influenza and/or absence of an alternative diagnosis.