Management of Suspected AVIAN INFLUENZA
SOP v1 08/08/22

1. IMMEDIATE ACTION

On initial suspicion, isolate the patient immediately in a side room, ideally under **negative** pressure. Minimise contact/exposure to staff and other patients and ask the patient to wear a surgical mask unless on O^2 therapy.

Wear personal protective equipment (PPE) – as a minimum, this should be a correctly fitted FFP3 respirator or equivalent (PAPR hood), gown, gloves and eye protection.

Case definition - Nov 2021 (UKHSA)

Clinical criteria

a) fever ≥ 38°C or

b) acute respiratory symptoms (cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing) or

c) other severe or life-threatening illness suggestive of an infectious process

Additionally, patients must fulfil a condition in either category 1 or 2 of the exposure criteria below.

Exposure criteria

1) close contact (within 1 metre) with live, dying or dead domestic poultry or wild birds, including live bird markets, in an area of the world affected by avian influenza** or with any confirmed infected animal, in the 10 days before the onset of symptoms or

2) in the 10 days before the onset of symptoms, close contact* with:

- a confirmed human case of avian influenza
- human case(s) of unexplained illness resulting in death from affected areas**
- human cases of severe unexplained respiratory illness from affected areas**

*This includes handling laboratory specimens from cases without precautions, or within 1 metre, directly providing care, touching a case or within close vicinity of an aerosol generating procedure, from 1 day prior to symptom onset and for duration of symptoms or positive virological detection.

** HCID country list plus China & Oman. Unsure? Discuss with UKHSA Clinical/Public Health team (CPH).

2. Assess against the case definition

No, does not meet case definition: unlikely to be avian influenza – treat and investigate as clinically indicated for other infections or causes.

Yes, does meet case definition: manage as possible case. **Caution**: be aware of other travellers associated respiratory infections such as Legionnaire's disease or MERS-CoV, if there is travel or potential exposure history for those infections.

Start oseltamivir treatment immediately if the patient meets case definition for avian influenza. For guidance on dosage refer to UKHSA guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza.

3. ACTIONS to prevent transmission of infection:

- **Surgical face mask** required to be worn by the patient until in **isolation** (ideally in negative pressure) and where able when staff are in the room. For ED presentations, the isolation room for HCIDs is to be used. For direct admissions, contact the clinical commander.

  Patient to wear a surgical mask when someone enters the room or if transferred to another area if tolerated. The patient's requirement to wear a surgical mask must never compromise their care, such as when oxygen therapy is required.

- **Follow high level isolation protocol 2** – all unnecessary equipment removed and door kept closed. Maintain a timed record of entry and a record of staff/patient contacts and submit to Infection Prevention and Control and Occupational Health as appropriate.

- **Droplet and Contact PPE as a minimum requirement:** *Gown; FFP3 mask or equiv; gloves; eye protection* to be worn by **all** persons entering the room where a patient is being isolated. This is advised from initial suspicion of a patient, through assessment until either confirmed or stepped down. Leave respiratory protection on until outside the room.

- **Equipment:** Keep non-disposable equipment to a minimum. Where required equipment cannot be left in the room (e.g. portable xray), it must be disinfected with Tristel on exit in the lobby area.

- **Cleaning:** decontaminate the room daily with Tristel, after any AGPs (ensure settle time completed prior to cleaning) and frequent touch points and the lobby at least twice daily. On discharge/transfer terminal clean with HPV or Double Tristel (clean once with Tristel – allow to dry and clean again with Tristel) and curtain change where applicable.

- **Waste and laundry management:** Waste must be disposed of as infectious waste (orange bags) swan neck seal the bag in the room and store in the infectious waste store.

  Likewise, laundry is managed as infectious and contained in alginate bags

  Restrict visitors: keep a list of all contacts

4. ACTIONS for managing the possible case:

- **Contact the duty/on-call microbiologist** if Avian Influenza is still possible after assessment and notify the IPCTeam.
- In addition to any other clinically appropriate therapy start oseltamivir treatment if not already done so (do not wait for results of avian influenza diagnostic tests). For guidance on dosage refer to the UKHSA guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza
- The dosage information provided for treatment of seasonal influenza is appropriate for initiating treatment of avian influenza cases.

- The **sample required** to diagnose Avian Influenza is a **viral swab in viral transport medium.**
- Label the tube with the patient details and mark with a “Danger of Infection” sticker.
- Samples **must not** be put in the pod system – they should be hand delivered to pathology in a rigid container.

Viral transport media kits that should be used – either red or green

The lab must be informed in advance of samples submitted from suspected or confirmed diagnosis of Avian Influenza, so that they can take the appropriate precautions to minimise risk to laboratory workers.

The microbiologist will notify UKHSA as appropriate.

5. Management of healthcare contacts of confirmed avian influenza

This table summarises recommendations for the management of contacts of presumptive positive or confirmed human cases of avian influenza who were exposed when the case was symptomatic or 1 day before symptom onset. This should only be initiated on the advice of a UKHSA-led incident management team, following receipt of presumptive positive or confirmed laboratory results in the case.

Category of contact	**Post-exposure chemoprophylaxis?**	**Follow-up**
*Household contact (more than 15 minutes, face to face contact) *UKHSA will contact and follow up	Yes	Active follow-up† for 10 days after last significant exposure
Healthcare workers and visitors to the hospital who have not worn recommended PPE during all exposures to the patient	Yes	Active follow-up for 10 days after last unprotected exposure
Healthcare workers who have worn recommended PPE during all exposures to the patient	No	Passive follow-up†† for 10 days after last exposure
Patient contacts (based on a risk assessment, related to factors such as duration more than 15 minutes, face to face in a closed setting)	Yes	Active follow-up for 10 days after last unprotected exposure

Advice to healthcare workers on exclusion from work will be determined by the IMT based on local situation. Advice on self-isolation will be based on risk assessment by the IMT.

In the event that any individual develops symptoms they will be assessed as a possible case according to criteria in section 1. They will require isolation as above until clinical assessment and investigation undertaken.