

CDC Influenza Division Key Points

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In this document:

- [Summary Key Messages](#) *Updated!*
- [FluView Activity Update](#) *Updated!*
- [Antiviral Drugs](#)
- [Antiviral Drug Supply](#)
- [Influenza and Parotitis This Season](#) *Updated!*
- [High Dose Influenza Vaccine in People 65 year and Older](#) *New!*
- [Vaccination](#)
- [Vaccine Match](#)
- [Influenza Vaccine Effectiveness: Early Estimates](#)
 - [Background on Vaccine Effectiveness](#)
- [Influenza-Associated Pediatric Deaths](#) *Updated!*

Summary Key Messages

- This week's [FluView](#) report indicates that flu activity is still elevated overall, but has begun to decrease and some severity indicators are declining or leveling off.
 - This week, 11 pediatric deaths were reported, bringing the total number of flu-associated pediatric deaths reported so far this season to 80. (Since 2004 when flu-associated pediatric deaths became a nationally notifiable condition, the number of deaths reported to CDC each season has ranged from 37 to 171.)
 - The proportion of deaths attributed to pneumonia and influenza (P&I) based on the 122 Cities Mortality Reporting System is still high, but decreased from 8.5% to 8.1%. (During recent previous flu seasons characterized as "moderately severe" with H3N2 viruses predominating, P&I has reached 10.4% [2003-2004] and 9.9% [2012-2013].)
 - The hospitalization rate for people 65 years and older is now 217.3 per 100,000 people, up slightly from 213.8 per 100,000 the prior week. The hospitalization rate for the ≥65 year old age group is always highest; this season's is the highest recorded since this type of record-keeping began in 2005. (During the 2012-2013 season—the last H3N2-predominant season—the hospitalization rate for week 5 was 145.6 per 100,000. The final hospitalization rate for that season was 183.2 per 100,000 people.)
- More hospitalizations and deaths are typical of H3N2 seasons, which tend to hit young children and older people harder. (CDC estimates that an average of 28,909 people died from flu during H3N2-predominant seasons, compared to 10,648 people during non-H3N2 predominant seasons.)
- Activity so far this season is most similar to the 2012-2013 season, the last season when H3N2 viruses predominated.

- Flu activity is likely to continue in parts of the country for several weeks, though some states have already experienced most of their flu season.
- About two-thirds of the H3N2 viruses circulating this season are different or "drifted" from the H3N2 vaccine virus.
- The predominance of drifted viruses is probably responsible for the reduced protection offered by this season's vaccine. (Early estimates indicate that getting a flu vaccine this season reduced a person's risk of having to go to the doctor because of flu by 23% among people of all ages.)
- The reduced protection offered by flu vaccine this season makes the appropriate use of influenza antiviral (or "anti-flu") medications more important than usual.
- Antiviral drugs are a second line of defense against influenza and can be used to treat flu illness. (See section "[Antiviral Drugs](#)" for more information.)
- CDC recommends that all hospitalized and high risk patients (either hospitalized or outpatient) with suspected influenza should be treated as soon as possible with one of three available influenza antiviral medications, without waiting for confirmatory influenza testing.
- While antiviral drugs work best when given early, therapeutic benefit has been observed even when treatment is initiated later.

Upcoming Noteworthy Dates

- The WHO consultative meeting on the composition of the Northern Hemisphere influenza vaccine for 2015-2016 will occur in Geneva, Switzerland February 23-26, 2015.
- The Vaccines and Related Biological Products Advisory Committee (VRBPAC) will meet in Washington, D.C. on March 4, 2015, to select the flu vaccine composition for the U.S. 2015-2016 season.
- The Advisory Committee on Immunization Practices will meet on February 25-26, 2015.
- The next Morbidity and Mortality Weekly Report Influenza Update will be published on March 5, 2015.
- An article on the effectiveness of high-dose influenza vaccine was published in [The Lancet](#) (see section [High Dose Influenza Vaccine in the Elderly](#) for more information).

FluView Activity Update

- According to this week's FluView report, influenza activity is still elevated, but is decreasing; some key indicators that measure severity are leveling off or decreasing also. Flu activity is likely to continue for several more weeks.

- The cumulative hospitalization rate for people 65 years and older is the highest of any age group but the rate of increase has slowed.
- Flu activity has been elevated for 12 consecutive weeks nationally. An average season lasts about 13 weeks. However, because this season started relatively early, it could last longer than average.
- Below is a summary of the key flu indicators for the week ending February 7, 2015:
 - For the week ending February 7, the proportion of people seeing their [health care provider](#) for influenza-like illness (ILI) decreased to 3.8%, but remains above the national baseline (2.0%) for the twelfth consecutive week. All 10 U.S. regions reported ILI activity at or above region-specific baseline levels. For the past 13 seasons ILI has remained at or above the national baseline for between one and 19 weeks each season, with an average of 13 weeks.
 - Puerto Rico and 15 states experienced high [ILI activity](#); a decrease from 26 states during the previous week. States reporting high ILI activity for the week ending February 7, 2015 include Arkansas, Colorado, Connecticut, Kansas, Louisiana, Mississippi, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, and West Virginia.
 - New York City and 15 states (Alabama, Arizona, California, Hawaii, Idaho, Massachusetts, Missouri, Nebraska, Nevada, New Mexico, Utah, Vermont, Virginia, Washington, and Wyoming) experienced moderate ILI activity. Eight states (Delaware, Georgia, Maine, Minnesota, New Hampshire, North Dakota, South Carolina, and South Dakota) experienced low ILI activity. Twelve states (Alaska, Florida, Illinois, Indiana, Iowa, Kentucky, Maryland, Michigan, Montana, Ohio, Oregon, and Wisconsin) experienced minimal ILI activity and the District of Columbia did not have sufficient data to calculate an activity level. ILI activity data indicate the amount of flu-like illness that is occurring in each state.
 - Widespread influenza activity was reported by Puerto Rico and 32 states. This decreased from 40 states in the previous week. Guam, the U.S. Virgin Islands and 16 states (Alabama, Colorado, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Michigan, Missouri, Nevada, South Dakota, Tennessee, Texas, Utah, and West Virginia) reported regional [geographic influenza](#) activity. Local flu activity was reported by the District of Columbia and two states (Alaska and Minnesota). Geographic spread data show how many areas within a state or territory are seeing flu activity.
 - A total of 12,065 laboratory-confirmed [influenza-associated hospitalizations](#) have been reported through the Influenza Hospitalization Surveillance Network (FluSurv-NET) since October 1, 2014. This translates to a cumulative overall rate of 44.1 hospitalizations per 100,000 population. Last week, the overall cumulative rate was 43.5 hospitalizations per 100,000 population. This is slightly higher than seen for the same week during the 2012-2013 season when the

overall hospitalization rate was 33.1 per 100,000 people. The number of new hospitalizations reported per week is decreasing.

- The hospitalization rate is high among people 65 and older, who account for more than 60% of all reported hospitalizations. The hospitalization rate in people 65 years and older is 217.3 per 100,000, which is the highest hospitalization rate recorded since data collection on laboratory-confirmed influenza-associated hospitalization in adults began during the 2005-2006 season. This is the highest rate of any age group. Last week, the hospitalization rate in people 65 years and older was 213.8 per 100,000. Previously, the highest recorded hospitalization rate was 183.2 per 100,000, which was the cumulative hospitalization rate for people 65 years and older for the 2012-13 season. (The 2012-2013 season was the last H3N2-predominant season.)
- The hospitalization rate for children 0-4 years is 40.4 per 100,000 population. During 2012-2013, the hospitalization rate for that age group for the same week was 45.7 hospitalizations per 100,000 population.
- Hospitalization data are collected from 13 states and represent approximately 9% of the total U.S. population. The number of hospitalizations reported does not reflect the actual total number of influenza-associated hospitalizations in the United States.
- The [proportion of deaths](#) attributed to pneumonia and influenza (P&I) based on the 122 Cities Mortality Reporting System decreased slightly to 8.1% this week, but remains high and above the epidemic threshold of 7.2%. Last week, P&I was 8.5%. (During 2012-2013, P&I peaked at 9.9%. This was the highest recorded P&I in nearly a decade, but was comparable to recorded percentages for past severe seasons, including the 2003-2004 season when P&I reached 10.4%.)
- Eleven [influenza-associated pediatric deaths](#) were reported to CDC during the week ending February 7.
 - Four deaths were associated with an influenza A (H3) virus and occurred during weeks 52, 3 and 4 (weeks ending December 27, 2014, January 24 and January 31, 2015). Five deaths were associated with an influenza A virus for which no subtyping was performed and occurred during weeks 53, 1, 2, and 3 (weeks ending January 3, January 10, January 17, and January 24, 2015). One death was associated with an influenza B virus and occurred during week 4. One death was associated with an influenza A and influenza B virus co-infection and occurred during week 5 (week ending February 7, 2015).
 - A total of 80 influenza-associated pediatric deaths have been reported for the 2014-2015 season at this time.

- Nationally, the percentage of [respiratory specimens](#) testing positive for influenza viruses in the United States during the week ending February 7 decreased from 17.5% to 14.9%. For the most recent three weeks, the regional percentage of respiratory specimens testing positive for influenza viruses ranged from 10.1% to 27.4%.
- [Influenza A \(H3N2\) viruses](#) have been most common in the United States this season. Few influenza B viruses have been detected and even fewer influenza A (H1N1)pdm09 viruses have been detected. During the week ending February 7, 2,768 (87.2%) of the 3,174 influenza-positive tests reported to CDC were influenza A viruses and 406 (12.8%) were influenza B viruses. Of the 1,064 influenza A viruses that were subtyped, 99.4 % were influenza A (H3) viruses and 0.6% were influenza A (H1N1)pdm09 viruses.
- CDC has [antigenically or genetically characterized](#) 809 influenza viruses, including 21 influenza A (H1N1)pdm09, 634 influenza A (H3N2) viruses and 154 influenza B viruses, collected in the United States since October 1, 2014.
 - All 21 influenza A (H1N1)pdm09 viruses tested were characterized as A/California/7/2009-like. This is the influenza A (H1N1) component of the 2014-2015 Northern Hemisphere quadrivalent and trivalent influenza vaccines.
 - 199 (31.4%) of the 634 influenza A (H3N2) viruses tested have been characterized as A/Texas/50/2012-like. This is the influenza A (H3N2) component of the 2014-2015 Northern Hemisphere quadrivalent and trivalent influenza vaccine.
 - The remaining 435 (68.6%) influenza A (H3N2) viruses tested were different from A/Texas/50/2012. The majority of these 435 influenza A (H3N2) viruses were antigenically similar to A/Switzerland/9715293/2013, the influenza A (H3N2) component of the 2015 Southern Hemisphere influenza vaccine.
 - 100 (93.4%) of the 107 B/Yamagata-lineage viruses were characterized as B/Massachusetts/2/2012-like, which is included as an influenza B component of the 2014-2015 Northern Hemisphere trivalent and quadrivalent influenza vaccines. Seven (6.6%) of the B/Yamagata-lineage viruses tested showed reduced titers to B/Massachusetts/2/2012
 - Forty-three (91.5%) of the 47 other influenza B viruses belonged to the B/Victoria lineage of viruses, and were characterized as B/Brisbane/60/2008-like. This is the recommended influenza B component of the 2014-2015 Northern Hemisphere quadrivalent influenza vaccine. Four (8.5%) of the B/Victoria-lineage viruses tested showed reduced titers to B/Brisbane/60/2008.

- Since October 1, 2014, CDC has tested 29 influenza A (H1N1)pdm09, 1,213 influenza A (H3N2), and 163 influenza B viruses for resistance to neuraminidase inhibitors (oseltamivir, zanamivir, and peramivir). While the vast majority of the viruses that have been tested are sensitive to oseltamivir, zanamivir, and peramivir, so far this season, one influenza A (H1N1)pdm09 virus showed resistance to oseltamivir and peramivir. (Because H1N1 viruses have been so rare this season, one virus accounts for 3.4% of the H1N1 viruses analyzed for antiviral resistance this season.)
 - Previously, the neuraminidase inhibitors oseltamivir and zanamivir were the only recommended influenza [antiviral drugs](#). On December 19, 2014, the [U.S. Food and Drug Administration approved Rapivab \(peramivir\)](#) to treat influenza infection in adults.
 - As in recent past seasons, high levels of resistance to the adamantanes (amantadine and rimantadine) continue to persist among influenza A (H1N1)pdm09 and influenza A (H3N2) viruses. Adamantanes are not effective against influenza B viruses.
- [FluView](#) is available – and past issues are [archived](#) – on the CDC website.

Note: Delays in reporting may mean that data changes over time. The most up to date data for all weeks during the 2014-2015 season can be found on the current [FluView](#).

Antiviral Drugs

Antiviral drugs can be used to treat flu illness and prevent serious flu complications.

- There are prescription drugs, called “influenza antiviral drugs” that can be used to treat the flu or to prevent infection with flu viruses.
- Treatment with antivirals works best when begun within 48 hours of getting sick, but can still be beneficial when given later in the course of illness.
- Treatment with flu antiviral drugs can make flu illness milder and shorter. Treatment with antivirals also can lessen serious flu complications that can result in hospitalization or death.
- Antiviral drugs become even more important when circulating flu viruses are different from the vaccine viruses, which can mean that the vaccine doesn't work as well in protecting against infection with those viruses.
- Antiviral drugs are effective across all age and risk groups.
- Studies show that antiviral drugs are under-prescribed for high risk people who get flu.

- One study showed that less than one-fifth (19%) of patients who were at high risk for flu complications and presented for care within two days of symptom onset (i.e., the period of time when antiviral treatment is most beneficial) received a prescription for antivirals, regardless of laboratory testing for influenza infection ([Havers, 2014](#)).
- The study demonstrates that clinicians are still more likely to prescribe antibiotics rather than antiviral medications to outpatients with flu, including to high-risk patients who would benefit from early empiric antiviral treatment.
- CDC has done some limited qualitative research into clinician knowledge, attitudes and practices (KAPs) related to antiviral drugs.
- The findings suggest that there are probably a number of factors involved that may act as barriers to prescribing, including low clinician awareness of CDC's antiviral guidance, a perception that these drugs may not work, that some physicians may require a positive flu test before they prescribe and that some physicians may not prescribe antivirals after the 2-day window during which benefit is optimal.
- These are all areas where CDC is working to improve clinician awareness.
- Treating high risk people or people who are very sick with flu with antiviral drugs is very important. It can mean the difference between having a milder illness instead of very serious illness that could result in a hospital stay.
- Health professionals should empirically give prompt treatment with antiviral medications to persons with suspected or confirmed flu who are hospitalized; have severe or progressive illness; or are at increased risk for influenza complications
- Three FDA-approved influenza antiviral agents are recommended for use in the United States during the 2014-2015 influenza season: oseltamivir, zanamivir and peramivir.
 - On December 19, 2014, the FDA approved peramivir (trade name Rapivab®), an intravenous antiviral drug, to treat uncomplicated influenza infection in adults age 18 and older. Read more at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm427755.htm>.
- A summary of antiviral recommendations for clinicians is available on the CDC website at <http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>.
- A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at <http://emergency.cdc.gov/HAN/han00375.asp>.
- Visit <http://www.cdc.gov/flu/professionals/antivirals/index.htm> for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community.

- CDC has provided an algorithm for medical offices to use to evaluate patients for possible influenza over the telephone:
<http://www.cdc.gov/flu/professionals/antivirals/office-evaluation.htm>.
- A CDC Expert commentary on antiviral recommendations for the 2014-2015 flu season is available through Medscape at <http://www.medscape.com/viewarticle/837284>.
- As always, people who are at high risk for influenza complications should see a health care professional promptly if they get flu symptoms, even if they have been vaccinated this season.
 - People at high risk for serious flu complications include: people with underlying chronic medical conditions such as asthma, diabetes, heart disease, or neurological conditions; pregnant women; those younger than 5 years or older than 65 years of age; or anyone with a weakened immune system. A full list of high risk factors is available at http://www.cdc.gov/flu/about/disease/high_risk.htm.
- More information about everyday preventive actions that help fight flu is available at <http://www.cdc.gov/flu/protect/habits.htm>.

Antiviral Drug Supply

- Influenza antiviral drugs are commercially manufactured and supplies of these drugs are dependent upon those commercial manufacturers.
- Manufacturers have stated they have sufficient product on hand to meet the projected high demand for the 2014-2015 flu season.
- CDC and influenza antiviral drug manufacturers are aware of some spot shortages being experienced, specifically for Tamiflu (oseltamivir).
- A statement on Tamiflu® supply from the manufacturer Genentech is available at: http://www.gene.com/media/statements/ps_121814.
- Rapivab® (peramivir)—an intravenous antiviral medication that was FDA-approved for use on December 19, 2014—is in ample supply and available for ordering during the 2014-2015 flu season.
- If needed, pharmacies should work with authorized distributors to obtain additional supplies of antivirals.
- Patients should consider calling a pharmacy in advance to see if they have drug on their shelf. If the pharmacy does not have product, they may be able to identify another pharmacy in the area that has antiviral drugs in stock.
- Patients who have been prescribed an influenza antiviral drug by their health care provider may need to call more than one pharmacy to fill their prescription.

- If the exact prescribed formulation cannot be located, patients should consult with their physician or pharmacist for additional options.
- It's also possible that in places with elevated influenza activity, locating influenza antiviral drugs may be more difficult.
- FDA and the American Society of Health-System Pharmacists (ASHP) provide updated information about specific drug shortages to guide patients and pharmacies:
 - FDA website: <http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>
 - ASHP website: <http://www.ashp.org/menu/DrugShortages>
- **CDC Antiviral Call Center:** For long-term care facilities experiencing difficulty accessing antiviral supplies, CDC will coordinate with commercial partners to facilitate the rapid resolution of large orders of antiviral drugs for these *institutional outbreak settings*.
 - As of Monday, January 12, the Division of Strategic National Stockpile (DSNS) is available from 7:00 a.m. to 7:00 p.m., EST Monday through Friday, to assist public health officials and health care facilities by coordinating with supply chain partners to rapidly redirect supply to the identified location.
 - Contact DSNS at dsns-Request@cdc.gov for assistance with facility specific unmet antiviral drug supply needs. For emergency needs overnight and on weekends, public health officials can contact the CDC Emergency Operations Center through established protocols.
- CDC and FDA will continue to work with manufacturers to assess influenza antiviral supply this season.

Flu and Parotitis This Season

- Since December 2014, multiple states have notified CDC of laboratory-confirmed influenza infections in persons who have swelling of their salivary glands (a condition called 'parotitis').
- Parotitis is not a common symptom of influenza infection, although cases of parotitis with influenza infection have been reported in the past.
- Parotitis is much more commonly seen following infection with other pathogens such as the mumps virus.
- Of the cases of influenza infection with parotitis that have been reported to CDC, the majority have occurred in young adults with influenza A (H3) infection, and have resulted in mild illness. No deaths have been reported.
- CDC is currently investigating the situation in order to understand the characteristics of patients and the occurrence of parotitis during the 2014-2015 influenza season.

- On January 10, 2015, CDC issued a request to state health departments to report laboratory-confirmed cases of influenza with parotitis.
- CDC will provide updates at www.cdc.gov/flu as more information becomes available.

Study: High Dose Influenza Vaccine in People 65 years and Older

New study of high-dose flu vaccine in people 65 years of age and older shows greater protection compared to standard-dose flu vaccine.

- On February 8, 2015, the Lancet published a CDC co-authored observational study that compared the protection provided by the high-dose flu vaccine to the standard-dose flu vaccine.
- The study analyzed data from more than 2 million Medicare beneficiaries 65 years and older who received the high-dose or standard-dose inactivated flu vaccine from community pharmacies during the 2012-13 flu season.
- Results showed that there were 22% fewer (95% confidence interval [CI]: 15% to 29%) probable flu cases in the high-dose group than in the standard-dose group.
- Likewise, the high-dose vaccine was 22% more effective (95% CI: 16% to 27%) for preventing flu-related hospital admissions.
- This marked the first time a significant reduction in flu-related hospitalizations was shown in people who had received the high dose vaccine versus the standard-dose flu vaccine.
- This study is available [online from the Lancet website](#).

Background

- The “high-dose” flu vaccine is a vaccine option designed specifically for people 65 years and older. This “high dose” flu vaccine (Fluzone® High-Dose) contains more antigen (the part of the vaccine that helps your body build up protection against flu viruses) than standard flu shots, and is intended to promote a better immune response in this age group.
- CDC and the Advisory Committee on Immunization Practices (ACIP) **have not expressed a preference** for the high dose vaccine over the standard-dose flu shot for people 65 years of age and older at this time.
- The higher dose flu vaccine may result in more of the mild side effects that can occur with standard-dose seasonal shots. Mild side effects can include pain, redness or swelling at the injection site, headache, muscle ache and fever.

Vaccination

- Protection from flu vaccination is reduced this season. Early estimates from CDC indicate that getting a flu vaccine this season decreased your risk of having to go to the doctor for flu by 23%. (See section "[Influenza Vaccine Effectiveness](#)" for more information.)
- CDC continues to recommend vaccination, even during seasons when the vaccine offers reduced protection.
 1. Flu vaccination can still reduce some flu illnesses, as well as prevent flu-related hospitalizations and deaths.
 - About one-third of circulating H3N2 viruses are well-matched with the vaccine virus.
 - Antibodies created through vaccination with one influenza virus can sometimes offer protection against drifted influenza viruses (this is called "cross-protection").
 2. There is some evidence to suggest that even if you do get sick, your symptoms will be milder if you got vaccinated.
 3. We cannot know which viruses will circulate over the season. The flu vaccine protects against three or four different influenza viruses, depending on which vaccine you get (trivalent or quadrivalent). It's possible there will be a second wave of flu activity this season and the flu vaccine should offer better protection against those viruses.
- Health care professionals should continue to vaccinate patients who have not yet received influenza vaccine this season.
- As of January 30, 2015, manufacturers reported having shipped [147.7 million doses of flu vaccine](#).
- The [HealthMap Vaccine Finder](#) can be used to locate flu vaccine.
- See the [Influenza Vaccine Effectiveness](#) section below for more information about measuring how well influenza vaccines work.

Vaccine Match

- Influenza viruses are constantly changing – they can change from one season to the next or they can even change within the course of the same season. This kind of gradual change is called "[antigenic drift](#)."
- In order for any vaccine to be delivered in the fall, the viruses in the vaccine must be chosen in February.

- When the vaccine viruses for the Northern Hemisphere 2014-2015 influenza season were selected, A/Texas/50/2012 was the most common circulating influenza H3N2 virus.
- Drifted H3N2 viruses were first detected during routine surveillance testing during late March 2014, after WHO recommendations for the vaccine composition for the Northern Hemisphere for the 2014-2015 season had been made in mid-February.
- At that time, just a very small number of these viruses had been found among the thousands of specimens that had been collected and tested.
- Influenza viruses are constantly changing and it is common to detect small numbers of antigenic variants that never circulate widely.
- Many antigenic variants emerge and spread in a limited way and then die out.
- Early on, there is no way to predict if a given antigenic variant will circulate widely.
- Over the summer, these viruses were detected in greater proportions and by the fall had become common among H3N2 viruses in the United States and abroad.
- By September 20, 2014, about half of H3N2 viruses isolated worldwide since May were drifted from the H3N2 vaccine virus component of the 2014-2015 Northern Hemisphere influenza vaccine.
- Since October 1, 2014, about two-thirds of H3N2 viruses collected in the United States that were characterized at CDC were drifted from the H3N2 vaccine virus component.
- When vaccine viruses and circulating viruses are not well-matched, how well the vaccine protects against circulating viruses can be reduced.

Influenza Vaccine Effectiveness: Early Estimates

- Since 2004-2005, CDC has been conducting vaccine effectiveness (VE) studies each season to measure how well the vaccine is protecting vaccinated people from having to go to the doctor because of flu.
- Study results from the U.S. Influenza Vaccine Effectiveness (Flu VE) Network have varied from 10% to 60% between [2004-2005 and 2013-2014](#). (See <http://www.cdc.gov/flu/professionals/vaccination/effectiveness-studies.htm> for adjusted vaccine effectiveness estimates for influenza seasons from 2005-2014.)
- Early estimates for the current season were published in the January 16, 2015 edition of the Morbidity and Mortality Weekly Report. The MMWR report is available on the CDC web site at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a4.htm?s_cid=mm6401a4_w.
- Data so far this season indicate that influenza vaccination reduced a vaccinated person's risk of having to go to the doctor for flu illness by about 23% across all ages.

- These early VE estimates are lower (about half) compared to some other seasons, likely reflecting the fact that about two-thirds of circulating H3N2 viruses this season have been antigenically or genetically different from the H3N2 vaccine virus.
- A meta-analysis of influenza vaccine effectiveness studies, published in 2012, found that VE against medically attended illness is around 60% during seasons when circulating viruses and vaccine viruses are well-matched.¹
- While offering reduced protection, this season's vaccine can still prevent some infections with currently circulating H3N2 viruses and also lessen related complications.
- The reduced protection offered by flu vaccine this season underscores the need for additional prevention and treatment efforts, including the appropriate use of influenza antiviral medications for treatment.

Background on Vaccine Effectiveness

- CDC conducts studies to measure the benefits of seasonal flu vaccination each flu season to help determine how well flu vaccines are working. These studies are called "vaccine effectiveness" studies or "VE" studies, for short.
- How well the flu vaccine works can vary by season, virus type/subtype, the vaccine, and age and other host factors of the people being vaccinated.
- Although antigenic match influences vaccine effectiveness, randomized studies of influenza vaccines have reported variable vaccine efficacy during seasons when antigenically drifted viruses predominated.
- VE is difficult to measure and study results can vary widely based on the study design, the outcome being measured and the population being studied.
- CDC has worked with researchers at universities and health systems since 2003-2004 to estimate VE in non-randomized, observational studies.
- The U.S. Flu VE Network consists of five study sites across the United States that measure the flu vaccine's effectiveness at preventing outpatient medical visits due to laboratory-confirmed influenza.
- CDC's observational studies at U.S. Flu VE Network sites measure outpatient visits for laboratory-confirmed influenza infection using a highly accurate lab test called rRT-PCR to verify the outcome.
- This is an observational study that compares the odds of vaccination among outpatients with acute respiratory illness and laboratory-confirmed influenza infection

¹ Osterholm MT, Kelley NS, Sommer A, Belongia EA. [Efficacy and effectiveness of influenza vaccines: a systematic review and meta-analysis](#). Lancet Infect Dis. 2012 Jan;12(1)36-44.

to the odds of vaccination among outpatients with ARI who test negative for influenza infection.

- The study uses a test-negative control design, which minimizes potential bias introduced by access to medical care and health care-seeking behavior.

Influenza-Associated Pediatric Deaths

- Eleven influenza-associated pediatric deaths were reported to CDC this week.
- A total of 80 influenza-associated deaths have been reported during the 2014-2015 season.
- Because of confidentiality issues, CDC does not discuss or give details on individual pediatric death cases.
- Additional information regarding pediatric deaths is available through [FluView Interactive](#).
- A pediatric death is a death in a person who is a U.S. resident and younger than 18 years old resulting from a clinically compatible illness with influenza that is confirmed by an appropriate laboratory test.
- During the 2013-2014 influenza season, a total of 109 influenza-associated pediatric deaths were reported to CDC.
- A review of the available pediatric death reports from the 2013-2014 season indicates that:
 - Of the 106 deaths in which the child's medical history was known, 54% occurred in children who had underlying medical conditions that placed them at high risk of developing serious flu-associated complications. However, 46% had no recognized underlying health problems.
 - About 80% of pediatric deaths occurred in unvaccinated children.
 - These proportions are largely consistent with what has been seen in the past.
- Since 2004, when flu-associated pediatric deaths became a nationally notifiable condition, the number of deaths reported to CDC each season has ranged from 37 (2011-2012 season) to 171 (2012-2013 season).
- During the 2009 H1N1 pandemic — April 15, 2009 to October 2, 2010 — 358 pediatric deaths were reported to CDC.
- These deaths are a somber reminder of the danger flu poses to children.
- Typically, most flu-related pediatric deaths occur in children who have not been vaccinated against flu.

- Among children 6 months and older, 80 to 85 percent of flu-related pediatric deaths occur in children who have not been vaccinated.
- The single best way to protect children against seasonal flu and its potential severe consequences is to have them receive a seasonal flu vaccine each year.
- Among children, vaccination is especially important for those younger than 5 years of age and those of any age with an underlying medical condition like asthma; [a neurologic, neuromuscular or neurodevelopmental disorder](#); or immune suppression. These children are at higher risk of serious complications if they get the flu.
- Yearly vaccination also is especially important for people who come in contact with high risk children in order to protect the child (or children) from the flu.
- Even previously healthy children can become seriously ill if they get the flu. Data on laboratory-confirmed influenza hospitalizations collected through FluSurv-Net during the 2013-2014 flu season indicated that 50.3% of children hospitalized with the flu had no identified underlying medical conditions.
- Flu-associated deaths in children younger than 18 years old should be reported through the Influenza-Associated Pediatric Mortality Surveillance System. The number of flu-associated deaths among children reported during the 2014-2015 flu season is updated each week and can be found at <http://www.cdc.gov/flu/weekly/>.
- Additional information about the pediatric deaths, including basic demographics, underlying conditions and week and place of death, for the 2014-2015 season as well as past influenza seasons, is available through the Influenza Associated Pediatric Mortality application of [FluView Interactive](#) at <http://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html>.