THE OFFICE

Preparing for H1N1's Uncertain Future

At press time, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices was expected to release recommendations for immunizing target populations against the novel 2009 H1N1 (pandemic) virus and for setting priorities in the likely event of a limited initial vaccine supply. Even with that guidance, though, I'm sure a lot of questions will remain about how this is really going to work.

BY DOUG CAMPOS-OUTCALT, M.D.

Rolling out the pandemic influenza vaccine to appropriate high-risk groups, while also keeping up with seasonal influenza immunizations, is going to be highly challenging and complex.

For starters, if the virus continues to be less virulent than expected for a pandemic, it may be difficult to convince even high-risk populations to get vaccinated. And should the virus mutate and become more virulent, how can we get people to stick to the priorities advised by ACIP, especially when the vaccine is likely to be administered in a variety of settings outside of physician offices? And, as additional vaccine supply becomes available, how can we quickly alter the public health message to match the epidemiology of the pandemic and encourage the right people to get their shots?

The only thing that seems clear at this point is that the future of the 2009 H1N1 pandemic virus is unpredictable. The fact that it has persisted through the summer is in itself unusual, and we should be prepared for infection rates to increase this fall when school is back in session.

So what can primary care physicians do right now to prepare their offices?

Make sure that you and your staff are vaccinated, as soon as vaccine is available, against both seasonal and pandemic influenza. The immunization of health care providers should be considered high priority, so set up a system for following up with your staff to make sure that everyone receives vaccine against both seasonal and pandemic flu. Remember that the pandemic vaccine will probably require two doses. Don't assume that everyone is immunized. Data show that up to one-half of health care providers are not immunized against the seasonal flu.

Chemoprevention strategies will change depending on the resistance pattern and availability of antiviral medications. Offices could stock oseltamivir (Tamiflu) or zanamivir (Relenza) to use as chemoprevention for staff until they are fully immunized, but that would be an expensive strategy and the added value over rigorous infection control practices is unknown.

It's probably wise to call your local pharmacy and ask if there is likely to be a problem getting the amount of antiviral medication you would need to treat yourself and your staff, should that become recommended.

Chemoprevention of health care staff might be recommended if the virus becomes more virulent as health care workers are waiting to finish a two-dose schedule of vaccine. Make a few calls now to see where supplies could be located should you need chemoprevention drugs quickly.

If patient volume has tapered during the summer months, use the time to do some in-service training on hand washing (wash-in, wash-out practices) for all staff with patient contact. Proper hand washing or sanitizing reduces the risk of infection and needs to be performed correctly and consistently. Teach your staff members by showing them what you want them to do. While the public health message on hand washing has been stressed, the reality is that many clinical settings have become somewhat lackadaisical about enforcing infection control practices.

Also take the time now to check on the supply of personal protective gear such as gloves, masks, and eye protection and review with your staff appropriate use of protective gear for all routine procedures that can lead to exposure to the virus. This includes collecting oropharyngeal and nasopharyngeal specimens for the laboratory.

Stock up on tissues and hand sanitizer and delegate the job of keeping those items in plentiful supply in the patient waiting area and exam rooms. Put up signs instructing patients to use respiratory hygiene in the clinic and instruct staff to politely point out to patients when they are not covering their coughs and sneezes.

Take some time now to do some strategic thinking about how you could maximize your office space to triage and separate potentially infectious patients should the pandemic hit your local region particularly hard. Consider rearranging the appointment schedule so that patients with infectious conditions are seen toward the end of the day.

Finally, delegate someone on your staff to check the local health department Web site regularly, as well as the site of the Centers for Disease Control and Prevention (www.cdc.gov/h1n1flu/). Check the guidance regularly on three key issues:

- ► Who should receive the vaccine in order of priority.
- ► Who should be treated with antivirals if ill (and what antivirals to use).
- ► Who should receive antivirals prophylactically (and what antivirals to use). ■

DR. CAMPOS-OUTCALT *is a liaison representative from the American Academy of Family Physicians to the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. He is also associate chair at the University of Arizona's department of family and community medicine in Phoenix.*

LETTERS

Not All Physicians Are MDs

I am offended by the headlines "MD Shortage Calls for Multipronged Approach" (July 2009, p. 60) and "Respiratory Therapy Bill Affects MD Supervision" (March 15, 2009, p. 39). Both headlines refer to physicians as MDs. What about DOs? Not all physicians are MDs, and FAMILY PRACTICE NEWS should recognize that fact.

Joshua Eskonen, D.O.
Martinsville, Ind.

Undue Influence?

The IOM's concerns about undue influence of industry on research and physicians' autonomy are valid, but it seems ironic that physicians have come under such intense scrutiny when our elected officials so often prove that they are without scruples when it comes to voting on issues which affect many lives and fortunes ("IOM Guidelines Aim to Curb Conflicts of Interest," May 15, 2009, p. 36).

It is quite clear that these pillars of rectitude are deeply affected by the last lobbyist who bought dinner, a golfing vacation, or a boondoggle trip for them, their families, and their friends. Perhaps the IOM might focus its efforts on the real problem, namely, the persons charged with making laws. I can't remember the last time a slice of pizza or a ballpoint pen made me do the wrong thing for a patient!

William H. Deschner, M.D.
Lake Arrowhead, Calif.

Propoxyphene Should Not Be Nixed

I strongly disagree with the conclusions presented on Darvon and Darvocet, "Analgesics With Propoxyphene May Head Off Market," Feb. 15, 2009, p. 1).

Propoxyphene (Darvon) and its products have been available since 1957 for use as a supplementary analgesic for mild to moderate pain. I have prescribed Darvocet-N 100 and other Darvon compounds for moderate pain resulting from rheumatoid arthritis, osteoarthritis, and other painful musculoskeletal and rheumatic disorders for many years with considerable success. Undesirable and adverse side effects are usually minimal in both incidence and severity.

Unfortunately, there have not been any randomized, controlled (blinded) studies of efficacy with Darvon and congeners. The available data are chiefly anecdotal, based on clinical observations. I would understand if the Food and Drug Administration wanted to reduce the use of opiates and opioids in chronic nonmalignant rheumatic disease. These potent products can be responsible for serious adverse events and deaths. I do not prescribe hydrocodone preparations, including Percocet, fentanyl, oxycodone (OxyContin), and other morphine products for noncancer chronic disorders.

One to three or four tablets of Darvocet-N 100 daily are usually well tolerated. As to the potential problem of addiction, in my considerable experience, I have not seen a true Darvon addict.

David H. Neustadt, M.D.
Louisville, Ky.

LETTERS

Letters in response to articles in FAMILY PRACTICE NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

Mail: Letters, FAMILY PRACTICE NEWS, 5635 Fishers Lane, Suite 6000, Rockville, MD 20852

Fax: 240-221-2541

E-mail: fpnews@elsevier.com