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Say Boo to the Flu

The sniffles have already begun, so it's vaccination time for one and all (staff included)! All staff pushing their facilities towards 100% compliance are eligible for the "roll up the sleeve to win" $75 prize. Let us know who wins the draw in your facility and GeriatRx will send a cheque their way.

Like last year, only one viral strain has been retained from the prior year's vaccine. The three components are: A/California (H1N1), A/Hong Kong and B/Brisbane. Most facilities have begun to vaccinate already. Residents (and staff) over 65 will get Fluad®, which contains an adjuvant to enhance the immune response. Other brands may make their way into the system, if supplies run short. Remember to have your GeriatRx adrenaline kit (or Epi-pen) on hand, in the unlikely event an anaphylactic reaction occurs.

If you haven't sent in your latest weights and creatinines, please do so. Remember, if an outbreak is suspected, call GeriatRx, **before you swab.** We want to get your Tamiflu® out early so you are ready in the event of a positive result. Good luck.

Is it Pneumonia?

Alberta Health Services has created an excellent checklist to assist with diagnosis and treatment of Nursing Home Acquired Pneumonia (NHAP). NHAP is the leading cause of death in LTC, with a mortality rate of 5 – 40%, so an efficient tool like the NHAP checklist (attached) can save lives.

Tachypnea (rapid breathing) is the best clinical indicator of NHAP. A respiration rate of 25 breaths per minute (bpm) or greater has a 90 – 95% positive correlation with NHAP. The presence of one other symptom: increased cough or sputum, fever, pleuritic chest pain, abnormal chest exam, breathing difficulty, tachycardia (heart rate greater than 125) or blood oxygen < 90% - if no COPD, confirms the diagnosis.

Fever presents a challenge in the elderly. A temperature at or above 37.8˚ C is normally considered febrile, but 1.1˚ C above baseline (usually on the low side in the elderly) is a better measure. A chest X-ray can also confirm the diagnosis, but treatment should not be delayed while waiting for one. The first dose of medication should be given within 4 to 8 hours of diagnosis.

Distinguishing between NHAP and other disorders can be a challenge. If the symptom set is similar, but respiratory rate is below 25 bpm, the illness is likely viral, with Influenza, parainfluenza or respiratory syncytial virus to blame. If fever is absent, an exacerbation of congestive heart failure or COPD is typically responsible. COPD and CHF increase susceptibility to pneumonia and can make diagnosis and treatment more challenging.

S. Pneumoniae is the main organism found in NHAP (as with community acquired) and is found in 55% of cases. Sputum samples are generally not reliable, as residents are not able to easily express samples from deep in their lungs. First line treatment regimens include Amoxil® 1 Gm TID for 7 days, Clavulin® 875 BID or Levaquin 750mg daily for 7 days. In residents with underlying lung disease, Zithromax®, Biaxin® or doxycycline may be added. If the resident cannot swallow, ceftriaxone (Rocephin®) i.m. may be effective. Transfer to hospital is indicated with: respiratory distress, low systolic BP, tachycardia, unstable blood oxygen (<92% on supplemental oxygen) or general clinical decline.

Search dobugsneeddrugsnhap for this tool and other helpful information on pneumonia.

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