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Grappling with the Flu

The third year should be a charm, because the last two have been anything but! Two years of unending outbreaks, called for a different strategy this season. To its credit MOHLTC has stepped up and given us a new weapon.

All residents 65 years of and over are to receive Fluzone® High-Dose. This advanced vaccine was available to the general population last year; however, it was not covered and quite expensive. It contains four times the amount of virus surface antigen as the standard (staff) version, so it provides a more robust antibody response in our seniors. On the bright side, the staff vaccine is quadrivalent, meaning it provides immunity against four influenza strains, vs. only three for the high powered resident version. Each vaccine is composed of inactive (dead) virus material, so it is not possible to contract the flu from the vaccine.

Hopefully the flu will take this year off, but let's give it a little help. Let's aim for 100% staff vaccination compliance. GeriatRx will chip in, as always, with our Flu Shot Challenge. All staff members who roll up their sleeves for the cause will be eligible to enter a draw for our $75 cash prize. Let us know who wins the draw in your facility and we will send a cheque their way.

Many facilities have completed their clinics already. A number have also sent creatinine data, to prep for what seems like the inevitable Tamiflu® blitz. We will be sending creatinine reports to the other homes shortly. Remember, Influenza can be lethal, but also increases risk of disability from stroke, pneumonia, muscle loss, hip fracture and CHF. Let's hope that vaccination plus preparation spares us from another rough year.

Inhaled Steroid Issues

In residents with advanced COPD a steroidal inhaler (e.g. Flovent®, Pulmicort® or a combination inhaler containing a steroid) is often added to optimize treatment. Although inhaled steroids provide limited respiratory benefit, they can reduce COPD exacerbations and potential trips to the hospital.

Unfortunately, this additional medication is not risk free. Sixteen randomized control trials showed a significant (20 – 25%) increase in fracture risk. A review of the Quebec health insurance database from 1990 through 2007, showed that inhaled steroid users developed diabetes 34% more often than non-users. Higher doses yielded more new diabetes cases and more severe disease.

Ironically, adding an inhaled steroid to bronchodilator therapy produced a 72% increase in pneumonias, according to a 2009 study in *Arch Intern Med*. The risk of developing tuberculosis is ten times as high!

According to the *GOLD 2017*, unless a patient has at least two exacerbations per year, or one that requires hospitalization, inhaled steroids should not be used. Standard therapy with one or two bronchodilators; a LABA (e.g. Serevent®), LAMA (e.g. Spiriva®) or a LAMA/LABA combination (Ultibro®, Inspiolto® or Anoro®) is the standard of care. Withdrawing the steroid from LAMA/LABA treatment is usually well tolerated, even in moderate to severe disease (*WISDOM* trial). Steroids are expensive and add risk. Let's consider stopping them in select cases.

Fewer LUs

Though there wasn't much fanfare, the limited use code requirements for quinolone antibiotics (e.g. Cipro®, Levaquin®, Avelox®) and the shingles antiviral, Famvir® were dropped a few months ago. Hurray!

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