



Dear Colleagues

Seasonal Influenza: Use of Antivirals 2021-22

1. While it is now relatively later in the flu season cycle, recent surveillance information provided by Public Health Scotland (PHS) indicates that there is growing evidence that there is sustained transmission of flu virus in the community. This may lead to a rise in the number of people displaying influenza-like illness in the coming weeks who are likely to be infected by influenza virus. There have also been laboratory confirmed influenza outbreaks in a few closed settings reported to PHS in recent weeks. Accordingly, antiviral medicines can now be prescribed for the prevention or treatment of influenza in the community where clinically indicated, and in particular, in those who are presenting with severe infection/symptoms where it is evident that their use may help reduce overall symptoms and mortality in hospitalised patients.

2. The clinical diagnosis of influenza has been made more challenging by the similarity of presentation of COVID-19, with the co-circulation of SARS-CoV-2. This is also impacting on the use of epidemiological surveillance to guide clinical diagnosis based on influenza prevalence. These factors favour increased use of virological testing to guide case management and outbreak response.

3. Antiviral medicines are not in any way a substitute for vaccination, which remains the most effective way of preventing illness from influenza.

Testing

4. Diagnosing COVID-19 is still the primary focus for testing. If an individual is displaying flu-like symptoms and has tested negative for COVID-19, please consider testing for influenza and other non-COVID pathogens to aid the monitoring of rising influenza cases. This also facilitates prompt treatment (where appropriate) as soon as symptoms start to present in individuals. Laboratories are also asked to refer positive flu samples to the West of Scotland Specialist Virology Centre (WoSSVC) for sequencing,

**From Chief Medical Officer
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Professor Sir Gregor Smith
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Addresses

For action

Chief Executives, NHS Boards
Medical Directors, NHS Boards
Directors of Public Health, NHS Boards
Directors of Nursing & Midwifery, NHS Boards
Directors of Pharmacy
General Practitioners
Practice Managers
Practice Nurses
Health Visitors
Immunisation Coordinators
CPHMs
Scottish Prison Service
Scottish Ambulance Service
Consultant Obstetricians
Occupational Health Leads

For information

Chairs, NHS Boards
Infectious Disease Consultants
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especially from cases which are severe, from suspected outbreaks, or vaccine failures.

5. Testing for COVID-19 and influenza also gives an opportunity to identify cases of individuals who may be presenting with both viruses at the same time (co-infection). Laboratories are also being asked to send all samples with co-infection with any other virus with influenza to WoSSVC.

6. UK Health Security Agency (UKHSA) guidance on antiviral treatment and antiviral resistance testing can be found at: [*Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/84122/guidance-on-use-of-antiviral-agents-for-the-treatment-and-prophylaxis-of-seasonal-influenza.pdf)

7. The advice contained within the existing UKHSA guidance and the PHS Addendum should be followed. The advice can be found here:

[PHS external guidance addendum: for UKHSA 'Guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza' - version 1 - PHS external guidance addendum: for UKHSA 'Guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza' - Publications - Public Health Scotland](#)

Seasonal influenza and COVID-19

8. The recommendations on the use of influenza antivirals are complicated by the co-circulation of SARS-CoV-2, as the similar presentations of fever and cough hampers the ability to be relatively confident of a diagnosis of influenza using clinical-epidemiological evidence alone. Co-infection of a patient with influenza and SARS-CoV-2 is possible and may be associated with increased mortality.

9. Increased virological testing should be used to strengthen diagnosis and support prompt initiation of influenza antivirals where appropriate, especially with the relative balance of COVID-19 cases being much higher compared to influenza cases in Scotland currently. As the situation develops in Scotland, and if influenza cases begin to rise relative to COVID-19, these recommendations may change.

10. Further recommendations on diagnostic testing for COVID-19 and influenza to guide the use of neuraminidase inhibitors (NAIs) is given in Table 1 (and can be found on p.7 of the UKHSA guidance). A summary of the UKHSA guidance prepared by PHS can be found at Annex B.

Of note:

- there are no data to indicate any adverse impact of initiating NAIs in patients with COVID-19;
- COVID-19 is not a contraindication to prescribing influenza antivirals where prompt initiation for suspected or confirmed influenza is required; and
- there are no data to support prescribing of influenza antivirals for the treatment of COVID-19.

Treatment of suspected or confirmed influenza

11. A summary algorithm for prescribing antiviral treatment for influenza from the UKHSA guidance is included in the attached Annex A. Details in chapter 2 of the UKHSA guidance are also provided for treatment of adults and children with uncomplicated/complicated influenza (including severely immunosuppressed); dosage in patients with renal dysfunction; treatment of oseltamivir-resistant influenza; management of influenza in critical care; and other licensed and unlicensed treatments.

12. Some influenza types are associated with a greater risk of developing oseltamivir resistance (in general, influenza A(H1N1)pdm09 is considered to have a higher risk compared to A(H3N2) and influenza B). The risk of resistance is greatest in people who are severely immunosuppressed.

13. Currently, the most prevalent strain circulating in Scotland is the H3N2 'Bangladesh-like' sub-type, based on a limited number of influenza strains available for sequencing by WoSSVC. Further information on the dominant circulating strain of influenza is reported in the [PHS weekly respiratory report](#).

Post exposure prophylaxis

14. Details in the UKHSA guidance are included on National Institute for Health and Care Excellence (NICE) guidance on antiviral use for prophylaxis of persons in at-risk groups following exposure to a person in the same household or residential setting with influenza-like illness when influenza is circulating in the community. Local Health Protection Teams are advised to carry out a risk assessment to determine whether to initiate post-exposure prophylaxis or not.

15. NICE guidance provides advice regarding prescription of antivirals, and this guidance should be read in conjunction with UKHSA guidance. The full NICE guidance on the use of antivirals can be accessed at:

<http://www.nice.org.uk/guidance/ta168> for treatment; and
<http://www.nice.org.uk/guidance/ta158> for prophylaxis.

Conclusion

16. It should be noted that PHS alert 2022(09) has indicated that influenza levels have increased and advise that the use of antivirals should be considered. When PHS indicate that influenza levels have reduced they will advise that the use of antivirals in the community should cease.

17. The relevant directions under NHS Circular PCA(M)(2010)22 remain in force (available at: [SE Health Department NHS, MEL \(scot.nhs.uk\)](#)) and this means clinicians are still able to prescribe antivirals for any individuals, including those not in recognised risk groups and children under one year of age.

18. However, it is expected that the use of antivirals for the general population would only be utilised if the clinician feels the individual is at serious risk of developing

complications or has developed these complications. Patients in the general population presenting with mild to moderate flu-like symptoms should be advised to take paracetamol and fluids and to seek further assistance should their condition deteriorate.

Prescriptions – Advice for Prescribers for Endorsing Prescriptions

19. Prescribers are reminded to endorse all prescriptions for antivirals with the reference “SLS”. Pharmacists can only dispense antivirals at NHS expense if this endorsement is made by the prescriber.

Access to Antivirals

20. The normal route for prescribing antiviral medication will be through GP10. Community Pharmacies are advised to review their stock levels of antivirals via their wholesalers in response to local demand. Directors of Pharmacy should make sufficient supplies of antivirals available to local Out of Hours services.

21. In the event of any national shortages of antiviral medicines further advice regarding the use of the national stockpile will be issued.

Yours sincerely,

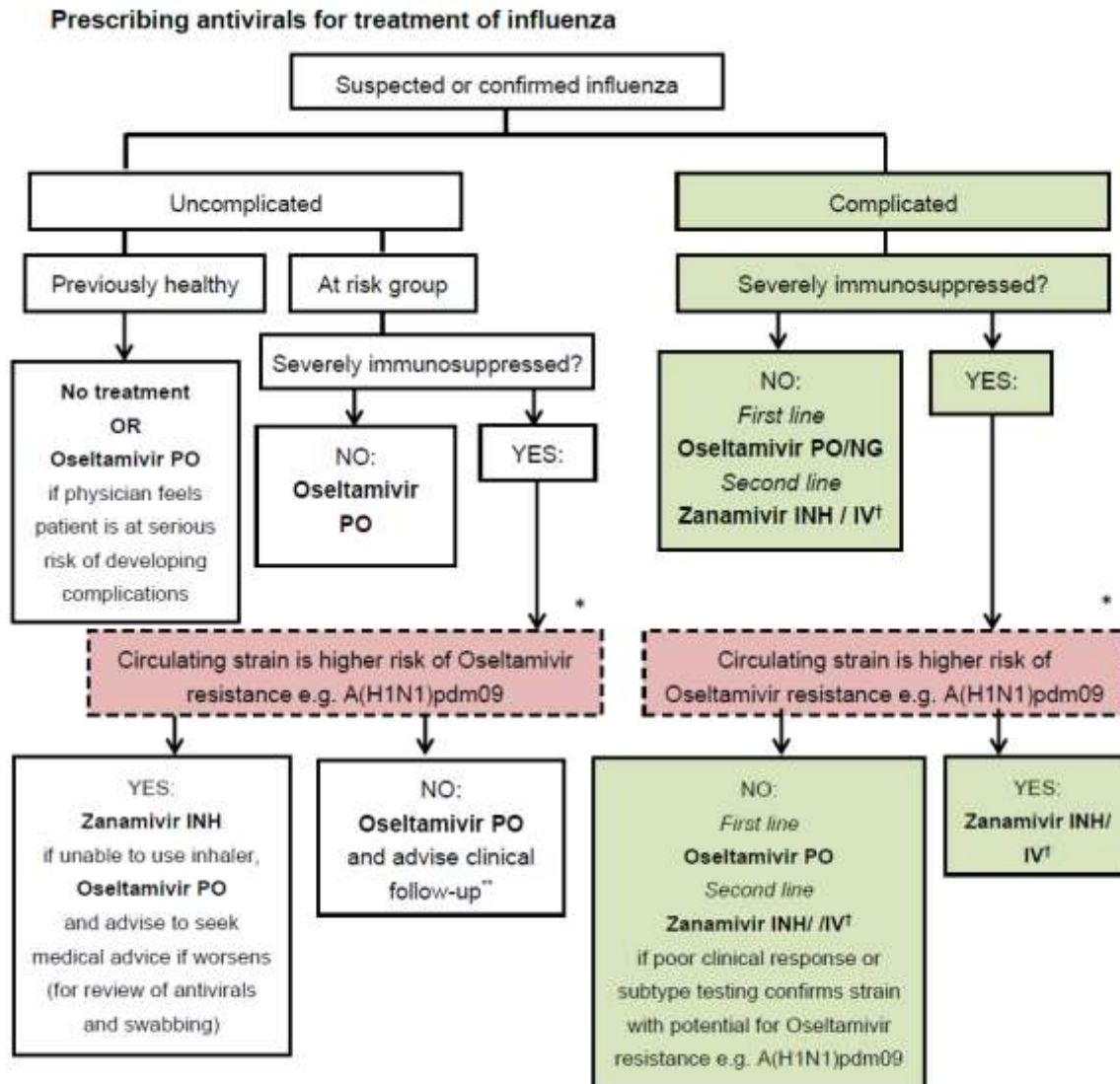
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Summary algorithm for prescribing antiviral treatment for influenza (UKHSA [Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza](#))



*As of week-ending 6th March 2022, the most prevalent strain circulating in Scotland is the H3N2 'Bangladesh-like' sub-type, based on sequencing provided by the West of Scotland Specialist Virology Centre, Glasgow (WoSSVC). Further information on the dominant circulating strain of influenza is reported in the [PHS weekly respiratory report](#).

ANNEX B

Table: Recommendations on the use of COVID-19 and influenza diagnostic tests when considering NAI initiation in at-risk patients (adapted from UKHSA [Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza](#))

	Indication in eligible at-risk patient group	CMO has notified GPs that flu is circulating	NAI initiation and testing for detection of COVID-19 (SARS-CoV-2) and/or influenza
1	Treatment: the person presents with complicated influenza-like illness, typically requiring hospitalisation.	Year round	If point of care tests (POCTs) for COVID-19 and influenza are unavailable, consider prompt NAI initiation prior to virological testing. Local or national surveillance may help inform this. Reassess indication for NAI once test results are available.
2a	Treatment: the person presents with an (uncomplicated) influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms as per licensed indications.	No CMO notification of influenza circulation	NAI use should usually be guided by influenza diagnostic tests. COVID-19 testing should be done if influenza is clinically suspected unless this has been specifically discounted. If the patient has onset during a virologically-confirmed influenza outbreak in a closed setting then this would be indication for empirical initiation of NAI.
2b	Treatment: the person presents with an (uncomplicated) influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms.	CMO has notified GPs that flu is circulating	COVID-19 testing should be done if influenza is clinically suspected unless this has been specifically discounted. Negative results for COVID-19 would usually be an indication for NAIs (in the absence of testing for other respiratory viruses) based on clinical-epidemiological probability. COVID-19 point of care testing with a lateral flow device may be used to inform antiviral use but is not a substitute for COVID-19 PCR testing in patients with relevant symptoms. If POCTs are unavailable, NAI should be started promptly without awaiting results of PCR testing if the clinician considers influenza to be highly probable (such as symptom onset following close contact with a confirmed influenza case). If available, testing for influenza should be undertaken alongside COVID-19 testing but is not required for NAI initiation.

	Indication in eligible at-risk patient group	CMO has notified GPs that flu is circulating	NAI initiation and testing for detection of COVID-19 (SARS-CoV-2) and/or influenza
3a	Post-exposure prophylaxis, where: (i) The person has been exposed to an influenza-like illness and is able to begin prophylaxis within the timescale specified in the marketing authorisations of the individual drugs (within 36 hours of contact with an index case for zanamivir and within 48 hours of contact with an index case for oseltamivir); and (ii) the person has not been effectively protected by vaccination.	No CMO notification of influenza circulation.	NAI use should usually be guided by influenza testing of the index case(s). COVID-19 testing of the index case(s) should be done if influenza is clinically suspected unless this has been specifically discounted.
3b	Post-exposure prophylaxis, where: (i) The person has been exposed to an influenza-like illness and is able to begin prophylaxis within the timescale specified in the marketing authorisations of the individual drugs (within 36 hours of contact with an index case for zanamivir and within 48 hours of contact with an index case for oseltamivir); and (ii) the person has not been effectively protected by vaccination.	CMO has notified GPs that flu is circulating.	COVID-19 testing of the index case should be done if influenza is clinically suspected in the index case(s) unless this has been specifically discounted. Negative results for COVID-19 would usually be an indication for NAIs (in the absence of testing for other respiratory viruses). COVID-19 point of care testing with a lateral flow device may be used to inform antiviral use but is not a substitute for COVID-19 PCR testing in patients with relevant symptoms. If available, testing for influenza in the index case(s) should be undertaken alongside COVID-19 testing but is not required for NAI initiation.

Notes for Table

Suspected or confirmed COVID-19 is not a contraindication to NAI initiation where suspected or confirmed influenza is part of the differential diagnosis.

An episode of COVID-19 may result in prolonged detection of SARS-CoV-2 by RT-PCR such that a positive COVID-19 PCR result in such a patient does not exclude that recent onset symptoms are due to influenza or another respiratory virus.

For empirically-initiated NAI treatment clinicians may continue with NAI where there is strong clinical suspicion despite a negative influenza result, guided by factors such as an epidemiological link to a case, high community incidence of influenza and/or absence of an alternative diagnosis.