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EPI-NEWS

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2024-25 INFLUENZA SEASON: Vaccine Recommendations & Disease Reporting

Introduction

The 2024-25 Influenza ("Flu") Season starts Sunday, September 29, 2024. On August 29, 2024, the Centers for Disease Control and Prevention (CDC) officially published the Advisory Committee for Immunization Practices (ACIP) recommendations on annual influenza vaccination.[1] There were two changes to the annual recommendations around influenza vaccination for the 2024-25 season: 1) the composition of 2024–25 U.S. seasonal influenza vaccines and 2) updated recommendations for vaccination of adult solid organ transplant recipients.[1,2] Highlights of the report are provided in this Epi-News issue; Northern Nevada Public Health encourages all providers to read the report for greater insight and information available at https://www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

ACIP Recommendations

Vaccine Components

All 2024-25 seasonal influenza vaccines available will be trivalent.[1,2] The U.S. seasonal influenza vaccine composition no longer includes influenza B/Yamagata, as there have been no confirmed detections of influenza B/Yamagata viruses in global influenza surveillance since March 2020.

U.S. egg-based influenza vaccines (i.e., vaccines other than culture–based inactivated [ccIIV3] and recombinant [RIV3]) will contain hemagglutinin (HA) derived from:[2]

- influenza A/Victoria/4897/2022 (H1N1)pdm09-like virus,
- influenza A/Thailand/8/2022 (H3N2)-like virus, and
- influenza B/Austria/1359417/2021 (Victoria lineage)-like virus.

U.S. ccIIV3 and RIV3 influenza vaccines will contain HA derived from:[2]

- influenza A/Wisconsin/67/2022 (H1N1)pdm09-like virus,
- influenza A/Massachusetts/18/2022 (H3N2)-like virus, and
- influenza B/Austria/1359417/2021 (Victoria lineage)-like virus.

Inactivated (IIV3), recombinant (RIV3), and one live attenuated influenza vaccine (FluMist, LAIV3) are expected to be available.[1,2]

Persons Recommended for Vaccination

Routine annual influenza vaccination continues to be recommended for **ALL** persons aged ≥6 months who do not have contraindications.[1,2] All persons should receive an age-appropriate influenza vaccine, with the exception that solid organ transplant recipients aged 18 through 64 years who are receiving immunosuppressive medication regimens may receive either high-dose inactivated influenza vaccine (HD-IIV3) or adjuvanted inactivated influenza vaccine (aIIV3) as acceptable options. Vaccination is especially important for individuals at an increased risk for severe illness and complications from influenza. If there is limited influenza vaccine, priority should be placed on high-risk groups and persons living with/caring for these individuals (e.g., healthcare providers, caretakers, household contacts). These high-risk groups include (in no particular order):[1,2]

- Children aged 6-59 months (<5 years)
- Adults ≥ 50 years
- Persons with chronic pulmonary, cardiovascular, renal, hepatic, neurologic, hematologic, or metabolic disorders
- Persons considered immunocompromised
- Persons who are or will be pregnant during the influenza season
- Children and adolescents (6 months -18 years) receiving medication with aspirin or salicylate

who might be at risk for Reye syndrome after influenza virus infection
- Residents of nursing homes or long-term care facilities
- American Indians or Alaskan Natives
- The extremely obese (BMI ≥ 40 in adults)

Prophylactic use of antiviral agents can be considered for preventing influenza among persons who cannot receive vaccine, particularly for those who are at higher risk for medical complications attributable to severe influenza.[1,2]

Consult manufacturer package inserts and CDC and ACIP guidance for information on dosage, administration, contraindications, and precautions for influenza vaccines in the full report here https://www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

Recommended Influenza Vaccines

- Adults aged ≥65 years should preferentially receive any higher dose or adjuvanted influenza vaccine: HD-IIV3, RIV3, or aIIV3. If none of these vaccines are available, then any other age-appropriate influenza vaccine should be used.[1,2]
- Persons with an egg-allergy should receive influenza vaccine (egg-based or non-egg based) that is otherwise appropriate for their age and health status. Additional safety measures are no longer recommended.[1,2]
- Immunocompromised persons should receive an age-appropriate IIV3 or RIV3 **but not an LAIV3**.[1,2]
- Solid organ transplant recipients aged 18 through 64 years who are receiving immunosuppressive medication regimens may receive either HD-IIV3 or aIIV3.[1,2]
- Persons who care for severely immunocompromised persons requiring a protected environment should not receive LAIV3. If administered, these individuals should avoid contact with such persons for 7 days after vaccination.[1,2] This does not apply to those caring or visiting the less severely immunocompromised.
- Pregnant persons should not receive LAIV3 but can when postpartum.[1,2]
- All other persons aged ≥6 months who do not have contraindications should receive a licensed and age-appropriate seasonal influenza vaccine.[1,2]
  - LAIV3 is *not recommended* for certain populations and is *not approved* for children aged <2 years or adults >49 years.
  - RIV3 is *not approved* for children aged <18 years.
  - HD-IIV3 and aIIV3 are *not approved* for persons aged <65 years.

Providers are reminded that all vaccines should be administered in settings in which personnel and equipment needed for rapid recognition and treatment of acute hypersensitivity reactions are available.[1,2] For more information on guidance for influenza vaccination in specific populations and situations see the full report here https://www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

Timing of Influenza Vaccination

For most people who require only one dose of vaccination (adults and children aged ≥9 years), vaccination should be administered during September or October, but continue to be offered as long as influenza viruses are circulating.[1,2] Vaccines given too early in the season (July and August) may result in suboptimal immunity as protection declines over time, particularly among older adults. Children requiring two doses (those 6 months-8 years of age and first season of vaccination) should receive the first dose as soon as the vaccine becomes available (including July and August), with the second dose given at least four weeks after the first dose (ideally by the end of October). Vaccination for adults (especially those 65 years old and older) and for pregnant persons in their first or second trimester should occur during September or October. Vaccination in July or August can be considered for children who require only one dose who have health care visits during these months, if there might not be another opportunity to vaccinate them or for pregnant persons in their third trimester to reduce the likelihood of influenza in the infant as they are too young to be vaccinated themselves.

For travelers who want to reduce their risk for influenza, influenza vaccination should be done preferably at least two weeks before departure.[1,2]

There is no recommendation for revaccination (booster dose) later in the season after initial vaccination, regardless of when the current season vaccine was received. [1,2]

For more information on timing of vaccination see the full recommendations at https://www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

Influenza Vaccine Coadministration
IIV3s and RIV3 can be administered simultaneously or sequentially with other inactivated vaccines or live vaccines.[1,2] Injectable vaccines that are coadministered should be administered at separate anatomic sites. LAIV3 can be administered simultaneously with other live or inactivated vaccines, however, if two live vaccines were not coadministered, wait at least four weeks after the administration of one live vaccine before giving another live vaccine. For more information on co-administration, see the full recommendations at https://www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.

Nevada Influenza Vaccination Estimates

The Healthy People 2030 target for vaccination coverage to reduce the burden of vaccine preventable diseases is 70%.[3] In the 2022-23 season, Nevada ranked third to last in the nation for influenza vaccinations among persons ≥6 months with a coverage of 39.9%.[4] The overall United States influenza vaccination coverage was 49.3% for the same season.[4] Influenza vaccination was estimated to have prevented 6 million illnesses, 2.9 million medical visits, 65,000 hospitalizations, and nearly 3,700 deaths during the 2022-23 season nationwide.[5] In order to improve vaccination coverage and to protect against seasonal influenza's potentially severe consequences in Washoe County, encourage influenza vaccination to patients, colleagues, family, and friends.

NNPH's Influenza Surveillance

NNPH's influenza surveillance consists of four major components: weekly reports of influenza-like illness by selected sentinel healthcare providers; the collection of a limited number of specimens by sentinel healthcare providers for sequencing; monitoring of influenza mortality through death certificates; and routine reporting and review of confirmed hospitalized cases of influenza. NNPH produces and disseminates reports each week during the influenza season. To receive these reports, email your name, organization, and email address to epicenter@nnph.org. Past influenza reports are located here: https://tinyurl.com/WCFluSurv. Future influenza reporting will be done along with other respiratory illnesses (e.g., RSV, COVID-19) and will be posted on a new Viral Respiratory Surveillance NNPH webpage in the coming weeks.

Influenza Reporting Requirements

Reporting requirements are listed in Chapter 441A of the Nevada Administrative Code (NAC). Influenza must be reported to your local health department if:

1. Hospitalized positive influenza case (regardless of reason for hospitalization).
2. Pediatric death with a positive flu test.
3. Influenza strain is known or suspected to pose a risk of a national or global pandemic as determined by the CDC or the World Health Organization.
4. Influenza strain is novel or untypable. Includes avian flu (e.g., H5N1, H7N9) and swine flu (e.g., H3N2v).
5. Suspect an influenza outbreak is occurring.

Reporting is not limited to physicians and laboratories. Schools, daycares, and correctional facilities are required to report influenza outbreaks. For a complete description of persons required to report, please see NAC 441A.225 - NAC 441A.260.

Reports of influenza using a Communicable Disease form located at http://tinyurl.com/WashoeDiseaseReporting can be faxed to 775-328-3764 or called into WCHD's Communicable Disease Line at 775-328-2447.

Reports of suspected influenza outbreaks can be reported securely online here:
https://washoecountynv.seamlessdocs.com/f/OutbreakReportingForm

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