Health Officers' Meeting On Asian Influenza

A MEETING of State and Territorial health officers, called by Surgeon General Leroy E. Burney to discuss Asian influenza, was held on August 27–28, 1957, in Bethesda, Md., and Washington, D. C.

Participating members divided into committees to discuss major aspects of the problem and to develop recommendations and guidelines. Certain of their recommendations are briefed in the following paragraphs.

Collection of Specimens

In the identification of an outbreak, throat washings and serum should be submitted from at least 12 clinical cases, accompanied by clinical abstract and data on how specimens were taken. The specimens should be gathered in the face of an explosive outbreak of upper respiratory illness within the first 3 days of illness and submitted through the State health authority.

Epidemic Surveillance

Epidemic investigation of influenza should include, but not be limited to, the symptoms, etiology (by laboratory confirmation of the representative sampling), complications, mortality, and the age groups involved.

States should plan to gather intelligence rapidly regarding the occurrence of pneumonia. Since bacterial identification by sputum specimens is as important as virus diagnosis, it is further recommended that sputum specimens for bacterial studies and antibiotic sensitivity be taken as soon as pneumonia is suspected. The pneumonia rate in the extremes of age should be used as a sensitive index to assess the severity of an epidemic.

National Reporting System

Each State should submit a weekly situation report to the Public Health Service for operational purposes. This information can be added to the usual weekly telegram to the National Office of Vital Statistics.

States should adopt a program of epidemic reporting by counties to the States and then on to the Public Health Service; a standard method of gathering and reporting information on outbreaks; and a method of sampling absentee rates in selected schools and industries. To facilitate analysis of data and to aid local, State, and national management of the epidemic, States are urged to participate in the proposed Public Health Service reporting programs.

The Committee on Epidemic Intelligence, a subcommittee of the State and Territorial Health Officers Association, working with the Communicable Disease Center, has developed a number of proposed forms for the collection of information. These are available from the Communicable Disease Center. Every State health officer should get these forms and see how they can be applied to his own State and local communities.

Technical Assistance

Assistance from the Public Health Service in support of virus laboratories and State health departments should include provision of diagnostic material; training of laboratory personnel; and loan of epidemiological personnel if requested by the State.

The Public Health Service could also assist the States by planning for regional conferences concerning epidemic progress if needed.

Community Planning

The health officer should estimate the possible effect of an epidemic on his community and determine current or potential resources to meet the problems which may be created, keeping in mind the following:

1. Prevention, an immunization program to stop the spread of infection.
2. Care of a patient and his family, including (*a*) medical and nursing care of the patient in the home, (*b*) hospitalization of complicated or other special cases, and (*c*) homemaking and feeding programs in households where the mother is a patient or all members of the household are ill at the same time.
3. Serious disruption of essential community services, including public safety, police and fire, public utilities, light, power, and telephones and transportation.

On the basis of these considerations, he should outline a plan for his community in cooperation with the medical society. The next step would be to bring into the campaign other community groups concerned or which have resources that might be useful. If a well-organized, effectively operating voluntary health council exists in the community, this probably would be the group. If not, a special ad hoc committee should be established, which may be the basis for a continuing local health council.

The health officer should confine his activities to those for which he is legally responsible. As to other essential community services, he should advise the head of his department of the possible effects on such services, so that the head of his government can take the steps that will assure a minimum disruption of community life. The health officer should stand ready to advise and act on the health aspects of community problems precipitated by the epidemic and referred to him by other existing governmental agencies.

This guideline also applies to the State health officer and State services and organizations.

Public Gatherings

There is no practical advantage in the closing of schools or the curtailment of public gatherings. However, in some instances there may be administrative reasons for closing schools due to illness of teachers, bus drivers, large absentee rates, and so forth.

Use of Local Resources

Each community is urged to make full use of local facilities and services, such as home nursing service, homemakers service, first aid and care of the sick, to supplement the care needed for ill persons in the home and to relieve the demand on hospitals.

Health officers should inform themselves of supplies and facilities available under civil defense in many communities which may be used in an epidemic if need be.

Home Care of Patients

Since the uncomplicated case of influenza runs less risk of cross-infections if cared for at home rather than in the hospital, maximum reliance should be placed upon home care of those ill, and hospitalization limited, as far as possible, to those cases of influenza with complications or to those with other diseases which might be aggravated by influenza.

Epidemiological Information

The Public Health Service should supply epidemiological information on the national situation and also on a State by State basis. States should be informed of the vaccine available and released, both as to totals and by allocations to the States. Press releases issued by the Public Health Service concerning this topic should be sent directly to the States at the same time they are sent to regional offices.

Vaccination Program

A system of interstate allocation of vaccine based on a voluntary agreement with the manufacturers is recommended.

The Surgeon General should recommend that physicians give priority to:

a) Those individuals whose services are necessary to maintain the health of the community.

b) Those individuals necessary to maintain other basic community services.

c) Persons with tuberculosis and others who in the opinion of the physician constitute a special medical risk.

The Committee on Influenza of the American Medical Association should be asked to as-

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Vaccination of Children

In children a high incidence of febrile but not dangerous reactions to the initial injection of vaccine may be expected. Most of the systemic reactions are related directly to the amount of vaccine given and occur within 24 hours of administration. Reactions are less frequent and milder following the second injection. Persons hypersensitive to egg should not receive the vaccine.

—*Excerpt from a statement by* EDWARD C. CURNEN, JR., M.D., *chairman, Committee on the Control of Infectious Diseases, American Academy of Pediatrics*

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sist in implementation of these recommendations.

Advisory Committees

Each level of government is encouraged to establish advisory committees, broadly representative in nature, to consider which groups are deemed essential to maintain necessary services.

Vaccination of Children

Doses recommended are as follows: for preschool children, 3 months to 5 years, 0.1 cc. intracutaneously or subcutaneously, repeated after an interval of 1 to 2 weeks; for children 5 to 12 years of age, 0.5 cc. subcutaneously, repeated after an interval of 1 to 2 weeks; for children 13 years of age and older, the dose for adults may be used.

Poliomyelitis and Influenza Vaccinations

The committee recommended that the poliomyelitis vaccination program and the influenza vaccination program be continued as independent and parallel programs.

National Commission on Influenza

The Surgeon General should appoint a national commission on influenza to identify research and other needs in relation to the effect of influenza on the civilian population of the Nation, and encourage, support, and coordinate, through existing channels, the planning and the execution of research and other activities designed to meet these needs.

This commission should consider not only the urgent problems in connection with the current epidemic, but also the long-range problems associated with the behavior of Asian and other strains of influenza during the next decade.

The commission should first study serious complications of influenza, particularly deaths, and the methods of their prevention.

The following participated in the plenary meetings:

Maj. Gen. S. B. Hays, Surgeon General of the Army; Dr. F. M. Davenport, director, Committee on Influenza, Armed Forces Epidemiological Board; Dr. M. R. Hilleman, chief, Department of Respiratory Diseases, Walter Reed Army Medical Center; and Dr. C. C. Dauer, medical adviser, National Office of Vital Statistics, Public Health Service.

Dr. K. E. Jensen, assistant chief, Virus and Rickettsia Section, Communicable Disease Center, Public Health Service; Dr. Roderick Murray, director, Division of Biologics Standards, Public Health Service; Dr. J. M. Andrews, director, National Institute of Allergy and Infectious Diseases, Public Health Service; and Frank Barton, secretary to the council on national defense, American Medical Association.

Dr. H. C. Lueth, chairman, Committee on Civil Defense, American Medical Association; Dr. D. A. Clark, chairman, Committee on Influenza, American Hospital Association; Dr. E. C. Curnen, chairman, Committee on Control of Infectious Diseases, American Academy of Pediatrics; and Col. D. M. Alderston, military assistant for professional services, Office of the Assistant Secretary of Defense (Health and Medical).

Col. Arthur Long, chief, Preventive Medicine Division, Office of the Surgeon General of the Army; Col. George Fair, chief, Preventive Medicine Division, Office of the Surgeon General of the Air Force; Capt. J. R. Seal, chief, Communicable Disease Branch, Bureau of Medicine and Surgery of the Navy; and Dr. W. H. Stewart, Assistant to the Surgeon General, Public Health Service, Dr. D. L. Finucane, director, Department of Public Health, District of Columbia.

The following were chairmen of the conference committees:

Dr. D. G. Gill, State health officer, Alabama State Department of Health; Dr. R. N. Barr, secretary and executive officer, Minnesota State Department of Health; Dr. F. D. Yoder, director of public health, Wyoming State Department of Public Health; and Dr. T. F. Sellers, director, Georgia Department of Public Health.

A limited edition of the proceedings has been published by the Public Health Service and distributed widely. The remaining copies may be obtained free of charge from Public Inquiries Branch, Office of the Surgeon General, Public Health Service, while the supply lasts.