



Flu Management Q&A

With Tracey Zivin-Tutela, MD



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If a person is treated for flu and then gets flu a second time, should they be treated again? Does it mean that they might give somebody else a resistant form of the flu if they are administered the same flu treatment?

We are not really sure. To get flu twice in the same season is unusual, but it can happen, especially in the flu seasons that run out until April or May. We have seen more flu in the summer this year than we have in most other years, which I hope is not an indication that we are going to a more year-round low level of flu than we normally have. We need annual data with baloxavir, oseltamivir, and all other agents plus we need to know our resistance for the current year because the virus changes every year.

I would not have an issue with giving any of the influenza treatments a second time if somebody had a second round of flu. The transmission of resistant virus is an issue when the person is shedding. If we can decrease viral shedding, then there is a reduced chance of passing the virus on to family, friends, and school and office mates.

I think it is important to decrease shedding by isolating at home. Do not go out in the public. Do not go into the office. If there is anything we have learned from COVID-19, it is if you are sick, please stay home. That is the takeaway that I try to emphasize as much as possible.

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Have resistance patterns been stable or have we seen fluctuations in resistance with antivirals?

Yes, resistance patterns have been stable. Prior to the last 3 years, we had a lot of circulating flu, so we had a large denominator, and we could comfortably say, "Okay, our resistance is x, y or z." However, circulating flu has been low the last few flu seasons so we have a small denominator and cannot be sure if the resistance is skewed or not. Since the flu season in the Southern Hemisphere typically predicts ours, I think we are going to have a busier flu season this year. I think we will have a better idea after this season.

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If you treat a person who is flu positive with an antiviral and then later they are exposed to the flu, would you treat with an antiviral for prophylactic measures?

If the person was treated and then was exposed again a few weeks or a few months later in the same season, I would treat with post-exposure prophylaxis if the person had risk factors for poor outcomes. This is because we do not know if it is flu A or flu B and, as I mentioned before, one flu is more common earlier in the season and the other flu is more common later in the season.



Are there any benefits to vaccinating a previously unvaccinated patient after they received treatment for influenza that same season?

If the US flu season is still going on—but not in March, April, or May—then getting the flu vaccine is beneficial because we do see patients who get flu A early mid-season, and then they get flu B later in the season.

In a typical season, flu A is earlier and flu B comes later. Therefore, if a patient tests positive for flu A and they are not vaccinated, I would wait until they have recovered and they feel better, and then I would have them get the vaccine shortly after. We usually recommend vaccination within 2 weeks as long as they are feeling better and not hospitalized, and that will help protect them for flu B for the rest of the season, or later in the season.



For patients who test positive for both COVID-19 and influenza, would you prefer an antiviral treatment for COVID-19 vs an antiviral for flu, or would you consider coprescribing both?

I suspect we will see a lot of flu and COVID-19 this year with the decrease of mitigation measures, and I would have no problem giving nirmatrelvir/ritonavir and flu treatment together as long as the patient has no contraindications for either. There is no contraindication to giving both together.

I think that the biggest concern would be potential nausea and GI upset. For the flu, oseltamivir has a 5-day treatment course and baloxavir has a 1-day course. For COVID-19, the treatment course with nirmatrelvir/ritonavir is also 5 days.



Is there a good way to avoid severe complications due to the flu besides yearly vaccinations? Are there any other kind of techniques or over-the-counter therapies that you would recommend?

While vaccination decreases the risk of complications and hospitalizations from the flu, data from the past few years has shown that mask and distance mitigation are protective for people who are at high-risk. I think everyone, especially people who are at higher risk for influenza, should take care of themselves by eating foods that boost the immune system and getting enough sleep as sleep is very important for the immune system. Stress is also a significant risk factor for becoming sick and can negatively impact your immune system. People who are at higher risk can also protect themselves by encouraging their family members and healthcare providers to get vaccinated.



Is there any benefit from taking over-the-counter supplements such as vitamin C, zinc, and vitamin D?

A recent metanalysis of 80 randomized controlled trials showed that supplements including zinc, vitamins C and D, and others may be modestly effective in preventing acute respiratory infections and improving their clinical course. However, the effect on severe respiratory infections is not clear. Once you have full-blown symptoms, supplements are not very helpful. I am not sure supplements are significantly better than getting rest, eating properly, exercising, and really making sure your family and people around you are vaccinated.



How long should a patient avoid dairy products after baloxavir administration?

Dairy should be avoided for 2 hours after baloxavir administration. This is to avoid reduced absorption of baloxavir due to chelation by the dairy products.



Should healthcare professionals consider bacterial infection in addition to a viral infection when evaluating patients with asthma or other significant lung disease?

Early on in disease, within the first few days of a flu infection, it is very unusual to have a coinfection, even in patients with asthma. If a person has prolonged clinical symptoms that sound like it may have been viral and it may now be bacterial, then yes, it would be reasonable to consider a bacterial infection. Also, studies have shown that the use of antimicrobials in hospitalized COVID-19 patients provides negligible benefits early in disease, with early bacterial coinfection reported in only 1.2% to 3.5% of patients with COVID-19.



How are flu rates usually calculated?

The calculation of influenza rates is very state dependent. For example, in California and in most states, flu is a reportable disease. The flu test results should be uploaded to a state Department of Health website and this information is used to gauge flu activity. Since states differ, I would highly recommend looking at your local recommendations and sign up for weekly emails for information on flu activity. It is important.