Influenza 1 (Prophylaxis)

Vaccination Prophylaxis in Pregnancy

Contraindications to vaccination

- Hypersensitivity to eggs or other components of influenza vaccine (ie, thimerosal preservative)
- Febrile illness (If moderate to severe febrile illness should wait until symptoms have abated)
- History of Guillain-Barre Syndrome within 6 weeks of previous flu vaccine

Do not vaccinate

- Vaccination with single dose trivalent inactivated influenza vaccine (TIV) of all pregnant women, regardless of trimester, during influenza season (October-March)
- Contraindicated to vaccinate with live, attenuated intranasal virus (FluMist)
- No preference for use of vaccine that does not contain thimerosal as a preservative
- Women who are breastfeeding can receive either TIV or live attenuated intranasal virus (FluMist)

Decision to use anti-viral chemoprophylaxis

Respiratory problems (e.g., Asthma, COPD)

Zanamivir (Relenza)
10 mg (2 inhalations) once daily for 10 days

Oseltamivir (Tamiflu)
75 mg capsule once daily for 10 days

Post-exposure Chemoprophylaxis for Unvaccinated Patients who are Pregnant or up to 2 weeks Postpartum

- Consider chemoprophylaxis in patients with close contact* with someone likely to have been infectious with influenza particularly if patient at high risk** for influenza complications
- Recommend prophylaxis for all women exposed during 3rd trimester, as well as those with comorbidities** exposed in the 2nd trimester
- Early treatment is an alternative to chemoprophylaxis for some pregnant and postpartum women (see Influenza Treatment algorithm)

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*Close contact*: Having cared for or lived with a person who has confirmed, probably, or suspected influenza, or having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of such a person, including having talked face-to-face with a person with suspected or confirmed influenza illness

**High Risk for Complications**: -BMI >40 -Comorbid medical condition: chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematologic (including sickle cell disease), metabolic (including diabetes), neurologic, neurodevelopmental disorders (including epilepsy and mental retardation) -Immunosuppression (including medication-induced or HIV) -Native Americans
Influenza Prophylaxis

   a. Pg. 20. Trivalent inactivated influenza vaccine is contraindicated and should not be administered to persons known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine unless the recipient has been desensitized.
   b. Pg 37. The American College of Obstetricians and Gynecologists and the American Academy of Family Physicians also have previously recommended routine vaccination of all pregnant women.
   c. Pg 41. In general, health-care providers should begin offering vaccination soon after vaccine becomes available and if possible by October. Vaccination efforts should continue throughout the season, because the duration of the influenza season varies and influenza might not appear in certain communities until February or March.
   d. Pg. 37. Live, attenuated influenza vaccine (LAIV) is not licensed for use in pregnant women, but postpartum women can receive LAIV or TIV.
   e. Pg 37. No preference is indicated for use of TIV that does not contain thimerosal as a preservative (see Vaccine Preservative [Thimerosal] in Multidose Vials of TIV) for any group recommended for vaccination, including pregnant and postpartum women.
   f. Pg. 37. Breastfeeding does not affect the immune response adversely and is not a contraindication for vaccination. Unless contraindicated because of other medical conditions, women who are breastfeeding can receive either TIV or LAIV.

   “The drug of choice for chemoprophylaxis of pregnant women…is less clear. Zanamivir may be the preferable antiviral for chemoprophylaxis of pregnant women because of its limited systemic absorption. However, respiratory complications that may be associated with zanamivir because of its inhaled route of administration need to be considered, especially in women at risk for respiratory problems. For these women, oseltamivir is a reasonable alternative.”


NOTIFICATION TO USERS

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur in pregnancy. They should not be interpreted as standard of care but instead represent guidelines for the management of these patients. Variation in practice should be taken into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities. The algorithms remain the intellectual property of the University Of North Carolina School Of Medicine at Chapel Hill. They cannot be reproduced in whole or part without the expressed permission of the school.

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