

A new influenza in a familiar setting

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Editor of EMERGENCIAS.

Since last April when the global warning was issued on what later became a new influenza pandemic, society, through its politicians and health managers, has prepared itself to deal with a hypothetical escalating demand for healthcare. This demand involves at least four major medical organizational structures: preventive medicine (for the introduction of appropriate prophylactic measures, both general hygiene and specific immunization), primary care (which probably handles most patient visits), emergency medical care (both pre-hospital and hospital), and specialized hospitalization (which will be provided in accordance with patient needs and the possibilities of each centre, in the form of beds in departments of internal medicine, pulmonology, infectious diseases or intensive). All of them together, under their corresponding administration guidelines, have been working to avoid being surprised (and overwhelmed) this coming winter. This editorial reflects on the role of emergency health care systems in this context, and on the three articles published in this issue which highlight three key points¹⁻³.

The *raison d'être* of triage manifests when there is a disproportion between healthcare demand and the resources available, and this is precisely what will characterize this pandemic. For years, triage has been one of the cornerstones of a modern comprehensive system of emergency healthcare. In their excellent article, Castro Delgado et al. review the adaptations to be carried out in this triage in response to the current situation¹. In addition to assigning the most suitable resource to each particular case, good triage should strive to avoid unjustified transfers involving emergency medicine resources, overcrowding with minor medical patients and the spread of the virus in these centres. The authors also offer proposals that in their experience could be useful if neces-

sary, such as the allocation of specific resources for outpatient care and the transfer of serious cases, or redirecting non-urgent cases who visit their ED to other healthcare facilities. To this end, a basic aspect is total health system backing for the triage system of classifying patients. For example, during the last week of July, the UK experienced an outbreak situation in which there were more than 50,000 new diagnoses of influenza in a single week, with a weekly rate that exceeded 400 cases per 100,000 inhabitants in places like London⁴. Despite this, normal ED activity was not significantly hampered during the outbreak (personal experience). Perhaps the factor that most contributed to this success was the massive media and telephone triage campaign which was launched to identify potentially treatable cases who were prescribed oseltamivir based on a computer program. In London alone this meant dispensing treatments from more than 5,000 strategically located points in the city to patients who did not visit an ED⁴. Or perhaps it was the clear and explicit guidelines from the administration to the population with mass messages displayed in public transport, the media and at the very doors of access to emergency services (Figure 1). In any case, I think we should take note of this experience so early and so close.

The second aspect, of crucial importance, will be that the system is able to detect those patients, estimated between 1% and 2%, who present severe disease expression and where their lives may be threatened. This is not a trivial issue. An overcrowded system working with a disease where 98% of the patients have a mild form, indistinguishable from seasonal influenza, is vulnerable to a high risk of errors.

And especially if one takes for granted that the more severe cases are solely to be found amongst the aged with previous cardiopulmonary disease,

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RECEIVED: 17-9-2009. **ACCEPTED:** 21-9-2009.

CONFLICT OF INTEREST: None

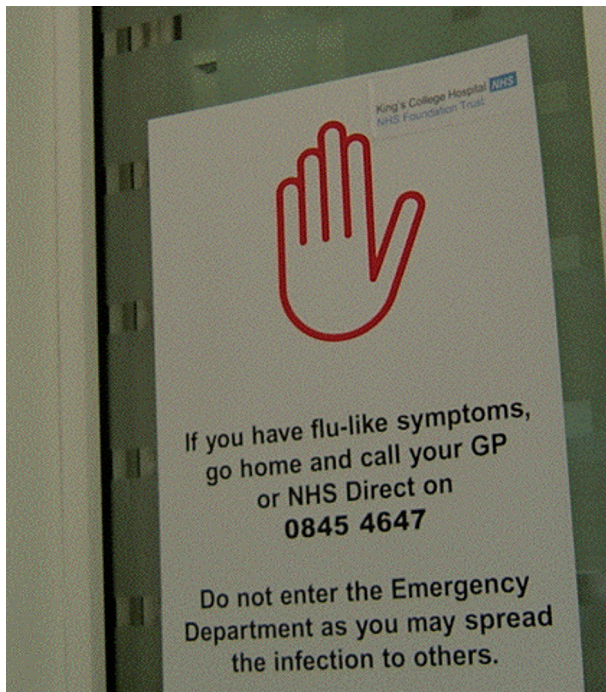


Figure 1. Notice at the entrance to the Emergency Department of a London hospital.

as we usually do with seasonal influenza. This is not exactly the case when dealing with new influenza A (H1N1), which so far has mostly affected patients aged less than 45 years. In this respect, the review by Boqué and Rello² is a great reminder that should be read by every physician who will be attending emergency cases this coming winter. We should pay particular attention to patients with certain debilitating diseases that are considered most at risk, and to pregnant and postpartum women, for the most severe cases have occurred in these patients.

The first medical colleagues to suffer the disease is another concern, as reflected in the work by Llorens et al³. And as expected, the professionals working in the ED appear to be at higher risk, at least in relation to other professionals working in the rest of the hospital. The fact that neither of the two ED professionals infected by influenza A

(H1N1) in the Llorens et al. study showed any evidence of community-acquired contagion further underlines the risk involved within the workplace. It is obvious that the structure of most Spanish EDs do not currently meet optimal conditions to prevent the spread of cases within the department itself. Thus, personal protection and case isolation measures attain particular significance in this situation. The proposal presented by the General University Hospital of Alicante is an excellent example. But in addition to this primary prevention, it is crucial to have a realistic contingency plan to cover for staff on sick leave in such a critical service as the ED.

It is obvious that this new influenza will be a test for the whole system of emergency care. However, the old stage has seen many epidemics which preceded the current pandemic and acted as an effective sentry in the first cases of influenza A (H1N1) diagnosed in Spain^{5,6}, and is familiar with aspects of triage, detection of severity and coverage of sick colleagues at the most inopportune of moments, as discussed here. Thus, regardless of the final score for performance of the whole of our society faced with this pandemic, it is reasonable to believe that our emergency services will live up to expectations.

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