Take 3 – Practical Practice Pointers© January 14, 2019 Edition

Influenza Chemoprophylaxis, Statin Use in DM, ADA DM Follow-up

A Question From a Colleague

1) Influenza Chemoprophylaxis

Question:
"Should I give tamiflu to someone exposed to the flu who got the flu shot?"

Answer:
The CDC provides very specific guidance regarding this:

Chemoprophylaxis

- **CDC does not recommend widespread or routine use of antiviral medications for chemoprophylaxis** except as one of multiple interventions to control institutional influenza outbreaks. **Routine use of post-exposure chemoprophylaxis is not recommended**; one reason for this is to avoid sub-therapeutic treatment dosing if infection is already established, although the possibility of whether antiviral resistant viruses could emerge is unknown.
- **Antiviral medications can be considered for chemoprophylaxis to prevent influenza in certain situations, such as the following examples:**
    - Prevention of influenza in people at high risk of influenza complications during the first two weeks following vaccination after exposure to a person with influenza.
    - Prevention for people at high risk for complications from influenza who cannot receive influenza vaccine due to a contraindication after exposure to a person with influenza.
    - Prevention for people with severe immune deficiencies or others who might not respond to influenza vaccination, such as people receiving immunosuppressive medications, after exposure to a person with influenza.
    - Patients receiving antiviral chemoprophylaxis should be encouraged to seek medical evaluation as soon as they develop a febrile respiratory illness that might indicate influenza.
- An emphasis on close monitoring and early initiation of antiviral treatment if fever and/or respiratory symptoms develop is an alternative to chemoprophylaxis after a suspected exposure for some people.
- To be effective as chemoprophylaxis, an antiviral medication must be taken each day for the duration of potential exposure to a person with influenza and continued for 7 days after the last known exposure. For people taking antiviral chemoprophylaxis after inactivated influenza vaccination, the recommended duration is until immunity after vaccination develops (antibody development after vaccination takes about two weeks in adults and can take longer in children depending on age and vaccination history).
- Antiviral chemoprophylaxis generally is not recommended if more than 48 hours have elapsed since the first exposure to a person with influenza.

- Patients receiving antiviral chemoprophylaxis should be encouraged to seek medical evaluation as soon as they develop a febrile respiratory illness that might indicate influenza.

Special Considerations for Institutional Settings
Use of antiviral chemoprophylaxis to control outbreaks **among high risk people in institutional settings**, such as long term care facilities, **is recommended.**

- An influenza outbreak is likely when at least two residents are ill within 72 hours, and at least one has laboratory confirmed influenza. When influenza viruses are circulating in the community, even one positive laboratory result in conjunction with other compatible illnesses on the unit indicates that an outbreak of influenza is likely occurring.
- When influenza is identified as a cause of a respiratory disease outbreak among nursing home residents, use of antiviral medications for chemoprophylaxis is recommended for all non-ill residents (regardless of whether they have received influenza vaccination). Antiviral chemoprophylaxis is meant for residents who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza, to prevent transmission.
- For unvaccinated health care personnel, antiviral chemoprophylaxis can be offered. For newly-vaccinated staff, antiviral chemoprophylaxis can be offered for up to two weeks (the time needed for antibody development) following influenza vaccination. Chemoprophylaxis can also be offered for all employees, regardless of their influenza vaccination status, if the outbreak is caused by a strain of influenza virus that is not well-matched by the vaccine. As noted above, an emphasis on close monitoring for signs and symptoms of influenza, and initiation of early antiviral treatment is an alternative to chemoprophylaxis for health care personnel.
- For institutional outbreak management, antiviral chemoprophylaxis should be administered for a minimum of two weeks, and continue for at least seven days after the last known case was identified.

My Comment:
The follow-up question from this colleague was, “What if they are demanding it – what could it hurt?”

This question seems a variation on the conversation regarding the prescribing of antibiotics for likely viral infections “on the chance that it’s bacterial or has become a bacterial superinfection” and gets into the realm of probability and risk/benefit, including the risk of medication side-effects or an allergic reaction. Under such circumstances, you’ll have to decide what the “right thing to do” is.

Unfortunately, the data suggest that the later in the day/shift you are, the greater likelihood will be that the prescription will be given. And from a “4th Aim” perspective, this is understandable. My encouragement is to at least pause, acknowledge the recommendations, and consciously make your clinical decision (rather than from a place of resignation). Both you and your patients deserve this.

Reference:
CDC Influenza Antiviral Medications: Summary for Clinicians 2018: Link

PS: From the Guidelines and our Pay for Value Work

2) Lipid Management/Statin use in persons with DM (SUPD)

The American Diabetes Association (ADA), in alignment with the American College of Cardiology/American Heart Association (ACC/AHA), has provided very specific guidance regarding the use of statins in persons with DM for 2019. These include:

- For patients of all ages with diabetes and atherosclerotic cardiovascular disease (ASCVD) or 10-year ASCVD risk >20%, high-intensity statin therapy should be added to lifestyle therapy. **A**
- For patients with diabetes aged <40 years with additional ASCVD risk factors, the patient and provider should consider using moderate-intensity statin in addition to lifestyle therapy. **C**
- For patients with diabetes aged 40–75 years **A** and >75 years **B** without ASCVD, use moderate-intensity statin in addition to lifestyle therapy.
- In patients with diabetes who have multiple ASCVD risk factors, it is reasonable to consider high-intensity statin therapy. **C**
- For patients who do not tolerate the intended intensity, the maximally tolerated statin dose should be used. **E**
- For patients with diabetes and ASCVD, if LDL cholesterol is ≥70 mg/dL on maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor). **A** Ezetimibe may be preferred due to lower cost.
- Obtain a lipid profile at initiation of statins or other lipid-lowering therapy, 4–12 weeks after initiation or a change in dose, and annually thereafter as it may help to monitor the response to therapy and inform medication adherence. **E**

My Comment:
This guideline provides compelling evidence for statin use for all patients with DM age ≥ 40, and in particular between the ages of 40 and 75. Since this is a measure on many insurer pay-for-performance programs, effective implementation of this recommendation becomes even more compelling. Next week's Take 3 will address a question from a reader regarding the use of statins for primary CVD prevention in those age > 75.

References:

- ADA Standards of Care 2019: Cardiovascular Disease and Risk Management. Diabetes Care. January 01 2019; volume 42 issue Supplement 1. Link
- Grundy S, et al. Guideline on the Management of Blood Cholesterol 2018. Journal of the American College of Cardiology. November 10, 2018. Article

PPS: From the ADA and a Request From my Chairman

3) Re-highlighting Specific ADA 2019 Standards

The January 7th Take 3 highlighted the 2019 ADA diabetes standards of care. There we some specific aspects of these standards that my departmental Chair thought important enough to re-highlight. These include:

Self-Management of Blood Glucose (SMBG) – Use of Glucometers:
- The evidence is insufficient regarding when to prescribe SMBG and how often testing is needed for insulin-treated patients who do not use intensive insulin

regimens, such as those with T2D using basal insulin with or without oral agents. However, for patients using basal insulin, assessing fasting glucose with SMBG to inform dose adjustments to achieve blood glucose targets results in lower A1C.
- In people with T2D not using insulin, routine glucose monitoring may be of limited additional clinical benefit.

Diabetic Kidney Disease:
- At least once a year, assess urinary albumin (e.g., **spot urinary albumin–to–creatinine ratio**) and estimated glomerular filtration rate in all patients with T2D, and in all patients with comorbid hypertension. **B**
- Continued monitoring of urinary albumin–to–creatinine ratio in patients with albuminuria treated with an ACE inhibitor or an ARB is reasonable to assess the response to treatment and progression of diabetic kidney disease. **E**

A1C Goals:
- A reasonable A1C goal for many nonpregnant adults is <7%. **A**
- Less stringent A1C goals (such as <8%) may be appropriate for certain patients, such as those with limited life expectancy, advanced complications, extensive comorbidities. **B**
- Older adults who are otherwise healthy with few coexisting chronic illnesses and intact cognitive function and functional status should have lower glycemic goals (such as A1C <7.5%, while those with multiple coexisting chronic illnesses, cognitive impairment, or functional dependence should have less stringent glycemic goals (such as A1C <8.0–8.5%). **C**
- Glycemic goals for some older adults might reasonably be relaxed as part of individualized care, but hyperglycemia leading to symptoms or risk of acute hyperglycemia complications should be avoided in all patients. **C**

Vitamin B12 Screening:
- **Periodic measurement of vitamin B12 levels** should be considered in metformin-treated patients, especially in those with anemia or peripheral neuropathy. **B**

My Comment:
Note that in our departmental scorecard, we are using A1C of < 9 as a scorecard metric. For most patients, in line with the recommendation above, this is not the ultimate A1C target. With regard to SMBG for patients not on insulin, the Choosing Wisely Campaign would say that in general this is low value care. Finally, note the recommendation for the use of the microalbumin-creatinine ratio to screen for nephropathy. This is considered the most accurate spot urine test.

Reference:
ADA Standards of Care 2019: Diabetes Care. January 01 2019; 42. Suppl.1: Table of Contents

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

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