

day to day practice. Roses should neither be nipped as buds nor soaked in blood.

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## Treatment Guidelines for Seasonal Influenza: Need for a Rethink

This year again, H1N1 influenza has arrived in several States of India, and public is likely to get panicky if the number of cases or mortality due to the virus rises. For appropriate disease management, H1N1 wards have been activated in various hospitals in Delhi and a document titled ‘National Treatment Guidelines for Treatment of Seasonal Influenza’ has been circulated among the hospitals by Directorate of Health Services, Delhi [1]. The new guidelines are not yet available on the website of Delhi Government which still displays the 2012 recommendations [2]. Salient features of the new guidelines are as follows:

H1N1 mostly presents like other seasonal influenza cases but may have severe manifestations in certain situations. Children mostly have influenza like illness (ILI), and are to be managed with home isolation and cough hygiene, along with immediate reporting to health facility if they present with warning signs (persistent high fever beyond 3-4 days, hemoptysis, breathing difficulty, chest pain, altered sensorium, worsening of associated comorbidity, inability to feed, vomiting, tachypnea, seizure in a young child). Mild or moderate complications include otitis media, bronchiolitis, croup, or reactive airway disease. Severe complications include diarrhea, dehydration, sepsis, exacerbation of chronic illness, or febrile seizure. Complications are more in ‘high-risk group’ that includes all children <5 y age, and those with chronic underlying pulmonary (e.g. asthma), cardiovascular (e.g. congenital heart disease), neurological (e.g. cerebral palsy), metabolic (e.g. diabetes), renal, hematologic (e.g.

thalassemia), or immunological (e.g. primary or secondary immunodeficiency) conditions. Severe cases include those with clinical and radiological signs of lower respiratory tract disease, shock and multi-organ failure, exacerbation of underlying illness, progressive disease with respiratory compromise, central nervous system complications, or invasive bacterial infection. Nasopharyngeal swabs for real-time polymerase-chain-reaction for influenza should be sent if the patient has severe, complicated, or progressive disease; cluster of cases; and in high risk cases with ILIs. Antivirals are indicated only in confirmed cases of H1N1. Need of hospitalization is determined on individual basis. There is no role of chemoprophylaxis for the contacts.

These guidelines appear evasive on certain issues. Previous guidelines [3] included categories A, B and C, but in present guidelines the categorization has been done away with. According to the present guidelines, nasopharyngeal sampling is advised for all under-five children with ILIs. In a typical Governmental set-up, under-five children comprise almost two-thirds of the total daily pediatric outpatient attendance in this season. Approximately half of these children have symptoms of ILIs which amounts to approximate case load of 150 per day in our hospital. As per the new guidelines, these children constitute the high-risk group, and need to be sampled, which is neither practical nor feasible. Lack of clear-cut categories may amount to delayed treatment of cases and continuation of the virus in circulation by ignoring the contacts for treatment. Children with suspected H1N1 infection need to be classified in four distinct categories *viz.* A: where no intervention is required; B: where we test, but do not treat; C: where we test and treat, but hospitalization is not required; and D: where testing is followed by in-hospital treatment. The new guidelines have also done away with chemoprophylaxis of con-

tacts, in keeping with the current international recommendations; however it does not specify whether contacts are to be sampled or not. WHO guidelines recommend giving presumptive treatment to high risk cases [4] but the Delhi Government guidelines forbid antiviral treatment, except in proven cases. In a suspected case, by the time results of PCR are available, the patient is either cured or it may be too late for the antivirals to have a meaningful effect on the course of the disease; though the guidelines recommend treatment whenever the positive H1N1 report is available, irrespective of the duration of illness. Finally, the role of vaccination is not clearly spelt out.

Government guidelines on management and control of a public health issue need to be a benchmark backed by bull-eye accuracy and evidence-base, since these are followed by a large group of care-providers, including those from private sector. With the expertise available, the guidelines could have been focused and practical. It is time for the Indian Academy of Pediatrics to lead and advise its members on the correct approach to management and diagnosis of H1N1 cases.

**Editor's Note:** After acceptance of this letter, Delhi Government has released another set of guidelines in the national newspapers which categorize patients as Category 1 (Low risk; no testing or treatment recommended), Category 2 (High risk; antiviral treatment without testing), and Category 3 (Severe disease; hospitalization, testing and treatment recommended).

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