# Take 3 – Practical Practice Pointers© September 2, 2019 Edition

## Flu Vaccine 2019, Wound Care Tips, Microaggression Part 2

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## From the CDC and the ACIP

## 1) Influenza Vaccination Recommendations 2019-2020

While most persons who contract influenza recover without serious complications or sequelae, it can result in serious illness, hospitalization, and death, particularly among older adults, very young children, pregnant women, and persons with certain chronic medical conditions. It is also is an important cause of missed work and school. Routine annual vaccination for all persons aged ≥6 months who do not have contraindications has been recommended by CDC and CDC's Advisory Committee on Immunization Practices (ACIP) since 2010.

This report updates the 2018–19 ACIP recommendations regarding the use of seasonal influenza vaccines and provides recommendations and guidance for vaccine providers regarding the use of influenza vaccines for the 2019–20 season.

**Primary Changes and Updates in the Recommendations:**
Routine annual influenza vaccination of all persons aged ≥6 months who do not have contraindications continues to be recommended. No preferential recommendation is made for one influenza vaccine product over another for persons for whom more than one licensed, recommended, and appropriate product is available.

The 2019–20 trivalent influenza vaccines will contain hemagglutinin (HA) derived from 2 2 influenza A strains and 1 B strain. Quadrivalent vaccines will contain HA derived from these three viruses and from an additional influenza B strain. This composition includes updates in the influenza A(H1N1)pdm09 and influenza A(H3N2) components.

**Formulations:** For the 2019–2020 season, ACIP expects inactivated influenza vaccines (IIVs), recombinant influenza vaccine (RIV), and live attenuated influenza vaccine (LAIV) to be available. Standard-dose, unadjuvanted, inactivated influenza vaccines will be available in quadrivalent formulations (IIV4s). High-dose (HD-IIV3) and adjuvanted (aIIV3) inactivated influenza vaccines will be available in trivalent formulations. Recombinant (RIV4) and live attenuated influenza vaccine (LAIV4; intranasal vaccine) will be available in quadrivalent formulations,

**Timing of the Vaccination:** Balancing considerations regarding the unpredictability of timing of onset of the influenza season and concerns that vaccine-induced immunity might wane over the course of a season, it is recommended that vaccination should be offered by the end of October.

**Populations at Higher Risk for Complications Attributable to Severe Influenza:**
Vaccination is particularly important for persons who are at increased risk for severe illness and complications from influenza. When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to persons at higher risk for medical complications attributable to severe influenza who do not have contraindications. These persons include (no hierarchy is implied by order of listing):

- All children aged 6 through 59 months and adults aged ≥50 years;
- Adults and children who have chronic pulmonary (including asthma), cardiovascular (excluding isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus);
- Persons who are immunocompromised due to any cause;
- Women who are or will be pregnant during the influenza season;
- Residents of nursing homes and other long-term care facilities;
- Persons who are extremely obese (body mass index ≥40 for adults).

For persons aged ≥65 years, any age-appropriate IIV formulation (standard or high dose, trivalent or quadrivalent, unadjuvanted or adjuvanted) or RIV4 is acceptable.

**My Comment:**
"Flu Season" is coming around again soon! According to the CDC, the overall estimated effectiveness of 2018-19 seasonal influenza vaccine for preventing medically attended, laboratory-confirmed influenza virus infection was 47%. While past performance does not predict future results, it sure helps motivate me.

**Reference:**
Grohskopf, L et al. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the ACIP - US, 2019–20. *Morbidity and Mortality Weekly Report (MMWR) Recommendations and Reports* / August 23, 2019 / 68(3);1–21. Link

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## From the Literature and Practice Experience

## 2) Wound Care Pointers: Wound Infection, Cellulitis, and Abx. Use

**Wound Infections:** All wounds are colonized with microbes; however, not all wounds are infected. Antibiotics do not promote healing in a wound that is absent of systemic signs of infection, nor do they effectively prevent chronic wounds from becoming infected. Infected wounds warranting antibiotics are those that exhibit purulence, induration, cellulitis, gangrene, osteomyelitis and systemic symptoms. In the absence of infection, bacterial colonization (or biofilm, bioburden) can negatively affect wound healing; but systemic antibiotics are a less effective and high-risk intervention. Foundational to wound healing are high-quality debridement, cleansing, and interventions to address underlying barriers to healing, such as venous or arterial insufficiency, diabetes, and smoking.

**Cellulitis:** Misdiagnosed cellulitis is estimated to cost between 195 – 515 million dollars annually in avoidable health care spending, with unnecessary antibiotics and hospitalization projected to cause 1,000 to 5,000 Clostridium difficile infections annually. The **CELLULITIS** acronym can be used to diagnosis cellulitis: **C**ellulitis history, **E**dema, **L**ocal warmth, **L**ack of alternate diagnosis, **U**nilateral, **L**eukocytosis, **I**nduration, **T**enderness, **I**nflammation, and **S**ystemic signs. Mimics of cellulitis include venous stasis dermatitis, lymphedema, contact dermatitis, gout, herpes zoster, acute lipodermatosclerosis, noninfectious phlebitis, insect bite hypersensitivity, Sweet's syndrome, and drug reaction. It is Important to note is that bilateral cellulitis is exceedingly rare. If bilateral extremity swelling is present, non-infectious etiologies should first be considered.

**Systemic Antibiotic Use:** In general, systemic antibiotics are overused in the context of wound care (see above). When systemic antibiotics are indicated, it is important to minimize associated risks - through appropriate indication, choice of agent, and duration of treatment, as well as use of probiotics and dietary modification. Risks of inappropriate or excessive use of systemic antibiotics include: antimicrobial-resistance pressure, *C difficile* -associated diarrhea and colitis; allergic reactions; drug-specific toxicities, including cardiac, hepatic, renal, and hematopoietic; and drug interactions. Multiple-species probiotics are effective toward avoidance of perturbations of patient's microbiome, particularly the prevention of *Clostridium difficile* diarrhea/colitis. Dietary modification toward avoidance of (or recovery from) intestinal dysbiosis includes: adequate consumption of protein and soluble fiber, avoidance of added sugar and excessive gluten and unsaturated fats.

**My Comment:**
Wound care is something that I know I can do a better job with, and therefore reached out to Ben Davis, MD, who is a Carilion Family Physician who specializes in wound care and is board certified by the American Board of Wound Management, to provide some Pointers based on what he commonly sees. Thanks as well to Justine Miller, M4, VTCSOM and Jana Manning, PA student, Radford-Carilion Health Sciences, for their assistance with these Pointers.

**References:**


- Ange D, et al. Wound infection in clinical practice. International Consensus Update. Wounds International 2016. 2016 Nov 11. Article
- Neill, et al. "CELLULITIS: A mnemonic to increase accuracy of cellulitis diagnosis." *Dermatology Online Journal* 2019, 25(1). Abstract


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## From the Literature and Consciousness Raising

## 3) Microaggressions in Health Care – Part 2: Responding

As covered in the August 26 Take 3, a microaggression is a "subtle snub, slight, and/or insult directed towards minorities, as well as to women and other historically stigmatized groups, that implicitly communicates or at least engenders hostility." This definition extends beyond verbal abuse to include general disrespect, devaluation, and the exclusion of recipients. Last week's Pointer defined the problem and presently understood types of microaggressions. This Pointer examines an approach to responding to a real and/or perceived microaggression.

When people encounter microaggressions, their first reaction is often to question whether the microaggression occurred and if they heard it correctly. In addition, it may not always be clear whether the slight was intended. Ambiguity leaves recipients of microaggressions posing themselves a series of questions such as: Did this person intend to insult me? Should I respond? How should I respond? What would happen if I say something? Is it worth the trouble? Am I making a big deal about nothing?

Additionally, recipients of microaggressions may want to consider their personal or psychological safety, the other person's willingness to have further conversation, and whether they will regret remaining silent.

Three main frameworks have been proposed for how to structure a response to microaggressions by either recipients or bystanders.

The "Observe, Think, Feel, Desire" approach begins with stating what was observed and proceeds through a discussion of how the comment was interpreted, how it made the recipient feel, and what the desired outcome might be. One example might be, "When you said [microaggression], it made me think that you [negative opinion]. I feel concerned about this because [reason], and I would like us to discuss this further so we can come to an understanding."

The second framework is ACTION, which follows these steps:

- **A**sk clarifying questions.
- **C**ome from curiosity, not judgment.
- **T**ell what you observed in a factual manner.
- **I**mpact exploration—discuss what the impact of the statement was.
- **O**wn your own thoughts and feelings around the situation.
- **N**ext steps.

An example of using the ACTION framework would be to start by stating, "I am not sure that I understood what you meant when you said [microaggressive comment]. I want to better understand; can you explain that to me?" The recipient can then follow up with their observation of the facts of what happened, followed by a statement such as, "When I hear comments like that, it makes me feel like you think I am only here because I am a minority, not because I can do the work." The discussion can then close with actions items for follow-up.

The third framework, and perhaps the simplest, is XYZ. This takes the form of, "I feel X when you say Y because Z." The primary similarity among these frameworks is the focus on what was observed (behaviors) and the recipient's resulting thoughts or feelings (use of "I" statements) to decrease the potential for defensiveness and encourage dialogue.

**My Comment:**
Remember, it all starts with awareness, both of yourself and your practice culture. There is no perfect framework, but any of these 3 can be used by those who are or may have been the recipients of microaggressions as well as those who are witnesses. This strategy is likely to have a more constructive outcome than responding with the more common reaction of anger and accusation.

**Reference:**
Torres M, et al. Recognizing and Reacting to Microaggressions in Medicine and Surgery. JAMA Surg. Published online July 10, 2019. Article

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

*Mark*

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