



## During the second wave of COVID-19, don't forget about influenza: a call to action

F Atallah,<sup>a</sup>  H Minkoff<sup>a,b</sup>

<sup>a</sup> Department of Obstetrics and Gynecology, Maimonides Medical Center, Brooklyn, NY, USA <sup>b</sup> Department of Obstetrics and Gynecology, SUNY Downstate Medical Center, Brooklyn, NY, USA

Correspondence: F Atallah, Department of Obstetrics and Gynecology, Maimonides Medical Center, 967 48th Street, Brooklyn, NY 11219, USA. Email: fatallah@maimonidesmed.org

Accepted 24 September 2020. Published Online 19 October 2020.

Please cite this paper as: Atallah F, Minkoff H. During the second wave of COVID-19, don't forget about influenza: a call to action. BJOG 2021;128:12–13.

Having lived through the havoc of COVID-19 in a hospital situated in one of the hardest hit zip codes in the USA, the thought that another wave could loom in the fall is bracing. Further, we are acutely aware of the herculean effort it took to reorganise the service to accommodate the needs of women infected with this new pathogen.<sup>1</sup> Many institutions, including ours, modified the frequency of prenatal visits, among other measures, to minimise in-person contacts, in an effort to reduce the likelihood of viral spread. However, it is those changes, along with our prior experience of treating women unimmunised against influenza that leads to our concern that a singular focus on COVID-19 could leave pregnant women at risk from a more familiar threat.

While COVID-19 is a threat to the health of individuals and society, its effect on pregnancy continues to be elucidated.<sup>2</sup> However, the toll of influenza in pregnancy is more clearly documented and is more severe.<sup>3</sup> In our institution, more pregnant patients with influenza during the last influenza season needed ICU care than did COVID-19 patients during the recent surge in New York. Admittedly, the higher admission rate to the ICU may be misleading. It is certainly possible that criteria for admission to ICUs may have been influenced by the pregnancy status. But even given that possibility, the fact that influenza ICU admission and mortality rates may be greater than COVID-19 raises grave concerns going forward. As opposed to COVID-19, putting aside the more rigorous application of social distancing, there are clearly missed opportunities to prevent some of the morbid events caused by influenza.

In the first instance, co-infection with COVID-19 and influenza has been reported to be as high as 11.8%.<sup>4</sup> Co-infection events will make diagnosis of either entity more difficult and could potentially increase morbidity. Thus, both because of the risks of co-infection and the known risks of influenza in

pregnancy, providers cannot afford to take their 'eye off the ball' and become less vigilant about vaccinating patients, even if some of the new protocols for fewer visits or telehealth visits remain in place. With fewer visits, comes the risk of missing both the vaccination 'window' and the opportunity to incorporate vaccination as an essential component of health maintenance and prenatal care. In addition, obstetricians' performance as vaccinators has been less than ideal, as only approximately half of pregnant women get influenza vaccines.<sup>5</sup> From the patients' perspective, major barriers to vaccination include issues related to the safety and efficacy of the vaccine, followed by the lack of recommendation from a healthcare provider. The barriers that healthcare providers face include little knowledge about the effects of the influenza vaccine, inadequate reimbursement and training, and increased workload.<sup>6</sup> To improve vaccination uptake in pregnancy, providers should:

- Make offering and recommending the influenza vaccine a routine pre-/inter-conception and antenatal procedure.
- Provide information and educational material using trusted sources.
- Promote easy access and administration through onsite standing orders and vaccination services, and community outreach.

Counselling patients on the vaccine should relay clear and strong messages<sup>7</sup> that include:

- Influenza vaccination is a normal part of prenatal care.
- Stating clearly that you would like the patient to get vaccinated.
- Highlighting positive experiences with vaccines from personal experience or from influencers.
- Addressing patient questions and any concerns about the vaccines, safety, efficacy and benefits, and the potential risks of not receiving the vaccine, and aim to dissipate unfounded fears or misconceptions.

Both patients and providers can benefit from public health efforts that rely on legislation and effective use of media. Opportunities to use social media to fight misinformation and promote vaccine confidence have been explored and may hold promise.<sup>8,9</sup>

In addition to vaccination, obstetricians must remain vigilant in order to prevent progression of disease among those who get infected. Oseltamivir provides the opportunity for secondary prevention. It has been shown to reduce maternal ICU admission and mortality.<sup>10</sup> Yet, as with vaccination, even before the COVID-19 epidemic, it was underutilised.<sup>11</sup>

Beyond committing to better use of medical interventions for influenza, obstetricians have to assure that just because they have lived through COVID-19, and the world's attention remains fixed on COVID-19, they don't become so COVID-19-focused that they fail to include influenza in the differential diagnosis of women reporting respiratory symptoms in the fall. Every fever and ache will not be COVID-19. If we delay consideration of the diagnosis of influenza, we will lose the opportunity to use oseltamivir before the window of eligibility closes. In the post-pandemic world, it will be hard to avoid cognitive biases, such as the availability heuristic (a strategy for making judgments about likelihood of occurrence based on the salience of the information) and confirmation bias (the tendency to gather evidence that confirms pre-existing expectations, typically by emphasising or pursuing supporting evidence while dismissing or failing to seek contradictory evidence). These can result in physicians being hammers and every respiratory symptom, a COVID-19 nail; especially when rapid COVID-19 tests are not uniformly available and don't yet have a uniformly high quality. This is the reverse of one of the most cited examples of the availability heuristic: 'In influenza season, it is tempting to consider all patients with fever and myalgias as having influenza.'<sup>12</sup> An enhanced situational awareness, i.e. recognising the influence of recent diagnoses on your diagnostic proclivities, will become an ever more crucial antidote to the hard-earned reflex response to fevers and aches that developed during the first wave of COVID-19.

In conclusion, it is our responsibility not to let the current COVID-19 pandemic prevent us from properly dealing with the possibility of overlapping epidemics (seasonal influenza and COVID-19) in the fall. Vaccination, rapid recourse to antivirals (e.g. oseltamivir) and community mitigation measures will be more important than ever. COVID-19 can kill, but so can influenza, and if we do our jobs, we can reduce that toll.

### Disclosure of interests

None declared. Completed disclosure of interest forms are available to view online as supporting information.

### Contribution to authorship

FA: Preparation and manuscript writing. HM: Conceptualisation, supervision, manuscript review and edit.

### Details of ethics approval

No ethics approval applicable for this commentary.

### Funding

There was no financial support for this commentary.

### Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article. ■

### References

- 1 London V, McLaren R Jr, Stein J, Atallah F, Fisher N, Haberman S, et al. Caring for pregnant patients with COVID-19: practical tips getting from policy to practice. *Am J Perinatol* 2020;37:850–3.
- 2 Allotey J, Stallings E, Bonet M, Yap M, Chatterjee S, Kew T, et al. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis. *BMJ* 2020;370:m3320.
- 3 Meijer WJ, van Noortwijk AG, Bruinse HW, Wensing AM. Influenza virus infection in pregnancy: a review. *Acta Obstet Gynecol Scand* 2015;94:797–819.
- 4 Yu C, Zhang Z, Guo Y, Shi J, Pei G, Yao Y, et al. Lopinavir/ritonavir is associated with pneumonia resolution in COVID-19 patients with influenza coinfection: a retrospective matched-pair cohort study. *J Med Virol* 2020:1–9. <https://doi.org/10.1002/jmv.26260>
- 5 Lindley MC, Kahn KE, Bardenheier BH, D'Angelo DV, Dawood FS, Fink RV, et al. Vital signs: burden and prevention of influenza and pertussis among pregnant women and infants – United States. *MMWR Morb Mortal Wkly Rep* 2019;68:885–92.
- 6 Wilson RJ, Paterson P, Jarrett C, Larson HJ. Understanding factors influencing vaccination acceptance during pregnancy globally: a literature review. *Vaccine* 2015;33:6420–9.
- 7 [[www.cdc.gov/vaccines/pregnancy/hcp-toolkit/talking-to-pregnant-patients.html](http://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/talking-to-pregnant-patients.html)]. Accessed 9 March 2020.
- 8 Wilson K, Atkinson K, Deeks S. Opportunities for utilizing new technologies to increase vaccine confidence. *Expert Rev Vaccines* 2014;13:969–77.
- 9 Glanz JM, Wagner NM, Narwaney KJ, Kraus CR, Shoup JA, Xu S, et al. Web-based social media intervention to increase vaccine acceptance: a randomized controlled trial. *Pediatrics* 2017;140:e20171117.
- 10 Greer LG, Sheffield JS, Rogers VL, Roberts SW, McIntire DD, Wendel GD Jr. Maternal and neonatal outcomes after antepartum treatment of influenza with antiviral medications. *Obstet Gynecol* 2010;115:711–6.
- 11 Greene SK, Shay DK, Yin R, McCarthy NL, Baxter R, Jackson ML, et al. Patterns in influenza antiviral medication use before and during the 2009 H1N1 pandemic, Vaccine Safety Datalink Project, 2000–2010. *Influenza Other Respir Viruses* 2012;6:e143–51.
- 12 [[www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/human\\_factors/Cognitive\\_biases/pdf/hf\\_common\\_cognitive\\_biases-e.pdf](http://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/human_factors/Cognitive_biases/pdf/hf_common_cognitive_biases-e.pdf)]. Accessed 5 May 2020.