done for any resident/patient with one or more acute respiratory symptoms, with or without fever, or any of the following without respiratory symptoms: temperature elevation or reduction, or behavioral change *(A-III)*.

52. Empiric antiviral treatment should be administered as soon as possible to any resident or patient with suspected influenza during an influenza outbreak without waiting for the results of influenza diagnostic testing *(A-III)*.

To Control an Influenza Outbreak in a Long-term Care Facility or Hospital, Should Antiviral Chemoprophylaxis Be Administered to Exposed Residents/Patients?

Recommendation

53. Antiviral chemoprophylaxis should be administered as soon as possible to all exposed residents or patients who do not have suspected or laboratory-confirmed influenza regardless of influenza vaccination history, in addition to implementation of all other recommended influenza outbreak control measures, when an influenza outbreak has been identified in a long-term care facility or hospital *(A-III)*.

During an Influenza Outbreak at a Long-term Care Facility, Should Antiviral Chemoprophylaxis Be Administered to Residents Only on Affected Units or to All Residents in the Facility?

Recommendation

54. Antiviral chemoprophylaxis should be administered to residents on outbreak-affected units, in addition to implementing active daily surveillance for new influenza cases throughout the facility *(A-II)*.

Which Healthcare Personnel Should Receive Antiviral Chemoprophylaxis During an Institutional Outbreak?

Recommendations

55. Clinicians can consider antiviral chemoprophylaxis for unvaccinated staff, including those for whom chemoprophylaxis may be indicated based upon underlying conditions of the staff or their household members (see recommendations 40–44) for the duration of the outbreak *(C-III)*.
56. Clinicians can consider antiviral chemoprophylaxis for staff who receive inactivated influenza vaccine during an institutional influenza outbreak for 14 days postvaccination *(C-III)*.
57. Clinicians can consider antiviral chemoprophylaxis for staff regardless of influenza vaccination status to reduce the risk of short staffing in facilities and wards where clinical staff are limited and to reduce staff reluctance to care for patients with suspected influenza *(C-III)*.

How Long Should Antiviral Chemoprophylaxis Be Given to Residents During an Influenza Outbreak in a Long-term Care Facility?

Recommendation

58. Clinicians should administer antiviral chemoprophylaxis for 14 days and continue for at least 7 days after the onset of symptoms in the last case identified during an institutional influenza outbreak *(A-III)*.

INTRODUCTION

These clinical practice guidelines are an update of the guidelines published by the Infectious Diseases Society of America (IDSA) in 2009 [17], just prior to the recognition of the emergence of influenza A(H1N1) pdm09 virus as the cause of the 2009 H1N1 pandemic. Since then, new rapid molecular diagnostic assays became available, new risk factors for severe disease were recognized, and a parenteral neuraminidase inhibitor (NAI), peramivir, was approved for use in the United States. In addition, many observational studies in hospitalized patients with seasonal influenza A or B virus infection have been conducted, including studies of influenza A(H1N1) pdm09 virus infections, that have addressed the effectiveness of antiviral treatment and adjunctive therapies. Additional information is also available about the emergence of antiviral resistance. However, only a small proportion of the new data arises from randomized controlled clinical trials.

The purpose of this guideline's recommendations is to provide clinicians with evidence-based recommendations for the diagnosis and treatment of seasonal influenza, including use of commercially available influenza diagnostic tests, use of approved antiviral agents for treatment and chemoprophylaxis of influenza, and use of antibiotics or other adjunctive measures for treatment of complications associated with influenza. The recommendations also address the use of diagnostic tests and antiviral agents for the control of institutional influenza outbreaks. The care of specific patient populations is addressed, including children, pregnant and postpartum women, and persons who are severely immunocompromised such as hematopoietic stem cell and solid organ transplant recipients. The target audience includes primary care clinicians, obstetricians, emergency medicine providers, hospitalists, and infectious disease specialists.

The guidelines do not provide recommendations on infection prevention and control (IPC) measures for seasonal influenza in all healthcare settings; these are available on the Centers for Disease Control and Prevention (CDC) website [18]. Influenza outbreaks outside of healthcare settings (eg, daycare, schools, and workplaces) are not addressed; public health authorities should be consulted for outbreaks in these settings. The guidelines do not provide recommendations on diagnosis or treatment of human infections with novel influenza A viruses of animal origin following exposure to poultry or pigs (eg, avian influenza A viruses, or swine-origin [variant] viruses); current recommendations for IPC, specimen collection, diagnosis, and treatment of novel influenza A virus infections are available on the CDC website [19, 20]. The guideline also does not provide specific recommendations for the supportive clinical management of critical illness resulting from complications of influenza virus infection. Influenza vaccination is not addressed because annual influenza vaccination recommendations are published by the Advisory Committee on Immunization Practices