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Guidance

Investigation and initial clinical management of possible human cases of avian influenza with potential to cause severe human disease

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Information for health professionals

Do not use this guidance document in relation to persons exposed to confirmed detections of avian influenza in avian species in the UK. There is [separate guidance \(https://www.gov.uk/government/publications/avian-influenza-guidance-and-algorithms-for-managing-incidents-in-birds\)](https://www.gov.uk/government/publications/avian-influenza-guidance-and-algorithms-for-managing-incidents-in-birds) for possible human cases that are associated with an incident involving avian species within the UK.

Before continuing with the initial assessment

Isolate the patient in a single occupancy room, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used. Patient to minimise contact with/exposure to staff and other patients, and ask the patient to wear a surgical mask when outside the room.

Wear personal protective equipment (PPE) – as a minimum, this should be a correctly fitted FFP3 respirator, gown, gloves and eye protection.

Start oseltamivir treatment immediately if the patient meets case definition for avian influenza. For guidance on dosage refer to [UKHSA guidance \(https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents\)](https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents) on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza.

Case definition for possible cases

Clinical criteria

a) fever $\geq 38^{\circ}\text{C}$

or

b) acute respiratory symptoms (cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing)

or

c) other severe or life-threatening illness suggestive of an infectious process

Additionally, patients must fulfil a condition in either category 1 or 2 of the exposure criteria below.

Exposure criteria

For H7N9, H9N2, H5N1, H5N6 and any other avian influenza associated with severe human disease:

1) close contact (within 1 metre) with live, dying or dead domestic poultry or wild birds, including live bird markets, in an area of the world affected by avian influenza** or with any confirmed infected animal, in the 10 days before the onset of symptoms

or

2) in the 10 days before the onset of symptoms, close contact* with:

- a confirmed human case of avian influenza
- human case(s) of unexplained illness resulting in death from affected areas**
- human cases of severe unexplained respiratory illness from affected areas**

*This includes handling laboratory specimens from cases without appropriate precautions, or was within 1 metre distance, directly providing care, touching a case or within close vicinity of an aerosol generating procedure, from 1 day prior to symptom onset and for duration of symptoms or positive virological detection.

**For H7N9, H5N1 and H5N6 see the [HCID country list](#) (<https://www.gov.uk/guidance/high-consequence-infectious-disease-country-specific-risk>). For H9N2, affected areas include China and Oman. If unsure, discuss with UKHSA Clinical and Public Health team (CPH).

Caution: Clinicians should be aware of other respiratory infections among travellers with similar presentations, such as Legionnaire's disease or MERS-CoV, if there is an appropriate travel or potential exposure history for those infections. Consult the [MERS-CoV possible case algorithm](#) (<https://www.gov.uk/government/publications/mers-cov-public-health-investigation-and-management-of-possible-cases>) to inform assessment.

1) Assess if the above case definition is met

a) No, does not meet case definition: unlikely to be avian influenza – treat and investigate as clinically indicated for other infections or causes.

b) Yes, does meet case definition: manage as possible case.

Important: The following precautions should be taken as soon as the possibility of avian influenza has been identified:

- staff PPE – correctly fitted FFP3 mask, gown, gloves and eye protection
- patient location – isolate in a single occupancy room to minimise contact or exposure to staff and other patients, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used; patient to minimise contact or exposure to staff and other patients, and ask the patient to wear a surgical mask*
- restrict visitors and keep a list of all contacts

*Patient to wear a surgical mask when someone enters the room or if transferred to another area if tolerated. The patient's requirement to wear a surgical mask must never compromise their care, such as when oxygen therapy is required.

i. Actions for health professionals managing the possible case:

- ensure appropriate isolation and infection prevention and control measures for aerosol transmission including correct use of specific PPE as above
- discuss case with the duty microbiologist or virologist at nearest [UKHSA Public Health Laboratory \(https://www.gov.uk/government/collections/public-health-laboratories\)](https://www.gov.uk/government/collections/public-health-laboratories)
- if the PHL duty microbiologist agrees that testing is indicated, follow the [laboratory investigations algorithm \(https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations\)](https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations) and inform the [local HPT \(https://www.gov.uk/health-protection-team\)](https://www.gov.uk/health-protection-team) and laboratory staff prior to sending the sample
- continue to manage the patient according to clinical need and with the input of the infection prevention and control team. Processing of laboratory specimens in autoanalysers may continue. Processing of microbiology samples should be undertaken only in Containment Level 3 in the local laboratory
- in addition to any other clinically appropriate therapy start oseltamivir treatment if not already done so (do not wait for results of avian influenza diagnostic tests). For guidance on dosage refer to the [UKHSA guidance on use of antiviral agents \(https://www.gov.uk/government/publications/influenza-](https://www.gov.uk/government/publications/influenza-use-of-antiviral-agents)

[treatment-and-prophylaxis-using-anti-viral-agents](#)) for the treatment and prophylaxis of seasonal influenza

- linen to be treated as infectious and waste to be disposed of as clinical waste

The dosage information provided for treatment of seasonal influenza is appropriate for initiating treatment of avian influenza cases.

ii. Actions for UKHSA regional health protection team

- complete possible case report form 1a (see internal documents) and send to acute.respiratory@ukhsa.gov.uk
- alert Colindale duty doctor for all persons being tested for avian influenza.

iii. Actions for Colindale duty doctors

Follow avian influenza communication cascade (see internal documents) for incidents where a diagnosis of avian influenza is under consideration.

2) Results of testing

a. Testing result = H5/H7 not detected (and Influenza A detected, OR Influenza A detected and subtyped as seasonal H3N2 or (H1N1)pdm09 or Influenza B detected)

i. Actions for clinical diagnostic testing laboratory: [see laboratory guidance \(https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations\)](https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations)

- PHL duty microbiologist or virologist informs the local HPT, the referring laboratory, and UKHSA Clinical and Public Health team (CPH)

ii. Actions for UKHSA regional health protection team:

- inform CPH (via acute.respiratory@ukhsa.gov.uk if out of hours)

b. Testing result = H5 or H7 detected (or Influenza A detected but unsubtypeable and has relevant exposure for non-H5/H7 avian influenza)

Treat as a presumptive positive case.

i. Actions for clinical diagnostic testing laboratory: [see laboratory guidance \(https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations\)](https://www.gov.uk/government/publications/avian-influenza-ah7-and-influenza-ah5-laboratory-investigations)

- duty microbiologist or Virologist informs the local HPT, the referring laboratory, and CPH

ii. Actions for UKHSA regional health protection team:

- local HPT informs CPH, Colindale (or Colindale duty doctor at any time if out of hours)
- CPH, Colindale follows avian influenza communication cascade (see internal documents)
- UKHSA to establish Incident Management Team

3) Public health management of contacts of confirmed human cases of avian influenza

This table summarises recommendations for the management of contacts of presumptive positive or confirmed human cases of avian influenza who were exposed when the case was symptomatic or 1 day before symptom onset. This should only be initiated on the advice of a UKHSA-led incident management team, following receipt of presumptive positive or confirmed laboratory results in the case.

Category of contact	Post-exposure chemoprophylaxis? (see next page for details)	Follow-up
Household contact (more than 15 minutes, face to face contact)	Yes	Active follow-up [†] for 10 days after last significant exposure
Healthcare workers and visitors to the hospital who have not worn recommended PPE during all exposures to the patient	Yes	Active follow-up for 10 days after last unprotected exposure
Healthcare workers who have worn recommended PPE during all exposures to the patient	No	Passive follow-up ^{††} for 10 days after last exposure
Other close contacts (based on a risk assessment, related to factors such as duration more	Yes	Active follow-up for 10 days after last unprotected exposure

Category of contact	Post-exposure chemoprophylaxis? (see next page for details)	Follow-up
than 15 minutes, face to face in a closed setting)		
Air travel (2 seats all around the index case) AND all crew members serving in that compartment	Based on risk assessment by IMT	Based on risk assessment by IMT

†Active follow-up: Individual should be contacted on a daily basis, and asked about relevant symptoms

††Passive follow-up: Individual is provided with health advice, and advised to contact the designated team if they develop relevant symptoms

Individuals who do not satisfy the above categories for contact with a symptomatic confirmed human case of avian influenza should be reassured that they do not need antiviral post-exposure prophylaxis, follow-up or self-isolation.

Advice to healthcare workers on exclusion from work will be determined by the IMT based on local situation. Advice on self-isolation will be based on risk assessment by the IMT.

Pre-exposure chemoprophylaxis is not recommended for healthcare workers who will be caring for cases with appropriate PPE.

In the event that any individual develops symptoms they will be assessed as a possible case according to criteria in section 1. They will be advised to self-isolate while arrangements are rapidly made for clinical assessment and investigation.

4) Guidance on post-exposure chemoprophylaxis of contacts

a. For H5N1/H5N6 and any other avian influenza associated with severe human disease

UKHSA advises post-exposure chemoprophylaxis for close contacts of presumptive positive or confirmed cases of avian influenza according to the

following schedule:

- start oseltamivir as soon as possible following exposure
- the standard adult dose of oral oseltamivir 75 mg once daily for 10 days (see the UKHSA guidance on the use of antivirals for the treatment and prophylaxis of influenza for information on prescribing for different consideration such as ages, weights and renal function)
- contacts should be monitored closely for signs of illness for up to 10 days following exposure and be managed as a possible case (as per possible case definition, above) if they develop compatible illness within this time period

For further guidance around the use of antivirals, see the [UKHSA guidance \(https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents\)](https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents) on the use of antivirals for the treatment and prophylaxis of influenza.

b. Specific guidance for avian influenza A(H7N9)

Resistance to neuraminidase inhibitors has been described for some avian influenza viruses, particularly H7N9. For people exposed to a confirmed case of H7N9, a treatment dose of oseltamivir (twice daily dosing) is recommended to reduce the risk of emergence of antiviral resistance.

UKHSA advises chemoprophylaxis for close contacts of confirmed cases of A(H7N9) avian influenza along the following guidelines:

- start treatment as soon as possible following exposure
 - a standard adult dose of 75mg oseltamivir twice daily for 5 days (see the [UKHSA guidance \(https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents\)](https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents) on the use of antivirals for the treatment and prophylaxis of influenza for information on prescribing for different consideration such as ages, weights and renal function)
- contacts should be monitored closely for signs of illness for up to 10 days following exposure

This is based on virological evidence of oseltamivir resistance in cases of avian influenza A(H7N9), and is in line with [CDC \(https://www.cdc.gov/flu/avianflu/novel-av-chemoprophylaxis-guidance.htm\)](https://www.cdc.gov/flu/avianflu/novel-av-chemoprophylaxis-guidance.htm) and [WHO \(http://www.who.int/influenza/human_animal_interface/influenza_h7n9/13_January_2013_PEP_recs.pdf?ua=1\)](http://www.who.int/influenza/human_animal_interface/influenza_h7n9/13_January_2013_PEP_recs.pdf?ua=1) advice.

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