Received September 2009, accepted October 2009

EDITORIAL

Swine flu: hype or serious threat requiring urgent national preparation?

I van Stijn, PW de Feiter, Rth Gerritsen, DW de Lange, JI van der Spoel

Task force H1N1 of the Dutch Society of Intensive Care

Keywords - Mexican flu, ALI/ARDS, intensive care capacity, national economy

The pandemic Influenza A (H1N1) is a strain of influenza virus, based upon a triple reassortant Influenza virus that is common in pigs. Triple-reassortant means that the virus contains genes from previous bird flu, swine flu and even remnants of the 1918 Spanish flu. Although basically incorrectly, this strain of pandemic influenza is variously described as swine flu, swine influenza, pig flu or the new flu; its official name is Influenza A (H1N1).

After initial worrisome reports in the media about Influenza H1N1 from Mexico as well as the US and Great Britain, we are now familiar with data from other countries on the Southern hemisphere. These reports show that the number of the patients that need hospitalization or treatment in an intensive care unit is probably smaller than previously expected. However, these numbers should not be disregarded. Especially considering the possibility that the virus will mutate and become more virulent. With so many unknown variables - what are our options? Fear is never the answer, preparation is! This is why the NVIC has set up the H1N1 task force. This task force has drawn up an initial concept for a protocol for treatment of patients with Influenza H1N1. More importantly, this task force has formulated a proposal concerning how to triage patients when all ICU capacity is in use. Of course additional capacity will be created, using recovery beds and ventilators for instance. But what do we do when even this additional capacity is in full use? Or, what do we do if we are not able to gear up to full capacity because the health care workers themselves have fallen ill? Unfortunately, evidence based medicine is of no use here. Triage rules in pandemic circumstances are based upon the available literature, which is scarce, and expert opinions.

Pressured by time and urged by the Department of Health, it was impossible to follow the usual route leading to the acceptance of a NVIC guideline. A concept guideline was developed by the small NVIC task force but subsequently the NVIC Commission of Quality and the NVIC Commission of Guidelines and the Dutch Medical Society (KNMG) were only able to perform a limited check.

The protocol (www.nvic.nl/influenza.php) contains details of practical aspects relating to intensive care patients in addition to the instructional guidance manuscript called “Leidraad” by J. Kluytmans, August 2009 (www.rivm.nl), and triage rules in the event of a national shortage of intensive care capacity. The part of the protocol in which these triage rules are described has not been made public. Performing triage in pandemic circumstances is completely different to what intensivists are trained for, i.e. “doing the best for an individual patient” instead of “doing the best for most” in the case of shortage of intensive care capacity. This implies that triage rules are the responsibility of the government rather than individual physicians or hospitals.

However, as experts in the field of intensive care medicine and more familiar with these diseases and the outcome in ICU patients than is the government, it is evident that we felt obligated to provide the content for the protocol, in coordination with the Public Health Inspectorate and the government. On the other hand, it seems logical that the government should accept the final responsibility for the protocol as it has to be this government that, in the event of the serious threat of scarcity of intensive care capacity, has to decide the point at which the triage rules have to be implemented in a uniform way throughout the entire country. Intensive care specialists cannot be expected to decide which patients will or will not be admitted to their intensive care departments other than according to commonly accepted rules pertaining for instance to futility, as stated in the society’s protocol on admission and discharge from ICU. (www.nvic.nl/richtlijnen_geaccordeerd.php?id=41&titel=Opname--en-Ontslagcriteria-voor-IC-patienten). If we deny treatment to patients on the basis of pandemic triage rules, we must rule out differences in local protocols. This implies that these triage rules are must be made clear to intensive care professionals and the public by our government before we are deluged by an influenza H1N1 pandemic.

Unfortunately, and in contrast to the previous agreement, the Department of Health has declined to validate the task force H1N1 concept protocol as the national standard and it has not provided an alternative protocol. In the absence of triage rules endorsed by the Department of Health, every hospital is now drawing up its own triage protocol. Uniformity in this situation is an illusion. The fairness of the triage rules should be discussed now. It is undesirable to have discussions about triage rules at a time when we need all doctors at the bedside. Although the risk of a full-scale pandemic that will flood our ICUs appears to be declining, no-one wants to be overwhelmed by it. Numerous expert teams in hospitals are now engaged in planning and creating their own local protocols. None of the Dutch hospitals want to be reported in the news as the one that was still waiting for the nationally validated protocol when it was hit by an outbreak of H1N1. Differences in admission criteria and triage rules in a pandemic are completely undesirable. The government should rise to the occasion and take responsibility by validating a national protocol or propose an alternative. Ignoring a grim prediction is not an alternative to “Hope for the best, yet plan for the worst”.

To bring this undesirable situation to an end we hope that the government will take its responsibility in the near future and validate a national triage protocol, so we can and will be uniformly prepared if a massive outbreak proves that fears about H1N1 were not a hype after all.

Correspondence

I van Stijn

E-mail: i.vanstijn@olvg.nl