'The Flu'

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Before antiviral agents, the diagnosis of influenza was clinical history and physical examination, and management was supportive and symptom-specific. New methods of diagnostic testing for specific Influenza serotypes have made it easier to tell what one ***has*** and to treat it, versus waiting many weeks to find out which virus one ***has***, helping differentiate among the many cough/sore throat/myalgia/nasal congestion symptom clusters we see in primary care.

But the increasing possibility of early diagnosis and treatment, along with the potential for significant morbidity and mortality of newer strains of influenza, has created not only a new mask and hand washing industry but also made primary care clinicians much more inclined to want to look at both what happened in the past year and what to anticipate for the future. This issue of the *Wisconsin Medical Journal (Journal)* has lots of important information based on Wisconsin's H1N1 experience from 2009 to 2010.

Temte and Prunuske offer a current review of influenza that updates both old and new information for physicians and learners alike.[1] Rezkala and Kloner offer a review of viral myocarditis,[2] a complication of influenza that has been important and continuing and, if there were to be another pandemic, might take a more significant place in both hospital and outpatient care. We think more often of pulmonary complications but, as they point out, the diagnosis and management of myocarditis can be delayed and should be on the minds of all of us in the coming season.

In an important "first look" paper, Davis and colleagues[3] report the factors that predisposed patients to being hospitalized with H1N1 in the most recent flu season. Their work has important ramifications for the entire health system, not just primary care. Their finding that a disproportionate number of minorities of all types were hospitalized compared to white patients is another area of health disparities in the state. Fortunately, the morbidity and mortality of H1N1 hospital admissions was no worse among all subpopulations. But along with being under 1 year of age and from a minority group, comorbitidies such as asthma, lung disease of any type, and obesity raise access issues for immunizations and management of chronic illness for those most vulnerable for hospitalization. In an era where every practice in the state could use basic practice population data from their billing and EHR to target high risk populations for outreach and early care, we should be finding those at risk in our practices and our communities ***now***, not after the fact. The result would be not only a decrease in hospitalization but a very large savings in unnecessary hospital costs.

Finally, in the *Journal's* new "Health Innovations" section, Young describes an effort to use the EHR[4] to get the most up-to-date management suggestions in front of primary care clinicians that, if used properly, can improve quality and decrease variability in treatment of H1N1. He demonstrates how clinicians, with the proper education and support, can change behavior in their practices. Health Innovations is where we will publish similar ideas for quality improvement and patient care.

References

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