IDMP GUIDELINES FOR DIAGNOSIS AND MANAGEMENT OF SEASONAL INFLUENZA: 2026-27 SEASON

These guidelines are for diagnosis and management of **seasonal** influenza.
For avian influenza, please see the UCSF Avian Influenza Guidance and Resources page

DIAGNOSTICS

WHICH PATIENTS SHOULD BE TESTED FOR INFLUENZA DURING INFLUENZA SEASON?

Inpatients/ER pending admission

- All patients on admission with:
  - Acute respiratory illness including pneumonia, with or without fever
  - Acute worsening of chronic cardiopulmonary disease (COPD, asthma, CAD, CHF)
  - Fever alone if immunocompromised or high risk
- All hospitalized patients who develop acute onset of respiratory symptoms without a clear alternative diagnosis

Outpatients/ER anticipated discharge

- High-risk patients (see below) with influenza-like illness (see below), pneumonia, or nonspecific respiratory illness, with or without fever
- Non-high-risk patients presenting with a complication of influenza (e.g., pneumonia)
- Consider in other patients with influenza-like illness, pneumonia, or nonspecific respiratory illness if it will change management including decisions around antivirals, antibiotics, further diagnostic testing, or infection control.

Influenza Signs and Symptoms (usually abrupt onset)

- Respiratory symptoms: dyspnea, cough, chest pain
- Systemic signs and symptoms: chills, malaise, fatigue, myalgia **with or without fever**
- ENT symptoms: headache, sore throat, hoarseness (nasal congestion, rhinorrhea more common in children)
- GI symptoms: abdominal pain, vomiting (diarrhea more common in children)

Patients at High Risk of Complications from Influenza Infection

- Adults ≥ 65 years or children <5 years (especially <2 years)
- Chronic pulmonary, cardiovascular, renal, hepatic, heme, neuro/neurodevelopmental, metabolic disorders (incl. diabetes)
- Immunocompromised
- Pregnant or postpartum (within 2 weeks after delivery)
- Children <18 years receiving aspirin or salicylate containing medications (risk of Reye syndrome if get flu)
- American Indians/Alaska Natives
- Extreme obesity (BMI ≥40)
- Residents of chronic care facilities

WHICH TEST SHOULD I ORDER IN SYMPTOMATIC PATIENTS?

During Flu Season

Inpatients/ER pending admission

- Critically ill or immunocompromised: COVID + RVP
- All other patients: COVID + Influenza A/B/RSV PCR

Outpatients/ER anticipated discharge

- COVID + influenza (POCT or influenza/RSV PCR depending on setting)
- Consider RVP instead of flu testing in significant immunocompromise

See Appendix A (below) for details on available tests

Important Notes on Testing

- The start of flu season will be indicated by UCSF Health with an institution-wide email based on internal influenza testing and SFDPH influenza surveillance. The onset of the influenza season varies but has been unusually early this year in Northern California; the end of the season also varies.

- To maximize detection, respiratory specimens should be collected as close to illness onset as possible, preferably <4 days after symptom onset (but can and should be done later if patients do not present early)
- **In critically ill patients, send upper and lower respiratory tract samples if possible for RVP to improve sensitivity for diagnosis of respiratory viral infection.**
- Co-infection with respiratory viruses can occur.

TREATMENT

WHICH PATIENTS WITH INFLUENZA/SUSPECTED INFLUENZA SHOULD BE TREATED WITH ANTIVIRALS (DURING FLU SEASON)?

Inpatients/ER pending admission

- **Timing of Treatment:** Initiate treatment as soon as influenza is suspected; do not delay while awaiting test results
- **Who to treat:** All inpatients with influenza or suspected influenza, irrespective of time of symptom onset
- Treatment is associated with lower mortality in inpatients, even if >48h of symptoms
- For critically ill patients, **see note below**, also if no enteral access expected within 8 hours, consider IV peramivir until enteral access obtained

Outpatients/ER anticipated discharge

- **Timing of Treatment:** Initiate treatment as early as possible and consider empiric therapy if test results will be delayed
- **Who to treat:** High risk patients or patients with severe or progressive illness
  - Treat irrespective of time of symptom onset
- Can consider treatment in:
  - Non-high-risk patients if ≤48h symptoms
  - Household contacts of high-risk patients
  - HCWs who take care of high-risk patients
  - Caregivers of children younger than 6 months of age

Note regarding critically ill patients: A preprint was recently posted from the REMAP-CAP adaptive platform trial suggesting that oseltamivir may not be beneficial in critically ill patients with influenza. Once the results have undergone peer review, they will be incorporated into UCSF guidelines. Until then, UCSF guidelines are unchanged.

Important Notes on Indications for Treatment

- Household contacts of healthcare workers (HCWs) who take care of high-risk patients should only be treated if they have a specific indication, not solely to prevent spread to the HCW.
- For young children, routine empiric influenza therapy in this age group is controversial. It is recommended to offer therapy to this group of patients, but individual treatment decisions may be considered via shared decision-making and incorporation of other clinical factors.

Antiviral options (Dosing linked to relevant IDMP page)

Drug	Route	Age	Adverse Effects	Comments
Preferred Treatment				
Oseltamivir	PO or FT	Birth or older	Nausea/vomiting, rare neuropsychiatric effects	Drug of choice for most patients, including hospitalized patients, immunocompromised patients, and patients who are pregnant or breastfeeding. See note above re: critically ill patients.
Alternative Treatments				
Peramivir	IV	6 mo or older	GI side effects, neutropenia	Consider use in hospitalized patients with influenza in whom there is a concern for GI absorption that would limit the use of oral oseltamivir, or if enteral access not expected to be available within 8 hours. All other use requires ID/ASP approval. See note above re: critically ill patients
Zanamivir	Inhaled	7 y or older	Cannot use in intubated patients or those with respiratory disease (asthma/COPD) as it can cause cough, bronchospasm	Consider if patient cannot take PO although requires patient participation with use. Inpatient use requires ID/ASP approval.
Baloxavir	PO	5 y or older	Diarrhea	Not routinely recommended given concerns about treatment emergent resistance. Can be considered for uncomplicated infection in immunocompetent outpatients. Not recommended for hospitalized patients, immunocompromised patients, or patients who are pregnant or breastfeeding given lack of data. Inpatient use requires ID/ASP approval.

Important Notes on Antiviral Therapy

- Please see IDMP (idmp.ucsf.edu) for dosing recommendations in children and adults
- The standard duration of therapy with oseltamivir is 5 days. However, severely immunocompromised patients may benefit from a longer duration of therapy or combination therapy based on severity of illness. Please consult ID for assistance in these cases.
- If antiviral therapy is initiated with peramivir because enteral access is unavailable, transition to oseltamivir if/when enteral access is established and complete the originally planned duration counting both peramivir and oseltamivir (see above re: durations).

Considerations Regarding Bacterial Superinfection in Patients with Confirmed Influenza

- Bacterial superinfection is more common at clinical presentation in influenza than in COVID (~10% of hospitalized patients with influenza vs. <1-3% of hospitalized patients with COVID). Decisions on antibacterial therapy should be based on individualized clinical assessment of the likelihood of bacterial superinfection and risks of delayed antibacterial therapy.
- If patients with influenza are started on antibiotics for CAP, consider early discontinuation (at 48-72h) if patient is clinically stable and there is a low suspicion for bacterial pneumonia based on labs and radiologic features.

PROPHYLAXIS

- These guidelines do not address the use of antivirals for chemoprophylaxis.
- For detailed guidance on indications for and use of antivirals for chemoprophylaxis, please see the CDC Antiviral Guidelines (section on chemoprophylaxis) which can be found here: https://www.cdc.gov/flu/hcp/antivirals/summary-clinicians.html

REFERENCES

1. Uyeki et al, IDSA 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza, CID 2019, 68:e1.
2. CDC, Influenza Antiviral Medications: Summary for Clinicians, https://www.cdc.gov/flu/hcp/antivirals/summary-clinicians.html, accessed October 22, 2026.
3. Metlay et al, Joint ATS/IDSA Guidelines for the Diagnosis and Treatment of Adults with CAP, AJRCCM 2019, 200:e45.

Appendix A:

INFLUENZA DIAGNOSTICS REFERENCE TABLE

UCSF APeX Name	Viruses	Sensitivity	Specificity	Sample	COVID on same swab?	Turnaround time
POCT FLU A and B RNA, QUAL RAPID[1]	Influenza A/B	95%	>95%	Nasal swab	No	15-20 min Available in Parnassus and Mission Bay ED
Influenza A/B/RSV PCR	Influenza A/B RSV	>95%	>95%	NP/NMT +/- OP swab recommended (AN+/-OP accepted[2])	Yes	8 h (STAT[3]) 12-24 h (routine)
Respiratory Viral Panel PCR (RVP)	Influenza A/B RSV Parainfluenza virus Metapneumovirus Rhinovirus Adenovirus	>95%	>95%	NP/NMT +/- OP swab (AN +/- OP accepted[2]) or lower tract sample (BAL, ET aspirate)	Yes	8 h (STAT[3]) 24-72h (Routine)

[1]Note: the POCT test is a rapid molecular test that is 95% sensitive (this is different from prior POCT antigen tests).
[2]AN swab is approximately 10-15% less sensitive than NP/NMT swabs for respiratory virus testing.
[3]STAT testing should be prioritized for new hospital admissions only when the results will change acute patient management.
Abbreviations: AN, anterior nares; BAL, bronchoalveolar lavage fluid; ET, endotracheal aspirate; NMT, nasal mid-turbinate; NP, nasopharyngeal; POCT, point of are testing; RSV, respiratory syncytial virus