Letters to the Editor

Healthcare Worker Influenza Vaccination in Nursing Homes

To the Editor:

The report on “Healthcare Worker Influenza Vaccination in Nursing Homes” is very interesting. Campbell et al reported that “Given that [nursing homes] generally have low employee influenza vaccination rates, it may be necessary to target low-performing facilities to achieve substantial improvements.” In fact, the problem of prevention for influenza among paramedical personnel and students is an important issue that is usually forgotten. To increase influenza vaccination is the aim of present infection control. Winston et al proposed an effective method to increase influenza vaccination rate among health care workers: the “mandated H1N1 vaccination.” Winston et al noted that “the mandate helped to increase [health care worker] influenza vaccination rates dramatically.” Naleway et al also noted that health care workers “said they would have been vaccinated if required by their employer.” To increase the vaccination rate in nursing homes, the mandatory vaccination policy should be applied for all centers and targeting “low-performing facilities,” as suggested by Campbell et al, might not give much advantage.

References


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Health Care Worker Influenza Vaccination in Oregon Nursing Homes: Correlates of Facility Characteristics

In Reply:

We appreciate the comments by Dr Sim and Dr Wiwanitkit on our article, where they raised some important issues regarding mandatory health care worker influenza vaccination programs. Although evidence suggests that mandatory vaccination policies increase health care worker vaccination rates in acute care settings, we note that there is a lack of evidence regarding the effectiveness of mandatory policies in long-term care settings and that there are legal and ethical challenges to mandatory vaccination.

For example, opponents of mandatory vaccination as a condition of employment for health care workers have stated that it interferes with First, Fifth, and Fourteenth Amendment rights, regarding freedom of religion, freedom of contract between employer and employee, and the right to due process. In addition, court decisions in both the United States and Canada have found mandatory influenza vaccination for health care workers unwarranted.

Therefore, although we agree with Drs Sim and Wiwanitkit on the benefits of mandatory influenza vaccination, we hesitate to recommend it as a strategy to combat low nursing home employee vaccination rates due to legal considerations and the lack of evidence on its effectiveness in this setting. In addition, mandatory vaccination programs may cause potential harms to care staff (eg, loss of autonomy and lack of trust in management).

Although voluntary programs, which may include free vaccine, convenient access to vaccine, education programs, and public reporting, may not achieve as high of an employee vaccination rate as mandatory programs do, voluntary programs in nursing homes may, over time, achieve improvements without facing as many legal or ethical challenges as mandatory programs. Protecting vulnerable nursing home residents is a top priority, but it seems that many domains, not just medical and economic, but moral, legal, and ethical, should be considered, as well as both patient and provider perspectives, before a decision that is beneficial to all stakeholders can be reached.

References

1. Campbell LJ, Li Q, Li Y. Health care worker influenza vaccination in Oregon nursing homes: Correlates of facility characteristics. J Am Med Dir Assoc; 2014
Refeeding Syndrome: Unrecognized in Geriatric Medicine

To the Editor:
Malnutrition is a well-established syndrome in geriatric medicine, affecting, in particular, fragile elderly individuals in the hospital and in long-term care facilities. Compensating for nutritional deficiencies is a constant and prevailing feature of medical management in geriatric care. Conversely, the potential dangers of refeeding are less well known in fragile, elderly individuals because of its unusual presentation in these patients (ie, sudden death, delirium, and hypothermia) and the lack of awareness among health care personnel.

Clinical Case
A female patient aged 75 years, with a history of depression, histrionic personality, and chronic back pain in association with balance and degenerative disorders, was hospitalized for viral gastroenteritis with diarrhea and vomiting that had started 8 days earlier. The patient was intubated and rehydrated, and received percutaneous endoscopic gastrostomy insertion.

Refeeding Syndrome
Refeeding syndrome is defined as the adverse effects that occur when nutrition is reintroduced in a malnourished patient, or in a patient who has been fasting for a prolonged period. The definition of the syndrome covers a wide spectrum of conditions, encompassing the biochemical and metabolic changes and clinical manifestations that may alter a patient’s general state after oral, enteral, or parenteral administration of carbohydrate-based nutrients. The shift to anabolic phase induces insulin secretion, and, subsequently, the introduction of glucose into the cell, creating an increased need within the cell for phosphate, potassium, and thiamine (all contributors to numerous enzyme activities), with a corresponding reduction in the serum concentrations of these agents. Hyperglycemia and hyperinsulinemia can cause sodium retention with secondary fluid overload and possibly congestive heart failure. These symptoms usually occur within the first 5 days of refeeding, and may cause abdominal pain, nausea, vomiting, muscle weakness, tremors, and even delirium. Some diseases are known to incur a high risk of refeeding syndrome, such as anorexia nervosa, depression, cancer, chronic alcoholism, and digestive inflammatory disease, and patients in the postoperative phase or in intensive care are also especially vulnerable.

Elderly patients, either in the hospital or in nursing homes, are often polymorbid with depleted physiological reserves, and thus should be considered at high risk of refeeding syndrome, particularly because the prevalence of malnutrition in this population can reach up to 50%. Refeeding syndrome is likely underdiagnosed in older hospitalized persons and those in long-term care facilities because of its unspecific clinical presentation in these patients (ie, patients who are undernourished, weak, confused, frail, with poor mobility). Indeed, it is quite uncommon for serum phosphate, potassium, or thiamine to be tested in these patients. In one case-control study in a cohort of 2307 hospitalized patients older than 65 years followed for 2.7 years, Kagansky et al reported that 14.5% of patients presented hypophosphatemia compatible with the refeeding syndrome. The guidelines of the National Institute for Health and Clinical Excellence (NICE) are recognized as a useful tool for the management of feeding in vulnerable patients and in long-term care facilities.