

MotherToBaby Expert Provides the Latest Facts About the Flu Vaccine During Pregnancy In New Medscape Article

BRENTWOOD, TN – Sonja Rasmussen, MD, MS, current member of the Organization of Teratology Information Specialists (OTIS), the professional society which provides the MotherToBaby service, published a new commentary in the New England Journal of Medicine highlighting the risks pregnant women face if not vaccinated against the flu. She recently sat down with the CDC for a Medscape Q & A article to address common questions about the flu, as well as the vaccine to prevent it, during pregnancy. For the full article click [here](#), or scroll below to read her interview, courtesy of Medscape.

If you have questions about specific vaccines, like the flu shot, during pregnancy or breastfeeding call MotherToBaby toll-FREE at 866-626-6847. You can also read our Fact Sheet on Influenza Vaccine In Pregnancy/Breastfeeding [here](#). MotherToBaby Pregnancy Studies, conducted by OTIS, is also currently following up with women who've recently received the influenza vaccine during pregnancy. To learn more and volunteer for the study, click [here](#).

From Medscape:

Vaccination, Early Flu Treatment Critical for Pregnant Women

Editor's note: What have we learned since the 2009 flu pandemic? That's the focus of a new commentary from CDC experts Sonja Rasmussen, MD, MS, and Denise J. Jamieson, MD, MPH, published October 9th in the New England Journal of Medicine. In the commentary, "2009 H1N1 Influenza and Pregnancy - 5 Years Later," the authors note that during the 2009 pandemic, pregnant women were at substantially higher risk for hospitalization than the general population, and they accounted for approximately 5% of flu-related deaths reported to the CDC.[1]

Dr. Rasmussen, acting director of CDC's Office of Public Health Preparedness and Response, recently spoke with Doug Jordan, MS, CDC Health Communications specialist, about what clinicians can do now to keep pregnant women safe from influenza.

Mr. Jordan: What was your motivation for doing this commentary, and what should pregnant women know about the dangers posed by influenza?

Dr. Rasmussen: Since the 2009 H1N1 pandemic, we have learned a lot about influenza and pregnancy. The results of many studies have provided evidence on the impact of influenza on pregnant women, the benefits of treatment with oseltamivir, the safety of the influenza vaccine, and the steps clinicians can take to increase vaccination rates among pregnant women. We know much more now than we did 5 years ago about how to keep women and their infants safe from influenza. Yet, last year, we heard reports of severe illness, hospitalization, and death among pregnant women, sadly reminiscent of calls we received during the 2009 H1N1 pandemic. The idea for this commentary was in response to those reports. My coauthor, Dr Denise Jamieson, and I wanted to take what we now know about flu and pregnant women and make sure that information was in the hands of the clinicians who care for these women.

Mr. Jordan: What are the most common misconceptions that pregnant women might have about the influenza vaccine?

Dr. Rasmussen: We find that pregnant women do not always know that they are at higher risk of developing influenza-related complications. In fact, changes in the immune system, heart, and lungs during pregnancy make pregnant women more prone to severe illness, hospitalization, and even death from influenza. Infants born to women severely ill with influenza also have an increased risk for adverse birth outcomes, including preterm birth and small size for gestational age.

We also find that pregnant women often are unaware of the benefits of influenza vaccination for their baby. Flu shots during pregnancy protect not only the pregnant woman, but also her unborn baby and even her infant during the first 6 months of life. Studies have also shown that vaccinating the mother during pregnancy may reduce the occurrence of adverse outcomes like small size for gestational age and preterm birth in infants.

Mr. Jordan: What do you anticipate this season in terms of flu activity and severity?

Dr. Rasmussen: We can't predict what kind of influenza season we will experience in the United States this year. Every flu season is different, and influenza infection can affect people differently. Similarly, we cannot know which viruses will circulate over the season. Influenza viruses can change from one season to the next or they can even change within the course of the same season. But we know that influenza vaccination during pregnancy can reduce the risk for influenza in the mother and her baby. And we know that pregnant women suspected of having influenza should receive prompt antiviral treatment, regardless of risk factors, severity of illness, history, or diagnostic testing.

Mr. Jordan: Which flu viruses does this season's vaccine protect against?

Dr. Rasmussen: For the 2014-2015 flu season, trivalent influenza vaccines are made to protect against three influenza viruses: two influenza A viruses (H1N1 and H3N2) and an influenza B virus. In addition, the quadrivalent influenza vaccines, which are made to protect against four flu viruses, protect against the same viruses, and an additional B virus, as the trivalent vaccine. Yearly seasonal influenza vaccination is the best way to prevent influenza.

Mr. Jordan: What are the current influenza vaccine recommendations during pregnancy?

Dr. Rasmussen: CDC recommends that everyone 6 months of age or older get vaccinated against influenza each year. Getting an influenza vaccination is the best way to prevent influenza infection. Inactivated influenza vaccine is safe for pregnant women and can be administered during any trimester. Live attenuated influenza vaccine (LAIV) is not recommended for use during pregnancy. Postpartum women can receive either LAIV or inactivated flu vaccine.

Mr. Jordan: What are some important points to remember when educating pregnant women about influenza vaccine safety?

Dr. Rasmussen: Recommendations from healthcare providers are a critical motivator for pregnant women to be vaccinated. Clinicians should remind pregnant women of their increased risk of developing influenza-related complications, and emphasize that influenza vaccination is safe for pregnant women and has been recommended for many years by both the Advisory Committee on Immunization Practices and the American College of Obstetricians and Gynecologists. Influenza vaccination is the best way to prevent influenza and influenza-related complications like hospitalization and death in pregnant women and their babies.

Mr. Jordan: What is the best way to raise influenza vaccination rates among pregnant patients?

Dr. Rasmussen: Influenza vaccination benefits the pregnant mother, the unborn child, and even the baby after birth, and we know that pregnant women are motivated to do what they can to ensure the health of their baby. When they learn that influenza vaccination can benefit their child before and after birth, they are more likely to get vaccinated. Clinicians play a vital role in sharing this information.

We also know that the best way to increase influenza vaccination rates in pregnant women is by recommending the influenza vaccine and offering it in your office. Women who reported that their doctor recommended and offered the vaccine were much more likely to get vaccinated than women whose doctors recommended the vaccine but did not offer the vaccine in their office.

Mr. Jordan: What treatment options are available for pregnant women with confirmed influenza?

Dr. Rasmussen: Pregnant women with confirmed or suspected influenza should be treated with oseltamivir as soon as possible, and they can be treated during any trimester. Your decision to treat should be based on clinical evaluation rather than on diagnostic testing because of the limited sensitivity of rapid influenza diagnostic tests and the time required to complete more definitive testing. If a pregnant patient is exhibiting the signs and symptoms of influenza, treatment should be started. Ideally, influenza antiviral treatment should begin less than 48 hours after onset of symptoms. However, there is still clinical benefit when treatment is started in a pregnant woman who is ill with influenza, even if 48 hours have already passed. There is no "48-hour rule" that prohibits later treatment.

Mr. Jordan: What else can pregnant women do to protect themselves and their families from flu?

Dr. Rasmussen: In addition to getting vaccinated, pregnant women should take everyday preventive actions against influenza, like avoiding close contact with sick people, staying home if they are sick, and washing their hands often with soap and water.

It is also important to emphasize that family members and caregivers should get vaccinated. Infants can benefit from added protection when everyone who cares for them gets an influenza vaccine. This includes all members of the household, relatives, and childcare providers.

Again, clinicians play a critical role in ensuring that pregnant women and their babies are protected from influenza. By educating women about vaccine safety and the benefits of influenza vaccine, and by offering the influenza vaccine in your office, you can help to ensure that your patients and their loved ones stay safe from influenza this season.

Questions? Call 866.626.6847 | Text 855.999.3525 | Email or Chat at MotherToBaby.org.

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Brentwood, TN – In a move that was several decades in the making, the U.S. Food and Drug Administration (FDA) has published a final rule that requires prescription drugs and biological products include more detailed labeling about their risks during pregnancy and breastfeeding. The Organization of Teratology Information Specialists (OTIS), the professional society that provides the MotherToBaby service and conducts observational research about exposures during pregnancy and breastfeeding, will provide additional support as health care providers and the public look to understand the new labels.

Up until the ruling announcement today, drug companies were required to use a category system to communicate risk of drugs or biological products during pregnancy. Since the implementation of this category system, the FDA has researched the system's impact, concluding it to be overly simplistic and confusing. The category system will begin to be phased out and pharmaceutical companies will be required to provide detailed risk information about the drugs, as well as relevant research, specific to pregnancy and breastfeeding.

“We know well that there is a plethora of information out there about these drugs and companies have chosen to not

include that information for whatever reason. Now, they have to," said Sandra Kweder, M.D., deputy director of the FDA's Office of New Drugs in the Center for Drug Evaluation and Research (CDER), during today's announcement.

The impact of a drug on breast milk will also have a dedicated section on the new labels, including whether medication gets into breast milk and whether it might affect the infant or not. In addition, the new labeling will include a section describing a medication's potential impact on fertility, birth control and any relevant pregnancy registry information.

"There will be a steep learning curve for clinicians and patients to feel comfortable with more detailed information as opposed to the simple letter category," said Christina Chambers, PHD, MPH, OTIS member and director of UC San Diego's Center for the Promotion of Maternal Health and Infant Development, the hub of where MotherToBaby pregnancy studies conducted by OTIS is located. "The MotherToBaby toll-free service can help," she added.

According to the FDA, there are 6 million pregnancies in the U.S. each year. In addition, pregnant women take an average of three to five prescription drugs during pregnancy. Those with pre-existing and chronic conditions, such as asthma or autoimmune diseases, often need to continue their medications during pregnancy or while breastfeeding. "Our hope is that the new labeling will help health care providers better understand the risks and benefits of these drugs so they can discuss the options with their pregnant and breastfeeding patients," said Chambers. "This is a huge step forward — and will make even clearer how critical the need is for more human pregnancy data for all medications likely to be used by women of reproductive age."

Chambers has also acted as a consultant for the FDA on issues related to communication of risk both to patients and providers. "Through the MotherToBaby service that OTIS provides, we're hoping to help the public understand the information provided on the new labels, as well as enroll participants into various observational research studies, the results of which will add even more useful information to the data."

Kweder echoed this importance. "Organizations like OTIS need to continue making sure its research gets published," she said.

MotherToBaby and OTIS are also suggested resources by many agencies including the Centers for Disease Control and Prevention (CDC). They are dedicated to providing evidence-based information to mothers, health care professionals, and the general public about medications and other exposures during pregnancy and while breastfeeding. Anyone wishing to receive a personalized risk assessment of drugs or other exposures can be connected with a MotherToBaby expert toll-FREE via its phone counseling service (866) 626-6847 or online at MotherToBaby.org.

MotherToBaby is currently conducting various research studies during pregnancy, including asthma, autoimmune diseases, and vaccines. To learn more, volunteer for a study, or refer a patient, please call (866) 626-6847 or visit the [Fact Sheets](#) page.

Media Contact: Nicole Chavez, 619-368-3259, nchavez@mothertobaby.org. Interviews in Spanish can also be arranged.

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