

Sirs.

Thank you for the opportunity to comment on the draft Pandemic Influenza Preparedness and Response Plan, DHHS, August 2004. I congratulate the authors on their excellent and comprehensive approach to providing information necessary for public health authority and private sector preparedness planning for an influenza pandemic. I especially appreciate the decision to use the format of a general core document with targeted annexes. This helps the reader achieve an overall appreciation of the issue while also permitting the reader to focus on those issues of particular relevance to the reader's interest. I also very much appreciate the complementary bedding of the US plan into the basic framework of the WHO pandemic plan. This coordinated preparedness approach will enhance the plan's effectiveness in the US, but more importantly provide guidance to other countries interested in developing their own plans. It serves as a demonstration of the complementariness needed between national and international efforts. I believe that this draft plan, once finalized and implemented will greatly further the US ability to effectively respond to a pandemic should one occur.

In reading through the draft document, however, I have noted a few items that the authors may wish to review and consider for amendment.

1.

Executive Summary. Page 8, D, first bullet: '...mortality of from influenza...'.
Page 8, E, first bullet: does 'virologic' mean 'laboratory'? Unclear what is intended.
Page 8, E, third and fourth sub-bullet under first bullet: uncommon use of English leading to confusion on what is intended.
Page 9,2), second sentence: double verb.

Annex 1. page 11, C.1. second paragraph, second bullet, : '~~it is~~, should be....'

Annex 1 Page 17, E 1. last paragraph: 'Timely...involved.': very confused English.
E 2. fifth bullet,: 'establish a hotline'?

Annex 3, page 4, Section V: This is a very different and unfortunately I believe more realistic interpretation of the potential impact of influenza and pandemics than what is presented in Annex 12, II page 2. Please see comments on Annex 12.

Annex 4, page 16, VI first paragraph: While there is nothing truly incorrect about what is stated in the paragraph, the first few lines suggest that WHO should have an animal disease surveillance program. However as WHO is a human public health organization, it has no mandate or authority to conduct animal disease surveillance. That activity rightly comes under the mandate of the FAO. WHO can encourage zoonotic disease surveillance, as a human or public health measure if a human health threat is identified. With the H5N1 virus, because of the human threat suggested by known cases of H5N1 infection, WHO was able to facilitate countries' efforts to implement avian and swine influenza surveillance in support of human disease prevention and control. Without an explicit statement of human health risk, however, WHO activities in animal health are rightly subject to criticism by other international organizations. Unfortunately, in the 2004 H5N1 outbreak in Asia, some other international organizations, more specialized in animal health, were slower than WHO to respond to the rapidly growing crisis.

Annex 6 page 9 , B. second paragraph, second line: 'the groups what? are at highest risk'

Annex 10, page 6, B, first paragraph: See comments in Annex 4. It may be helpful to change the wording to avoid implying that WHO is mandated to conduct animal disease surveillance. It is not. The first sentence could be modified to focus more on the animals as the source of the human influenza threat. For example: ' While no organized WHO program currently exists to conduct influenza surveillance in probable sources, avian species and swine, the value of this type of surveillance in assessing the human health risk is understood and such activities are likely to be expanded.'

Annex 12, page 2, IIA: While much needs to be learned about H5N1, I believe strongly that we should not automatically equate the pandemic potential of a virus with its virulence. Given what we have experienced to date with the H5N1 outbreak in susceptible species, humans and poultry, I believe the assumptions made in this section are very optimistic. We obviously do not have good numbers from Asia to determine a true human attack rate for this virus. But the estimated case fatality rate in known cases lies somewhere between 60 and 70 %, not the 1% projected in the draft as based on the experience with the other two pandemics in 1957 and 1968. We experienced in poultry, the other non-reservoir susceptible species, that both the exposed flock attack rate and case fatality rate are very high, close to 100%. I cannot discuss the virulence of the 1957 and 1968 viruses, but from what I've seen of the H5N1, this virus kills and kills quickly. The duration of symptomology in infected poultry was about 4 to 6 hours only. Signs noted in poultry were compatible with a massive cytokine dysregulation. If the speed and pathogenic mechanism is similar in humans, I am not certain that the US health care system will be able to keep a fatality rate near a 1% level. even with an adequate (quality and quantity) surge capacity in the US. I question the assumption that with ancillary home care measures we will be able to provide quality health care to all those in need. While significant improvement have been made in medical care over the last 90 years, routine nursing care will not prevent many fatalities, health care providers and volunteers will again be afraid and reluctant to aid the ill, and as our capacity to safely handle the ill becomes overtaxed, care centers will be avoided by the general public. I believe that what we know of the 1918 pandemic will be a closer model for a H5N1 pandemic that we would like. Given my pessimism, I do applaud every effort being done to develop an effective H5N1 vaccine. Adequate vaccine supplies will do much to counter the threat of H5N1.

CONOPS, page 6, OSG bullet: The professional category 'veterinarians' is not listed. While a small PHS Commissioned Corps Category, veterinarians are as required to participate in CCRF as other professionals and can contribute to medical emergencies in more roles than just food safety inspectors. For example, as stated in the main draft influenza pandemic plan, influenza originates as a veterinary disease, and zoonotic disease surveillance and zoonotic disease prevention and control activities, that is the practice of veterinary public health, are currently underway and expanding. The contribution of veterinarians to mitigating medical emergencies should be no more relegated to 'other' than some of the other professions listed in the paragraph.

Again, the minor nature of these comments demonstrate the quality of the work undertaken.

Sincerely,

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