Vital Signs Town Hall Teleconference
Zika Virus: Protecting Pregnant Women and Babies
Question & Answer
April 11, 2017
2:00 pm ET

Dagny Olivares: Thank you for these excellent presentations today. For those of you who have called in to the presentation, remember you can get in the queue to ask a question by pressing star 1. Say your name when prompted and the operator will announce when it's your turn. Please address your question to a specific presenter or indicate that it's a question for all of the presenters.

I also encourage folks who called in to share your own strategies, lessons learned, challenges and success stories about this topic. We have quite a few states and organizations on the call. And this town hall is a forum for you to discuss different methods, practices and experiences with Zika virus surveillance and prevention.

Operator, we are ready for questions. Is there anyone in the queue?

Coordinator: Welcome and thank you for standing by. At this time, we would like to begin the question and answer session. To ask a question, please press Star then 1 to record your first and last name. To withdraw your question, press Star then 2. One moment please to see if we gather questions.

The first question comes from (Brenda Cressville). Your line is open.

(Brenda Cressville): Hi. This question is directed towards Dr. Dolan. The algorithm you referenced is that something that's being followed across the United States or is it just in New York City?

Dr. Dolan: No, that algorithm has been published by the CDC. And it's both in the MMWR and then there's also a guidance for obstetricians caring for women with possible Zika virus exposure. So that algorithm is widely published, not specific to New York City.

Dr. Jamieson: This is Denise Jamieson from CDC. And I just wanted to follow-up on that comment. So we have got - as you might see from the algorithm, it's quite complex. And we have gotten a lot of feedback from partners that it's a complex algorithm.

We also understand that the serologic testing can be confusing and complex to interpret. So we are working on trying to simplify that algorithm and incorporate some new evidence to update that algorithm. So we hope that in the near future we'll have an update to that widely disseminated algorithm.

Dr. Lee: This is Ellen Lee at the New York City Department of Health. I should add as well that at the Health Department when we were doing all of the testing for New York City residents, we actually used a different algorithm.

And we were able to offer both nucleic acid testing as well as serologic testing for all individuals requesting testing and met the testing criteria. So we used a more simple - test everyone with molecular and serologic testing.

Now that more testing is happening through commercial laboratories, I think that people are turning more to this algorithm through CDC. But again, for many months of 2016, all individuals meeting testing criteria had both PCR and IgM testing ordered.

Dr. Jamieson: Just to follow-up, Ellen, it was New York City and New York State's excellent experience in their labs that really helped us re-evaluate this issue. So many thanks.

Dr. Lee: I'll let our lab colleagues know about your comment. Thank you very much.

Coordinator: The next question comes from (Dean Bartholomew). Your line is open.

(Dean Bartholomew): Hi. I haven't seen anything in regards to cost for testing for the Zika. And, if so, does that have any impact on maybe some of the impoverished areas and people getting tested for Zika?

Dr. Lee: This is Ellen Lee. I can comment from the New York City Department of Health perspective. And, Dr. Dolan, I'm not sure if maybe you might be able to comment from your experience.

At the Health Department, though as of late last year, as I mentioned before, we have been recommending commercial laboratory testing for routine testing of pregnant women. We have left open the possibility of going through our public health laboratory if an individual met testing criteria and either had no insurance or inadequate insurance to cover Zika testing costs.

I do think that the testing costs are different and need to be considered when determining which tests to request. So, again, as I was just mentioning, we would do serum and urine PCR as well as serum IgM routinely for the test requests that we were handling.

But to do that, using the commercial labs, would come at a significant cost. So I think that clinicians and patients are having to make tough decisions about what they think would be their higher yield tests.

We do see that there are some cases of inappropriate testing that's being done, I think, as clinicians are trying to understand the very confusing array of tests. And each commercial lab seems to be packaging up the tests in different ways.

So you actually have to evaluate each commercial lab separately and figure out how their tests are being packaged up and which is appropriate for any individual patient.

Dr. Dolan: Yes, this is Siobhan Dolan. I agree. I think what we did was use the New York State laboratory for the first many months of the data that you've seen today. And that did not incur costs to the individual patient.

And now that we've moved into commercial laboratory availability, New York State Medicaid, in particular, is quite good coverage. So cost hasn't become a predominant on our list of barriers or hurdles.

Some of the challenges we do face are language. Because many of these women who may be at greatest risk might have - a common example would be folks who lived in either the Dominican Republic or Puerto Rico and then sort of halfway through the pregnancy might have moved to New York don't necessarily have, you know, a sense that they should come in for testing, get screened by their provider and then come over to see us for testing.

So kind of starting from scratch with, you know, because you lived there you were at risk and, you know, the testing. So that has been a little bit of a barrier that some women have faced.

And the other is that we see folks who want to have testing. They don't want to wait either the six months or the eight weeks. They want to come even if they don't meet the criteria. They're not pregnant yet.

And they want to get tested and then start to try to get pregnant before they waited the full period. And we really have to talk people out of that because, you know, a negative test doesn't guaranty there was no exposure and so forth.

So those are two of the scenarios we've seen. We haven't had a big problem with frank cost being prohibitive.

Coordinator: Thank you.

Dagny Olivares: Thank you, operator. I think we're ready for the next question.

Coordinator: The next question comes from Genevieve Buser. Your line is open.

Dr. Buser: Thank you. This is Genevieve Buser from Oregon. I have two more questions about testing. One was regarding, I have a patient who is three weeks post-natal and has been in the NICU. And we're now finding that mom had exposure. She's now reporting she had exposure during the first trimester. So what would you recommend for postnatal testing that far out since the infant guidelines are really within the first 48 hours?

And then secondly is there anything up and coming regarding partner testing? So we get a lot of requests, as I'm sure you do, regarding, say, husbands or partners who travel and how can they know that they're clear? Thank you.

Dr. Lee: This is Ellen Lee at the New York City Department of Health. I can take that first question. In that situation here in New York City, we would recommend testing of the infant because, as you mentioned, the mother is now outside of the window where you could hope to get a positive IgM in most circumstances.

So we have specific guidance that we've developed, and kind of in our own algorithm, to get at those challenging situations that aren't quite covered in the testing guidance. But again, for a mother who is more than 12 weeks outside of her exposure period, we would recommend testing the infant.

Dr. Buser: And up to what point are you okay testing the infant? I presume with both the PCR and IgM. Is it the same 12 weeks postnatally or?

Dr. Lee: We actually have been stretching for how long we might consider testing an infant for a possible congenital infection. So we would actually - granted, we've been sort of discussing this. And I think we have said up for four months. And I think we might even consider longer than that. I think there seems to be so much that's unknown about the persistence of IgM in infants.

So we have tested infants as old as, actually, I think the oldest one was about five months. That was a more complicated case. But we will consider testing up to four months for possible congenital infections understanding that a negative is not so helpful because we would presume that the IgM, if it's negative, it may mean that it had been there previously but had waned.

But depending on the clinical scenario, we might consider the plaque reduction neutralization testing for that infant to look to see if there are IGG antibodies that would be positive for Zika. So we deal with those on a case-by-case, but we would consider testing. And again, depending on the clinical scenario, consider the plaque reduction neutralization testing.

Dr. Dolan: Yes. This is Siobhan. The other thing I wanted to add, and I'm not a pediatrician, but we're trying to help point out and help with the transition of care from the obstetric side to the pediatric side. Because, as we saw in the Vital Signs, you know, only 25 percent of babies got the head imaging. So we're trying to sort of beef up that transition.

And so for babies where there's a question mark, you know, like not a clear cut confirmed Zika, the testing wasn't positive but we still have a concern about exposure, there's a really great checklist on the cdc.gov/zika Web site.

And it talks about the different categories of the prenatal exposure. And then it has a timeline for the first year of life that includes head imaging, hearing screening, vision screening.

And so really great care guidelines for, you know, everything from suspected to confirmed infection. And I think that can be extremely helpful. In fact, we're giving it to some of our moms to help transition again into the pediatric care.

Because certainly, even if we don't know it's a classic case of congenital Zika syndrome, doing vision screening, hearing screening, you know, we may learn more about the spectrum of this syndrome. And so we don't want to miss some of these areas of intervention. And so this first year algorithm is fantastic and is freely available on the cdc.gov/zika Web site.

Dr. Jamieson: Hi. This is Denise. I just wanted to jump in. What Ellen was talking about in terms of testing beyond two days of life is spot on and included in our new updated Web guidance for infants that we posted last Monday that, you know, testing outside the two-day window is a reasonable thing to do.

Dagny Olivares: Thank you. Any questions...

Dr. Jamieson: I don't know if the caller can repeat the second part of the question if it hasn't been addressed. We had trouble hearing it.

Dr. Buser: Oh, sure. The second was regarding partner testing. So for partners who travel and come back, we get a lot of requests, again, for testing for them. Are you just recommending commercial testing? How are you doing those guidelines? And is there is anything in the pipeline for having that more available for sort of non-pregnant women that aren't being tested due to Health Departments? Thanks.

Dr. Jamieson: This is Denise from CDC. So we do get a lot of requests for that type of testing. We don't recommend that. Unless a person has been exposed and is symptomatic, we don't recommend testing for a variety of reasons, including the risk of false reassurance to the person.

There's also been a call for testing of semen to see if the virus persists in semen of people who have traveled. But at this point, we're not recommending any testing for people attempting conception. But we do recommend those waiting periods of eight weeks for women and six months for men.

Dr. Lee: This is Ellen Lee again from the New York City Department of Health. The other thing I would mention in addition to that is that, as I mentioned also during the presentation, is that we've been seeing quite a large proportion of IgM test results coming from the commercial labs that are false positives, meaning that when we repeat them at our New York State lab, they are IgM negative.

And we seem to see that certainly with a greater frequency among the patients who had very low risk for Zika in the first place. So I can understand the concern and the desire to be tested. I think that the other part of that is to consider the potential for a false positive, especially given a lower risk population in the first place.

And also, I think our New York State protocol of repeating IgM testing for a positive result that came from a commercial lab, I think that's a little bit unusual. And so it may not be possible through other health departments.

Dr. Buser: Great. Thank you.

Dagny Olivares: Operator, I think we're ready for the next question.

Coordinator: As a reminder, to ask a question, please press Star 1 to record your first and last name. Our next question comes from (Shamika Williams). Your line is open.

(Shamika Williams): Hi. This question is for all presenters. I am just curious from a prevention perspective, what are the places that you would recommend absolutely getting outreach materials to?

Dr. Dolan: This is Siobhan. You know, in the Bronx, we're trying to work with materials in both English and Spanish. And we're also trying to target those to, like, community centers.

And, you know, because these are prevention messages before you become pregnant, we're trying to get them out into community-based organizations, not exclusively health care settings. Because a lot of times, like I said before, by the time they come to us, you know, we see the anxiety or the stress that we cause by pointing out that there was an exposure.

The time for prevention is prior to the pregnancy, prior to the travel. So community-based messages in English and Spanish would be my recommendation and then kind of looking at your community resources. And, you know, what are the groups where young women are participating, again, prior to pregnancy?

(Shamika Williams); Dr. Jamieson, are there places that CDC has specifically focused on putting messages to reach at-risk women?

Dr. Jamieson: There have been some groups that have provided outreach to places like bridal fairs, health fairs, neighborhood festivals, anywhere where women and families might attend, local food banks, women's shelters, places like that, adolescent health centers, school-based health centers, family planning clinics to really incorporate prevention messages into their programs.

I think the other place for outreach is with health care providers. As we mentioned, only 1 in 4 babies are being appropriately worked up for possible congenital Zika virus infection. And we don't know why that is. But there may be a disconnect between the OB providers and the pediatricians.

And so I think we focus throughout the outbreak on the role that obstetricians and health care providers to take care of pregnant women play. And I think we probably need to spend more time on the role that pediatricians play in preventing the effects of Zika.

Dr. Lee: This is Ellen Lee at the New York City Department of Health. I certainly agree with the need to include pediatric care providers more in this discussion. And I think that sometimes some of the messaging goes to the prenatal care providers. And the pediatric side doesn't get as much as the sort of aggressive outreach.

But I would certainly also second what Dr. Dolan mentioned about working at the community level. It's really ongoing to, let's say, do presentations at local hospitals where we find out that the patient population that is serviced by a hospital where we think there's probably a larger at-risk group, those patients would most likely get their information from places that we didn't even think about so beauty parlors and car services and some other things that we hadn't thought about.

So, I think, it's sort of individualized for each community. And it seems like it's both working with your providers at all different facilities and then having a sense of the community that you're trying to target for outreach.

(Shamika Williams): Thank you.

Coordinator: The next question comes from (Debra Murrray). Your line is open.

(Debra Murray): Hi. Good afternoon. Thank you for taking my call. This question is specifically for Dr. Denise Jamieson from the CDC. How are we supposed to react to clients and participants after they read the back of insect repellent that contains about anywhere from between 25 to 30 percent DEET that says hazard to humans and domestic animals and keep out of inside and outside drains?

Dr. Jamieson: So the EPA approved insect repellents are safe and effective for pregnant women. There have been studies, surprisingly a large number of studies in pregnant women with insect repellent such as DEET.

You know, there were early tie studies where basically pregnant women used fairly high concentrations of DEET. So we have fairly good safety data. I am not familiar with the labels. That's a label on DEET? I'm not familiar with that specific label.

(Debra Murray): Yes, it is. It's on the OFF. It's on Cutter Backwoods insect repellent. It's on Ben's Tick and Insect Repellent that the New Jersey State Department of Health has allowed WIC programs to distribute to their pregnant women as well as Repel, which contains permethrin for clothing and gear insect repellent.

Dr. Jamieson: So, yes. I'll have to look into that. I was not aware that there was a warning on it.

(Debra Murray): Absolutely. There is.

Dr. Jamieson: Yes. I mean, the key is, used as directed, it's safe and effective.

(Debra Murray): Although it says hazard to humans and domestic animals.

Dr. Jamieson: Yes, I guess it - I assume they're referring to the potential hazard if not used according to the labeling instructions. But I was unaware of that.

(Debra Murray): Okay. FYI. Thank you.

Dr. Dolan: Sorry. This is Siobhan. I just wanted to add to that. I try to run through with women how to use it; what “according to guidelines” means. Because, you know, I think, and everyone else can correct me if I'm wrong, but you're supposed to wear, like, long sleeves and pants that have long pants. And then only apply the insect repellent to exposed areas.

Because, you know, you have sort of different types of people. But some people are very cavalier. And they're, like, oh, what's the big deal of insect repellent?

And then you don't want someone else to, like, spray their entire body top to bottom, you know, and overdo it, right? So the idea is to kind of cover yourself, but then on exposed areas use both insect repellent and sunscreen.

So, you know, with patients that I think are maybe inclined to, you know - anyway, with everybody, I just review what the proper usage of insect repellent is on exposed areas to try to just put that issue to rest in terms of we don't want you to use too much. We want you to use the right amount. And so that I have found reassuring women who have raised that concern with us.

(Debra Murray): I don't know how you can control that? You know, don't go far so? It's so cool how they can control that. Okay.

Dagny Olivares: Thank you. Operator, do we have any...

Dr. Jamieson: Can I just comment? We just looked up the OFF Deep Woods label. And it looks like it's primarily talking about hazards if swallowed or it's in your eyes, I think, what that sentence is referring to. So I think the key, when counseling patients, is to use as directed.

Dagny Olivares: Thank you, Dr. Jamieson.

Coordinator: Our next question comes from Dagoberto Martinez. Your line is open.

Mary Ann Fore: Yes. Hello. This is Mary Ann Fore. I'm a nurse midwife. Unfortunately, he's with patients. And I wanted to ask a question. We're from Brownsville, Texas, health care providers to pregnant women.

And I would like to know what is the preconception counseling or testing for our patients that live in this area, obviously, the preventative measures for women that want to get pregnant? What should we be doing and counseling them?

Dr. Jamieson: So if you're within the yellow area, which I assume - if your patients are living, residing within the yellow area of Brownsville, then they would fall under the guidance for women residing in an area of active Zika virus transmission. So we would recommend testing twice during pregnancy.

In addition, for any woman living along the border who is traveling back and forth frequently to Mexico, we would also consider her to have frequent exposure. And she should also be tested routinely in pregnancy.

Mary Ann Fore: Right. And we do test in all our patients. We were just doing it once. But we just got the notice that we should do it in second trimester. But my question is for pre-conception, those of our patients that want to get pregnant.

Dr. Jamieson: I'm sorry. Yes, so for pre-conception, we are not recommending any testing for a variety of reasons. And we are recommending for women who don't reside in an area but are traveling to an area, we recommend those waiting periods.

And as you are well aware, for women residing in areas with active Zika virus transmission, it's a much more complex decision. And, of course, unless they have symptoms. If they have symptoms, then they should be tested.

Dagny Olivares: Thank you. Operator, I believe we have time for one more question in today's town hall.

Coordinator: The next question comes from (Jonathan Notch). Your line is open.

(Jonathan Notch): Hi. Thank you. I just want to have a follow-up on this line of thinking about pre-conception testing. I'm not really sure what is supposed to happen that once a woman becomes pregnant then we would recommend testing.

I understand Dr. Dolan and Lee were talking about false positive testing results. But I don't really see - I mean, the risk of having a false positive would seem to me just to be the same once a woman becomes pregnant compared to if she was traveling to an area where she may have been exposed.

Why wouldn't you try to prevent that potential pregnancy if they have that knowledge beforehand? Why wouldn't you consider doing that ahead of time?

Dr. Jamieson: So what we would recommend would be the waiting periods. Because basically we're saying that we can't, sort of, trust the testing during that period. There's risk of false positives and false negatives. So we recommend waiting periods rather than testing.

(Jonathan Notch): So you think it gets better when you get further out from potential exposure? Because I think Dr. Lee had three out of seven were negative or positive IgM and PSR were negative. So the testing gets better further along in the pregnancy? Or would it be better to test it earlier on when they were closer to the potential travel exposure?

Dr. Jamieson: I'm not sure. So the idea is to wait from the possible exposure to ensure that you don't have Zika basically, persistent Zika virus.

(Jonathan Notch): So waiting longer from potential exposure increases your chance of getting a true positive?

Dr. Jamieson: I'm sorry. Could you repeat your comment?

(Jonathan Notch): I guess if you're waiting longer from the potential travel exposure to test, which would be presumably further into the pregnancy, you're more likely to have a true positive result?

Dr. Jamieson: So the waiting period is to ensure that there's no - that Zika is not - that you're far enough from the exposure that you won't have persistent asymptomatic virus. So, for example, persistence of virus has been seen in semen even when the blood is negative. So the idea is to wait that period before attempting conception.

(Jonathan Notch): Ideally. But if you have a patient in front of you, you know, they're 38 years old. They just traveled to an area and their partner and they don't want to wait six months for a variety of reasons. Then you're sort of in this limbo.

Dr. Jamieson: So if it's a travel, that's why we recommend that people attempting conception not travel to areas with ongoing Zika virus transmission. So that's why our recommendations are the way they are. However, if you're residing in an area, then, as you say, it's a complex decision based on a whole lot of factors, including, you know, maternal age and lots of other things.

(Jonathan Notch): Right. Okay. Thank you.

Dagny Olivares: Thank you. This is Dagny Olivares, your moderator again. And I wanted to invite everyone who joined us today to please let us know how we can improve these teleconferences. You can email your suggestions to ostltsfeedback@cdc.gov that's o-s-t-l-t-s-feedback, all one word, at cdc.gov.

I also want to acknowledge that we had a number of questions in the queue today that we didn't get to because of our time limit. If you still have a question that you want to ask, please send those questions to ostltsfeedback@cdc.gov and we will work with our colleagues to address them.

We also hope that you're able to join us for next month's town hall, which will be held on Tuesday, May 9. We'll be talking about African-American health, which is the subject of next month's vital signs. Thank you to our presenters and everyone who attended the call today. I'd like to ask our presenters to please remain on the line. And now I'll turn our call back over to the operator.

Coordinator: This concludes today's conference. Thank you for your participation. You may all disconnect at this time.

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