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Editorials

Beyond Identification of Patients Experiencing Intimate Partner Violence

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In this issue of *American Family Physician*, DiCola and Spaar give pragmatic guidance to family physicians on their role in responding to patients who are experiencing intimate partner violence (IPV).[1] Their approach accords with the U.S. Preventive Services Task Force recommendation to screen all women for IPV. The United States is one of the few countries with a policy of screening for IPV. Guidelines from the United Kingdom's National Institute for Health and Care Excellence[2] and the World Health Organization[3] recommend a low threshold for physicians to ask about IPV, but do not recommend routine screening. The evidence for screening in health care settings is contradictory, hence the discrepancy between the systematic review underpinning the U.S. Preventive Services Task Force guidelines[4] and the Cochrane review on which the National Institute for Health and Care Excellence guidelines are based.[5,6]

I propose that we move beyond this debate, particularly in the context of family medicine, and focus instead on action that will protect the safety of patients experiencing IPV. My rationale for this proposal is twofold.

First, screening programs are not all that different from targeted inquiry approaches. We know that screening programs increase disclosure of IPV in health care settings. We also know that training family physicians to ask about IPV, particularly when there is a referral pathway to further support the patient, also increases disclosure.[7] There are no head-to-head trials of screening vs. clinical inquiry (or active case finding), so we do not know which is more effective. Given that even in trials screening by physicians is only partial, in reality, the operational difference in the family medicine clinic between an IPV screening program and a targeted clinical inquiry program is likely to be minimal. Physicians do not implement screening not only because of time constraints, lack of training, and discomfort with asking about abuse, which would affect any IPV identification method, but also because they are skeptical about the evidence base.[8]

Second, the IPV screening vs. active case finding debate is a distraction for researchers, systematic reviewers, and physicians, because it focuses attention and resources on what is only the first step in an effective (and safe) response to survivors of IPV in clinical settings. The ensuing steps after a patient has disclosed abuse to a physician (or physician's assistant or nurse) are as important as eliciting disclosure, regardless of the identification method. These steps include the physician giving an appropriate and validating response, checking for safety, offering referral to IPV support agencies, facilitating uptake of that referral (i.e., more than just offering a list of agencies), and offering ongoing physician contact.

What is the thread that ties effective identification of IPV survivors to effective management? Training. Given the absence or low profile of undergraduate or postgraduate medical training on IPV, how can we expect physicians and other clinicians to engage with the issue? They often do not understand the epidemiology of IPV, its coercive reality, the entrapment of survivors, and the severe safety risks, which may inhibit disclosure of the abuse or use of support services. Asking about IPV in a family medicine setting, via a screening tool or in the course of taking a clinical history, requires training and practice. A systematic review of nine trials of IPV training interventions for physicians showed that only multifaceted physician training that combined education with system support interventions changed physician behavior related to IPV. System support activities included displaying posters and brochures about violence in waiting areas, and providing prompts to physicians, checklists in medical records for IPV diagnosis, ▶

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Efficacy of Fluzone High-Dose in Adults 65 Years of Age and Older

Study 2 (NCT01427309) was a multi-center, double-blind post-licensure efficacy trial conducted in the US and Canada in which adults 65 years of age and older were randomized (1:1) to receive either Fluzone High-Dose or Fluzone. The study was conducted over two influenza seasons (2011-2012 and 2012-2013); 53% of participants enrolled in the first year of the study were re-enrolled and re-randomized in the second year. The per-protocol analysis set for efficacy assessments included 15,892 Fluzone High-Dose recipients and 15,911 Fluzone recipients. The majority (67%) of participants in the per-protocol analysis set for efficacy had one or more high-risk chronic comorbid conditions.

In the per-protocol analysis set, females accounted for 57.2% of participants in the Fluzone High-Dose group and 56.1% of participants in the Fluzone group. In both groups, the median age was 72.2 years (range 65 through 100 years). Overall, most participants in the study were White (95%); approximately 4% of study participants were Black, and approximately 6% reported Hispanic ethnicity.

The primary endpoint of the study was the occurrence of laboratory-confirmed influenza (as determined by culture or polymerase chain reaction) caused by any influenza viral type/subtype in association with influenza-like illness (ILI), defined as the occurrence of at least one of the following respiratory symptoms: sore throat, cough, sputum production, wheezing, or difficulty breathing; concurrent with at least one of the following systemic signs or symptoms: temperature >99.0°F, chills, tiredness, headaches or myalgia. Participants were monitored for the occurrence of a respiratory illness by both active and passive surveillance, starting 2 weeks post-vaccination for approximately 7 months. After an episode of respiratory illness, nasopharyngeal swab samples were collected for analysis; attack rates and vaccine efficacy were calculated (see Table 3).

Table 3: Study 2[a]: Relative Efficacy Against Laboratory-Confirmed Influenza[b] Regardless of Similarity to the Vaccine Components, Associated with Influenza-Like Illness[c], Adults 65 Years of Age and Older

	Fluzone High-Dose N[d]=15,892 n[e] (%)	Fluzone N[d]=15,911 n[e] (%)	Relative Efficacy % (95% CI)
Any type/subtype[f]	227 (1.43)	300 (1.89)	24.2 (9.7; 36.5)[g]
Influenza A	190 (1.20)	249 (1.56)	23.6 (7.4; 37.1)
A (H1N1)	8 (0.05)	9 (0.06)	11.0 (-159.9; 70.1)
A (H3N2)	171 (1.08)	222 (1.40)	22.9 (5.4; 37.2)
Influenza B[h]	37 (0.23)	51 (0.32)	27.4 (-13.1; 53.8)

[a] NCT01427309
[b] Laboratory-confirmed: culture- or polymerase-chain-reaction-confirmed
[c] Occurrence of at least one of the following respiratory symptoms: sore throat, cough, sputum production, wheezing, or difficulty breathing; concurrent with at least one of the following systemic signs or symptoms: temperature >99.0°F, chills, tiredness, headaches or myalgia
[d] N is the number of vaccinated participants in the per-protocol analysis set for efficacy assessments
[e] n is the number of participants with protocol-defined influenza-like illness with laboratory confirmation
[f] Primary endpoint
[g] The pre-specified statistical superiority criterion for the primary endpoint (lower limit of the 2-sided 95% CI of the vaccine efficacy of Fluzone High-Dose relative to Fluzone >9.1%) was met.
[h] In the first year of the study the influenza B component of the vaccine and the majority of influenza B cases were of the Victoria lineage; in the second year the influenza B component of the vaccine and the majority of influenza B cases were of the Yamagata lineage

A secondary endpoint of the study was the occurrence of culture-confirmed influenza caused by viral types/subtypes antigenically similar to those contained in the respective annual vaccine formulations in association with a modified CDC-defined ILI, defined as the occurrence of a temperature >99.0°F (>37.2°C) with cough or sore throat. The efficacy of Fluzone High-Dose relative to Fluzone for this endpoint was 51.1% (95% CI: 16.8; 72.0).

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HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Single-dose, prefilled syringe, without needle, 0.5 mL (NDC 49281-399-88) (not made with natural rubber latex). Supplied as package of 10 (NDC 49281-399-65).

Storage and Handling

Store Fluzone High-Dose refrigerated at 2° to 8°C (35° to 46°F). DO NOT FREEZE. Discard if vaccine has been frozen. Do not use after the expiration date shown on the label.

PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information).

- Inform the patient or caregiver that Fluzone High-Dose contains killed viruses and cannot cause influenza.
- Among persons aged 65 years and older, Fluzone High-Dose stimulates the immune system to produce antibodies that help protect against influenza.
- Among persons aged 65 years and older, Fluzone High-Dose offers better protection against influenza as compared to Fluzone.
- Annual influenza vaccination is recommended.
- Instruct vaccine recipients and caregivers to report adverse reactions to their healthcare provider and/or to Vaccine Adverse Event Reporting System (VAERS).

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and information on accessing services and referral for patients.

In the United States and internationally, we need to prioritize effective IPV training of physicians and other clinicians, whatever guidelines we use to identify IPV survivors. If they do not exist already, we need to establish explicit referral pathways to IPV advocacy support, which may be outside of health care organizations in the social care or community nonprofit sectors.

Physician offices may be one of the few safe spaces for patients to disclose their abuse. We know that survivors want us to ask about IPV and to respond appropriately and safely.[9] Training and system support will allow us to do that.

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