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(symptom onset more than 48 hours after admission) or 26.3% (more than 24 hours after admission).

ACKNOWLEDGMENTS

Financial support. Funding for this research is provided by the Public Health Agency of Canada.

Potential conflicts of interest. All authors report no conflicts of interest relevant to this article. All authors submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest, and the conflicts that the editors consider relevant to this article are disclosed here.

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Reply to Vanhems et al

To the Editor—We would like to thank Dr. Vanhems and colleagues¹ for their interest in our study.² We agree that development of a standard definition of healthcare-associated influenza (HAI), which currently does not exist, is an important priority to allow research in this area to progress.

Since it is uncommon for a specific source of influenza infection to be identified in patients who become symptomatic following admission, an agreed-upon time limit will likely be necessary, similar to National Healthcare Safety Network definitions for other healthcare-associated infections.³ This time limit should represent the estimated incubation period for naturally occurring influenza—either median or maximum. Using a median incubation period is problematic since, as Dr. Vanhems and colleagues point out, it is likely subject to patient-to-patient variability related to virus strain type,⁴ dose, and host factors, as reflected in variability in incubation periods seen even in point source outbreaks.^{5,6}

In our study,² designed to assess the burden of disease and seasonal variability in frequency of HAI, we elected to choose a maximum incubation period of 96 hours. Infections occurring beyond 96 hours after admission would be considered HAI, so that the HAI proportion would be conservatively estimated. In the 6 study years using this definition, 17.3% of hospitalized cases were considered HAI (range by year, 6.6%–33.1%). A further 4.2% of patients became symptomatic between 48 and 96 hours after admission (range by year, 2.9%–8.1%), and 4.8% developed symptoms between 24 and 48 hours after admission (range, 3.0%–7.8%). If these cases were added, the HAI proportion of all cases would be 21.5%

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Infect Control Hosp Epidemiol 2014;35(8):1075–1075

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