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TECHNICAL BULLETIN

DATE: December 30, 2025

TOPIC: Respiratory Season Guidelines

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TO: Health Care Providers, Medical Facilities, Medical Laboratories, and Local Health Authorities

Influenza, COVID-19 (SARS-CoV-2), and Respiratory Syncytial Virus (RSV) will continue to co-circulate during the 2025–26 respiratory season. Nevada's statewide approach prioritizes rapid case ascertainment for severe outcomes or potential H5N1 exposures, sustained virologic surveillance, and timely reporting to local health authorities (LHAs) and the Office of State Epidemiology (OSE) to guide prevention and clinical decision-making.

- Additional reporting of pediatric deaths: As of November 2025, deaths in persons <18 years attributable to COVID-19 or RSV are reportable (RSV is voluntarily reportable) to the Local Health Authority (LHA) within 24 hours of identification. The LHA will coordinate clinical and epidemiologic data collection with OSE. See Table 1 for more details.

All other reporting, testing, and surveillance guidance below remains unchanged from the prior season, except where clarified for readability.

Test (Diagnostic Strategy)

Indications

- Test symptomatic patients at risk for severe disease, those requiring admission, those part of outbreak/cluster evaluations, and patients for whom antiviral/monoclonal therapy would be considered.
- Test symptomatic patients with potential H5N1 exposure prior to symptom onset.[1]

Specimens & Platforms

- For seasonal influenza, COVID-19 (SARS-CoV-2), and RSV, the preferred upper respiratory specimen is a nasopharyngeal (NP) swab in viral/universal transport medium, with assay-authorized alternatives (e.g., nasal mid-turbinate, anterior nasal, or combined nasal–throat/oropharyngeal swabs) used as permitted in the test's instructions for use.
- When highly pathogenic avian influenza A(H5) is suspected, clinicians should prioritize collection of both NP and oropharyngeal (OPA/OP) swabs (in separate tubes), and for patients with lower respiratory tract involvement, add a lower respiratory specimen (e.g., sputum, tracheal aspirate, or

[1] For influenza A (H5), the first three human cases detected by the state public health lab must be sent to CDC for confirmation. After CDC confirms those three cases, the state lab can consider all subsequent H5 positives as confirmed.

bronchoalveolar lavage) when available to improve diagnostic yield. If the patient presents with conjunctivitis, a conjunctival swab should also be collected, as H5N1 has been associated with ocular involvement in prior cases. Paired specimen collection (e.g., NP and conjunctival) may enhance detection in such presentations.

Subtyping/Lineage

- *Influenza A:* For any hospitalized case reported as "influenza A, unsubtyped," perform H1/H3 subtyping within 24 hours (public health lab or a validated clinical lab). Specimens not confirmed as H1 or H3 should undergo H5 subtyping.[2] Influenza A subtyping and novel virus detection should align with CDC's 2025–26 Influenza Season Surveillance Guidance, which includes recommendations for specimen types (including conjunctival swabs for H5), and subtyping thresholds.
- *Influenza B lineage:* Lineage testing not indicated; B/Yamagata has not circulated in the U.S. since early 2020.
- *SARS-CoV-2:* Clinical management does not require variant characterization. Retain residual specimens and submit to the public health laboratory for sequencing. Facilities submitting SARS-CoV-2 positive specimens for sequencing should follow the CDC NS3 guidance for biweekly submissions, specimen types, and storage requirements.
- *RSV A/B:* Routine A/B typing is not indicated clinically. Participate in public health typing upon request.

Treat (Therapeutics)

- *Influenza:* Initiate neuraminidase inhibitors (e.g., oseltamivir) promptly for hospitalized patients, progressive/severe disease, or high-risk outpatients; do not delay pending test results when clinical suspicion is high. Treat empirically if patient has suspected H5 exposure.
- *COVID-19:* Use authorized antivirals per NIH/IDSA guidance based on risk, timing, and drug–drug interactions.
- *RSV:* For infants <8 months not adequately protected by maternal RSV vaccine, consider nirsevimab or clesrovimab as pre-exposure prophylaxis per ACIP; for select high-risk children 8–19 months entering a second season, use nirsevimab. Supportive care remains the mainstay of treatment for RSV infection.

Report (Timeframes, Mechanisms, and Data Elements)

Facilities should report cases pursuant to Nevada Administrative Code (NAC) 441A.225 and as indicated in Table 1 to their LHA (Table 2). The LHA will coordinate with OSE to complete case investigation and mortality data abstraction.

LHAs should notify OSE at dpbhepi@health.nv.gov pursuant to NAC 441A.290. If your facility is not automatically sending case reports to public health via electronic lab reports (ELR) or electronic case reports (eCR), please complete the Confidential Morbidity Report (CMR) found here and notify your local health authority via phone or fax.

[2] Subtyping of influenza A positive specimens is recommended for all severely ill persons, particularly those with relevant exposure history; however, if volume, resources, or other reasons require prioritization, focus on the most critical, such as persons in the ICU.

4150 Technology Way, Suite 300 ● Carson City, NV 89706 ● (775) 684-4200 ● Fax (775) 687-7570 ● dpbh.nv.gov

Table 1: Reportability of Respiratory Viruses in Nevada, 2025-2026

Condition	Reportable	Timeframe for Reporting
Influenza	• Hospitalizations • Deaths (regardless of age) • If known or suspected to be a pandemic strain • If novel or untypable • Outbreaks	Pandemic-potential strain (including H5), outbreaks: Immediately Pediatric Deaths: Within 24 hours of identification All others: Next working day
RSV	• Positive results • Pediatric deaths (voluntary reporting)* • Outbreaks	Outbreaks: Immediately Pediatric Deaths: Within 24 hours of identification Positive results: Next working day
SARS-CoV-2	• Positive results • Pediatric deaths* • Outbreaks	Outbreaks: Immediately Pediatric Deaths: Within 24 hours of identification Positive results: Next working day

**Indicates a change from the 2024-2025 respiratory disease season*

Minimum data set for pediatric mortality notifications

When reporting a pediatric death, document in the person's medical record, at minimum: demographics; residence; healthcare facility; dates (symptom onset, first positive test, admission/ICU, death); location of death; infancy status; underlying conditions; vaccination/immunoprophylaxis status and dates (influenza, COVID-19, nirsevimab/palivizumab); diagnostic test type(s)/specimen(s)/result(s); antimicrobial/antiviral therapies and timing; imaging and major complications; autopsy status; and cause-of-death chain.

Submit (Public Health Sentinel Surveillance Specimens)

- All clinical facilities—not just designated sentinel sites—are encouraged to submit respiratory specimens for public health surveillance. Facilities may choose to send specimens on a weekly or biweekly basis, depending on their capacity. While there is no strict limit on the number of specimens submitted, if more than three surveillance specimens are received from a single facility in a given week, the public health laboratory may sample from the submissions to align with testing capacity and state surveillance goals. Submissions should aim to represent a diverse cross-section of age groups, geographic areas, and care settings. Coordinate with the receiving public health laboratory for packaging, cold-chain, and transport; store residuals at ≤−70°C when longer-term hold is requested.
- Sentinel specimens may/may not be tested in accordance with laboratory capacity.

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Table 2: Nevada Local Health Authorities

Local Health Authority	County(ies)	Fax & Phone Number to Report
Carson City Health and Human Services (CCHHS)	Carson City, Douglas, and Lyon	Fax: 775-887-2138 Ph: 775-887-2190 (24 hours)
Central Nevada Health District (CNHD)	Churchill, Mineral, Eureka, and Pershing	Fax: 877-513-3442 Ph: 775-866-7535 (24 hours)
Northern Nevada Public Health (NNPH)	Washoe	Fax: 775-328-3764 Ph: 775-328-2447 (24 hours)
Southern Nevada Health District (SNHD)	Clark	Fax: 702-759-1414 Ph: 702-759-1300 (24 hours)
Nevada Division of Public and Behavioral Health (DBPH) Office of State Epidemiology	All other counties	Fax: 775-684-5999 Ph: 775-400-0333 (24 hours)

Questions

For updated guidance, review the Division of Public and Behavioral Health Technical Bulletin web page regularly. Email dpbhepi@health.nv.gov for other questions regarding respiratory virus testing.

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