BC Centre for Disease Control
An agency of the Provincial Health Services Authority

British Columbia Influenza Surveillance Bulletin

Influenza Season 2018-19, Number 5, Week 49
December 2 to December 8, 2018

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Influenza activity increasing in BC; A(H1N1)pdm09 predominant

During week 49, the majority of surveillance indicators pointed to a notable increase in influenza activity across BC, with A(H1N1)pdm09 continuing to predominate.

In week 49, 25% of specimens tested by laboratories in BC were positive for influenza, a further increase from recent prior weeks. Among influenza viruses typed at the BCCDC PHL since week 40, virtually all have been influenza A and, among those subtyped, more than 80% have been A(H1N1)pdm09.

Children less than 10 years of age and non-elderly adults comprise about 80% of all A(H1N1)pdm09 detections to date, with children in particular disproportionately involved. Conversely, elderly adults are overrepresented among A(H3N2) detections in BC, accounting for about three-quarters of detections thus far.

Since our last bulletin in week 47, 2 laboratory-confirmed influenza outbreaks in long term care facilities (LTCF) have been reported (one A(H3N2), one unknown subtype). Since week 40, there have been a total of 3 lab-confirmed LTCF outbreaks this season (one other A(H3N2)). In contrast, between weeks 40 and 49 of the A(H3N2) dominant 2016-17 and 2017-18 seasons, 11 and 6 lab-confirmed LTCF outbreaks, respectively, had been reported. The lower number to date this season is consistent with fewer LTCF outbreaks expected during seasons of dominant A(H1N1)pdm09 compared to dominant A(H3N2) circulation.

Prepared by BCCDC Influenza & Emerging Respiratory Pathogens Team

Report Disseminated: December 13, 2018

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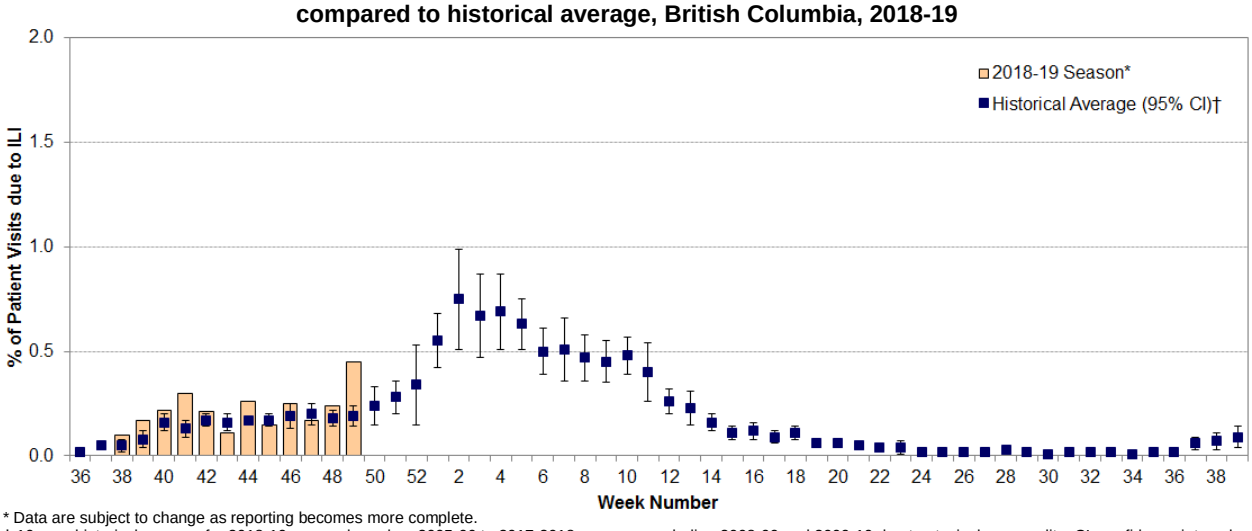
British Columbia

Sentinel Physicians

In week 49, influenza-like illness (ILI) rates among patients presenting to sentinel sites increased considerably in week 49 compared to week 48 (**Figure 1**). Rates are subject to change as reporting becomes more complete. Fourteen (52%) of sentinel sites have reported data for week 49.

Figure 1: Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2018-19



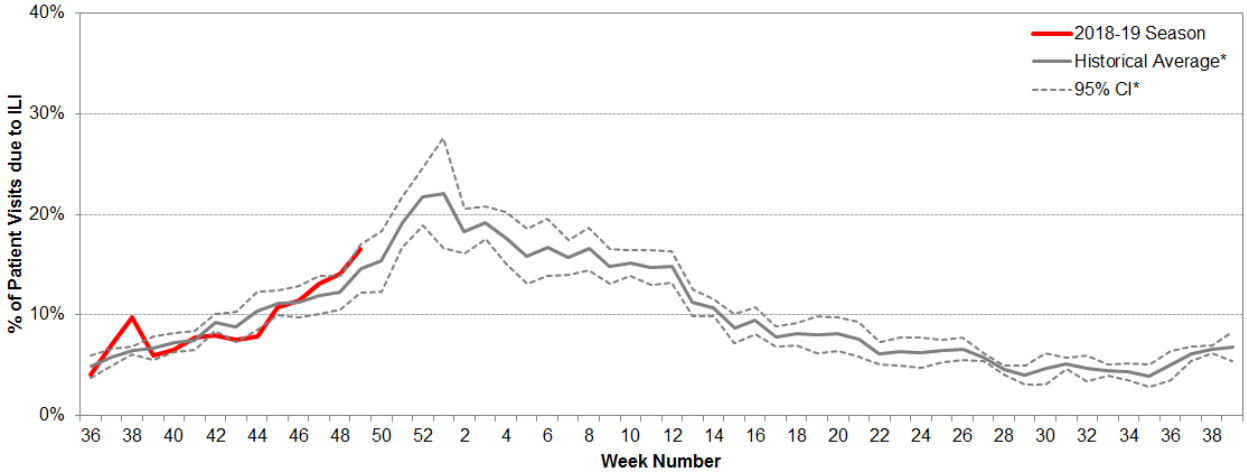
* Data are subject to change as reporting becomes more complete.
† 10-year historical average for 2018-19 season based on 2005-06 to 2017-2018 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

[Corrected post-hoc on December 18, 2018, to include missing week 49 data. Corrections to the narrative are indicated in red text.]

BC Children's Hospital Emergency Room

In week 49, the proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI has continued to increase and remains above the historical average for the past 5 seasons, overlapping the upper 95% confidence interval (**Figure 2**).

Figure 2: Percent of patients presenting to BC Children's Hospital ER attributed to influenza-like illness (ILI), British Columbia, 2018-19

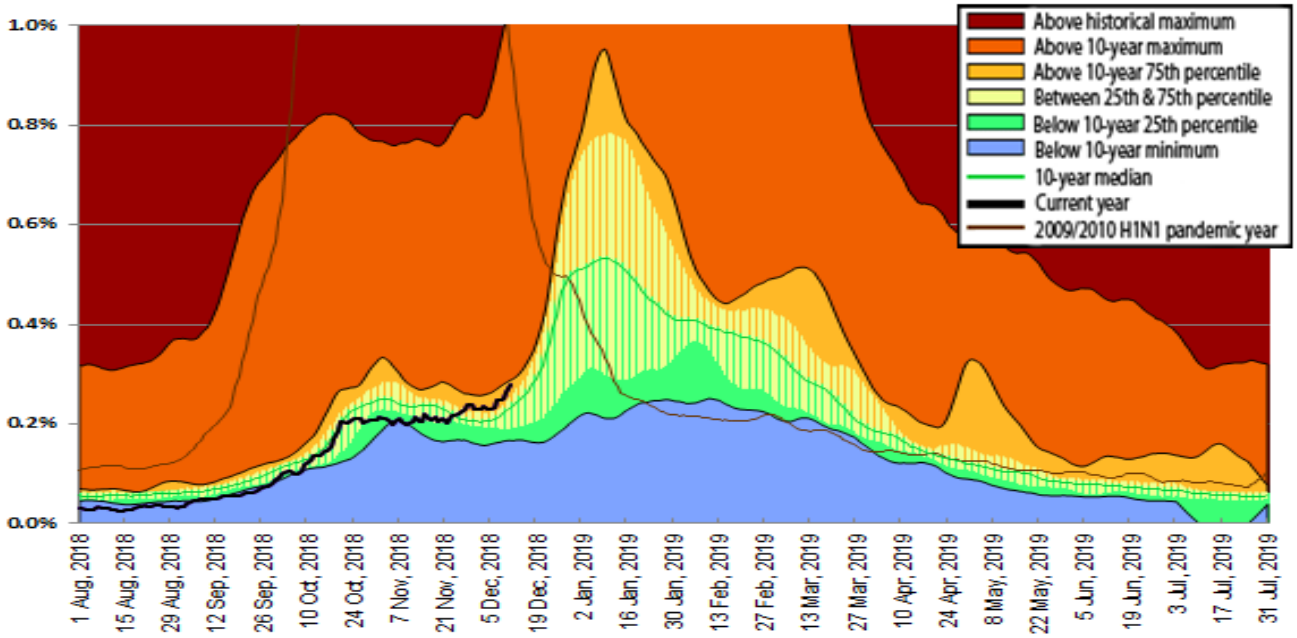


Source: BCCH Admitting, Discharge, Transfer database (ADT). Data includes records with a triage chief complaint of "flu" or "influenza" or "fever/cough."
* 5-year historical average for 2018-19 season based on 2012-13 to 2017-18 seasons; CI=confidence interval.

Medical Services Plan

In week 49, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, has increased and remains above the 10-year 75th percentile overall for the province (**Figure 3**). Some regional variation has been observed (**Figure 4**). In particular, the proportion of claims submitted for II has exceeded the 10-year maximum for this stage of the season over the last few weeks in the Interior and on Vancouver Island. This will require further monitoring.

Figure 3: Service claims submitted to MSP for influenza illness (II)* as a proportion of all submitted general practitioner service claims, British Columbia, 2018-19



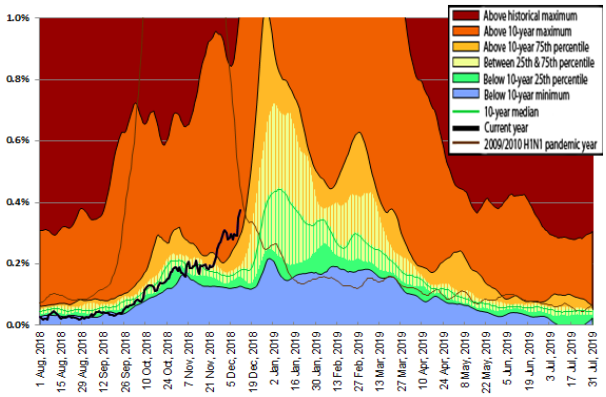
* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).

Data for the period August 1, 2009 to July 31, 2010 have been excluded from the 10-year median calculation due to atypical seasonality during the 2009/2010 H1N1 pandemic year. MSP data beginning August 1, 2018 corresponds to sentinel ILI week 31; data are current to December 11, 2018.

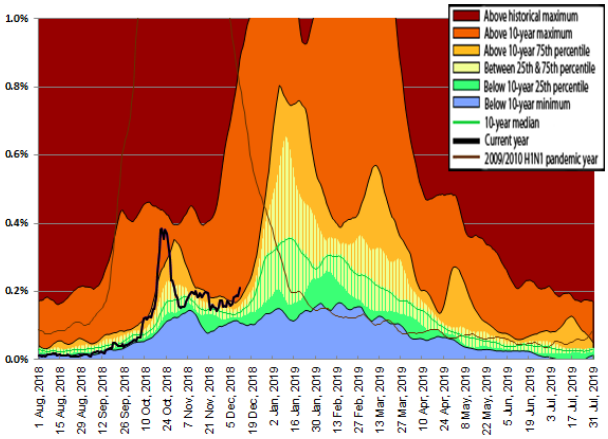
Data provided by Population Health Surveillance and Epidemiology, BC Ministry of Health Services.

Figure 4

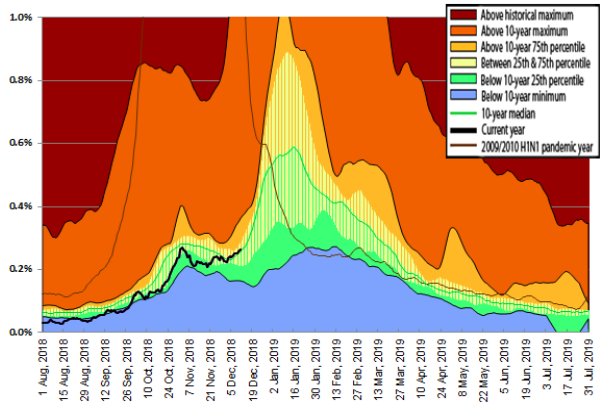
Interior



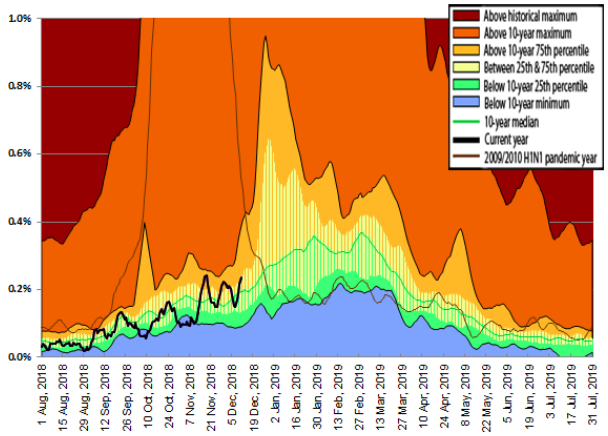
Vancouver Island



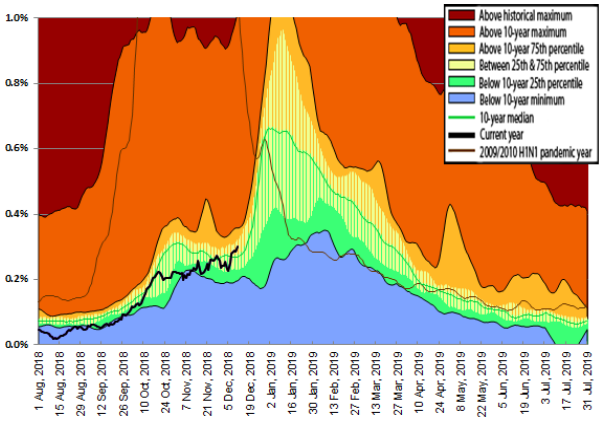
Fraser



Northern



Vancouver Coastal



British Columbia Laboratory Reports

In recognition of expanded influenza testing by additional laboratories across British Columbia, this section of the bulletin now includes respiratory specimens tested at sites beyond the BCCDC Public Health Laboratory (PHL) in deriving the test-positivity indicator. This change was implemented in the last bulletin (issued week 47) and represents a change from earlier bulletins of this and previous seasons. Type and subtype distribution will continue to be derived from the BCCDC PHL.

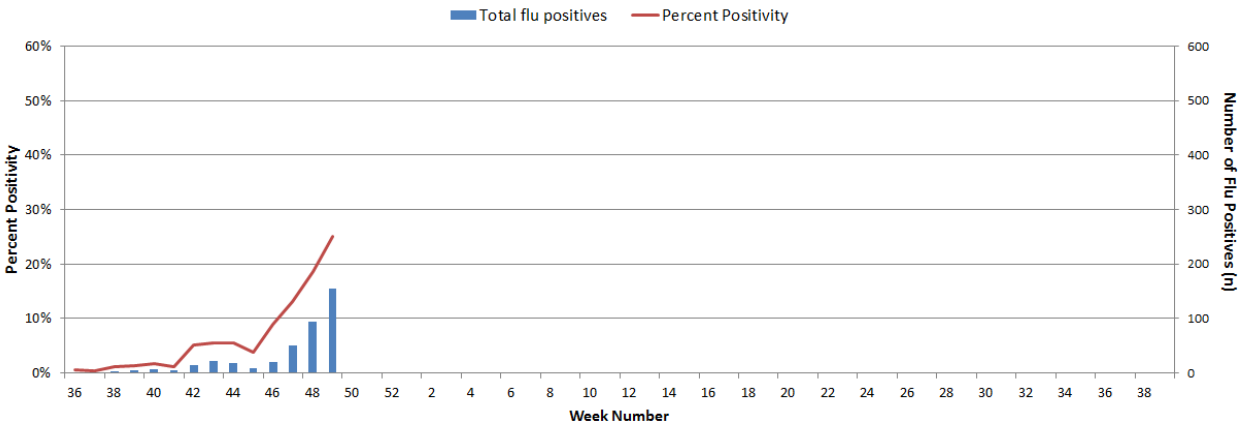
Cumulatively, during the 2018-19 season (since week 40, starting October 1, 2018), 394/3699 (11%) specimens tested positive for influenza at participating laboratories across British Columbia (BC) (as submitted to FluWatch). In week 49, 155/620 (25%) specimens tested positive for influenza at these laboratories, representing a continued increase over previous weeks (**Figure 5**).

Cumulatively, during the 2018-19 season (since week 40, starting October 1, 2018), 338 patients tested positive for influenza at the BC Centre for Disease Control (BCCDC) Public Health Laboratory (PHL), of which 336 (99.4%) were typed as influenza A [47 (14%) A(H3N2), 250 (74%) A(H1N1)pdm09, 39 (12%) subtype unknown] and 2 (0.6%) as influenza B. Among influenza A viruses subtyped, therefore, 250/297 (84%) were A(H1N1)pdm09. Of 114 typed influenza viruses in week 49, all were influenza A. Among these influenza A viruses, 14 (12%) were identified as A(H3N2), 71 (62%) as A(H1N1)pdm09, and for 29 (26%) subtype was unknown. In week 49, therefore, 71/85 (84%) influenza A viruses subtyped were A(H1N1)pdm09 indicating its continued predominance with lesser A(H3N2) contribution **(Figure 6).**

Since week 40, approximately half (51%) of A(H1N1)pdm09 detections were among adults 20-64 years of age and 32% were among children ≤ 9 years old with lesser involvement of those 10-19 years (4%) or among elderly adults (13%). Children under 10 are therefore disproportionately represented among A(H1N1)pdm09 detections in BC (comprising about 10% of the BC population). Conversely, the majority (76%) of A(H3N2) detections were among elderly adults, and 18% among adults 50-64 years of age, with lesser involvement of adults 20-49 years (4%), or those 10-19 years (2%) and with none to date among children ≤ 9 years (**Figures 7 and 8**). Elderly adults are overrepresented among A(H3N2) detections in BC (comprising less than 20% of the population but 76% of A(H3N2) detections)[1].

Entero/rhinoviruses (n=27) were the most commonly detected other respiratory virus (excluding influenza) at the BCCDC in week 49; these detections have decreased considerably compared to week 48 (**Figure 6**).

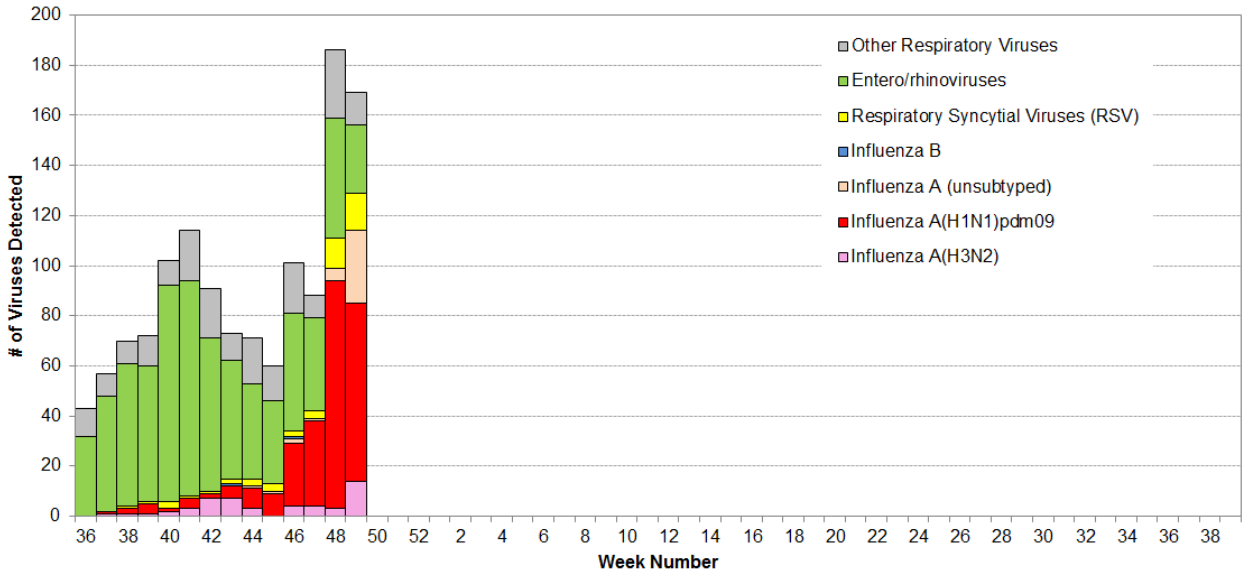
Figure 5: Flu positivity derived from influenza specimens submitted to participating laboratories across BC, 2018-19



Source: Based on respiratory specimens tested by laboratories in BC and reported to FluWatch.

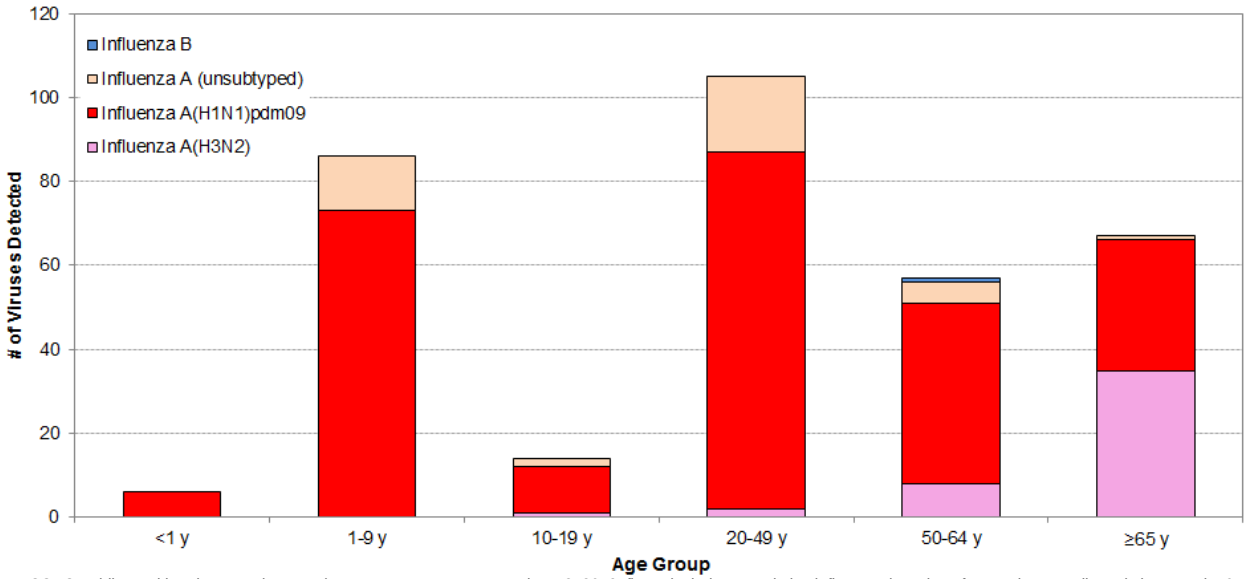
1 Government of British Columbia, BC Stats. Population Estimates 2017. URL: https://www.bcstats.gov.bc.ca/apps/PopulationEstimates.aspx. Date accessed: December 13, 2018.

Figure 6: Influenza and other virus detections among respiratory specimens submitted to BCCDC Public Health Laboratory, 2018-19



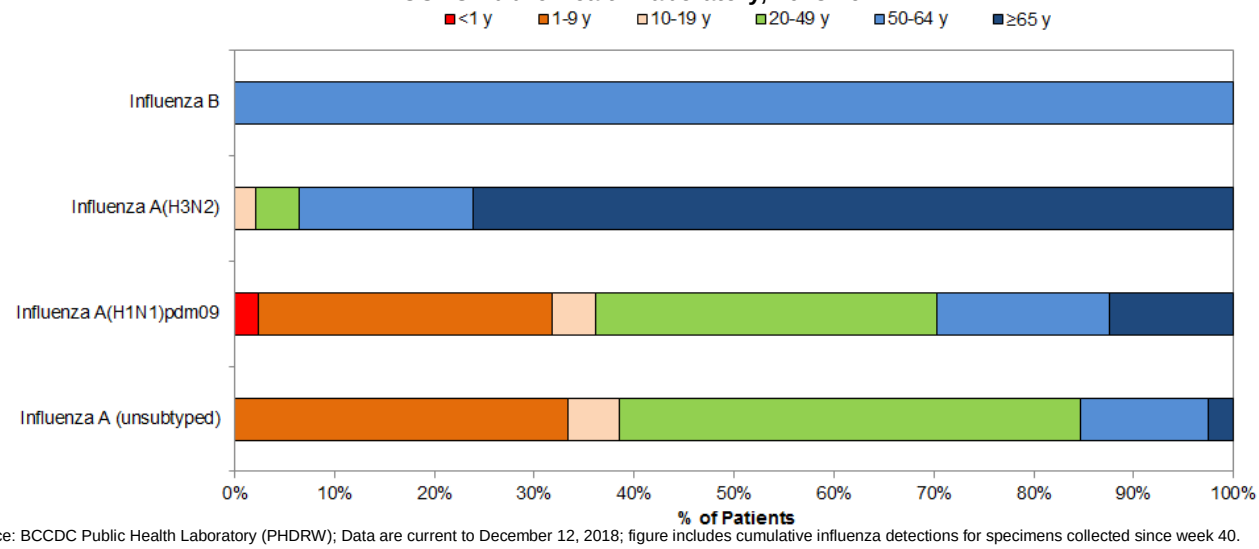
Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 12, 2018.

Figure 7: Cumulative number (since week 40) of influenza detections by type, subtype, and age group, BCCDC Public Health Laboratory, 2018-19



Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 12, 2018; figure includes cumulative influenza detections for specimens collected since week 40.

Figure 8: Age distribution of influenza detections (cumulative since week 40), BCCDC Public Health Laboratory, 2018-19

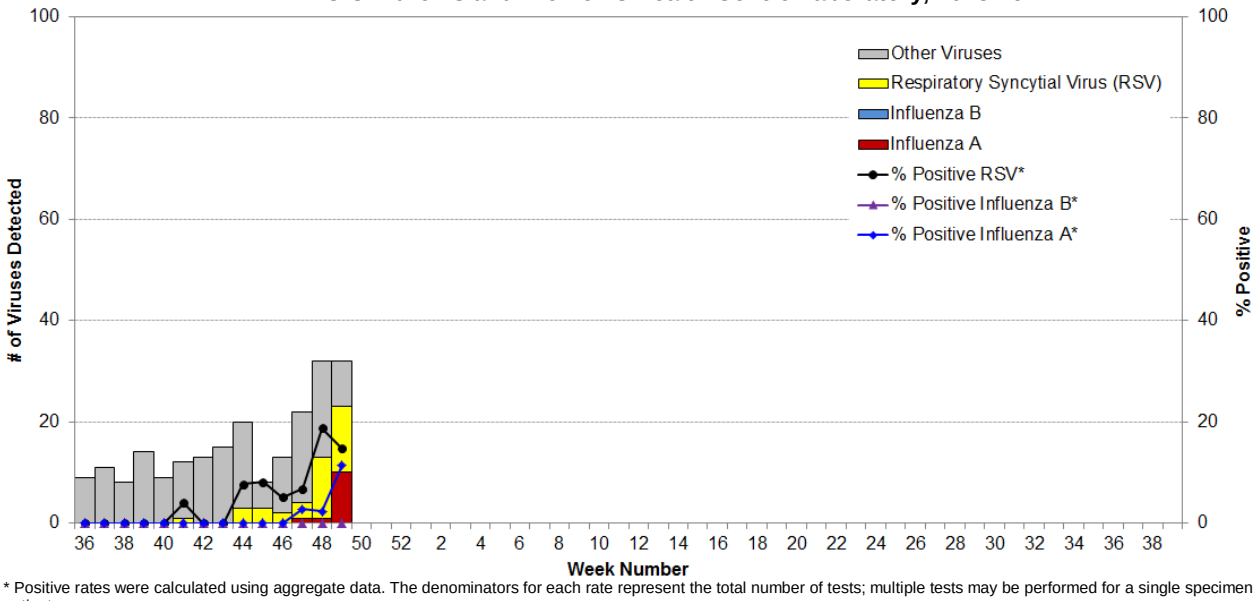


Source: BCCDC Public Health Laboratory (PHDRW); Data are current to December 12, 2018; figure includes cumulative influenza detections for specimens collected since week 40.

BC Children's and Women's Health Centre Laboratory

In week 49, 87 tests for influenza and 88 tests for respiratory syncytial virus (RSV) were conducted at the BC Children's and Women's Health Centre laboratory. Of these, 10 were positive for influenza A (not subtyped), 0 for influenza B, and 13 were positive for RSV. Influenza A test positivity increased considerably in week 49 compared to week 48 (12% vs 2%), while respiratory syncytial virus (RSV) test positivity decreased (15% vs 19%). In week 49, RSV was the most commonly detected respiratory virus (**Figure 9**).

Figure 9: Influenza and other virus detections among respiratory specimens submitted to BC Children's and Women's Health Centre Laboratory, 2018-19



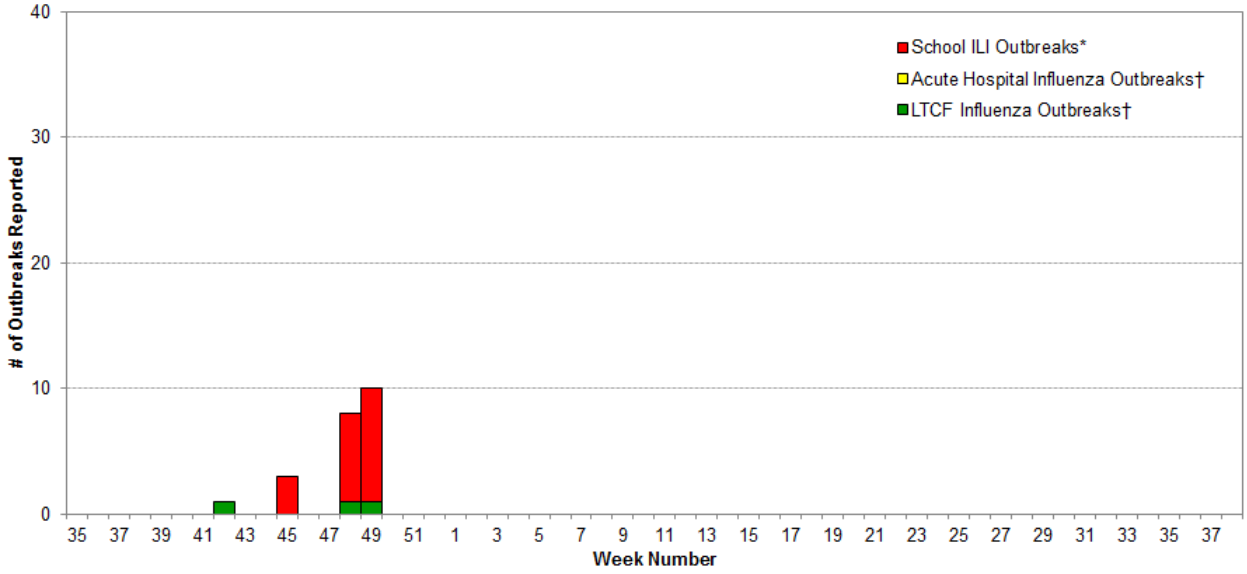
* Positive rates were calculated using aggregate data. The denominators for each rate represent the total number of tests; multiple tests may be performed for a single specimen and/or patient.

Influenza-like Illness (ILI) Outbreaks

One laboratory-confirmed influenza A (subtype unknown) long-term care facility (LTCF) outbreak and nine school ILI outbreaks were reported in week 49. Since week 40, a total of 3 LTCF (two A(H3N2) and one subtype unknown) and 19 school outbreaks have been reported (**Figures 10 and 11**).

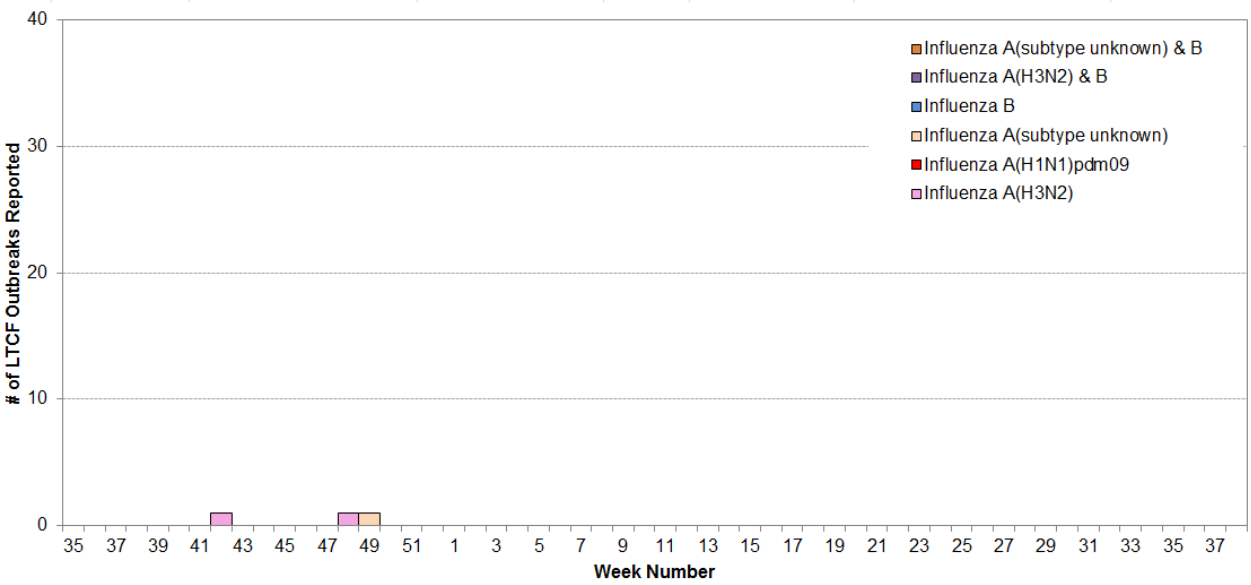
By way of comparison, between weeks 40 and 49 of the 2016-17 and 2017-18 seasons, 11 and 6 lab-confirmed LTCF outbreaks, respectively, had been reported.

Figure 10: Number of influenza-like illness (ILI) outbreaks reported, British Columbia 2018-19



* School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI. Onset
† Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one laboratory-confirmed case of influenza.

Figure 11: Number of influenza outbreaks by type/subtype in long-term care facilities (LTCF), British Columbia 2018-19†



† Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one laboratory-confirmed case of influenza.

Emerging Respiratory Viruses

Cases of acute flaccid myelitis (AFM) – possibly associated with enterovirus D68 (EV-D68) - reach record high in the US

Since September, the US CDC has reported an increase in paediatric cases of acute flaccid myelitis (AFM), a subset of acute flaccid paralysis (AFP) (often referred to as "polio-like illness" in the media). As of December 7th 2018, the CDC has confirmed 158 cases of AFM across 36 states – predominantly affecting children under 5 years of age. Patients have presented with neurological features, specifically single or multi-limb weakness, with most requiring hospitalization. More than 90% of AFM cases reported a mild respiratory illness or fever - consistent with a viral infection - in the weeks preceding symptom onset. AFM has a variety of possible causes, including non-polio enterovirus infection. Among 71 confirmed cases tested, just over half (54%) tested positive for enterovirus or rhinovirus at the time of AFM diagnosis (37% for enterovirus D68 (EV-D68), 29% for enterovirus A71 (EV-A71)); however, a clear and consistent etiology has not yet been identified.

The number of confirmed cases has now surpassed that of the previous high in 2016 (when 149 confirmed cases were detected in the US). These reports indicate that 2018 represents another biennial peak, similar to that observed during EV-D68 epidemics in 2014 and 2016. The latter EV-D68 epidemics were noteworthy for including cases with severe respiratory manifestations (less prominently noted in 2018); however, neurological complications were also identified. Accordingly, the US CDC has escalated its response by establishing an AFM task force to aid investigation efforts.

Whilst low-level EV-D68 activity has been detected in BC this autumn, as may be expected at this time of the year, we are not aware of any cases presenting with neurological manifestations. To date, no AFM cases have been reported to the BCCDC. Elsewhere in Canada, a possible uptick in reports of AFP has been noted; however, thus far, the number of confirmed cases falls within the annual expected range. The number of cases of sudden onset muscle weakness in children reported to the Public Health Agency of Canada in 2018 can be found at the link below.

Additional information is available from the following sources:

US CDC AFM webpage: https://www.cdc.gov/acute-flaccid-myelitis/index.html

US CDC factsheet on EV-D68: https://www.cdc.gov/non-polio-enterovirus/about/ev-d68.html

PHAC information sheet on AFM in Canada: https://www.canada.ca/en/public-health/services/diseases/acute-flaccid-myelitis.html

A summary of the 2014 experience in BC was published in Euro Surveillance, available from: https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2015.20.43.30047

National

FluWatch (week 48, November 25 to December 1, 2018)

At the national level, influenza activity continued to increase in week 48. Influenza A is the most common influenza virus circulating in Canada, and the majority of detections continue to be A(H1N1)pdm09. The percentage of laboratory tests positive for influenza increased from 15.3% in week 47, to 18.1% in week 48. FluWatch indicates that the proportion of tests positive for influenza A is higher this year compared to the same period during the previous eight seasons Details are available at: https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance/weekly-influenza-reports.html.

National Microbiology Laboratory (NML): Strain Characterization

From September 1, 2018 to December 13, 2018, the National Microbiology Laboratory (NML) has antigenically characterized 159 influenza viruses [2 A(H3N2), 144 A(H1N1)pdm09 and 13 B(Yamagata lineage)] received from Canadian laboratories.

Influenza A(H3N2): The two influenza A(H3N2) viruses were considered antigenically similar to A/Singapore/INFIMH-16-0019/2016, the WHO-recommended A(H3N2) component of the 2018-19 northern hemisphere influenza vaccine. The characterized viruses belonged to genetic group 3C.2a1.

Influenza A(H1N1)pdm09: All of the 144 A(H1N1)pdm09 viruses characterized were antigenically similar to the A/Michigan/45/2015 virus: the WHO-recommended influenza A(H1N1) component of the 2018-19 northern hemisphere influenza vaccine.

Influenza B: The 13 influenza B viruses characterized were antigenically similar to the B/Phuket/3073/2013 virus, which belongs to the B Yamagata lineage: the WHO-recommended influenza B component of the 2018-19 northern hemisphere *quadrivalent* influenza vaccine. Of note, the WHO-recommended influenza B component of the *trivalent* vaccine is a B/Colorado/06/2017-like virus of the B Victoria lineage.

National Microbiology Laboratory (NML): Antiviral Resistance

From September 1, 2018 to December 13, 2018, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing.

Amantadine: Of the 132 influenza viruses [20 A(H3N2) and 112 A(H1N1)pdm09] tested against amantadine, all were resistant.

Oseltamivir: Of the 185 influenza viruses [22 A(H3N2), 150 A(H1N1)pdm09, and 13 B] tested against oseltamivir, all were sensitive.

Zanamivir: Of the 185 influenza viruses [22 A(H3N2), 150 A(H1N1)pdm09, and 13 B] tested against zanamivir, all were sensitive.

International

USA (week 48, November 25 to December 1, 2018)

During week 48, influenza activity increased slightly but remained at low levels in the United States. Since week 40, the most frequently identified influenza subtype reported by public health laboratories has been influenza A(H1N1)pdm09. The proportion of deaths attributed to pneumonia and influenza was below the system-specific epidemic threshold. No influenza-associated pediatric deaths were reported during week 48. The proportion of outpatient visits for ILI remained at 2.2%, which is at the national baseline of 2.2%. The US CDC has posted a summary of influenza activity in the US and elsewhere for week 48, available at: https://www.cdc.gov/flu/weekly/index.htm

WHO (December 10, 2018, based on data up to November 25, 2018)

In the temperate zone of the northern hemisphere, influenza detections continued to increase, but still remained low overall. Some countries in Southern and South-East Asia reported increased influenza activity. Influenza activity in the temperate zones of the southern hemisphere has returned to inter-seasonal levels. Worldwide, influenza A(H1N1)pdm09 viruses have predominated.

From November 12 to November 25, 2018, the WHO GISRS laboratories tested more than 118,399 specimens. Of these, 6,596 were positive for influenza viruses, of which 5,995 (90.9%) were typed as influenza A and 601 (9.1%) as influenza B. Of the subtyped influenza A viruses, 3,019 (85.5%) were A(H1N1)pdm09 and 511 (14.5%) were A(H3N2). Of the characterized influenza B viruses, 39 (38.6%) belonged to the B(Yamagata) lineage and 62 (61.4%) to the B(Victoria) lineage.

The full report is available at: www.who.int/influenza/surveillance_monitoring/updates/en/.

WHO Recommendations for Influenza Vaccines

WHO Recommendations for 2018-19 Northern Hemisphere Influenza Vaccine

On February 22, 2018, the WHO announced the recommended strain components for the 2018-19 northern hemisphere trivalent influenza vaccine (TIV)*:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus; †
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage) ‡.

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

* Recommended strains represent a change for two of the three components used for the 2017-18 northern hemisphere TIV

† Recommended strain represents a change from the 2017-18 season vaccine which contained an A/Hong Kong/4801/2014 (H3N2)-like virus

‡ Recommended strain represents a change from the 2017-18 season vaccine which contained a B/Brisbane/60/2008-like virus.

For further details: http://www.who.int/influenza/vaccines/virus/recommendations/2018_19_north/en/

WHO Recommendations for the 2019 Southern Hemisphere Influenza Vaccine

On September 27, 2018, the WHO announced recommended strain components for the 2019 southern hemisphere trivalent influenza vaccine (TIV):*

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Switzerland/8060/2017 (H3N2)-like virus;‡
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage).§

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage).

* Recommended strains represent a change for two of the three components used for the 2018 southern hemisphere TIV.

‡ Recommended strain represents a change from the 2018 season vaccine which contained an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus

§ Recommended strain for the influenza B component represents a lineage-level change from a B(Yamagata)-lineage virus in the 2018 vaccine to a B(Victoria)-lineage virus in the 2019 vaccine.

For further details: http://www.who.int/influenza/vaccines/virus/recommendations/2019_south/en/

Additional Information

Explanatory Note:

The surveillance period for the 2018-19 influenza season is defined starting in week 40. Weeks 36-39 of the 2017-18 season are shown on graphs for comparison purposes.

List of Acronyms:

ACF: Acute Care Facility
AI: Avian influenza
FHA: Fraser Health Authority
HBoV: Human bocavirus
HMPV: Human metapneumovirus
HSDA: Health Service Delivery Area
IHA: Interior Health Authority
ILI: Influenza-Like Illness
LTCF: Long-Term Care Facility
MSP: BC Medical Services Plan
NHA: Northern Health Authority
NML: National Microbiological Laboratory
A(H1N1)pdm09: Pandemic H1N1 influenza (2009)
RSV: Respiratory syncytial virus
VCHA: Vancouver Coastal Health Authority
VIHA: Vancouver Island Health Authority
WHO: World Health Organization

Current AMMI Canada Guidelines on the Use of Antiviral Drugs for Influenza:
www.ammi.ca/?ID=122&Language=ENG

Web Sites:

BCCDC Emerging Respiratory Pathogen Updates:
www.bccdc.ca/health-professionals/data-reports/emerging-respiratory-virus-updates

Influenza Web Sites

Canada – Influenza surveillance (FluWatch): https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance.html
Washington State Flu Updates: http://www.doh.wa.gov/portals/1/documents/5100/420-100-fluupdate.pdf
USA Weekly Surveillance Reports: www.cdc.gov/flu/weekly/
Joint ECDC – WHO/Europe weekly influenza update (Flu News Europe): flunewseurope.org
WHO – Weekly Epidemiological Record: www.who.int/wer/en/
WHO Collaborating Centre for Reference and Research on Influenza (Australia): www.influenzacentre.org/
Australian Influenza Report:
www.health.gov.au/internet/main/publishing.nsf/content/cda-surveil-ozflu-flucurr.htm
New Zealand Influenza Surveillance Reports: www.surv.esr.cri.nz/virology/influenza_weekly_update.php

Avian Influenza Web Sites

WHO – Influenza at the Human-Animal Interface: www.who.int/csr/disease/avian_influenza/en/
World Organization for Animal Health: www.oie.int/eng/en_index.htm

Contact Us:

Tel: (604) 707-2510
Fax: (604) 707-2516
Email: InfluenzaFieldEpi@bccdc.ca

Communicable Disease Prevention and Control Services (CDPACS)
BC Centre for Disease Control
655 West 12th Ave, Vancouver BC V5Z 4R4

Online: www.bccdc.ca/health-professionals/data-reports/influenza-surveillance-reports

Link to fillable Facility Outbreak Report Form: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Epid/Influenza%20and%20Respiratory/OutbreakReportForm_2018.pdf

Communicable Diseases & Immunization Service
655 W. 12th Ave. Vancouver BC V5Z 4R4
Phone: (604) 707-2510; Fax: (604) 707-2516

Reset Form

Submit By Email

Version: 30 Jul 2018

Influenza-Like Illness (ILI) Outbreak Summary Report Form

Please complete and email to ilioutbreak@bccdc.ca

Note: This form is for provincial surveillance purposes.
Please notify your local health unit per local guidelines/requirements.

ILI: Acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia, or prostration which *could* be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.
Schools and work site outbreak: greater than 10% absenteeism on any day, most likely due to ILI.
Residential institutions (facilities) outbreak: two or more cases of ILI within a seven-day period.

A — Reporting Information

Person Reporting: Title:
Contact Phone: Email:
Health Authority: HSDA:
Full Facility Name:

Is this report: ☐ First Notification *(complete section **B** below; section **D** if available)*
☐ Outbreak Over *(complete section **C** and section **D** below)*

Report Date (dd/mm/yyyy):

B — First Notification

Type of facility*: ☐ Long Term Care Facilities, Nursing Homes ☐ Acute Care Facility
☐ Other Setting:

If ward or wing, please specify name/number:

Date of onset of first case of ILI (dd/mm/yyyy):
Date outbreak declared (dd/mm/yyyy):

***Long Term Care Facilities, Nursing Homes:** Facilities that provide living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping or other residential care facilities where provincial/territorial public health is responsible for outbreak management under provincial legislation; **Acute Care Facility:** Publicly funded facilities providing medical and/or surgical treatment and acute nursing care for sick or injured people, through inpatient services. (i.e. hospitals including inpatient rehabilitation and mental facilities); **Other Setting:** Any locations not otherwise specified here in which outbreaks of influenza or ILI may occur (e.g. retirement homes, assisted living or hospice settings, private hospitals/clinics, correctional facilities, colleges/universities, adult education centres, shelters, group homes, and workplaces).

C — Outbreak Declared Over

Date of onset for last case of ILI (dd/mm/yyyy):
Date outbreak declared over (dd/mm/yyyy):

Numbers to date	Residents
Total	
With ILI	
Hospitalized*	
Died*	

*suspected to be linked to case of ILI

D — Laboratory Information

Specimen(s) submitted? ☐ Yes (location:) ☐ No ☐ Don't know
If yes, organism identified? ☐ Yes ☐ No ☐ Don't know

Please specify organism/subtype: ☐ Influenza A (subtype:) ☐ Influenza B
☐ Parainfluenza ☐ Entero/rhinovirus ☐ Coronavirus ☐ RSV
☐ HMPV ☐ Adenovirus ☐ Other: