Influenza- and respiratory syncytial virus-associated adult mortality in Soweto
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Influenza is a major cause of seasonal excess mortality and hospitalisation in adults (particularly the elderly) in high-income countries. Little information exists on the impact of these infections on adults in Africa.

Objectives. To estimate influenza- and RSV-related adult mortality, stratified by age and hospitalisation in Soweto.

Study design. A retrospective hospital-based study in Soweto from 1997 to 1999 to estimate influenza- and RSV-related excess all-cause deaths and hospitalisation using a rate-difference method. The study was based on influenza seasons of varying severity, provided by surveillance data.

Results. Influenza seasons were significantly associated with excess mortality in adults across all 3 years, except for influenza seasons of varying severity. We aimed to determine influenza- and RSV-associated mortality and hospitalisation among adults and to stratify these results by ages ≥65 years and 18 - 64 years.

Methods

Study design and study population
Ours was a retrospective cohort study of adults admitted to the Department of Medicine, Chris Hani Baragwanath Hospital, Soweto, from January 1997 to December 1999. To calculate mortality and hospitalisation attributable to influenza or RSV, we used differences by calendar year between the rates of these events when the viruses were circulating, and the rates when neither virus was present above baseline levels.

Results

Influenza seasons were significantly associated with excess mortality in adults across all 3 years, except for 18 - 64-year-olds in 1998. Excess mortality was highest in those ≥65 years of age: 82.8/100 000 population in the mild 1997 season and 220.9/100 000 in the severe 1998 season. Influenza significantly increased adult medical hospitalisation in the severe 1998 season alone. RSV did not significantly affect mortality or hospitalisation.

Conclusion. Influenza-related mortality was substantial and disproportionately affected the elderly. Influenza vaccination for the elderly warrants consideration. The RSV-related burden was not significantly increased but merits observation over a longer period.
Influenza and RSV seasons were defined as the period of at least 2 consecutive weeks in which each week accounted for ≥3% of total annual isolates respectively. The baseline period was defined as periods of at least 2 consecutive weeks in which both influenza and RSV isolations were <2% of the annual total.

Mortality and hospitalisation data

The numbers of adult and paediatric patients who died in the hospital were extracted from the mortuary register and classified by week. The numbers and ages of adults from the medical wards were recorded. All-cause mortality was used as there were insufficient data in many patients' clinical records to enable cause of death or predisposing disorder to be accurately assigned. The number of all-cause adult medical hospitalisations per week was extracted from the admission ward register. The data for age and reasons for hospitalisation were incomplete.

Excess events

The effects of influenza and RSV were estimated by using a rate-difference method. For each calendar year, the average number of events (death or hospitalisation) per week was calculated for the baseline and the influenza or RSV season. The excess events per week were calculated by subtracting the baseline rates from the rates during an influenza or RSV season. These results were expressed as a percentage increase. The excess rate per week was multiplied by the total number of weeks of influenza or RSV predominance to give a total number of events in the season. The excess number of events was applied to the Soweto population (based on the 1996 census) to give rates per 100 000 population.

Statistical analysis

Descriptive statistics were calculated using STATISTICA (StatSoft, Version 6, Tulsa, USA). The squared coherence, which describes the strength of association in time series analysis, is reported at a frequency of 52 weeks across all 3 years in the dataset. Differences between means, together with the 95% confidence interval (CI) of these differences, were calculated using Confidence Interval Analysis (C.I.A., version 2.1.2 Build 50, University of Southampton, UK).

Ethical approval

This study was approved by the Committee for Research on Human Subjects of the University of the Witwatersrand.

Results

Influenza and RSV seasons

The weekly isolations are represented in Fig. 1. The severe (and early) 1998 influenza season was essentially RSV-free and was sandwiched for comparison between the mild 1997 influenza season with a separate RSV season and the moderately severe 1999 season with an overlapping RSV season. Influenza subtype A/Sydney/5/97-like H3N2 was dominant in all three seasons.

Mortality

The squared-coherency between influenza season and all-cause adult medical mortality was 0.90 (Fig. 2). Modelling for lag periods at the end of a season did not affect the results (results not shown). In Table I, all-cause mortality for the entire hospital (adult and paediatric) and all-cause mortality for the adult medical department are presented. There were slightly more than 100 deaths per week in the hospital in the baseline period of each study year, of which approximately 60 occurred in the adult medical wards. In all three influenza seasons, total hospital deaths and adult medical deaths were significantly increased. RSV-associated mortality was not significantly increased in any year.

Table I shows all-cause mortality for patients ≥65 years old in the adult medical wards. Mortality increased by 80% in the 1997, 1998 and 1999, respectively. All-cause mortality was 0.90 (Fig. 2).

Fig. 1. Seasonal distribution of influenza and RSV isolates 1997 - 1999 by week and month.

Fig. 2. Weekly influenza isolates and all-cause adult medical mortality.
1997 season and the overlapping 1999 season (Table II). RSV season excess deaths were not significant in either age group.

Table II shows the excess death rates/100 000 population for Soweto adults. For those ≥6 years of age, the excess mortality rate was 221.9/100 000 in the severe 1998 season, and 82.8/100 000 in the mild 1997 season.

Hospitalisation

The mean weekly hospitalisation in the adult medical wards in the baseline period increased from 561 in 1997 to 596 in 1998 and 611 in 1999. Only in the 1998 influenza season alone was there a significant increase in weekly admissions to 678 – an increase of 14% (95% CI 8 - 20%). This increase in admissions in the 1998 influenza season was 88.4/100 000 population. No significant RSV-related increase was found (data not shown).

Discussion

In our 3-year study, influenza seasons were significantly associated with excess all-cause mortality in adults (except in 18 - 64-year-olds in 1998), particularly in the elderly, and with excess all-cause medical hospitalisation in the severe 1998 season only. RSV did not significantly affect mortality or hospitalisation.

The occurrence of the severe 1998 H3N2 influenza season sandwiched by the mild 1997 season and the intermediate 1999 season provided a useful period for studying the impact of influenza seasons on hospitalisation and mortality in a previously unstudied community and country. After taking the RSV seasons into consideration, the 1999 season was compromised by the marked overlap of the two seasons, i.e. one could not place as much store on the results from 1999 owing to the overlap of RSV and flu.

We used a rate-difference method to estimate the effects of influenza and RSV season on hospitalisation and mortality as we had only three seasons to consider. A potential weakness is that this method does not control for seasonal effects. Against this significant confounder was the early epidemic in 1998 and that RSV covered similar periods and was not found to have a significant impact. As in most other studies, the viral seasons were based on surveillance data and the infections were not directly confirmed.

The mortality in the elderly in 1998 of 221/100 000 is among the highest recorded. In the developed world, all-cause mortality in the elderly ranges from 116 to 136/100 000 but mortality is smoothed out over a number of seasons. In the USA, ≥90% of deaths occur in those aged ≥65 years. In Soweto, this ranged from 31% to 64% by year, largely because the elderly represented only 6% of adults. There was a significant influence on mortality in those aged 18 - 64 years in 1997 and 1999 at a similar rate to the 6.4 - 12.5/100 000 found in those aged 50 - 64 years in developed countries.

Although the impact of RSV on mortality did not reach significance, the rates in the elderly of 70.2 - 110.5/100 000 are
similar to those of high-income countries.\textsuperscript{3,5,7,12} The burden of
RSV warrants further study across more seasons in this setting.

The increase in influenza-associated mortality across all
seasons was not mirrored in hospitalisation figures; this may be
depicted by the increasing number of patients admitted
over the years of the study, mostly owing to HIV-related
disease, which might have caused a loss of seasonality.

There are limitations to this study, which was conducted in
a paper-based system without back-up data sources or disease
classifications. It was performed in a single, large hospital, the
only public sector hospital in Soweto. Approximately 80% of
the population does not have medical aid cover for private
sector health services, and most of them would use public
hospitals. We did not adjust the population denominator for
those who might have accessed private medical care or used
other hospitals, as there was no information on which to base
such adjustment. Some people would have died at home.
People from outside Soweto might have used this hospital,
as a Soweto address was needed to ensure hospitalisation. In
our opinion, the excess rates in this study would represent
a minimum estimate for the effect of influenza in Soweto.
The influenza and RSV seasons overlapped in 1999 and the
effects of each season could not be separated. The seasons
were discrete in 1997 and 1998; in those years, only influenza-
attributable increases reached significance, and modelling for
lag periods at the end of a season did not affect the results.
Inadequate data precluded a study of hospitalisation by age
and consideration of influenza- and RSV-related conditions.
Growing numbers of HIV-related admissions might have
affected excess hospitalisation and possibly mortality data.
HIV infection may exacerbate the severity of influenza\textsuperscript{27} but,
because few patients had been tested, we did not use data on
HIV infection.

South Africa’s guidelines for using influenza vaccine focus
on the elderly and people with high-risk conditions.\textsuperscript{28} As far
as we could ascertain, there was almost no usage of influenza
vaccine in the community of Soweto during this study.

Therefore, influenza vaccine should be provided to the elderly
of Soweto until new strategies or vaccines become available.
Controversy surrounds evidence for the degree of effectiveness
of influenza vaccine in the elderly.\textsuperscript{19,20} A long-term study of a
defined home-based (i.e. non-institutionalised) community
designed to answer some criticisms of previous studies,
demonstrated a 27% reduction in the risk of hospitalisation
for pneumonia or influenza, and a 48% reduction in the
risk of death.\textsuperscript{21} A case control study on the effectiveness of
influenza vaccination in the elderly over one season was done
by a South African private medical funding organisation.
The research results were inconclusive, owing to a relatively
mild season, limitations inherent in the study design and
potential confounders.\textsuperscript{22} Since the influenza season in the
southern hemisphere occurs after that in the northern season,
the match between circulating viruses and vaccine strains is
generally better. A vaccination programme in this vaccine-naïve
population could answer some of the remaining questions on
the effects of vaccination of the elderly.

\textbf{Conclusion}

Influenza had an important effect on mortality among adults
in Soweto, particularly those ≥65 years old, across seasons of
varying severity. Its effect on hospitalisation was significant
only in the most severe season. An influenza vaccination
programme targeting the elderly appears to be a logical
outcome of this study.

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References


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