Safety of the Influenza A (H1N1)2009 Vaccine in Chronic Obstructive Pulmonary Disease: A Matched Case-Control Study

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Abstract

Background: The safety of influenza A (H1N1) 2009 among chronic obstructive pulmonary disease (COPD) patients has not been investigated yet. Our objective was to investigate the safety of the A (H1N1) 2009 vaccine, especially for mortality after vaccination.

Methods: From October 2009 to March 2010, we collected records from all Japanese hospitals registered in the Japanese Respiratory Society. We conducted a 1:1 matched case-control study. Patients with COPD who died in the study period were determined as case group patients (n=36). Patients with COPD who survived the study period were determined as control group patients (n=36). To control the group selection process, we selected age, sex, period of home oxygen therapy (measure for COPD severity), hospital, and calendar time as matching factors. We then compared the proportion of patients who received the influenza A (H1N1) 2009 vaccine in each group and evaluated the conditional odds ratio.

Results: Both the case and control groups had 36 COPD patients, 32 of whom were men. The mean age was 76.6 years (SD=8.6) in the case group and 76.9 years (SD=8.3) in the control group. The mean period of home oxygen therapy in both groups was 1.8. The proportion of patients receiving A (H1N1) 2009 vaccinations was 47.2% in the case group and 63.9% in the control group. The crude conditional odds ratio of mortality in the winter was 0.33 (95% confidence interval: 0.06-1.34) and adjusted conditional odds ratio was 0.37 (95% confidence interval: 0.09-1.52) with no significance.

Conclusions: Our study detected no statistically increased risk of mortality after influenza A (H1N1) 2009 vaccination among COPD patients. The results are, however, limited by the small sample size and low statistical power. A similar larger-scale study is needed in the future to confirm our findings.

Keywords: Influenza vaccines; Vaccine safety; Influenza A Virus, H1N1 subtype; Chronic obstructive pulmonary disease; Mortality; Case-control studies; Vaccines; Influenza, Human

Abbreviations: COPD - Chronic Obstructive Pulmonary Disease; SD - Standard Deviation

Introduction

Since the novel influenza A (H1N1) 2009 virus was identified in Mexico and the United States in April 2009, it has spread worldwide. In response to this situation, the World Health Organization raised the pandemic alert level to phase 6 [1]. Since seasonal influenza vaccines were not expected to prevent influenza A (H1N1) 2009 virus infection [2], the development of efficient and safe new influenza vaccines was an urgent need.

The suspected side effects of the seasonal influenza vaccine include acute disseminated encephalomyelitis and Guillain-Barre syndrome [3-8]. After the dissemination of an estimated 82.4 million doses of A(H1N1)2009 vaccines, 48 fatal cases were reported to the Vaccine Adverse Event System in United States [6]. When the new influenza A (H1N1) 2009 spread in Japan, beginning in September 2009, the new vaccines were administered to the Japanese population. One hundred thirty-one patients with underlying diseases, including 22 with chronic kidney diseases, 12 with chronic obstructive pulmonary diseases (COPD), and 11 interstitial pneumonias, were reported to have died after the vaccinations [9,10]. The cause of death was undetermined between adverse events resulting from the vaccinations, the effects of the underlying diseases, or exacerbation of the underlying diseases by the vaccination. To our knowledge, thus far, no studies have tested the safety of the influenza vaccine among COPD patients.

To clarify the mortality risk associated with the vaccinations, we undertook a case-control study in which the patients who died with COPD (case) were matched with those who survived COPD (control). Patients with incurable COPD usually consult a respiratory physician throughout their lives in hospitals registered with the Japanese Respiratory Society in Japan. Our study was designed to determine the safety of the influenza A (H1N1) 2009 vaccine among COPD patients [10]. We aimed at exploring whether the A (H1N1) 2009 vaccine increased the mortality in patients with COPD.
Methods

Case definition and control selection

COPD is generally diagnosed by a respiratory physician according to the guidelines published by the Japanese Respiratory Society. The case group included patients aged 18 or above who had been diagnosed with COPD, received home oxygen therapy (HOT), and died during the study period (October 1, 2009 to March 31, 2010), regardless of the cause of death. In this matched case-control study, for each case (dead) COPD patient, we selected 1 control (surviving) COPD patient in the same hospital on the same day when the selected case control group patient died ("index date") [11]. The pairs of case group and control group (i.e. dead and surviving) patients were matched according to sex, age (±3 years), and the HOT period (±2 years). COPD gradually increases in severity along with the HOT period [12], and the control patient had to be at the same risk of death as the case patient. We, therefore, used the HOT period as an available standard to determine the COPD severity, and we matched the case and control pair according to the HOT period on the index date. If more than 1 control patient matched a case patient in the same hospital on the index date, the control patient who was first in terms of alphabetical order of their last names was chosen. Thus, all necessary information about a case-control pair was collected from clinical records on the index date. Moreover, information on the control after the index date was not used in this study [11].

Exposure to vaccine

Information on whether a patient was administered to 0.5 mL of influenza A (HIN1) 2009 vaccine (a monovalent, inactivated vaccine with 15 μg hemagglutinin per 0.5 mL content without adjuvant) prior to the index date was reported by the physician and was, thus, available in the clinical record.

Covariates

Information on 2 covariates considered to be confounders was gathered simultaneously from clinical records. The covariates identified were seasonal influenza vaccination records in that winter and the presence of diabetes mellitus. The history of seasonal influenza vaccination might indicate that the patient tended to be administered the vaccine by the respiratory physician. The history of diabetes mellitus might also have been a confounder that affected the COPD severity, as steroids are usually administered to COPD patients and can trigger drug-induced diabetes. Thus the results were adjusted for these 2 covariates.

Statistical analysis

We estimated the crude conditional odds ratio (OR) and its 95% confidence interval (CI) to determine the association between A (HIN1) 2009 vaccination and mortality. Subsequently, using conditional logistic regression [13], we estimated the conditional ORs and their CIs, conditioned by age, sex, and HOT period, after adjusting for diabetes mellitus as a complication and history of seasonal influenza vaccination. For small-sample studies, the exact permutation test provides more accurate values of OR and CI than the conventional conditional logistic regression method; therefore, we used the exact permutation test. We used 95% CIs instead of two-sided p values because they are more informative than the latter. In addition, we conducted 2 sensitivity analyses as follows: (1) in one, the primary outcome was not death from all causes but was restricted to death due to pneumonia, COPD exacerbation, or cardiac failure (26 pairs); (2) in the second, the case group patients were restricted to those who were not in poor physical condition nor in shortage of vaccines (27 pairs).

All statistical analyses were performed using SAS version 9.3 (Cary, NC, USA).

This study protocol was approved by the Ethics Review Committee of the Faculty of Medicine, University of Yamanashi, according to the regulations of the Declaration of Helsinki. Informed consent was not required for the study.

Results

Participant characteristics

We received patient information from 110 hospitals and enrolled 36 case-control pairs in the study. Of the 36 pairs of enrolled case-control patients, 32 pairs were of men. The mean age was 76.6 (SD=8.6) in the case group and 76.9 (SD=8.3) in the control group. The mean HOT period was 1.8 (SD=2.0) years in the case group and 1.8 (SD=2.1) years in the control group. Of the 36 patients in each group, 17 (47.2%) in the case group and 23 (63.9%) in the control group were vaccinated. Data on the history of seasonal influenza vaccination, infection of influenza, history of diabetes mellitus, and smoking statuses are shown in Table 1. Among the causes of mortality in the case group, pneumonia was the most frequent, followed by exacerbation of COPD (Table 2). Table 3 lists the reasons why physicians did not vaccinate patients in either group. For the case group, the most common reason was shortage of the vaccine.
the case-control pairs.

Table 4: Crude conditional mortality odds ratio, adjusted conditional mortality odds ratio, and their confidence intervals (Cis). Odds ratios (ORs) were calculated for the case-control pairs.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Crude OR (CI)</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A(H1N1)2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>vaccination (36)</td>
<td>0.33 (0.06-1.34)</td>
<td>0.43 (0.07-1.81)</td>
<td>0.31 (0.05-1.26)</td>
<td>0.37 (0.06-1.52)</td>
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<tr>
<td>Seasonal influenza</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>vaccination (32)</td>
<td>0.43 (0.07-1.88)</td>
<td>0.47 (0.11-1.96)</td>
<td>—</td>
<td>0.44 (0.10-1.85)</td>
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<tr>
<td>Diabetes mellitus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(33)</td>
<td>0.50 (0.05-3.49)</td>
<td>—</td>
<td>0.36 (0.06-2.37)</td>
<td>0.43 (0.06-3.34)</td>
</tr>
</tbody>
</table>

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References


5. (2012) Seasonal Flu Shot. CDC


