Impact of Oseltamivir Treatment on Influenza-Related Lower Respiratory Tract Complications and Hospitalizations

Laurent Kaiser, MD; Cynthia Wat, MBBS, MRCP; Tracy Mills, MSc; Paul Mahoney, MSc; Penelope Ward, MBBS; Frederick Hayden, MD

Background: Influenza causes lower respiratory tract complications (LRTCs), particularly bronchitis and pneumonia, in both otherwise healthy adults and those with underlying conditions. The aim of this study was to assess the effect of oseltamivir treatment on the incidence of LRTCs leading to antibiotic treatment and hospitalizations following influenza illness.

Methods: We analyzed prospectively collected data on LRTCs and antibiotic use from 3564 subjects (age range, 13-97 years) with influenzalike illness enrolled in 10 placebo-controlled, double-blind trials of oseltamivir treatment. Results: In adults and adolescents with a proven influenza illness, oseltamivir treatment reduced overall antibiotic use for any reason by 26.7% (14.0% vs 19.1% with placebo; P<.001) and the incidence of influenza-related LRTCs resulting in antibiotic therapy by 55% (4.6% vs 10.3% with placebo; P<.001). In those subjects considered at increased risk of complications, 74 (18.5%) of 401 placebo recipients developed an LRTC leading to antibiotic use compared with 45 (12.2%) of 368 oseltamivir recipients (34.0% reduction; P=.02). Hospitalization for any cause occurred in 18 (1.7%) of 1063 placebo recipients compared with 9 (0.7%) of 1350 oseltamivir-treated patients (59% reduction; P=.02). In contrast, among subjects with an influenzalike illness but without a confirmed influenza infection, the incidence of LRTCs (6.7% vs 5.3%), overall antibiotic use (19.7% vs 19.3%), or hospitalizations (1.7% vs 1.9%) was similar between placebo and oseltamivir recipients, respectively.

Conclusion: Oseltamivir treatment of influenza illness reduces LRTCs, antibiotic use, and hospitalization in both healthy and “at-risk” adults.

Arch Intern Med. 2003;163:1667-1672
Table 1. Summary of Randomized, Double-blind, Placebo-Controlled Trials of Oseltamivir Therapy in Adults and Adolescents

<table>
<thead>
<tr>
<th>Study No.</th>
<th>Population (Age, y)</th>
<th>Region or Country</th>
<th>No. Enrolled</th>
<th>No. Randomized</th>
<th>Season</th>
<th>Predominant Influenza Virus</th>
<th>% of Patients Infected</th>
<th>Patients With Antibiotics at Study Start, No. (%)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>WV15670</td>
<td>Adult (18-68)</td>
<td>NH</td>
<td>482</td>
<td>477</td>
<td>Dec 1997-Mar 1998</td>
<td>A-H3N2</td>
<td>67.0</td>
<td>13 (2.7)</td>
<td>9</td>
</tr>
<tr>
<td>WV15671</td>
<td>Adult (18-64)</td>
<td>USA</td>
<td>418</td>
<td>418</td>
<td>Dec 1997-Mar 1998</td>
<td>A-H3N2</td>
<td>60.4</td>
<td>11 (2.6)</td>
<td>8</td>
</tr>
<tr>
<td>WV15730</td>
<td>Adult (18-65)</td>
<td>SH</td>
<td>60</td>
<td>58</td>
<td>Jul-Sep 1998</td>
<td>A-H3N2</td>
<td>65.5</td>
<td>1 (1.7)</td>
<td>10</td>
</tr>
<tr>
<td>WV15707</td>
<td>Elderly (≥65)</td>
<td>SH</td>
<td>27</td>
<td>26</td>
<td>Jul-Sep 1998</td>
<td>A-H3N2</td>
<td>46.2</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>M76001</td>
<td>Adult (≥13-80)</td>
<td>USA</td>
<td>1459</td>
<td>1447</td>
<td>Dec 1998-Feb 1999</td>
<td>A</td>
<td>73.5</td>
<td>48 (3.3)</td>
<td>11</td>
</tr>
<tr>
<td>WV15812</td>
<td>Adults with COAD (≥13)</td>
<td>USA and NH</td>
<td>304</td>
<td>402</td>
<td>Jan-Mar 1996</td>
<td>A-H3N2</td>
<td>66.6</td>
<td>10 (2.5)</td>
<td>12</td>
</tr>
<tr>
<td>WV15672</td>
<td>Adults with COAD (≥13)</td>
<td>SH</td>
<td>100</td>
<td></td>
<td>Jun-Sep 1999</td>
<td>A</td>
<td>50.0</td>
<td>10 (2.5)</td>
<td>12</td>
</tr>
<tr>
<td>WV15819</td>
<td>Elderly (≥65)</td>
<td>USA and NH</td>
<td>172</td>
<td></td>
<td>Jan-Mar 1999</td>
<td>A</td>
<td>71.6</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>WV15876</td>
<td>Elderly (≥65)</td>
<td>SH</td>
<td>99</td>
<td>736</td>
<td>May-Sep 1999</td>
<td>A</td>
<td>46.5</td>
<td>12 (1.6)</td>
<td>12</td>
</tr>
<tr>
<td>WV15978</td>
<td>Elderly (≥65)</td>
<td>USA and NH</td>
<td>470</td>
<td></td>
<td>Nov 1999-Feb 2000</td>
<td>A</td>
<td>66.2</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 1 displays the trial profiles and shows the proportions of subjects enrolled. The enrolled patients included otherwise healthy immunized adults and adolescents (age 13-64 years) and a substantial number of at-risk patients, defined as immunized or unimmunized community-living elderly persons 65 years or older and adults and adolescents with chronic obstructive airways disease, asthma, and/or cardiac disease of sufficient severity to require regular outpatient medical care. Patients with New York Heart Association class IV and American Thoracic Society stage III status were excluded from participation. All studies were conducted in compliance with the Declaration of Helsinki (and subsequent amendments), and written informed consent was obtained from patients (and parent or guardian for adolescents under the legal age of consent) prior to inclusion into each study.

Abbreviations: COAD, chronic obstructive airways disease; NH, northern hemisphere; SH, southern hemisphere.

*Data on file, Hoffmann-LaRoche, Inc, Nutley, NJ.

STUDY DESIGN

The oseltamivir database includes 10 double-blind, placebo-controlled, multicenter phase 3 trials investigating the safety and efficacy of oseltamivir use in adults and adolescents during the northern and southern hemisphere influenza seasons, from 1997 to 2000. Table 1 displays the trial profiles and shows the proportions of subjects enrolled. The enrolled patients included otherwise healthy immunized adults and adolescents (age 13-64 years) and a substantial number of at-risk patients, defined as immunized or unimmunized community-living elderly persons 65 years or older and adults and adolescents with chronic obstructive airways disease, asthma, and/or cardiac disease of sufficient severity to require regular outpatient medical care. Patients with New York Heart Association class IV and American Thoracic Society stage III status were excluded from participation. All studies were conducted in compliance with the Declaration of Helsinki (and subsequent amendments), and written informed consent was obtained from patients (and parent or guardian for adolescents under the legal age of consent) prior to inclusion into each study.

PATIENTS AND DRUG ADMINISTRATION

All patients were enrolled during periods when influenza virus was documented to be circulating in their communities. Patients were eligible if they presented within 36 hours of first symptom onset and met a standard case definition including fever (temperature ≥ 37.8°C in adults and adolescents aged <65 years; ≥37.5°C in adults aged ≥65 years) plus at least 1 respiratory symptom (cough, sore throat, or coryza) and 1 constitutional symptom (headache, myalgia, chills/sweats, or fatigue). Patients were randomized to receive oseltamivir (75 mg twice daily) or placebo, for 5 days. The results from the 150-mg dose arms from 2 studies of otherwise healthy adults are not included in the current analysis. Randomization was computer-generated by a central randomization facility, which had sole access to the code. Each center provided its own medication in individually numbered packs, according to the instructions of the randomization center. When appropriate, stratification was randomized according to the presence and disease status of any comorbid conditions (eg, chronic obstructive pulmonary disease or cardiac dis- ease) and influenza immunization status within the season of study. Patients self-administered the medication and were asked to record the date and time of each dose on their diary card. Monitoring of diary card entries found that approximately 90% of enrolled patients were fully compliant.

As described previously, influenza infection was confirmed by virus isolation from combined nose and throat swabs or by 4-fold or greater rises in hemagglutination-inhibition antibody titers to the circulating strain. The virologic studies were performed by independent, certified laboratories during the course of the individual trials and were completed prior to unblinding of the results.

CLINICAL MONITORING

Patients were evaluated in person at baseline, mid-therapy (day 2, 3, or 4), immediately after treatment (day 5 or 6), and at day 28. They also measured oral temperatures and completed a symptom diary twice daily for the duration of the study or until all symptoms (cough, nasal obstruction, sore throat, fatigue, headache, myalgia, and/or feverishness) were reported alleviated (score, 0 [absent] or 1 [mild]) for at least 24 hours. Five selected complications involving the upper (sinusitis or otitis media) and lower (bronchitis, lower respiratory tract infection, or pneumonia) respiratory tract were prospectively recorded on case report forms, as was the use of antibiotics for any indication. The diagnosis of complications and the need for antibiotics were determined by individual treating physicians using their clinical judgment; no microbiological or radiologic tests were required. Hospitalizations and other complications or adverse events were collected on the case record forms.

OUTCOMES AND DATA ANALYSIS

The primary end point in this analysis was the occurrence of LRTCs requiring antibiotic intervention (prospectively defined as bronchitis, lower respiratory tract infection, or pneumonia) following influenza illness that started at least 48 hours after the start of study treatment and before day 28. Other outcomes examined included hospitalizations, upper respiratory tract complications (URTCs), and overall antibiotic use. An individual subject could have reported more than 1 URTC or LRTC. The Fisher 2-tailed exact test was used to compare frequencies and relative risk for the comparison of antibiotic use.
Table 2. Demographic and Clinical Characteristics of Individuals With Laboratory-Proven Influenza Illness or Influenzalike Illness Not Due to Influenza Virus Infection*  

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Placebo bid (n = 1063)</th>
<th>Oseltamivir, 75 mg bid (n = 1350)</th>
<th>Placebo bid (n = 478)</th>
<th>Oseltamivir, 75 mg bid (n = 673)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, median (range), y</strong></td>
<td>44.5 (13-97)</td>
<td>40.0 (13-96)</td>
<td>42.0 (13-95)</td>
<td>42.0 (13-91)</td>
</tr>
<tr>
<td>Male</td>
<td>516 (49)</td>
<td>618 (46)</td>
<td>188 (39)</td>
<td>286 (42)</td>
</tr>
<tr>
<td><strong>Influenza type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza A</td>
<td>945 (89)</td>
<td>1168 (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza B</td>
<td>112 (11)</td>
<td>172 (13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>6 (&lt;1)</td>
<td>9 (&lt;1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not infected</td>
<td>0</td>
<td>1 (&lt;1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duration of illness before study start, median (range), h</strong></td>
<td>25.0 (0.0-58.8)</td>
<td>24.7 (0.0-60.0)</td>
<td>24.7 (0.2-51.6)</td>
<td>24.5 (0.0-229.3)</td>
</tr>
<tr>
<td>At-risk individuals‡</td>
<td>401 (38)</td>
<td>368 (27)</td>
<td>200 (42)</td>
<td>237 (35)</td>
</tr>
<tr>
<td>Elderly ≥65 y</td>
<td>294 (28)</td>
<td>285 (21)</td>
<td>146 (31)</td>
<td>191 (28)</td>
</tr>
<tr>
<td>Chronic respiratory and/or cardiac disease</td>
<td>157 (15)</td>
<td>137 (10)</td>
<td>84 (18)</td>
<td>90 (13)</td>
</tr>
<tr>
<td>Current vaccination</td>
<td>188 (18)</td>
<td>206 (15)</td>
<td>128 (27)</td>
<td>151 (22)</td>
</tr>
</tbody>
</table>

Abbreviation: bid, twice daily.  
*Data are given as number (percentage) unless otherwise specified.  
†One patient was erroneously included in the influenza-infected population when not influenza infected.  
‡Some subjects fulfill both criteria of being elderly and having chronic respiratory and/or cardiac conditions.

RESULTS

PATIENT CHARACTERISTICS

The 10 studies enrolled 3591 adults and adolescents (subsequently, 1541 individuals were randomized to placebo and 2023 randomized to oseltamivir, 75 mg twice daily), who comprised the intent-to-treat population (Table 1). Among placebo recipients 74 (4.8%) subjects withdrew early, 28 (1.8%) for adverse events. Among oseltamivir recipients, 113 (5.9%) withdrew prematurely, 35 (1.8%) for adverse events. These subjects were included in the analyses up to the date of withdrawal. Of the enrolled subjects, 68% had laboratory-confirmed influenza (12% influenza B and 88% influenza A, predominantly influenza A H3N2), and 32% had an influenza-like illness but no evidence of influenza virus infection. The demographic and clinical characteristics of the influenza-positive and influenza-negative populations and the oseltamivir and placebo subgroups were comparable (Table 2). Among infected persons, the proportion of at-risk individuals tended to be higher in the placebo group (38% vs 27%; P < .001). A small proportion of subjects were taking antibiotics at the time of enrollment (Table 1); these individuals were included in the analysis of complications and hospitalizations.

LRTCs LEADING TO ANTIBIOTIC USE

The overall incidence of LRTCs leading to antibiotic use was higher (10.3%) among influenza-infected placebo recipients compared with those without influenza (6.7%; P = .03) (Table 3). The proportions of individuals with clinically diagnosed pneumonia (1.8% vs 1.9%) was similar in the 2 groups, but the incidence of bronchitis in the influenza-infected population (8.2%) was almost double that observed in the noninfected population (4.4%; P = .007).

As shown in Table 3, among influenza-infected persons, oseltamivir use reduced the incidence of LRTCs leading to antibiotic intervention by 55% compared with placebo (4.6% vs 10.3%; P < .001). In contrast, there was no difference in the incidence of LRTCs between oseltamivir (5.3%) and placebo (6.7%) recipients without influenza. Most of these events occurred within the first 10 days after enrollment (Figure 1). The frequency of LRTCs and the reductions found with oseltamivir were similar in both influenza A– and B–infected subjects (Table 3). Following influenza A illness, LRTCs were observed in 10.5% of placebo- and 4.7% of oseltamivir-treated patients. Similarly, in influenza B–infected subjects, the incidence of LRTCs in placebo and oseltamivir recipients was 8.9% and 4.1%, respectively. No important effect of timing of therapy was observed, since the risk of a specified LRTC leading to antibiotic use was reduced by 54% (95% confidence interval [CI], 35%-84%) among oseltamivir recipients treated within 24 hours of symptom onset and by 44% (95% CI, 30%-65%) among those treated in 24 hours or more compared with placebo.

Among placebo recipients with influenza infection, the incidence of complications was, as expected, significantly higher in the at-risk patients (18.5%) compared with otherwise healthy adults (5.3%; P < .001). Compared with placebo, oseltamivir treatment reduced the incidence of LRTCs associated with antibiotic use by 34% (95% CI, 19.6%-47.9%) in at-risk subjects (18.3% vs 12.2%; P = .02) and by 67% (95% CI, 34.6%-99.9%) in the healthy adult population (5.3% vs 1.7%; P < .001).

OTHER RESPIRATORY EVENTS AND ANTIBIOTIC USE

Oseltamivir use reduced the overall incidence of respiratory events following influenza infection by 28% compared with placebo (11.9% vs 16.9%; P = .001). How-
ever, no differences were observed in physician-diagnosed URTCs leading to antibiotic use (most commonly sinusitis) between oseltamivir (6.8%) and placebo (5.9%). Overall, 19.1% of the influenza-infected placebo recipients compared with 14.0% of oseltamivir recipients (26.7% reduction; \( P < .001 \)) took an antibiotic for any reason. In contrast, for those without influenza infection, oseltamivir did not reduce the incidence of respiratory complications compared with placebo (12.5% vs 13.6%; \( P = .64 \)) or of overall antibiotic use (19.3% vs 19.7%).

**HOSPITALIZATIONS**

Among placebo recipients with a documented influenza illness, the percentage hospitalized for any reason was small but was 4-fold higher (3.2% [13/401]) in the at-risk population compared with the otherwise healthy group (0.8% [5/662]) (Table 4). The overall percentage of patients hospitalized for any cause was 1.7% (18/1063) in the placebo group compared with 0.7% (9/1350) in the oseltamivir group (59% reduction; \( P = .02 \)). The reduction in overall hospitalizations in the oseltamivir-treated, influenza-infected at-risk patients was 50% compared with placebo recipients (1.6% vs 3.2%; \( P = .17 \)). Most hospitalizations occurred within 10 days of study enrollment, although later hospitalizations were noted (Figure 2). In contrast, no beneficial effect on hospitalizations was seen in those without influenza infection (Table 4).

The percentage of infected individuals hospitalized for conditions probably or possibly related to influenza (venous thrombosis, cerebrovascular disease, cardiac disorders, exacerbation of comorbid conditions, and respiratory diseases) was lower in oseltamivir recipients (0.4%) than in those receiving placebo (1.1%) (Table 4). Hospitalizations due to respiratory disease were 50% lower among oseltamivir recipients (0.3%) compared with placebo recipients (0.6%). Two patients who took placebo were admitted to the intensive care unit and required ven-

---

**Table 3. Lower Respiratory Tract Complications (LRTCs) Leading to Antibiotic Use in Influenza-Infected and Uninfected Subjects With Influenzalike Illness**

<table>
<thead>
<tr>
<th>LRTCs Leading to Antibiotic Use</th>
<th>Confirmed Influenza Illness</th>
<th>Otherwise Healthy (Age 13-65 y)</th>
<th>At Risk</th>
<th>Influenza Uninfected</th>
<th>Otherwise Healthy (Age 13-65 y)</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo (n = 1063)</td>
<td>Oseltamivir (n = 1350)</td>
<td></td>
<td>Placebo (n = 662)</td>
<td>Oseltamivir (n = 982)</td>
<td></td>
</tr>
<tr>
<td>All LRTCs, No. (%)</td>
<td>109 (10.3)</td>
<td>62 (4.6)*</td>
<td></td>
<td>35 (5.3)</td>
<td>17 (1.7)*</td>
<td></td>
</tr>
<tr>
<td>Bronchitis, No. (%)</td>
<td>87 (8.2)</td>
<td>53 (3.9)</td>
<td></td>
<td>25 (3.8)</td>
<td>15 (1.5)</td>
<td></td>
</tr>
<tr>
<td>Unspecified LRTCs, No. (%)</td>
<td>4 (0.4)</td>
<td>1 (0.1)</td>
<td></td>
<td>0</td>
<td>3 (0.7)</td>
<td></td>
</tr>
<tr>
<td>Pneumonia, No. (%)</td>
<td>19 (1.8)</td>
<td>9 (0.7)</td>
<td></td>
<td>9 (1.4)</td>
<td>2 (0.2)</td>
<td></td>
</tr>
<tr>
<td>Influenza A, No./total infected (%)</td>
<td>99/945 (10.5)</td>
<td>55/1168 (4.7)</td>
<td></td>
<td>31/579 (5.4)</td>
<td>15/840 (2.0)</td>
<td></td>
</tr>
<tr>
<td>Influenza B, No./total infected (%)</td>
<td>10/112 (8.9)</td>
<td>7/172 (4.1)</td>
<td></td>
<td>4/77 (5.2)</td>
<td>2/133 (1.5)</td>
<td></td>
</tr>
</tbody>
</table>

*Comparison of oseltamivir vs placebo, \( P < .001 \).
†Comparison of at-risk placebo vs otherwise healthy placebo, \( P < .001 \).
‡Comparison of oseltamivir vs placebo, \( P = .02 \).
Influenza Uninfected
At Risk
At Risk
curred with comparable frequency following influenza A corded events following influenza illness. These events oc-
ing to 65% and 91%, respectively, of all prospectively re-
common complications observed in both healthy adults
delayed therapy or no treatment.13

tions, antibiotic use, and hospitalizations compared with
onset) appeared to reduce the likelihood of complica-
plication reduces influenza-related hospitalizations. Of note,
antiviral and specifically neuraminidase inhibitor treat-
tion of subjects considered to be at increased risk for com-
ent study extends these observations to a larger popula-
low frequency of hospitalizations (0.4% overall). The pres-
fluenza complications and a reduction in hospitaliza-
ment reduces influenza-related LRTCs, associated
ness with the neuraminidase inhibitor oseltamivir sig-
Our analysis found that early treatment of influenza ill-
with the neuraminidase inhibitor oseltamivir sig-
ificantly reduced influenza-related LRTCs, associated

antibiotic use, and the risk of hospitalization. This effect
was observed in both at-risk subjects and otherwise
healthy individuals. Most hospitalizations occurred in the
at-risk population, and in this group oseltamivir use was
associated with a 50% reduction in hospitalization rate.

Our data complement those previously reported in
which inhaled zanamivir was shown to reduce the inci-
dence of LRTCs by 40% in mainly healthy subjects with
acute influenza.3 However, in this earlier report, only 12%
of the analyzed population was considered at risk for in-
fluenza complications and a reduction in hospitalizations
was not observed, possibly in part because of the low frequency of hospitalizations (0.4% overall). The present
study extends these observations to a larger population
of subjects considered to be at increased risk for compli-
cations and provides the first prospective evidence that
antiviral and specifically neuraminidase inhibitor treatment
reduces influenza-related hospitalizations. Of note,
a recent retrospective analysis of the open-label, com-
passionate use of oseltamivir in nursing home residents
found that early treatment (within 2 days of symptom
onset) appeared to reduce the likelihood of complica-
tions, antibiotic use, and hospitalizations compared with
delayed therapy or no treatment.13

Lower respiratory tract complications were the most
common complications observed in both healthy adults
and B virus infections. Among these complications, acute
bronchitis was the most common event in both healthy
adults (71%) and the at-risk population (84%). This is con-
sistent with prior studies that have found that acute bron-
chitis was a leading complication of influenza.14,15 Such find-
ings support the conclusion that bronchitis is a part of
influenza illness. This is also supported by the additional
observation that bronchitis was more frequent among in-
fluenza-infected persons compared with those without in-
fluenza. This is of major importance, since acute bronchi-
tis is a leading cause of antibiotic overuse in clinical
practice.16 Therefore, awareness that acute bronchitis is a
frequent event following influenza illness and that oselta-
mivir treatment can prevent this complication may en-
able reductions in excess antibiotic use when influenza is
circulating in the community.

All of the studies included in this analysis were
double-blind, placebo-controlled, randomized trials that
used prospective diagnosis of specified URTCs and LRTCs.
One limitation of these studies was the lack of standard-
ized clinical guidelines across participating centers for
diagnosing complications. Thus, it is unclear how often

Figure 2. Day of hospitalization among placebo- or oseltamivir (75 mg twice
daily)-treated adults with influenza infection. Date of hospitalization was
missing for 1 oseltamivir and 2 placebo recipients. One oseltamivir-treated
patient had 2 hospitalizations over different dates and is included twice in
the figure.

Our analysis found that early treatment of influenza ill-
ness with the neuraminidase inhibitor oseltamivir sig-
ificantly reduced influenza-related LRTCs, associated
antibiotic use, and the risk of hospitalization. This effect
was observed in both at-risk subjects and otherwise
healthy individuals. Most hospitalizations occurred in the
at-risk population, and in this group oseltamivir use was
associated with a 50% reduction in hospitalization rate.
Oseltamivir use did not affect the incidence of respira-
tory complications or antibiotic use in patients without
proven influenza infection, which indicated that the ben-
efit observed was specifically related to its antiviral ef-
fects. The magnitude of the reduction in LRTCs was simi-
lar in both influenza A– and B–infected subjects, which
is consistent with the antiviral spectrum of oseltamivir.

Our data complement those previously reported in
which inhaled zanamivir was shown to reduce the inci-
dence of LRTCs by 40% in mainly healthy subjects with
acute influenza.3 However, in this earlier report, only 12%
of the analyzed population was considered at risk for in-
fluenza complications and a reduction in hospitalizations
was not observed, possibly in part because of the low frequency of hospitalizations (0.4% overall). The present
study extends these observations to a larger population
of subjects considered to be at increased risk for compli-
cations and provides the first prospective evidence that
antiviral and specifically neuraminidase inhibitor treatment
reduces influenza-related hospitalizations. Of note,
a recent retrospective analysis of the open-label, com-
passionate use of oseltamivir in nursing home residents
found that early treatment (within 2 days of symptom
onset) appeared to reduce the likelihood of complica-
tions, antibiotic use, and hospitalizations compared with
delayed therapy or no treatment.13

Lower respiratory tract complications were the most
common complications observed in both healthy adults
and the at-risk population receiving placebo, contrib-
ting to 65% and 91%, respectively, of all prospectively re-
corded events following influenza illness. These events oc-
curred with comparable frequency following influenza A

COMMENT

Table 4. Number of Hospitalizations in Influenza-Infected and Uninfected Subjects With Influenzalike Illness (ILI)

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>Confirmed Influenza Illness</th>
<th>Influenza Uninfected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Otherwise Healthy (Age 13-65 y)</td>
<td>At Risk</td>
</tr>
<tr>
<td>Placebo (n = 1083)</td>
<td>Oseltamivir (n = 1350)</td>
<td>Placebo (n = 662)</td>
</tr>
<tr>
<td>Possibly related to ILI, No. (%)</td>
<td>12 (1.1)</td>
<td>6 (0.4)*</td>
</tr>
<tr>
<td>All causes of hospitalizations, No. (%)</td>
<td>18 (1.7)</td>
<td>9 (0.7)†</td>
</tr>
</tbody>
</table>

*Comparison of oseltamivir vs placebo, P = .14.
†Comparison of oseltamivir vs placebo, P = .02.
‡Comparison of oseltamivir vs placebo, P = .17.

Our analysis found that early treatment of influenza ill-
ness with the neuraminidase inhibitor oseltamivir sig-
ificantly reduced influenza-related LRTCs, associated
antibiotic use, and the risk of hospitalization. This effect
was observed in both at-risk subjects and otherwise
healthy individuals. Most hospitalizations occurred in the
at-risk population, and in this group oseltamivir use was
associated with a 50% reduction in hospitalization rate.
Oseltamivir use did not affect the incidence of respira-
tory complications or antibiotic use in patients without
proven influenza infection, which indicated that the ben-
efit observed was specifically related to its antiviral ef-
fects. The magnitude of the reduction in LRTCs was simi-
lar in both influenza A– and B–infected subjects, which
is consistent with the antiviral spectrum of oseltamivir.

Our data complement those previously reported in
which inhaled zanamivir was shown to reduce the inci-
dence of LRTCs by 40% in mainly healthy subjects with
acute influenza.3 However, in this earlier report, only 12%
of the analyzed population was considered at risk for in-
fluenza complications and a reduction in hospitalizations
was not observed, possibly in part because of the low frequency of hospitalizations (0.4% overall). The present
study extends these observations to a larger population
of subjects considered to be at increased risk for compli-
cations and provides the first prospective evidence that
antiviral and specifically neuraminidase inhibitor treatment
reduces influenza-related hospitalizations. Of note,
a recent retrospective analysis of the open-label, com-
passionate use of oseltamivir in nursing home residents
found that early treatment (within 2 days of symptom
onset) appeared to reduce the likelihood of complica-
tions, antibiotic use, and hospitalizations compared with
delayed therapy or no treatment.13

Lower respiratory tract complications were the most
common complications observed in both healthy adults
and the at-risk population receiving placebo, contrib-
ting to 65% and 91%, respectively, of all prospectively re-
corded events following influenza illness. These events oc-
curred with comparable frequency following influenza A

and B virus infections. Among these complications, acute
bronchitis was the most common event in both healthy
adults (71%) and the at-risk population (84%). This is con-
sistent with prior studies that have found that acute bron-
chitis was a leading complication of influenza.14,15 Such find-
ings support the conclusion that bronchitis is a part of
influenza illness. This is also supported by the additional
observation that bronchitis was more frequent among in-
fluenza-infected persons compared with those without in-
fluenza. This is of major importance, since acute bronchi-
tis is a leading cause of antibiotic overuse in clinical
practice.16 Therefore, awareness that acute bronchitis is a
frequent event following influenza illness and that oselta-
mivir treatment can prevent this complication may en-
able reductions in excess antibiotic use when influenza is
circulating in the community.

All of the studies included in this analysis were
double-blind, placebo-controlled, randomized trials that
used prospective diagnosis of specified URTCs and LRTCs.
One limitation of these studies was the lack of standard-
ized clinical guidelines across participating centers for
diagnosing complications. Thus, it is unclear how often

Downloaded From: https://jamanetwork.com/ by a Non-Human Traffic (NHT) User on 01/05/2020
tion of the many participating physicians with regard to use of antibiotics and need for hospitalization, the results are reflective of current patterns of practice in the participating countries.

As expected, the incidence of LRTCs and hospitalizations was higher among the at-risk subjects than among the otherwise healthy adults and adolescent population.

The effectiveness of oseltamivir in reducing the incidence of LRTCs among the at-risk population (34%) was lower than that observed in the otherwise healthy population (67%). This may be due to the more complex pathological condition in at-risk individuals. This further supports the importance of prevention of influenza with annual vaccination in target populations. Nevertheless, the reduction in complications among these at-risk individuals is a substantial benefit and supports the use of antiviral treatment to prevent serious sequelae of influenza in those developing illness despite vaccination or in case of emergence of drifted strain not covered by the vaccine.

In our at-risk population we observed a hospitalization rate of 3.2% following influenza illness compared with 0.8% in otherwise healthy subjects. Others have reported higher hospitalization rates among at-risk populations, but our protocols excluded those with unstable or poorly controlled comorbid diseases.6,18 The data in this study are therefore more representative of the healthy older persons living in the community and individuals with stable chronic disorders. Although some subjects were hospitalized for coincidental conditions (eg, acute appendicitis or hernia repair), many were hospitalized for reasons that are known to be associated with influenza, including exacerbation of underlying conditions and coagulation disorders.6,18 Among the influenza-infected at-risk population, the 39% overall reduction in hospitalizations due to influenza-related illness in the oseltamivir group was proportionate to the observed 34% reduction in LRTCs.

We have observed that acute bronchitis is the most frequent respiratory complication following influenza illness and that approximately 1 in 5 of at-risk subjects with confirmed influenza illness experienced an LRTC. Early oseltamivir treatment significantly reduced the rate of these complications, including associated antibiotic use, and also reduced the numbers of hospitalizations following influenza. These important clinical benefits were observed both in otherwise healthy adults and at-risk subjects.

Accepted for publication October 17, 2002.

This study was supported by F. Hoffmann-La Roche Ltd, Basel, Switzerland.

We gratefully acknowledge the help with statistical analysis provided by Vivien Mitchell, MSc (Roche Global Development). We also would like to thank the many participants, investigators, and colleagues at F. Hoffmann–La Roche (Welwyn, England; Basel, Switzerland) and Gilead Sciences Inc (Foster City, Calif) for all their contributions to the individual studies from which these data are derived.

Corresponding author and reprints: Frederick Hayden, MD, Division of Infectious Diseases, PO Box 800473, University of Virginia Health Sciences Center, Charlottesville, VA 22908 (e-mail: fgh@virginia.edu).

REFERENCES


