

H1N1 – One Year Follow Up Study

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Abstract

Objective: We performed a one year follow up case series study to evaluate any residual systemic diseases in the patients who presented to our intensive care with H1N1 infection during the 2010/2011 flu epidemic. Twelve patients were admitted with H1N1 infection over a period of two months. Most of them had multi organ failure and needed various supports. All needed respiratory support varying from, non invasive ventilation, conventional ventilation, high frequency oscillation with some requiring extracorporeal support. Six patients suffered acute renal failure due to the infection and received renal replacement therapy.

Aim : This is a one year follow up case series study to evaluate any impairment in respiratory, cardiac and renal function, neurocognitive assay in this cohort of patients who had suffered and treated for H1N1 infection

Study design: Case Series study

Method: We assessed seven patients one year after they had suffered from H1N1 infection. They were evaluated for pulmonary, cardiac, renal and neurocognitive function in our clinic. Rest five were interviewed over phone

Results: Three of the seven patients had poor pulmonary function indicating significant parenchymal lung injury. Two had moderate to severe restrictive lung disease. Few patients expressed decreased quality of life and cognitive impairment. Five patients had impaired phonological fluency which may be due to hypoxic brain injury post H1N1 ARDS if this was a new finding. One of the patients who had suffered acute renal failure still has renal impairment.

Conclusion: Though all of these patients had survived and had been discharged home, a number of them in this small cohort still suffer from quantifiable sequel of the disease.

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Key words:

H1N1 infection. , Neuro-cognitive function, Phonological disorder.

Introduction

Twelve patients were admitted to our intensive care with H1N1 infection at the time of H1N1 pandemic (December/January 2010/2011). All these twelve patients were admitted within a period of two months. Severity of the disease ranged from mild to severe with multi organ impairment. All required respiratory support; two required non invasive ventilation, ten required invasive ventilation. Four patients went on to receive high frequency oscillation (HFOV) and three required extracorporeal (ECMO) support. Six required renal replacement therapy (Table 1). Most of these patients were young or middle aged with no prior intensive care admissions before the influenza infection. Four of the seven had predisposing factors including obesity, immunosuppression and one was peripartum. All survived and were discharged home after prolonged intensive care treatment.

There have been several studies identifying the epidemiology, risk factors associated with morbidity and mortality and treatment of H1N1 infection¹. There are also a number of studies looking at the respiratory^{2,3,6} and neurocognitive^{5,3,6} functions of survivors of ARDS who required prolonged intensive care treatment and ventilation. These studies clearly showed reduced neurocognitive function and restrictive lung function changes with a definitive reduction in the quality of life in that cohort of patients.

Aim

This is a one year follow up case series study to evaluate any impairment in respiratory, cardiac and renal function, neurocognitive assay in this cohort of patients who had suffered and treated for H1N1 infection..

Methods.

Ethical approval was obtained from University of Limerick Hospital ethical board. This study was performed in intensive care. Mid-Western Regional Hospital Limerick, Ireland.

Inclusion Criteria

All patients admitted to Mid Western Regional Hospital intensive care in the month of December and January 2010 and 2011 with H1N1 infection during the time of H1N1 pandemic and consented to participate in the study.

Since this was a follow up study, all the patients were contacted over phone and also by letter to consent to participate in the study. The letter contained information leaflets and invitation to attend the clinic. Seven of the twelve patients consented for the study and five declined to attend our clinic for the follow up study. Two among these five patients were not normally resident in this country and had returned to their domicile. All these five patients were happy to be interviewed over phone and also consented for their general practitioners for interview regarding their health status.

In our clinic we assessed these patients for respiratory, cardiac, neurocognitive and renal function. Sofa scores were taken from health records at the time of ICU admission. Over the phone we had asked the patients and their general practitioner regarding their overall health status and comorbidities they are suffering from if at all.

Respiratory Function

Pulmonary function tests, Chest X-Ray, High Resolution Lung CT (computed Tomography) scan and six minutes walk test were performed to assess respiratory function. Pulmonary function testing was performed with measurements of spirometry, lung volumes (Helium Dilution) and gas diffusion (Jaeger PFT (pulmonary function test) Masterscreen). Chest X-Ray and high resolution CT were performed to identify any lung parenchymal or airway damage due to the disease process. . CT examinations were performed using a 64 slice MDCT scanner (Somatom Sensation 64, Siemens Medical Solutions, Erlangen, Germany). Routine departmental High Resolution Computed tomography protocol (HRCT) was employed. One experienced radiologist with 8 years of experience of reading HRCT reviewed all of the HRCT examinations

Six minute walk test.

A premarked flat level corridor of the hospital, 100ft in length was used for the six minute walk test. This was performed according to the American Thoracic Society guidelines⁷. Oxygen saturation, heart rate, blood pressure, body weight and height were measured before the beginning of the test. The pulseoximeter used was Nelcor Ect. The heart rate and oxygen saturation were also measured at the end of the test. Recent myocardial infarction (within a month), high blood pressure (systolic >180mm of hg, diastolic > 100 mm of hg) or tachycardia (pulse >120/minute) precluded performing the walk test. A doctor or nurse accompanied the patients throughout the performance. Defibrillator trolley and emergency medication were immediately available if needed.

Predicted distance was calculated using the equation:

Men $(7.57 \times \text{height in centimetre}) - (5.02 \times \text{age}) - (1.76 \times \text{weight in kg}) - 309 \text{ m}$.

Female $(2.11 \times \text{height in centimetre}) - (2.29 \times \text{weight in kg}) - (5.78 \times \text{age}) + 667 \text{ m}$.

Percentage of predicted distance was calculated according to the distance covered, which gave an assessment to their exercise capacity. A fall in SpO₂ of more than 4 percent (ending below 93 percent) was defined as significant desaturation,

Cardiac Functions

Electrocardiography (ECG) and transthoracic echocardiography was performed aimed predominantly to assess right heart function. ARDS patients or patients with chronic respiratory disease (e.g. COPD), may have compromised right ventricular function. All Echocardiography was performed by a single investigator who is certified in echocardiography (European Diploma in Adult Echocardiography).

Renal Functions

Renal function was assessed by performing serum urea and electrolytes. Given the time constraints involved in an outpatient study we elected not to measure creatinine clearance. Creatinine Clearance was subsequently calculated based on their age, weight and serum creatinine level. Full blood count was also performed to identify any abnormalities.

Neurocognitive function

Addenbrooke's cognitive examination (ACE-R) final revised version A(2005) was administered at 12 months post discharge from ICU of H1N1 infected patients. It assesses attention & concentration, memory, language, verbal fluency, and visio-spatial ability. To assess verbal fluency, patients were required to say as many words as possible in two different categories (semantic and phonemic) and was scored accordingly. ACE-R also incorporates commonly used cognitive screening tool – MMSE (mini mental state examination).

Cut off <88 gives 94% sensitivity and 89% specificity for dementia.

Cut off <82 gives 84% sensitivity and 100% specificity for dementia.

Emotional functioning was assessed using Beck's depression inventory (BDI) and Beck's anxiety inventory (BAI). On BDI score of 1-10 is considered normal, 11-16 mild mood disturbance, 17-20 borderline clinical depression, 21-30 moderate depression, 31-40 severe depression, over 40 extreme depression. On BAI score of 0-21 indicative of very low anxiety, 22-35 moderate anxiety, greater than 35 indicate severe anxiety. Quality of life was assessed using General health questionnaire (GHQ). It is 12 question mental health portfolio used in variety of clinical situations. Higher scores indicate poor quality of life.

Results.

Table 1. General demography of the patients along with their results of pulmonary function test and creatinine clearance.

Patients	Age	SOFA score	NIV	IPPV	HFOV	ECMO	FEV1(L - %)	FVC(L - % predicted)	TLC - He(l) - %	DLCO % Pred	6 min walk test(mts)	SPO ₂ at 6 mins	CRRT	CC(mg/ml)
1	60	5	No	Yes	yes	Yes	90.4	91.3	66.1	64.1	310 (76.39%)	98%	Yes	130.6
2	55	4	Yes	No	No	No	95.5	94.3	95.5	82.51	510 (87%)	98%	No	102.06
3	26	9	No	Yes	Yes	Yes	105.4	97.3	98.6	62.6	460 (62.7%)	88%	Yes	104.63
4	27	3	Yes	No	No	No	92.7	90.6	93.62	84.32	540 (79.2%)	98%	No	124.73
5	56	7	No	Yes	No	Yes	80.9	81.8	67.2	40.5	550 (99.7%)	86%	Yes	65.19
6	45	10	Yes	Yes	Yes	No	96.8	105.4	93.8	77.6	540 (72%)	98%	No	85.65
7	44	3	Yes	No	No	No	114.1	106.3	100	76.4	600 (88.5%)	90%	No	126.31

NIV – non invasive ventilation ,IPPV –intermittent positive pressure ventilation HFOV- high frequency oscillatory ventilation, CRRT- continuous renal replacement therapy, CC- Creatinine clearance, HRCT –High resolution CT scan.. SOFA – sequential organ failure assessment score . FEV – forced expiratory volume. TLC – total lung capacity.

Of the seven patients participating in the study, three had pulmonary function testing indicating significant parenchymal lung injury. Two (Patients No. 1 and No. 5) had moderate severity restrictive lung disease with impaired gas exchange (table 1). One of these patients (Patient No.5) had significant desaturation while performing the 6 minute walk test (the full six minute of walk test however was completed). This patient was already attending the respiratory service and his respiratory function has much improved since discharge. One of the three (Patient No. 3) had mild impairment of his gas diffusion but with normal lung volumes; he also had significant desaturation with exercise. None of these parameters correlated with duration of ventilation nor did it correlate with receiving ECMO. Two of the patients with moderate to severe restrictive lung disease, demonstrated imaging findings consistent with post- ARDS fibrosis⁸. In both the cases, HRCT findings were similar with predominantly bibasilar, pulmonary fibrosis characterized by reticular thickening of the interstitium and traction bronchiectasis. No previous imaging was available for comparison .

Cardiac evaluation showed no evidence of right ventricular disease. Clinically no patient had symptomatology consistent with cardiac dysfunction.

Three out of this seven patients needed renal replacement therapy during their treatment. One of the three continues to have impaired renal function based on their blood urea, electrolyte and creatinine clearance. None of the cohort had known renal impairment prior to admission (table 1)

All patients cooperated fully with neurocognitive assessment procedure and none appeared unduly anxious during assessment . Neurocognitive functions could not be performed on one patient due to poor understanding and communication in English (table 2).

Table 2. Results of the depression , anxiety and neurocognitive assay

Patients	Age	GHQ	BAI	BDI	MMSE (30)	Attention & Orientation(18)	Memory (26)	Fluency (14)	Language (26)	Visio- Spatial Skills(16)	ACER(100)
1	61	18	8	9	28	18	19	8	23	13	85
3	27	6	0	2	30	18	22	8	25	16	89
4	27	4	2	3	30	18	26	11	26	15	96
5	56	14	3	5	29	18	24	9	26	16	93
6	45	9	0	0	30	18	25	9	26	16	94
7	45	16	2	7	30	18	19	6	24	16	83

GHQ-general health questionnaire;BAI –Beck's Anxiety index; BDI- Beck's depression index; MMSE –mini mental state examination;ACE-R -Adenbrooke's cognitive examination –revised.

Patients appeared cognitively intact using MMSE as screening tool. On MMSE all patients scored 28 or greater, four pt scored 30/30. But on further testing using ACE-R two (patient 1and 6) out of six has a score indicative of cognitive impairment. Both patients with cognitive impairment had difficulty with their memory. Five (patient 1,3,5,6 and 7) out of six patients had evidence of phonological fluency impairment which was tested using category and word fluency. Impaired phonological fluency is well documented in schizophrenic and demented patients. This is also reported post hypoxic brain injury or in people exposed to low partial pressure of oxygen in High altitudes.⁹

Visio-spatial skill was intact in all except in patient one who also had cognitive impairment. Patient 3, who did not meet cut off criteria for cognitive impairment, has shown some impairment with memory & phonological fluency. All patients demonstrated good attention and calculation during cognitive testing. Two (patient 1 and 3) of the three patients who had received ECMO had impaired neurocognitive functions and also poor quality of life. Half (patient 1, 5 and 7) of patient had scored high on GHQ indicating of poorer quality of life post H1N1 infection. But none of patient met criteria for anxiety or depression using Beck's anxiety & depression inventory.

Five patients who had refused to participate in the study were interviewed over phone along with their general physicians to correlate the findings. One patient had suffered cerebrovascular accident while on ECMO. He had a residual left sided hemiplegia with mild visual loss. He was undergoing active rehabilitation. The other four had no medical co morbidities at that moment and two had returned to work (Table 1). They could not be evaluated of their neurocognitive funvtiobs over phone.

Discussion

Twelve patients were treated in our intensive care for H1N1 infection during the period December 2010/January 2011. All these patients were contacted to participate in the study. Five patients declined the invitation to participate in this follow up but agreed to interview. Within these five patients, one patient (age 27 years) had a left sided hemiplegia and visual loss post CVA while he was on ECMO whereas the other four were in good health.

Of the seven patients who participated in our study, one patient continued to have impaired renal function based on blood urea, electrolytes and creatinine clearance. He required renal replacement therapy along with five other patients.

Three out of the seven have significantly reduced respiratory function³, but this did not correlate with receiving ECMO, or duration of ventilation in this very small cohort. Two patients have developed pulmonary fibrosis. These patients continue to receive follow up in respiratory OPD. Both have reduced physical capacity and activities due to respiratory impairment and have not returned to work^{3,6,7}.

Five of our patients have impaired phonological fluency. These patients have no past record of phonological disorder. This could signify hypoxic brain injury during their period of treatment if this was a new development similar to findings in Paolaa et al study⁹. None of the patients had suffered from depression though two of them had slightly reduced neurocognitive functions and three had decreased feeling of well being. Though our study group was small, the findings were similar to Hopkins et al study should reduced long term neurocognitive functions in patients who had suffered critical illness including ARDS which included depression and anxiety^{2,3,5}. All of these patients were employed previous to the disease. Four out of seven who participated had gone back to work within the preceding six months with improved quality of life.

The number of patients were very small which attributed to the weakness of the study. As the number of patient in this study was very small, it was not possible to correlate outcome to therapies required during their illness. However there was no evidence in this small cohort that persistent respiratory dysfunction was connected to degree of respiratory support required.

Conclusion

H1N1 Pandemic was essentially a new disease causing in particular severe respiratory failure with particular difficulty with oxygenation. Given the severity of their illness and the length of admission, we were keen to see how our cohort were one year post admission.

Though this was a small cohort of twelve patients, this group like many other critically ill patients continue to significant residual effects from their illness. One of the patients has permanent neurological deficit at a very young age as a complication of extracorporeal treatment. Five others demonstrated, impaired phonological fluency which could possibly be due to hypoxic brain injury during the course of their illness. Moderate to severe restrictive lung disease have affected three patients as a sequel of H1N1 ARDS. None of them should any cardiac involvement and one patient suffered renal impairment.

A larger cohort of patients or a nationwide study would help us access more fully the effect of H1N1 on the patients admitted during the two major outbreaks in 2009/2010 and 2010/2011. The nature of the flu virus and seasonal variations can have a major impact on our health service as did the H1N1 in those two years. Each new pandemic will bring no doubt different experiences but we

need a medical community to learn as much as possible from each event to help inform us as much as possible to help manage the effects each new variant as they will no doubt emerge

Ethics:

Institutional ethical approval from Mid Western Regional Hospital, Limerick, Ireland was obtained prior to the start of the study.

Funding.

No funding from any source was available for our study and no competing interest declared

Acknowledgement.

Many thanks to Mr Paul Murphy, clinical psychologists, UCHG Galway for helping us with the assessment of the results.

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