Influenza and morbidity and mortality risk in patients in Mexico with systemic arterial hypertension alone or with comorbidities: a retrospective, observational, cross-sectional study from 2014 to 2020

Alejandrina Malacara-Villaseñor,1 Hermes Ilaraza-Lomeli,2 Roberto Tapia-Conyer,3 Elsa Sarti1

ABSTRACT

Objectives In Mexico, patients with systemic arterial hypertension (SAH) are excluded from the influenza vaccination programme despite their risk of cardiovascular events as influenza-related complications. We investigated the impact of influenza on morbidity and mortality in patients with SAH.

Design This was a retrospective cross-sectional study that analysed data from early 2014 to mid-2020.

Setting Data were obtained from the Influenza Epidemiological Surveillance System in Mexico database.

Participants 32 663 cases of influenza in people aged ≥20 years with a confirmed case of influenza-like illness, severe respiratory infection and/or influenza death were investigated.

Primary and secondary outcome measures Influenza deaths, hospitalisation frequency and the impact on hospitalisation and/or death due to influenza by the SAH variate alone and in combination with diabetes, obesity, chronic obstructive pulmonary disease, cardiovascular disease and/or smoking, and by vaccination status were assessed.

Results The hospitalisation frequency increased with age. Notably, 46.0% (15 033/32 663) of confirmed influenza cases had at least one comorbidity, with SAH (19.2%; 6260/32 663) and obesity (18.7%; 6106/32 663) being the most prevalent. Most confirmed SAH cases (80.8%; 3057/32 660) were in those who had not been vaccinated against influenza. There were 3496 deaths due to influenza (mortality rate, 0.69×10 000 inhabitants), with the highest rates seen in those aged ≥80 years (80–89 years, 2.0%; ≥90 years, 3.6%). The case fatality rate due to influenza and SAH was significantly higher than those due to influenza without SAH in those aged <50 years, but not in the other age groups (20–29 years, 9.8%, p<0.0005; 30–39 years, 8.2%, p<0.035; 40–49 years, 17.8%, p<0.0005; vs 15.1%–20.0%, p=0.31–0.99 for those aged ≥50 years).

Conclusions Our findings support the need to include SAH in public policies of influenza vaccination as a secondary prevention measure to avoid fatal outcomes.

INTRODUCTION

Influenza, which is caused by an RNA virus, is a public health problem affecting approximately 5%–10% of adults and 20%–30% of children worldwide, with 3–6 million cases reported each year and more than 640 000 deaths per year.1 2 Additionally, influenza has a great potential to cause respiratory disease pandemics.3 4 Vaccination is one of the most cost-effective strategies for the prevention and control of many diseases. In the case of influenza, the implementation of vaccination campaigns worldwide has decreased mortality and morbidity.5 Currently, the vaccination policy offered in Mexico covers children <5 years old; adults ≥60 years of age; those aged 5–60 years with risk factors such as asthma, heart
Open access


The present study was a retrospective cross-sectional study using data from the Influenza Epidemiological Surveillance System in Mexico (SISVER). As this was an observational study with a secondary data source, it was not considered research with risk per article 17 of the Regulations of the General Health Law in the Field of Health Research.19

The SISVER sentinel surveillance system uses an influenza case definition as follows: (a) suspected cases include a clinical diagnosis of influenza-like illness (ILI) and/or an epidemiological association and (b) confirmed cases are diagnosed by real-time quantitative RT-PCR (qRT-PCR). The system collects biological samples and exhaustive clinical and epidemiological information on 10% of ILI cases and 100% of severe acute respiratory infection (SARI) cases and deaths due to influenza that occur in Mexico.6 19 The sampling strategy for deciding which of the 10% of ILI cases were collected and analysed is as follows: in each health unit from SISVER, samples were to be taken from the first suspected case and sent to the laboratory for confirmation. Samples were not collected for the following nine cases and the process was repeated for every 10 cases.6 19 Regarding the information collected, if the case was ambulatory, the clinical information was collected through patient interview, but if it was an in-hospital case, it was collected from medical chart review. A case was considered an in-hospital case if the patient spent at least 24 hours in hospital. In cases where the patient died, the information was also collected from the death certificate.

In this retrospective cross-sectional study, the SISVER database (Oficina de transparencia DGE-DGAE de la Secretaría de Salud con número 005533 referente a la Solicitud 0012000189920 del 4 de junio de 2020; the database was provided via a disk for the purpose of analysis and is not publicly available) entries from 1 January 2014 to 15 May 2020 were included. The analysis included all records of patients ≥20 years old who were diagnosed with a laboratory confirmed influenza infection of ILI or SARI by qRT-PCR and who requested medical attention. A case of death by influenza included any deceased patient with ILI or SARI, who had a positive laboratory result for influenza, and whose death certificate contained a diagnosis of influenza or pneumonia as the basic cause of death. If something other than influenza or pneumonia was listed as the basic cause of death on the death certificate, that individual was not considered to be a case of death by influenza and was excluded from the present study. All influenza deaths were rectified or ratified by an influenza-specific governmental scientific committee. Deaths ratified by this committee were included in the present study.19

Outcomes and statistical analysis

A descriptive analysis of the variables studied was performed, as well as bivariate and stratified (by age group) analyses considering the impact on hospitalisation and/or death due to influenza by the SAH variate alone and/or combined with diabetes, obesity, chronic obstructive pulmonary disease (COPD), CVD and/or smoking, and by influenza vaccination status. ORs were calculated considering the comparison between confirmed influenza cases with SAH alone or with other comorbidities, versus confirmed influenza cases without SAH, diabetes, obesity, COPD, CVD or a smoking habit. However, they could have diseases or lesions other than those listed. Statistical significance was determined using the $\chi^2$ test or Fisher’s exact test. Incidence rates were estimated considering the total number of new confirmed influenza cases per 100,000 inhabitants of each specific age group and totalled for persons-years of observation. Similarly, case fatality rates were determined by calculating the cases with influenza-related death over the confirmed cases per 100 inhabitants. Although the incidence rate calculations did not take into account the sampling scheme, the mortality and hospitalisation calculations took into account 100% of influenza cases reported in Mexico. For statistical analyses, Microsoft Excel (Microsoft Corp, Redmond, Washington, DC, USA), SPSS-PC (IBM, Armonk, New York, USA) and Epi Info software (Centers for Disease Control and Prevention, Atlanta, Georgia, USA) were used.

Patient and public involvement

Patients or the public were not involved in the design, conduct, or reporting or dissemination plans of our research.
RESULTS

Cases

A total of 32,663 confirmed cases of influenza were analysed; most of them were women (56.0% (18,284/32,663) vs 44.0% (14,379/32,663) men), the mean and median ages for women were 46 and 44 years, and for men, 47 and 46 years, respectively. The years 2014 (21.1%, 6892/32,663), 2016 (21.9%, 7149/32,663) and 2017 (15.8%, 5147/32,663) had the highest number of confirmed influenza cases, which corresponded to the seasons that also had the highest rates.

The highest proportion of cumulative cases was in the group aged 30–39 years (21.3%, 6952/32,663), followed by the group aged 40–49 years (20.8%, 6806/32,663); however, the highest incidence rate per 100,000 inhabitants corresponded to elderly patients, especially those aged ≥80 years. Among all confirmed influenza cases, 19,948/32,663 (61.1%) were inpatient cases, and 12,715/32,663 (38.9%) were outpatient cases. The highest proportion of hospitalised influenza cases was in patients aged ≥80 years, with the frequency of hospitalisation increasing with age. For each outpatient case of influenza, 1.56 persons were hospitalised (online supplemental table S1).

Among all confirmed influenza cases, 46.0% (15,033/32,663) of patients had at least one comorbidity. SAH and obesity were the most prevalent, at 19.2% (6260/32,663) and 18.7% (6106/32,663), respectively, followed by type 2 diabetes (17.7%, 5794/32,663), smoking (11.4%, 3711/32,663), COPD (6.5%, 2136/32,663) and CVD (4.9%, 1607/32,663). When comorbidities were broken down by age group, the burden of influenza disease and obesity was notable mainly in those <50 years of age, and among those aged ≥50 years, SAH and diabetes were more prevalent (figure 1). The combination of SAH with another comorbidity of interest was more frequent for diabetes (8.8%, 2884/32,663) and obesity (6.6%, 2143/32,663) and less frequent for COPD (2.8%, 925/32,663), smoking (2.7%, 881/32,663) and CVD (2.4%, 772/32,663).

Regarding the vaccination history against influenza, 80.8% of those with a confirmed case of SAH (5,057/6,260) had not been vaccinated, and only 15.1% (944/6,260) had been vaccinated. The percentages do not add up to 100% because the vaccination status was unknown for some patients.

Deaths

In total, 3,496 deaths due to influenza (overall mortality rate of 0.69×100000 inhabitants) were reported, with the group aged ≥80 years presenting the highest rates, followed by the group aged 60–69 years. Regarding case fatality rates, the overall rate was 10.7% (3,496/32,663), with the group aged 60–69 years presenting the highest rate (19.4%, 690/3562), even when compared with the group aged ≥90 years (17.1%, 72/421).

Similar trends were observed with the mortality rates of influenza and SAH, where the higher the age group, the higher the mortality rate; however, in the case of fatality due to influenza and SAH, the groups aged <50 years had significantly higher rates in comparison with the same age groups but without SAH, showing that having influenza with SAH leads to worse outcomes in specific age groups (table 1).

The influenza case fatality rates found in patients with SAH (16.3%; 1020/6260) increased when data were analysed by pairs of SAH plus other comorbidities such as diabetes (19.5%; 534/2741), obesity (18.6%; 385/2068),

Figure 1  Cumulative influenza cases by age and comorbidity groups. COPD, chronic obstructive pulmonary disease; CVD, cardiovascular disease; SAH, systemic arterial hypertension.
CVD (19.1%; 138/721), COPD (16.8%; 146/871) and smoking (21.8%; 185/849) (online supplemental table S2).

When observing the influenza case fatality rates with the presence of SAH alone (figure 2A) compared with those who died without a history of SAH, a clear impact of this morbid condition was observed in those aged <50 years (mainly in those aged 20–29 years), but not in those aged ≥50 years, where it seems that the effect of age itself contributed to death.

When the analysis was performed considering the different SAH pairs, a greater risk effect was observed in the group of patients aged 30–39 years when combined with diabetes, obesity, COPD, CVD and smoking. Notably, in the combination of SAH with obesity, the greatest risk was found in the group aged 20–29 years (table 2).

Concerning vaccination history, age groups and the presence or absence of SAH, influenza-related deaths were notably lower among patients who were vaccinated (<2%) compared with unvaccinated patients (range 7%–17%) (figure 2B). Similar trends were observed in patients with SAH and other comorbidities.

The risk of hospitalisation (OR 3.3; 95% CI 3.1 to 3.5; p<0.0001) and death due to influenza (OR 1.9; 95% CI 1.8 to 2.1; p<0.0001) was shown in patients with SAH, and these risks increased more in the presence of other comorbidities (online supplemental table S2). The risks...
**Table 2**  Case fatality rates of influenza and systemic arterial hypertension (SAH) combined with other comorbidities and ORs of these rates when compared with patients who died without comorbidities

<table>
<thead>
<tr>
<th>Age group, years</th>
<th>Influenza deaths (n)/influenza cases (n) (with SAH and diabetes)</th>
<th>CFR with SAH and diabetes, %</th>
<th>Influenza deaths (n)/influenza cases (n) (without SAH and diabetes)</th>
<th>CFR without SAH and diabetes</th>
<th>OR</th>
<th>CI</th>
<th>P value</th>
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<tr>
<td>20–29</td>
<td>0/23</td>
<td>0.0</td>
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<td>22.1</td>
<td>698/6417</td>
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<tr>
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<td>0.7</td>
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</tr>
<tr>
<td>≥90</td>
<td>15/65</td>
<td>23.1</td>
<td>57/356</td>
<td>16.0</td>
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<td>0.8</td>
<td>0.32</td>
</tr>
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<td>Total</td>
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<td>18.5</td>
<td>2962/29 779</td>
<td>10.0</td>
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<table>
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<tr>
<th>Age group, years</th>
<th>Influenza deaths (n)/influenza cases (n) (with SAH and CVD)</th>
<th>CFR with SAH and CVD, %</th>
<th>Influenza deaths (n)/influenza cases (n) (without SAH and CVD)</th>
<th>CFR without SAH and CVD</th>
<th>OR</th>
<th>CI</th>
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<tr>
<td>60–69</td>
<td>42/195</td>
<td>21.5</td>
<td>648/3367</td>
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<td>1.1</td>
<td>0.8</td>
<td>0.52</td>
</tr>
<tr>
<td>70–79</td>
<td>25/171</td>
<td>14.6</td>
<td>313/2004</td>
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<td>80–89</td>
<td>18/109</td>
<td>16.5</td>
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</tr>
<tr>
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<td>17.1</td>
<td>66/386</td>
<td>17.1</td>
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<td>0.99</td>
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<td>3358/31 891</td>
<td>10.5</td>
<td>1.2</td>
<td>1.0</td>
<td>0.09</td>
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<table>
<thead>
<tr>
<th>Age group, years</th>
<th>Influenza deaths (n)/influenza cases (n) (with SAH and smoking)</th>
<th>CFR with SAH and smoking, %</th>
<th>Influenza deaths (n)/influenza cases (n) (without SAH and smoking)</th>
<th>CFR without SAH and smoking</th>
<th>OR</th>
<th>CI</th>
<th>P value</th>
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<tbody>
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<td>20–29</td>
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<td>0.58</td>
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<tr>
<td>≥90</td>
<td>6/35</td>
<td>17.1</td>
<td>66/386</td>
<td>17.1</td>
<td>1.0</td>
<td>0.4</td>
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<td>3350/31 738</td>
<td>10.5</td>
<td>1.2</td>
<td>1.0</td>
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of hospitalisation and death due to influenza were also high among unvaccinated patients, and these risks further increased in the presence of other comorbidities (online supplemental table S3).

**DISCUSSION**

Several studies have investigated the impact of influenza and vaccination against influenza on morbidity and mortality in patients with comorbidities such as CVDs, diabetes, obesity, COPD and cerebrovascular disease, among others.\(^6\)\(^–\)\(^9\) However, few studies have been published regarding patients with only SAH and the impact of influenza vaccination. One Danish study showed that vaccination against influenza is associated with a reduction in the risk of all-cause mortality, cardiovascular mortality and myocardial infarction or stroke mortality in hypertensive patients without CVD.\(^13\)\(^,\)\(^14\) Nevertheless, this study did not compare this population with non-hypertensive patients, as all patients studied had SAH. Others have reported alterations in circulation in patients with influenza and patients with hypertension,\(^8\)\(^,\)\(^15\) and there is a high prevalence of hypertension (63%) and mortality due to myocardial infarction and influenza.\(^8\)\(^,\)\(^16\) The present study is among the few in which an association was found that explains the impact of influenza on morbidity and mortality in patients having SAH only.

In the present study, most of the patients with confirmed cases of influenza presented associated comorbidities, and 19.2% of the entire population evaluated, including patients >20 years of age, had SAH. This percentage is very similar to that published by the ENSANUT,\(^11\) which was 18.4% among a population >20 years of age. Therefore, despite the limitations of our study, we can infer that the results adequately reflect the situation in the country.

### Table 2 Continued

<table>
<thead>
<tr>
<th>Age group, years</th>
<th>Influenza deaths (n)/influenza cases (n) (with SAH and smoking)</th>
<th>CFR with SAH and smoking, %</th>
<th>OR</th>
<th>CI</th>
<th>P value</th>
<th>Influenza deaths (n)/influenza cases (n) (without SAH and smoking)</th>
<th>CFR without SAH and smoking, %</th>
<th>OR</th>
<th>CI</th>
<th>P value</th>
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<tr>
<td>30–39</td>
<td>10/62</td>
<td>16.1</td>
<td>3.0</td>
<td>1.5 to 5.9</td>
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<td>1.7</td>
<td>1.1 to 2.6</td>
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<td>40/201</td>
<td>19.9</td>
<td>1.3</td>
<td>0.9 to 1.8</td>
<td>0.2</td>
<td>62/319</td>
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<td>0.9 to 2.1</td>
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<td>80–89</td>
<td>22/93</td>
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<td>1.1 to 2.8</td>
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<td>1.0 to 4.8</td>
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<td>1.7</td>
<td>1.0 to 3.4</td>
<td>0.0001</td>
<td>197/1068</td>
<td>21.0</td>
<td>2.2</td>
<td>1.9 to 2.5</td>
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CFR, case fatality rate; COPD, chronic obstructive pulmonary disease; CVD, cardiovascular disease.
Regarding influenza fatality, most publications report that the older the age, the higher the death rate. However, in our study, the group with the highest case fatality rate was the group aged 60–69 years, even when compared with the case fatality rate in the groups aged ≥70 years. This supports the vaccination programme in Mexico where vaccination is offered free of charge to the whole population aged >60 years.

However, it is worth reflecting on other age groups. For instance, in the group aged 50–59 years, the case fatality rate was similar to that of the group aged 70–79 years and was even higher than that of the group aged 80–89 years. This has already been recognised by the Mexican health authorities, and even though the recommendation by the collegiate bodies on vaccination includes this group (in those >50 years old), the immunisation policy has yet to include this age group. A similar result was recently reported in a cross-sectional epidemiological study, in which the case fatality and mortality rate in this age group (50–59 years) was similar to that of patients >60 years old, equivalent to an estimated range of 0.5–2.9 million cases per year. The same study also reported that vaccination of this population is cost-effective; thus, implementing vaccination in this age group would be a necessary step.

People with a diagnosis of SAH alone are not considered as a vulnerable or at-risk population in the official guidelines. In the present study, the highest ORs were found in groups <50 years of age, mainly in the group aged 20–39 years, and these are groups that are not considered in the vaccination recommendations either because of their age or because of a comorbidity with hypertension. In the last national health survey of the country, it was reported that among adults aged 20–29 years, 5.6% had a previous diagnosis of SAH, in addition to 6.5% who were detected as hypertensive during the survey; in the group aged 30–39 years, these frequencies were 8.4% and 7.7%, respectively, and in the group aged 40–49 years, the frequencies increased to 16.8% for previous diagnosis and 12.1% by survey finding. Combining these results with our present findings, we found that 12.1% of those aged 20–29 years, 16.1% of the group aged 30–39 years and 28.9% of the group aged 40–49 years had a mortality risk from influenza that was 1.7 to 4 times higher than that in the population without a comorbidity with SAH. The population with SAH is not recommended for vaccination in the current policy in Mexico, which would lead to an increase in the risk of hospitalisation and death from influenza in unvaccinated patients with SAH especially when other comorbidities are present.

Conversely, the effect of SAH in younger age groups was not observed in those aged 60–79 years where the highest overall fatality was observed. A possible explanation is that because this group of patients is known to be hypertensive, they were hospitalised earlier and received a more careful medical supervision, thus avoiding a fatal outcome. Of note, the official recommendations include this group among those recommended for vaccination.

It is essential to point out that hypertension alone is not the direct cause of death, but rather that influenza can lead to a cardiovascular event in a hypertensive patient. In this regard, there is evidence indicating that in patients with coronary artery disease, it is advisable to vaccinate against influenza since it is associated with a decrease in all-cause mortality. The same occurs with heart failure patients in whom this decrease in all-cause mortality is also shown.

Overall, findings from this study support the need to apply the vaccine recommendation to those >50 years of age and to include populations with SAH in the influenza vaccination programme as a secondary prevention measure to avoid fatal outcomes. Specifically, we recommend the current guidelines be changed to replace ‘Cardiovascular disease excluding SAH’ with ‘Cardiovascular disease including SAH’. We expect that this new recommendation will benefit around 15 million people.

The present study has some limitations. Data for this study were obtained from a government database, and there are generally several limitations that must be considered for a correct interpretation of the results. For example, even though the results presented here give an epidemiological overview of the country, they do not represent the burden of disease (morbidity) because SISVER in Mexico operates under a sentinel model that covers less than 10% of the total number of health units in the country. This is not the case for deaths because according to official guidelines, 100% of influenza deaths should be reported to SISVER. Other possible reporting biases are related to vaccination history and comorbidities. Regarding the vaccination history, this is obtained by questioning the patient instead of via the submission of documents, so having an electronic vaccination system would objectively substantiate the vaccination status of any patient. As for the presence of comorbidities, this can be substantiated in inpatients, as opposed to outpatients, where it is only based on the information given by the patient. Additionally, we were not able to adjust for unknown potential risk factors because either the information was not requested from patients or may not have been listed in the clinical record and, as such, could not be reported in the database.

CONCLUSIONS

The present analysis of data from confirmed influenza cases collected by a sentinel system and 100% of deaths from influenza in Mexico during 2014 to week 20 of the year 2020 clearly shows the impact and risk that influenza has on morbidity, hospitalisation and death in patients with SAH (as the only comorbidity) as well as in those with SAH and other comorbidities. This publication adds value to the current literature in
that the data show that having SAH might represent an additional risk for complications in patients infected with influenza, highlighting the need for this group of patients to be vaccinated to reduce the morbidity and mortality risks. Therefore, we recommend that patients with SAH be included in the national recommendations for vaccination against influenza, per 2020 WHO recommendations.

Author affiliations
1 Departamento Medico, Sanofi Pasteur Mexico, Ciudad de Mexico, Mexico
2 Facultad de Medicina, Universidad Nacional Autonoma de Mexico, Ciudad de Mexico, Mexico

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ORCID iD
Elsa Sarti http://orcid.org/0000-0003-3112-2679

REFERENCES


