factors, such as lack of access to health care and psychosocial issues, were also noted.

Reviewers’ Comments. This article presents several key risk factors for life-threatening asthma that may assist health care providers in recognizing those high-risk asthmatics. There were some weaknesses of the study that were also mentioned by the author, including the lack of a control group, the fact that data were based on self- or proxy reportings, and that the study was limited to 1 urban community. Overall, however, any data on the risk factors for fatal asthma are worth noting.

THE BURDEN OF INFLUENZA ILLNESS IN CHILDREN WITH ASTHMA AND OTHER CHRONIC MEDICAL CONDITIONS

Neuzil KM, Wright PF, Mitchel EF, M.S., Griffin MR. J Pediatr. 2000;137:856–864

Purpose of the Study. To measure the burden of influenza among children with asthma and other medical conditions, many of whom do not receive influenza vaccination.

Study Population. Study participants included black and white children aged <15 years who were enrolled in the Tennessee Medicaid program from 1973–1993. Three high-risk patient categories were established including asthma, other lung disease, and other chronic disease. The second data set included ongoing prospective virus surveillance system at Vanderbilt University, which permits precise definition of the influenza season on an annual basis.

Methods. A retrospective cohort analysis was used to determine the rates of hospitalization for acute cardiopulmonary disease, outpatient visits, and antibiotic courses throughout the year. Annual differences between event rates when influenza virus was circulating and event rates during winter months when there was no influenza in the community were used to calculate influenza-attributable morbidity.

Results. Influenza accounted for an average of 19, 8, and 2 excess hospitalizations for cardiopulmonary disease yearly per 1000 high-risk children aged <1 year, 1 to <3 years, and 3 to <15 years, respectively. For every 1000 children, an estimated 120 to 200 outpatient visits and 65 to 140 antibiotic courses were attributed to influenza annually. Specifically in the group of asthmatic children <15 years, an estimated 10% to 20% had an additional outpatient visit during an average influenza season, and approximately 14% of these children received an additional antibiotic prescription.

Conclusions. Children <15 years with asthma and other chronic medical conditions experience substantial morbidity requiring inpatient and outpatient care during the influenza season. The hospitalization rates in this study are comparable to rates in adult high-risk populations for whom influenza vaccination is recommended. More effective targeting of this population for annual influenza immunization is warranted.

Reviewer’s Comments. Despite an increase in published medical evidence supporting the benefits of immunizing children with chronic lung diseases, particularly asthma, the rates of actual vaccination remain low. For example, in the United States, it is estimated that only up to 25% of children with moderate to severe asthma receive the influenza vaccine. In an average year, up to 30% of children will be infected with influenza, and this disease may cause substantial morbidity in children with and without chronic illnesses such as asthma. Current vaccine coverage rates for influenza among children with asthma remain unacceptable and creative strategies to utilize this preventive therapy, especially in patients with asthma, will continue to be a challenge that health care providers need to resolve.

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DOES INFLUENZA VACCINATION PREVENT ASTHMA EXACERBATIONS IN CHILDREN?


Objective. Influenza is known to aggravate asthma; however, the effectiveness of the influenza vaccine in preventing influenza-related asthma is not known.

Study Population. Children 1 through 6 years old with asthma from 4 large health maintenance organizations.

Methods. This was a population-based, retrospective cohort study that used medical and vaccination records from 4 large health maintenance organizations within the United States during the 1993–1994, 1994–1995, and mid-1995–1996 influenza seasons. Children with asthma were identified by searching computerized databases of medical encounters and pharmacy records. The main outcome measures were exacerbations of asthma that were treated in the emergency room or hospital.

Results. Unadjusted rates of asthma episodes were higher after influenza vaccination than before vaccination. However, after adjusting for asthma severity, the incidence rate ratios of asthma exacerbations after vaccination were 0.78, 0.59, and 0.65 compared with the period before vaccination during the 3 respective influenza seasons.

Conclusion. After controlling for asthma severity, the authors found that influenza vaccination protects against acute asthma exacerbations in children.

Reviewer’s Comments. This is a useful study in that it supports the recommendation to provide influenza vaccinations to children with asthma, especially for those children with more severe asthma. Although other viruses clearly cause more asthma exacerbations than influenza, at least this one can be prevented. Additional prospective studies in larger populations to confirm these results would be very helpful.

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INSIGHT INTO PATIENT DISSATISFACTION WITH ASTHMA TREATMENT


Purpose. Measures of patient satisfaction or dissatisfaction with treatment are increasingly being used as indicators of quality of care. As these measures become more widely used, it is important to know if patient dissatisfaction is associated with important processes or outcomes of medical care.

Patient Population and Methods. Survey of patient-reported asthma management issues using the Asthma Therapy Assessment Questionnaire in a Kaiser health maintenance organization in the Pacific Northwest. Associations between patient dissatisfaction with asthma treatment and patient-reported measures of asthma control, patient-provider communication, and belief in asthma medications (self-efficacy) were examined.
Does Influenza Vaccination Prevent Asthma Exacerbations in Children?
Christopher Randolph

Pediatrics 2002;110:453

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Christopher Randolph
*Pediatrics* 2002;110;453

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