Oseltamivir Resistance in Adult Oncology and Hematology Patients Infected with Pandemic (H1N1) 2009 Virus, Australia


We describe laboratory-confirmed influenza A pandemic (H1N1) 2009 in 17 hospitalized recipients of a hematopoietic stem cell transplant (HSCT) (8 allogeneic) and in 15 patients with malignancy treated at 6 Australian tertiary centers during winter 2009. Ten (31.3%) patients were admitted to intensive care, and 9 of them were HSCT recipients. All recipients of allogeneic HSCT with infection <100 days posttransplantation or severe graft-versus-host disease were admitted to an intensive care unit. In-hospital mortality rate was 21.9% (7/32). The H275Y neuraminidase mutation, which confers oseltamivir resistance developed in 4 of 7 patients with PCR positive for influenza after ≥4 days of oseltamivir therapy. Three of these 4 patients were critically ill. Oseltamivir resistance in 4 (13.3%) of 30 patients who were administered oseltamivir highlights the need for ongoing surveillance of such resistance and further research on optimal antiviral therapy in the immunocompromised.

Immunocompromised patients are at risk for serious complications from seasonal influenza (1). This group of patients has also been disproportionately represented among those with severe infections from influenza A pandemic (H1N1) 2009, comprising 3.4%–19.6% of patients admitted to intensive care units in case series from North America (2–4).

The protective effect of seasonal influenza vaccination is reduced in patients with hematologic malignancy and recipients of an allogeneic hematopoietic stem cell transplant (HSCT) (5,6). Therefore, these patients are likely to remain at increased risk for complications from the pandemic (H1N1) 2009 virus, despite the availability of an effective vaccine. Furthermore, the emergence of resistance to neuraminidase inhibitors may limit the utility of prophylaxis in this population (7–12).

During 2009, the predominant strain of influenza in Australia was influenza A pandemic (H1N1) 2009 virus (13,14). In the state of Victoria, after the initial 3 months of community transmission of pandemic (H1N1) 2009 virus, 50% of patients who died had an underlying hematologic malignancy (15). We describe in detail the clinical features, treatment, and outcomes of immunocompromised patients hospitalized in 6 tertiary centers in Australia during winter 2009.

Study Design and Population

Six Australian tertiary centers, 5 in Melbourne, Victoria, and 1 in Sydney, New South Wales (NSW), participated in the study. The 5 centers in Melbourne provide most specialist adult hematology services to the state of Victoria (population 5.4 million), and 2 of these centers perform all
allogeneic HSCTs for the state. The participating Sydney center is the largest of 2 centers that perform adult allogeneic HSCT for the state of NSW (population 7 million). Approval for this study was obtained from human research ethics committees of each center.

Patients were included in the study if they had the following characteristics: 1) ≥18 years of age hospitalized at 1 of the 5 Melbourne study centers during May 1–August 30, 2009, or hospitalized at the Sydney center during May 1–September 15, 2009; 2) recipient of an HSCT or had an underlying malignancy (hematologic or solid tumor); and 3) had laboratory-confirmed pandemic (H1N1) 2009 virus infection identified by nucleic acid testing (NAT) during their hospital stay. At each center, investigators were directly involved in active surveillance and management of patients with pandemic (H1N1) 2009, allowing cases to be identified. Data were retrospectively abstracted onto standardized case record forms.

Influenza Virus Diagnostics

All cases were confirmed in laboratories whose performance is accredited by the National Association of Testing Authorities in Australia. For the Victorian cases, all but 1 case-patient had laboratory confirmation of pandemic (H1N1) 2009 at the Victorian Infectious Diseases Reference Laboratory (VIDRL) with pandemic (H1N1) 2009-specific NAT by using reverse transcriptase–PCR (RT-PCR) as described (16). NAT for the other case-patient from Victoria was performed by the laboratory at the hospital where the patient was treated. The NSW cases were all confirmed at the state’s reference laboratory with RT-PCR assays as previously described (17). Patient specimens had repeat NAT at the discretion of the treating clinicians. Virus isolates or clinical samples from patients whose NAT results were positive after 4 days of oseltamivir therapy were analyzed to determine the presence of the H275Y neuraminidase (NA) mutation (N1 numbering) by using either a pyrosequencing assay (Biotage AB, Uppsala, Sweden) according to the manufacturer’s instructions, or rolling circle amplification (18). The H275Y mutation confers high-level oseltamivir resistance and has been detected in all of the oseltamivir-resistant pandemic (H1N1) 2009 viruses reported to date, as well as in local circulating seasonal influenza A (H1N1) strains (8,12). Samples also underwent NAT for other respiratory viruses by using a multiplex PCR.

Definitions and Statistics

Data were stored in Microsoft Access 2003 (Microsoft, Redmond, WA, USA), and descriptive statistics were summarized with proportional outcomes. Nosocomial acquisition was defined as the development of symptoms attributable to pandemic influenza after 48 hours in the hospital that were not present on admission. Steroid-refractory or grade III–IV graft-versus-host-disease (GVHD) was defined as severe GVHD.

Length of stay was calculated as length of hospital admission or period of confinement after onset of symptoms for those with nosocomial acquisition. Epidemic curves for the 2 states were aligned with epidemic curves of community pandemic influenza activity ascertained from surveillance data (14,19). Daily corticosteroid doses were calculated by using relative glucocorticoid potency to convert prednisolone equivalents, and mean daily values were determined for patients who received regular intermittent dosing (20).

Thirty-two patients fulfilled the inclusion criteria. Patient demographics and clinical features are summarized in Table 1. Seven (21.7%) of the 32 patients died; median length of stay was 6.5 d (interquartile range 4.0–13.5 d).

Patient Demographics and Baseline Features

Eight patients were recipients of an allogeneic HSCT (Table 1). Six patients had a human leukocyte antigen (HLA) matched related, 1 (patient 1) an HLA mismatched related, and 1 (patient 7) an HLA mismatched unrelated allogeneic HSCT. Patient 6 was the recipient of 2 allogeneic HSCTs. Three patients (5, 6, and 8) were diagnosed with pandemic (H1N1) 2009 within 100 days of the allogeneic HSCT. Six were receiving calcineurin inhibitors. Patient 3 was the only allogeneic HSCT recipient that had documented recurrence of underlying disease posttransplant.

At the time they sought treatment, all 8 recipients of autologous HSCT were ≥2 years posttransplant. These patients had their malignancy diagnosed between 5 and 8 years before pandemic (H1N1) 2009, except patient 11, who had multiple myeloma that had been diagnosed 3 years previously. All autologous HSCT recipients had a relapse of malignancy after transplantation, and 7 of these patients were continuing to receive active treatment for malignancy.

Two patients (26 and 29) who had had recent a diagnosis of malignancy were in remission and continuing on the primary chemotherapy treatment plan. Seven nontransplant recipients had either not shown a response or were deemed by their treating clinicians to be refractory to their current treatments. Patient 17 had an influenza-like illness (ILI) before admission for chemotherapy and autologous HSCT (further details below). Sixteen patients (3 allogeneic HSCT recipients, 6 autologous HSCT recipients, and 10 nontransplant recipients) were receiving corticosteroids before the onset of pandemic (H1N1) 2009 infection. The mean dose in prednisolone equivalents was 40.9 mg/d (range 5.0–156 mg/d).

Findings at Initial Visit

Clinical features at patients’ initial visit coincided with peak activity of pandemic (H1N1) 2009 in the Victorian and
NSW communities (Figure; online Technical Appendix, www.cdc.gov/EID/content/16/7/1068-Techapp.pdf). Patient 17 acquired the infection during interstate travel and sought treatment in late August, 2 days after return to Melbourne. Four patients had contact with family members with ILL, and 4 patients had nosocomial acquisition without an identifiable primary or index case (Table 1).

Most patients exhibited fever (94%) and cough (91%). Dyspnea, sore throat, and rhinorrhea were reported in 53%, 50%, and 50% of patients, respectively. Sixteen patients (50%) sought treatment within 48 h of symptom onset. Four patients visited the hospital after experiencing prolonged symptoms: for 12 d (patient 4), 14 d (patients 22 and 25), and 21 d (patient 14). Three of these patients had biphasic illnesses with initial prolonged mild upper respiratory tract illnesses and, on examination, had consolidation shown on chest radiograph. Patient 25 had 2 weeks of dyspnea associated with an exacerbation of chronic obstructive pulmonary disease. Patient 16 sought treatment for shock and respiratory failure.

Diagnosis of pandemic (H1N1) 2009 was confirmed by NAT of bronchial washings of 3 patients (2, 16, 17). One of them, patient 17, had symptoms of a viral respiratory tract infection for 20 d with negative results for pandemic (H1N1) 2009 virus by RT-PCR of nasopharyngeal swab specimens taken 2 and 16 d before bronchoscopy. All

### Table 1. Demographics and clinical findings among patients who had malignancy or HSCT and influenza A pandemic (H1N1) 2009 virus, Australia*

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age, y/sex</th>
<th>Underlying malignancy</th>
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</table>

*HSCT, hematopoietic stem cell transplant; ICU, intensive care unit; GVHD, graft-versus-host disease; CML, chronic myeloid leukemia; AML, acute myeloid leukemia; CLL, chronic lymphocytic leukemia; ALL, acute lymphocytic leukemia.
†Household contacts with influenza-like illness identified.
‡Severe GVHD.
§Chronic GVHD.
¶Patient 17 had onset of influenza-like symptoms on returning to Victoria from interstate travel.
other patients had the diagnosis confirmed on NAT of nasopharyngeal swab samples. Six patients (19%) had a baseline peripheral blood lymphocyte count ≤200 cells/mL, and 18 (56%) patients had pneumonia shown on baseline chest radiograph.

**Antiviral Therapy**

Thirty patients (94%) were administered oseltamivir therapy. Of these patients, 13 (41%) were administered therapy within 48 hours, and 16 began therapy >48 hours after symptom onset. Duration of illness before receiving oseltamivir was unknown for patient 2. Nine patients received NA inhibitors for >5 days. Three of these patients (1, 12, 18) had a positive NAT result >5 days after oseltamivir treatment began. Antimicrobial drug treatment was changed to zanamir for patients 1 and 8 after they received initial therapy with oseltamivir (see below). The longest duration of antiviral therapy was 43 d (patient 1). Patients 15 and 31 had uncomplicated infections and were not administered oseltamivir therapy.

**Co-pathogens**

Four patients had notable co-pathogens identified. Patient 2 had 4 concurrent herpesviridae (cytomegalovirus, Epstein-Barr virus, herpes simplex virus 2, and human herpesvirus 6) detected by NAT in respiratory specimens and blood. Treatment for patient 2 included liposomal amphotericin B and foscarnet. Patient 7 had *Staphylococcus aureus* bacteremia from an unrelated source. Patient 17, who came to transplant with an ILI, had bronchial washings that were positive for pandemic (H1N1) 2009 by NAT, galactomannan antigen, and *Aspergillus* spp. by NAT 5 days after transplant. Pulmonary nodules consistent with invasive fungal infection were seen on a high-resolution computed tomography scan. Patient 13 was infected with respiratory syncytial virus, which was detected by multiplex NAT on a nasopharyngeal swab.

**Patients Admitted to Intensive Care Unit**

Ten (31.3%) patients were admitted to intensive care (Table 1). In each case, the primary reason for admission to intensive care was respiratory failure. Seven (70%) of these patients died, 6 in intensive care and 1 (patient 5) of recurrent pneumonia after being discharged from intensive care. Preterminal events included progressive respiratory failure (n = 5) and multiorgan failure (n = 2).

All allogeneic HSCT recipients with the following features required admission to intensive care for mechanical ventilation: transplantation within 100 d, severe GVHD, and nosocomial acquisition of pandemic (H1N1) 2009. However, onset of symptoms for patient 1 was day 119 after allogeneic transplantation.

Eight of 10 patients admitted to intensive care had evidence of pneumonia on baseline chest radiograph. Patient
1 initially had normal chest radiograph results, despite the acute onset of hypoxia. Patient 24 was transferred to intensive care after 3 days in the hospital, at which point bilateral infiltrates were seen on chest radiograph, and oseltamivir therapy was begun.

**Oseltamivir Resistance**

Ten patients had repeat NAT testing to determine clearance of viral shedding. Eight had ≥1 further positive NAT (2 on sputum, 5 on nasopharyngeal swab specimen, and 1 on bronchoalveolar lavage sample) after receiving oseltamivir. Five of these patients had a positive NAT after >5 d of oseltamivir therapy. The longest recorded duration of viral shedding during oseltamivir therapy was 28 d (patient 1).

The H275Y NA mutation, a substitution known to confer a high level of oseltamivir resistance, was detected in 4 (57%) of 7 patients who had detectable nucleic acid after ≥4 d of oseltamivir therapy. These 4 patients comprised 13.3% of the 30 patients who received oseltamivir. The findings for the 4 patients who were infected with oseltamivir-resistant influenza virus are summarized in Table 2. The H275Y mutation was undetectable in initial diagnostic samples from these patients. Additionally, the H275Y mutation was detected in all available samples collected from these patients after they received oseltamivir therapy. Three of the 4 patients who had oseltamivir-resistant pandemic (H1N1) 2009 virus infection were HSCT recipients who had been admitted to intensive care. Virus isolation in MDCK cells was attempted for the samples that contained the H275Y mutation but was unsuccessful after 2 passages. This precluded the use of the phenotypic NA inhibition assay to further analyze the samples.

Patient 12, who survived despite shedding oseltamivir-resistant pandemic (H1N1) 2009 virus, had a biphasic clinical course. She initially stabilized while she was treated with oseltamivir; progressive respiratory failure then developed, which coincided with her recovery from neutropenia before later improvement. The other patient who survived despite shedding oseltamivir-resistant 2009 pandemic (H1N1) virus (patient 20) had an ILI without pneumonia. Of the 2 patients with resistant isolates who died, patient 5 first experienced the apparent resolution of pneumonia but later succumbed to recurrent pneumonia, and patient 1 had persisting pneumonia despite 36 days of oseltamivir therapy.

Patient 24 had multiple positive NATs, none with the H275Y mutant detected. His NAT was positive 4 d after he began oseltamivir therapy, and he died 1 d after his last specimen, a nasopharyngeal swab, was collected.

**Conclusions**

We report a case series of hospitalized cancer patients with influenza A pandemic (H1N1) 2009 virus infection and their outcomes. Patients with hematologic malignancies accounted for 50% of deaths of persons with pandemic influenza in Victoria during the first 3 months of the pandemic (15). The strongest effects of illness from pandemic influenza among hospitalized cancer patients in the present series occurred in HSCT recipients. Nine of the 10 cancer patients admitted to intensive care were HSCT recipients. Furthermore, of 7 deaths from pandemic (H1N1) 2009 in this series of hospitalized cancer patients, 6 occurred in HSCT recipients (comprising 37.5% of these patients). Our observations are similar to those seen with seasonal influenza. In a series of hematology patients with respiratory virus infection, including seasonal influenza, from 1 large cancer center, the largest number of infections and deaths occurred in recipients of allogeneic HSCTs (21). Our observations support the importance of existing recommendations for control of transmission of influenza infection in HSCT recipients during an influenza pandemic (22).

Half of the 24 cancer patients who had not received an allogeneic HSCT had underlying multiple myeloma (n = 8) and chronic lymphocytic leukemia (n = 4). There was also a paucity of patients with solid tumors (n = 2). The severity of illness from influenza in patients who have underlying multiple myeloma and chronic lymphocytic leukemia has not previously been widely appreciated, although a high rate of pneumonic illness from influenza has previously been demonstrated at 1 center (21). Patients with multiple myeloma have impaired cell-mediated immunity, in addition to humoral immune deficits (6,23,24). All 4 patients with multiple myeloma admitted to intensive care had previously received an autologous HSCT, which likely further compromised immunologic function. They also had been diagnosed with myeloma for several years.

Bacterial co-pathogens that cause pneumonia were not identified in our study cohort. However, patients received broad-spectrum antibacterial agents on admission. In con-
trast, a small number of investigators have identified bacte-
rial superinfections in up to 30% of fatal cases of pandemic
influenza (3,25). For patient 17 in this series, a diagnosis of
pulmonary aspergillosis was made after autologous HSCT,
an association previously reported with seasonal influenza
in allogeneic HSCT recipients (26).

When there is a circulating strain of influenza not con-
tained in the recent influenza vaccine, postexposure osel-
tamivir prophylaxis is an attractive strategy that can prevent
the development of influenza infection (27–29). Postexpos-
ure prophylaxis of healthcare workers and family members
may reduce the likelihood of exposure through prevention
of influenza infection in close contacts of HSCT recipients.
Our observations that would support post-exposure osel-
tamivir prophylaxis are 1) 4 of 5 allogeneic HSCT recipi-
ents who died or were admitted to intensive care had either
nosocomial or household acquisition; 2) 5 of 11 HSCT recipi-
ents who had pneumonia before beginning oseltamivir
therapy died; 3) none of the patients in this study were
known to have received postexposure prophylaxis at the
time of symptom onset, despite use of this strategy during
the study period (29); and 4) 3 patients acquired the infec-
tion in the hospital from unidentified sources. This nosoco-
mial transmission occurred despite heightened awareness
during this pandemic, which demonstrates the difficulties
of effective containment in the hospital setting (28,29).

The finding of oseltamivir-resistant influenza virus in
4 of 7 patients with a positive pandemic (H1N1) 2009–spe-
cific RT-PCR result after 24 d of oseltamivir therapy is a
cause for concern. In Australia, oseltamivir-resistant pan-
demic (H1N1) 2009 has been described in another immu-
nocompromised patient, a renal transplant recipient (30).
No oseltamivir-resistant pandemic (H1N1) 2009 strains
have been detected in nonhospitalized patients in Australia
(B. Wang and A. Hurt, pers. comm.). The risk of pandem-
ic influenza developing the H275Y mutation that confers
oseltamivir resistance is considered to be higher in immu-
nocompromised patients (10,12). Immunocompromised
patients have also been overrepresented in deaths associ-
ated with oseltamivir-resistant seasonal influenza (31,32).
If repeat NAT on respiratory specimens had been routinely
performed for all treated patients in the present series, rates
of oseltamivir resistance may have been even higher than
we observed. Our findings indicate an urgent need to opti-
mize oseltamivir dosing in immunocompromised patients.
Further research into the role of combination antiviral ther-
apy should be considered (33,34). Immunocompromised
patients should have serial screening for ongoing viral
shedding and oseltamivir resistance. The oseltamivir-resis-
tant H275Y mutants remain susceptible to the alternative
NA inhibitor zanamivir, and therefore the use of this drug
should be considered in patients who are shedding these
viruses (10).

Only 1 of the patients who was in intensive care and
had oseltamivir-resistant pandemic (H1N1) 2009 virus sur-
vived. The effects of oseltamivir-resistant influenza virus
in this patient are uncertain. The deterioration of her con-
dition after initial stabilization may have been related to
development of oseltamivir-resistance and persistent influ-
enza viral replication similar to that seen in a recent case
report (30). Others have shown development of resistance
to oseltamivir within 3 d of therapy (30), and we observed
resistance develop within 4 d for 1 patient. Undoubtedly,
other explanations for her biphase illness are possible. Im-
une recovery with resolution of neutropenia may have
enabled viral clearance and recovery.

Universal chemoprophylaxis for HSCT recipients
during an outbreak with an influenza strain that is not con-
tained in the available influenza vaccine has been recom-
mended by international guidelines supported by North
American and European Blood and Marrow Transplant
groups, Infectious Diseases Society of America, and the
US Centers for Disease Control and Prevention (22). One
of the study centers instituted universal chemoprophyl-
axis for patients admitted to receive an allogeneic HSCT
after 2 cases of nosocomial-acquired infection before
engraftment (P. Ferguson, pers. comm.). Although the
strategy led to apparent success, with no further nosoco-
mial infections observed, we have concern about this ap-
proach based on 1) the high rate of oseltamivir resistance
(4/30 [13.3%] administered oseltamivir) observed in this
study; 2) overrepresentation of postexposure prophylaxis
in cases of oseltamivir-resistant pandemic (H1N1) 2009
influenza (12); 3) the potential that pandemic (H1N1)
2009 H275Y mutant viruses may transmit and spread
throughout the community, similar to outcomes recently
observed with seasonal influenza A (H1N1) viruses with
the same H275Y mutation (8,11,35); and 4) the paucity of
hospital-acquired cases seen in this series during height-
ened surveillance and control measures of a pandemic. A
more judicious approach may be surveillance, infection
control measures, and early treatment until vaccination
becomes available (12,22,28). Additionally, education of
patients and their close contacts to facilitate early treat-
ment and avoidance of exposure is essential. When a vac-
cine becomes available, close contacts of those infected,
their family members, and healthcare workers should be
vaccinated.

One of the strengths of this study is the relatively high
coverage of the major hematology centers in a single state,
which reduces the effect of bias on patient ascertainment.
However, patients whose treatment was managed in the
community were excluded, and this information will be es-
tential to our understanding as to which co-factors predict
clinical progression and outcomes for pandemic (H1N1)
2009 infection in immunocompromised patients.
A high rate of oseltamivir resistance developed in critically ill HSCT recipients, particularly in those who continued to shed pandemic (H1N1) 2009 virus after 4 d of oseltamivir treatment. Consequently, surveillance, infection control measures, and early treatment of those at greatest risk of pandemic (H1N1) 2009 infection may prove more useful than universal chemoprophylaxis during an outbreak with an influenza strain that is not contained in the available influenza vaccine. Continued surveillance for oseltamivir-resistant influenza virus strains is needed, particularly in the immunocompromised.

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Oseltamivir Resistance in Adult Oncology and Hematology Patients Infected with Pandemic (H1N1) 2009 Virus, Australia

Technical Appendix

Laboratory detection of influenza viruses at selected public hospital laboratories for weeks ending May 15–September 4, 2009, New South Wales, Australia. Obtained with permission from New South Wales Health’s Population Health division.

Note: Excludes point of care tests. Influenza laboratory diagnoses using virology are reported by South Eastern Area Laboratory Services (SEALS), Institute of Clinical Pathology and Medical Research (ICPMR), South West Area Pathology Services (SWAPS): from 12/6, Pacific Laboratory Medicine Services (PeLMS): from 19/6, Royal Prince Alfred Hospital (RPAH), Hunter Area Pathology Services (HAPS), Nepean-from 24/7 and St Vincent’s Hospital (SYDPATH).