To the editor: In their recent paper, Thompson et al. describe the detection of influenza A(H3N2) viruses belonging to the emergent clade 3C.2a in oral fluid from a subset of children in England with a clinical diagnosis of mumps from December 2014 to February 2015 [1]. We conducted influenza testing of mumps virus-negative specimens without age restriction in British Columbia (BC), Canada, in response to reports of unexpected numbers of influenza-associated parotitis in the United States during the 2014/15 influenza season [2], and unusual mumps-like illness in BC also temporally associated with the influenza season.

The BC Public Health Microbiology and Reference Laboratory (PHMRL) conducts all diagnostic testing for mumps virus in BC. A total of 122 specimens collected between 1 September 2014 and 17 February 2015 were submitted to the BC PHMRL with a request for mumps virus testing and were negative by real-time reverse transcription polymerase chain reaction (RT-PCR). Although details on clinical presentation were not systematically collected, all cases presented with symptoms that prompted the clinician to request diagnostic testing for mumps. Further patient details, including immunisation status, were not obtained.

All of these specimens were re-tested for influenza A virus, influenza B virus and respiratory syncytial virus (RSV) using an in-house RT-PCR multiplex assay [3]. Testing for other non-influenza or non-RSV respiratory viruses was not undertaken.

Of the 122 mumps virus RT-PCR-negative specimens, 16 (13%), comprising 15 buccal swabs and one throat swab, were positive for influenza A virus, comparable to the 15% positivity reported by Thompson et al. [1] but higher than the 7% reported by Shepherd et al. in their cohort of patients in Scotland [4]. The latter difference may reflect variation in the date of collection of mumps virus-negative specimens included in the analysis in relation to the timing, mix and intensity of influenza and other respiratory virus circulation regionally. One (1%) mumps virus-negative specimen in BC was positive for RSV.


Influenza virus was detected in mumps virus-negative specimens collected from 19 December 2014 (week 51) to 15 February 2015 (week 7), with the highest number and percentage of specimens that were influenza positive having been collected in week 53, corresponding to the peak of the influenza A(H3N2) clade 3C.2a epidemic in BC (Figure).

Influenza virus was detected in mumps virus-negative specimens across all patient age groups (age range: 4–70 years) but with peak influenza positivity in children aged 5–9 years (n = 6/16), followed by that in children under five years (n = 2/12) and 10–14 years (n = 2/12). The remaining influenza virus detections were in non-elderly adults aged 20–59 years (n = 4/64) and
elderly adults 65 years and over (n = 2/12). Of the 16 influenza virus-positive specimens, eight were from children aged under 10 years, compared with 20 of 106 (19%) influenza virus-negative specimens. No influenza viruses were detected in mumps virus-negative specimens collected from 15–19 year-old adolescents.

The median age of influenza-positive cases detected among those who were mumps virus negative was 10 years (age range: 4–70) compared with 26 years (age range: 1–90) among influenza virus-negative cases. Conversely, most mumps cases reported in Canada are among adults aged 20–45 years who received only one childhood dose of a mumps virus-containing vaccine [6]. Among patients whose specimens were mumps virus negative, those who were influenza virus positive were more often male than were those who were influenza virus negative (14/16 vs 46/104).

Our Canadian findings corroborate those reported in Great Britain by Thompson et al. [1] and Shepherd et al. [4] and provide evidence for laboratory-confirmed influenza A infection among children and adults with suspected mumps infection during the 2014/15 winter in North America. Mumps infection is infrequent in BC, with provincial incidence rates typically ranging from less than 1 per 100,000 population to 3 per 100,000 annually. Public immunisation campaigns in BC target children at one year of age and at school entry (4–6 years-old), and coverage of mumps virus-containing vaccine exceeds 85% in these age groups [7,8]. While parotitis is a common clinical presentation for mumps, cases of influenza-associated parotitis, although uncommon, have been recognised for several decades [9]. Clinicians should consider influenza as a possible cause of acute parotitis during seasonal influenza epidemics, particularly among paediatric patients in regions where immunisation coverage of a mumps-virus containing vaccine is high.

Conflict of interest
Within 36 months, Mel Krajden has received research grants from Roche, Merck, Hologic, Siemens and Boehringer Ingelheim. All other authors declare that they have no conflict of interest.
Authors’ contributions
Conception or design of the work: DMS, CC, MK; data acquisition: MM, RG, SP, DH, SA, MK; data/specimen analysis: DMS, CC, SS, MK; interpretation of the data for the work: All authors; approval of manuscript submission: All authors.

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