What Could This Infection Take Away?

Making every risk conversation personal

Thank you to everyone who joined us in person or via the live stream for our recent session on adult vaccination in practice. It was great to see such strong engagement around respiratory syncytial virus (RSV), shingles, and how we make preventive conversations more relevant to the individual patient.

One theme stayed with me after the session:
We often take independence for granted — until it is lost.

Most of us can think of a patient who was doing well until an infection changed everything.

They were driving. Shopping. Living independently. Perhaps still working, caring for their partner or picking up the grandchildren.

Then they became unwell.

They survived the acute illness.

But they never quite returned to where they were before.

Those patients stay in our memory. Sometimes they also leave us with an uncomfortable question:
Could anything have been done differently?

That is what I mean by making a risk conversation personal.
We often describe disease risk using age thresholds, comorbidities, hospitalisation rates and mortality. All of those matter. But they do not always capture what matters most to the person sitting in front of us.

A different question is:

> **What could this disease take away from this particular patient?**

RSV: survival does not always mean recovery

RSV is still commonly thought of as a childhood infection.
But in older adults, the same virus lands on a very different host.

Age-related changes in immunity, together with common conditions such as chronic obstructive pulmonary disease, asthma, heart failure, coronary disease, diabetes and chronic kidney disease, increase the risk of significant RSV disease. The clinical spectrum ranges from an apparently routine respiratory infection through to pneumonia, exacerbation of underlying cardiopulmonary disease, hospitalisation and death.

But mortality and hospitalisation are not the only outcomes worth thinking about.
One of the most striking pieces of data we discussed was what happens **after** hospital discharge.

In a prospective study of adults aged 60 years and older hospitalised with laboratory-confirmed RSV, up to approximately one-third had worse functional status six months later. The proportion living independently fell from 40% before hospitalisation to 32% six months afterwards.

That matters.

A patient may have technically “recovered” from the infection, yet no longer be able to manage the stairs, drive, shop independently or care for their spouse.

For an older person, avoiding one major respiratory illness may mean preserving something much bigger than avoiding several days in hospital.

It may mean **preserving independence**.
So rather than saying only:
“RSV can put you in hospital.”

A more meaningful conversation may be:
“You are doing well now. One of the things we are trying to protect is your ability to keep doing what you are doing.”

Shingles: sometimes what is lost is normal life

Shingles illustrates the same principle from a different direction.

Almost all adults over 50 have already been exposed to varicella-zoster virus, which remains latent after primary infection. Around one in three people will develop shingles during their lifetime, with risk increasing as cell-mediated immunity declines with age.

Clinicians are very familiar with the rash.

Patients often remember something else.

The pain.

Burning. Stabbing. Shock-like. Sometimes severe enough that clothing touching the skin becomes intolerable.

And for some patients, the problem does not end when the rash resolves. Post-herpetic neuralgia can persist for months, and management of established neuropathic pain can be difficult. Shingles can interfere with sleep, mobility, work and normal activities of daily living.

For the otherwise well 55- or 65-year-old, the consequence may not be permanent loss of independence.

It may instead be **weeks or months of normal life that they assumed they would have.**

Unable to work normally.

Unable to sleep properly.

Unable to care for a parent, partner or grandchildren.

Again, the risk becomes more meaningful when we move away from:
“You are over 50, so your risk is higher.”
and towards:
“What happens to everything else you do if this disease temporarily takes you out of it?”

From eligibility to what we are trying to protect

There are clear recommendations and funding criteria for both RSV and shingles vaccination, and these remain important in deciding who should be offered vaccination. The recent educational session reviewed current eligibility, efficacy, safety and practical implementation for both RSV and shingles vaccination.

But eligibility is only the beginning of the conversation.

When I look at an older patient who is well and independent, I increasingly think the more useful question is not simply:
“Are they eligible?”

It is:
“What are we trying to preserve?”

For one patient, it is the ability to remain living at home.

For another, it is continuing to work.

For another, it is caring for a spouse.

For another, it may simply be maintaining the freedom to drive, travel, exercise or spend time with grandchildren.

We cannot prevent every infection.

Vaccination does not remove risk completely.

And we cannot always predict which apparently well patient will struggle to recover after an acute illness.

But prevention gives us an opportunity that we no longer have once function, independence or months of normal life have already been lost.

The question I would leave you with

The next time you discuss vaccination with an older patient, rather than thinking only about their statistical risk of disease, consider asking yourself:

> **What could this disease take away from this person?**

Because when we make risk personal, vaccination stops being another item on a preventive-health checklist.

It becomes a conversation about protecting the life that patient is still living.

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