To the Editor: Influenza-associated acute respiratory distress syndrome (ARDS) remains a devastating clinical picture. [1] From December 2017 to January 2018, ten patients with influenza-associated ARDS were admitted to three different hospital’s Intensive Care Units (ICUs) in Chongqing, with all cases resulting in demise. The main documented reasons for their admission to the ICU were due to progressive dyspnea and worsening hypoxemia which lead to endotracheal intubation and mechanical ventilation in these patients. Identification of influenza viruses was achieved using nucleic-acid testing from venous blood. This study was approved by the Institutional Review Board of Daping Hospital, Army Medical University.

Clinical characteristics of the ten patients presenting with influenza-associated ARDS are shown in Table 1. Seven of these patients were infected with influenza A (H1N1) virus, two with influenza B virus, and one was infected with both strains. The most common clinical manifestations were cough, fever >38°C, shortness of breath, and chest computed tomography (CT) and/or X-ray-confirmed pneumonia and/or ARDS. Radiologically, all patients presented with a mixture of patchy consolidations and ground glass opacities. [2] Seven patients required assessment using an additional lung CT scan during their ICU stay. Clinically, suspected ARDS can be easily confirmed by lung ultrasonography through the recognition of a typical pattern characterized by Kerley B lines, subpleural consolidations, as well as spared areas. Patient histories revealed the following comorbidities: two patients with a history of rheumatoid arthritis, three with a history of chronic diseases. It is vital to establish an influenza surveillance system to increase the awareness of influenza viral infection, and the clinical features of influenza viral infection can be concealed by the increase of chronic diseases. It is vital to establish an influenza surveillance system in patients with a profound depressed cellular immune system and an influenza-like illness (including pain, fever, and pneumonitis) are consistent with the diagnosis of disseminated influenza infection. [3]

In conclusion, a severe influenza virus can lead to CD8+ T cellular failure and thus affecting rehabilitation. The elderly patient had a chronic disease increase, a process often accompanied by an influenza viral infection, and the clinical features of influenza viral infection can be concealed by the increase of chronic diseases. It is vital to establish an influenza surveillance system in patients with a profound depressed cellular immune system as a requirement of the ICU in hospitals. We recommend an imaging-oriented approach combining lung ultrasonography and thoracic CT as a suitable technique for management of disseminated influenza infection.

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influenza-associated ARDS during diagnosis, mechanical ventilation, and weaning. Finally, prone ventilation and ECMO technologies can prolong an ICU stay.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**CONFLICTS OF INTEREST**

There are no conflicts of interest.

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