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The National Foundation for Infectious Diseases (NFID) applauds CDC’s Advisory Committee for Immunization Practices (ACIP) for its unanimous vote to recommend universal influenza vaccination for all healthy infants and children 6 to 23 months of age and their caregivers.

Children in this age group are at increased risk for influenza-related hospitalizations similar to rates among persons 65 years and older. NFID encourages health care providers to plan pediatric influenza immunization programs for the 2004–2005 season.

* ACIP recommendations are forwarded to the CDC director and secretary of Health and Human Services for review. If the ACIP recommendations are accepted by the CDC director and HHS secretary, they are published in the Morbidity and Mortality Weekly Report and become recommendations of the CDC.

**Two doses of inactivated influenza vaccine administered more than one month apart are recommended for previously unvaccinated children less than 9 years of age. If possible, the second dose should be administered before December. All subsequent annual influenza vaccinations require only one dose of vaccine.

Made possible by an unrestricted educational grant to the National Foundation for Infectious Diseases from Aventis Pasteur.
Indications (mild to moderate infections)

Acute bacterial otitis media and acute maxillary sinusitis (adults and adolescents) due to *H. influenzae* (including β-lactamase producing strains), *S. pneumoniae* (penicillin-susceptible strains only), and *M. catarrhalis* (including β-lactamase producing strains). Use of cefdinir in the treatment of acute maxillary sinusitis in pediatric patients is supported by evidence from adequate and well-controlled studies in adults and adolescents.

Pharyngitis/Tonsillitis due to *S. pyogenes*. Cefdinir is effective in the eradication of *S. pyogenes* from the oropharynx.

Cefdinir has not, however, been studied for the prevention of rheumatic fever following *S. pyogenes* pharyngitis/tonsillitis. Only intramuscular penicillin has been demonstrated to be effective for the prevention of rheumatic fever.

Safety information

- OMNICEF is contraindicated in patients with known allergy to the cephalosporin class of antibiotics
- For patients with previous hypersensitivity reaction to penicillins, caution should be exercised because cross-hypersensitivity among β-lactam antibiotics has been clearly documented. If an allergic reaction to cefdinir occurs, the drug should be discontinued.
- Safety and efficacy in neonates and infants less than 6 months have not been established.
- 2% of 2,289 pediatric patients discontinued medication due to adverse events in US and ex-US clinical trials. Discontinuations were primarily for gastrointestinal disturbance, usually diarrhea.
- The most common reported adverse events occurring in ≥1% of pediatric patients in US clinical trials (N=1,783) were diarrhea (8%), rash (3%), and vomiting (1%).

Reference: 1. OMNICEF (cefdinir) for Oral Suspension Prescribing Information; Abbott Laboratories.

Please see brief summary of prescribing information on following page.
For Children and Adolescents Who Start Late or Who Are >1 Month Behind

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

### Catch-up schedule for children age 4 months through 6 years

<table>
<thead>
<tr>
<th>Dose 1 (Minimum Age)</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (6 wk)</td>
<td></td>
<td>4 wk</td>
<td>4 wk</td>
<td>6 mo</td>
<td>6 mo^t</td>
</tr>
<tr>
<td>IPV (6 wk)</td>
<td></td>
<td>4 wk</td>
<td>4 wk</td>
<td>4 wk^t</td>
<td></td>
</tr>
<tr>
<td>HepB (birth)</td>
<td></td>
<td>4 wk</td>
<td>8 wk (and 16 wk after first dose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (12 mo)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib^v (6 wk)</td>
<td></td>
<td>4 wk: if first dose given at age &lt;12 mo and current age &lt;24 mo</td>
<td>8 wk (as final dose): if current age &gt;12 mo and second dose given at age &lt;15 mo</td>
<td>8 wk (as final dose): this dose only necessary for children age 12 mo-5 y who received 3 doses before age 12 mo</td>
<td>8 wk (as final dose): this dose only necessary for children age 12 mo-5 y who received 3 doses before age 12 mo</td>
</tr>
<tr>
<td>PCV^w (6 wk)</td>
<td></td>
<td>4 wk: if first dose given at age &lt;12 mo and current age &lt;24 mo</td>
<td>8 wk (as final dose): if current age &gt;12 mo</td>
<td>8 wk (as final dose): this dose only necessary for children age 12 mo-5 y who received 3 doses before age 12 mo</td>
<td>8 wk (as final dose): this dose only necessary for children age 12 mo-5 y who received 3 doses before age 12 mo</td>
</tr>
<tr>
<td>Varicella (12 mo)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Catch-up schedule for children age 7 through 18 years**

<table>
<thead>
<tr>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Booster Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Td: 4 wk</td>
<td>Td: 6 mo</td>
<td>Td: 6 mo: if first dose given at age &lt;12 mo and current age &lt;11 y &lt;7 mo if first dose given at age ≥12 mo and third dose given at age &lt;7 y and current age ≥11 y 10 y: if third dose given at age ≥17 y</td>
</tr>
<tr>
<td>IPV: 4 wk</td>
<td>IPV: 4 wk</td>
<td>IPV: 4 wk</td>
</tr>
<tr>
<td>HepB: 4 wk</td>
<td>HepB: 8 wk (and 16 wk after first dose)</td>
<td>HepB: 8 wk (and 16 wk after first dose)</td>
</tr>
<tr>
<td>MMR: 4 wk</td>
<td>Varicella: 4 wk</td>
<td>Varicella: 4 wk</td>
</tr>
</tbody>
</table>

1. DTaP: The fifth dose is not necessary if the fourth dose was given after the fourth birthday.
2. IPV: For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was given at age ≥4 years. If both OPV and IPV were given as part of a series, a total of 4 doses should be given, regardless of the child’s current age.
3. HepB: All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.
4. MMR: The second dose of MMR is recommended routinely at age 4 to 6 years but may be given earlier if desired.
5. Hib: Vaccine is not generally recommended for children age ≥5 years.
6. Hib: If current age ≤2 months and the first 2 doses were PRP-OMP (PedvaxHIB or ComVax [Merck]), the third (and final) dose should be given at age 12 to 15 months and at least 8 weeks after the second dose.
7. PCV: Vaccine is not generally recommended for children age ≥5 years.
8. Td: For children age 7 to 10 years, the interval between the third and booster dose is determined by the age when the first dose was given. For adolescents age 11 to 18 years, the interval is determined by the age when the third dose was given.
9. IPV: Vaccine is not generally recommended for persons age ≥18 years.
10. Varicella: Give 2-dose series to all susceptible adolescents age ≥13 years.

### Reporting Adverse Reactions

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.org or call the 24-hour national toll-free information line (800) 822-7967.

### Disease Reporting

Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Web site at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

January 2004 www.aapnews.org  AAP News 25
New 4th generation VIGAMOX™ solution takes bacterial conjunctivitis treatment to new heights.

Next generation VIGAMOX™ solution combines a broad spectrum of coverage with quick kill rates and low MICs for greater efficacy. All in a therapy that's safe and BAC*-free. And, kids will flip for the convenient dosing. Get on board with new VIGAMOX™.

*Benzalkonium chloride

VIGAMOX™ solution is indicated for the treatment of bacterial conjunctivitis. In vitro data are not always indicative of clinical success or microbiological eradication in a clinical setting. The dosing of VIGAMOX™ solution is one drop in the affected eye(s) 3 times daily for 7 days.
XOPENEX® FOR BRONCHOSPASM

Freedom to breathe

Important Safety Information

Xopenex is contraindicated in patients with a history of hypersensitivity to levosalbuterol HCl or racemic albuterol.

Patients receiving the highest dose of Xopenex Inhalation Solution should be monitored closely for adverse effects and the risks of such effects should be balanced against the potential for improved efficacy.

In patients aged 6 to 11 years, the adverse events occurring in ≥2% of patients and more frequently than with patients receiving placebo, were (0.31 mg Xopenex; 0.63 mg Xopenex; and placebo, respectively): headache (7.6%; 11.9%; 8.5%), pharyngitis (3%; 10.4%; 6.8%), rhinitis (6.1%; 10.4%; 1.7%), asthma (3.1%; 9%; 5.1%), fever (9.1%; 3%; 5.1%), viral infection (7.6%; 9%; 5.1%), rash (NR¹; 75%; NR¹), accidental injury (6.1%; 4.5%; 3.4%), diarrhea (1.5%; 6%; NR¹), pain (3%; 1.5%; 3.4%), asthenia (3%; 3%; NR¹), lymphadenopathy (3%; NR¹; NR¹), and urticaria (NR¹; 3%; NR¹).

In patients aged 12 years and older, the adverse events occurring in ≥2% of patients and more frequently than with patients receiving placebo, were (0.63 mg Xopenex; 1.25 mg Xopenex; and placebo, respectively): nervousness (2.6%; 9.6%; NR¹), tremor (NR¹; 6.8%; NR¹), flu syndrome (4.2%; NR¹; NR¹), and tachycardia or increased heart rate (2.8%; 2.7%; NR¹).

¹The mean duration of effect, as measured by a >15% increase from baseline FEV₁, was approximately 5 hours after administration of 0.63 mg of levosalbuterol and approximately 6 hours after administration of 1.25 mg of levosalbuterol after 4 weeks of treatment. In some patients, the duration of effect was as long as 8 hours.

²Less than 2% reported.

Please see brief summary of prescribing information on adjacent page.


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IMPORTANT DATA VALIDATE THE VALUE OF XOPENEX

- Greater peak mean % change in FEV₁ in severe asthmatics with Xopenex 1.25 mg*¹
- Long duration of action: TID dosing for greater patient convenience¹,²
- Well-established safety profile across the dosing range, supported by over 250 million doses prescribed¹,⁴

*FEV₁ <60% of predicted.

Xopenex®
(levosalbutamol HCl)
Inhalation Solution, 0.31 mg, 0.63 mg and 1.25 mg*

Breathing is Believing

*Potency expressed as levalbuterol.
Indications (mild to moderate infections)¹

**Acute bacterial otitis media** and **acute maxillary sinusitis** (adults and adolescents) due to *H influenzae* (including β-lactamase producing strains), *S pneumoniae* (penicillin-susceptible strains only), and *M catarrhalis* (including β-lactamase producing strains). Use of cefdinir in the treatment of acute maxillary sinusitis in pediatric patients is supported by evidence from adequate and well-controlled studies in adults and adolescents.

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