CHILDHOOD ASTHMA AND ALLERGIES:
IMPROVING EVIDENCE-BASED TREATMENT
AND THE ROLE OF INHALED CORTICOSTEROIDS

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ACTIVITY PURPOSE
This activity is intended to update practicing pediatricians, primary care physicians, and other health care practitioners on the growing burden of childhood asthma and allergic rhinitis and provide current evidence on the appropriate diagnosis and treatment of these potentially coexisting conditions.

STATEMENT OF NEED
Asthma is the leading serious chronic childhood illness, affecting ~6.3 million children younger than 18 years. In 2001, 4.2 million children had an asthma episode. These asthma attacks substantially impact children, families, and the health care system. Children miss 14 million days of school annually because of asthma. For children younger than 15 years, asthma is the third leading cause of hospitalization. Although only 22% of the US population is younger than 15 years, >43% of hospital discharges for asthma occurred in this age group.

Children with asthma also may have concomitant allergic rhinitis. There is increasing knowledge of the interrelationship among allergic airways diseases, and evidence suggests that asthma and allergic rhinitis are linked epidemiologically and pathophysiologically, supporting the concept of “one airway, one disease.” Importantly, symptoms of allergic rhinitis have been reported to occur in as many as 86% of patients with asthma, while asthma affects up to 43% of patients with allergic rhinitis. The Centers for Disease Control reports that allergic rhinitis and asthma each account for ~9 million annual visits to office-based physicians. Finally, seasonal allergic rhinitis affects 10–25% of the population and is more common among children and adolescents than adults.

Despite the dissemination of asthma (NAEPP) and allergic rhinitis (ARIA) guidelines that recommend inhaled and nasal corticosteroids as preferred therapy, appropriate use of these medications by pediatricians and primary care physicians continues to be an important clinical goal.

LEARNING OBJECTIVES
After this activity, participants should be able to improve health outcomes for children with asthma and allergic rhinitis by:
1. Identifying the interrelationship between asthma and allergic disorders
2. Recognizing the importance of early diagnosis
3. Applying new evidence supporting the efficacy and safety of nasal and inhaled corticosteroids

TARGET AUDIENCE
This educational activity is designed for pediatricians, physician assistants, nurses, nurse practitioners, family physicians, and other health care practitioners with an interest in pediatric allergic airways diseases.

ACCREDITATION STATEMENT
National Jewish Medical and Research Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This activity has been jointly planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCMCE) through the joint sponsorship of National Jewish Medical and Research Center and Clarus Health, LLC.

DESIGNATION STATEMENT
National Jewish Medical and Research Center designates this educational activity for a maximum of 1 hour in category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

National Jewish is provider approved by the California Board of Registered Nursing, Provider Number CEP 12274, for 1.0 contact hours.

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FOR ADDITIONAL INFORMATION VISIT
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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.
**CONTRAINdications:** OMNICEF (cefdinir) is contraindicated in patients with known allergy to the cephalosporin class of antibiotics. Furthermore, cefdinir should not be given to patients who have shown an allergic reaction to any of the ingredients in the OMNICEF formula.

**Interactions:** Antacids: may decrease absorption of cefdinir. If given simultaneously, take cefdinir at least 1 hour before or 2 hours after antacids.

**Laboratory Tests:** Cefdinir is not metabolized by the liver. However, patients with impaired renal function or those who are taking other drugs that may affect the kidneys should be monitored closely.

**Excretion:** Ceftin is excreted in breast milk. Women who are breastfeeding should consult their physician before taking this medication.

**Duration of Therapy:** The duration of therapy should be determined by the nature of the infection and the response of the patient to treatment. Generally, the median duration of therapy for adults is 7 to 10 days, but may be longer for certain infections.

**Storage:** Store at room temperature, 20°C to 25°C (68°F to 77°F). Excursions of up to 30°C (86°F) are permitted.

**Overdosage:** Symptoms of overdose may include nausea, vomiting, diarrhea, dizziness, disorientation, and confusion. In case of severe overdose, supportive and symptomatic treatment should be administered.

**Pregnancy:** There is no evidence of harm to the fetus due to use of OMNICEF during pregnancy. However, if the possibility of pregnancy exists, the benefits of treatment should be weighed against the possible risks of the drug to the fetus.

**Lactation:** It is not known whether cefdinir is excreted in breast milk. If cefdinir is used during lactation, it is recommended that the patient's milk be withheld from the infant until 2 hours after the last dose. If this is not possible, the infant should be monitored for any adverse effects.
Before you know it, the whole

That’s why you need a treatment

When you see a condition that moves as quickly as bacterial conjunctivitis, you need to tackle it fast. New data show that moxifloxacin (VIGAMOX™) eradicates *Staphylococcus aureus* 20X faster and *Staphylococcus epidermidis* 16X faster than ciprofloxacin (CILOXAN®). And VIGAMOX™ solution covers important pink-eye-causing bacteria that CILOXAN® solution doesn’t, with conjunctival concentrations 2X higher.²⁴

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References
2. VIGAMOX™ solution prescribing information.
3. CILOXAN® solution prescribing information.

VIGAMOX™ solution is indicated for the treatment of bacterial conjunctivitis. VIGAMOX™ solution is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other fluoroquinolones, or to any of the components in this medication. 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.

Please see brief summary of prescribing information on adjacent page.

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ElixSure™. The first spill-resistant children’s medicine. Now you can be sure your patients get all the relief you recommend.

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READ AND FOLLOW LABEL DIRECTIONS.
XOPENEX® FOR BRONCHOSPASM

Freedom to breathe

Important Safety Information
Xopenex is contraindicated in patients with a history of hypersensitivity to levalbuterol HCI 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 (3.1%; 3%; 5.1%), viral infection (7.6%; 9%; 5.1%), rash (NR; 75%; NR), accidental injury (6.1%; 4.5%; 3.4%), diarrhea (1.5%; 6%; NR), pain (3%; 1.5%; 3.4%), asthenia (3%; 3%; NR), lymphadenopathy (3%; NR; NR), and urticaria (NR; 3%; NR).

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 (2.8%; 9.6%; NR), tremor (NR; 6.8%; NR), flu syndrome (4.2%; NR; NR), and tachycardia or increased heart rate (2.9%; 2.7%; NR).

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

Less than 2% reported.

Please see brief summary of prescribing information on adjacent page.

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 convenience*₁,₂
- Well-established safety profile across the dosing range, supported by over 250 million doses prescribed*₁-₄

*FEV₁ <60% of predicted.

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

Breathing is Believing

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Great Minds Think Alike

Think Taste. Think Guidelines. Think OMNICEF.

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

Please see brief summary of prescribing information on following page.
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.

Universal Influenza Vaccination for All Healthy Infants and Children 6 to 23 Months of Age and Their Caregivers**

Effective Fall 2004

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NFID encourages health care providers to plan pediatric influenza immunization programs for the 2004–2005 season.

Strategies to help pediatricians and family practitioners implement the new pediatric influenza recommendation are highlighted in a new NFID publication. Please visit our Web site: http://www.nfid.org/publications

SPONSORED BY
National Foundation for Infectious Diseases

* 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.
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