

**Guidelines For Prophylaxis For RSV Infections  
In High-Risk Infants In Hawaii  
(Developed by Consensus Committee – July 30, 2009)**

Patient Population

1. All children younger than 2 years old at the beginning of the season (see below for definition) with Chronic Lung Disease and Congenital Heart Disease requiring treatment/medical management within 6 months of the anticipated season (Born on or after September 15, 2007; and continuing medical treatment after March 15, 2009).
2. All children born prematurely at 28 weeks gestation or earlier, who are less than 1 year chronological age at the beginning of the season (Born on or after September 15, 2008) .
3. All children born prematurely between 29 and 32 weeks gestation, who are less than 6 months chronological age at the beginning of the season (Born on or after March 15, 2009).
4. All children born prematurely between 33 and 35 weeks gestation requiring significant respiratory support in the neonatal period (significant positive pressure support with oxygen requirement) and having an additional risk factor (child care attendance, school-aged siblings, congenital abnormalities of the airways or severe neuromuscular disease), who are less than 3 months chronological age at the beginning of the season (Born on or after June 15, 2009)
5. There are several children with other illnesses in the Pediatric age group who may be considered for prophylaxis, although these are not FDA-approved indications for the use of this drug (Synagis ®). The Committee recommends that Pediatricians evaluate these children on a case-by-case basis and, if necessary, in consultation with an appropriate Sub specialist.
6. All children after cardiopulmonary bypass and with indication for use of Synagis should be considered for additional prophylaxis after discharge. Further, children with cardiac disease undergoing cardiopulmonary bypass during the season and currently receiving prophylaxis should receive an additional dose of prophylaxis, within a few days after bypass. They should continue to receive subsequent prophylaxis until the end of the season.

Season

RSV infections occur all year round in our community. However, based on available epidemiological data for the previous year, the incidence is significantly higher from September through February. For infants eligible for immunoprophylaxis, the beginning of the season will be considered **September 15, 2009**, and immunoprophylaxis should be continued to provide immunity through the end of **February 2010**.

Prophylaxis

1. Prophylaxis for infants identified by criteria reflected under patient population should be started between September 15, 2009 and September 30, 2009.
2. Prophylaxis should be continued, to provide immunity until the end of February 2010.
3. Should a child develop RSV during the course of the season, prophylaxis should be continued after recovery until the end of the season.
4. The maximum number of doses should be limited to five in all children listed in patient population above.\*
5. The interval between the first and second dose should be as close as possible to 28 days. All subsequent dose intervals should be as close to 30 days as possible (range 28 – 35 days).

These recommendations are meant to be guidelines.

Additional factors that need to be considered are:

1. Education of the family that although Prophylaxis is not 100% effective, it may lead to a decrease in severity of subsequent illness. To this effect, consideration should be given to obtaining an informed consent prior to drug administration.
2. Family education with respect to:
  - a. Use of good hand-washing practices during the wet and cooler months

- b. Avoiding exposure to smoke and dust especially passive smoke exposure in the presence of smokers in the family
- c. Avoiding contact with ill persons especially those with respiratory symptoms
- d. Avoiding unnecessary exposure to crowds

The Committee welcomes comments from community pediatricians and other health care providers regarding RSV infections in their practices and the impact of these guidelines on the same. Communication with the Committee may be directed to any of the Committee members listed below. This feedback is especially important since these guidelines are evolving with significant changes made re: duration of treatment especially towards the end of the season.

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\*The consensus committee feels that there is inadequate data to support the limiting treatment in 33-35 wk infants to three doses or less than 90 days of age, as recommended by the National AAP. Our guidelines have always targeted only the sick 33-35 week infants (which is different from the National AAP recommendations) since inception and the committee would recommend prophylaxis with a maximum of 5 doses or until the end of the season in this small but select population of premature infants needing invasive respiratory support in the neonatal period