

**Guidelines For Prophylaxis For RSV Infections
In High-Risk Infants In Hawaii
(Developed by Consensus Committee – June 13, 2011)**

Patient Population

1. All children younger than 2 years old at the beginning of the season (see below for definition) with Chronic Lung Disease requiring treatment/medical management within 6 months of the anticipated season (born on or after September 15, 2009; and continuing medical treatment after March 15, 2011).
2. All children younger than 2 years old at the beginning of the season with hemodynamically significant Congenital Heart Disease and or persistent pulmonary hypertension should be considered for prophylaxis (born on or after September 15, 2009)
3. 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, 2010).
4. All children born prematurely between 29 and 31 weeks gestation, who are less than 6 months chronological age at the beginning of the season (born on or after March 15, 2011).
5. All children born prematurely between 32 and 34 weeks gestation requiring significant respiratory support in the neonatal period (significant positive pressure support-Ventilator, CPAP or High Flow nasal cannula, and with oxygen requirement-above 30% in the first 72 hours of life) and having an additional risk factor (child care attendance and school-aged siblings under the age of 5 years), who are less than 3 months chronological age at the beginning of the season (born on or after June 15, 2011)
6. There are several children with other illnesses in the Pediatric age group who may be considered for prophylaxis in the first two years of their life, although these are not FDA-approved indications for the use of this drug (Synagis®). These conditions include but are not limited to congenital abnormalities of airway, severe neuromuscular disease, Cystic Fibrosis, Perinatal lung injury from respiratory illness in the newborn period with residual lung disease. (born on or after September 15, 2009). The Committee recommends that Pediatricians and Primary Care Physicians evaluate these children on a case-by-case basis and, if necessary, in consultation with an appropriate Sub specialist.
7. 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 because of an average drop of protective antibody levels by 58%. 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 March. For infants eligible for immunoprophylaxis, the beginning of the season will be considered **September 15, 2011**, and immunoprophylaxis should be continued to provide immunity through the end of **March 2012**.

Prophylaxis

1. Prophylaxis for infants identified by criteria reflected under patient population should be started between September 15, 2011 and September 30, 2011.
2. Prophylaxis should be continued, to provide immunity until the end of March 2012 or until a total of five doses have been administered (whichever is earlier).
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. Every effort should be made to provide the doses every 30 days to maintain effective immunity (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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Footnote regarding recommendations:

1. The gestational ages referred to in the document above reflect completed GA and encompass everyone between (0 and 6 days. Eg: 31 weeks above means anyone in between 31+0 to 31+6)
2. The group described under patient population #5 above is a more restrictive group than the description under the Red Book 2009 guidelines. This restrictive group definition has been in place since the first Hawaii consensus statement and reflects the committee/expert opinion belief that RSV disease in Hawaii is milder and as such the target group needs to have evidence of more pulmonary illness. Given this different patient population, the Consensus Committee continues to recommend prophylaxis for these infants to continue until the end of the season or for a maximum of five doses. From an economic perspective the Committee believes that the restrictive guidelines and the recommendation for a 5 doses maximum prophylaxis are cost neutral. One of the committee members is actively collecting information that will allow us to better define the treatment guideline for this group of patients. Results are anticipated to be available later this year.
3. The season has been expanded to include March 2012. Data obtained from Kapiolani IP and ED visits over the past five years seems to indicate that in the three of five years, there continued to be a relatively high incidence of documented cases in March. This change has no impact on the maximum number of doses that an infant would be administered during the season