Guidelines For Prophylaxis For RSV Infections
In High-Risk Infants In Hawaii
(Developed by Consensus Committee – July 17, 2006)

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, 2004; continuing medical treatment after March 15, 2006).
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, 2005) .
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, 2006).
4. All children born prematurely between 33 and 35 weeks gestation requiring significant respiratory support in the neonatal period (positive pressure support) 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 6 months chronological age at the beginning of the season (Born on or after March 15, 2006)
5. There are several children with other illnesses who may be considered for prophylaxis, although this is not an FDA-approved indication for the use of these drugs (Respigam® and Synagis ®). The Committee recommends that Pediatricians evaluate these children on a case-by-case basis and, if necessary, in consultation with an appropriate Subspecialist.

Season

RSV infections occur all year round in our community. However, based on available epidemiological data, the incidence is significantly higher from September through February. For infants eligible for immunoprophylaxis, the beginning of the season will be considered **September 15, 2006**, and immunoprophylaxis should be continued to provide immunity through February 2007.

Prophylaxis

1. Prophylaxis for infants identified by criteria reflected under patient population should be started no earlier than September 15, 2006, and no later than September 30, 2006. Prophylaxis for children who qualify based on age at the beginning of the season should be continued for the duration of that season.
2. Prophylaxis should be continued to provide immunity at least until the end of February 2007.
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. Infants with cardiac disease who have been on cardiac bypass during surgery should receive an additional dose soon after surgery and the subsequent doses for the season should be continued on a monthly basis from that date.
5. The maximum number of doses should be limited to five unless the season is extended by the Consensus Committee.
6. 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

3. **This vulnerable population should also be considered for Influenza immunization in addition to RSV prophylaxis, if they are over the age of six months.**

The Consensus Committee will meet again in October 2006 and February 2007 to review data to make recommendations regarding the ending of the season for 2006 – 2007.

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, or by contacting:

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