

Respiratory Syncytial Virus (RSV)

Respiratory Syncytial Virus is responsible for thousands of hospitalizations each year.

Palivizumab, (Synagis®) is a monoclonal antibody given intramuscularly monthly that is effective in preventing severe RSV disease. In Hawaii, a consensus committee meets every September and February to decide the start and end of the “season” and to discuss criteria for administration of Palivizumab. The **Consensus Guidelines-September 8, 2004** are on the following pages.

In the past several years, Arlington Clinical Pharmacy has administered Synagis to many of the patients but will not do so this year. Pharmacare has been asked to assume the administration of Palivizumab and has agreed to participate this year. As usual, Dr. Venkataraman Balaraman will send out a list of patients to each primary care physician who should qualify for the prophylaxis, but it does not include patients with hemodynamically significant cardiac disease. Each pediatrician will need to determine which cardiac patients could qualify for Synagis. For more information on administration of Palivizumab and the authorization process, please call Pharmacare (840-5600).

Medimmune, Inc. has sponsored a study to look at severity of RSV. For the past two years, Dr. V. Balaraman (983-6000) has been the principal investigator looking at hospitalized patients at KMCWC with RSV. Dr. Bala is also the local principal investigator for a study of a new drug, Numax, possibly 10 times more potent than Synagis. He is asking that you contact him for any patients born at 35 weeks or less that you wish to enroll.

Thank you,
Dr. Vernon Azuma, Consensus Committee Member

**Guidelines for Prophylaxis for RSV infections in High Risk Infants in Hawaii
(Developed by Consensus Committee Meeting – September 8, 2004)**

Patient Population:

1. All children younger than 2 years at the beginning of the season (see below for definition) with Chronic Lung Disease requiring treatment within six months of the anticipated season.
2. All children born prematurely at 28 weeks gestation or earlier who are less than one-year chronological age at the beginning of the season.
3. All children born prematurely between 29 and 32 week gestation who are less than six months chronological age at the beginning of the season. The definition of 32 weeks is clarified to be (32+0).
4. All children less than 2 yr of age with Congenital Heart Disease requiring medical management.
5. There are several children with other chronic 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 the Pediatrician evaluate these on a case-by-case basis, and in consultation with an appropriate Sub-specialist if necessary.

Season:

RSV infections occur in the community all year round. To identify eligible infants for immunoprophylaxis, the beginning of the season will be considered October 15, 2004. Based on the available epidemiological data, peak of RSV infections occur between November and February. During 2002 and 2003, the number of RSV cases seen in the State was significantly lower than the previous years. The committee feels that passive immunoprophylaxis should be continued to provide immunity through the end of February 2005.

Treatment:

1. Treatment should be started no earlier than October 15, 2004 and no later than November 1, 2004 in infants identified by criteria noted under Patient Population. In case of children who qualify based on age at the beginning of the season, treatment should be continued for the duration of that season.
2. Treatment should be continued to provide immunity at least until the end of February 2005.
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 monthly basis from this date.
5. Treatment should not be restricted based on number of doses administered.

These recommendations are meant to be guidelines.

Additional Factors that need consideration:

1. Education of the family that Prophylaxis is not 100% effective, but may lead to a decrease in the severity of subsequent illness. To this effect, consideration should be given towards obtaining an informed consent prior to drug administration.
2. Family Education with respect to the following:
 - I. Good hand washing practices during the wet and cooler months.
 - II. Avoidance of smoke and dust exposure. This is especially true as far as passive smoke exposure in the presence of smokers in the family.
 - III. Avoid contact with ill persons, especially with respiratory symptoms.
 - IV. Unnecessary exposure to crowds.

The committee has made a commitment to the community by pledging to be available to meet at least annually or if necessary, more often to review these guidelines and make modifications as appropriate based on variations in the RSV infection pattern in the community. This year, the committee has decided to have a second meeting in February 2005 to evaluate the season and make recommendations about additional immunoprophylaxis based on the epidemiologic variation during the current year.

The committee also 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 can be directed to one of the members noted below or by mail to V. Balaraman, Department of Pediatrics, Room 750, 1319 Punahou Street, Honolulu, HI 96826 (e-mail: vbalaraman@kapiolani.org).

Committee Members:

Raul Rudoy, MD (Chair)

Vernon Azuma, MD

Venkataraman Balaraman, MD

Marta Derieg, MD

Matthew Ho, MD

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Douglas Kwock, MD

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Wallace Matthews, MD

Richard Mitsunaga, MD (non-voting)

William Moore, MD

Charles Neal, MD

Mary Elaine Patrinos, MD

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