Greetings SOID Members and AAP Chapter Leaders! It has been a very hot, humid summer here in the Southeast. I’m looking forward to fall.

Unfortunately, to date, the AAP has not received any follow up from the Centers for Medicare and Medicaid Services (CMS) pertaining to the letter sent by the AAP protesting CMS assignment of “bundled” billing codes to the 4 Interprofessional Telephone Consult Codes approved by the CPT Advisory and RUC Committees in 2013. Should we receive any new information after the publication of the fall SOID Newsletter, a group e-mail will be sent to all SOID members.

Please examine your calendars and make plans to attend the 2014 AAP National Conference and Exhibition in San Diego, CA. Besides our usual extensive offering of infectious diseases-related topics, SOID will be sharing education sessions with the Section on Perinatal Pediatrics and the Section of Allergy/Immunology. Some great educational opportunities await you in San Diego! Hope to see you there. You can view these sessions on the SOID website. http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-infectious-diseases/Pages/NCE-ID-Sessions.aspx

The SOID has continued to get responses from members for the survey we sent out earlier this year. We are delighted to have two SOID members volunteer to write short articles for this edition of the SOID Newsletter; Kathy Moffett,
Chair's Letter  Continued from Page 1

MD, “Cystic Fibrosis Advances in 2014” and Saul Hymes, MD, “Antibiotic Resistance and Farm Antibiotic Use”. Our goal is to spotlight at least one SOID member in each subsequent SOID Newsletter over time. If you have not done so already, please complete your SOID Member Survey (https://www.surveymonkey.com/s/JTJKMTT), especially if you have interest in assisting with the “work” of the SOID. The survey will also help SOID leadership identify those areas which could make membership more meaningful to you.

For your information, work on the SOID-sponsored Challenging Cases PediaLink topics (Pertussis, Clostridium difficile, Travel Medicine, and Vaccine Hesitancy) is continuing to progress. In fact, the Clostridium difficile module is now available (http://bit.ly/c-difficile) and is authored by Robert Frenck, MD and Andrea Hahn, MD. Thanks to all the SOID members and AAP staff who have accepted the challenge to make these educational sessions interesting and informative.

This will be my last SOID Newsletter as your Chair. While I will be replaced as Chair, beginning November 1st, by the very capable Tina Tan, MD, I will remain as the SOID Liaison to the COID until June 30, 2015. It has truly been an honor and privilege to serve as the Chair of the SOID. One of my last actions as Chair will be to give the SOID Lifetime Education Award to my former student and good friend John Bradley, M.D. While there is always more than our Section can accomplish, our membership numbers are stable to increasing, we have become a leader within the AAP by having three fellows-in-training serving in leadership positions, and, are working to more fully engage SOID members in the work of the Section by developing the expertise survey discussed above. Also, a workforce survey of infectious disease physicians, which is being developed through a joint effort of SOID and Pediatric Infectious Diseases Society, may provide important information regarding the subspecialty and serve as an advocacy resource in future activities both between and throughout our organizations. I would like to express my personal thanks to past and current members of the SOID Executive Committee, the Subcommittee on Education and, to those SOID members who have helped with various “work” required of the SOID, as well as the AAP as an organization for a fulfilling and meaningful 4 years as your SOID Chair.

Finally, I would be remiss if I didn’t also publicly acknowledge and thank Suzanne Kirkwood, our AAP Staff Liaison, for all her hard work. Suzanne works part-time and staffs three sections (Hematology/Oncology, Infectious Disease and Nephrology) for the AAP. Thanks in large measure to Suzanne’s efforts, the many SOID activities and AAP required reports get assigned, organized and accomplished. Suzanne’s enthusiasm for SOID and her outstanding organizational skills made my job as SOID Chair so much easier. While I won’t miss all the extra work, I will miss Suzanne's dedication, her weekly e-mails as well as our monthly telephone conference calls.

Please let Suzanne, me, or, after November 1, 2014, Dr. Tan know if there is anything we can do to improve your membership experience in the SOID. Thanks.

Dennis L. Murray, MD, FAAP, FIDSA
Professor, Department of Pediatrics
Chief, Pediatric Infectious Diseases
Georgia Regents University
and Chair, AAP SOID
Section on Infectious Diseases Award for Lifetime Contribution In Infectious Diseases Education

This award is given annually to an Academy member who has made outstanding contributions to education in infectious diseases. The candidate's contribution is indicative of a substantial long-term dedication to the highest ideals of education. This year we are pleased to present the award to Dr. John Bradley.

Dr. Bradley's impressive curriculum vitae speaks for itself. Dr. Bradley attended medical school at the University of California at Davis. He completed his Pediatric residency at the Kaiser Foundation Hospital in San Francisco and an infectious diseases fellowship at Stanford University Medical Center.

Dr. Bradley lectures regularly for the Academy's CME courses, including the NCE and the PREP ID live course, and has done so for many years. He is an enormously enthusiastic and informative teacher, always receiving top ratings from his audience. Despite his many, ongoing hospital, academic, and pediatric community activities, Dr Bradley is a tireless mentor and always says “Yes” when “No” to various educational opportunities would make his life far easier and less hectic.

Dr. Bradley's current and past positions on various national committees and prior awards, attest to his expertise in infectious diseases and recognition among his colleagues. He has served on many Academy groups, most notably as a member of the Committee on Infectious Diseases between 2004-2010.

Among his many publications, Dr. Bradley currently serves as the Editor of The Pocket Book of Antimicrobial Therapy, which is now updated annually, and serves as an important clinical resource for both academicians and office-based clinicians. With its up-to-date information on antimicrobial indications, dosage, interactions, and safety concerns, this publication has given clinicians a reliable source of information and facilitated judicious and appropriate pediatric outpatient as well as inpatient antimicrobial therapy for many years.

Finally, Dr Bradley, in addition to responsibilities at Rady Children's Hospital, is a consistent source of infectious disease advice to community pediatricians, not only for the occasional curbside-consult but even more so for his highly-regarded CME lectures to the pediatric groups in the San Diego area. His contributions to the development and publication of clinical guidelines for the management of pediatric influenza, community-acquired pneumonia, and bone and joint infections have been of enormous value to practitioners. His most recent participation in the development of the anthrax guidelines will provide important guidance to pediatricians in the event of an anthrax release.

Please join us at the award presentation for Dr. Bradley to be held at the Meet the Red Book Committee session (session S3019) on October 13, 2014 at 8:00 am at the AAP National Conference and Exhibition in San Diego Convention Center, Room 24.
Welcome
We would like to welcome Rana Hamdy, MD, to the Section on Infectious Disease (SOID) Executive Committee. We would also like to congratulate Andrea Hahn, MD, on her new position as an Assistant Professor of Pediatrics in the Division of Infectious Disease at Children's National Medical Center beginning in October 2014.

Rana Hamdy, MD, MPH
Dr. Rana Hamdy is an infectious diseases fellow at the Children's Hospital of Philadelphia, and is very excited to be joining the AAP Section on Infectious Disease Executive Committee as the new fellow trainee liaison. Rana received her medical degree from the Johns Hopkins University School of Medicine and a Master of Public Health degree from the Johns Hopkins Bloomberg School of Public Health. She completed her pediatrics residency at the Johns Hopkins Hospital. During residency she served as her residency program's liaison to the AAP, and took advantage of their proximity to Washington, D.C. to attend and facilitate residents' attendance at multiple AAP legislative advocacy events in Washington. She has testified before legislative committees in Annapolis, Maryland in support of the Clean Air Act, among other acts promoting child health. During residency she was awarded a Community Access to Child Health (CATCH) grant by the AAP to enact a project entitled “Medical Homes for Baltimore Latino Children.” Following residency, Rana worked for three years as an attending physician in the pediatric emergency department and as a pediatric hospitalist at Franklin Square Hospital in Baltimore, Maryland. During those years she remained active in her local AAP chapter, as the co-chair of the Young Physicians section of the Maryland chapter of the AAP as well as the co-CATCH facilitator, assisting grant applicants, helping to score CATCH grant applications, and promoting CATCH projects in Maryland.

Rana is now in her second year of infectious diseases fellowship at the Children's Hospital of Philadelphia where she is pursuing a Master of Science in Clinical Epidemiology degree, and studying the optimal use of antibiotics in children and the implementation of antimicrobial stewardship interventions on improving clinical outcomes while limiting the emergence of antimicrobial resistance.

Annabelle de St. Maurice, MD
Annabelle de St. Maurice, MD will continue as SOID training fellow liaison as she enters her third year as a Pediatric Infectious Disease fellow at Vanderbilt University and pursues a Master's of Public Health degree. She has been working closely with the Pediatric Infectious Diseases Society to develop strategies for attracting medical students and residents to the field of infectious diseases. They hope to highlight the breadth of opportunities in pediatric infectious diseases through webinars and discussions with practicing pediatric infectious disease physicians with careers in transplant medicine, hospital epidemiology, public health and non-governmental agencies. This fall, Annabelle will be working with Dr. Kathryn Edwards and Dr. Jesse Hackell to develop a PediaLink module on vaccine hesitancy. Finally, have you checked out the fellow resources page (http://www.aap.org/en-us/about-the-aap/Committes-Councils-Sections/Section-on-infectious-diseases/Pages/Resources-for-Fellows.aspx) on the SOID website? Additional career resource and job opportunity links have been added and updated.

In addition to her work with the Section on Infectious Diseases, Annabelle spent the month of July in Geneva, Switzerland working with a group at the World Health Organization and Centers for Disease Control and Prevention that studies bacterial meningitis epidemiology. The purpose of the network is to use meningitis surveillance to document the impact of vaccination globally. Annabelle has been analyzing the data from regions and sites that participate in the network to determine the quality of the data that has been collected to improve surveillance efforts. Her data will be presented at a conference in Geneva in October 2014.
Review of the Recent Infectious Disease Literature

These summaries and commentaries are completed by volunteer Contributing Editors from the SOID. Each is responsible for reviewing the current infectious disease literature for several journals. They select an interesting article and present it for your review to help keep you current on various issues.


Reviewed by: Jane Gould, MD, FAAP, Associate Professor of Pediatrics, Drexel University College of Medicine, Hospital Epidemiologist, Attending Physician, Section of Infectious Diseases, St. Christopher's Hospital for Children, Philadelphia, PA

This retrospective cohort study describes a 17 year experience (January 1995 through December 2012) of hospitalized neonates with adenoviral infections at two large urban pediatric hospitals in Dallas, Texas, as well as an English language literature review on the subject. All 26 study neonates (<28 days of age) had laboratory-confirmed adenoviral infections and were identified by review of virology laboratory data (performed by DFA or viral culture until 2008 then by PCR detection), NICU admission data and by discharge ICD-9 codes for adenoviral infection. Disseminated infection was defined as clinical or laboratory involvement of two or more organs, or one body site or organ and a positive PCR or culture of blood or cerebrospinal fluid. Most of the neonates were full term with a mean gestational age of 39 weeks +/- 1.5, range 34-40 weeks and were hospitalized because of respiratory signs and temperature instability. Bacterial co-infection was uncommon. Most had developed their adenoviral infection horizontally and 58% had documented ill contacts. Nineteen percent of the cohort had disseminated disease (n=5) and 80% of those died, in contrast to those with only localized infection with 0% mortality. Of those with disseminated disease, only one neonate had co-detection of another respiratory virus. Most of those with disseminated disease had severe pneumonia with hypoxia requiring ECMO. Literature review combined with study data revealed that disseminated adenoviral disease was more likely in neonates less than 14 days of age and was more likely to result in death than localized disease (48% vs 8%; P<.001). Antiviral therapy, historically with ribavirin and later with cidofovir combined with probenicid as well as intravenous immune globulin, did little to alter the outcome of those in the study with disseminated disease. The limitations of this study, clearly stated by the authors, include all those inherent in a retrospective study along with suboptimal laboratory detection prior to 2008 which may have missed some adenovirus-infected patients.

Reviewer's Commentary:
The results of this study highlight the grim nature of neonatal adenoviral infections. Most pediatric infectious diseases physicians have cared for neonates with adenoviral infections and know that despite timely identification with state of the art laboratory techniques and critical care support, there is little therapeutically that is helpful. What is needed are improved antivirals that have fewer toxicities than cidofovir, a better understanding of how to interpret blood adenovirus quantitative PCR tests so as to predict response to antivirals, and better prevention strategies such as adenoviral vaccine development. Since there are reports of mother-to-child transmission of adenovirus, antiviral treatment of infected mothers prior to delivery may also represent a prevention strategy that is worthy of study. Additionally, better infection prevention strategies are necessary to prevent the tragic occurrence of hospital-associated adenoviral infection which can result in NICU outbreaks and have devastating consequences. Lastly, for general pediatricians, this study should heighten awareness of the severity of neonatal adenoviral infections and prompt timely referral of affected neonates to a pediatric tertiary care hospital.


Reviewed by: Sherman Alter, MD, FAAP, Professor of Pediatrics, Boonshoft School of Medicine Wright State University, Director, Division of Infectious Diseases, Dayton Children's Hospital, Dayton, OH

Cholera has occurred in Guinea since the 1970's. A new outbreak was reported in the capital, Conakry, in 2012

*Continued on Page 6*
caused by circulation of *Vibrio cholerae* serogroup O1, biotype El Tor. Outbreak response interventions included free-of-charge medical care, access to safe water, improved sanitation, and promotion of better hygiene. Additionally, as recommended by the World Health Organization (WHO), nonselective mass vaccinations within two prefectures were implemented using two doses of an oral cholera vaccine (Shanchol, Shantha Biotechnics) with an interval of at least 2 weeks between doses. The vaccine, one of three licensed oral cholera vaccines (OCV), is composed of killed *V. cholerae* cells. Researchers from Medecins sans Frontieres set out to evaluate the effectiveness of cholera vaccine for the first time in an outbreak setting.

In a matched case-control study carried out between June 8 and October 12, 2012, vaccine effectiveness (VE) was assessed by comparing vaccination rates among 40 case-patients with laboratory-confirmed cholera with 160 age- and sex-matched controls. Vaccine coverage ranged from 69% to 84% in the areas where the vaccine was offered. Receipt of cholera vaccine was ascertained in face-to-face interviews and subjects were asked to show vaccination cards. Median age of study participants was 28.0 years (interquartile range, 16.5 to 39.0). After adjusting for potentially confounding variables, vaccination with two doses was associated with significant protection against cholera (VE 86.6%; 95% CI 56.7 to 95.8; \( P = 0.001 \)). The estimate of VE with an incomplete course of vaccine was not precise enough to be conclusive (42.8%; 95% CI, -83.6 to 82.2; \( P = 0.35 \)). Importantly, while stored in cold chain, transport and use of the vaccine at ambient temperature on the day of vaccination did not impair the vaccine’s short-term protection.

**Reviewer’s Commentary:**

An estimated 3-5 million cholera cases and 100,000-200,000 deaths due to cholera occur annually. Effective responses to outbreaks have relied on provision of safe water and improved sanitation. Promising results using new generation OCVs, however, have prompted WHO to recommend cholera immunization along with traditional prevention and control strategies in cholera-endemic areas and in areas at risk for cholera outbreaks.

Despite the small sample size, this study clearly illustrates a role of OCV in epidemic control efforts, demonstrating that two doses of OCV provide significant protection against cholera in an outbreak setting with VE approaching 87%. The vaccine in previous studies has also demonstrated long term protection, with inferred herd protection and immunity lasting up to 5 years. Immunization appears to be safe (48 patients among 312,250 doses administered reported adverse reactions, none severe). Shanchol does not require the addition of a buffer and costs about $1.85 per dose. Despite its efficacy and safety, some questions remain. What is the efficacy of one versus two doses of OCV? Can OCV be stored at room temperature bypassing the cold-chain requirement? What about use of the vaccine in pregnant women and in infants (OCV is approved for use in children >1 year of age)? As the vaccine is stockpiled by WHO, how will utilization priorities be determined when multiple simultaneous outbreaks occur? Despite these areas of uncertainty, this study provides further evidence on the utility of OCV administration in cholera outbreaks.

**References:**


**Reviewed by:** Stephen C. Aronoff, MD FAAP Temple University School of Medicine

The mechanisms of drug resistance and approaches to therapy for 5 classes of multidrug-resistant, Gram-negative infections are reviewed. Organisms harboring extended-spectrum β-lactamases (*E. coli*, *Klebsiella species*, and *P. Mirabilis*) are phenotypically resistant to penicillins, cephalosporins, and aztreonam. Typically, the enzymes expressed...
by these organisms are inhibited by clavulanate, tazobactam and sulbactam, although these strains may harbor multiple β-lactamas. First line agents for systemic infections with these pathogens include meropenem and imipenem-cilastin; ciprofloxacin and trimethoprim-sulfamethoxazole are alternative choices. Organisms that express AmpC β-lactamases (chromosomal enzymes) include all Enterobacteriaceae. These enzymes produce multi-drug resistance when expressed constitutively, either on a plasmid or via derepression. The recommended therapy for infections caused by these pathogens is identical to that for organisms that harbor extended-spectrum enzymes. In addition, cefepime may be used in low inoculum infections.

The last three groups of pathogens are all resistant to both β-lactam agents and carbapenem. Infections caused by Enterobacteriaceae and Ps.aeruginosa isolates with carbapenem MICs of 4 - 8 µg/ml may be successfully treated with carbapenem administered as a 3 hour infusion plus either an aminoglycoside, a fluoroquinolone, colistin, or tigecycline, depending on susceptibilities. For isolates with MICs exceeding 8 µg/ml, combination therapy with an aminoglycoside, a fluoroquinolone, fosfomycin, colistin, or tigecycline is recommended, depending on susceptibilities. For carbapenem-resistant isolates of Acinetobacter, ampicillin-sulbactam may be included in the combination.

Reviewer's Commentary:
Pedicatric infections with multi-drug resistant Gram-negative organisms are increasing in prevalence (PIDJ 2013; 32:e151-e154). This article summarizes the mechanisms of resistance and provides an evidence-based approach to the therapy of these infections in children. At present, most of this information is based on adult studies; as the pediatric experience grows, the approach to these infections may change, particularly in neonates.

New Archived Webinar Now Available regarding:
Updated AAP Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of RSV Hospitalization

The American Academy of Pediatrics held a webinar on July 28th that provided an overview of the policy statement and technical report “Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection”, that was early released on July 28th and was published in the August 2014 Pediatrics. The webinar explains the basis of the new policy and provides a summary of the recommendations. There is no cost to view this archived webinar which may be accessed at AAP Red Book Online: www.aapredbook.org/site/resources/webinars.xhtml

Presenters:
• James M. Perrin, MD, FAAP - President, American Academy of Pediatrics
• H. Cody Meissner, MD, FAAP - Tufts University School of Medicine
• Shawn L. Ralston, MD, FAAP - Dartmouth Medical School

The policy statement (http://pediatrics.aappublications.org/content/134/2/415) and technical report (http://pediatrics.aappublications.org/content/134/2/e620) update and replace the Respiratory Syncytial Virus chapter in the current 2012 edition of Red Book (p 609-618). Please see the related AAP News article (http://aapnews.aappublications.org/content/35/8/1.1.full) for more details. In addition, the AAP has developed a comprehensive resource page (http://www.aap.org/en-us/my-aap/Pages/rsv.aspx?nfstatus=200&ntoken=60eae689-a558-4ca1-9389-f02922bf4906&nfstatusdescription=Set+the+cookie+token) for AAP members (member log-in required). This page includes speaking points, frequently asked questions, and parent resources.
Teen with 16 mm Tuberculin Skin Test: Treat for Tuberculosis?

ID Pearls and Other Gems:

Chris Harrison, MD, FAAP, Professor of Pediatrics at the Children’s Mercy Hospital and UMKC, Kansas City, MO. Dr. Harrison will be happy to receive contributions from you and, if published, will be duly cited. Please send them to charrison@cmh.edu.

Case: A 14-year-old female has 16 mm of induration from a tuberculin skin test (TST) that was placed because she is volunteering at a local central Ohio hospital. The hospital has asked her to see you in case she needs treatment before she begins volunteer work. The question is whether this teen has tuberculosis (TB disease, latent TB infection (LTBI), or this is a false positive TST? How do we differentiate these three conditions? Will the relatively new test, the Interferon Gamma Release Assay (IGRA) 1, help us in this conundrum?

The overriding intent in testing for TB is to diagnose as early as possible children who might have TB disease or LTBI in order to reduce long-term sequelae or mortality. This teen lives in a low TB endemic area. She has no known TB exposures, has not traveled outside the United States, has normal growth and development without any weight loss, adenopathy or fever. Her chest x-ray is normal. She has not received BCG vaccine and has no other known risk factors nor any signs or symptoms that point toward TB disease. Therefore she does not currently have contagious TB disease. But you still need to differentiate LTBI from a false-positive TST. So how valid is the TST in this situation and how does it compare to the IGRA?

**TST:**
The TST has known issues related to sensitivity (50-85% for clinically diagnosed to laboratory confirmed TB disease), specificity (many false positives in low TB endemic areas), subjectivity (often misread or results differ with different observers), and reproducibility (15% variability in same patient on same day administered in different forearms). 3-6 Yet the TST is the TB screening test with which we have been the most familiar for decades.

Clinicians have traditionally diagnosed LTBI based on TST test results in a patient who has risk factors or exposure history (household exposure or residence/travel to endemic areas), but the patient also has to have negative imaging results and a lack of signs/symptoms of active TB disease to qualify for a diagnosis of LTBI.

So you first confirm that a TST in a patient such as the teen above (low risk with no known exposure) must show ≥15mm induration to be considered “positive”. You then confirm the measurement did not include any surrounding area of erythema in the measurement and that it was measured with a clear ruler from side-to-side (transverse) not up-to-down (longitudinal) on the forearm. You find out that 16 mm is the real result and confirm that it is greater than the requisite 15 mm.

But you also know that TST results are often confounded by lack of specificity, such that false positives lead to potential overtreatment. This is well described in patients who have received BCG before entering the U.S. or who have nontuberculous mycobacteria (NTM) exposures. A number of the antigens in TSTs are found in BCG vaccine and in some species of NTM such as *Mycobacterium avium-intracellulare* (MAI) 4,5,7 While most NTM cross reactions cause <10 mm of TST induration, some patients will have > 15 mm induration. So is this teen a true LTBI or an unusual false positive (larger than usual induration for NTM) TST?

**Two IGRA s and Results Interpretation:**
Both commercially available IGRA s (Quantiferon-TB Gold (QFT) and the T-SPOT) are blood tests. The sensitivity of IGRA s is not remarkably different than TST (60-85%). But the specificity can be better, particularly in BCG-experienced patients and those with NTM exposures. 8-12 Each IGRA uses different methodology to test the immune memory of CD4 cells for TB antigens, so results of the gamma interferon release are reported in 2 different formats.

The QFT is positive if the result is greater than 0.35 IU/mL. The QFT can also be reported as indeterminate if the controls do not function properly. (Table 1)
ID Pearls and Other Gems: Teen with 16 mm Tuberculin... Continued from Page 8

TABLE 1. QuantiFERON-TB Gold (QFT) Reported as International Units (IU) of Interferon Gamma (IFN-γ) per mL in Plasma from Blood Incubated in Differing Conditions

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>Nil*</th>
<th>Mitogen **</th>
<th>TB Antigens ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>≤8.0</td>
<td>≥0.5</td>
<td>&lt;0.35 or &lt;25% of Nil</td>
</tr>
<tr>
<td>Positive</td>
<td>&gt;8.0</td>
<td>&lt;0.5</td>
<td>≥0.35 and ≥25% of Nil</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>≤8.0</td>
<td>&lt;0.5</td>
<td>&lt;0.35 or &lt;25% of Nil</td>
</tr>
</tbody>
</table>

*From blood incubated without antigen.
**From blood incubated with mitogen minus Nil.
***From blood incubated with a peptide mix (early secretory antigenic target-6 (ESAT-6) plus culture filtrate protein-10 (CFP-10), plus part of TB 7.7) minus Nil value.


The T-SPOT is reported as the number of spot-forming cells. A positive result is greater than eight spots. The test is reported as equivocal if between five and seven spots are detected. The T spot can also be reported as invalid if the controls do not function properly. (Table 2)

TABLE 2. T-SPOT.TB Test (T-Spot) Results Reported as Spots Produced from Differing Incubation Conditions

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>Nil*</th>
<th>Mitogen **</th>
<th>TB Antigens***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Up to 10 spots</td>
<td>≥20 Spots</td>
<td>≤4 spots</td>
</tr>
<tr>
<td>Positive</td>
<td>&gt;10 spots</td>
<td>&lt;20 spots</td>
<td>≥8 spots</td>
</tr>
<tr>
<td>Equivocal</td>
<td>&gt;20 Spots</td>
<td>≥20 Spots</td>
<td>5-7 spots</td>
</tr>
<tr>
<td>Invalid**</td>
<td>&gt;10 spots</td>
<td>&lt;20 spots</td>
<td>&lt;5 spots</td>
</tr>
</tbody>
</table>

*Nil = Incubation of PBMCs in media without antigens.
**Mitogen = Incubation of PBMCs with mitogen (all patients should respond to mitogens).
***TB Antigens = Two test conditions used: incubation of PBMCs with 1. early secretory antigenic target-6 (ESAT-6) peptides, or 2. peptides from culture filtrate protein-10 (CFP-10). Reported result is the higher of the two numbers of spots produced after subtracting the spot number from the Nil incubation.


Indeterminate, equivocal or invalid tests need to be repeated and seem to occur in ~5-15% of tests.

**LTBI Diagnosis:**

It is known that the induration from TST poorly differentiates cell-mediated immunity (CMI) induced by *M. tuberculosis* in LTBI from CMI induced by prior NTM. So could an IGRA help in this situation? IGRAAs have higher specificity (90-100% in a meta-analysis), and can usually differentiate LTBI from false positive TST testing at most ages. In contrast, one study of over 200 children showed that 77% of children in the New York area appeared to have false positive TST when compared to QFT and less likelihood of actual LTBI. There is now consensus that IGRAAs are reasonable alternatives for children > 5 years of age. Expert opinion is split on those 2-5 years of age.

This child is 14 years old and fits best as a low risk person who will be in a healthcare position. This is an age and sit-
uation where IGRA is acceptable (maybe preferable) and has higher specificity. The CDC website suggests this situation (positive TST with low risk of TB infection based on negative exposure history and examination findings) as a reasonable time to use an IGRA: (http://www.cdc.gov/tb/publications/factsheets/testing/IGRA.htm) “A person has a low risk of TB infection and progression from infection to TB disease. Requiring a positive result from the second test as evidence of infection increases the likelihood that the test reflects infection.”

The QFT is the version available to your clinic. Results of the IGRA: NIL ≤8.0 IU/mL, TB Antigen <0.35 IU/mL (also <25% of Nil) and Mitogen ≥0.5 IU/mL.

You interpret this as a negative result that indicates that it is highly unlikely that this child has any TB infection. Therefore this is not LTBI. She can go to her volunteer position at the hospital without further intervention. The IGRA differentiated a false positive TST (likely due to inadvertent exposure to a NTM) from LTBI and saved this patient from needing 9 months of isoniazid.

The unusual aspect of this case is that the TST results were 16 mm of induration, which should occur in <10% of NTM cross reactions to TST. This is a situation where a more expensive blood test saved healthcare costs and possible adverse effects of the potential medical intervention which otherwise would have seemed necessary. Sometimes newer is better.

**IGRA Caveats:**
1. Both IGRA and TST rely on CMI for positive results. Therefore immunocompromised hosts require special consideration because CMI testing will not be reliable. A clinical report from the Committee on Infectious Diseases of AAP is due to be released by the end of 2014 and readers are referred to this source when it becomes available.
2. Neither TST nor IGRA can of themselves differentiate LTBI from active TB. Clinical and imaging and sometimes microbiologic data are required for this.
3. TSTs overall remain preferred for children < 2 years of age and by many experts for children < 5 years of age.
4. There is no “gold standard” for TB infection, so rarely the TST can be “correct” and the IGRA result can be a false negative. Some experts would treat with isoniazid regardless of the IGRA, given a 16 mm induration from the TST. An alternative approach to the one above is to discuss options with the teen and her parents to allow their input on the decision about treating. Some want to avoid treatment unless absolutely necessary and they would decline treatment. Others fear any chance of TB infection and may want to treat.

• “Statements and opinions expressed in this publication are those of the authors and not necessarily those of the American Academy of Pediatrics.”

**References:**

*Continued on Page 11*
ID Pearls and Other Gems: Teen with 16 mm Tuberculin . . . Continued from Page 10


Request for Content: Images and Video for Red Book Online Visual Library

The Editor for the AAP Red Book Visual Library, Dr. Cody Meissner, would appreciate any videos and images to enhance the multimedia area that is available as a part of Red Book Online. This subscription website for health care professionals includes the full text of Red Book from the American Academy of Pediatrics Committee on Infectious Diseases, as well as other infectious disease resources.

There are currently approximately 2,500 images that include clinical manifestations, etiology, epidemiology, and vectors or carriers for the infectious disease summaries found in Section 3 of the Red Book; many of which have been contributed by pediatric infectious disease professionals. We are looking for additional and updated images to help health care providers use the resource, as well as videos as we are integrating a video platform into the site. Video is a powerful educational tool to help enrich health care providers’ diagnosis, performance of procedures, counseling, and implementation of recommendations for treatment and management.

If you have video and/or images that you would like to be reviewed for inclusion, please contact Mark Ruthman, Manager, Electronic Product Development at AAP to discuss details at mruthman@aap.org or 847.434.7640. You will be acknowledged on the site for your contribution, and may retain copyright if you desire. If you transfer copyright to AAP, you will still be able to use the media in your own educational presentations.
Policy Highlights from the Committee on Infectious Diseases (COID)

Policy Topics under Consideration:
1. Revision of Policy Statement (PS): Infection Prevention and Control in Pediatric Ambulatory Setting
2. New policy statement (PS): Antimicrobial Stewardship in Hospitals
3. Revision of Policy Statement (PS): Chemical- Biological Terrorism and Its Impact on Children

AAP statements under development
3. CR: Adolescent Immunizations
4. TR: Prevention and treatment of congenital toxoplasmosis
5. CR: Polio End-Game Strategy
6. CR: TB testing
7. PS: Infection Control in Organized Sports
8. CR: Biologic Response Modifiers

Statements in Revision
1. PS: Acute Otitis Media and Meningitis in Children with Cochlear Implants- Sawyer
2. PS: Recommendation for Mandatory Influenza IZ of All Health Care Personnel – Bernstein
3. TR: The Non-Therapeutic use of Antibiotics in Animal Agriculture: Implications for Pediatrics
4. CR: Revision of Head Lice

The following AAP clinical practice guidelines are in the process of development:
1. Fever in Infants Under 3 Months of Age
2. Management of Bronchiolitis in Infants and Young Children

Guidelines in Progress with External Organizations
1. HICPAC is working on a guideline for prevention of infections among patients in neonatal intensive care units (NICU)
2. Kawasaki Disease and Endocarditis with Committee on Cardiovascular Disease in the Young (AHA)
3. Diagnosis and Management of Bone and Joint Infections (IDSA/PIDS)
4. Clinical Guidelines for Diagnosis and Antiviral Management of Seasonal and Pandemic Influenza in Adults and Children (IDSA)
5. Inappropriate Antibiotic Use for Acute Respiratory Tract Infections (AHRQ)
Cystic Fibrosis Advances in 2014

Kathryn Moffett, MD, FAAP, Professor of Pediatrics, West Virginia School of Medicine, Department of Pediatrics, Section Chief, Pediatric Infectious Diseases, Center Director, Cystic Fibrosis, Co-Clerkship Director

Cystic fibrosis (CF) is an inherited life-shortening syndrome. Since 2011, all newborns in the United States are screened for CF at birth (incidence of CF is 1 in 3000 live births). The current life expectancy is 39 years; however most CF centers have adult patients living into their 50's and 60's. It is estimated that in several years, there will be more adults over the age of 21 years with CF than children.

The genetic defect in CF produces a faulty protein called CF Transmembrane Regulatory (CFTR) protein. Healthy CFTR functions by opening the salt channel in mucous cells. In CF, salt (and water) do not diffuse out of cells, making mucous thick, sticky, and dehydrated, leading to clogged airways and sinuses, pancreatic insufficiency, and male infertility. The majority of patients with CF die of respiratory/lung failure. By the age of 50 years, nearly half of persons with CF will develop CF-related diabetes. Liver failure from cirrhosis is the second leading cause of death.

Despite early diagnosis, aggressive nutrition, chest physiotherapy treatments, and adherence to strict infection control policies, chronic infection of the sinopulmonary tract is inevitable. *Pseudomonas aeruginosa* is still the predominant bacterial pathogen, while additional bacteria, such as *Staphylococcus aureus*, *Stenotrophomonas, Achromobacter, Burkholderia cepacia*, and atypical Mycobacteria also lead to chronic infection in the lower airway. Any of these bacterial pathogens cause frequent exacerbations, bronchiectasis, and ultimately mortality from respiratory failure. Surveillance for *Pseudomonas* in young children has demonstrated that early eradication is possible. Azithromycin is recommended for chronic anti-inflammatory treatment of *Pseudomonas*-negative children as well as patients with chronic *Pseudomonas* infection. The age when patients acquire chronic *Pseudomonas* infection (*mucoidy*- the biofilm-producing phenotype) has been delayed to older teens. Inhaled antibiotics (tobramycin and aztreonam) are licensed as suppressive therapy in patients with chronic *Pseudomonas*. Unfortunately once the decline of lung function begins in a person with CF, that rate of decline is the same as it was 25 years ago.

A recent breakthrough in CF treatment involves the 2012 licensure of the CFTR corrector/potentiator medication, Kalydeco (ivacaftor), for persons with gating mutations, such as G551D (about 4-6% of the CF population in the US). Ivacaftor enters the cell and potentiates the faulty CFTR protein to open up the salt channel. Although not a cure, ivacaftor-treated patients have shown improved lung function, weight gain, lower sweat chloride values, improved quality of life, and less need for antimicrobial therapy. A combination medication of ivacaftor/lumicaftor has been studied in patients homozygous for the most common CF mutation, delta F508. Although the response to medication is not as robust as in persons with gating mutations, there is improvement in patient outcomes. Licensure is pending, and other medications are in the pipeline for clinical trials. These breakthroughs in treatment provide hope for an eventual cure for cystic fibrosis. For additional information regarding this topic go to: www.cff.org

• “Statements and opinions expressed in this publication are those of the authors and not necessarily those of the American Academy of Pediatrics.”

From the ACIP Meetings in February and June, 2014


The slide sets for the meeting of June 25-26, 2014 have been posted at: http://www.cdc.gov/vaccines/acip/meetings/slides-2014-06.html Each set contains slides in pdf format. The minutes of the June meeting will be available at: http://www.cdc.gov/vaccines/acip/meetings/meetings-info.html
Chapter Corner

AAP British Columbia Chapter:
Infectious Disease Issues and Initiatives

Dr. William Abelson, President, AAP BC Chapter and Dr. Wilma Arruda, Advocacy Chair, AAP BC Chapter

In British Columbia, although vaccines are available at no cost to the public for many childhood diseases, a fee is charged for vaccines to cover meningococcal diseases, travel vaccines, hepatitis A, influenza, and human papillomavirus (HPV) in some situations (e.g., publicly funded HPV vaccine is only given to girls in grades 6/9). The AAP BC Chapter is championing the uptake of these non-publicly funded (NPF) vaccinations for British Columbians through several initiatives.

A series of factsheets and professional resources for physicians provide information about the diseases and vaccines, reflect challenges experienced by physicians with regard to NPF vaccines and address questions typically received by physicians related to NPF vaccine discussions.

- The first factsheet addresses meningococcal disease vaccines, highlighting disease incidence and characteristics, vaccines available and providing take-away messages about the vaccine for parent discussions.
- Professional resources remind physicians of the reasons and importance of considering NPF vaccines in certain situations and include links to additional resources.
- A set of resources about NPF vaccines have also been prepared for physicians to give to families: Trusted websites, information about costs, whether the vaccines are covered by insurance, and directions on how to access the vaccines from pharmacies.

To view or access these resources visit: http://bcpeds.ca//Programs/showcontent.aspx?MenuID=1763

Three projects have explored the effectiveness of methods used to distribute information about NPF vaccines to physicians to share with parents:

- The first two projects distributed information by mail to physician offices and by internal regional health offices in partnership with a provincial Health Authority, respectively.
- The third project used posters to communicate directly with parents in the community. The in-community study revealed that parents who do not speak or read English require more and personal assistance than their English-speaking counterparts, even though translations were available in three additional languages.

Throughout these projects parents consistently reported that they look to their physicians for information about NPF vaccines (whether they are immunizing physicians or not). A downloadable checklist received by participants in all three projects is available in four languages from the ImmunizeBC website at: http://www.immunizebc.ca/get-vaccinated/non-publicly-funded-vaccines-children

For additional questions regarding this information contact: Stephanie Stephenson, Executive Director, AAP British Columbia Chapter, SStevenson-02@cw.bc.ca

Ohio Chapter:
Measles & Mumps Outbreak Sparks New Legislation in Ohio

The Ohio Chapter, American Academy of Pediatrics, with several Ohio lawmakers, has helped introduce new immunization legislation after large outbreaks of two infectious diseases. Ohio House Bill 536 would require that children enrolled in state-licensed childcare facilities be immunized in accordance with the schedule recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.

Ohio ranks below the national average of children who receive all vaccines by 35 months and also ranks above the national average for refusal, according to the CDC. This legislation will help protect Ohio’s young people from all infectious diseases including two that caused large outbreaks in 2014.

Continued on Page 15
Two unvaccinated Amish individuals traveled to the Philippines for a service project in early 2014. According to the Centers for Disease Control and Prevention (CDC), the Philippines is in the middle of an epidemic of the measles, with 26,000 new cases reported this year. The two Amish individuals returned to Ohio with the measles and the infection spread quickly among their community in Knox County, located in the middle of the state.

The Ohio Department of Health (ODH) reports 377 cases of the measles in nine Ohio counties, with 11 cases requiring hospitalization. The first case was reported on March 24 and most recent case was reported on July 23. ODH reports this is part of the largest measles outbreak in the U.S. since 1994.

Public health workers investigating the measles outbreak found that most in the Amish community were not against vaccinations; they merely lacked education on the need for vaccines. The Ohio Department of Health and local health departments launched large-scale clinics and vaccinated tens of thousands of people. ODH now believes the measles outbreak is near its end.

The state also is experiencing the largest outbreak of mumps in 35 years. As of July 20, there were 460 reported cases. The case with the first onset of symptoms began in early January and the most recent case was reported on July 12. A source for the outbreak has not been identified.

More than half of the mumps cases are linked to the Ohio State University campus. Many of these cases of the mumps were reported in adults who had been vaccinated. According to the CDC, outbreaks of the mumps in 2006 and 2009 in the U.S. showed outbreaks spread even among vaccinated people in environments in which people are in close contact, like college campuses. While the report of new cases have slowed during the summer, health care workers are warning of a second peak in the fall when classes begin and thousands of students return to campus.

In response to the outbreaks, the Ohio Chapter, American Academy of Pediatrics worked with lawmakers to introduce a bill in May 2014 to restore immunization requirements for children entering state-licensed childcare facilities. Ohio House Bill 536 will be discussed in committee when lawmakers return to session in the fall. Anyone wishing to express their support for the legislation should contact their Ohio senator or representative (ohiohouse.gov & ohiosenate.gov).

Melanie Farkas
Director of Communications & Immunization Programs
Ohio Chapter, American Academy of Pediatrics
614-846-6258 | OhioAAP.org

Sources:
Ohio Department of Health
Columbus Public Health
Centers for Disease Control and Prevention

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**New Online Course Informs on Identifying & Treating *Clostridium difficile* Infections**

Challenging Cases: *Clostridium difficile*, a new online course from PediaLink, delivers the latest information needed to identify and treat *Clostridium difficile* Infections (CDI). Case studies present information on risk factors, testing methods, treatment options for first-time and recurrent infections, newly available medications, the changing epidemiology of CDI, the significance of CDI in infants, and infection control measures. Estimated course time is 30 minutes and it qualifies for AMA PRA Category 1 Credit(s)™. More: [http://bit.ly/c-difficile](http://bit.ly/c-difficile)
Taking (Live)stock: Antibiotic resistance, farm antibiotic use, & what we can do about it

Saul R. Hymes, MD, FAAP, Assistant Professor of Clinical Pediatrics, Pediatric Infectious Diseases, Stony Brook Children’s Hospital

Antibiotic resistance is a topic that is increasingly in the news and on the minds of our patients, providers, and even our government (http://www.wired.com/2014/07/pcast-2/). We all know we need to try to decrease inappropriate antibiotic use. According to the CDC’s Threat Report 2013 (http://www.cdc.gov/drugresistance/threat-report-2013/) on antibiotic resistance and its ensuing morbidity and mortality (23,000 attributable deaths yearly), and notwithstanding all that we know about our own antibiotic overuse, we physicians (and allied clinicians) are only, at best, half of the problem. Of course we are far from innocent. Unnecessary antibiotic use for viral infections has, in some areas, even increased (http://www.wired.com/2014/07/pcast-2/) in the past 20 years and efforts to decrease antibiotic overuse and increase stewardship are more needed than ever. However, in fact, 70% of all antibiotic use in this country occurs in livestock.

Farm antibiotic use can be divided into two categories: treatment, given by veterinarians for animals who are actually sick, and low-dose constant use in feed, given to prevent infections or bacterial overgrowth and (reportedly) to ensure the health and fitness of animals grown in overcrowded factory-farm conditions. It has been shown in study (http://www.ncbi.nlm.nih.gov/pubmed/23769367) after study (http://www.ncbi.nlm.nih.gov/pubmed/18502931) that use of low-level antibiotics leads to the emergence of resistant bacteria. While there may be less direct evidence that all of these organisms can and do transfer to humans, we are all familiar with problematic foodborne outbreaks (http://www.cdc.gov/media/releases/2014/p0701-antibiotic-resistance.html), and there are certain specific cases where farmers contracted infections with extended spectrum beta-lactamase positive organisms or other resistant organisms from animals. If we care about antibiotic resistance overall and in particular the spread of these infections in humans, we need to do something about unrestricted antibiotic use in animals.

Our generation is not the first to cry foul about antibiotic use on farms but given the increase in antibiotic resistance overall, furor over it has risen to new and appropriate, heights. The FDA is listening…faintly. In December a new regulation (http://www.nytimes.com/2013/12/12/health/fda-to-phase-out-use-of-some-antibiotics-in-animals-raised-for-meat.html?pagewanted=all&_r=1&) required veterinarians to more strictly oversee antibiotic use and (non-bindingly) advised drug companies to state on the label that the antibiotics are not for growth promotion. But this new guideline probably does not go far enough; low-level antibiotics to prevent disease are still allowed, and there is little legal recourse against drug companies or farms that don’t comply.

So what can we do? Many large agribusiness companies and their lobbyists claim reducing antibiotics will lead to increased costs in order to house animals in ways that prevent disease (they point to pricier organic meat and poultry). But in Europe, stricter regulations have already landed. In The Netherlands, Dutch farmers are already removing antibiotics (http://modernfarmer.com/2014/06/abstinence-method/) (other than to treat the sick) from their animal husbandry methods with, if anything, increased profits from the healthier, larger animals that result from improved living conditions. Many U.S. lawmakers are unaware of these success stories. And they are often still unaware of the horrors resistant organisms can wreak. Worse yet, many of our patients and families are unaware of the problem. That’s where we come in.

Pediatricians, and our constituent organizations like the AAP, are nothing if not advocates for our patients and their families:

• Every visit, we can inform our patients and families about antibiotic-free or organic milk, meat, or poultry in an effort to reduce their exposure to resistant organisms.

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Taking (Live) stock: Anitbiotic resistance, farm… Continued from Page 16

• For those who used to avoid going to AAP lobbying days—‘what would I say?’, now we can go and discuss antibiotic usage in livestock and other areas of agriculture with our state legislator, representative, or senator.
• Many of us sit on hospital safety and quality committees—raise the issue of having your institution only purchase antibiotic-free meats and related products. Some of you have already done so (http://hsnewsbeat.uw.edu/story/uw-medical-center-opts-antibiotic-free-pork-poultry).

This is a fixable problem but it will take hard work by people who know about and care about the problem, as well as by all of us affected by it. We can and should be among those working to fix the problem.

Editor’s Note: The AAP Committee on Environmental Health and Committee on Infectious Disease are currently revising the AAP technical report, “The Non-Therapeutic use of Antibiotics in Animal Agriculture: Implications for Pediatrics” (http://pediatrics.aappublications.org/content/114/3/862.full).

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Infectious Diseases Physician Needed for PREP Self-Assessment Editorial Board

We are asking your assistance in identifying qualified individuals to serve on the PREP Self-Assessment Editorial Board. We are seeking nominations to fill five open positions.

• General Pediatrician
• Developmental/Behavioral Specialist
• Neonatologist
• Infectious Diseases Specialist
• Endocrinology

The deadline for receipt of nomination materials is 4:30 PM (CDT), Friday, November 14, 2014. Please see the list of Editorial Board Member Responsibilities at: http://www2.aap.org/attachments/2_PREP_ED_2015_job_desc.doc

Nominees must submit:
• A completed and signed PREP Self-Assessment Editorial Board Fact Sheet - http://www2.aap.org/attachments/1_PREP_ED_2015_fact_sheet.doc
• A current CV
• A writing sample
• A completed AAP Full Disclosure Form - http://www2.aap.org/attachments/3_AAP_Disclosure_Form_PREP_Subspecialty_1-24-14.doc

The AAP Disclosure Policy can be viewed at: http://www2.aap.org/attachments/AAP_CME_Disclosure_Policy_updated-Jan_2013.doc

The writing sample should be a short essay or question and critique, 1-2 typed pages, which has not been published or edited by others. Please be sure to complete the fact sheet in full, including the certification statement on the third page. All information must be sent electronically. Email attachments should be in MSWord, RTF or PDF format.

Nominees should email materials to Lisa Donato, Division Coordinator, at ldonato@aap.org
Please do not hesitate to contact me at spiscoran@aap.org if you have questions. Thank you in advance for your help in this process.
Spotlight on AAP International Affairs

The AAP Office of International Affairs (OIA) comprises of three major areas of focus: grants and programs, business development, and professional relationships. This feature focuses on key global health initiatives and international partnerships as it relates to infectious diseases.

Luiza Helena Falleiros Arlant, SLIPE President - 2013-2015

SLIPE, Latin American Society of Pediatric Infectious Diseases, was created in Chile in 1990. Its president and management change every two years and SLIPE’s head office rotates across different Latin American countries according to the current president’s country of residence. The current president, appointed for the period 2013-2015, is Dr Luiza Helena Falleiros Arlant based in Sao Paulo, Brazil.

One of the most important objectives of SLIPE is to increase communication on pediatric infectious diseases, news and updates, through the organization of different kinds of academic and scientific activities and events across the Latin American region.

SLIPE has about 900 members (most of them are experts in pediatric infectious diseases) and continues to grow. Every two years, SLIPE organizes a very important Latin American Congress which has more than 1,500 attendees. The last one was held in June 2013, in Brazil.

The next XVI Latin American Pediatric Infectious Diseases Congress will be organized jointly with the LXII Annual Puerto Rico Pediatric Society Congress, and will be held in Puerto Rico from June 24-27, 2015. It will bring together pediatric infectious diseases specialists from Latin America and the Caribbean for educational purposes, knowledge sharing, and mutual support. It has grown over the years, and the attendance of approximately 2,500 participants from all over the Caribbean and Latin America is expected.

In order to help accomplish its mission, SLIPE appoints several committees focused on different subjects such as perinatal infections, HIV, immunization, bacterial resistance, etc., which work on and develop diverse documents and papers. It also organizes consensus statements on a number of subjects regarding pediatric infectious diseases.

SLIPE also has representatives in the World Society for Pediatric Infectious Diseases (WSPID), as Board and Scientific Committee members. It has been organizing a SLIPE Symposium during WSPID Congresses, as well as during the International Congress on Infectious Diseases (ICID).

Moreover, SLIPE participates in several congresses and events across Latin America, participating in various conferences and symposia, such as Jornadas Brasileiras de Imunização/Congress 2013 and 2014, API (Asociación Panamericana de Infectología) Congresses, SLIPE Symposium during the ICID held in Cape Town in 2013, Peruvian Pediatric Congress 2014, and the XXXIII Interamerican Pediatric Infectology Congress in Mexico 2014.

In early 2014, the Society published the SLIPE Vaccination Schedule Recommendations, and has actively contributed to the Ibero-American Vaccination Schedule jointly with Asociación Española de Pediatría (AEP), Sociedad Portuguesa de Pediatría (SPP), Asociación Latinoamericana de Pediatría (ALAPE). Since 1995, it has also issued three editions of

Continued on Page 19
the SLIPE Vaccines Manual. The fourth edition, which will be an on-line version, is being reviewed, and is expected to be launched by the end of 2014.

Moreover, the Society has been working on a SLIPE position paper, “Challenges of the Inactivated Polio Vaccine Change in Latin America”, which aims to review polio immunization programs in the region and to explore better mechanisms to support the WHO initiative of the Polio Endgame. It is expected to be published this year.

SLIPE is currently represented on the AAP Committee on Infectious Diseases by Dr. Marco Aurelio Palazzi Safadi who serves as a liaison. SLIPE has contributed its recommendations to the Red Book preparation since 2011. It also has a dedicated page in the Journal of the Pediatric Infectious Diseases Society (JPIDS) entitled “SLIPE Highlights” to include medical updates, summaries and announcements. SLIPE is in close contact with the American Academy of Pediatrics in order to evaluate possible collaborations between both societies.

For detailed information about SLIPE please visit the website: www.slipe.org or contact the Society by email: juntadirectiva.brasil@slipe.org and info@slipe.org.

ID Sessions at The AAP’s National Conference and Exhibition (NCE) October 11-14, 2014, San Diego, CA

For the descriptions of the ID sessions sponsored by the SOID go to: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-infectious-diseases/Pages/NCE-ID-Sessions.aspx

In addition, below are other sessions sponsored by other Sections that may be of interest:

2. 10/11/2014; 2:00 pm – 3:30 pm: S1110 – Probiotics, prebiotics, and synbiotics: which ‘biotic” is appropriate for children (repeats as S2112)
3. 10/11/2014; 5:00 pm – 5:45 pm: F1153 – Outbreak!: working with your health department
4. 10/12/2014; 7:00 am – 8:00 am: X2007 – Infectious Disease Issues in Internationally Adopted Children
5. 10/12/2014; 8:00 am – 5:30 pm: H2025 – Section on International Child Health
6. 10/13/2014; 2:00 pm – 2:45 pm: F3089 Management of animal and human bites (repeats as F4018)

For the complete NCE program go to: http://www.planion.com/EvalCenter/AAP/AAP_NCE2014_ALLSessions.pdf
Welcome to our New SOID Members

If you know of others who might be interested in joining the Academy and the Section please have them call 1-800-433-9016 ext 5885 or go to www.aap.org. The link entitled Member Benefits will take them to an application. Current Academy members may join the Section by accessing the online application (member ID and login required) at: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Council-Section-Membership.aspx

AAP Fellows and Candidate Members

<table>
<thead>
<tr>
<th>Jeannette Comeau, MD</th>
<th>Hasan Merali, MD</th>
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<tr>
<td>Bozeman, MT</td>
<td>Atlanta, GA</td>
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<tr>
<td>Peter Easter, DO, FAAP</td>
<td>Ravishankar Ayathu Venkata, MBBS DCH DNB</td>
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<td>Plano, TX</td>
<td>Philadelphia, PA</td>
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<tr>
<td>James Grubbs, MD, FAAP</td>
<td>Leticia Watanabe, MD</td>
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<tr>
<td>Philadelphia, PA</td>
<td>Surprise, AZ</td>
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<td>Sarah Khan, MD</td>
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<td>Aurora, CO</td>
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International Members

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<tr>
<th>Oliver Medzihradsky, MD, MSc, MPH, FAAP</th>
<th>Samuel Siegel, MD</th>
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<tr>
<td>Sao Paulo, Brazil</td>
<td>Chennai, India</td>
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Resident Members

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<tr>
<th>James David, MD</th>
<th>Angela Veesenmeyer, MD, MPH, FAAP</th>
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<tr>
<td>Davis, CA</td>
<td>Cleveland, OH</td>
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SOID Travel Grant Recipients

One of the roles of the SOID is to promote the education of physicians interested in infectious diseases. We are pleased to be able to offer NCE travel grants to AAP members who are residents with an interest in infectious diseases and ID fellows in training. The following recipients were selected by lottery and will receive $1,200 to defer the costs of airfare, registration, hotel, meals, and incidentals to attend the 2014 AAP National Convention and Exhibition.

<table>
<thead>
<tr>
<th>Laura Harrison, MD</th>
<th>Andrew Nuibe, MD</th>
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<tr>
<td>Baystate Medical Center/Tufts School of Medicine Springfield, MA</td>
<td>University of Utah Salt Lake City, UT</td>
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<tr>
<td>Sabina D. Holland, MD</td>
<td>Matthew Vogt, MD</td>
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<tr>
<td>Warren Alpert Medical School at Brown/Lifespan Providence, RI</td>
<td>Boston Children's Hospital Boston, MA</td>
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<tr>
<td>Carol Kao, MD</td>
<td>Philip Zachariah, MD</td>
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<tr>
<td>North-Shore/LIJ Hospital Manhasset, NY</td>
<td>Columbia University New York, NY</td>
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Welcome to our New SOID Members  Continued from Page 20

A special welcome to training fellows who were automatically added to the Section.  
(As of July 1, 2010, Section dues for infectious diseases training fellows were eliminated.)

<table>
<thead>
<tr>
<th>Name</th>
<th>City, Country</th>
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<tbody>
<tr>
<td>Edwin Asturias, MD, FAAP</td>
<td>Oakville, ON, Canada</td>
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<tr>
<td>Jeffrey McKinney, MD, FAAP</td>
<td>Sterling, VA</td>
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<tr>
<td>Hamid Bassiri, MD, FAAP</td>
<td>South Richmond Hill, NY</td>
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<tr>
<td>Angelika Ostrowski, MD, FAAP</td>
<td>Lexington, MA</td>
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<tr>
<td>Angela Campbell, MD, FAAP</td>
<td>Toronto ON, Canada</td>
</tr>
<tr>
<td>Amruta Padhye, MD, FAAP</td>
<td>Boston, MA</td>
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<tr>
<td>Jennifer Duchon, MD, FAAP</td>
<td>Minneapolis, MN</td>
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<tr>
<td>Michelle Sewnarine, MD</td>
<td>Columbia, MO</td>
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<tr>
<td>Elizabeth Jamme, MD, FAAP</td>
<td>Wyndmoor, PA</td>
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<tr>
<td>Elizabeth Swanson, MD</td>
<td>San Francisco, CA</td>
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<tr>
<td>Suhasini Kaushal, MD, FAAP</td>
<td>Madison, WI</td>
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<tr>
<td>Laura Vella, MD, FAAP</td>
<td>Houston, TX</td>
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<tr>
<td>Anya Kristina Keitel-Hasler, MD</td>
<td>Montreal, QC, Canada</td>
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<tr>
<td>Alpana Waghmare, MD, FAAP</td>
<td>Fitchburg, WI</td>
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<tr>
<td>Stephen Ko, MD, FAAP</td>
<td>Birmingham, AL</td>
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<tr>
<td>Heather Young, MD</td>
<td>Seattle, WA</td>
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Suet Lam, MD  
Yonkers, NY

New Policy/Guidelines

Andrea Sperduto, MD FAAP

Besides the individual web sites listed below, links to the AAP ID policies, IDSA policies and the CDC ID Recommendations and Reports are all available at the SOID website:  http://www2.aap.org/sections/infectdis/policy.cfm

1. AAP
   a. AAP Clinical Report: Pediatric Anthrax Clinical Management: Executive Summary  
      http://pediatrics.aappublications.org/content/133/5/940.full.pdf+html
   b. AAP Clinical Report: Pediatric Anthrax Clinical Management  
      http://pediatrics.aappublications.org/content/133/5/e1411.full.pdf+html
   c. AAP Technical Report: Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection  
      http://pediatrics.aappublications.org/content/134/2/e620.abstract?rss=1

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New Policy/Guidelines  Continued from Page 21

d. AAP Policy Statement: Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection
http://pediatrics.aappublications.org/content/134/2/415.abstract?rss=1

e. AAP Policy Statement: Updated Recommendations on the Use of Meningococcal Vaccines
http://pediatrics.aappublications.org/content/134/2/400.abstract?rss=1

2. MMWR
   i. Third conjugate vaccine now recommended for use in infants 2-23 months who are at increased risk for meningococcal disease.
   ii. Infants at increased risk include:
      1. Persistent complement component deficiencies.
      2. Functional or anatomic asplenia (includes sickle-cell disease).
      3. Healthy infants in communities with meningococcal disease outbreaks.
      4. Traveling or residing in areas where disease is hyperendemic or epidemic.
         http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6324a2.htm

b. Prevention and Control of *Haemophilus influenza* Type b Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2014. MMWR February 28, 2014/63(1);1-14.
   i. Comprehensive summary of previously published recommendations.
   ii. Does not contain any new recommendations.
   iii. Summarizes current HIB epidemiology, HIB vaccines licensed in US and guidelines for antimicrobial chemoprophylaxis.
         http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6301a1.htm

3. IDSA
   i. Updated 2005 guidelines.
   ii. Diagnosis and treatment ranging from minor superficial infections to life-threatening.
   iii. Addresses the immunocompromised host and children.
         http://cid.oxfordjournals.org/content/early/2014/06/14/cid.ciu296.full

   i. Replaces 2009 guidelines.
   ii. Added new antiretroviral drugs and classes.
   iii. New section on metabolic comorbidities has been added (e.g. Dyslipidemia).
   iv. Maternal-to-child transmission and pediatric and adolescent recommendations are included.
         http://cid.oxfordjournals.org/content/early/2013/11/12/cid.cit665.full.pdf+html
Update on HIV Guidelines

Andrea Sperduto, MD FAAP

Complete guidelines and information are available at: http://aidsinfo.nih.gov/guidelines and are updated periodically.

1. Guidelines for the Use of Antiretroviral (ARV) Agents in Pediatric HIV Infection.
   a. Updated 2/12/14 (previously updated 11/1/12).
   b. Initiation of cART (combination antiretroviral therapy) in children of all ages with HIV RNA levels >100,000 copies/mL.
   c. Treatment should not be interrupted once started in a child who has been shown to be infected.
   d. Special section on treatment of preterm infants and infants <15 days of age has been added.
   e. Specific drugs are discussed and recommended.

2. Guidelines for the Use of ARV agents in HIV-1-infected Adults and Adolescents.
   a. Updated 5/1/14 (previously updated 2/12/13).
   b. Cost considerations of ARV therapy discussed.
   c. Change in recommendations in frequency of CD4 count monitoring based on viral load suggested.
   d. “Recommended” ARV regimens are made and replace the term “Preferred”.

   b. Key changes involve:
      i. Preconception care for HIV-Infected women
      ii. Reproductive options for HIV-concordant and serodiscordant couples
      iii. Recommendations for use of ARV drugs in pregnancy
      iv. Intrapartum ARV treatment/prophylaxis
      v. Postpartum follow up
      vi. Infant ARV prophylaxis

   a. Updates 2009 guidelines.
   b. Guidelines for postpubertal adolescents can be found in the adult OI guidelines (See http://aidsinfo.nih.gov/guidelines) since their drug pharmacokinetics and response to treatment may differ from younger prepubertal and pubertal adolescents.
   c. Includes updates on immunization recommendations.
   d. Drug dosing information included.
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