Chair’s Letter

Greetings SOID members! Greetings also to AAP State Chapter Presidents, Vice Presidents and Executive Directors, and Pediatric Infectious Disease Fellowship Program Directors! Summer is moving along, public schools and colleges in our area (East Central GA) start up next week, and another AAP NCE will soon be upon us.

Nothing new to report at this time concerning interprofessional telephone consult codes. I expect some information from the Centers for Medicare and Medicaid Services (CMS) will be forthcoming this fall. Once CMS makes a determination about funding/not funding the formal interprofessional telephone consult codes approved by the AMA’s CPT Editorial Board, we will get this information to you.

In my last Chair’s Letter, I informed you that my state (GA) eliminated both inpatient and outpatient consult codes for Medicaid patients. With the help of the GA AAP, an attempt to reverse this decision was made through the state legislature. I’m sorry to say that the attempt failed to reverse Medicaid’s decision; however, we are apparently now being paid at a higher reimbursement rate for the office visit and inpatient admission codes that have been substituted. Living on the border of two states (GA, SC), one of which honors consult codes and one that does not, makes for some interesting billing and RVU calculations.

In this current issue of the SOID Newsletter we have several interesting items. Dr. Annabelle de St. Maurice will be

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our new ID fellow in training on the SOID Executive Committee, and Dr. Leena Bhattacharya Mithal will be the first ID fellow in training on the SOID Education Subcommittee. A hearty “welcome” to both! Dr. Kathryn Edwards is our 2013 Awardee for Lifetime Contributions to Infectious Disease Education. Congratulations to Kathy who richly deserves this award. Dr. Chris Harrison has taken on a leadership role for a work group important to both SOID and the Pediatric Infectious Disease Society (PIDS) concerning an ID Workforce Survey. Finally, there is a fascinating article on emerging infections caused by Haemophilus influenzae type a in Alaskan children. For those of us who trained prior to the Haemophilus influenzae type b conjugate vaccine era, this report calls to mind the specific problems these organisms present to Alaskan and Native American children.

Prep ID for 2013 was held in Chicago in late July, and, by all accounts, the meeting was highly successful. Once again participants were able to receive the “little yellow book”, Nelson's Pediatric Antimicrobial Therapy 19th Edition by John Bradley et al. John recently informed me that he has already begun work on the 20th Edition. Thank you to the faculty and PREP ID Planning Group: S. Michael Marcy, David Hunstad, Lorry Rubin, Gordon Schutze, Lilly Immergluck and Dwight Powell, along with the AAP and PIDS staff, for their commitment to make this course such a success.

Thanks to the efforts of many people, the ID Sessions at the upcoming AAP NCE are once again broad based and plentiful for both the general pediatrician and the subspecialist. “I’ve got you under my skin”, a presentation about fungal infections and infestations, sounds intriguing as does “Crushing the creepy crawlies” (bed bugs and lice). The Committee on Infectious Disease recently published a policy statement on Clostridium difficile and a clinical report on management of neonates born to women with active genital herpes. Both of these topics as well as Quantiferon TB Gold testing and many others will be presented at NCE.

Finally, several times per year Suzanne Kirkwood and I are asked for the names of SOID members to volunteer for assignments on a variety of AAP initiatives/activities. While we have an SOID roster with each member’s name and ID#, preferred address and expiration date of membership, we don’t have a listing of the 1 or 2 ID specific areas in which each member may have interest. I am planning on discussing this specific issue at our SOID Executive Committee meeting in October. However, if you would like to send us a note with a particular interest (RSV, fever in infants, lab diagnosis of ID, etc), we will start a file so that we can more easily contact interested members should we be requested to identify a SOID member for a specific activity. Remember to contact Suzanne Kirkwood (Skirkwood@aap.org) or me (dmurray@gru.edu) if you have concerns or ideas for your organization, the SOID and thanks for your membership! Until 2014, have an enjoyable and productive fall.

Dennis L. Murray, MD, FAAP, FIDSA
Professor, Department of Pediatrics
Chief, Pediatric Infectious Diseases
Georgia Health Sciences University
Augusta, GA
and
Chair, SOID Executive Committee

In Memoriam: Robert W. Tolan, MD, FAAP

Dr. Robert W. Tolan was a member of the AAP Sections on Infectious Diseases and Emergency Medicine, the New Jersey Chapter and also served on the editorial board for Prep ID and as a contributing section editor for AAP Grand Rounds.

For the AAP News article regarding Dr. Tolan's career and contributions go to:
http://aapnews.aappublications.org/content/34/9/44.3.full.pdf
Section on Infectious Diseases Award for Lifetime Contribution In Infectious Disease 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. Kathryn Edwards.

**Kathryn Edwards, MD**, is an exceptional educator and mentor of physicians and physician-scientists and is most deserving of the prestigious AAP SOID Education Award. Dr. Edwards is a graduate of the University of Iowa College of Medicine and served her Pediatric residency and infectious diseases fellowship at the Children's Memorial Hospital (now the Ann & Robert H. Lurie Children's Hospital of Chicago) in Chicago. She completed a postdoctoral fellowship in immunology at Presbyterian St. Luke's Hospital in Chicago.

Dr. Edwards is the Sarah H. Sell and Cornelius Vanderbilt Chair in Pediatrics and Director of the Vanderbilt Vaccine Research Program. She is one of our nation's leading vaccinologists. As Director of the Vanderbilt Vaccine Research Program, she has conducted and coordinated multicenter trials of vaccines for influenza, including the H1N1 vaccine, pertussis, pneumonia, and vaccinia. Her expertise is sought after by national and international health organizations. She has 332 publications and 159 invited presentations. She serves on 7 editorial boards (6 are academic journals related to infectious diseases and vaccines, plus Pediatrics), and is a reviewer for 16 journals.

In 2010, Dr. Edwards was elected a Fellow of the American Association for the Advancement of Science, an honor bestowed by her AAAS peers. She was cited for her contributions to the field of pediatric infectious diseases and vaccine science, particularly for the evaluation of vaccines against respiratory viruses and bacteria. Currently, she is a member of the American Academy of Pediatrics Committee on Infectious Diseases, Section on Infectious Diseases, the Pediatric Infectious Diseases Society, the Council of the American Pediatric Society, the Board of Scientific Counselors, NIAID, NIH; and is Secretary of the Infectious Diseases Society of America.

Dr. Edwards has maintained strong ties to teaching and patient care. She has mentored a vast number of up and coming clinicians and pediatric researchers over the years. She regards mentoring young investigators and teaching medical students about pediatric infections as among the key functions of her work. Since her arrival at Vanderbilt University School of Medicine in 1980, Dr. Edwards has had a major commitment to mentoring, particularly in the area of research, medical students, residents, fellows, and junior faculty. Dr. Edwards meets weekly with each of the individuals she mentors. She is a sought-after mentor both because of her professional accomplishments and the genuine interest and personal attention she provides for each mentee. In 2006, Dr. Edwards was awarded the IDSA Mentor Award. She has catalyzed the careers of numerous students, residents, fellows, and faculty members. Dr. Edwards has contributed to numerous educational activities both nationally and internationally, including invited speaker presentations for the AAP, ICAAC, IDSA and many other academic institutions and society conferences. Her scientific accomplishments and commitment to education and training make her a superb role model for educators and physician-scientists.

Please join us at the award presentation for Dr. Edwards to be held at the Meet the Red Book Committee session (session S3029) on October 28, 2013 at 8:00 am at the AAP National Conference and Exhibition in Orlando, Florida in the Orange County Convention Center, Valencia A room.

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**Looking for an ID Fellowship?**

New ID Training Fellows serving the SOID

We would like to introduce two new Pediatric Infectious Disease Fellows to the SOID, Dr. Annabelle de St. Maurice and Dr. Leena Bhattacharya Mithal.

Dr. Annabelle de St. Maurice is the new training fellow liaison who will serve on the SOID Executive Committee for the next two years. Annabelle was raised in Southwestern Pennsylvania; however, her family is originally from France. She received her BA degree in Biology with a French minor from Washington University in St. Louis, Missouri. She attended medical school at the University of Rochester in Rochester, New York. After medical school she completed residency at the Children's Hospital of Pittsburgh of the University of Pittsburgh Medical Center. Currently she is beginning her second year of fellowship in Pediatric Infectious Diseases at Vanderbilt University in Nashville, Tennessee, where she is supported by an NIH T32 grant.

As a graduating medical student, Annabelle was awarded the Robert Haggerty award in Pediatrics as well as the Gold Humanism in Medicine award. As a resident, Annabelle became interested in community health and served as a leader of the Community Oriented Resident Education (CORE) program. The CORE program sought to educate residents about community and public health issues as well as teach advocacy skills necessary to improve children's health. Annabelle also served as a resident liaison for the AAP and as an Assistant District Coordinator. Currently in addition to her role as liaison to the Section on Infectious Diseases within the AAP, she is also serving as a training fellow liaison to the Council on Pediatric Subspecialties.

Annabelle is currently a member of the AAP, PIDS, IDSA, and CoPS. With her advocacy background and interest in community health, she will be pursuing a Masters in Public Health as part of her fellowship to train further in the field of epidemiology. Her fellowship project will focus on understanding the epidemiology of invasive pneumococcal disease following the introduction of the 13-valent pneumococcal conjugate vaccine in Tennessee. She will be working with Dr. Natasha Halasa, who will serve as her primary mentor. Through her training she hopes to pursue an academic career in the epidemiology of infectious diseases, specifically respiratory pathogens in both healthy and immunocompromised children.

Dr. Leena Bhattacharya Mithal is our new SOID Education Subcommittee fellow member, and was selected to serve in this position for the next two years. Leena is a native of Chicago and was part of the Honors Program in Medical Education at Northwestern University in Chicago, IL. She first received her BA degree in Psychology followed by her medical degree from Northwestern University, Feinberg School of Medicine. She completed her Pediatrics residency through Baylor College of Medicine at Texas Children's Hospital in Houston, TX. She returned to Chicago and worked as a neonatal hospitalist at Prentice Women's Hospital prior to starting her Pediatric Infectious Diseases Fellowship at the Ann and Robert H. Lurie Children's Hospital of Chicago. She is currently a second year fellow and is also pursuing her Master of Science in Clinical Investigation degree through Northwestern University Clinical and Translational Sciences Institute.

As a medical student and resident during the advent of the HPV vaccine, pertussis outbreaks in infants, and the H1N1 pandemic; Leena initiated a prospective survey-based study focusing on young adult immunizations. The study examined student awareness and uptake of recommended vaccines and primary care provider immunization practices. Inspired by her experience with neonatal infections as a hospitalist, her current research focus is novel methods for diagnosis of sepsis in preterm infants. She is investigating the potential of serum biomarkers, placental histopathology and advanced computer-based clinical technologies to improve the accurate and timely detection of sepsis in preterm infants. Leena has a passion for education, both in the medical field and in the community. As Chair of the Volunteer Committee for the philanthropy One Hope United's Auxiliary Board, she organizes workshops to educate young, reforming parents on vaccination, environmental safety, and nutrition. She has also presented six research abstracts at two national meetings and has two original research publications. Leena is a member of the AAP, PIDS,

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ID Training Fellow Column  Continued from Page 4

IDSA, and SPR. She is excited to serve in the SOID Education Subcommittee.

Infectious Disease Workforce Survey – Dr. Andrea Hahn
As the senior training fellow liaison to the SOID, I will be participating in the development of the Pediatric Infectious Disease Workforce Survey, co-sponsored by the AAP SOID and the Pediatric Infectious Disease Society (PIDS). From a fellow perspective, I hope to find out more from recent pediatric ID fellowship graduates about the transition to faculty positions after they finished their fellowship. In particular, I think it would be beneficial for fellows to know how new positions were identified and if the positions available aligned with the career goals the recent graduates had developed in fellowship. If you are a training fellow and have particular concerns or questions you feel should be addressed by the Pediatric Infectious Disease Workforce Survey, I encourage you to contact me at andrea.hahn@cchmc.org.

Have you Checked Out the SOID Website Lately?
The SOID website (www.aap.org/sections/infectdis) has recently received a face-lift and has a new look and feel that is consistent with the other Academy Committee, Councils and Sections. Most importantly it offers easier access to infectious diseases education, MOC and other professional resources for members. Among the changes are:

• Information for pediatricians interested in exploring a career in pediatric infectious diseases
• Resources for fellows in training
• Information for pediatricians participating in maintenance of certification
• Links to AAP advocacy initiatives at the international, national and local levels

Thank you to Drs. Jane Carnazzo, Sabah Kalyoussef and Beth Doby for their assistance in revising the website. We would appreciate your feedback as well as suggestions regarding resources and links that you find helpful. Please contact Lilly Immergluck, MD, FAAP at: lilly.immergluck@choa.org or Suzanne Kirkwood at skirkwood@aap.org.

Welcome to our New SOID Members
Welcome to all the AAP member who have joined the Section! The list can be accessed at: http://www2.aap.org/attachments/New_SOID_Members_2.15.13_-_7.2013.docx. 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 “Your Membership Matters” 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.
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: Stephen C. Aronoff, MD FAAP, Temple University School of Medicine

This case-control study used the Kaiser Permanente (KP) database to compare the effect of pertussis vaccination using the whole cell (DTwP) or acellular (DTaP) preparation as part of the basic series in a cohort of subjects born between 1994 and 1998. Those members of the cohort who had proven *Bordetella* infection by PCR between January 2010 and December 2011 were defined as cases. Two control groups were derived from the cohort: 1) members of the cohort who tested negative for pertussis during the study period; and 2) demographically matched individuals who were members of KP during the test period.

138 subjects met the case definition; 899 patients comprised the first control group and 54,339 patients comprised the second control group. All groups were comparable for age distribution (10-17 years of age), mean age, race and sex. When the composition of the 4 dose basic series was compared among PCR-tested individuals (control group 1), positivity rates were 3.4%, 9.6% and 18.3% for those vaccinated only with DTwP, those who received a mixture of DTwP and DTaP and those who received only DTaP, respectively (for trend, p<.001). Using group 2 as a control, individuals who received a basic series of 4 DTaP or a mixture of both preparations were more likely to have a PCR + illness than those who received 4 DTwP (OR 6.27; 95% CI: 2.97-13.21 and OR 3.12; 95% CI: 1.35-7.20, respectively).

Reviewer's Commentary:

This study is one of a trilogy from KP that together provide strong evidence that DTaP is inferior to DTwP with regards to duration of protection and that waning immunity was most likely a major factor in the 2010-2011 pertussis outbreak in California. In the first paper (NEJM 2012; 367:1012-1019) the authors employed a similar case-control design in a population aged 4 to 12 years and demonstrated an inverse relationship between risk for a PCR-positive illness and time of the last DTaP vaccination (OR 1.42 per year 95% CI: 1.21 to 1.66). The second study (Clin Infect Dis 2013; 56:1248-1254) examined an expanded cohort of KP members born between 1990 and 2001. Subjects who received the 4 dose basic series and 1 booster exclusively with DTaP were 8.57 times more likely to have a PCR + illness than individuals who received at least one dose of DTwP; the relative risk was 3.57 when similar comparisons were made among individuals who received 2 boosters. It will be interesting to see if ACIP changes the recommendations for pertussis vaccination in the near future.

**Koo HL, Neill FH, Estes MK et al. Noroviruses: the most common pediatric viral enteric pathogen at a large university hospital after introduction of rotavirus vaccination. Journal of the Pediatric Infectious Diseases Society 2013; 2(1):57-60.**

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 longitudinal epidemiologic study was conducted at Texas Children's Hospital to compare norovirus and rotavirus prevalence in the time periods before and after the introduction of rotavirus vaccination to the U.S. immunization program in 2006. Stools submitted for viral enteropathogen testing from February 2002 to June 2010 were examined. Rotavirus and adenoviruses were detected by electron microscopy except during rotavirus increased frequency periods from January to April 2002-2008 when a membrane-based immunogold assay was used as the initial assay and only if negative was EM performed. This practice was continued in 2009. Remaining stools were tested for norovirus
using initially a conventional reverse transcription polymerase chain reaction then changing to a more sensitive real-time reverse transcription polymerase chain reaction in the later time periods of the study. Concordance between the two methods was reportedly high (95%). All stools from February 2002 to March 2004 were tested for norovirus. However, from 2006 to 2010 a convenience sample of 10% throughout each year was selected in a systematic way without prior clinical or laboratory information for testing. In total, stool specimens from 8173 patients were analyzed over an 8.5 year study time period. Results revealed an overall norovirus prevalence of 10.9%; ranging from 5.6% to 16.8% between years 2002-2006, and from 12.1% to 14.9% between years 2007-2010. GII noroviruses predominated, with the GII.4 genotype most commonly identified each year. The prevalence of norovirus increased for all pediatric age groups less than 60 months of age over the 2 time periods with the greatest increase in children aged 12-17 months of age. During the same two time periods, the mean annual prevalence of rotavirus positive stools was 14.6% from years 2002-2006 compared with 5.2% from years 2007-2010, representing a 64% decrease after rotavirus vaccine introduction. The greatest reduction in rotavirus activity after vaccine introduction was observed in children less than 36 months with 51.2–77.6% decreases. However, substantial reductions also were seen in older children unlikely to have received vaccine, suggesting herd immunity. Adenovirus detection was uncommon ranging from 0.9% to 2.6% in years 2002-2006 and from 1.2%- 2.0% in years 2007-2010.

Reviewer's Commentary:

Although this study was performed at only one institution, with stool viral testing done only if requested by a physician, with convenience sampling for norovirus RT-PCR testing, a change to a more sensitive molecular method for norovirus detection during the study and did not examine clinical information to assess a causal relationship between viral detection and a clinical syndrome, it did involve a large number of patients over an extended time period. This study is important for pediatricians and pediatric infectious diseases physicians because it demonstrates the increasing prevalence of norovirus in the post-rotavirus vaccine period and has uncovered the need for an effective norovirus vaccine. Subsequent to this publication, an FDA-approved RT-PCR test for norovirus is now on the market as part of Luminex’s xTAG® gastrointestinal pathogen panel. This will greatly improve the estimation of norovirus disease burden in the U.S.


Reviewed by: Alter, MD, FAAP, Associate Professor of Pediatrics, Boonshoft School of Medicine Wright State University, The Children’s Medical Center of Dayton,

The development of Guillain-Barre syndrome (GBS) following influenza vaccination has been a concern since the 1976 H1N1 swine influenza vaccine program. The relative risk of GBS following receipt of that vaccine was estimated at 7-8.1 It is believed that evidence favored a causal relation between that vaccine and GBS.2 There does not appear to be a similar link to seasonal vaccines.3 Using a large provincial health-care database, investigators from Ontario, Canada, assessed the risk of GBS after seasonal influenza vaccination (FLUV) and after patients were seen for influenza-coded health-care encounters (a proxy for seasonal influenza illness).

The health records from all Ontario residents who sought health-care from April 1993 through March 2011 were analyzed. Residents have universal access to health-care services and influenza vaccination. A self-controlled risk-interval design was used which required only cases with a history of exposure (vaccination or an influenza-coded health-care encounter) and the development of GBS within a defined period. The investigators linked hospitalizations for GBS during a 42-week period after exposure to FLUV (trivalent inactivated influenza vaccines only) or influenza illness.

The study identified 2831 admissions (no repeat admissions) for GBS during the period; 330 received FLUV and 109 had an influenza-coded healthcare encounter with 42 days before hospital admission. The risk of GBS within 6 weeks of FLUV was 52% higher than in the interval of 9-42 weeks after vaccination (relative incidence 1.52; 95% CI 1.17-1.99). The greatest risk occurred 2-4 weeks after FLUV, being highest in individuals aged 18-64 years. The risk

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of GBS within 6 weeks of influenza, however, was greater than that for vaccination (15.81; 95% CI 10.28-24.32). The attributable risks were estimated to be 1.03 GBS admissions per million vaccinations compared with 17.2 following influenza-coded health-care encounters.

**Reviewer’s Commentary:**
The small risk of GBS after FLUV is similar to that in previous studies, but this large study was powered to provide a more precise risk period following vaccination. The risk for GBS after FLUV was highest during weeks 2-4, whereas risk following an influenza-coded health-care encounter was greatest in the first week of illness and remained high for up to 4 weeks. An accompanying commentary in the issue; however, does observe that autoimmune events (such as GBS) might have substantially longer latency periods (months to years after vaccination). The six-week interval between exposure and outcome, often used as evidence of plausible causality, might not be sufficient then to fully explain the risks of FLUV and GBS. Patients should be informed of the GBS risks following both FLUV and influenza illness. They must also be advised of the considerable benefits of immunization in the prevention of morbidity and mortality.

**References:**

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**SOID Travel Grant Recipients**

One of the roles of the SOID is to promote the education of those physicians interested in infectious diseases. We are pleased to be able to offer NCE travel grants to residents or fellows in training with an interest in infectious diseases. 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 2013 AAP National Convention and Exhibition.

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<td>Leena Bhattacharya, MD</td>
<td>Ann &amp; Robert H. Lurie Children's Hospital</td>
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<td>Amelia Keaton, MD</td>
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<td>Rana Hamdy, MD</td>
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<td>Kathryn Rappaport, MD</td>
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<td>Anthonia Hananiya, MD</td>
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Highlights from the Committee on Infectious Diseases (COID) Meeting of April 16-17, 2013

**AAP statements under development**
1. Policy Statement: Raw Milk
2. Policy Statement: Tuberculosis Testing
6. Clinical Report: Judicious Use of Antibiotics (collaborative project with CDC)
8. Clinical Report: Anthrax (collaborative project with AAP Council on Disaster Preparedness and CDC)

**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. Immunization of Immunosuppressed Children (*IDSA*)
2. Kawasaki Disease and Endocarditis with Committee on Cardiovascular Disease in the Young (*AHA*)
3. Prevention & Treatment of Opportunistic Infections/HIV (*DHHS*)
4. Diagnosis and Management of Bone and Joint Infections (*IDSA/PIDS*)

The COID is considering the development of new statements regarding the following topics: vaccine hesitancy, thimerosal, adolescent vaccination, and congenital toxoplasmosis.

**Strategic Planning:**
A portion of the spring meeting was devoted to strategic planning by the Committee. Key outcomes of this session included defining the:
1. Mission: To provide optimal health of all children by diminishing the adverse health effects of infectious diseases
2. Vision: To create AAP policies that represent the most current clinical practice for the prevention and treatment of infectious diseases in children
3. The COID will be using a balanced score card (BSC) format going forward to set yearly objectives for policy development.
Dr. Broder has been named to the Board of Directors of the Infectious Diseases Society of America (IDSA) for a three-year term. She is the first pediatrician to be elected to a Board position by the IDSA membership. Congratulations to Dr. Broder for this distinction and for her dedication and service to pediatric infectious diseases.

The highlights of the Section on Infectious Diseases (SOID) Executive Committee Meeting of May 18, 2013

**PREP ID 2015**
While we have just finished the 2013 course, activities are already underway to prepare for the 2015 course. Please take a moment to answer 4 questions to assist in this planning at: [https://www.surveymonkey.com/s/P2VCD3X](https://www.surveymonkey.com/s/P2VCD3X)

**Pediatric Infectious Diseases Workforce Survey**
The Section, in collaboration with the Pediatric Infectious Diseases Society (PIDS), will be participating in an AAP Workforce Survey of Pediatric Medical Subspecialties and Surgical Specialties that was rolled out in 2012 and will continue for several years. This initiative has been developed and is managed by the AAP Division on Workforce and Medical Education Policy. The Section participated in the initial workforce survey, which occurred in 2000 and the results of the 17 AAP subspecialty section workforce surveys are available at [http://www.aap.org/fope2](http://www.aap.org/fope2). The results were groundbreaking for many subspecialties, and even today, the data generated as a result of those surveys remain some of the only existing data regarding subspecialty workforce issues.

All AAP pediatric medical subspecialty and surgical specialty sections have been invited to participate in the planned Workforce Survey. Part I of the survey will consist of a set of general questions administered to all participating sections. Part II of the survey will include specialty-specific questions. The survey work group includes:

- Chris Harrison, MD, FAAP – Work Group Chair
- Andrea Hahn, MD
- Vini Vijayan, MD, FAAP
- Sylvia Yeh, MD, FAAP

**Judicious Use of Antibiotics EQIPP**
In conjunction with the forthcoming AAP/CDC clinical report (Principles of Judicious Antibiotic Use for Pediatric Upper Respiratory Tract Infections), an application was approved and funding has been secured to develop an Education in Quality Improvement in Pediatric Practice (EQIPP) course ([http://eqipp.aap.org/](http://eqipp.aap.org/)) that will be an important education and quality improvement resource for pediatricians. In addition, EQIPP courses assist pediatricians fulfill MOC part 4 requirements. The three member work group that will serve as the subject matter experts to develop the course content under the direction of Academy Education staff are:

- Mary Anne Jackson, MD, FAAP
- Angela Myers, MD, MPH, FAAP
- Theoklis Zaoutis, MD, FAAP

Watch for more information over the next year regarding the progress of these activities.
Influenza Season is Upon Us: Information and Resources


Showing that all your office staff is immunized for influenza lets your patients know how important immunization is to you and that they can feel confident bringing their children to your office. It should encourage them to immunize their kids, too. The AAP Section on Administration and Practice Management (SOAPM) in partnership with the Childhood Immunization Support Program (CISP) developed a customizable template for the ‘Earn Your Stripe’ poster to promote immunization against influenza. Click here to make your own ‘Earn Your Stripe’ poster featuring your staff and post in patient areas. http://www2.aap.org/immunization/pediatricians/influenzaguidance.html

Are You a PIDS Member?

Mission
The mission of PIDS is to enhance the health of infants, children, and adolescents by promoting excellence in diagnosis, management and understanding of infectious diseases through clinical care, education, research and advocacy.

Who is eligible?
If you are a physician, doctoral-level scientist, pharmacist, infection control practitioner, nurse or other allied health professional who has training or is in the course of training in infectious diseases or its related disciplines, and are identified with the discipline of pediatric infectious diseases through clinical practice, research, teaching, and/or administration activities you are eligible for membership. In addition, physicians and others without formal infectious diseases training are eligible for membership if they are identified with the discipline of pediatric infectious diseases or its related disciplines through clinical practice, research, teaching, administration or any combination of these activities. Resident membership in PIDS is open to persons enrolled in pediatric residency training programs that are approved for credit toward certification by the American Board of Pediatrics, the American Osteopathic Board of Pediatrics, the Royal College of Physicians and Surgeons of Canada, or La Corporation Professionelle des Medecins du Quebec. This year, the Society added a new membership category. Medical Students who have an interest in pediatrics and/or pediatric infectious diseases or a related field can join PIDS for free.

Benefits of Membership:
Membership helps you keep abreast of the latest advances in the field through the subscription to the Journal of the Pediatric Infectious Diseases Society included with membership and by attendance at the many educational activities developed by PIDS or by PIDS and the AAP, the Pediatric Academic Societies (PAS), the Infectious Diseases Society of America (IDSA), and other groups. You can also take advantage of or participate in the PIDS advocacy activities that benefit pediatric infectious diseases as a subspecialty and pediatric infectious diseases physicians as a group.

Additional membership benefits include reduced tuition at the PREP-ID review course and online services on the PIDS website such as the job listing section and the Directory of Pediatric Infectious Diseases Training Programs. PIDS also sponsors grants for fellows and young investigators and co-sponsors the St. Jude/PIDS Pediatric Infectious Diseases Research Conference, Pediatric Antimicrobial Stewardship Conference, and workshops and sessions at the PAS and IDWeek meetings each year.

How to Join:
Please join PIDS in its mission to advance knowledge of pediatric infectious diseases. The dues are $225 for domestic and international members. Medical Students, residents and fellows can join for free! To join, download the membership application located on the Homepage of the PIDS website (www.pids.org) and fax or mail to PIDS Headquarters with your remittance. If you have any questions or concerns regarding membership, please contact the Membership Services Department at (703) 299-6764.
ID Pearls and Other Gems:
What You Should Know about Bat Rabies and Its Prevention

Submitted by Chris Harrison, MD, 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.

The most common source for clinical cases of rabies in the U.S. is bats. Summer is “bat season” in temperate parts of North America where bats tend to enter houses from May through September, particularly in the Midwest where I live. They leave buildings to hibernate as the weather gets colder. This colder weather gives people a chance to “bat-proof” their houses after the bats leave for the winter. Bats in the home also increase the chance for human-bat contact and can lead to questions about whether to administer rabies vaccine.

Giving the vaccine is relatively easy. We know about the relatively new 4 dose human diploid rabies vaccine (HDCV) or purified chick embryo cell vaccine (PCEC) schedule that replaced the original 5 dose schedule (IM in deltoid area, 1 dose on days 0, 3, 7 and 14 per 2012 Red Book, pp 604-605). We also are aware that rabies immune globulin (RIG) is usually required at a dose of 20 IU/kg. If anatomically feasible, the full dose should be infiltrated around/into the wound(s). The remainder is given intramuscular at an anatomical site distant from vaccine administration site. Also, RIG and vaccine should not be in the same syringe. Be aware that more than the recommended RIG dose might partially suppress active production of rabies virus antibody from the vaccine. [http://pediatrics.aappublications.org/content/127/4/785/T1.expansion.html](http://pediatrics.aappublications.org/content/127/4/785/T1.expansion.html). The tricky part is usually deciding not how but if to start HDCV/RIG. This decision requires digging for details in the history and knowing your local resources. Decisions can be made easier by consultation with an expert associated with the state Health Department or CDC. But the more we understand the issues, the easier it is to make sure we collect the best history and make the best recommendations about animal handling plus vaccine/RIG.

Most bats don’t have rabies. Only a few species are the predominant carriers, i.e. migratory tree-roosting hoary bats (*Lasiurus cinereus*) and silver-haired bats (*Lasionycteris noctivagans*). The CDC website estimates that ~6% of captured, obviously weak or sick bats are rabid. Further a Canadian study revealed that among those bat species that carry rabies, <1% of in-the-wild bats carry rabies. (1)

During the most recent decade with complete U.S. data (1997-2006), one or two human rabies cases occurred annually, and 17/19 naturally acquired human rabies cases were bat-associated. Of these, 3 (males ages 20, 29 and 64 years) had no known bat encounters but died of bat-associated rabies viruses, while 14 had confirmed bat encounters:

• 6 handled a bat while removing it from their home
• 4 awoke when a bat landed on them
• 1 awoke as a bat bit him
• 1 bitten while exiting from the home
• 1 bitten while releasing a bat after finding it on the floor inside a building
• 1 picked up and tried to care for a sick bat found on the ground outdoors

Note that young children may not be fully awake due to a bat knocking about their room or even from a bite. Even if they are aware of a bite, children may not think to report it. The CDC gives two examples.

1. Fatal bat-rabies occurred in a 4-year-old girl, who remained sleeping when caregivers, who themselves were awakened by strange noises, found a bat on her bedroom floor. Thereafter, tingling and itching on her neck at

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what was probably the bat bite site was reported and she became symptomatic several weeks later.

2. A 10-year-old found a bat in his bedroom and put it outside without adult supervision. Several months later he developed tingling and itching on his arm and one side of his head as his first rabies symptoms.

The phone calls that we receive are often variations on these themes. Sometimes a bat has been found somewhere in a house. Other times there are more specifics, e.g. a bat was found in the bedroom of a sleeping infant, or a child has a break in the skin that could be a bat bite coincident with a bat being in the bedroom. Alternatively, someone handled a bat with a scratch/bite that breaks through the skin.

Unless there is proof by laboratory examination that the bat is rabies-free, each of the above scenarios requires post-exposure prophylaxis (PEP). Bats’ small teeth may leave marks not easily seen. Also some people may not know if they have been bitten by a bat at all. Therefore, there are certain circumstances when a person might not be aware or able to tell if a bite has occurred.

The end result is that 20,000-30,000 persons receive PEP in the U.S. annually. Because the incubation period (1–3 months) is long, PEP by immunization is highly effective. Therefore, rabies vaccine/RIG administration is not so urgent that an immediate night time ED visits are required. Despite the 2012 Red Book suggesting PEP as soon as possible after bites of known or suspected rabid animals, the long incubation gives time to collect the necessary information and set up the PEP during regular work hours when information and resources become most available.

The 2012 Red Book indicates (Page 603) that PEP should be considered for direct human contact with a bat, unless the exposed person can be certain a bite, scratch, or mucous membrane exposure did not occur or the bat tests negative for rabies. In all instances of potential human exposures to bats, the bat should be safely collected, if possible, and submitted for rabies diagnosis.

When a bat is found indoors but there is no history of bat-human contact, the likely effectiveness of PEP must be balanced against the low risk such exposures appear to present. This means that merely finding a bat in the home does not require all household members get PEP. However PEP can be considered for persons who were in the same room as a bat and who might be unaware that a bite or direct contact had occurred (e.g., a sleeping person awakens to find a bat in the room or a bat in the room with a previously unattended child, mentally disabled person, or intoxicated person) and rabies cannot be ruled out by testing the bat.

Because it is impossible to tell if a bat is rabid simply by looking at it, rabies can only be confirmed by laboratory tests. Nevertheless, bats that are unable to fly, are active by day, are easily approached/captured or in places where bats are not usually seen (in houses or on the lawn) are more likely rabid than those flying wild outside at night. Families may need to check with the animal-rabies control office in their city, county or state to discover how to secure the bat and where to transport it for testing.

If animal control/capture services are not available in your area, instructions and even a 10 minute video on how to safely do this is available at: [http://www.batcon.org/index.php/bats-a-people/removing-a-bat.html](http://www.batcon.org/index.php/bats-a-people/removing-a-bat.html). The general principles are on the CDC website and include:

1. Obtain a small container (box or a large can) and cardboard large enough to cover the container opening. Punch small air holes in the cardboard.

2. Put on leather work gloves. When the bat lands, approach slowly and place container over it. Slide the cardboard under the container to trap the bat inside.
3. If you are certain there has been no contact between the bat and any people or pets, carefully hold the cardboard over the container and take the bat outdoors to release it away from people/pets. PS. We have been dismayed on multiple occasions when bats are released only to later find out there was an exposure – so children end up getting PEP when they might not have needed it.

4. If there is any question about contact between the bat and people/pets, save the bat for testing. Tape the cardboard to the container, securing the bat inside and then contact your health department to have the bat tested.

General Principles of Prevention:

- **Teach children “Love your own, leave other animals alone”**
  - Children should never handle unfamiliar animals, wild or domestic, even if they appear friendly.

- Wash any wound from animals thoroughly with soap and water, and seek medical advice/attention immediately.

- Have all dead, sick, or easily captured bats tested for rabies if there is any chance of exposure to people or pets occurs.

- As much as possible, prevent bats from entering living quarters or occupied homes, churches, schools, and other areas where they might contact people or pets.

Principles of Bat-proofing Houses:

- There is no reason to evict bats from sites if there is little chance for contact with people. Some bat colonies live in sites for decades and do not need to be disturbed. However, bats must not be allowed into homes. The most reliable approach is to contact an animal-control professional or a wildlife conservation agency for assistance with “bat-proofing” a home. If a family chooses to do the “bat-proofing”, CDC’s suggestions are to prevent bats from roosting in attics or buildings by covering outside entry points.

- Become a “gap detective”. Carefully look for holes around eaves or other junctures that might allow bats entry into living quarters.

- Become a “gap sealer”. Caulk openings larger than a quarter-inch by a half-inch. Place screens on all open windows, cap all chimneys, and put draft-guards beneath doors to attics. Fill electrical and plumbing holes with insulating foam, stainless steel wool or caulking. Ensure that all doors to the outside close tightly.

If bats already roost in the home, become a “bat-watcher”. At dusk, watch where bats may exit. If exiting bats are seen, they will likely re-enter at the same place. To keep them from coming back, loosely hang clear plastic sheeting or bird netting over these areas. Additional bats that may still be in the house can still crawl around the plastic/netting to leave the home. But the plastic/netting prevents their flying back in (bats almost always fly directly into the gaps and do not crawl to re-enter). After one is comfortable that all the roosting bats have exited, take down the loose plastic/netting and permanently seal the openings/gaps.

But it is not usually wise to seal a home from May through August. Young bats born in the home can't fly, so keeping the adults out will trap the young who will die and perhaps cause considerable odor. Even worse, the babies try to get out without flying and may make their way into rooms in the house. Most bats leave homes in the fall/winter to hibernate, making these seasons the best times to permanently seal the gaps.

Hopefully these data will allow easier decisions when the next call or patient comes in concerning bat exposures and whether to give rabies vaccine/RIG.

References:


Chapter Corner

Invasive *Haemophilus influenzae* type a infections emerging in Alaskan children

Rosalyn Singleton MD MPH, Alaska Native Tribal Health Consortium,
Guest researcher: Arctic Investigations Program-CDC, ris2@cdc.gov

In Alaska, before introduction of *Haemophilus influenzae* type b (Hib) vaccine, rates of invasive Hib disease among Alaska Native children, were among the highest reported worldwide. Widespread Hib immunization in the United States, starting in 1991, has led to a 99% decrease in Hib disease. However, since 2002 *H. influenzae* type a (Hia) infections have emerged in Alaska, centered in the rural Southwestern region.

State-wide surveillance has documented a total of 32 Hia cases, including 3 deaths, in children less than 5 years through the end of 2012, with a 4th death in 2013 (Figure). Forty-four percent of cases presented with meningitis and most cases (94%) occurred in Alaska Native children. The overall incidence (2002-2012) in Alaska Native < 5 year olds is 18/100,000, while the incidence in Southwestern Alaska Native <5 year olds is 74/100,000.1 In addition to Alaska, there has been an ongoing lower level of Hia activity in Navajo children <5 years of age (incidence 20/100,000/yr, 1988-2003)2 Also, Hia has emerged among northern Canadian indigenous children who are experiencing an incidence of 100/100,000/yr in children < 2 years.3

The emergence of Hia disease in Alaska and northern Canada is concerning because of its severity and the lack of a vaccine to provide protection against Hia. Alaska pediatricians are collaborating with State and CDC epidemiologists to increase our understanding of Hia disease risk factors and clinical manifestations and explore potential solutions, including a Hia vaccine. For additional information contact Stephanie Monahan, Executive Director, The All Alaska Pediatric Partnership, The AAP, Alaska Chapter, Stephanie@a2p2.com.

References:
1. Bruce M, Emerging Infectious Diseases 2013: http://wwwnc.cdc.gov/eid/article/19/6/12-1805_article.htm

Pennsylvania Immunization Education Program (PA IEP)

PA IEP offers a one-hour, on-site, interactive Immunization Update presented by a pediatrician or family medicine physician and a VFC nurse for:
- Physicians and the entire practice staff at pediatric and family medicine offices
- Professional meetings
- Grand Rounds
- Immunization coalitions
- Medical, nursing students
- Department meetings
- Other professional education

Program content:

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- Vaccine storage and handling recommendations and PA VFC requirements
  - CDC recommendations on refrigerator and freezers
  - VFC-approved thermometers to ensure correct storage and transportation
- New pediatric recommendations for influenza, pneumococcal, and meningococcal vaccines
- Human papillomavirus (HPV) vaccination – How are we doing? How can we do better?
- FAQs on vaccine safety
- Handouts, resources

The PA IEP also offers a 3-hour skills training to groups of 35 medical assistants, nurses, and others. Immunization Skills Training includes a lecture on vaccine administration, storage and handling, vaccine safety, and other basics, and then breaks into smaller groups for a hands-on training portion.

The Immunization Updates and Immunization Skills Trainings are free to sites and are approved for AMA PRA Category 1 Credit™. The AAP PA Chapter is funded by the PA Department of Health (PA DoH) Vaccines for Children (VFC) Program for EPIC®. For additional information visit the website at [http://paiep.org/](http://paiep.org/) or contact awishner@paaap.org

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**Immunizations a key focus of the AAP New Jersey Chapter**

The New Jersey Immunization Network (NJIN), jointly co-founded by the New Jersey Chapter, American Academy of Pediatrics (NJAAP) and the New Jersey Academy of Family Physicians, is a statewide public-private coalition committed to advancing immunization rates across the lifespan by providing information to health care providers, the public, and policy makers. With over 350 members representing over 140 organizations, the Network has active subcommittees whose work currently is focused on Education, School Immunization, Adult Immunization, and Interface/Technology (for the New Jersey Information System/Registry). NJIN meets 10 times per year; meetings include presentations by experts on immunization issues, reports by subcommittees, and discussion of immunization challenges facing the state.

Upcoming programs, which reflect the mission of NJIN outline above, include the following:

- NJIN will sponsor a webinar in the end of July to give providers information for the upcoming influenza season, including a review of newly available vaccines.
- A presentation is planned in September for the United Nations Foundation Shot@Life campaign.
- Immunization Action Coalition Executive Director Deborah L. Wexler, MD will give a presentation to the NJIN membership in August on the hepatitis B birth dose.

An active Government Affairs Committee of NJAAP closely follows upcoming legislation regarding immunization, advocating for children and families by providing information to legislators about immunization issues. For more information regarding the NJIN contact: Noel Harbist, MD, MPH, FAAP at 609.842.0014 or [www.aapnj.org](http://www.aapnj.org).

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**New York AAP, District II Annual Vaccine Summits**

The New York State AAP, District II, which is comprised of New York Chapters 1, 2, and 3, held their annual Vaccine Summits on June 6-8 ([http://www2.aap.org/attachments/brochure2013_Saratoga-05-07-11-30-10.pdf](http://www2.aap.org/attachments/brochure2013_Saratoga-05-07-11-30-10.pdf)) and June 27-29 ([http://www2.aap.org/attachments/brochure2013_Thayer-05-07-11-30-34.pdf](http://www2.aap.org/attachments/brochure2013_Thayer-05-07-11-30-34.pdf)) in Saratoga Springs and West Point in NY. The summits are funded by a grant from the NYS Department of Health.

Pediatric infectious disease specialists, including Dr. Joseph Domachowske, Dr. Leonard Krilov, and Dr. Paul Lee, educated pediatricians on topics such as the latest on influenza vaccine, vaccines in the pipeline, immunization...
registries, vaccine for children, storage and handling of vaccines, and their own infectious disease research in the area of vaccines. Primary care pediatricians came together with specialists to advance their knowledge of vaccinations so that they could then share this information with their own pediatric practices.

This was the ninth annual summit. Prior topics have included vaccine refusers, adolescent vaccination updates, and vaccine preventable disease outbreaks. For more information please contact Jessica Geslani at 516-326-0310 or jgeslani@aapdistrictii.com.

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Human Papillomavirus Vaccination Coverage Among Adolescent Girls

During a press release in July, the CDC and the AAP announced that HPV vaccination rates in girls aged 13-17 years failed to increase between 2011 and 2012, according to data from the Centers for Disease Control and Prevention (CDC). Three-dose coverage actually declined slightly from 2011 to 2012.

The article in CDC’s Morbidity and Mortality Weekly Report (MMWR) drew on data from the 2012 National Immunization Survey-Teen (NIS-Teen) and can be accessed at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6229a4.htm?s_cid=mm6229a4_w.

For additional information see two related AAP News articles:

2. Why HPV vaccination can't wait by Larry K. Pickering, M.D., FAAP http://aapnews.aappublications.org/content/early/2013/07/25/aapnews.20130725-2.

Additional resources for pediatricians: and families can be found at:

2. Adolescent vaccination resources and communication strategies: http://www2.aap.org/immunization/pediatricians/adolescents.html.

Additional Information for families:


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From the ACIP Meeting of February and June, 2013

The slide sets for the meetings on February 20-21, 2013 have been posted at: http://www.cdc.gov/vaccines/acip/meetings/slides-fEB-2013.html and those for the June 19-20, 2013 have been posted at: http://www.cdc.gov/vaccines/acip/meetings/slides-jun-2013.html Each set contains slides in pdf format.

The minutes of the February meeting are available at: http://www.cdc.gov/vaccines/acip/meetings/downloads/min-archive/min-feb13.pdf
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
      iii. More specific recommendations on treatment options for those patients with allergy to penicillin. http://pediatrics.aappublications.org/content/early/2013/06/19/peds.2013-1071
   c. The Diagnosis and Management of Acute Otitis Media. Pediatrics 2013;131;e964-e999.
      i. Revision of 2004 guidelines.
      ii. Management of uncomplicated acute otitis media in ages 6 months to 12 years.
      iii. New guidelines offer option of observation without antibiotic treatment in 6 months old and up if otitis media is unilateral and patient has mild symptoms.
      iv. Guidelines discuss choice of antibiotic, length of therapy and follow-up. http://pediatrics.aappublications.org/content/131/3/e964.full.html

2. MMWR
      i. Compendium of all current recommendations.
      ii. Includes recommendations for HIV infected individuals, measles post-exposure prophylaxis, prevention of Congenital Rubella Syndrome, determinations of evidence for immunity and contraindications to vaccination. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm
      i. Summarizes changes since 2005 which have previously been published with summary found in Box 1, page 2 of report.
      ii. Includes section on evaluation and management of suspected outbreaks of meningococcal disease. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm
      i. Guidelines focus on children with immunocompromising conditions such as functional or anatomic asplenia, cerebrospinal leaks, cochlear implants and HIV infections. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6225a3.htm
      i. Studies on persistence of antipertussis antibodies following a dose of Tdap show levels decrease sub-
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- substantially after 1 year.
  - ii. ACIP concluded that a single dose of Tdap at one pregnancy would be insufficient to provide protection for subsequent pregnancies.
  - iii. ACIP has concluded that experience with tetanus toxoid containing vaccines suggests no excess risk for severe adverse events for women receiving Tdap with every pregnancy.
  - iv. Pregnant women should receive a dose of Tdap during each pregnancy irrespective of patient's prior history of having rec'd Tdap. [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm)


  - i. First national recommendations.
  - ii. Reviews: Q fever recognition, clinical and laboratory diagnosis, treatment, management, and reporting for professionals.
  - iii. Addresses treatment in children, adults, pregnant women and occupational exposures. [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6203a1.htm?s_cid=rr6203a1_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6203a1.htm?s_cid=rr6203a1_w)

**3. IDSA**

  - i. Revision of 2008 guidelines.

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**A Comprehensive Review and Update of Pediatric Infectious Diseases**

The 2013 PREP: ID course was held on July 22-27, 2013. Watch for information in early 2015 regarding the next course.

**However, you can purchase the Complete Package** [http://www.dcpprovidersonline.com/aap/?event_id=AAP21](http://www.dcpprovidersonline.com/aap/?event_id=AAP21) **from this course for Only $799.00**

The Complete Course Package includes an MP3 audio file of the session plus an SAV (Synchronized Audio/Video) file in MP4 format when available. Download the lectures and slides presented at the courses to have access at your convenience. Course presentations are recorded and synced with slides so you can refer back to content anytime you want to review.

**Attention Attendees!!!**

Please contact Digital Conference Providers at 630-963-8311 to purchase this package for the attendee price of $179!

*Availability of Sessions Subject to Change*
Guidelines for the use of antiretrovirals are available at: http://aidsinfo.nih.gov/guidelines, and are updated periodically. Changes in the guidelines for adults and adolescents were to incorporate new data.


The following key changes were made to update the March 2012 version of the guidelines:

**Initiating antiretroviral therapy in treatment-naïve patients:**
- Antiretroviral therapy is recommended for all HIV-infected patients in order to decrease the risk of HIV disease progression. The strength of and evidence for this recommendations varies by the individual’s CD4 cell count (cells/mm³) prior to initiation of treatment (greatest for those with CD4 counts < 350, lesser for those with CD4 counts between 350 and 500, and lesser still for those with CD4 counts > 500).
- Use of antiretroviral therapy is recommended for HIV-infected individuals in order to prevent transmission of HIV. The strength of and evidence for this recommendation varies by transmission risks (highest for mother-to-child transmission and heterosexual transmission, weaker for other transmission risk groups).
- Patients initiating antiretroviral therapy should understand the benefits and risks of such therapy, as well as the importance of adherence to therapy. Such patients should be willing and able to commit themselves to adhere to treatment. Patients may elect to postpone initiation of therapy and clinicians may choose to defer prescribing therapy based on various factors.

**Choosing what regimen to initiate in antiretroviral-naïve patients**
- Based on clinical trial results, a rilpivirine (RPV)-based regimen is now recommended as an alternative NNRTI-based regimen only in patients with pre-treatment HIV RNA ≤ 100,000 copies/mL.
- A fixed-dose combination of elvitegravir/cobicistat/tenofovir/emtricitabine is recommended as an alternative regimen for antiretroviral-naive patients with pre-treatment creatinine clearance > 70 mL/min.
- Three-NRTI regimens are no longer recommended regimens for antiretroviral-naive patients.

**Acute and Recent (Early) HIV Infection**
- ‘Early’ HIV infection refers to both the acute phase of HIV infection and recent HIV infection.
- Patients with early infection should be offered initiation of antiretroviral therapy.

**HIV-Infected Women**
- Efavirenz can be continued in pregnant women using an efavirenz-based regimen who present for antenatal care during the first trimester if the regimen does provide virologic suppression.
- Intravenous zidovudine during labor may be omitted in those women who have viral loads under 400 copies/mL shortly before delivery. Oral combination antiretroviral therapy should be continued during the intrapartum period.

**Drug-Drug Interaction**
- New information regarding the use of ritonavir and cobicistat as pharmacokinetic enhancers was incorporated.

**Drug-Resistance Testing**
- In persons failing integrase strand transfer inhibitor-based regimens, a genotypic assay for INSTI resistance should be performed to determine whether to include a drug from this class in subsequent regimens.

**Co-Receptor Tropism Assay**
- Before initiating a CCR5 antagonist-containing regimen, a genotypic tropism assay should be used as an alternative to a phenotypic tropism assay.
ID Sessions at The AAP’s National Conference and Exhibition (NCE) October 26-29, 2013

For the descriptions of the ID sessions go to: [http://www2.aap.org/url/soid/2.htm](http://www2.aap.org/url/soid/2.htm) and for the complete NCE program go to: [http://www.aapexperience.org/2013/PreliminaryProgram.pdf](http://www.aapexperience.org/2013/PreliminaryProgram.pdf)

*Indicates sessions sponsored by the Section on Infectious Diseases

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<td>2:00 – 3:30 pm</td>
<td>S3090</td>
<td>When Should I Consider Immunodeficiency in Patients With Recurrent Infections?</td>
</tr>
<tr>
<td>*Monday</td>
<td>3:00 – 3:45 pm</td>
<td>F3101</td>
<td>Bacterial and Aseptic Meningitis in the PCV Era</td>
</tr>
<tr>
<td>*Monday</td>
<td>4:00 – 5:30 pm</td>
<td>S3129</td>
<td>Recurrent and Periodic Fevers (x2)</td>
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<tr>
<td>*Monday</td>
<td>5:00 – 5:45 pm</td>
<td>F3136</td>
<td>Management of Animal and Human Bites (x2)</td>
</tr>
<tr>
<td>*Tuesday</td>
<td>8:30 – 10:00 am</td>
<td>S4030</td>
<td>Recurrent and Periodic Fevers (x2)</td>
</tr>
<tr>
<td>Tuesday</td>
<td>8:30 – 10:00 am</td>
<td>S4029</td>
<td>Current Controversies in the Management of Children and Vescoureter With UTIal Reflux (VUR): The Changing Landscape</td>
</tr>
<tr>
<td>*Tuesday</td>
<td>12:30 – 1:30 pm</td>
<td>X4055</td>
<td>Otitis Media and Sinusitis: An Update (x2)</td>
</tr>
<tr>
<td>*Tuesday</td>
<td>12:30 – 1:30 pm</td>
<td>X4058</td>
<td>Recurrent Staphylococcus aureus Skin and Soft Tissue Infections: Treatment and Prevention</td>
</tr>
<tr>
<td>*Tuesday</td>
<td>2:00 – 3:30 pm</td>
<td>S4073</td>
<td>Antibiotic Update for the Pediatrician (x2)</td>
</tr>
</tbody>
</table>
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