

Continued from previous page

These results conflict with some previous data that suggest there is a benefit to adenoidectomy in selected children with otitis media with effusion. The practice has become more common in recent years, particularly among children who are undergoing a second tube placement. Although the Pittsburgh study didn't look specifically at children undergoing a second M&T, I think the new data suggest that, at least in children below the age of 4 years, there is no benefit. Indeed, I believe we should reevaluate the role in adenoidectomy for all children with otitis media with effusion.

Another study by the Galveston group, this one led by Dr. David P. McCormick, demonstrated that children with bilateral acute otitis media were significantly more likely to have *H. influenzae* isolated from their middle ear fluid and to have more severe inflammation of the tympanic membrane following treatment than were children with unilateral AOM. That finding, from a secondary data analysis of 566 children, supports those who suggest that the American Academy of Pediatrics AOM treatment guidelines should be modified to address the issue of laterality and who recommend that antimicrobial treatment be considered for children with both ears affected because they are more likely to fail watchful waiting.

Finally, I'd like to call attention to a report that illustrates the problems affecting our

colleagues in the developing world—even in 2007. Specifically, there remains significant morbidity associated with untreated recurrent OM in developing countries.

Dr. Olubunmi Akinpelu of Obafemi Awolowo University, Ile Ife, Nigeria, provided data from 178 children aged 6 months to 15 years with chronic suppurative OM (CSOM) seen during 2004-2006.

The average duration of otorrhea before presentation was 15 months. However, 64% had attempted some form of treatment prior to presenting for medical care, including goat nasal discharge, honey, traditional herbal preparations, and nonprescription eardrops. One-third of

patients had practiced plugging the ear discharge with a cotton bud.

Not surprisingly, Dr. Akinpelu told us, poverty and lack of access to care were strongly associated with CSOM: Two-thirds of the population lived in rural areas, and one-third reported poverty-related problems. The complications seen among these children included disabling hearing loss (7%), subperiosteal mastoid abscess (5%), intracranial suppurations (6%), meningitis (4%), and facial nerve palsy (2%).

CSOM has become less and less common in the developed world, except perhaps in native populations and among those without access to medical care. Dr.

Akinpelu's report reminds us that otitis is a potentially serious, chronic, and disabling disease that accounts for hearing loss in many children. We spend a lot of time focused on deadly illnesses in developing nations like HIV/AIDS, malaria, and tuberculosis. Yet common problems like otitis, which are nearly universal in children, are capable of causing disability as well as suffering. ■

DR. PELTON is chief of pediatric infectious disease and also is the coordinator for the Maternal-Child HIV Program at Boston Medical Center. Write to Dr. Pelton at our editorial offices at [pdnews@elsevier.com](mailto:pdnews@elsevier.com).

## Fungal Infections Dangerous After Lung Transplant

SAN FRANCISCO — Children who contract pulmonary lung infections in the year after receiving a lung transplant are 70% more likely to die than are those with no such infections, Dr. Lara A. Danziger-Isakov reported in a poster presentation at the American Transplant Congress.

This suggests that clinicians should consider prophylaxis in children judged to be at risk, concluded Dr. Danziger-Isakov, of the Cleveland Clinic, and her colleagues.

The multicenter, retrospective cohort analysis involved 555 patients at 12 centers, all of whom had data collected from the time of transplant until death, retransplantation, or 365 days after transplantation. During that time, 92 (17%) of those children contracted 99 pulmonary fungal infections, and 12 died.

The fungal infections occurred throughout the posttransplant year, with a mean of 78 days and a median of 26 days post transplant. Children with infections were significantly older than those without (15.2 years versus 12.6 years), and were significantly more likely to have pretransplant colonization. *Candida* and *Aspergillus* species were the most common organisms recovered from the infected children; 23% of the children with *Aspergillus* and the 7% of the children with *Candida* died, they said at the meeting cosponsored by the American Society of Transplant Surgeons and the American Society of Transplantation.

—Robert Finn

### Oddly enough, the way they describe their GERD may be why it's often overlooked.



- #1 prescribed acid-suppressing agent by PGEs\*<sup>2</sup>
- Only FDA-approved PPI for kids as young as 12 months<sup>3,8</sup>
- Available as capsules and strawberry-flavored PREVACID for Oral Suspension or PREVACID SoluTab



#### Important safety and other information

- The safety and effectiveness of PREVACID have been established in patients 12 months to 17 years of age for the short-term treatment of symptomatic GERD and erosive esophagitis.
- PREVACID use in this population is supported by evidence from adequate and well-controlled studies in adults along with additional clinical and PK/PD studies performed in pediatric patients. The pediatric studies were uncontrolled, open-label studies performed in 66 patients aged 1 to 11 years old and 87 patients aged 12 to 17 years old. The safety and effectiveness of PREVACID have not been established in patients <1 year of age.
- The most frequently reported adverse events in patients aged 1 to 11 years were constipation (5%) and headache (3%).

References 1. Rudolph CD, Mazur LJ, Liptak GS, et al. *J Pediatr Gastroenterol Nutr.* 2001;32(suppl 2):S1-S31. 2. Data on file, TAP Pharmaceutical Products Inc. 3. PREVACID Complete Prescribing Information. 4. Aciphex® (rabeprazole sodium) Complete Prescribing Information. 5. Nexium® (esomeprazole magnesium) Complete Prescribing Information. 6. Prilosec® (omeprazole) Complete Prescribing Information. 7. Protonix® (pantoprazole sodium) Complete Prescribing Information. 8. Zegerid™ (omeprazole) Complete Prescribing Information.

IMS Health Xponent is not a trademark of TAP Pharmaceutical Products Inc.

©2006 TAP Pharmaceutical Products Inc. 2006-030-07626 06/06

In patients aged 12 to 17 years, the most frequently reported adverse events were headache (7%), abdominal pain (5%), nausea (3%), and dizziness (3%). The adverse event profile in children and adolescents resembled that of adults taking PREVACID, where the most common adverse events were diarrhea (3.8%), abdominal pain (2.1%), and nausea (1.3%). Symptomatic response to therapy does not preclude the presence of gastric malignancy. PREVACID formulations are contraindicated in patients with known hypersensitivity to any component of the formulation.

Individual results may vary.

See adjacent page for brief summary of prescribing information.

\*Based on IMS Health Xponent® data, December 2005.

Visit [www.prevakidsHCP.com](http://www.prevakidsHCP.com) for more information.



Individual patients. Individual answers.