

# Accelerate Routine Vaccines for Young Travelers

BY JANE SALODOF MACNEIL  
Southwest Bureau

ASPEN, COLO. — Routine vaccinations can be accelerated to protect very young travelers against infectious diseases in developing countries, Sarah K. Parker, M.D., advised at a conference on pediatric infectious diseases sponsored by Children's Hospital, Denver.

"They can be really protected by about 13½ months of age," said Dr. Parker of

Children's Hospital and a faculty member in pediatric infectious diseases at the University of Colorado Health Sciences Center, Denver.

Dr. Parker also recommended that physicians do a pretravel assessment to identify additional vaccination requirements by endemic conditions in destination countries.

The assessment would include consideration of chemoprophylaxis and counseling parents on ways to prevent infec-

tious disease while traveling abroad.

"Infection only causes about 1% of traveler deaths. However, it is a large fraction of what causes illness while traveling," she said. About 50%-70% of travelers become ill. Diarrhea accounts for about 40% of illnesses. Plus, it can be more severe and prolonged in children.

Routine vaccinations can start at 6 weeks of age, she said, outlining an accelerated schedule. Babies can receive four doses of inactivated polio vaccine; three doses of

DTaP vaccine, *Haemophilus influenzae* type b vaccine, and 7-valent pneumococcal polysaccharide vaccine; and two doses of hepatitis B virus vaccine by 14 weeks.

MMR can be given at 6 months, she said, but does not count. If given at 12 months, it can be followed by a booster at 13 months. The accelerated schedule also permits hepatitis A virus vaccine off label at 12 months.

A family traveling to Africa's "meningitis belt" should use the polysaccharide conjugate vaccine for children older than 11 years, the polysaccharide meningococcal vaccine for children 2-11 years, and consider its use off label in younger children at high risk, she said.

The polysaccharide vaccine has been studied at 3 months with a 12-month booster with a rise in titers against meningococcus A, the predominant strain in Africa. Varicella zoster virus (VZV) and influenza vaccines cannot be accelerated, however.

If one is protecting against hepatitis A with hepatitis A immunoglobulin, Dr. Parker noted that hepatitis A IgG interferes with MMR and VZV. Therefore, MMR and/or VZV vaccines should be given 2 weeks earlier, she said, adding that hepatitis A vaccine and IgG can be given together.

## Rx only

### Axid® (nizatidine) Oral Solution

**BRIEF SUMMARY:** Please see package insert for full prescribing information.

**Contraindication:** Axid Oral Solution is contraindicated in patients with known hypersensitivity to the drug. Because cross-sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including nizatidine, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency (see Dosage and Administration).

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

**Drug Interactions**—No interactions have been observed between nizatidine and theophylline, chloridiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Nizatidine does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 13 times the recommended human dose based on body surface area) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of nizatidine (2,000 mg/kg/day, about 27 times the recommended human dose based on body surface area) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 5 times the recommended human dose based on body surface area), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for nizatidine.

Nizatidine was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day (about 17.5 times the recommended human dose based on body surface area) produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category B**—Oral reproduction studies in pregnant rats at doses up to 1500 mg/kg/day (about 40.5 times the recommended human dose based on body surface area) and in pregnant rabbits at doses up to 275 mg/kg/day (about 14.6 times the recommended human dose based on body surface area) have revealed no evidence of impaired fertility or harm to the fetus due to nizatidine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers**—Studies conducted in lactating women have shown that 0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Because of the growth depression in pups reared by lactating rats treated with nizatidine, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Effectiveness in pediatric patients <12 years of age has not been established. Use of nizatidine in pediatric patients from 12 to 18 years of age is supported by evidence from published pediatric literature, adequate and well-controlled published studies in adults, and by the following adequate and well-controlled studies in pediatric patients: (see DOSAGE AND ADMINISTRATION)

**Clinical Trials (Pediatric)**. In randomized studies, nizatidine was administered to pediatric patients for up to eight weeks, using age appropriate formulations. A total of 230 pediatric patients from 2 to 18 years of age were administered nizatidine at a dose of either 2.5 mg/kg b.i.d., or 5.0 mg/kg b.i.d., (patients 12 years and under) or 150 mg b.i.d. (12 to 18 years). Patients were required to have either symptomatic, clinically suspected or endoscopically diagnosed GERD with age-relevant symptoms. In patients 2 to 18 years of age, nizatidine was found generally safe and well-tolerated. In these studies in patients 12 years and older, nizatidine was found to reduce the severity and frequency of GERD symptoms, improve physical well-being, and reduce the frequency of supplemental antacid consumption. No efficacy in pediatric patients <12 years of age has been established. Clinical studies in patients 2 to 12 years of age with GERD, demonstrated no difference in either symptom improvements or healing rates between nizatidine and placebo or between different doses of nizatidine.

**Geriatric Use**—Of the 955 patients in clinical studies who were treated with nizatidine, 337 (35.3%) were 65 and older. No overall differences in safety or effectiveness were observed between these and younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (see Dosage and Administration).

**Adverse Reactions in Adults:** Worldwide, controlled clinical trials of nizatidine included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group.

**Incidence in Placebo-Controlled Clinical Trials in the United States and Canada**—Table 7 lists adverse events that occurred at a frequency of 1% or more among nizatidine-treated patients who participated in placebo-controlled trials. The cited figures provide some basis for estimating the relative contribution of drug and non-drug factors to the side-effect incidence rate in the population studied.

**Table 7.**  
Incidence of Treatment-Emergent Adverse Events in Placebo-Controlled Clinical Trials in the United States and Canada

Body System/ Adverse Event*	Percentage of Patients Reporting Event		Body System/ Adverse Event*	Percentage of Patients Reporting Event	
	Nizatidine (N=2,694)	Placebo (N=1,729)		Nizatidine (N=2,694)	Placebo (N=1,729)
<b>Body as a Whole</b>			<b>Nervous</b>		
Headache	16.6	15.6	Dizziness	4.6	3.8
Pain	4.2	3.8	Insomnia	2.7	3.4
Asthenia	3.1	2.9	Abnormal dreams	1.9	1.9
Chest pain	2.3	2.1	Somnolence	1.9	1.6
Infection	1.7	1.1	Anxiety	1.8	1.4
Injury, accident	1.2	0.9	Nervousness	1.1	0.8
<b>Digestive</b>			<b>Respiratory</b>		
Diarrhea	7.2	6.9	Rhinitis	9.8	9.6
Dry mouth	1.4	1.3	Pharyngitis	3.3	3.1
Tooth disorder	1.0	0.8	Sinusitis	2.4	2.1
<b>Musculoskeletal</b>			Cough, increased	2.0	2.0
Myalgia	1.7	1.5	<b>Skin and Appendages</b>		
			Rash	1.9	2.1
			Pruritus	1.7	1.3
			<b>Special Senses</b>		
			Amblyopia	1.0	0.9

\*Events reported by at least 1% of nizatidine-treated patients are included.

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to 3 times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of nizatidine. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of nizatidine.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered nizatidine and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients who received nizatidine and by those given placebo. Rare reports of gynecostasia occurred.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine- than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient who was treated with nizatidine and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported. Vasculitis has been reported rarely. **Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Body as a Whole**—Serum sickness-like reactions have occurred rarely in conjunction with nizatidine use.

**Genitourinary**—Reports of impotence have occurred.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

**Adverse Reactions (Pediatric):** In controlled clinical trials in pediatric patients (age 2 to 18 years), nizatidine was found to be generally safe and well tolerated. The principal adverse experiences (>5%) were pyrexia, nasopharyngitis, diarrhea, vomiting, irritability, nasal congestion and cough. Most adverse events were mild or moderate in severity. Mild elevations in serum transaminase (1-2 x ULN) were noted in some patients. One subject experienced a seizure by EEG diagnosis after taking Axid Oral Solution 2.5 mg/kg b.i.d. for 23 days. The adverse reactions reported for nizatidine may also occur with Axid Oral Solution.

**Overdosage:** Overdoses of nizatidine have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

**Signs and Symptoms**—There is little clinical experience with overdosage of nizatidine in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg, respectively.

In the two 8-week pediatric exposure trials of nizatidine in 256 pediatric patients, there were no cases of deliberate overdosage. In one study of nizatidine 10 mg/kg/day, drug compliance rates up to 7.5% above 100% compliance were not associated with clinically significant adverse events.

**Treatment**—To obtain up-to-date information about the treatment of overdosage, a good resource is your certified Regional Poison Control Center. Telephone numbers of certified Poison Control Centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

#### Dosage and Administration:

**Active Duodenal Ulcer**—The recommended oral dosage for adults is 300 mg once daily at bedtime. An alternative dosage regimen is 150 mg twice daily.

**Maintenance of Healed Duodenal Ulcer**—The recommended oral dosage for adults is 150 mg once daily at bedtime.

**Gastroesophageal Reflux Disease**—The recommended oral dosage in adults for the treatment of erosions, ulcerations, and associated heartburn is 150 mg twice daily.

**Active Benign Gastric Ulcer**—The recommended oral dosage is 300 mg given either as 150 mg twice daily or 300 mg once daily at bedtime. Prior to treatment, care should be taken to exclude the possibility of malignant gastric ulceration.

Each mL of Axid Oral Solution contains 15 mg of nizatidine. In adults, Axid Oral Solution may be substituted for any of the above indications using equivalent doses of the oral solution.

**Pediatric Dosing**—Each mL of oral solution contains 15 mg of nizatidine. Axid Oral Solution is indicated for pediatric patients 12 years of age or older. For pediatric patients 12 years of age and older, the dosage of nizatidine is 150 mg b.i.d. (2 tsp, b.i.d.)

The following dosage recommendations are provided:

**Erosive Esophagitis**—For pediatric patients 12 years or older, the dosage is 150 mg b.i.d. (300 mg/d). The maximum daily dose for nizatidine PO is 300 mg/d. The dosing duration may be up to eight weeks.

**Gastroesophageal Reflux Disease**—For pediatric patients 12 years or older, the dosage is 150 mg b.i.d. (300 mg/d). The maximum daily dose for nizatidine PO is 300 mg/d. The dosing duration may be up to eight weeks.

**Dosage Adjustment for Patients With Moderate to Severe Renal Insufficiency**—The dose for patients with renal dysfunction should be reduced as follows:

Active Duodenal Ulcer, GERD, and Benign Gastric Ulcer		
Creatinine Clearance	Dose	
20-50 mL/min	150 mg daily	
<20 mL/min	150 mg every other day	

Maintenance Therapy		
Creatinine Clearance	Dose	
20-50 mL/min	150 mg every other day	
<20 mL/min	150 mg every 3 days	

Some elderly patients may have creatinine clearances of less than 50 mL/min, and, based on pharmacokinetic data in patients with renal impairment, the dose for such patients should be reduced accordingly. The clinical effects of this dosage reduction in patients with renal failure have not been evaluated.

Based on the pharmacokinetic data in elderly patients with renal impairment, pediatric patients with creatinine clearances less than 50 mL/min should have their dose of nizatidine reduced accordingly. The clinical effects of this dose reduction in pediatric patients with renal failure have not been evaluated.

#### How Supplied:

Axid (nizatidine) Oral Solution 15 mg/mL is formulated as a clear, yellow, oral solution with bubble gum flavor, available as:

Bottles of 480 mL (16 fl. oz.) — NDC# 52268-147-62

Store at 25°C (77°F); excursions permitted to 15° - 30°C (59° - 86°F) [see USP Controlled Room Temperature] and dispense in light, light-resistant container.

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7/05

## Visits to Families Abroad Pose Risks

Foreign-born families taking young children to meet relatives in their home countries face significantly greater health risks, compared with other travelers, said Dr. Parker.

The youngsters are often very young; mothers may travel while pregnant; and, sometimes, family members are ill even before they leave on trips timed to family occasions, she said.

These families also stay longer, use less safe local transportation, and have difficulty refusing unsafe food or water in the homes of friends and relatives, Dr. Parker observed. As a result, visitors of friends and relatives are 10 times as likely to get malaria or typhoid as other travelers.

Yet, foreign-born parents often do not seek medical advice before these journeys, according to Dr. Parker. Even if they have concerns, many don't seek pretravel advice because of the expense.

Some do not believe their families have to worry about organisms in the communities where they grew up. These travelers often see themselves and their children as "already immune," which in large part is a myth, especially for their children, said Dr. Parker.

Even if they see a physician, travelers going back home are less likely to follow medical advice than are ecotourists, adventurers, missionaries, or relief workers traveling to developing countries.

Hepatitis A IgG must be repeated every 5 months while the child is in an endemic area.

Dr. Parker urged primary care physicians to consider prevalence of disease in destination nations when reviewing itineraries. Influenza should not be overlooked, she said. It is endemic year around close to the equator and from March to October in the southern hemisphere. She suggested stockpiling flu vaccine released in October for use through June 30.

Meningococcal vaccine is required for pilgrims making the hajj, according to Dr. Parker. She said it also should be considered, even if off label, for children heading to Africa's "meningitis belt" and other potential risk areas.

Causing 22 million cases a year, *Salmonella typhi* is a concern throughout the developing world, she said. She advised vaccinating anyone older than 2 years of age who is heading to an endemic area.

Two vaccines are options if typhoid is a risk, Dr. Parker said. The injectable capsular polysaccharide vaccine is approved for children over 2 years and can be given 2 weeks prior to travel. Oral live, attenuated Ty21 a virus vaccine is approved for children older than 6 years but cannot be given if the child is immunodeficient.

Yellow fever vaccine is indicated for travel to endemic areas and required by some countries unless contraindicated. It should not be given to infants younger than 4 months old and is contraindicated in infants 5-9 months of age.

Because encephalitis can be a side effect, "you don't want to give it to some-

one who doesn't need it," she advised.

Japanese encephalitis is a risk in parts of Asia. Mortality is high, however, with deaths in 5%-30% of those who develop symptoms, according to Dr. Parker.

If mosquito exposure is likely during an extended stay in an endemic area during the endemic season, she recommended vaccination with an inactivated virus. It is approved for persons over 1 year of age. Because severe allergic reactions can occur up to 10 days afterward, she said this vaccine should be given at least 2 weeks in advance of travel.

No drug can prevent malarial infection, Dr. Parker said, but some agents can pre-

vent disease. For pediatric considerations in prophylaxis, she referred physicians to a journal article (Semin. Pediatr. Infect. Dis. 2004;15:137-49).

Whether or not prophylaxis is used, families should try to prevent mosquito bites by making careful use of *N,N*-diethyl-m-toluamide (DEET), wearing permethrin-treated clothing, and covering exposed skin.

Dogs and sweets pose special risks when traveling with young children who love both.

Along with the usual dietary precautions, Dr. Parker warned that frozen desserts may not be pasteurized. Parents

should be told to seek care early if a child gets diarrhea.

Much of the world has dog rabies, Dr. Parler added, so teaching children not to pet animals is very important, albeit difficult. She recommended vaccinating children against rabies before travel to highly endemic areas, where good health care and rabies immunoglobulin are not readily available. But she warned that a vaccinated child would have to be revaccinated if bitten.

"Vaccination is not enough. It just buys time," Dr. Parker said, noting that post-exposure prophylaxis is not available in some countries. ■

## Selected Travel Health Web Sites

**CDC Traveler's Health Web Site**  
[www.cdc.gov/travel/destinat.htm](http://www.cdc.gov/travel/destinat.htm)

**CDC Yellow Book**  
<http://www.cdc.gov/travel/yb/index.htm>

**World Health Organization Vaccine Preventable Diseases Monitoring System**  
(Vaccine schedules listed by country)  
[www.who.int/immunization\\_monitoring/en/globalsummary/scheduleselect.cfm](http://www.who.int/immunization_monitoring/en/globalsummary/scheduleselect.cfm)

**WHO Global Health Atlas**  
(Communicable disease, including rabies)  
[www.who.int/globalatlas](http://www.who.int/globalatlas)

**Pan American Health Organization**  
[www.paho.org](http://www.paho.org)

**International Association for Medical Assistance to Travelers (IAMAT)**  
[www.iamat.org](http://www.iamat.org)

**U.S. State Department**  
[http://travel.state.gov/travel/travel\\_1744.html](http://travel.state.gov/travel/travel_1744.html)

Source: Dr. Parker

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