

Disrupted Ecology May Protect La. From West Nile

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

A mosquito-eradication program is underway in storm-ravaged Gulf coast states, and federal officials hope that effort, combined with the hurricane's impact on the vector cycle, will prevent a surge in West Nile virus and other mosquito-borne diseases.

The aerial spray program began in mid-September and will continue as long as is

necessary to control mosquito populations, according to the Louisiana State Department of Health.

Although the huge expanses of standing floodwaters are conducive to a mosquito population explosion, the total disruption of the region's normal ecology may discourage mosquito-borne epidemics, said Jennifer Morcone, a spokesperson for the Centers for Disease Control and Prevention.

"Historically, we have not seen increases

in these diseases after a storm like this," she said. "You need a bird population to fuel the transmission cycle and, right now, the bird population in these areas is almost nonexistent."

However, she said, the CDC has deployed entomologists to monitor mosquito populations and to assist with vector control in the affected areas.

The Louisiana Department of Health and Hospitals—in coordination with the Louisiana Department of Agriculture

and Forestry, the CDC, the Agency for Toxic Substances and Disease Registry, U.S. Environmental Protection Agency, the Department of Defense, and local mosquito control districts—is implementing a plan to reduce mosquitoes and flies in the areas affected by Hurricane Katrina.

The health and hospitals department had developed a management plan in anticipation of the hatching of mosquitoes and flies due to the massive flooding in the area. Mosquito control is needed to protect public health from the nuisances and diseases they transmit; flies will also be monitored. The plan will continue, based on field monitor of mosquitoes and flies in the region.

People face two types of increased risks for mosquito-borne diseases in the region: the rise in the number of mosquitos and increased exposure to the insects. "People are spending a lot more time outside, and

New Virus Found To Infect Lower Respiratory Tract

A newly identified parvovirus appears to cause lower respiratory tract infections in children, a team of scientists in Sweden and Singapore reported.

They detected the virus—provisionally named human bocavirus (HBoV)—through a rapid new system for large-scale molecular virus screening of clinical samples without the need for cultures and with minimal hands-on effort. Their method should make it feasible to systematically explore all viruses that affect humans, including unidentified ones, reported Tobias Allander, M.D., of Karolinska University Hospital, Stockholm, and his associates (*Proc. Natl. Acad. Sci. USA* 2005;102:12891-6).

To assess HBoV's clinical effects, the investigators screened culture-negative nasopharyngeal aspirate samples from 266 pediatric patients and 112 adults seen in clinics. Seven samples from infants and children were positive for HBoV. A subsequent retrospective study of all 540 aspirates available from the pediatric infectious diseases ward at the hospital found HBoV in 17 patients (3%), and 14 of these had no other viruses present. HBoV is the likely cause of the respiratory distress and fever in these patients, the investigators concluded.

Seven of the 14 patients underwent chest x-ray, and results showed interstitial bilateral infiltrates in 6 patients.

Approximately 250,000 infants and young children are hospitalized each year in the United States for lower respiratory tract infection, and no etiologic agent is found in 12%-39% of cases.

The virus screening system that detected HBoV employs host DNA depletion, random polymerase chain reaction amplification, large-scale sequencing, and bioinformatics.

—Sherry Boschert

Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed DAPTACEL®

By only

BRIEF SUMMARY: Please consult package insert for full prescribing information.

INDICATIONS AND USAGE: DAPTACEL® is indicated for active immunization against diphtheria, tetanus and pertussis in infants and children 6 weeks through 6 years of age (prior to seventh birthday).

Children who have had well-documented pertussis (culture positive for *B. pertussis* or epidemiologic linkage to a culture positive case) should complete the vaccination series with DT; some experts recommend including acellular pertussis vaccine as well. Although well-documented pertussis disease is likely to confer immunity, the duration of protection is unknown.¹

CONTRAINDICATIONS: This vaccine is contraindicated in children and adults seven years of age and older. Hypersensitivity to any component of the vaccine is a contraindication to further administration.²

The following events after receipt of DAPTACEL® are contraindications to further administration of any pertussis-containing vaccine:²

- An immediate anaphylactic reaction. Because of uncertainty as to which component of the vaccine may be responsible, no further vaccination with diphtheria, tetanus or pertussis components should be carried out. Alternatively, such individuals may be referred to an allergist for evaluation if further immunizations are to be considered.
- Encephalopathy not attributable to another identifiable cause (e.g., an acute, severe central nervous system disorder occurring within 7 days after vaccination and consisting of major alterations in consciousness, unresponsiveness or generalized or focal seizures that persist more than a few hours, without recovery within 24 hours). In such cases, DT vaccine should be administered for the remaining doses in the vaccination schedule.

The decision to administer or delay vaccination because of a current or recent febrile illness depends on the severity of symptoms and on the etiology of the disease. According to the ACIP, all vaccines can be administered to persons with mild illness such as diarrhea, mild upper-respiratory infection with or without low-grade fever, or other low-grade febrile illness.^{1,2} However, children with moderate or serious illness should not be immunized until recovered.⁴

Elective immunization procedures should be deferred during an outbreak of poliomyelitis because of the risk of provoking paralysis.^{5,6,7}

WARNINGS: The stopper to the vial of this product contains dry natural latex rubber that may cause allergic reactions.

If any of the following events occur within the specified period after administration of a whole-cell pertussis DTP or DTPa vaccine, providers and parents should evaluate the risks and benefits of subsequent doses of whole-cell pertussis DTP or DTPa vaccines:²

- Temperature of ≥40.5°C (105°F) within 48 hours, not attributable to another identifiable cause.
- Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours.
- Persistent crying lasting ≥3 hours within 48 hours.
- Convulsions with or without fever within 3 days.

When a decision is made to withhold pertussis vaccine, immunization with DT vaccine should be continued.⁴

Because of the risk of hemorrhage, DAPTACEL® should not be given to children with any coagulation disorder, including thrombocytopenia, which would contraindicate intramuscular injection unless the potential benefit clearly outweighs the risk of administration.

Studies suggest that, when given whole-cell pertussis DTP vaccine, infants and children with a history of convulsions in first-degree family members have a 2.4-fold increased risk for neurologic events.⁸ However, ACIP has concluded that a history of convulsions or other central nervous system disorders in parents or siblings is not a contraindication to pertussis vaccination and that children with such family histories should receive DTPa vaccines according to the recommended schedule.^{1,3,4}

For infants or children at higher risk for seizures than the general population, an appropriate antiepileptic may be administered (in the dosage recommended in its prescribing information) at the time of vaccination with a vaccine containing an acellular pertussis component (including DAPTACEL®) and/or the following 24 hours, to reduce the possibility of post-vaccination fever.^{2,9}

Whether to administer DAPTACEL® to children with proven or suspected underlying neurologic disorders must be decided on an individual basis. An important consideration includes the current local incidence of pertussis. The ACIP has issued guidelines for such children.¹⁰

PRECAUTIONS: General: Care is to be taken by the health-care provider for the safe and effective use of this vaccine.

Epinephrine Hydrochloride Solution (1:1,000), other appropriate agents and equipment must be available for immediate use in case an anaphylactic or acute hypersensitivity reaction occurs. Health-care providers must be familiar with current recommendations for the initial management of anaphylaxis in non-hospital settings, including proper airway management.¹¹

Before an injection of any vaccine, all known precautions should be taken to prevent adverse reactions. The expected immune response to DAPTACEL® may not be obtained in immunosuppressed persons.⁴ Pertussis-containing vaccines are not contraindicated in persons with HIV infection.¹²

IT IS EXTREMELY IMPORTANT WHEN A CHILD RETURNS FOR THE NEXT DOSE IN THE SERIES THAT THE PARENT OR GUARDIAN SHOULD BE QUESTIONED CONCERNING ANY SYMPTOMS AND/OR SIGNS OF AN ADVERSE REACTION AFTER THE PREVIOUS DOSE OF VACCINE. (See CONTRAINDICATIONS AND ADVERSE REACTIONS.)

Drug Interactions: As with other intramuscular (I.M.) injections, use with caution in patients on anticoagulant therapy.

Immunosuppressive therapies, including irradiation, antimetabolites, alkylating agents, cytotoxic drugs and corticosteroids (used in greater than physiologic doses), may reduce the immune response to vaccines. Although no specific studies with pertussis vaccine are available, if immunosuppressive therapy is to be soon discontinued, it seems reasonable to defer immunization until the patient has been off therapy for one month; otherwise, the patient should be vaccinated while still on therapy.⁴

If DAPTACEL® is administered to persons with an immunodeficiency disorder, or immunosuppressive therapy or after a recent injection of immune globulin, an adequate immunologic response may not occur.

For information regarding simultaneous administration with other vaccines refer to DOSAGE AND ADMINISTRATION. If passive immunization is needed for tetanus or diphtheria prophylaxis, Tetanus Immune Globulin (Human) (TIG), or Diphtheria Antitoxin, if needed, should be given in a separate site, with a separate needle and syringe.³

Carcinogenesis, Mutagenesis, Impairment of Fertility: DAPTACEL® has not been evaluated for its carcinogenic or mutagenic potential or impairment of fertility.

Pregnancy Category C: Animal reproduction studies have not been conducted with DAPTACEL®. It is not known whether DAPTACEL® can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. DAPTACEL® is NOT recommended for use in a pregnant woman.

Geriatric Use: This product is NOT recommended for use in adult populations.

Pediatric Use: SAFETY AND EFFECTIVENESS OF DAPTACEL® IN INFANTS BELOW 6 WEEKS OF AGE HAVE NOT BEEN ESTABLISHED. (See DOSAGE AND ADMINISTRATION.)

THIS VACCINE IS NOT RECOMMENDED FOR PERSONS 7 YEARS OF AGE OR OLDER. Tetanus and Diphtheria Toxoids Adsorbed For Adult Use (Td) is to be used in individuals 7 years of age or older.

ADVERSE REACTIONS: Over 11,400 doses of DAPTACEL® have been administered to infants and toddlers in 6 clinical studies. In all, 3,994 children received a total of 3 doses and 476 children received 4 doses of DAPTACEL®.^{12,13,14,15,16,17,18}

In the Sweden I Efficacy Trial, information on systemic and local reactions were recorded on a standard diary card kept for 14 days after each dose, and follow-up telephone calls were made 1 and 14 days after each injection. Telephone calls were made monthly to monitor the occurrence of severe events and/or hospitalizations for the 2 months after the last injection. As shown in Table 1, the 2,587 infants who enrolled to receive DAPTACEL® at 2, 4 and 6 months of age had similar rates of reactions within 24 hours as recipients of DT and significantly lower rates than infants receiving whole-cell pertussis DTP.¹²

EVENT	Dose 1 (2 MONTHS)			Dose 2 (4 MONTHS)			Dose 3 (6 MONTHS)		
	DAPTACEL® N = 2,587	DT N = 2,574	DTP N = 2,102	DAPTACEL® N = 2,563	DT N = 2,555	DTP N = 2,040	DAPTACEL® N = 2,549	DT N = 2,538	DTP N = 2,001
Local									
Tenderness (Any)	8.0*	8.4	59.5	10.1*	10.3	60.2	10.8*	10.0	50.0
Redness ≥2 cm	0.3*	0.3	6.0	1.0*	0.8	5.1	3.7*	2.4	6.4
Swelling ≥2 cm	0.9*	0.7	10.6	1.6*	2.0	10.0	6.3*	3.9	10.5
Systemic									
Fever† ≥38°C (100.4°F)	7.8*	7.6	72.3	19.1*	18.4	74.3	23.6*	22.1	65.1
Fretfulness‡	32.3	33.0	82.1	39.6	39.8	85.4	35.9	37.7	73.0
Anorexia	11.2*	10.3	39.2	9.1*	8.1	25.6	8.4*	7.7	17.5
Drowsiness	32.7*	32.0	56.9	25.9*	25.6	50.6	18.9*	20.6	37.6
Crying ≥1 hour	1.7*	1.6	11.8	2.5*	2.7	9.3	1.2*	1.0	3.3
Vomiting	6.9*	6.3	5.2*	5.8	5.8	7.4	4.3	5.2	3.5

N = Number of evaluable subjects *p<0.001; DAPTACEL® versus whole-cell pertussis DTP †p<0.003; DAPTACEL® versus whole-cell pertussis DTP ‡p<0.0001; DAPTACEL® versus DT † Rectal temperature †† Statistical comparisons were not made for this variable DT: Swedish National Biologics Laboratories DTP: Aventis Pasteur Inc. In patients who received DAPTACEL®, the incidence (rates per 1,000 doses) of rectal temperature ≥40°C (104°F) within 48 hours of vaccination was 0.39 following dose 1 and 2 and 0.39 following dose 1 and 2 and 0.39 following dose 1 and 2, respectively.

One case of whole limb swelling and generalized symptoms, with resolution within 24 hours, was observed following dose 2 of DAPTACEL®. No episodes of anaphylaxis or encephalopathy were observed. No seizures were reported within 3 days of vaccination with DAPTACEL®. Over the entire study period, 6 seizures were reported in the DAPTACEL® group, 9 in the DT group and 3 in the whole-cell pertussis DTP group, for overall rates of 2.3, 3.5 and 1.4 per 1,000 vaccinees, respectively. One case of infantile spasms was reported in the DAPTACEL® group. There were no instances of invasive bacterial infection or death.^{12,13}

Rates of serious adverse events that are less common than those reported in the Sweden I Efficacy Trial are not known at this time.

Table 2 summarizes the safety results from the Phase II Study in Canada in children who were immunized at 2, 4, 6 and 17-18 months of age with DAPTACEL®. Local and systemic adverse events were consistently less common in DAPTACEL® recipients at 2, 4 and 6 months of age than in those who received whole-cell pertussis DTP vaccine. Following the fourth dose, the same trends were observed, except for rates of severe redness and swelling which did not differ between the 2 vaccine groups. Rates of local reactions of redness and swelling were increased following the fourth dose compared with the first 3 doses as was mild tenderness but there was no increase in severe tenderness.

TABLE 2
PERCENTAGE OF CHILDREN FROM PHASE II STUDY IN CANADA WITH LOCAL OR SYSTEMIC REACTIONS WITHIN 72 HOURS OF VACCINATION WITH DAPTACEL® AND WHOLE-CELL PERTUSSIS DTP VACCINE AT 2, 4, 6 AND 17-18 MONTHS OF AGE

EVENT	Dose 1 (2 MONTHS)		Dose 2 (4 MONTHS)		Dose 3 (6 MONTHS)		Dose 4 (17 MONTHS)	
	DAPTACEL® N = 324	DTP* N = 108	DAPTACEL® N = 321	DTP* N = 106	DAPTACEL® N = 320	DTP* N = 104	DAPTACEL® N = 301	DTP* N = 97
Local								
Redness								
Any	12.7*	44.4	20.6*	57.5	22.2*	51.9	36.5*	55.7
≥10 mm	1.2*	13.9	7.8*	22.6	10.0*	17.3	27.9	36.1
≥35 mm	0.3*	3.7	0.3*	5.7	1.6	1.9	21.9	20.6
Swelling								
Any	4.3*	23.1	4.3*	32.1	4.7*	25.0	18.6*	28.9
≥10 mm	1.9*	15.7	2.2*	21.7	3.8*	14.4	15.9*	25.8
≥35 mm	0.3*	6.5	0*	5.7	0.9*	4.8	11.3	15.5
Tenderness†								
Any	10.2*	37.0	7.5*	51.9	8.8*	48.1	23.9*	86.6
Moderate + Severe	0.9*	13.0	1.2*	20.8	1.3*	17.3	3.0*	53.6
Severe	0*	4.6	0.3*	7.5	0*	4.8	0.3*	12.4
Systemic								
Fever‡								
Any	12.0*	43.7	7.7*	50.0	14.8*	53.2	14.5*	67.9
≥38°C (100.4°F)	0.7	1.9	0*	7.8	1.2*	11.7	1.9*	17.9
≥40°C (104°F)	0.3	0	0	1.0	0	1.1	0	0
Irritability‡								
Any	41.0*	65.7	41.4*	68.9	40.9*	67.3	36.9*	79.4
Moderate + Severe	9.0*	18.5	6.9*	22.6	5.0*	22.1	5.0*	24.7
Severe	0	1.9	0.3	0	0	1.0	0	2.1
Anorexia‡								
Any	16.0	22.2	9.0*	16.0	11.6*	23.1	17.6*	41.2
Moderate + Severe	1.5	3.7	0.9	2.8	1.3	1.9	2.0*	13.4
Severe	0	0	0.3	0	0	0	0	2.1
Drowsiness‡								
Any	43.2	52.8	21.8*	33.0	14.4*	32.7	13.3*	29.9
Moderate + Severe	7.7	8.3	2.8*	7.5	1.3	0	1.0*	6.2
Severe	0.3	0	0	0	0	0	0	0
Crying ≥3 Hours	0.6	0.9	0.3	0.9	0	1.0	0	1.0

N = Number of evaluable subjects # DTP: whole-cell pertussis DTP vaccine (Aventis Pasteur Limited) * Significantly less redness than whole-cell vaccine, p < 0.05 † Moderate = sustained cry with gentle pressure at injection site ‡ Severe = cries when leg is moved † Temperature measurements were axillary § Number of evaluable subjects for DAPTACEL®/DTP = 301/102, 298/102, 257/94 and 207/78 at 2, 4, 6 and 18 months, respectively ¶ Moderate = more difficulty with setting, even with cuddling; Severe = persistent crying/ screaming and inability to console † Moderate = missed one or two feeds; Severe = little or no intake for more than two feeds † Moderate = sleeping much more than normal; Severe = sleeping most of the time with difficulty arousing The US Bridging Study was designed, in part, to assess the safety of DAPTACEL® in infants at 2, 4 and 6 months of age, with routinely recommended, concurrently given childhood vaccines (Haemophilus influenzae type b vaccine, OPV and hepatitis B). The incidence of redness, swelling, pain or tenderness at the injection site after each dose was 12.5% - 19.7%, 14.3% - 17.8% and 15.9% - 30.5%, respectively. Fever ≥38°C (100.4°F) was observed in 9.9% - 11.9% of subjects. One afebrile seizure occurred within 24 hours post dose 2 immunization (n = 321).¹³

Additional adverse reactions evaluated in conjunction with pertussis, diphtheria and tetanus vaccination are as follows:

- As with other aluminum-containing vaccines, a nodule may be palpable at the injection sites for several weeks. Sterile abscess formation at the site of injection has been reported.^{4,19}
- Rarely, anaphylactic reactions (i.e., hives, swelling of the mouth, difficulty breathing, hypotension or shock) have been reported after receiving preparations containing diphtheria, tetanus and/or pertussis antigens.⁴

Arthus-type hypersensitivity reactions, characterized by severe local reactions (generally starting 2-8 hours after an injection), may follow receipt of tetanus toxoid. A few cases of periorbital neuropathy have been reported following tetanus toxoid administration, although the evidence is inadequate to accept or reject a causal relation.²⁰

A review by the Institute of Medicine (IOM) found a causal relation between tetanus toxoid and brachial neuritis and Guillain-Barré syndrome.²¹ The following illnesses have been reported as temporally associated with some vaccines containing tetanus toxoid: neurological complications^{22,23} including cochlear lesion, brachial plexus neuropathies,²⁴ paralysis of the radial nerve,²⁵ paralysis of the recurrent laryngeal nerve, accommodation paresis and EEG disturbances with encephalopathy (with or without permanent intellectual or motor function impairment).^{26,27} In the differential diagnosis of polyradiculoneuropathies following administration of a vaccine containing tetanus toxoid, tetanus toxoid should be considered as a possible etiology.²⁸

DOSAGE AND ADMINISTRATION: JUST BEFORE USE, SHAKE THE VIAL WELL, until a uniform, cloudy suspension results. WITHDRAW AND INJECT A 0.5 mL DOSE. Administer the vaccine intramuscularly (I.M.). In children younger than 1 year (i.e., infants), the anterolateral aspect of the thigh provides the largest muscle and is the preferred site of injection. In older children, the deltoid muscle is usually large enough for I.M. injection. The vaccine should not be injected into the gluteal area or areas where there may be a major nerve.

Do NOT administer this product intravenously or subcutaneously.

Immunization Series: A 0.5 mL dose of DAPTACEL® is approved for administration as a 4 dose series at 2, 4 and 6 months of age, at intervals of 6-8 weeks; and at 17-20 months of age. The customary age for the first dose is 2 months of age, but it may be given as early as 6 weeks of age and up to the seventh birthday. The interval between the third and fourth dose should be at least 6 months. It is recommended that DAPTACEL® be given for all doses in the series because no data on the interchangeability of DAPTACEL® with other DTPa vaccines exist. At this time, data are insufficient to establish the frequency of adverse events following a fifth dose of DAPTACEL®.

Persons 7 years of age and older who have previously received 4 doses of DAPTACEL® or DTPa vaccine may be used to complete immunizations series in infants who have received 1 or more doses of whole-cell pertussis DTP. However, the safety and efficacy of DAPTACEL® in such infants have not been fully demonstrated.²

PERSONS 7 YEARS OF AGE AND OLDER SHOULD NOT BE IMMUNIZED WITH DAPTACEL® OR ANY OTHER PERTUSSIS-CONTAINING VACCINES. DAPTACEL® should not be combined through reconstitution or mixed with any other vaccine. If any recommended dose of pertussis vaccine cannot be given, DT (For Pediatric Use) should be given as needed to complete the series. Pre-term infants should be vaccinated according to their chronological age from birth.¹

Interruption of the recommended schedule with a delay between doses should not interfere with the final immunity achieved with DAPTACEL®. There is no need to start the series over again, regardless of the time between doses.

STORAGE: DAPTACEL® should be stored at 2° to 8°C (35° to 46°F). DO NOT FREEZE. Product which has been exposed to freezing should not be used. Do not use after expiration date.

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even when inside, they may have broken windows and screens that let mosquitoes into the house," Ms. Morcone said.

It's too soon to predict what impact Hurricane Katrina will have on West Nile virus in the Gulf region, she added. "What we do know is that the virus did exist in every one of these states before the storm and that it is still there. We want people to take precautions against exposure, and we will facilitate that as much as possible."

As of early September, 821 cases of West Nile virus—of which 18 cases were fatal—had been reported in the United States, marking this as the slowest West

Nile season since 2002.

By early September 2002, 737 cases had been reported, with 35 fatalities. Numbers soared in 2003 to almost 1,900, with 37 fatalities, and stayed high last year, with 1,191 cases and 30 fatalities.

As in previous years, the highest number of cases (268) occurred in California. Of those, 7 have been fatal; 93 showed neurologic complications (West Nile meningitis, encephalitis, or myelitis). Other hard-hit states include South Dakota (138 cases; 1 fatality; 25 neuroinvasive illnesses); Illinois (89 cases; 1 fatality; 52 neuroinvasive); and Louisiana (52 cases; 4 fatalities; 40 neuroinvasive). Texas has re-

ported only 27 cases, but almost all of them (24) were neuroinvasive; there was 1 fatality.

The reason for the decline this year is unclear, Ms. Morcone said. "If there's one thing we know about West Nile, it's that there's no such thing as a typical season. We have seen areas with large epidemics 1 year and very small case counts the next. Weather and ecology are among the factors that play a part in West Nile prevalence."

Even though the cases are relatively low, physicians should still stress prevention to their patients. Repellents with DEET(N, N-diethyl-m-toluamide) are

most effective for those who are outdoors for extended periods. Repellents with oil of lemon eucalyptus and picaridin are probably sufficient for "backyard exposure," she said.

West Nile virus has also been identified in blood from 163 blood donors, according to the CDC. Most of the donors (49) were from California. Other states with high numbers were Texas (32), Nebraska (22), South Dakota (14), and Louisiana (10).

Of these donors, 3 subsequently developed West Nile neuroinvasive illness, 38 developed West Nile fever, and 3 developed other illnesses. ■

Use Prednisolone When IVIG Fails In Kawasaki

A 3-day course of prednisolone appears effective in Kawasaki disease patients who are unresponsive to multiple infusions of intravenous immunoglobulin, Seiichiro Takeshita, M.D., and colleagues reported.

Their success in treating nonresponders with prednisolone infusion suggests that IVIG-resistant patients with Kawasaki disease may not require steroid pulse therapy, which has been associated with an increased risk of coronary aneurysm rupture, hypertension, seizures, and gastric erosion in this group (Clin. Pediatr. 2005;44:423-6).

Dr. Takeshita of the University of Shizuoka, Japan, and his colleagues administered 3-day courses of prednisolone every 8 hours (1-2 mg/kg per day) to six children, aged from 10 months to 9 years, who did not respond to repeated courses of IVIG for Kawasaki disease. Five of the children also received ulinastatin, a serine protease inhibitor not currently available in the United States.

Three patients had complications of the disease, including arthritis, myocarditis, and depressed left ventricular systolic function. All patients had dilated coronary arteries before prednisolone was administered.

Five of the children became afebrile and had a significant decrease in C-reactive protein (CRP) levels within 24 hours of their first course of prednisolone.

The sixth patient had a persistent low-grade fever and high-CRP level after the first course, and developed a high-grade fever and high-CRP level 3 days after the first course ended. He then received a second, 3-day course of prednisolone (1.5 mg/kg per day). Within 24 hours, he became afebrile and had a significant drop in CRP level. No patient experienced an adverse event related to the prednisolone. No patient experienced further progression of coronary artery dilation; all dilated arteries returned to normal diameters during the follow-up period that ranged from 16 months to 6 years.

—Michele G. Sullivan

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