

decongestants on their primary outcome measure, which was persistent AOM at 2 weeks.

There was at least one significant difference, however—patients taking antihistamines and/or decongestants experienced significantly more side effects than did patients taking placebo.

“I conclude that for decongestants and antihistamines in acute otitis media [there is] no benefit for early cure rate, no benefit for symptom reduction, no benefit for prevention of complications, and increased risk for side effects,” Dr. Chonmaitree said at the meeting, which was sponsored by the American Pediatric So-

ciety, Society for Pediatric Research, Ambulatory Pediatric Association, and American Academy of Pediatrics.

Corticosteroids have similar evidence of inefficacy, and the bottom line is that the symptomatic treatment of AOM should include only an analgesic/antipyretic, she said.

Regarding the use of steroids, decongestants, or antihistamines in AOM, Dr. Richard M. Rosenfeld of Long Island College Hospital, New York, said in an interview that he largely agrees with Dr. Chonmaitree. “I would say the evidence [for their use] is quite weak. Occasionally you’ll find a little statistically significant

benefit pop out on one of the outcomes. . . but looked at as a whole the benefits are quite small if not trivial or absent. And when you then factor in the issue of potential side effects, it’s a real tough case to recommend adding these adjuvant therapies. . . In the child who’s a frequent flyer and manages every couple of weeks to get a new episode of acute otitis, I think that it becomes even more ludicrous to repeatedly expose them to therapies of questionable benefit but significant adverse effects.” Dr. Rosenfeld is cochair of the American Academy of Pediatrics Subcommittee on Otitis Media With Effusion. ■

## International Vaccine Records Usually Valid

BY ROBERT FINN  
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SAN FRANCISCO — Records for most vaccines from most countries of origin for children adopted internationally are trustworthy, Dr. Bindy Crouch said in a poster presentation at the annual meeting of the Pediatric Academic Societies.

For this reason, Dr. Crouch of the State University of New York at Stony Brook and her colleagues recommend that antibody titers should be tested before revaccinating adopted children who have documentation of vaccines that were given in their countries of origin.

The study involved a retrospective chart review of 219 internationally adopted children seen between January 2003 and December 2004.

Of those children, 72 came from China, 87 from Russia, 28 from Korea, 19 from Guatemala, 4 from Ethiopia, 2 each from Belarus, Colombia, and the Philippines, and 1 each from India, Kazakhstan, and Romania.

At the time of adoption, 73% were under the age of 2 years.

With the exception of hepatitis B among children adopted from Korea and mumps among all children, the percentages of positive antibody titers were similar to rates that have been reported in U.S. vaccine studies.

For example, of the children with records of DTP vaccine, 99% were titer positive for diphtheria antibody and 88% were titer positive for tetanus. Children with records of polio vaccine were 95% titer positive, those with records of measles vaccine were 92% titer positive, and those with reported rubella vaccine were 92% titer positive.

On the other hand, of children adopted from Asian countries other than China (28 of 31 of these children came from Korea), only 63% of those who had records of hepatitis B vaccine were titer positive. This was a significantly lower percentage of positive titers than that seen in children from all other areas.

The investigators suggested that the lower percentage of positive hepatitis B titers in children from Korea may be due to the manufacturing, storage, or administration of vaccine, but it is also plausible that Korean children have poorer responses to the vaccine.

Only 67% of all the adopted children with records of mumps vaccine had positive titers, which the investigators said was significantly lower than the percentage reported in U.S. vaccine studies. Investigators said that this may be attributable to issues with vaccine handling and storage, inaccurate record keeping, or an impaired immune response to the mumps vaccines used.

The meeting was sponsored by the American Pediatric Society, Society for Pediatric Research, Ambulatory Pediatric Association, and American Academy of Pediatrics. ■

## ...AND STILL PREVALENT

### CHILDREN 2 TO 17 YEARS OLD ARE OFTEN CONTACTS OF HIGH-RISK PERSONS, YET ARE RARELY IMMUNIZED

The CDC/ACIP recommend influenza vaccination for children who are household contacts of high-risk individuals.<sup>2</sup> Nearly 1 in 3 children aged 2 to 17 years is a household contact of a high-risk person (29.3% according to a CDC estimate).<sup>6</sup> Yet in a recent study, the vaccination rate for this group was only 12.3%—even lower than the rate for *non*-targeted persons <50 years (see chart).<sup>6</sup> Since children play a major role in influenza transmission, this statistic is especially alarming.

### ACIP HAS EXPANDED ITS RECOMMENDATIONS FOR THE 2006-2007 INFLUENZA SEASON

#### Children Aged 2 to 5 Years and Their Close Contacts<sup>8</sup>

During its February meeting, the ACIP expanded the original recommendation for vaccinating children aged 6 to 23 months to include children aged 24 to 59 months. The ACIP also recommends expanding routine influenza vaccination for household contacts and out-of-home caregivers of children aged 24 to 59 months. Approximately 5.3 million more children and 11.4 million more healthy close contacts will be included in the new recommendations.

### THE CHALLENGE—AND OPPORTUNITY—AT HAND

There is a pressing need for increasing vaccination rates among children in the ACIP-recommended priority groups: children aged 6-59 months, and children who are household contacts of these and other high-risk individuals. The newly expanded recommendations may present further challenges to immunization efforts, particularly among the 24- to 59-month age group and their household contacts. Moreover, studies have shown that increasing vaccination rates among all children aged 2-17 years can decrease influenza morbidity and mortality in the general population.<sup>5</sup>

### WHAT YOU CAN DO TO HELP: INITIATE THE VACCINATION CONVERSATION

Immunization outcomes are strongly influenced by physicians’ recommendations.<sup>9</sup> This holds true for both healthy and high-risk children. Immunization outcomes showed that 70% of children were vaccinated if the parents recalled a physician’s recommendation versus only 3% if they did not. Physicians must therefore play a proactive role in 1) identifying children who are recommended by the ACIP for influenza vaccination and 2) educating parents about the importance of immunization. Such grassroots efforts, combined with comprehensive vaccination strategies, will better help protect children, their families, and the entire community against influenza.

**References:** 1. Bhat N, Wright J, Broder K, et al. Influenza-associated deaths among children in the United States, 2003-2004. *N Engl J Med*. 2005;353(24):2559-2567. 2. Centers for Disease Control and Prevention. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 2005;54(RR-08):1-40. 3. Monto AS, Sullivan KM. Acute respiratory illness in the community. Frequency of illness and the agents involved. *Epidemiol Infect*. 1993;110:145-160. 4. Elveback LR, Fox JP, Ackerman E, et al. An influenza simulation model for immunization studies. *Am J Epidemiol*. 1978;103:152-165. 5. Reichert TA, Sugaya N, Fedson DS, Glezen WP, Simonsen L, Tashiro M. The Japanese experience with vaccinating schoolchildren against influenza. *N Engl J Med*. 2001;344:889-896. 6. Centers for Disease Control and Prevention. Interim estimates of populations targeted for influenza vaccination from 2003 National Health Interview Survey Data and Health Estimates for 2004 based on influenza vaccine shortage priority groups. Available at: <http://www.cdc.gov/flu/professionals/vaccination/pdf/targetpopchart.pdf>. Accessed June 16, 2006. 7. Centers for Disease Control and Prevention. Estimated influenza vaccination coverage among adults and children—United States, September 1, 2004–January 31, 2005. *MMWR*. 2005;54(12):304-307. 8. Centers for Disease Control and Prevention. CDC’s advisory committee recommends expanded influenza vaccinations for children (press release). Available at: <http://www.cdc.gov/oc/media/pressrel/r060223.htm>. Accessed June 16, 2006. 9. Poehling KA, Speroff T, Dittus RS, et al. Predictors of influenza virus vaccination status in hospitalized children. *Pediatrics*. 2001;108:E99.