

Teens Tap Doctors, Parents, Net for Health Info

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WASHINGTON — Teen vaccine educational material must be quick, accurate, understandable, and relevant, said Dr. Sharon Humiston at a meeting of the National Vaccine Advisory Committee.

The bottom line is that no single information source will hit everyone in a target audience, and some sources will hit unexpected targets, said Dr. Humiston, a pediatrician at the University of Rochester (N.Y.).

Dr. Humiston presented data to NVAC on behalf of the subcommittee on Communications and Public Engagement, and she cited results from a survey of 150 adolescents conducted by Parents of Kids with Infectious Diseases, a national non-profit group. The goal of the survey was

to determine where and how teens get their health information, and the data can be used to develop educational strategies for adolescent vaccination.

Surprisingly, some adolescents surveyed said that they actually read the one-page vaccine information statements available in many physicians' offices. "Most parents don't look at those information sheets," Dr. Humiston noted. The survey results included responses from 150 adolescents, 53% of whom were male.

Half of the adolescents said that they had talked with parents about immunizations within the past year and that parents had initiated the conversation in 70% of the cases. In addition, 70 of 150 (47%) reported having talked with a health professional about immunizations.

Although 91% of the respondents said that they had ever been immunized, only 16% believed that they knew all their necessary immunizations.

The adolescents were asked to choose

all sources from which they remembered receiving any health information.

A doctor's office was the most popular resource, chosen by 80% of the respondents, followed by school (78%) and home (75%). In addition, 57% reported receiving health information from the Internet at home.

For the complete survey results, visit www.pkids.org/pdf/pkidstvi-report.pdf.

Human Plague Cases Total 13, Most Since 1994

So far this year, 13 cases of human plague have been reported in four states. This marks 2006 as the year with the largest number of reported cases in the United States since 1994.

According to the Centers for Disease Control and Prevention, the chief cause of the increase is thought to be related to the increased reproduction rates and survival of rodents and fleas in the southwestern United States in the past 2 years caused by wet, early springs and intervening cool summers (MMWR 2006;55:1-3). Human infection is usually acquired through bites from rodent fleas infected with *Yersinia pestis*.

The mean age of the 13 people infected with the plague was 43 years (range 13-79 years), and more than half (8) were female. The dates of illness ranged from Feb. 16 to Aug. 14, and most cases were reported in New Mexico (seven), followed by Colorado (three), California (two), and Texas (one). Two people died from the illness.

More than half of the cases (eight) were bubonic plague, while the rest were primary septicemic plague. Two patients developed secondary plague pneumonia.

Suspected modes of transmission among six of the patients summarized in the report included one who handled raw rabbit meat, one who skinned rabbit carcasses while hunting, and one who had a dog and a rock squirrel on her property with serologic evidence of past infection with *Y. pestis*.

The report advises clinicians to consider a diagnosis in patients who "have unexplained fever, suspected sepsis, or pneumonia with or without lymphadenopathy or a classic bubo, and live in or have traveled to a plague-endemic region" such as the western United States. Streptomycin and the tetracyclines are effective against the plague. The report noted that gentamicin and fluoroquinolones have been used successfully to treat the plague, but have not been approved by the Food and Drug Administration for this indication.

—Doug Brunk

In the treatment of Acute Otitis Media and Pharyngitis

The One for

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"Works great."

According to published peer-reviewed literature,^{1,3} compliance factors that make an antibiotic easy to take include:

- Taste (palatability)
- Tolerability
- Short duration of treatment
- Number of daily doses

Indications (mild to moderate infections caused by susceptible microorganisms in pediatric patients 6 months through 12 years).⁴

Acute Bacterial Otitis Media due to *H influenzae* (including β-lactamase producing strains), *S pneumoniae* (penicillin-susceptible strains only), and *M catarrhalis* (including β-lactamase producing strains).
Pharyngitis/Tonsillitis due to *S pyogenes*. Cefdinir is effective in the eradication of *S pyogenes* from the oropharynx. Cefdinir has not, however, been studied for the prevention of rheumatic fever following *S pyogenes* pharyngitis/tonsillitis. Only intramuscular penicillin has been demonstrated to be effective for the prevention of rheumatic fever.

Important Safety Information[†]

- To reduce the development of drug-resistant bacteria and maintain the effectiveness of OMNICEF and other antibacterial drugs, OMNICEF should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria
- OMNICEF is contraindicated in patients with known allergy to the cephalosporin class of antibiotics
- For patients with previous hypersensitivity reaction to penicillins, caution should be exercised because cross-hypersensitivity among β-lactam antibiotics has been clearly documented. If an allergic reaction to cefdinir occurs, the drug should be discontinued

"Easy to take."

- Safety and efficacy in neonates and infants less than 6 months of age have not been established
- 2% of 2,289 pediatric patients discontinued medication due to adverse events in US and non-US clinical trials. Discontinuations were primarily for gastrointestinal disturbance, usually diarrhea
- The most common reported adverse events occurring in ≥1% of pediatric patients in US clinical trials (N=1,783) were diarrhea (8%), rash (3%), and vomiting (1%)

References: 1. Brixner DL. Improving acute otitis media outcomes through proper antibiotic use and adherence. *Am J Manag Care*. 2005;11(6 suppl):S202-S210. 2. Kardas P. Patient compliance with antibiotic treatment for respiratory tract infections. *J Antimicrob Chemother*. 2002;49:897-903. 3. Ramgoolam A, Steele R. Formulations of antibiotics for children in primary care. *Pediatr Drugs*. 2002;4:323-333. 4. OMNICEF (cefdinir) Capsules and for Oral Suspension Prescribing Information, Abbott Laboratories.

Please see adjacent brief summary of full prescribing information.

(cefdinir) for oral suspension

125 mg/5 mL and 250 mg/5 mL

"Works great." "Easy to take."

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