

Human Bocavirus Reported in U.S. Children

BY JANE SALODOF MACNEIL
Southwest Bureau

SAN FRANCISCO — A new parvovirus linked to respiratory tract infections in young children is circulating in the New Haven area of Connecticut, an infectious disease laboratory at Yale University has reported.

Dr. Deniz Kesebir said the laboratory found the pathogen, human bocavirus (HBoV), in respiratory specimens from

22 (5.2%) of 426 children under the age of 2 years who presented with respiratory symptoms at hospitals and clinics associated with the university.

"To our knowledge, this is the first description of human bocavirus in the United States," Dr. Kesebir, of Yale University, New Haven, said at the annual meeting of the Pediatric Academic Societies.

Canine and bovine forms of the virus are known to infect animals of all ages, but cause illness primarily in infants of those

species, according to Dr. Kesebir.

Investigators at Karolinska University Hospital, Huddinge, Sweden, published the first report of a bocavirus infecting a human in September of last year (Proc. Natl. Acad. Sci. U S A 2005;102:12891-6). They identified the virus in 17 (3.1%) of 540 children less than 3 years old who were hospitalized for respiratory disease.

A month later, an Australian group reported finding the new pathogen in 18 (5.6%) of 324 children in the same age

group who had respiratory tract infections (J. Clin. Virol. 2006;35:99-102).

Japanese investigators published a third report this March (J. Clin. Microbiol. 2006;44:1132-4). They found HBoV in 18 (5.7%) of 318 nasal swabs from children under the age of 3 years who were treated for respiratory tract infections.

Dr. Kesebir said the Yale infectious diseases laboratory headed by Dr. Jeffrey S. Kahn did a retrospective search for HBoV in children less than 2 years of age who presented with respiratory symptoms but screened negative on a direct immunofluorescence assay (DFA) for adenovirus, respiratory syncytial virus, and various influenza viruses.

All the positive samples were taken from children who presented with symptoms from October through April. Specimens collected from May through September were negative for HBoV.

The group also screened specimens from a matched control group of 96 children in an ongoing epidemiologic study of respiratory viruses in children. None of the asymptomatic children were positive for HBoV.

Rare polymorphisms in the positive samples established that the New Haven

CIPRODEX (ciprofloxacin 0.3% and dexamethasone 0.1%) STERILE OTIC SUSPENSION

DESCRIPTION

CIPRODEX (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension contains the synthetic broad-spectrum antibacterial agent, ciprofloxacin hydrochloride, combined with the anti-inflammatory corticosteroid, dexamethasone, in a sterile, preserved suspension for otic use. Each mL of CIPRODEX Otic contains ciprofloxacin hydrochloride (equivalent to 3 mg ciprofloxacin base), 1 mg dexamethasone, and 0.1 mg benzalkonium chloride as a preservative. The inactive ingredients are boric acid, sodium chloride, hydroxyethyl cellulose, tyloxapol, acetic acid, sodium acetate, edetate disodium, and purified water. Sodium hydroxide or hydrochloric acid may be added for adjustment of pH.

Ciprofloxacin, a fluoroquinolone is available as the monohydrochloride monohydrate salt of 1-cyclopropyl-6-fluoro-1,4-dihydro-4-oxo-7-(1-piperazinyl)-3-quinolincarboxylic acid. The empirical formula is $C_{17}H_{18}FN_3O_3 \cdot HCl \cdot H_2O$. Dexamethasone, 9-fluoro-11(beta),17,21-trihydroxy-16(alpha)-methylpregna-1,4-diene-3,20-dione, is an anti-inflammatory corticosteroid. The empirical formula is $C_{22}H_{29}F_05$.

CLINICAL PHARMACOLOGY

Pharmacokinetics: Following a single bilateral 4-drop (total dose = 0.28 mL, 0.84 mg ciprofloxacin, 0.28 mg dexamethasone) topical otic dose of CIPRODEX Otic to pediatric patients after tympanostomy tube insertion, measurable plasma concentrations of ciprofloxacin and dexamethasone were observed at 6 hours following administration in 2 of 9 patients and 5 of 9 patients, respectively.

Mean \pm SD peak plasma concentrations of ciprofloxacin were 1.39 ± 0.880 ng/mL (n=9). Peak plasma concentrations ranged from 0.543 ng/mL to 3.45 ng/mL and were on average approximately 0.1% of peak plasma concentrations achieved with an oral dose of 250-mg[®]. Peak plasma concentrations of ciprofloxacin were observed within 15 minutes to 2 hours post dose application. Mean \pm SD peak plasma concentrations of dexamethasone were 1.14 ± 1.54 ng/mL (n=9). Peak plasma concentrations ranged from 0.135 ng/mL to 5.10 ng/mL and were on average approximately 14% of peak concentrations reported in the literature following an oral 0.5-mg tablet dose[®]. Peak plasma concentrations of dexamethasone were observed within 15 minutes to 2 hours post dose application. Dexamethasone has been added to aid in the resolution of the inflammatory response accompanying bacterial infection (such as otorrhea in pediatric patients with AOM with tympanostomy tubes).

Microbiology: Ciprofloxacin has *in vitro* activity against a wide range of gram-positive and gram-negative microorganisms. The bactericidal action of ciprofloxacin results from interference with the enzyme, DNA gyrase, which is needed for the synthesis of bacterial DNA. Cross-resistance has been observed between ciprofloxacin and other fluoroquinolones. There is generally no cross-resistance between ciprofloxacin and other classes of antibacterial agents such as beta-lactams or aminoglycosides.

Ciprofloxacin has been shown to be active against most isolates of the following microorganisms, both *in vitro* and clinically in otic infections as described in the **INDICATIONS AND USAGE** section.

Aerobic and facultative gram-positive microorganisms: *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Aerobic and facultative gram-negative microorganisms:* *Haemophilus influenzae*, *Moraxella catarrhalis*, *Pseudomonas aeruginosa*.

INDICATIONS AND USAGE: CIPRODEX Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below: **Acute Otitis Media** in pediatric patients (age 6 months and older) with tympanostomy tubes due to *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa*. **Acute Otitis Externa** in pediatric (age 6 months and older), adult and elderly patients due to *Staphylococcus aureus* and *Pseudomonas aeruginosa*.

CONTRAINDICATIONS

CIPRODEX Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections.

WARNINGS

FOR OTIC USE ONLY (This product is not approved for ophthalmic use.) NOT FOR INJECTION

CIPRODEX Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment.

PRECAUTIONS

General: As with other antibacterial preparations, use of this product may result in overgrowth of nonsusceptible organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. If otorrhea persists after a full course of therapy, or if two or more episodes of otorrhea occur within six months, further evaluation is recommended to exclude an underlying condition such as cholesteatoma, foreign body, or a tumor. The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has led to lesions or erosions of the cartilage in weight-bearing joints and other signs of arthropathy in immature animals of various species. Guinea pigs dosed in the middle ear with CIPRODEX Otic for one month exhibited no drug-related structural or functional changes of the cochlear hair cells and no lesions in the ossicles. CIPRODEX Otic was also shown to lack dermal sensitizing potential in the guinea pig when tested according to the method of Buehler. No signs of local irritation were found when CIPRODEX Otic was applied topically in the rabbit eye. **Information for Patients:** For otic use only. (This product is not approved for use in the eye.) Warm the bottle in your hand for one to two minutes prior to use and shake well immediately before using. Avoid contaminating the tip with material from the ear, fingers, or other sources. Protect from light. If rash or allergic reaction occurs, discontinue use immediately and contact your physician. It is very important to use the ear drops for as long as the doctor has instructed, even if the symptoms improve. Discard unused portion after therapy is completed. **Acute Otitis Media in pediatric patients with tympanostomy tubes:** Prior to administration of CIPRODEX Otic in patients (6 months and older) with acute otitis media through tympanostomy tubes, the solution should be warmed by holding the bottle in the hand for one to two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**). **Acute Otitis Externa:** Prior to administration of CIPRODEX Otic in patients with acute otitis externa, the solution should be warmed by holding the bottle in the hand for one to two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear (see **DOSAGE AND ADMINISTRATION**).

Drug Interactions: Specific drug interaction studies have not been conducted with CIPRODEX Otic. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term carcinogenicity studies in mice and rats have been completed for ciprofloxacin. After daily oral doses of 750 mg/kg (mice) and 250 mg/kg (rats) were administered for up to 2 years, there was no evidence that ciprofloxacin had any carcinogenic or tumorigenic effects in these species. No long term studies of CIPRODEX Otic have been performed to evaluate carcinogenic potential. Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin, and the test results are listed below: *Salmonella*/Microsome Test (Negative), *E. coli* DNA Repair Assay (Negative), Mouse Lymphoma Cell Forward Mutation Assay (Positive), Chinese Hamster V79 Cell HGPRT Test (Negative), Syrian Hamster Embryo Cell Transformation Assay (Negative), *Saccharomyces cerevisiae* Point Mutation Assay (Negative), *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative), Rat Hepatocyte DNA Repair Assay (Positive). Thus, 2 of the 8 tests were positive, but results of the following 3 *in vivo* test systems gave negative results: Rat Hepatocyte DNA Repair Assay, Micronucleus Test (Mice), Dominant Lethal Test (Mice). Fertility studies performed in rats at oral doses of ciprofloxacin up to 100 mg/kg/day revealed no evidence of impairment. This would be over 100 times the maximum recommended clinical dose of topical ciprofloxacin based upon body surface area, assuming total absorption of ciprofloxacin from the ear of a patient treated with CIPRODEX Otic twice per day according to label directions. Long term studies have not been performed to evaluate the carcinogenic potential of topical otic dexamethasone. Dexamethasone has been tested for *in vitro* and *in vivo* genotoxic potential and shown to be positive in the following assays: chromosomal aberrations, sister-chromatid exchange in human lymphocytes and micronuclei and sister-chromatid exchanges in mouse bone marrow. However, the Ames/Salmonella assay, both with and without S9 mix, did not show any increase in His+ revertants. The effect of dexamethasone on fertility has not been investigated following topical otic application. However, the lowest toxic dose of dexamethasone identified following topical dermal application was 1.802 mg/kg in a 26-week study in male rats and resulted in changes to the testes, epididymis, sperm duct, prostate, seminal vesicle, Cowper's gland and accessory glands. The relevance of this study for short term topical otic use is unknown.

Pregnancy

Teratogenic Effects. Pregnancy Category C: Reproduction studies have been performed in rats and mice using oral doses of up to 100 mg/kg and IV doses up to 30 mg/kg and have revealed no evidence of harm to the fetus as a result of ciprofloxacin. In rabbits, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion, but no teratogenicity was observed at either dose. After intravenous administration of doses up to 20 mg/kg, no maternal toxicity was produced in the rabbit, and no embryotoxicity or teratogenicity was observed. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Animal reproduction studies have not been conducted with CIPRODEX Otic. No adequate and well controlled studies have been performed in pregnant women. Caution should be exercised when CIPRODEX Otic is used by a pregnant woman.

Nursing Mothers: Ciprofloxacin and corticosteroids, as a class, appear in milk following oral administration. Dexamethasone in breast milk could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical otic administration of ciprofloxacin or dexamethasone could result in sufficient systemic absorption to produce detectable quantities in human milk. Because of the potential for unwanted effects in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and efficacy of CIPRODEX Otic have been established in pediatric patients 6 months and older (937 patients) in adequate and well-controlled clinical trials. Although no data are available on patients less than age 6 months, there are no known safety concerns or differences in the disease process in this population that would preclude use of this product. (See **DOSAGE AND ADMINISTRATION**.) No clinically relevant changes in hearing function were observed in 69 pediatric patients (age 4 to 12 years) treated with CIPRODEX Otic and tested for audiometric parameters.

ADVERSE REACTIONS

In Phases II and III clinical trials, a total of 937 patients were treated with CIPRODEX Otic. This included 400 patients with acute otitis media with tympanostomy tubes and 537 patients with acute otitis externa. The reported treatment-related adverse events are listed below:

Acute Otitis Media in pediatric patients with tympanostomy tubes: The following treatment-related adverse events occurred in 0.5% or more of the patients with non-intact tympanic membranes.

Adverse Event	Incidence (N=400)
Ear discomfort	3.0%
Ear pain	2.3%
Ear precipitate (residue)	0.5%
Irritability	0.5%
Taste perversion	0.5%

The following treatment-related adverse events were each reported in a single patient: tympanostomy tube blockage; ear pruritus; tinnitus; oral moniliasis; crying; dizziness; and erythema. **Acute Otitis Externa:** The following treatment-related adverse events occurred in 0.4% or more of the patients with intact tympanic membranes.

Adverse Event	Incidence (N=537)
Ear pruritus	1.5%
Ear debris	0.6%
Superimposed ear infection	0.6%
Ear congestion	0.4%
Ear pain	0.4%
Erythema	0.4%

The following treatment-related adverse events were each reported in a single patient: ear discomfort; decreased hearing; and ear disorder (tingling).

DOSAGE AND ADMINISTRATION

CIPRODEX Otic SHOULD BE SHAKEN WELL IMMEDIATELY BEFORE USE

CIPRODEX Otic contains 3 mg/mL (3000 µg/mL) ciprofloxacin and 1 mg/mL dexamethasone.

Acute Otitis Media in pediatric patients with tympanostomy tubes: The recommended dosage regimen for the treatment of acute otitis media in pediatric patients (age 6 months and older) through tympanostomy tubes is: Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed. **Acute Otitis Externa:** The recommended dosage regimen for the treatment of acute otitis externa is: For patients (age 6 months and older): Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed.

HOW SUPPLIED

CIPRODEX Otic (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension is supplied as follows: 5 mL fill and 7.5 mL fill in a DROP-TAINER[®] system. The DROP-TAINER[®] system consists of a natural polyethylene bottle and natural plug, with a white polypropylene closure. Tamper evidence is provided with a shrink band around the closure and neck area of the package. NDC 0065-8533-01, 5 mL fill; NDC 0065-8533-02, 7.5 mL fill. **Storage:** Store at controlled room temperature, 15°C to 30°C (59°F to 86°F). Avoid freezing. Protect from light.

Clinical Studies: In a randomized, multicenter, controlled clinical trial, CIPRODEX Otic dosed 2 times per day for 7 days demonstrated clinical cures in the per protocol analysis in 86% of AOMT patients compared to 79% for ofloxacin solution, 0.3%, dosed 2 times per day for 10 days. Among culture positive patients, clinical cures were 90% for CIPRODEX Otic compared to 79% for ofloxacin solution, 0.3%. Microbiological eradication rates for these patients in the same clinical trial were 91% for CIPRODEX Otic compared to 82% for ofloxacin solution, 0.3%. In 2 randomized multicenter, controlled clinical trials, CIPRODEX Otic dosed 2 times per day for 7 days demonstrated clinical cures in 87% and 94% of per protocol evaluable AOE patients, respectively, compared to 84% and 89%, respectively, for otic suspension containing neomycin 0.35%, polymyxin B 10,000 IU/mL, and hydrocortisone 1.0% (neo/poly/Hc). Among culture positive patients clinical cures were 86% and 92% for CIPRODEX Otic compared to 84% and 89%, respectively, for neo/poly/Hc. Microbiological eradication rates for these patients in the same clinical trials were 86% and 92% for CIPRODEX Otic compared to 85% and 85%, respectively, for neo/poly/Hc.

References:

- CIPRODEX Otic package insert.
- Wolans Kluwer, Source Prescriber; for the year ending December 2005.
- Roland PS, Pien FD, Schultz CC, et al. Efficacy and safety of topical ciprofloxacin/dexamethasone versus neomycin/polymyxin B/hydrocortisone for otitis externa. *Curr Med Res Opin*. 2004;20:1175-1183.
- Roland PS, Block SL, Latiolais TG, et al. A comparison of ciprofloxacin/dexamethasone and neomycin/polymyxin B/hydrocortisone for the treatment of acute otitis externa. Presented at: The American Society of Pediatric Otolaryngology meeting; May 27-30, 2005; Las Vegas, NV.
- Campoli-Richards DM, Monk JP, Price A, Benfield P, Todd PA, Ward A. Ciprofloxacin: a review of its antimicrobial activity, pharmacokinetic properties and therapeutic use. *Drugs*. 1988;35:373-447.
- Loew D, Schuster O, Graul E. Dose-dependent pharmacokinetics of dexamethasone. *Eur J Clin Pharmacol*. 1986;30:225-230.

U.S. Patent Nos. 4,844,902; 6,284,804; 6,359,016
CIPRODEX Otic is a registered trademark of Bayer AG. Licensed to Alcon, Inc. by Bayer AG.

Manufactured by Alcon Laboratories, Inc.

Rx Only

Revision date: 17 July 2003

©2006 Alcon, Inc. 4/06



The researchers do not know whether the virus jumped species or just had not been detected in humans before.

DR. KESEBIR

virus is identical to two HBoV genotypes identified in Sweden. Asked in an interview how the same virus got from Sweden to Yale, or vice versa, Dr. Kesebir said the question was on a long list of questions the investigators are trying to answer about the new pathogen.

"That's interesting. I don't know. It's exactly the same," she said.

Dr. Kesebir reported on 20 of the 22 positive cases at the meeting, which is sponsored by the American Pediatric Society, Society for Pediatric Research, Ambulatory Pediatric Association, and American Academy of Pediatrics. Her presentation excluded data on one child whose chart was unavailable for review and another who was coinfecting with an adenovirus.

She said 15 (75%) of the remaining 20 infected children were hospitalized for up to 18 days. Nine children were hospitalized for 1-3 days and three for 4-18 days. Another three developed nosocomial infections. The other five children were seen in an emergency department or clinic. Seventeen children (85%) had a comorbidity, which she defined as asthma, eczema, bronchopulmonary dysplasia, or seizures.

For signs and symptoms, she reported that 19 children presented with rhinorrhea, 15 with fever, and 14 with cough. Ten children presented with wheezing, and six had oxygen saturation levels below 87%.

Abnormal chest x-rays were seen in 13 (72.2%) of 18 children for whom chest

Continued on following page

Alcon
ALCON LABORATORIES, INC.
Fort Worth, Texas 76134
www.alcon.com

Dexamethasone Is Protective in Bacterial Meningitis

BY KATE JOHNSON
Montreal Bureau

CHICAGO — Dexamethasone treatment can reduce the sequelae of pediatric bacterial meningitis when given prior to or concurrent with antibiotic therapy, according to Dr. Marianne Gausche-Hill.

"Although this issue has been controversial in the past, I think we are on the pro side now," she said at a meeting sponsored by the American College of Emergency Physicians.

The goal of corticosteroid therapy is to reduce the inflammatory response that



In a recent study, steroids before or with antibiotics was associated with protection from death or severe morbidity.

DR. GAUSCHE-HILL

can lead to thrombotic changes, vasculitis, increases in cerebral pressure, and neuronal injury, she said.

"Reducing inflammation is the key to preventing sequelae," she said. "Obviously, antibiotics are important, but early reduction of inflammation is essential—especially in reducing the risk of hearing loss."

Until recently, there was some controversy about whether corticosteroid therapy was appropriate for pneumococcal meningitis because some studies suggested it might impair the cerebrospinal uptake of vancomycin, said Dr. Gausche-Hill, who is director of emergency medical services and pediatric emergency medicine fellowships at Harbor-UCLA Medical Center and professor of medicine at the University of California, Los Angeles.

Both the Infectious Diseases Society of America and the American Academy of Pediatrics Committee on Infectious Diseases

previously released cautionary statements about the use of steroid therapy in pediatric pneumococcal meningitis, she said.

But a more recent study showing significantly improved outcomes with adjuvant corticosteroid therapy in pneumococcal meningitis (*Arch. Dis. Child.* 2005;90:391-3) has shifted medical opinion in favor of this therapy for both *Haemophilus influenzae* and pneumococcal meningitis, she said.

The study of 120 cases of pediatric pneumococcal meningitis included 15 chil-

dren who died and 39 who sustained permanent neurologic impairment from the infection. Corticosteroid therapy either before or with parenteral antibiotics was associated with protection from death or severe morbidity (odds ratio of 0.21), Dr. Gausche-Hill said.

She suggested the algorithm for children with suspected bacterial meningitis should be an immediate lumbar puncture (if not contraindicated) and blood cultures, followed by dexamethasone and

empiric antibiotic therapy.

In treating adolescents, she said, consideration of the adult literature is helpful. Although many authors recommend dexamethasone and antibiotics for all forms of adult bacterial meningitis, the Infectious Diseases Society of America recommends dexamethasone for pneumococcal disease only—noting inadequate data to recommend this therapy for other forms of bacterial meningitis, such as meningococcal disease, Dr. Gausche-Hill said. ■

Continued from previous page

x-rays were available. Dr. Kesebir cited peribronchial cuffing, infiltrates, and hyperinflation.

Of particular interest were eight children who presented with gastrointestinal symptoms. Dr. Kesebir and her colleagues concluded that HBOV is associated with upper and lower respiratory tract disease in children, and speculated that it also may be the cause of gastrointestinal symptoms.

Among the future studies planned are screening of children up to age 5 for HBOV, DFA screening of positive specimens for coinfection with other viruses, and a search for the cause of gastrointestinal symptoms.

In the interview, Dr. Kesebir said the researchers do not know whether the virus jumped species or just had not been detected in humans before. "It is in adults as well, but most of the findings of symptoms are in children. ... Probably the adults are carriers and less symptomatic or immune," she said. ■

PEDIARIX may help ensure timely vaccination with fewer injections

- With just 1 dose at 2, 4, and 6 months of age (in infants born of HBsAg-negative mothers)

*Based on analysis of the first four DTaP doses in the most recent National Immunization Survey (2003) of 21,210 children 19–35 months of age.

In clinical studies, adverse events in infants receiving PEDIARIX included injection-site reactions (pain, redness, or swelling), fever, and fussiness. Administration of PEDIARIX was associated with higher rates of fever relative to separately administered vaccines (see Adverse Reactions section of the brief summary). PEDIARIX is contraindicated in infants with known hypersensitivity to any component of the vaccine including yeast, neomycin, and polymyxin B. As with any vaccine, vaccination with PEDIARIX may not protect 100% of susceptible individuals.



Please see brief summary for PEDIARIX on the following page.

References: 1. Centers for Disease Control and Prevention. National, state, and urban area vaccination coverage among children aged 19–35 months—United States, 2003. *MMWR*. 2004;53(29):658–661.

PEDIARIX and *Tip-Lok* are registered trademarks of GlaxoSmithKline. The five-color star is a trademark of GlaxoSmithKline. Manufactured by GlaxoSmithKline Biologicals, Rixensart, Belgium. Distributed by GlaxoSmithKline, Research Triangle Park, NC 27709.



Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B (Recombinant) and Inactivated Poliovirus Vaccine Combined

