

Pediatric Infectious Disease Program  
for Immunocompromised Hosts  
PIDPIC

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# Meetings

- Roll out starting in Sept
  - Presented at Transplant Quality meeting: 9.23
  - Met with Rheumatology, GI and SCT during 9-10
- Started weekly working group meetings since 10.13
  - To discuss priority issues and develop draft protocols
- Updating individual groups
  - Cardiology, GI, Renal (scheduled)

# Protocol Drafts-Respiratory Viruses

- Influenza:
  - All pretransplant patients > 6mo
    - TIV or LAIV
  - All posttransplant patients > 6mo
    - TIV
    - 2 doses first season after transplant regardless of age
  - All family members > 6mo
    - Preference given to TIV but LAIV not contraindicated

# Protocol Drafts-Respiratory Viruses

- RSV Prophylaxis
- Background
  - Severe disease and increased incidence of rejection in SOT recipients
- Forty-nine percent (33/67) of transplant programs reported using RSV prophylaxis
  - Unpublished data shows infection with RSV was reported in 4/109 (4%) SOT recipients who received prophylaxis and in 22/195 (11%) children who received SOT but did not receive prophylaxis ( $p = 0.03$ ). Michaels, et al *Pediatr Transplantation* 2009; 13: 451–456

# RSV Prophylaxis

- Recommended for high risk groups
  - Infant and children < 24mo
  - Immediate posttransplant
- Recommended monthly syngis (Nov-Mar) for:
  - Candidates < 24 mo
  - Posttransplant <24 mo

# RSV prophylaxis

- Who would qualify: 30 patients
  - Heart: 2 pretransplant, 6 posttransplant
  - Liver: 3 pretransplant, 17 posttransplant
  - Renal: 1 pretransplant
  - SB/Liver: 1 pretransplant
- Started to test the logistics and insurance
  - CCS no issue
  - Private pay, mostly no issue
  - Kaiser: split

# Protocol Drafts-Respiratory Viruses

- **Preemptive measure for all listed patients:**
  - Check-ins to the families to assess for symptoms, reminder for parents to call for any symptoms
    - May be feasible in EPIC with questionnaires
  - Education to families to call with any symptoms indicating that it may not impact transplant and best to identify if possible which virus to target treatment
- **Preventive strategies for all listed patients and donor recipients**
  - Flu vaccine and palivizimab (see protocols)

# RSV and Parainfluenza

- Recipient
  - If symptomatic and requiring hospitalization: Inhaled ribovarin before transplant and IVIg (400mg/kg) after transplant x1
  - If symptomatic and not hospitalized no interventions, if transplant becomes available and still symptomatic, IVIg and ribovarin if feasible:
  - if no symptoms at time of organ offer, no intervention
- Donor positive
  - no interventions



# Respiratory Viruses

- **Rhinovirus and Human MetaPneumovirus**
  - Recipient: If symptomatic: before and after transplant IVIg (400mg/kg) x1
  - Donor positive, no interventions
- **Influenza**
  - Recipient: If symptomatic: oseltamivir (5 days can straddle transplant)
  - Donor positive: start oseltamivir in donor and finish a total of 5 day course in recipient

# Respiratory Viruses

- Adenovirus: delay transplant
- If no time to test and identify the infecting organism and patient symptomatic, send respiratory PCR and give IVIg 400mg/kg
- Symptoms are objective evidence of URI/LRI  
no fever. ? CXR pretransplant?

# Tuberculosis

- All organ recipient candidates should be screened for tuberculosis
  - For children <5 years of age preferred screening is with PPD
  - For children 5-18 years preferred screening is with PPD but IGRA acceptable
- If Tb screening test is positive:
  - Referral to Peds ID

# Tuberculosis

- All organ recipients who are found to be TB screen positive should be referred to Peds ID for evaluation and treatment.
  - Screening should include both PPD and QFT to increase sensitivity