Update of recommendations on the use of palivizumab as prophylaxis in RSV infections

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Abstract The Standards Committee of the Spanish Neonatology Society (SENeo) considers that the new document from the American Academy of Pediatrics, including recommendations for palivizumab use to prevent serious infections produced by the Respiratory Syncytial Virus (RSV), provides no new scientific evidence which would justify the modification of the current recommendations of the SENeo. However, some adjustments to the criteria of the existing recommendations are proposed to reduce the cost of the drug by its correct and judicious management.

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The recent recommendations of the American Academy of Pediatrics (AAP) regarding palivizumab prophylaxis for children at risk to prevent serious respiratory syncytial virus (RSV) infections and hospitalisation due to these infections⁠¹ oblige us to consider updating the current Recommendations of the Spanish Society of Neonatology (SENeo).²⁻³ An analysis of the AAP document does not provide new scientific evidence that would justify modifying the SENeo’s current recommendations. In the United States palivizumab is appreciably more expensive than in Spain and the financial aspects may have influenced the AAP’s decision. However, it should not be forgotten that one way of reducing the cost of a drug is to administer it properly and sensibly, and in this respect there is room for improvement in palivizumab prophylaxis for Spanish infants born prematurely. Several issues need to be highlighted:

- In preterm infants with no bronchopulmonary dysplasia (BPD) or congenital heart disease and with a gestational age ≤ 28 weeks and 6 days, prescribing palivizumab in the first 12 months of life could mean repeating the complete course (5 doses), in the next season, in high-weight infants aged over 9 months. This second course could be advised against, which would lead to a substantial saving in resources, prescribing it only to those under 9 months. If the start of the RSV season is taken as 15 October, it will include those born from 15 January inclusive.
- The limit of 35 weeks 0 days for the moderately preterm group is liable to cause confusion, since the number of days is sometimes not known and all 35-week preterm infants are included. It seems more reasonable to include those of up to 34 weeks and 6 days, which would exclude all 35-week preterms from the recommendations. Avoiding this overtreatment would also reduce the cost of prophylaxis. It should be remembered that out of the group of preterms with a gestational age of between 32 weeks 0 days and 34 weeks 6 days the only ones treated, exceptionally, would be those that met the two main criteria: age below 10 weeks at the start of the season (born from 6 August onwards inclusive) and with at least one sibling attending school or nursery school. This subgroup accounts for approximately 18% of the total of these preterm infants.
- The intermediate gestational age group, between 29 weeks 0 days and 31 weeks 6 days (instead of 32 weeks 0 days, for the same reason already put forward above), would be treated if their age at the start of the season was less than 6 months (born from 15 April onwards inclusive).
- Neonates with congenital heart disease and with persistent haemodynamic disturbance or BPD requiring treatment in the past 12 months should be treated for a second year.

For prophylaxis of respiratory infections in infants and small children, including those due to RSV, the importance of hygienic measures, especially proper handwashing, should not be forgotten. The conjunction of such measures and appropriate administration of palivizumab will make it possible to reduce the health care overload (in hospital and outpatient services) and the stress for families caused by an RSV infection in children whose age and history make them vulnerable.

Conflicts of interest

The authors have no conflicts of interest to declare.

Appendix A. Standards Committee of the SENeo

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