

In Type 1 diabetes, lack of adherence to treatment and a failure to maintain glycaemic control can lead to long-term complications & loss of quality of life. Young age Children are at higher risk of long-term complications. Chronic illness places the adolescent at a greater risk because of added emotional difficulties and stress in coping with rigorous regimens and restrictions. Other problems are economic and social, in the form of stigma like delay in marriage or reduced job opportunities. Among the several problems faced by the young diabetic, the most common and often most difficult to deal with is that of adherence or compliance to a regimen. Children with diabetes in developing countries face profound challenges in managing their diabetes.

Obstacles in Palestine are similar to universal ones mentioned. In my experience important obstacles in Palestine are; lack of cooperation & coordination between health providers, lack of national treatment guidelines, insufficient preventive and control policies, shortage of human and financial resources, lack of well trained health provider team and important specialists, lack of patient and family education about management and coping, and finally inadequate financial coverage for the management cost.

Proper management of diabetic children in Palestine as a developing country with special political situation, face many obstacles at different levels (national, MOH programs, family & school)

My experience and my recommendations in Palestine will concentrate on cooperation of physicians and nurses to help diabetic children and their families cope with their disease, improve their quality of life by proper management & reducing morbidities. This can be achieved by follow-up of this group of patients in **Proposed** specialized well equipped **clinic** by a well trained team (physicians, nurses, psychologist, educator, and dietician), increase the awareness of their families and teachers about this disease and how to deal in emergencies (education programs), recruitment activities during holidays (camps, trips, sports), and home visits for special cases.

25) Review of Influnza Vaccine update 2008 in Children

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Abstract

Each year, flu places a large burden on the health and well-being of children and families. Children commonly need medical care because of influenza, especially before they turn 5 years old. Hospitalization and sometimes death are important complications of flu in children. Severe influenza complications are most common in children younger than 2 years old. Children with chronic health problems like asthma and diabetes are at especially high risk of developing serious flu complications.

Vaccination is the best method for preventing flu and its potentially severe complications in children. CDC recommends that all children aged 6 months up to their 19th birthday get a flu vaccine. CDC also recommends that people in contact with certain groups of children get a flu vaccine in order to protect the child (or children) in their lives from the flu.

Examples of contacts are close contacts of children younger than 5 years old, out-of-home caregivers (nannies, daycare providers, etc.) of children younger than 5 years, People who live with or have other close contact with a child or children of any age with a chronic health problem (asthma, diabetes, etc.), in addition, CDC recommends that all health care workers be vaccinated each year to keep from spreading the flu to their patients.

Yearly flu vaccination should begin in September or as soon as vaccine is available and continue throughout the flu season, into December, January, and beyond. While influenza outbreaks can happen as early as October, most of the time flu activity peaks in January or later.



Children and adolescents at high risk for influenza complications continue to be a focus of vaccination efforts. Children and adolescents at higher risk for influenza complication are those: aged 6 months–4 years; who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus); who are immunosuppressed (including immunosuppression caused by medications or by human immunodeficiency virus); who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration; who are receiving long-term aspirin therapy who therefore might be at risk for experiencing Reye syndrome after influenza virus infection; who are residents of chronic-care facilities; and, who will be pregnant during the influenza season.

Children less than nine years of age being vaccinated for the first time should receive two doses of influenza vaccine, spaced at least 4 weeks apart in the initial year. For inactivated (injectable) vaccine, the dose for children aged 6–35 months is 0.25 cc, and the dose for children aged 36 months–9 years is 0.5cc.

Updates on live vaccine use and antiviral drug use in children will be also reviewed

26) SCID patients, clinical presentation/diagnosis/ outcome in the city of Nablus/ Palestine

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Introduction: SCID (Severe combined immune deficiency) is a heterogeneous group of severe immune deficiency that affect T lymphocytes. If untreated, it causes death early in life. Treatment is T cell depleted bone marrow transplant as early as possible. This treatment modality is not available locally. Early diagnosis plays a positive role of outcome of this procedure. Diagnostic facilities like flowcytometry is not available locally and we had to depend on laboratories outside our area to establish diagnosis. The mortality rate is high. Economic, political, and medical factors causing late diagnosis (knowledge of the medical community about this disease) played very important role in the poor outcome of this illness in our area.

I present some of my cases of SCID, with the clinical presentation, phenotypes, and outcome.

Methods: My practice is in private office in the city of Nablus as a general pediatrician. Patients presented or referred to my office and got the diagnosis of SCID were included, (12/1999 - September 2008). Diagnosis was made depending on the clinical presentation, the lymphocyte phenotyping. Only patients from the city of Nablus are included.

Data: Number of patients included is 10 patients. 6 males and 4 females. Age at presentation ranging from 2 weeks old (for those who had an infant who died with SCID and wanted to screen the sibling) to 6 months old. The followings are the clinical signs and symptoms at presentation;

- 1- Early onset of skin rash, eczema like, # of cases: 4.
- 2- Prolonged fever: # of cases: 2.
- 3- Chronic diarrhea/ failure to thrive: # of cases: 4.
- 4- Chronic bronchiolitis/ chronic chest infection: # of patients is 5. All received steroids by their primary health provider and also were given the diagnosis of early onset asthma.
- 5- Lymphopenia: 7 out of 10 patient.
- 6- Number of patients who were screened as one family member was affected and were positive for SCID: 3 patients. One patient of this group died as the family refused the method of treatment provided.
- 7- The following was the reported lymphocyte phenotyping
 - A- T negative, B negative, NK positive: # of cases 8.

