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 received 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/ out come in the city of Nablus/ Palestine

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Introduction:SCID (Severe combined immune deficiency)is a heterogenous 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 flowcytometery is not available locally and we had to depend on laboratories out side 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 sings 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.

B- T positive , B negative, NK positive : # of cases is 2, diagnosed as Omenn's syndrome.

Other phenotyping were not reported in our series.

All of the cases were autosomal recessive.

All patients except the 3 who were screened for SCID received live vaccination by a health care professional.

3 patients received blood transfusion that was not irradiated, nor leukocyte depleted.

Mortality: **7 patients died out of 10**, making the mortality rate 70%, 6 of these died in Nablus before be able to transfer them to a tertiary care center. One patient died at home as the family refused the bone marrow transplant. One patient died 24 hours after arriving the tertiary care center. 3 patients were transplanted, and currently still in the tertiary care center: diagnosis was made early and promptly in these patients and referral was provided to them.

Conclusion: Severe combined immune deficiency seems to be reported in our area higher than that of the western country, consanguineous marriage is responsible for that. I reported only cases from the city of Nablus.

Late diagnosis played an important factor for the high mortality rate that we have. All who had chest infections or diarrhea at presentation died. Actually those who survived are only those who were screened as a sibling died with SCID or a disease suggestive of SCID.

27) ' Surviving sepsis Campaign: - International guidelines for management of severe sepsis and septic shock in pediatric:-2008'

Presenter: Dr. Abdulrazzaq Abu Mayyaleh, Pediatrician, *Hebron*

Abstract:

Objective: to provide an update to the original Surviving Sepsis Campaign clinical management guidelines, "Surviving Sepsis Campaign Guidelines for Management of Severe Sepsis and septic shock," published in 2004.

Design: we used the grades of Recommendation , Assessment, Development and Evaluation (GRADE) system to guide assessment of quality of evidence from high (A) to very low (D) and to determine the strength of recommendation. A strong recommendation:-

Indicates that an intervention's desirable effects clearly outweigh its undesirable effects (risk, burden, and cost) or clearly do not. Weak recommendations.

Indicates that the tradeoff between desirable and undesirable effects is less clear.

The grade of strong or weak is considered of greater clinical importance than a difference in later level of quality of evidence.

Recommendations are grouped into those directly targeting severe sepsis, recommendations targeting general care of the critically ill patient that are considered high priority in severe sepsis, and pediatric considerations.

Results: Recommendation specific to pediatric severe sepsis include greater use of physical examination therapeutic end points (2C); dopamine as the first drug of choice for hypotension (2C); steroids only in children with suspected or proven adrenal insufficiency (2C) and a recommendation against the use of recombinant activated protein C in children (1B).

Conclusions: There was strong agreement among a large cohort of international experts regarding many level 1 recommendations for the best current care of patients with severe sepsis. Evidenced- based