Sociedad Argentina de Pediatría

Dirección de Congresos y Eventos

Semana de Congresos y Jornadas Nacionales 2017

"Por un niño saño, en un mundo mejor"

8° Congreso Argentino de Infectología Pediátrica

Situaciones controvertidas en el viajero pediátrico

Mesa Redonda SAP – SLAMVI

"Migraciones y medicina del viajero"

2017

Dra. M. Paula Della Latta

Infectóloga pediatra

Hospital de Niños R. Gutiérrez - Hospital Alemán - Centros médicos Stamboulian

¿Cuál es la decisión cuando la bibliografía no alcanza?

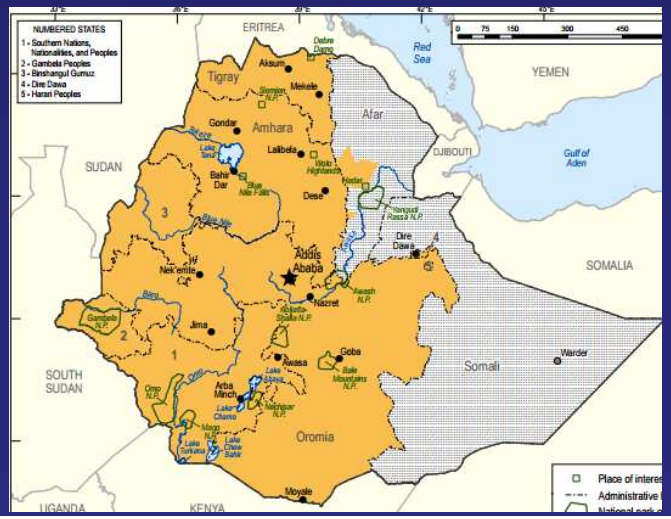
Sin conflictos de interés

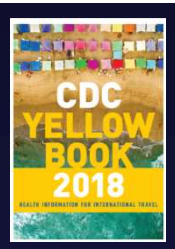
Situación 1- vacunación con FA en menores de 6 meses que viajan a zonas endémicas

1- lactante de 7 meses viajero a Paraguay a visitar familiares.

2- Consulta pre viaje: pareja con bebé de 3 meses de vida que viajan expatriados a Etiopía por 2 años. Ambas, madre e hija, tienen precaución y contraindicación respectivamente, para vacuna de FA.

3- lactante de 6 meses viajero a Colombia, la madre trabajara en una misión del "alto el fuego" y residirá en la selva, el niño viviría en la selva o zona urbana cercana, desconoce en cuál.





Efectos adversos graves

- **Enfermedad viscerotrópica (YFV-AVD):** 1 –18 días postvacuna (mediana 4)

Elevada mortalidad (48%), solo con la 1ra dosis. Incidencia:1-60 años: 0.3 casos/100.000 dosis, en >60 años: 1.2/100.000 dosis, y es mayor en los >70 años.

- **Enf. neurológica asociada (YFV-AND):** 3 – 56 días postvacuna

Manifestaciones neurológicos variables: Meningoencefalitis, Guillain-Barré, ADEM, etc.

Incidencia:1-60 años: 0.8 casos/100.000 dosis; en > 60 años: 2,2/100.000. En <6 meses: 50-400/100.000.

- **Anafilaxia:** se reporta en 1,3/100.000 dosis.

Trans Trop Med Hyg 2007; 101:967.
https://wwwnc.cdc.gov/travel/yellowbook/2016/infectious-diseases-related-to-travel/yellow-fever

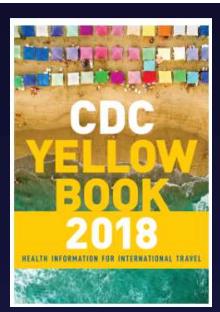


Table 3-24. Contraindications and precautions to yellow fever vaccine administration

CONTRAINDICATIONS	PRECAUTIONS
• Allergy to vaccine component[1]	• Age 6–8 months
• Age <6 months	• Age ≥60 years
• Symptomatic HIV infection or CD4 T-lymphocytes <200/mm^3 (or <15% of total in children aged <6 years)[2]	• Asymptomatic HIV infection and CD4 T-lymphocytes 200–499/mm^3 (or 15%–24% of total in children aged <6 years)[2]
• Thymus disorder associated with abnormal immune-cell function	• Pregnancy
• Primary immunodeficiencies	• Breastfeeding
• Malignant neoplasms	
• Transplantation	
• Immunosuppressive and immunomodulatory therapies	

http://wwwnc.cdc.gov/travel/yellowbook/2016/infectious-diseases-related-to-travel/yellow-fever

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Yellow fever vaccine-associated adverse events following extensive immunization in Argentina

Cristián Biscayart[a,*], María Eugenia Pérez Carrega[a], Sandra Sagradini[a], Ángela Gentile[b], Daniel Stecher[c], Tomás Orduna[d], Silvia Bentancourt[e], Salvador García Jiménez[f], Luis Pedro Flynn[g], Gabriel Pirán Arce[h], María Andrea Uboldi[i], Laura Bugna[i], María Alejandra Morales[j], Clara Digilio[j], Cintia Fabbri[j], Delia Enría[j], Máximo Diosque[a], Carla Vizzotti[a]

- Dosis distribuidas: 1.943.000 (enero 2008-enero 2009)
- 165 ESAVI
  - 100 errores programáticos
  - 4 eventos coincidentes
  - 49 relacionados (mediana: 37 años, R:1-69, 77% hombres):
    - 12 YEL-AND (9 meningoencefalitis; 2 ADEM)/1 mielitis) (1 niño 11 años)
    - 12 YEL-AVD (1 confirmado; curso fatal) (1 niño 1 año)
  - 12 no concluyentes (1 fatal, 1 grave)

-Incidencia ESAVI serios: 12,3/1.000.000 dosis (50% eran > 50años, R:1-67)

-Incidencia YEL-AVD : 6/1.000.000 dosis (incluye probables)

Biscayart , C., et al. Vaccine 32 (2014) 1266–1272

Vaccine. 2011 Jun 20;29(28):4544-55. doi: 10.1016/j.vaccine.2011.04.055. Epub 2011 May 5.

Active and passive surveillance of yellow fever vaccine 17D or 17DD-associated serious adverse events: systematic review.

Thomas RE[1], Lorenzetti DL, Spragins W, Jackson D, Williamson T.

Author information

Abstract

PURPOSE: To identify the rate of serious adverse events attributable to yellow fever vaccination with 17D and 17DD strains reported in active and passive surveillance data.

- Australia:0/210.656 dosis de “eventos neurológicos serios”, 1/210.656 de YEL-AVD.
- Brazil: 9 hipersensibilidad; 0,23 anafilaxia; 0,84 YEL-AND y 0,19 YEL-AVD/ 1.000.000 dosis.
- US: 6,6 YEL-AVD y YEL-AND/ 1.000.000 dosis y estima 11,1 -15,6 eventos neurológicos serios/1.000.000.
- UK: 34 eventos neurológicos serios/1.000.000.
- Suiza: 14,6 eventos neurológicos y 40 eventos serios no neurológicos/1.000.000 dosis.

- **A pesar de estas variaciones en la estimación del daño grave, en general la vacuna contra la fiebre amarilla 17D y 17DD ha demostrado ser una vacuna muy segura y altamente eficaz.**

Adverse Events Following a Mass Yellow Fever Immunization Campaign — Kongo Central Province, Democratic Republic of the Congo, September 2016

John O. Otshudiema, MD[1,2]; Nestor G. Ndakala, MD[3]; Maurice L. Loko, MD[4]; Elande-taty K. Mawanda, MD[5]; Gaston P. Tshapenda, MD[6]; Jacques M. Kimfuta, MD[5]; Abdou S. Gueye, MD, PhD[7]; Jacob Dee, MPH[8]; Rossanne M. Philen, MD[7], Coralie Giese, MA, MPH[7], Christopher S. Murrill, PhD[9]; Ray R. Arthur, PhD[7]; Benoit I. Kebela, MD[6]

Morbidity and Mortality Weekly Report

TABLE. Adverse events following immunization (AEFIs) after a mass yellow fever vaccination campaign, identified through active surveillance system — Matadi Health Zone, Kongo Central Province, Democratic Republic of the Congo, September 2016

Patient	Sex	Age (yrs)	Date reported	Vaccine receipt to onset (days)	Description of AEFI (other associated medical conditions)*	Provisional classification peripheral level	Outcome
1†	F	23	5/27/2016	2	Cutaneous allergic reaction, rash, itching	Nonserious	Recovered
2	M	16	5/28/2016	3	Unexplained fever	Nonserious	Recovered
3	M	25	5/28/2016	2	Gastrointestinal syndrome, vomiting, fever	Nonserious	Recovered
4†	M	59	5/30/2016	2	Cutaneous allergic reaction, rash, itching	Nonserious	Recovered
5†	F	36	5/30/2016	2	Injection-site pain and erythema, tiredness, muscle pain	Nonserious	Recovered
6	M	3	5/30/2016	3	Undetermined hematuria and tiredness	Nonserious	Recovered
7†	F	26	5/31/2016	2	Cutaneous allergic reaction, rash, itching	Nonserious	Recovered
8†	F	49	5/31/2016	2	Cutaneous allergic reaction, rash, itching	Nonserious	Recovered
9†	F	14	5/31/2016	2	Cutaneous allergic reaction, rash, itching, fever	Nonserious	Recovered
10†	F	45	5/31/2016	2	Cutaneous allergic reaction, rash, itching, allergic reaction on lips	Nonserious	Recovered
11†	M	29	6/1/2016	2	Cutaneous allergic reaction, rash, itching, injection site pain and erythema	Nonserious	Recovered
12	F	25	6/1/2016	3	Allergic reaction on lips	Nonserious	Recovered
13	F	7	6/2/2016	2	Gastrointestinal syndrome, muscle pain, injection-site pain and erythema (severe malaria and urinary tract infection)	Serious	Recovered after 7-day hospitalization
14	M	17	6/4/2016	2	Eye allergic reaction, conjunctivitis	Nonserious	Recovered
15	F	22	6/11/2016	5	Spontaneous abortion of an unrecognized early pregnancy (endometritis)	Serious	Recovered after 7-day hospitalization

Adverse Events Following a Mass Yellow Fever Immunization Campaign — Kongo Central Province, Democratic Republic of the Congo, September 2016

John O. Otshudiema, MD[1,2]; Nestor G. Ndakala, MD[3]; Maurice L. Loko, MD[4]; Elande-taty K. Mawanda, MD[5]; Gaston P. Tshapenda, MD[6]; Jacques M. Kimfuta, MD[5]; Abdou S. Gueye, MD, PhD[7]; Jacob Dee, MPH[8]; Rossanne M. Philen, MD[7], Coralie Giese, MA, MPH[7], Christopher S. Murrill, PhD[9]; Ray R. Arthur, PhD[7]; Benoit I. Kebela, MD[6]

AEFIs included cutaneous allergic reactions, itching, fever, and injection site erythema. The incidences were 6.2 per 100,000 vaccine doses administered for all identified AEFIs and 0.8 for serious AEFIs. The AEFI incidence rate using the previous passive EPI surveillance data was 3.3 per 100.000 vaccine doses administered. Previous studies in African settings have found an expected AEFI rate of 8.2 per 100,000 yellow fever vaccine doses administered for all reported AEFIs and 0.4 for any serious AEFI (*4*).

The revised global yellow fever risk map and recommendations for vaccination, 2010: consensus of the Informal WHO Working Group on Geographic Risk for Yellow Fever

	Criterio de clasificación	Riesgo de infección	Vacunación
Endémico	Áreas con transmisión viral persistente por períodos largos, presencia de vectores y de huéspedes no humanos, y reportes repetidos de casos en humanos y/o primates, o seroprevalencia elevada, etc.	Alto	Recomendada a > 9 meses
De transición	Áreas que bordean zonas endémicas, con transmision viral durante las epidemias, presencia de vectores y huéspedes no humanos y reportes de casos en humanos y/o primates esporádicos, etc.	Moderado a alto	Recomendada a > 9 meses
Bajo potencial de exposición	Rodean a áreas de transición. Vectores y primates presentes. No evidencia de infección humana	Bajo	Generalmente no recomendada
Sin riesgo	Áreas sin documentación de FA. Condiciones ecoepidemiológicas desfavorables para la transmisión.	Sin riesgo	No recomendada
Algunos criterios no tienen base científica sólida para su definición (p. ej., “alto riesgo”; “Periodicidad baja”) y hacen preciso el uso de la experiencia en la materia.			

Lancet Infect Dis 2011; 11:622-32.

The revised global yellow fever risk map and recommendations for vaccination, 2010: consensus of the Informal WHO Working Group on Geographic Risk for Yellow Fever

Figure 3: Areas with risk of yellow fever virus transmission in South America, 2010

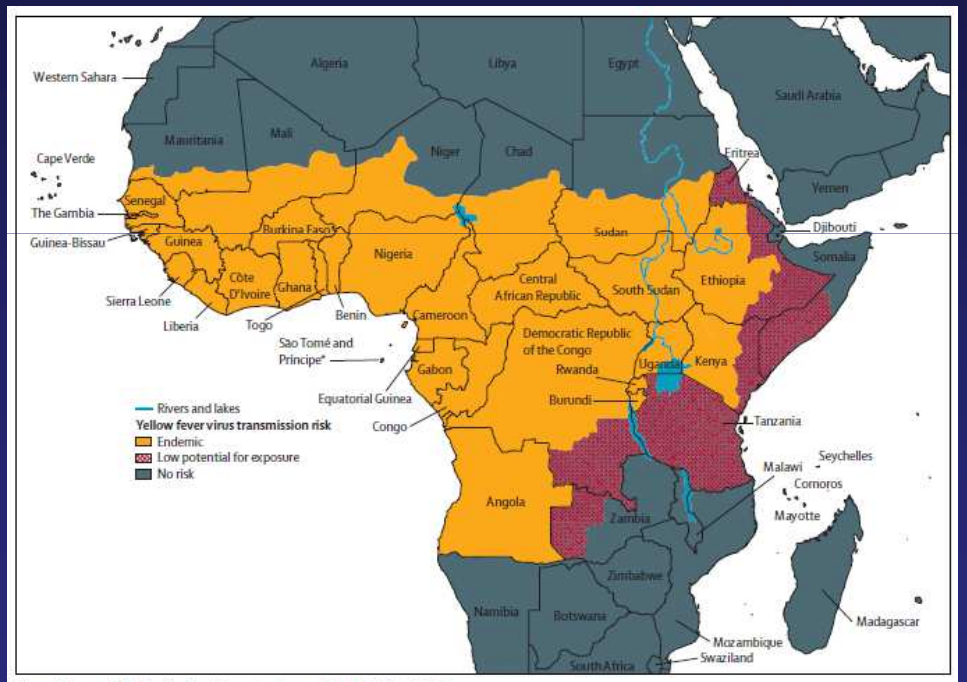


Figure 4: Areas with risk of yellow fever virus transmission in Africa, 2010
*São Tomé and Principe was classified as low potential for exposure.

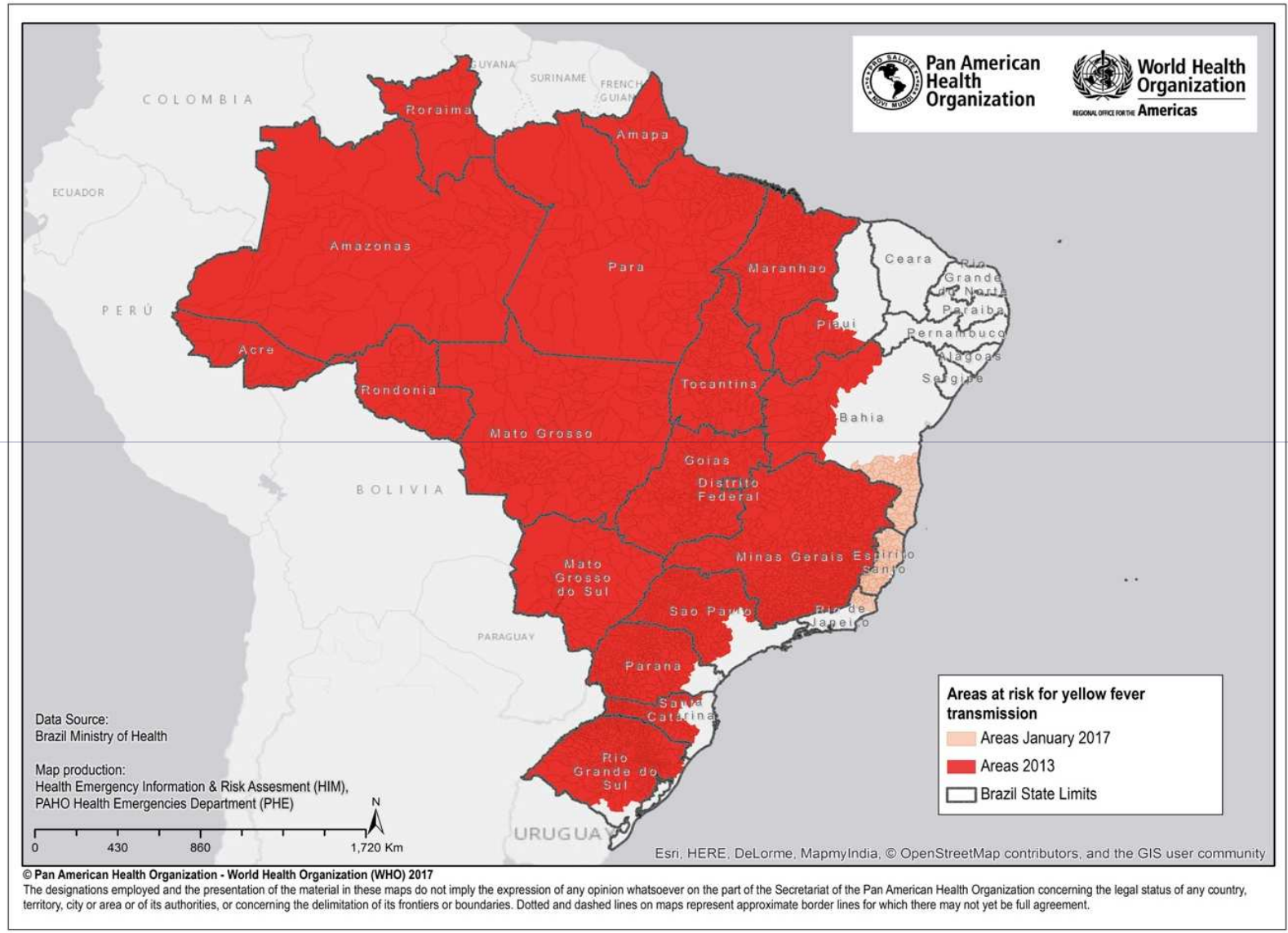
Lancet Infect Dis 2011; 11:622-32.

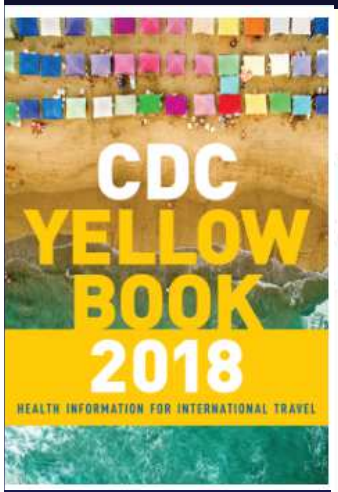
Riesgos calculados de FA en los viajes

- Para África:
  - Durante epidemias: 1/267 de enfermedad y 1/1333 de muerte por 2 semanas de estadía.
  - Durante interpepidémicos (silentes): 1,1-2,4/1000 de enfermedad y 0,2-0,5/1000 de muerte.

- Para América:
  - 1/20.000 de enfermedad y 1/100.000 de riesgo de muerte por 2 semanas de estadía.

Monath T, Cetron M. Clin Infect Dis 2002; 34: 1369-78





- From 1970 through 2015, a total of 10 cases of yellow fever were reported in unvaccinated travelers from the United States and Europe who traveled to West Africa (5 cases) or South America (5 cases).
- Eight (80%) of these 10 travelers died.
- There has been only 1 documented case of yellow fever in a vaccinated traveler.
- In early 2016, >15 long-term travelers from Africa and Asia developed yellow fever disease after visiting Angola, where one of the largest urban outbreaks was occurring. None of the ill travelers was vaccinated.

Precautions

Infants aged 6–8 months

Age 6–8 months is a precaution for yellow fever vaccination. Two cases of YEL-AND have been reported among infants aged 6–8 months. In infants <6 months of age, the rates of YEL-AND are elevated (50–400 per 100,000). By 9 months of age, risk for YEL-AND is believed to be substantially lower. ACIP generally recommends that, whenever possible, travel to yellow fever–endemic countries should be postponed or avoided for children aged 6–8 months. If travel is unavoidable, the decision of whether to vaccinate these infants needs to balance the risks of YFV exposure with the risk for adverse events after vaccination.

Claves/consideraciones para tomar la decisión

- Evaluar en cada caso la decisión teniendo en cuenta:

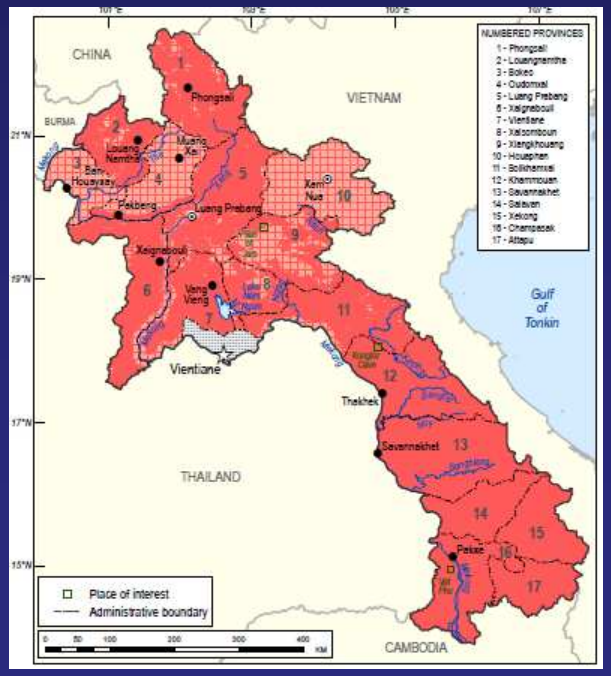
✓ Características del viaje (riesgo de exposición)
✓ Necesidad e importancia familiar del viaje
✓ Características de la familia y compromiso frente al sistema de salud, relación con médico de cabecera, etc.
✓ Nivel sociocultural familiar

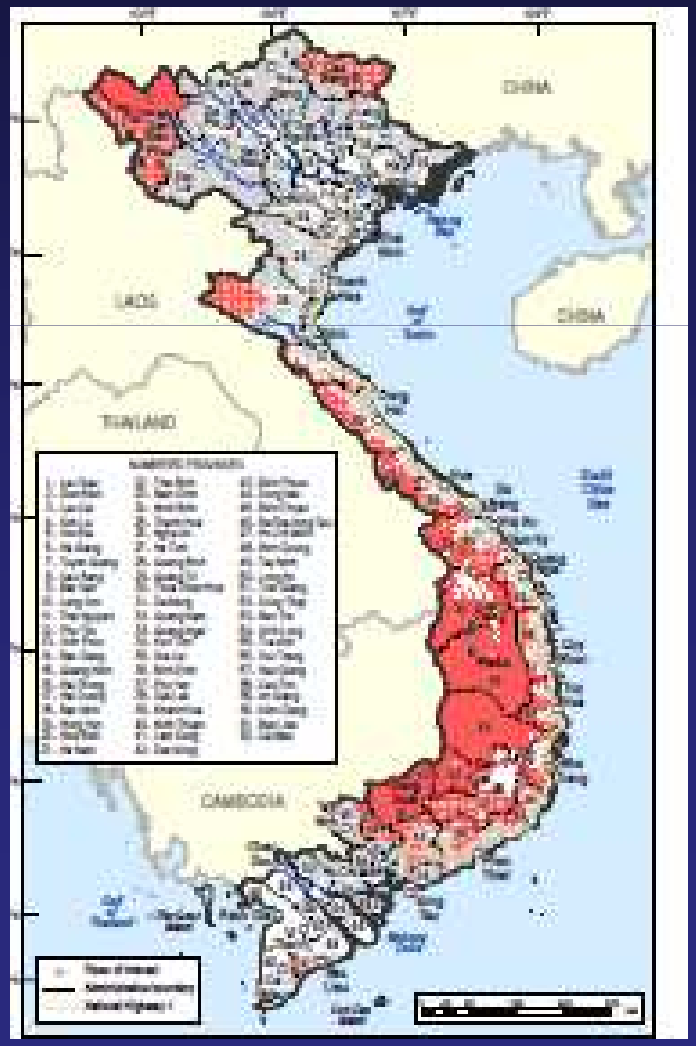
Estrategias para la toma de decisión

- Explicar los riesgos/beneficios de la vacuna
- Respaldarse con la bibliografía
- Evaluar en cada caso la decisión teniendo en cuenta los diversos factores expuestos
- Entregar material escrito informativo
- Diferir la decisión para una 2da consulta
- Lo ideal es tomar la decisión en forma conjunta con el pediatra de cabecera y la familia
- Consentimiento informado?

Situación 2- profilaxis de malaria en menores de 8 años viajeros a áreas mefloquino-resistentes

- Familia que consulta previaje a Vietnam durante 10 días y eventual Laos, con niña de 7 años de edad





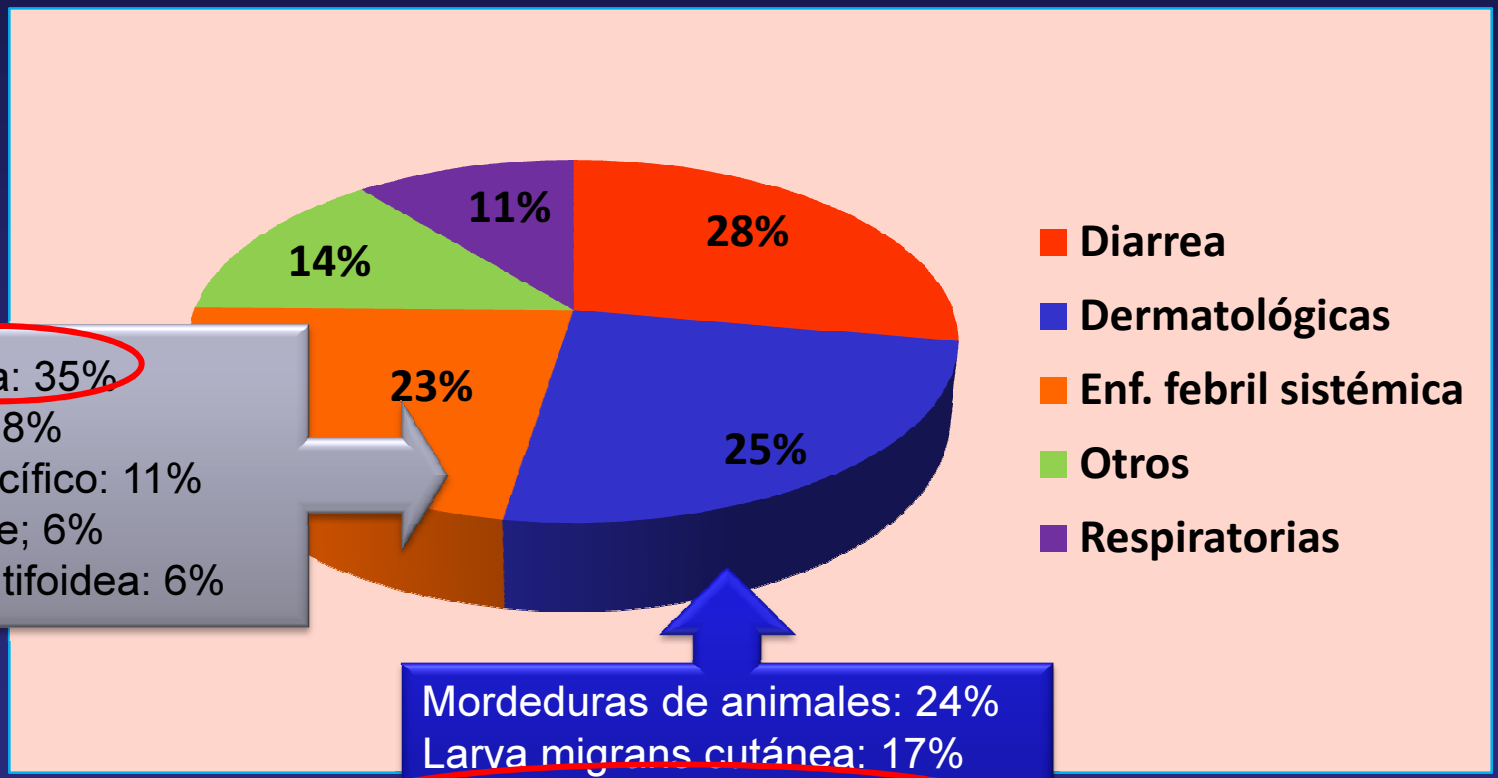
Region*	Level of risk
Sub-Saharan Africa	High
Pacific Islands: Papua New Guinea, Solomon Islands, Vanuatu	High
Indian Subcontinent	Intermediate
Hispaniola	Intermediate
Southeast and East Asia	Low
Central and South America	Low
*Relative risk varies even within each region.	

Illness in Children After International Travel: Analysis From the GeoSentinel Surveillance Network

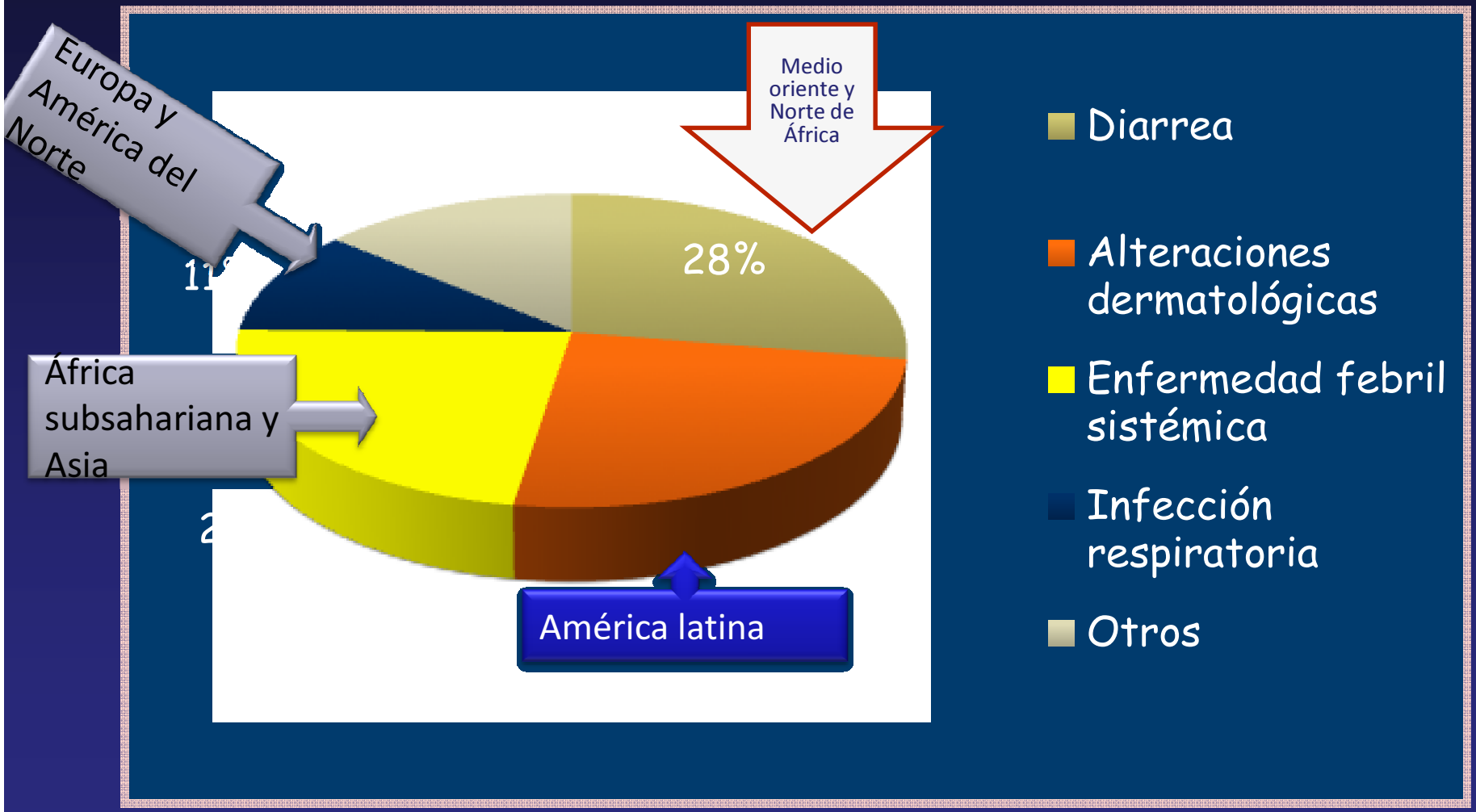
Stefan Hagmann, Richard Neugebauer, Eli Schwartz, Cecilia Perret, Francesco Castelli, Elizabeth D. Barnett, William M. Stauffer and for the GeoSentinel Surveillance Network

Pediatrics 2010;125;e1072-e1080; originally published online Apr 5, 2010; DOI: 10.1542/peds.2009-1951

Diagnósticos sindromáticos al regreso

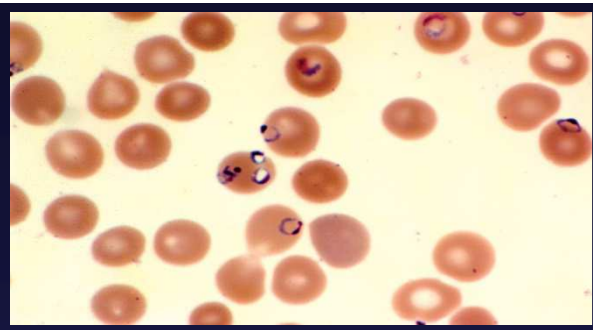


Diagnósticos sindromáticos según destino



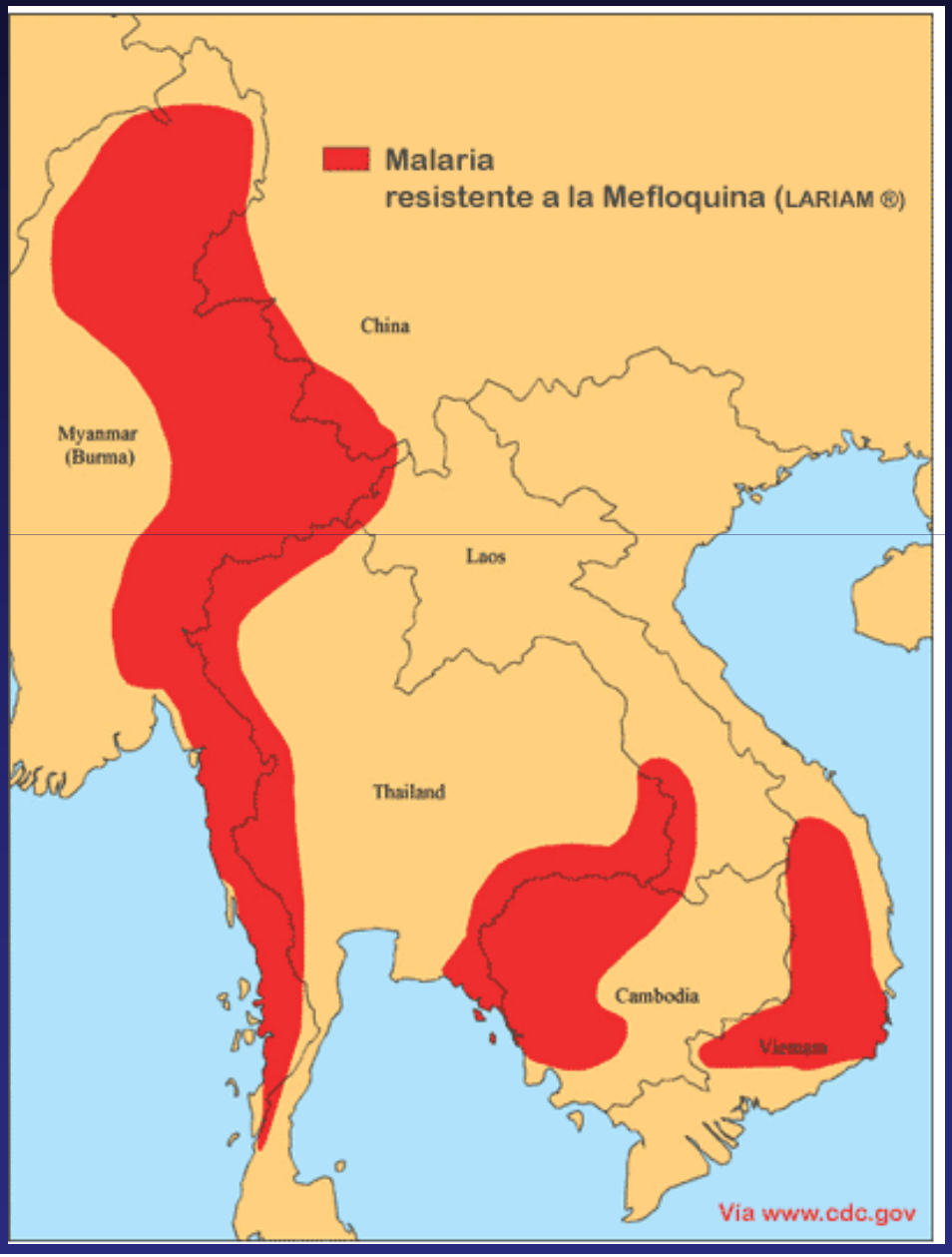
Illness in Children After International Travel: Analysis From the GeoSentinel Surveillance *Pediatrics 2010;125;e1072*

Malaria en niños



- Es la infección mas grave que pueden adquirir los niños
- Cursan con rápido incremento de la parasitemia
- Tienen mayor riesgo de complicaciones: shock, convulsiones
- Sin tratamiento la malaria grave por *P. falciparum* es mortal en la mayoría de los casos.
- Alto riesgo de adquirirla en niños que visitan familiares

Distribución geográfica de Malaria resistente a mefloquina (CDC)



Profilaxis de Malaria en niños

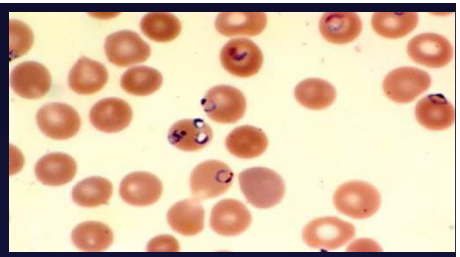


TABLE 4. Antimalarial chemoprophylaxis for children

Antimalarial	Indication for chemoprophylaxis	Dosing	Description
Atovaquone-proguanil	>5 kg body wt per CDC[a] >11 kg body wt per manufacturer and some European countries	Daily Pediatric tablets	Palatable Expensive
Chloroquine (hydroxychloroquine)	All ages and weights	5 mg base/kg weekly	Limited use due to resistance
Proguanil	All ages and weights	3 mg/kg/day	Only in combination with chloroquine
Doxycycline	Children >8 yr old	1.5 mg salt/kg daily	Contraindicated for small children
Mefloquine	Children >5 kg	5 mg/kg weekly	Bitter taste
Primaquine	Children >4 yr old per WHO CDC specifies no lower age limit	0.5 mg/kg base Daily	G6PD testing essential Last choice

[a] New recommendations for 2007.

Clin Microbiol Rev, July 2008: 466–472

Gaillard et al. Malar J (2017) 16:148
DOI 10.1186/s12936-017-1797-9

Malaria Journal

REVIEW Open Access

The end of a dogma: the safety of doxycycline use in young children for malaria treatment

Tiphaine Gaillard[1], Sébastien Briolant[2,3], Marylin Madamet[2,3,4] and Bruno Pradines[2,3,4*]

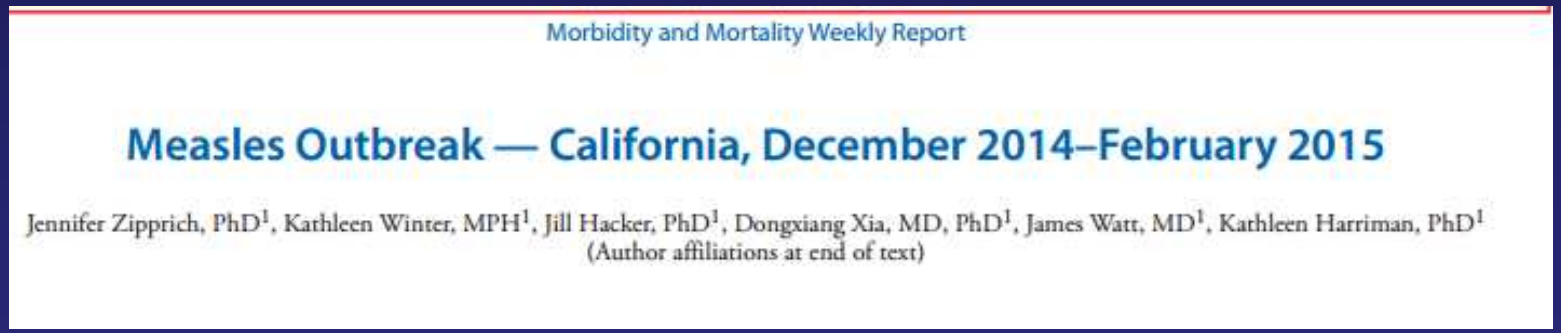
Abstract

Anti-malarial drug resistance to chloroquine and sulfadoxine–pyrimethamine has spread from Southeast Asia to Africa. Furthermore, the recent emergence of resistance to artemisinin-based combination therapy (ACT) in Southeast Asia highlights the need to identify new anti-malarial drugs. Doxycycline is recommended for malaria chemoprophylaxis for travel in endemic areas, or in combination with the use of quinine for malaria treatment when ACT is unavailable or when the treatment of severe malaria with artesunate fails. However, doxycycline is not used in young children under 8 years of age due to its contraindication due to the risk of yellow tooth discolouration and dental enamel hypoplasia. Doxycycline was developed after tetracycline and was labelled with the same side-effects as the earlier tetracyclines. However, recent studies report little or no effects of doxycycline on tooth staining or dental enamel hypoplasia in children under 8 years of age. In the United States, the Centers for Disease Control and Prevention have recommended the use of doxycycline for the treatment of acute and chronic Q fever and tick-borne rickettsial diseases in young children. It is time to rehabilitate doxycycline and to recommend it for malaria treatment in children under 8 years of age.

Keywords: Antibiotics, Doxycycline, Malaria, *Plasmodium falciparum*, Anti-malarial drug, Resistance, Prophylaxis, Treatment, Children

Situación 3- vacunación del viajero inmunosuprimido pediátrico

- Paciente de 5 años, LLA (debut a los 2 ½ años) 2da recaída, viajero a Disney.
- Vacuna: única dosis de MMR a los 12 meses.



Morbidity and Mortality Weekly Report

Measles Outbreak — California, December 2014–February 2015

Jennifer Zipprich, PhD[1], Kathleen Winter, MPH[1], Jill Hacker, PhD[1], Dongxiang Xia, MD, PhD[1], James Watt, MD[1], Kathleen Harriman, PhD[1]
(Author affiliations at end of text)

- Cuándo vacunar? Cuándo contraindicar el viaje?

Vaccine 35 (2017) 1216–1226

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Review

Safety of live vaccinations on immunosuppressive therapy in patients with immune-mediated inflammatory diseases, solid organ transplantation or after bone-marrow transplantation – A systematic review of randomized trials, observational studies and case reports

Evelina Croce [a], Christoph Hatz [a,b,c], Emile F. Jonker [d], L.G. Visser [d], Veronika K Jaeger [e], Silja Bühler [a,*]

[a] Department of Public Health, Division of Infectious Diseases/Travel Clinic, Epidemiology, Biostatistics and Prevention Institute, Hirschengraben 84, 8001 Zurich, Switzerland
[b] Department of Medicine and Diagnostics, Swiss Tropical and Public Health Institute, Socinstrasse 57, 4051 Basel, Switzerland
[c] University of Basel, Petersplatz 1, 4003 Basel, Switzerland
[d] Department of Infectious Diseases, Leiden University Medical Center, Leiden, The Netherlands
[e] Department of Rheumatology, Basel University Hospital, Petersgraben 4, 4031 Basel, Switzerland

Table 3
Safety of live vaccines in immune-mediated inflammatory diseases, solid organ transplant and bone marrow transplant patients.

Vaccination		IMID	SOT	BMT
		(n = 20,556)	(n = 339)	(n = 187)
Yellow Fever	Vaccinated doses	233	20	0
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	1 (0.4)[a]	–	–
Mumps, measles, rubella	Vaccinated doses	474	172	152
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	1 (0.2)[b]	2 (1.2)[g]	–
Varicella	Vaccinated doses	202	192	38
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	2 (1.0)[c]	14 (7.3)[h]	4 (10.5)[i]
Herpes zoster	Vaccinated doses	19,630	0	0
	Local or systemic SAEs; n (%)	11 (0.06)	–	–
	Infection through vaccine strain; n (%)	5 (0.03)	–	–
Oral Polio	Vaccinated doses	1	0	0
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	1 (100.0)[d]	–	–
BCG	Vaccinated doses	5	24	0
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	1 (20.0)[e]	–	–
Live typhoid	Vaccinated doses	10	0	0
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	–	–	–
Small pox	Vaccinated doses	1	0	0
	Local or systemic SAEs; n (%)	–	–	–
	Infection through vaccine strain; n (%)	1 (100)[f]	–	–

[a] Unknown whether primary or secondary vaccination.
[b] One patient with active systemic JIA received the 1st MMR dose and experienced a rash and fever 20 days after vaccination (interpreted as disease-related [personal communication with authors]).
[c] One patient developed varicella after a primary vaccine dose, one after a secondary vaccine dose.
[d] No symptoms but stool culture positive for poliovirus Sabin 1-like RNA.
[e] BCG was given to infant whose mother was treated with infliximab during pregnancy.
[f] A patient with atopic dermatitis under topic steroid treatment developed isolated lesions around eyes and mouth developed 9 days after vaccination with widespread umbilicated vesicles and pustules in these areas. The patient had extensive swelling of his face and neck and also fever and headache.
[g] Two patients developed parotitis after MMR vaccination, unclear whether after 1st or 2nd dose.
[h] 12/14 developed vaccine-associated varicella after a primary vaccination, the remaining two after a re-vaccination.
[i] in 1 patient it was unclear whether the patient developed a vaccine-related varicella-like rash after a primary or a secondary vaccination, in the other 3 patients a disseminated rash occurred in seronegative patients.

Refuerzos para vacuna de Fiebre Amarilla (ACIP 2015)

BOX. Recommendations for use of yellow fever vaccine booster doses*

- A single primary dose of yellow fever vaccine provides long-lasting protection and is adequate for most travelers [Category A].
- Additional doses of yellow fever vaccine are recommended for certain travelers:
  - Women who were pregnant (regardless of trimester) when they received their initial dose of yellow fever vaccine should receive 1 additional dose of yellow fever vaccine before their next travel that puts them at risk for yellow fever virus infection [Category A];
  - Persons who received a hematopoietic stem cell transplant after receiving a dose of yellow fever vaccine and who are sufficiently immunocompetent to be safely vaccinated should be revaccinated before their next travel that puts them at risk for yellow fever virus infection [Category A];
  - Persons who were infected with human immunodeficiency virus when they received their last dose of yellow fever vaccine should receive a dose every 10 years if they continue to be at risk for yellow fever virus infection [Category A].
- A booster dose may be given to travelers who received their last dose of yellow fever vaccine at least 10 years previously and who will be in a higher-risk setting based on season, location, activities, and duration of their travel [Category B]. This would include travelers who plan to spend a prolonged period in endemic areas or those traveling to highly endemic areas such as rural West Africa during peak transmission season or an area with an ongoing outbreak.

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Inmunodeficiencias primarias

Inmunodeficiencia	**Vacuna CONTRAINDICADA**
Agammaglobulinemia IDCV (común variable)	OPV - BCG *Salmonella typhi* T y 21a Considerar sarampión y varicela
IDCS (combinada severa)	Todas las vacunas atenuadas
Deficiencias del complemento	NINGUNA
EGC (Enf. granulomatosa crónica)	BCG *Salmonella typhi* T y 21a

Consultorio de viajeros

Conclusiones

- Los viajeros pediátricos representan un desafío para el infectólogo pediatra en la consulta pre viaje.
- Las conductas se deben ir adaptando acorde a los cambios epidemiológicos.
- Idealmente en las situaciones controvertidas se debe acordar estrategias con el pediatra de cabecera.

Gracias …

SLAMVI
Sociedad Latinoamericana de Medicina del Viajero

HA Hospital Alemán
Deutsches Hospital

Por un niño sano en un mundo mejor

Dr. STAMBOULIAN
Medicina del Viajero
La primera escala de su viaje.