Infecciones virales en pacientes ambulatorios

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Instituto de Investigaciones

CEMIC
Centro de Educación Médica
e Investigaciones Clínicas
"Norberto Quirno"

SOLO USO INTERNO

CEMIC

Paciente	[redacted] DELFINA	Nº Historia Clínica	150327903	Fecha de Nacimiento	27/3/2015
Edad	, 4 meses, 24 días	Sexo	F	Plan	
Tipo Doc.	DNI	Nº Doc.	54702151	Fecha de Ingreso	20/7/2015
Convenio	O.SOC.DEL PODER JUDICIAL(PRES.	Nº Afiliado	6917631	Fecha de Egreso	21/7/2015
Tipo de Alta	SANATORIAL	Días de Internación	1		

E P I C R I S I S

Centro de Atención : **H. U. SAAVEDRA** Departamento : **PEDIATRIA**

Motivo de Internación

BRONQUIOLITIS

Antecedentes

Diagnósticos al Egreso

BRONQUIOLITIS

Resumen de Internación

PACIENTE DE TRES MESES DE EDAD, SIN ANTECEDENTES PATOLOGICOS DE RELEVANCIA, INGRESA EL DIA 20/7 A SALA DE INTERNACION PEDIATRICA POR BRONQUIOLITIS. LA NIÑA COMENZO 15 DIAS PREVIIOS CON CVAS Y LUEGO SILBILANCIAS, CONSULTANDO EN VARIAS OPORTUNIDADES A GUARDIA DE ESTA INSTITUCION. CONSULTA EL 20/7 POR REGULAR MECANICA VENTILATORIA, SE DECIDE SU INTERNACION PARA OBSERVACION Y EVENTUAL OXIGENOTERAPIA. PERMANECIO EN BEG, CON MEJORIA DE TAQUIPNEA Y DE MECANICA VENTILATORIA, SIN REQUERIMIENTO DE OXIGENO, CON SALBUTAMOL C/ 4 HS Y METILPREDNISONA 1MG/KG/DIA C/ 8 HS (RECIBIO 3 DIAS DE TTO CORTICOIDE EN TOTAL) . SE REALIZA VSNF: PENSIENTE RESULTADO. POR BUENA EVOLUCION CLINICA, SIN REQUERIMIENTO DE OXIGENO, SE DECIDE OTORGAR EL EGRESO SANATORIAL.

Indicaciones al Alta

Destino de Alta

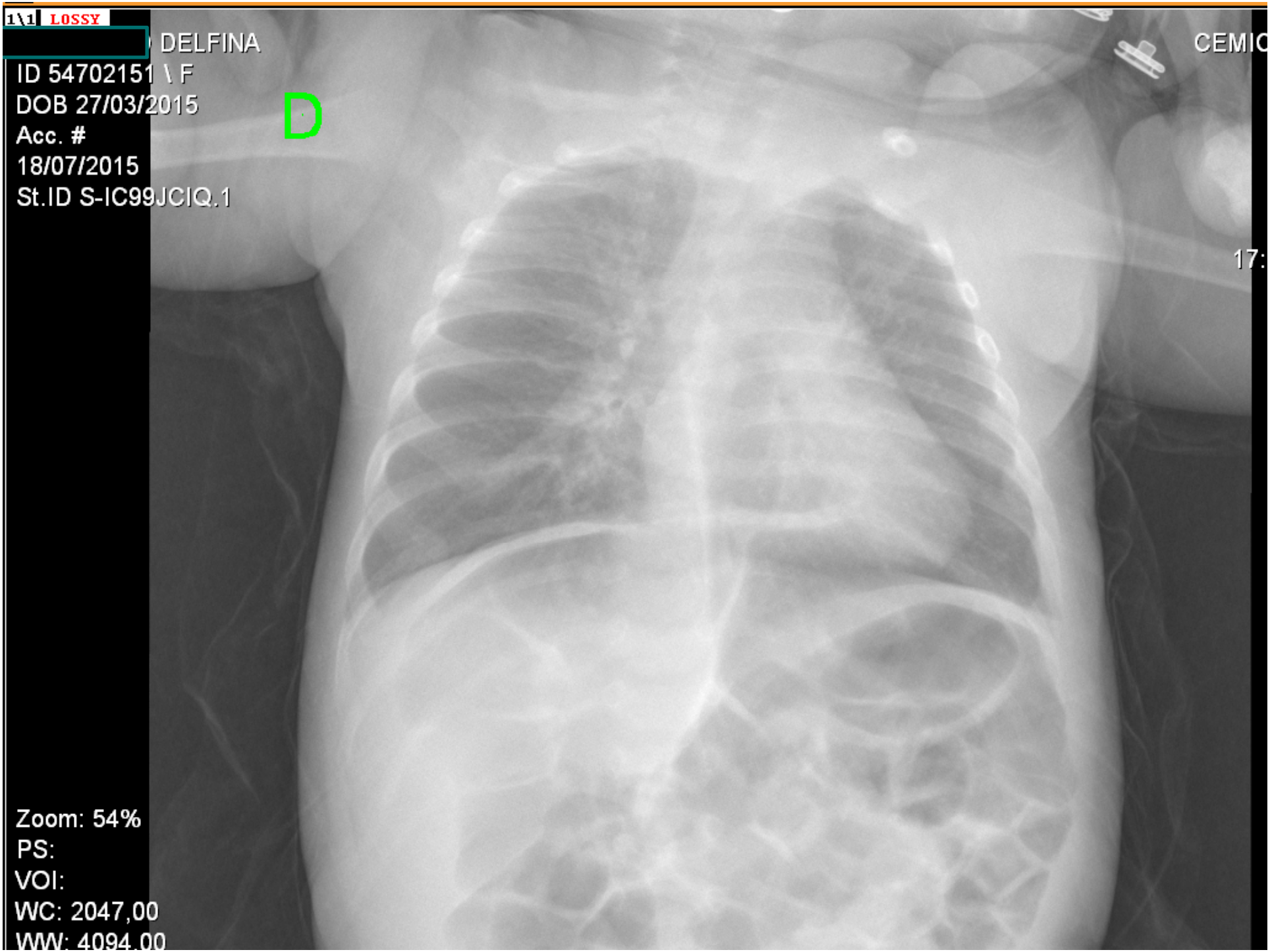
DOMICILIO

Indicaciones Farmacológicas

SALBUTAMOL mg VIA VO 2 PUFF C/ 4 HS

Indicaciones No Farmacológicas

PAUTAS DE ALARMA CONTROL CON PEDIATRA DE CABECERA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Recomendaciones para el manejo de las infecciones respiratorias agudas bajas en menores de 2 años

Recommendations for the management of acute lower respiratory infections in children under 2 years of age

Comité Nacional de Neumonología, Comité Nacional de Infectología y Comité de Medicina Interna.

Coordinadores: *Dra. Laura Moreno, Dr. Fernando Ferrero.*
Colaboradores: *Dr. Néstor Abramovich, Dra. Verónica Aguerre, Dra. Miriam Bruno, Dra. Miriam Calvari, Dra. Ana Ceballos, Dra. Ángela Gentile, Dra. Norma González, Dr. Alberto Maffey, Dra. Patricia Paba, Dr. Raúl Ruvinsky, Dr. Santiago Vidaurreta, Dr. Fernando Vila.*

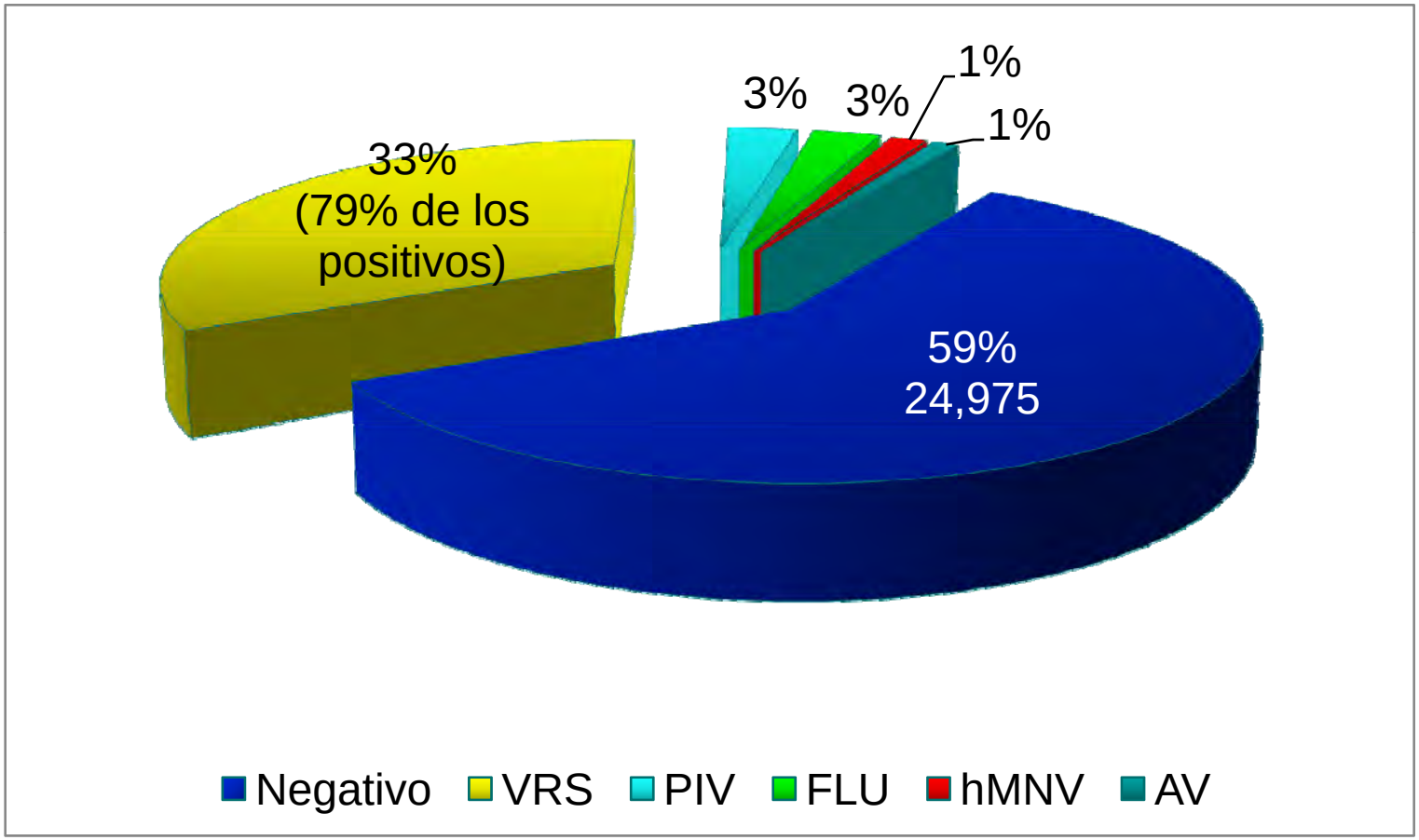
Bronquiolitis

- Definición:
  - Primer (o segundo) episodio de sibilancias asociado a manifestaciones clínicas de infección viral en un niño menor de dos años. Es una inflamación difusa y aguda de las vías aéreas inferiores, de naturaleza infecciosa (IRAB), expresada clínicamente por obstrucción de la vía aérea pequeña.

Sociedad Argentina de Pediatría. Subcomisiones, Comités y Grupos de Trabajo. Archivos Argentinos de Pediatría Vol. 113 Nro 4 – Agosto 2015

Sistema Nacional de Vigilancia Epidemiológica por Laboratorios de Argentina (SIVILA – SNVS)

42.481 menores de 2 años estudiados



SOLO USO INTERNO

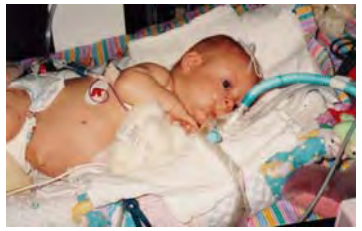
CEMIC

Paciente: [redacted] **DELFINA**		N° Historia Clínica:	**150327903**
Edad:	**100 Años**	Sexo:	**F**
Tipo Doc:	**DNI**	N° Doc:	**54702151**
Convenio:	**PODER JUDICIAL N°PRESTADOR 4082**	Plan:	**900**
N° Afiliado:	**6917631**	Sucursal/Orden:	**2/1383713**

Estudio	Determinación	Resultado	Unidades
RINOVIRUS PCR	RINO VIRUS PCR	NEGATIVO	
VSR-ANTIGENO (VIRUS SINCICIAL RESPIRATORIO)	VSR VIRUS SINCICIAL ANTIGENO	NEGATIVO	
VSR-ANTIGENO (VIRUS SINCICIAL RESPIRATORIO)	MUESTRA VIRUS SINCICIAL ANTIGE	ANF	
ADENOVIRUS-ANTIGENO	ADENOVIRUS ANTIGENO	NEGATIVO	
ADENOVIRUS-ANTIGENO	MUESTRA ADENOVIRUS ANTIGENO	ANF	
INFLUENZA A-ANTIGENO	INFLUENZA A-ANTIGENO	NEGATIVO	
INFLUENZA A-ANTIGENO	MUESTRA INFLUENZA A-ANTIGENO	ANF	
INFLUENZA B-ANTIGENO	INFLUENZA B-ANTIGENO	NEGATIVO	
INFLUENZA B-ANTIGENO	MUESTRA INFLUENZA B-ANTIGENO	ANF	
PARAINFLUENZA 1-3-ANTIGENO	PARAINFLUENZA ANTIGENO	NEGATIVO	
PARAINFLUENZA 1-3-ANTIGENO	MUESTRA PARAINFLUENZA ANTIGENO	ANF	

Opciones terapéuticas actuales para VSR

- Terapia de soporte (oxígeno suplementario, hidratación, permeabilizar narinas, alimentación)



- No ha vacunas disponibles (se encuentran en desarrollo)

- Inmunización pasiva profiláctica con palivizumab
  (Pre-términos< 32 semanas de edad gestacional)

Respiratory Syncytial Virus and Recurrent Wheeze in Healthy Preterm Infants

Maarten O. Blanken, M.D., Maroeska M. Rovers, Ph.D., Jorine M. Molenaar, M.D., Pauline L. Winkler-Seinstra, M.Sc., Adam Meijer, Ph.D., Jan L.L. Kimpen, M.D., Ph.D., and Louis Bont, M.D., Ph.D., for the Dutch RSV Neonatal Network

Niños entre 33 y <36 semanas de edad gestacional

Table 3. Infants with Wheezing.*

Variable	Palivizumab (N=214)	Placebo (N=215)	Absolute Reduction†	Relative Risk Reduction (95% CI)†
Any wheezing — no. of infants (%)	66 (30.8)	101 (47.0)	16.2	34 (14–53)
Wheezing episodes — no.	137	266	129	48 (32–62)
Recurrent wheezing — no. of infants (%)	24 (11.2)	45 (20.9)	9.7	47 (14–80)

* Any wheezing was defined as at least one episode of wheezing during the first year of life. A wheezing episode was defined as a respiratory episode with wheezing on more than 1 day. Recurrent wheezing was defined as three or more episodes of wheezing during the first year of life. P<0.001 for the between-group comparisons for any wheezing and wheezing episodes and P=0.005 for recurrent wheezing.

† The values for absolute reduction are percentage points, and the values for relative risk reduction are numbers of episodes.

El tratamiento con palivizumab redujo significativamente las sibilancias recurrentes en niños sanos durante el primer año de vida. Esto demuestra la importancia del VSR como mecanismo de producción de sibilancias en ésta edad

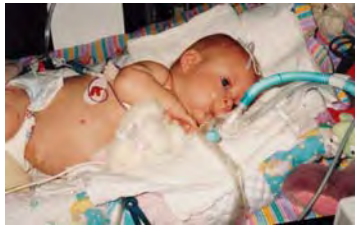
Figure 2. Cumulative Wheezing Days for 429 Preterm Infants during the First Year of Life.

P<0.001 for the comparison between palivizumab and placebo with the use of Poisson regression.

CONCLUSIONS

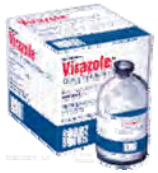
In otherwise healthy preterm infants, palivizumab treatment resulted in a significant reduction in wheezing days during the first year of life, even after the end of treatment. These findings implicate RSV infection as an important mechanism of recurrent wheeze during the first year of life in such infants. (Funded by Abbott

Opciones terapéuticas actuales para VSR



- Terapia de soporte (oxígeno suplementario, hidratación, permeabilizar narinas, alimentación)
- No ha vacunas disponibles (se encuentran en desarrollo)
- Inmunización pasiva profiláctica con palivizumab (Pre-términos< 36 semanas de edad gestacional)

- Tratamiento con Rivavirin en aerosol



- Los corticoides, broncodilatadores, montelukast, adrenalina y ClNa 3% no han demostrado ser útiles en el tratamiento de la enfermedad

THE LANCET Infectious Diseases

Volume 7, Issue 9, September 2007, Pages 575

Newsdesk

Steroids confer no benefit in children with RSV bronchiolitis

Cathel Kerr

http://dx.doi.org/10.1016/S1473-3099(07)70199-8, How to Cite or Link Using DOI

Permissions & Reprints

Study of Montelukast for the Treatment of Respiratory Symptoms of Post–Respiratory Syncytial Virus Bronchiolitis in Children

Hans Bisgaard[1], Alejandro Flores-Nunez[2], Anne Goh[3], Parvin Azimi[4], Andrew Halkas[5], Marie-Pierre Malice[6], Jean-Louis Marchal[6], S. Balachandra Dass[6], Theodore F. Reiss[6], and Barbara A. Knorr[6]*

Conclusions: In this study, montelukast did not improve respiratory symptoms of post-RSV bronchiolitis in children.

Clinical trial registered with www.clinicaltrials.gov (NCT00076973).

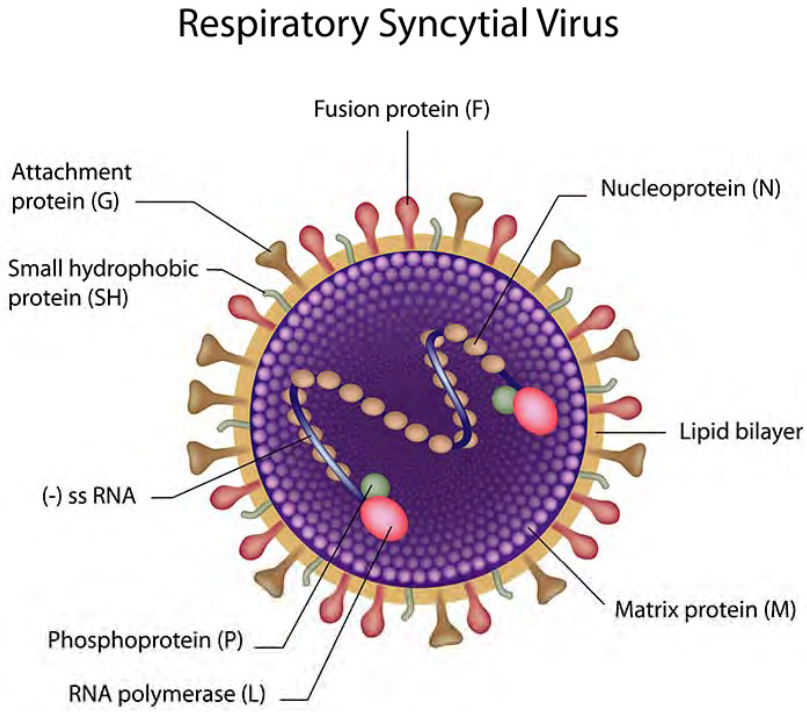
The NEW ENGLAND JOURNAL of MEDICINE

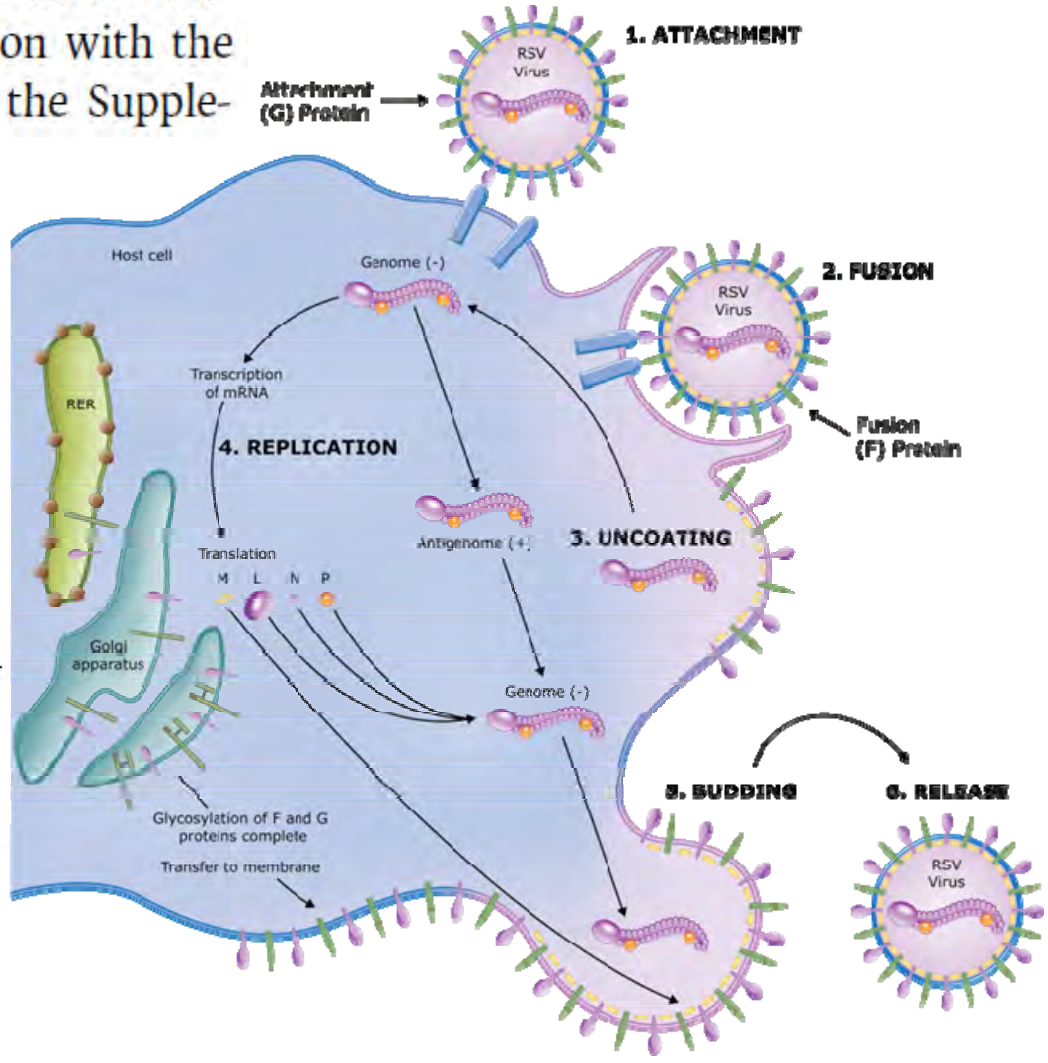
ORIGINAL ARTICLE

Oral GS-5806 Activity in a Respiratory Syncytial Virus Challenge Study

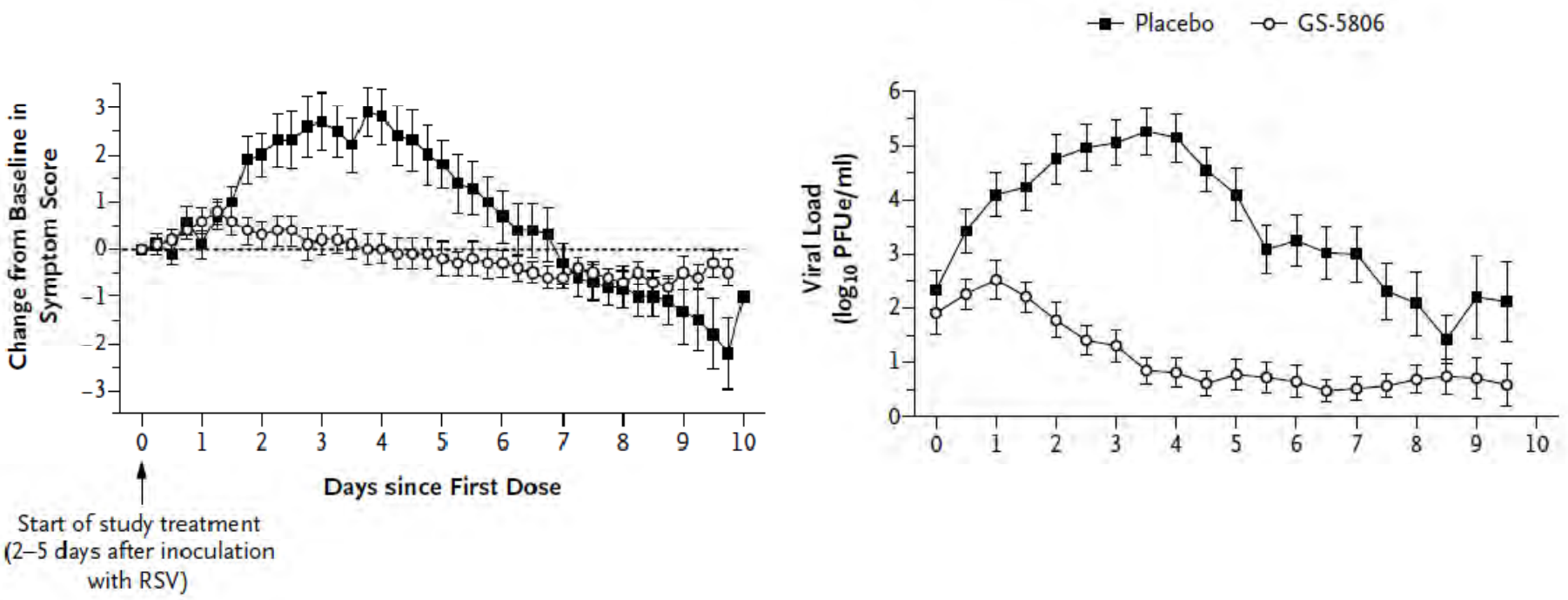
John P. DeVincenzo, M.D., Richard J. Whitley, M.D., Richard L. Mackman, Ph.D., Cecilia Scaglioni-Weinlich, M.D., Lisa Harrison, M.L.T., Eric Farrell, B.S., Stephen McBride, B.S., Robert Lambkin-Williams, Ph.D., Robert Jordan, Ph.D., Yan Xin, Ph.D., Srini Ramanathan, Ph.D., Thomas O'Riordan, M.D., Sandra A. Lewis, M.S., Xiaoming Li, Ph.D., Seth L. Toback, M.D., Shao-Lee Lin, M.D., Ph.D., and Jason W. Chien, M.D.

GS-5806 is a novel oral small molecule that inhibits RSV entry at low nanomolar concentrations by blocking viral-envelope fusion with the host-cell membrane (for details see the Supple-





Administración de la droga vía oral, al comenzar los síntomas o 5 días después de la inoculación intranasal de VRS en adultos.



CONCLUSIONS

Treatment with GS-5806 reduced the viral load and the severity of clinical disease in a challenge study of healthy adults. (Funded by Gilead Sciences; ClinicalTrials.gov number, NCT01756482.)

The Impact of Viral Dynamics on the Clinical Severity of Infants With Respiratory Syncytial Virus Bronchiolitis

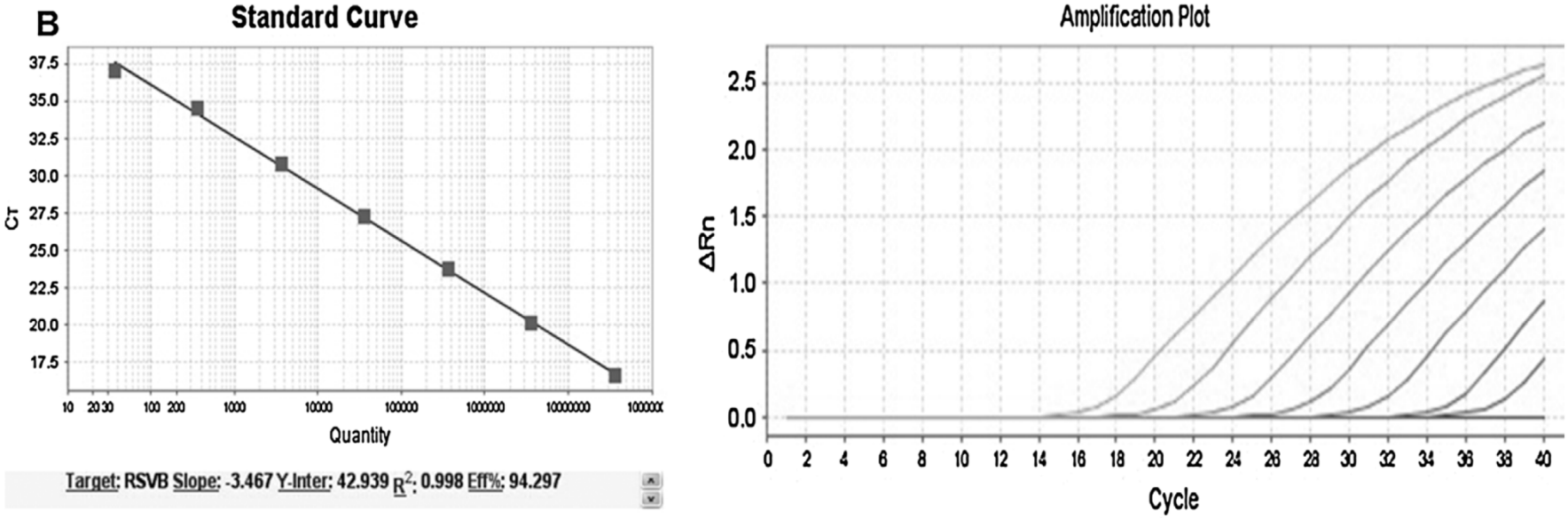


Fig. 1. Representative results from the real-time qPCR quantification of serial dilutions of RSVA and RSVB plasmids (10^1–10^7 copies/reaction). The baseline-corrected fluorescence was plotted against the cycle number. **A**: Standard curve and amplification plot of RSVA.

Lili Zhou, Journal of Medical Virology 87:1276–1284 (2015)

Dynamic RSV Load and Clinical Severity

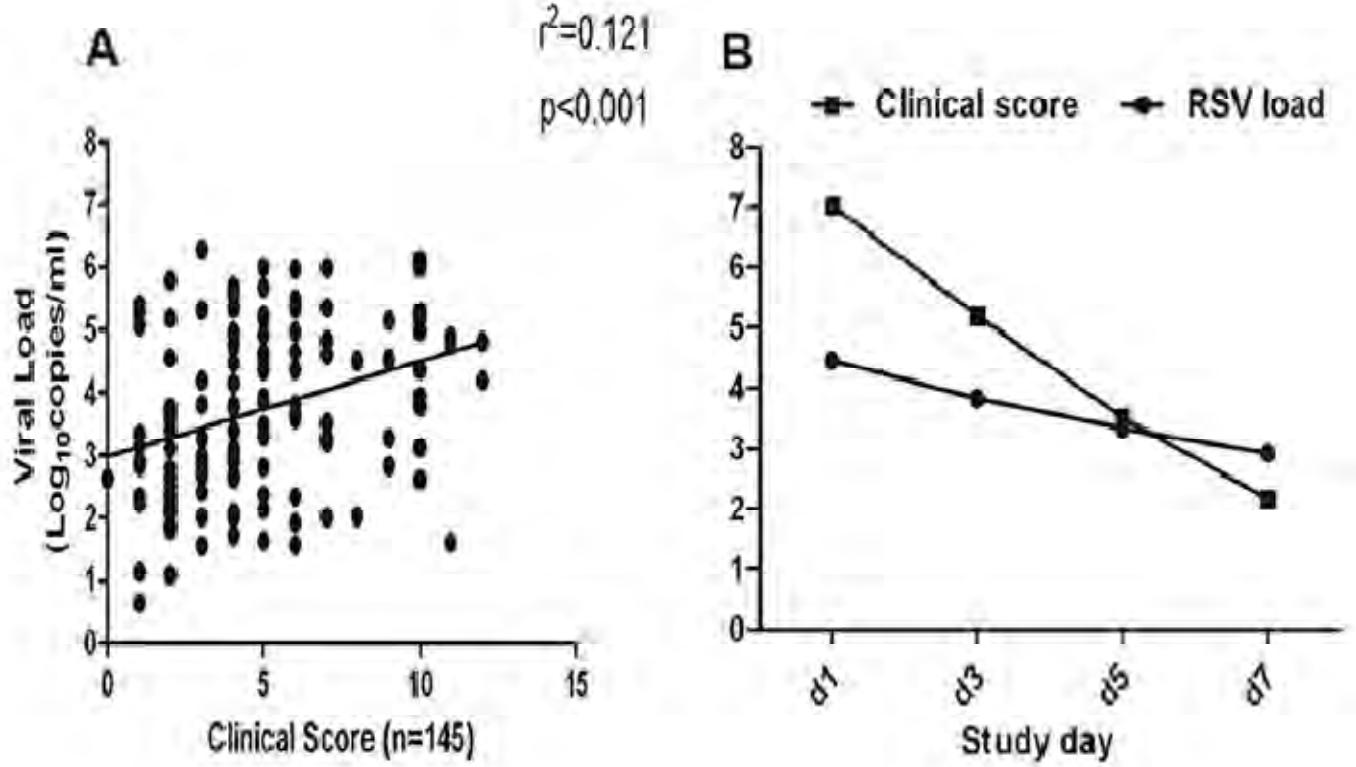
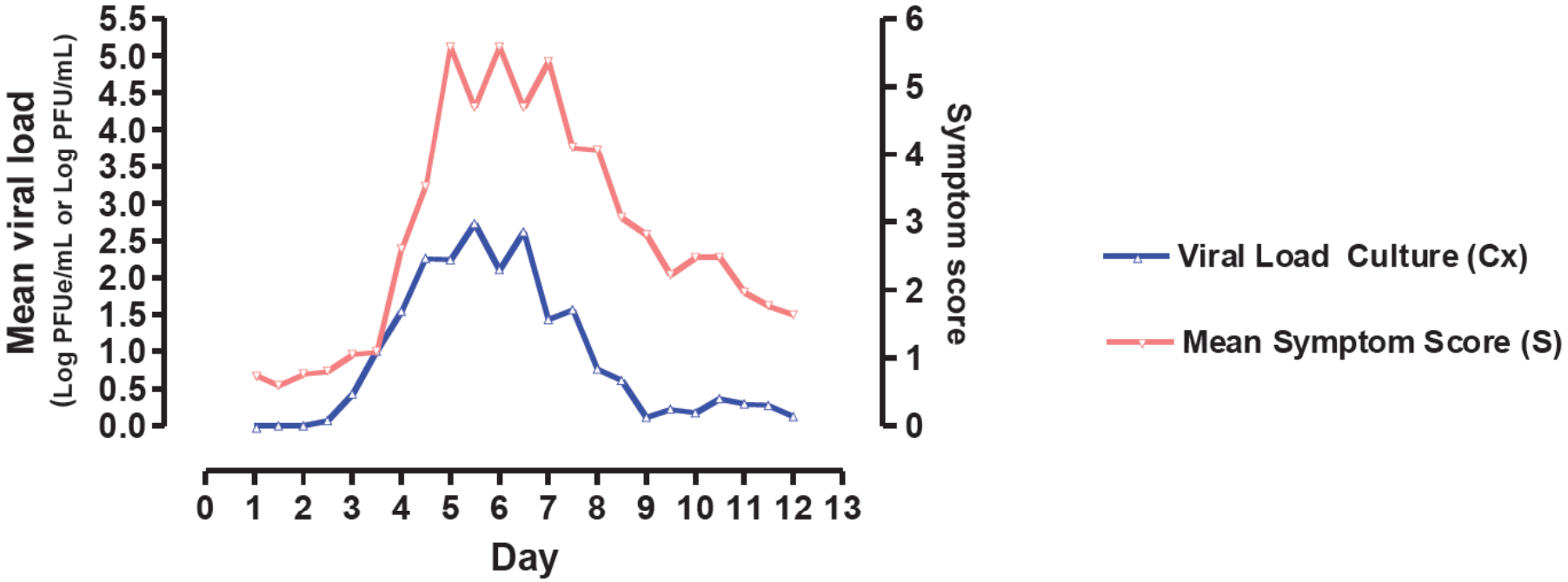


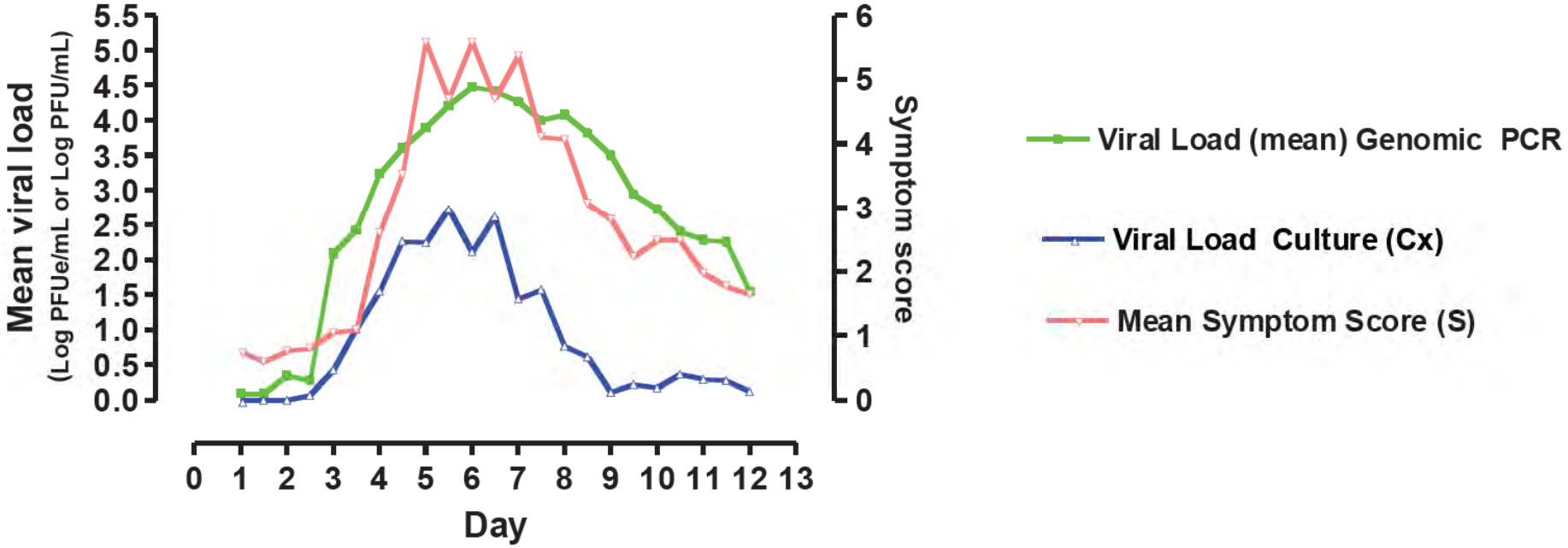
Fig. 3. **A**: Relationship between the clinical score and RSV load, as determined by correlation analysis. These points are all of the points from all of the patients at all of the collection time points with the exception of the 15 specimens mentioned in **Figure 2. B:** Timing of mean RSV load and clinical score. The mean data from all of the infected infants from each collection time point

Viral Load Drives Disease in Humans Experimentally Infected with Respiratory Syncytial Virus



John P. DeVincenzo Am J Respir Crit Care Med Vol 182. pp 1305–1314, 2010

RSV Clinical Disease and Viral Replication (PCR)

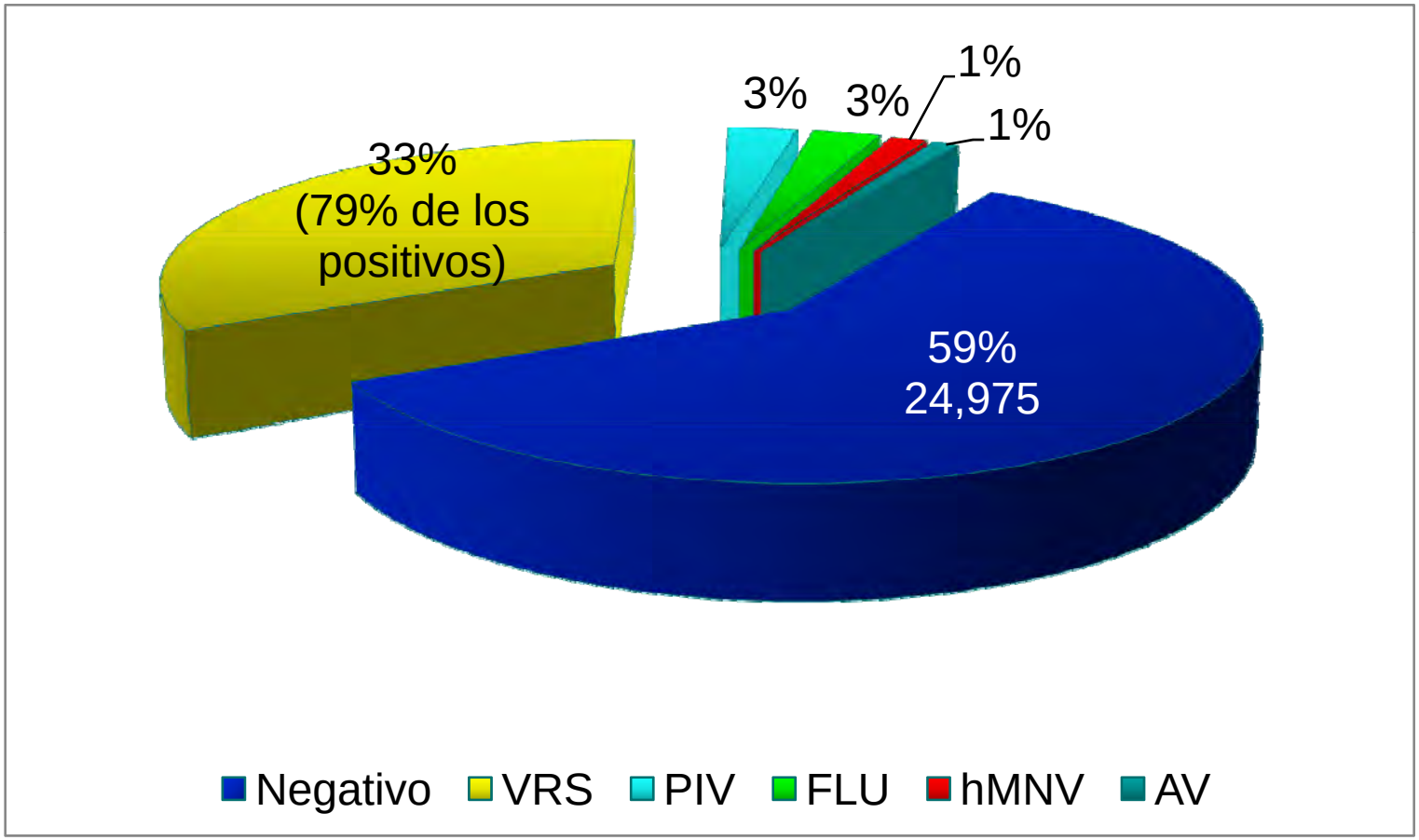


La PCR en Tiempo Real detecta al VSR por mayor tiempo, con una excelente correlación con los síntomas

John P. DeVincenzo Am J Respir Crit Care Med Vol 182. pp 1305–1314, 2010

Sistema Nacional de Vigilancia Epidemiológica por Laboratorios de Argentina (SIVILA – SNVS)

42.481 menores de 2 años estudiados



Viral Etiology of Acute Respiratory Infections in Hospitalized and Outpatient Children in Buenos Aires, Argentina

Débora Natalia Marcone, MSc, Alejandro Ellis, MD,†‡ Cristina Videla, PhD,* Jorge Ekstrom, MD,† Carmen Ricarte, MLT,* Guadalupe Carballal, MD, PhD,* Santiago Manuel Vidaurreta, MD,† and Marcela Echavarría, PhD**

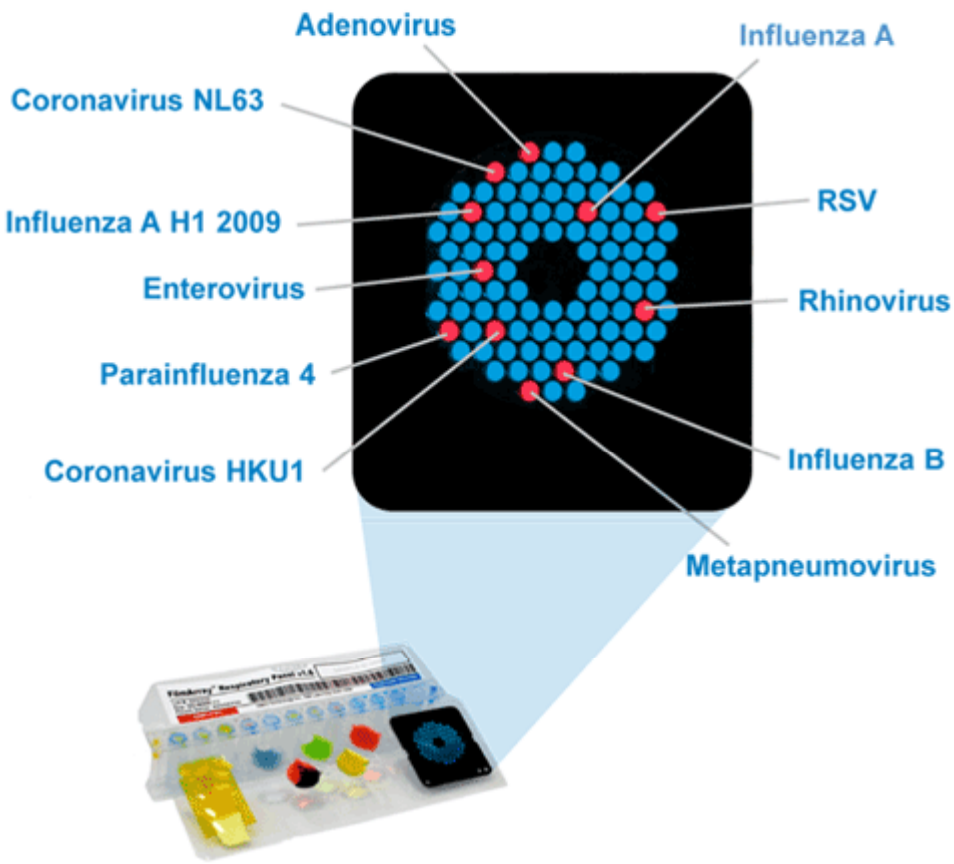
Población	Total Negativos n (%)	Total Positivos n (%)	Virus detectado HRV n (%)	RSV n (%)	hMPV n (%)	FluA n (%)	PIV n (%)	AdV n (%)	FluB n (%)
Hospitalizados (n=434)	73 (16,8)	361 (83,2)	202 (46,5)	136 (31,3)	40 (9,2)	14 (3,2)	6 (1,4)	14 (3,2)	3 (0,7)
Ambulatorios (n=186)	71 (38,2)	115 (61,8)	50 (26,9)	29 (15,6)	13 (7,0)	7 (3,8)	14 (7,5)	1 (0,5)	9 (4,8)
Total (n=620)	144 (23,2)	476 (76,8)	252 (40,6)	165 (26,6)	53 (8,5)	21 (3,4)	20 (3,2)	15 (2,4)	12 (1,9)

El diagnóstico de los virus respiratorios se realizó por IFI para: sincicial respiratorio (RSV), influenza A y B (FluA, FluB), parainfluenza (PIV), adenovirus (AdV); IFD para metapneumovirus (hMPV) y RT-PCR en tiempo real para rinovirus (HRV).

Detecting 20 Respiratory pathogens simultaneously in a rapid and closed format: The Filmarray Multiplex PCR Device

Echavarría M[1], Marcone D[1], Ricarte C[1], Videla C[1], Vidaurreta S[1], Bourzac K[2], Kanack K[2], Poritz M[2], Carballal G[1].

[1]Cemic University Hospital Buenos Aires, Argentina and [2]IDAHO Technology, Salt Lake City, UT, USA



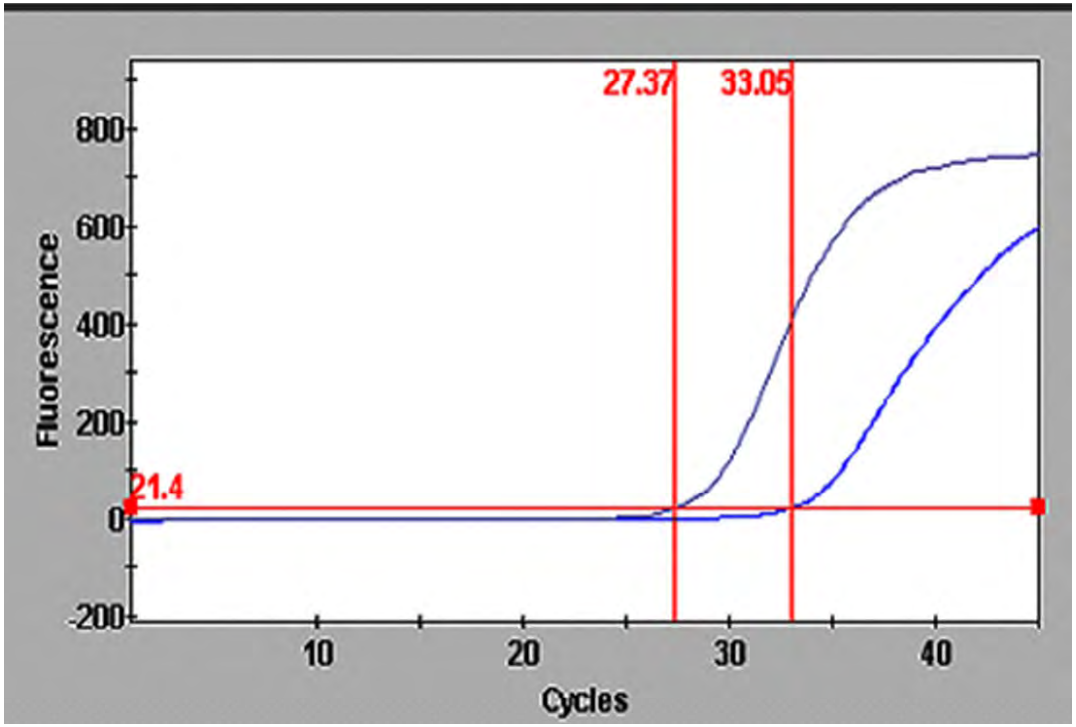
Resultados de HRV

Población	pacientes positivos					
	V		hBoV		Coronavirus	
	%	n	%	n	%	
Hospitalizados	',4)	10	(15,4)	6	(14,1)	
Ambulatorios	',0)	6	(10,7)	4	(7,9)	
Total	',2)	16	(13,2)	10	(21,6)	

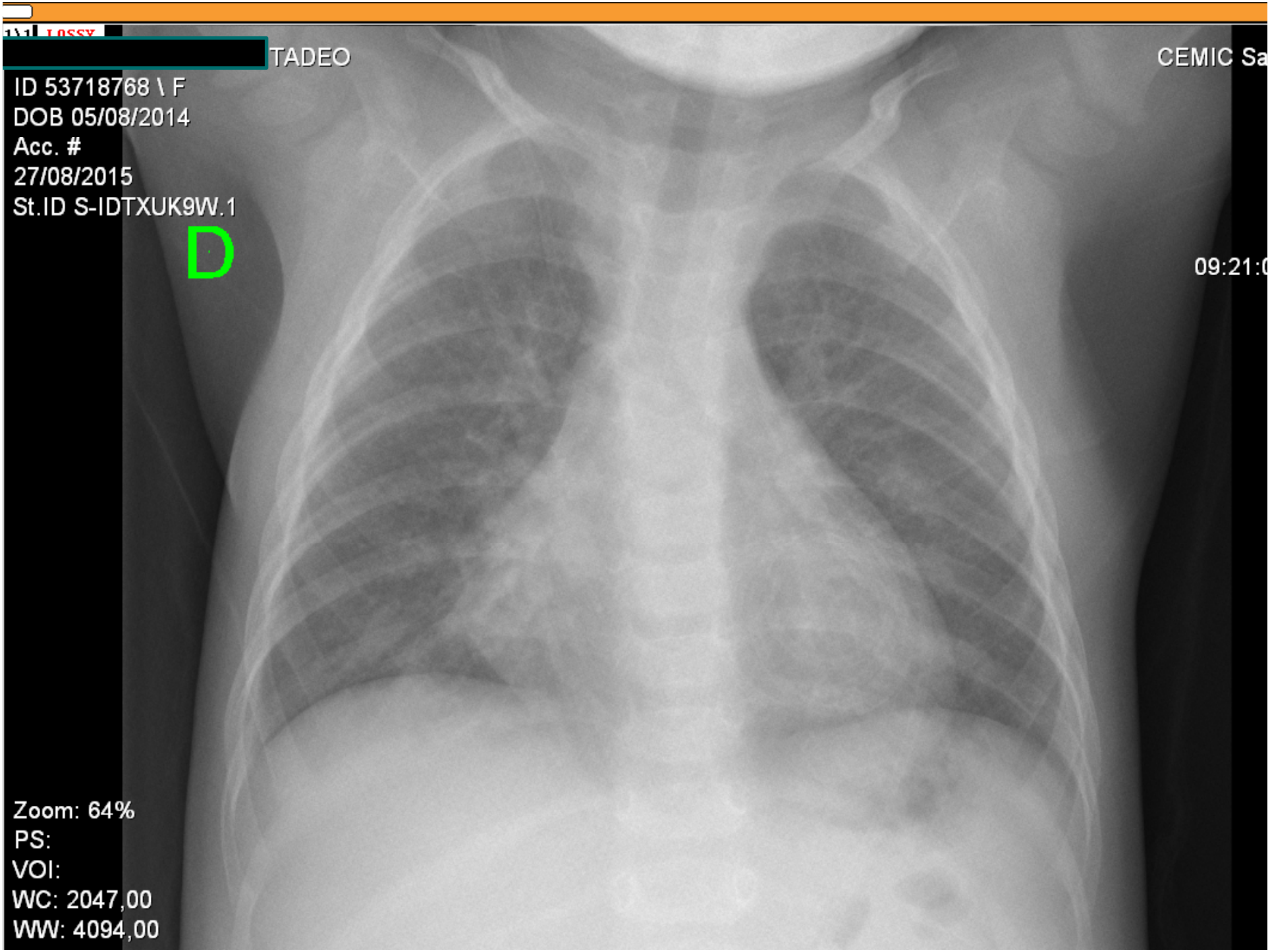
Rhinovirus detection by real-time RT-PCR in children with acute respiratory infection in Buenos Aires, Argentina

DÉBORA N. MARCONE[1], CRISTINA VIDELA[1], CARMEN RICARTE[1], GUADALUPE CARBALLAL[1], SANTIAGO VIDAURRETA[2], MARCELA ECHAVARRÍA[1*]

[1]Unidad de Virología y Laboratorio de Virología Clínica y [2]Departamento de Pediatría, Centro de Educación Médica e Investigaciones Clínicas (CEMIC) Hospital Universitario. Av. Galván 4102, Buenos Aires, Argentina.
**Correspondence. E-mail: mechavarriaf@hotmail.com*



Revista Argentina de Microbiología (2012) 44: 259-265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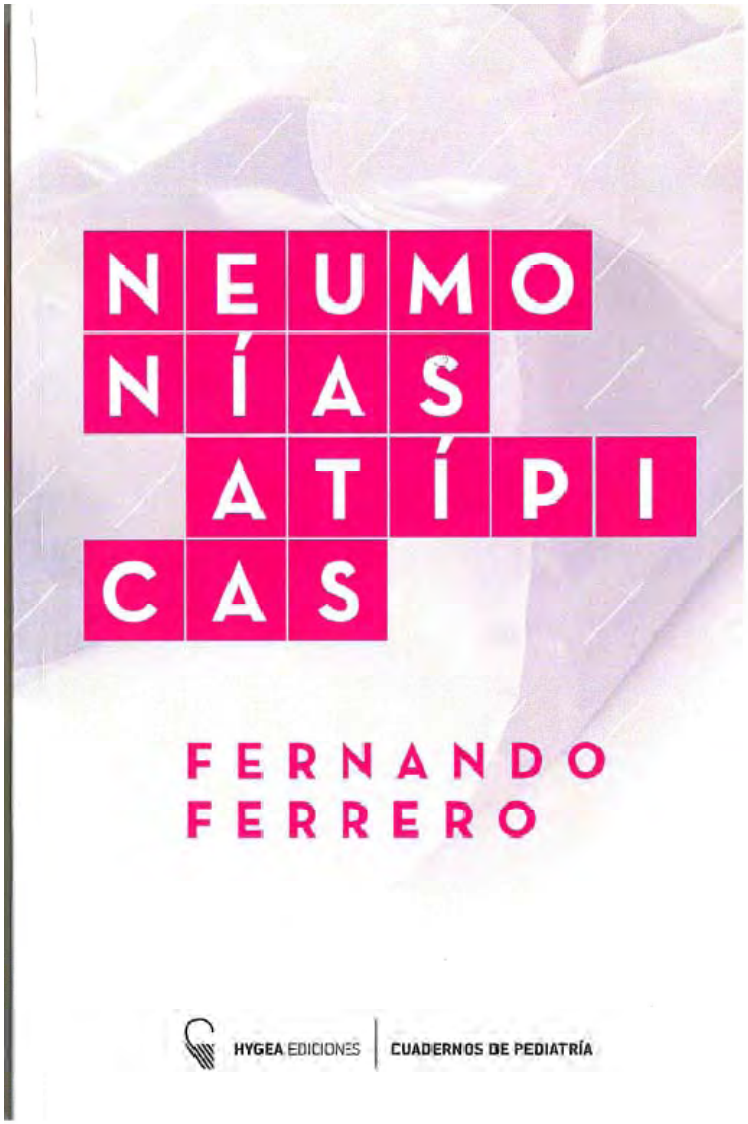
MED CICLOPEDIA

CLASIFICACIÓN INTERNACIONAL DE LAS ENFERMEDADES, ICD-10

NEUMONITIS

J18.9	Neumonitis (aguda) (primaria) (ver también Neumonía)
J67.7	Neumonitis por aire acondicionado
J67.9	Neumonitis alérgica
J67.9	Neumonitis alérgica debida a polvo orgánico
J67.8	Neumonitis alérgica debida a polvo especificado NCOP
J67.8	Neumonitis alérgica debida a secoyosis
J69.0	Neumonitis por aspiración
J69.1	Neumonitis por aspiración de aceites y esencias
J69.0	Neumonitis por aspiración de alimento(s)
J95.4	Neumonitis por aspiración debida a anestesia
O29.0	Neumonitis por aspiración debida a anestesia durante el embarazo
O89.0	Neumonitis por aspiración debida a anestesia durante el puerperio
O74.0	Neumonitis por aspiración debida a anestesia durante el trabajo de parto y parto
J69.0	Neumonitis por aspiración de leche
P24.9	Neumonitis por aspiración neonatal
J69.8	Neumonitis por aspiración de sangre
J69.0	Neumonitis por aspiración de secreciones gástricas
J69.8	Neumonitis por aspiración de sólidos y líquidos especificados NCOP
J69.0	Neumonitis por aspiración de vómito
J84.8	Neumonitis por colesterol
J69.1	Neumonitis debida a aceites y esencias
	Neumonitis debida a aspiración (ver Neumonitis, aspiración)

J67.1	Neumonitis debida a bagazo de la caña de azúcar
J68.0	Neumonitis debida a berilo
J68.0	Neumonitis debida a cadmio
J69.0	Neumonitis debida a comida o vómito (aspiración)
J69.8	Neumonitis debida a detergentes
J68.0	Neumonitis debida a humos y vapores (inhalación)
J68.0	Neumonitis debida a inhalación de gases, humos, vapores y sustancias químicas
J68.0	Neumonitis debida a manganeso
J68.0	Neumonitis debida a nitrógeno dióxido
J68.0	Neumonitis debida a polímeros fluorocarbonados
J69.8	Neumonitis debida a sólidos y líquidos NCOP
B58.3 - J17.3	Neumonitis debida a toxoplasmosis (adquirida)
P37.1 - J17.3	Neumonitis debida a toxoplasmosis congénita
J68.0	Neumonitis debida a vanadium
J82	Neumonitis eosinófila
J67.9	Neumonitis por hipersensibilidad (ver también Neumonitis, alérgica)
B22.1	Neumonitis linfoide intersticial resultante de enfermedad por VIH (SIDA)
P24.0	Neumonitis por meconio
O29.0	Neumonitis postanestésica en embarazo
O74.0	Neumonitis postanestésica en trabajo de parto o parto
O89.0	Neumonitis postanestésica en postparto, puerperal
T41.2	Neumonitis por sobredosis o sustancia errónea administrada o tomada
	Neumonitis por sobredosis de anestésico especificado (ver Tabla de medicamentos y productos químicos)
J95.8	Neumonitis por sobredosis de sustancia correcta, administrada apropiadamente
J95.8	Neumonitis postoperatoria
J68.0	Neumonitis química, debida a humos, gases y vapores (inhalación)
J70.0	Neumonitis por radiación
P35.0	Neumonitis por rubéola, congénita
J67.7	Neumonitis por ventilación (aire acondicionado) (humidificador)



En la actualidad, suele utilizarse el término «neumonía atípica» para designar aquella patología respiratoria infecciosa que presenta disociación entre el cuadro clínico y lo que se esperaría observar en la radiografía, es decir, que no presenta una consolidación lobar, segmentaria o subsegmentaria

… Si bien éste término se utiliza en lo cotidiano, su alcance debería reservarse para aquellas entidades de comportamiento clínico o epidemiológico verdaderamente atípico. Los microorganismos habituales (virus, *Mycoplasma pneumoniae,* clamidias) suelen presentar cuadros clínicos bastante característicos, por lo que la denominación de «atípico» es imprecisa.

Septiembre 2015

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Comparing treatment of non-severe pneumonia in children aged 2 to 59 months with and without antibiotics

Authors' conclusions:

There is a clear need for RCTs to address this question in representative populations. We do not currently have evidence to support or challenge the continued use of antibiotics for the treatment of non-severe pneumonia, as suggested by WHO guidelines.

No encontramos evidencias en la actualidad que avalen la utilización de antibióticos para el tratamiento de neumonías «no severas» como sugiere la OMS

Published: 26 May 2014

Antibiotics for community-acquired lower respiratory tract infections secondary to *Mycoplasma pneumoniae* in children (Review)

Gardiner SJ, Gavranich JB, Chang AB

THE COCHRANE COLLABORATION®

The Cochrane Library. **Published:** 8 January 2015

Quality of evidence

Overall the quality of the evidence for each of the main outcomes is very low as there are insufficient data for any outcome. Hence, currently, there is insufficient evidence to show conclusively that antibiotics are effective in children with LRTI caused by *M. pneumoniae*.

Sigue existiendo una necesidad de estudios de alta calidad, doble ciegos, randomizados y controlados para demostrar la eficacia y seguridad de los antibióticos para IRAB por *M. pneumoniae* en niños

There is insufficient evidence to draw any specific conclusions about the efficacy of antibiotics for this condition in children (although one trial suggests macrolides may be efficacious in some children with LRTI secondary to *Mycoplasma*). The use of antibiotics has to be balanced with possible adverse events. There is still a need for high quality, double-blinded RCTs to assess the efficacy and safety of antibiotics for LRTI secondary to *M. pneumoniae* in children.

Read the full abstract...

The Cochrane Library. **Published:** 8 January 2015

THE ROLE OF RESPIRATORY VIRAL INFECTIONS AMONG CHILDREN HOSPITALIZED FOR COMMUNITY-ACQUIRED PNEUMONIA IN A DEVELOPING COUNTRY

*Cristiana M. Nascimento-Carvalho, MD, PhD,**

Abstract: We report an investigation for 16 bacteria and viruses among 184 children hospitalized with pneumonia in Salvador, Brazil. Etiology was established in 144 (78%) cases. Viral, bacterial, and mixed infections were found in 110 (60%), 77 (42%), and 52 (28%) patients, respectively. Rhinovirus (21%) and *Streptococcus pneumoniae* (21%) were the most common pathogens. Our results demonstrate the importance of viral and pneumococcal infections among those patients.

M. pneumoniae infections were significantly more common in children ≥2 years of age (15%) than in those <2 years of age (3%) ($P = 0.005$).

Detecting 20 Respiratory pathogens simultaneously in a rapid and closed format: The Filmarray Multiplex PCR Device

Echavarría M[1], Marcone D[1], Ricarte C[1], Videla C[1], Vidaurreta S[1], Bourzac K[2], Kanack K[2], Poritz M[2], Carballal G[1].

[1]Cemic University Hospital Buenos Aires, Argentina and [2]IDAHO Technology, Salt Lake City, UT, USA

	Hospitalizados (n = 68)		Ambulatorios (n = 57)	
M. pneumoniae	2	2,9	0	0,0
B. Pertussis	1	1,5	0	0,0
PIV4	1	1,5	0	0,0
Coinfecciones				
Dobles	23	33,8	12	21,1
Triples	6	8,8	3	5,3
Negativos	3	4,4	1	1,8

Clinical efficacy of macrolide antibiotics against genetically determined macrolide-resistant *Mycoplasma pneumoniae* pneumonia in paediatric patients

YASUHIRO KAWAI,[1] NAOYUKI MIYASHITA,[2] TETSUYA YAMAGUCHI,[1] AKI SAITOH,[1] EISUKE KONDOH,[1] HIROKI FUJIMOTO,[1] HIDETO TERANISHI,[1] MIKA INOUE,[1] TOKIO WAKABAYASHI,[1] HIROTO AKAIKE,[1] SATOKO OGITA,[1] KOZO KAWASAKI,[1] KIHEI TERADA,[1] FUMIO KISHI[3] AND KAZUNOBU OUCHI[1]

Departments of [1]Pediatrics, [2]Internal Medicine 1 and [3]Molecular Genetics, Kawasaki Medical School, Okayama, Japan

SUMMARY AT A GLANCE

There have been no studies evaluating the microbiological efficacy of macrolides in patients with macrolide-resistant (MR) *Mycoplasma pneumoniae* infections. This study showed that the microbiological and clinical efficacies of macrolides for treating patients with MR *M. pneumoniae* pneumonia were low.

Este estudio demuestra que la eficacia clínica y microbiológica de los macrólidos para tratar pacientes con *M. pneumoniae* resistente a los macrólidos es baja

Respirology (2012) **17**, 354–362

Macrolide-Resistant *Mycoplasma pneumoniae*, United States[1]

Emerging Infectious Diseases • www.cdc.gov/eid • Vol. 21, No. 8, August 2015

Using genotypic and phenotypic methods, we detected high-level MRMP in 13.2% of 91 *M. pneumoniae*–positive specimens from 6 US locations.

Clinical outcomes and macrolide resistance in *Mycoplasma pneumoniae* infection in Scotland, UK

Journal of Medical Microbiology (2013), **62**, 1876–1882

Macrolide resistance conferred by the 23S rRNA gene mutation was found in samples from 6 out of 32 patients (19 %) in the subset tested. The results suggest that the recent *M. pneumoniae* epidemic was associated with a significant burden of hospital admission locally. The study also describes the first case series of macrolide-resistant *M. pneumoniae* in the UK, indicating that macrolide resistance surveillance is warranted in preparation for the next epidemic.

Macrolide Resistance in *Mycoplasma pneumoniae*, Israel, 2010

Diana Averbuch,[1] Carlos Hidalgo-Grass,[1]
Allon E. Moses, Dan Engelhard, and Ran Nir-Paz

Conclusions

The observed rate of resistance in our hospital-based patients in the current surge of *M. pneumoniae*–associated cases is 30%.

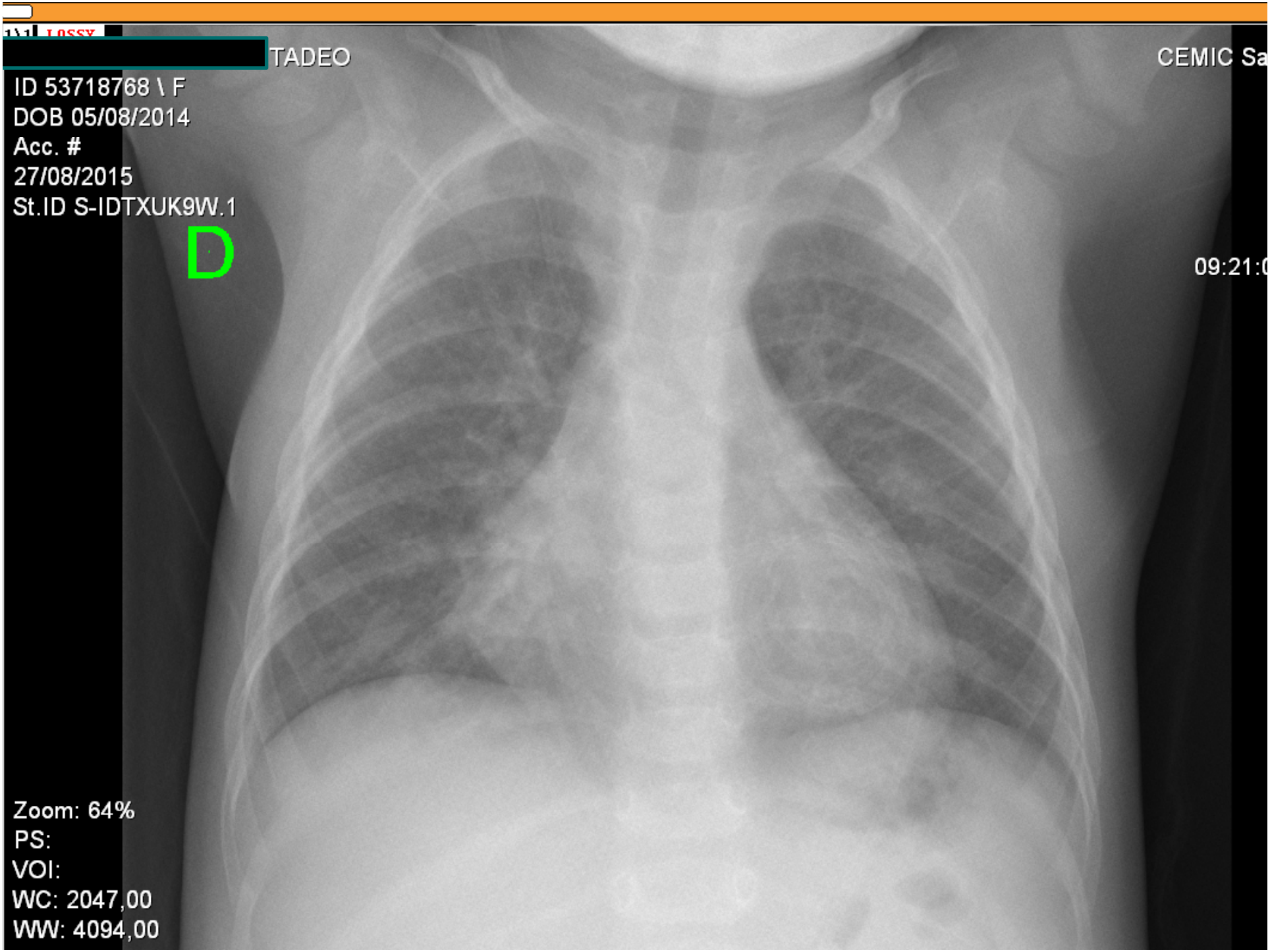
Molecular Mechanisms of Macrolide Resistance in Clinical Isolates of *Mycoplasma pneumoniae* from China[▽]

Deli Xin,[1]* Zuhuang Mi,[2] Xu Han,[3] Ling Qin,[2] Jing Li,[1] Tianli Wei,[1] Xiaogeng Chen,[1] Shaojie Ma,[1] Ancun Hou,[1] Gui Li,[1] and Dawei Shi[1]

Fifty clinical *Mycoplasma pneumoniae* strains were isolated from 370 children with respiratory tract infections. Four strains were susceptible to macrolides, while the other 46 (92%) were macrolide resistant. The molecular mechanism of resistance was shown to be associated with point mutations in 23S rRNA at positions 2063 and 2064.

Cincuenta cepas *Mycoplasma pneumoniae* fueron aisladas de 370 niños con infecciones de las vías respiratorias. Cuatro cepas fueron sensibles a macrólidos, mientras que las otras 46 (92%) fueron resistentes a macrólidos. Los mecanismos moleculares de la resistencia han demostrado estar asociados con mutaciones puntuales en rRNA 23S en las posiciones 2063 y 2064.

ANTIMICROBIAL AGENTS AND CHEMOTHERAPY, May 2009, p. 2158–2159


[redacted] TADEO
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27/08/2015
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WW: 4094,00

SOLO USO INTERNO

CEMIC

Paciente: [redacted] TADEO
Nº Historia Clínica: **140805915**
Edad: **1 Años 0 Meses 21 Días**
Sexo: **M**
Tipo Doc: **DNI**
Nº Doc: **53718768**
Convenio: **GALENO ARGENTINA S.A**
Plan: **900**
Nº Afiliado: **017871370101**
Sucursal/Orden: **2/1398612**

Estudio	Determinación	Resultado	Unidades	Valor
VSR-ANTIGENO (VIRUS SINCICIAL RESPIRATORIO)	VSR VIRUS SINCICIAL ANTIGENO	NEGATIVO		
VSR-ANTIGENO (VIRUS SINCICIAL RESPIRATORIO)	MUESTRA VIRUS SINCICIAL ANTIGE	ANF		
ADENOVIRUS-ANTIGENO	ADENOVIRUS ANTIGENO	NEGATIVO		
ADENOVIRUS-ANTIGENO	MUESTRA ADENOVIRUS ANTIGENO	ANF		
INFLUENZA A-ANTIGENO	INFLUENZA A-ANTIGENO	NEGATIVO		
INFLUENZA A-ANTIGENO	MUESTRA INFLUENZA A-ANTIGENO	ANF		
INFLUENZA B-ANTIGENO	INFLUENZA B-ANTIGENO	NEGATIVO		
INFLUENZA B-ANTIGENO	MUESTRA INFLUENZA B-ANTIGENO	ANF		
PARAINFLUENZA 1-3-ANTIGENO	PARAINFLUENZA ANTIGENO	NEGATIVO		
PARAINFLUENZA 1-3-ANTIGENO	MUESTRA PARAINFLUENZA ANTIGENO	ANF		
RINOVIRUS PCR	RINO VIRUS PCR	POSITIVO		

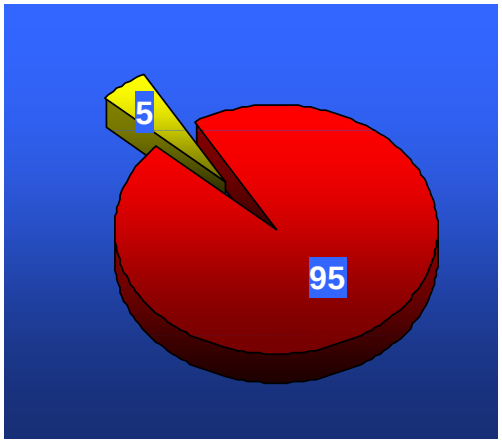
Muchas Gracias

svidaurreta@gmail.com

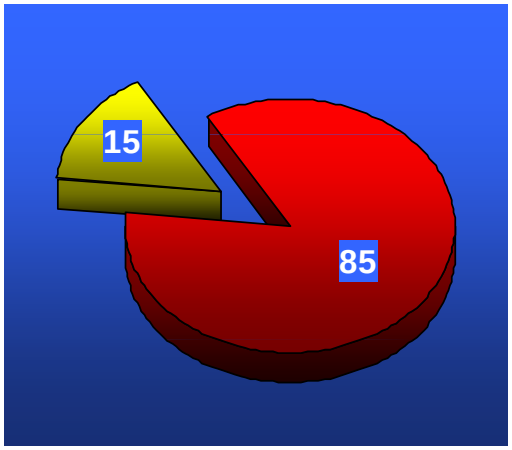
Exacerbaciones asmáticas. Etiología

- Asociación de virus con exacerbaciones
  - 2/3 de las detecciones corresponden a RVH

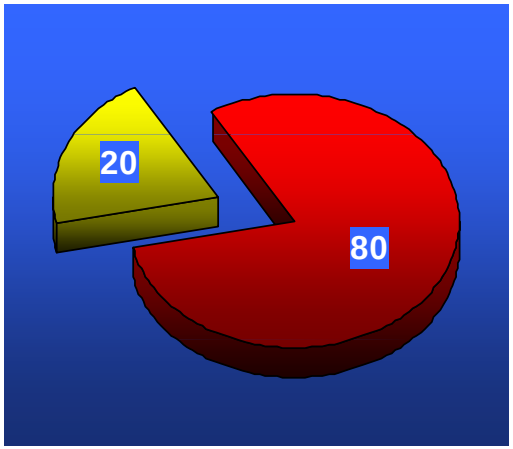
Pre-escolares



Escolares



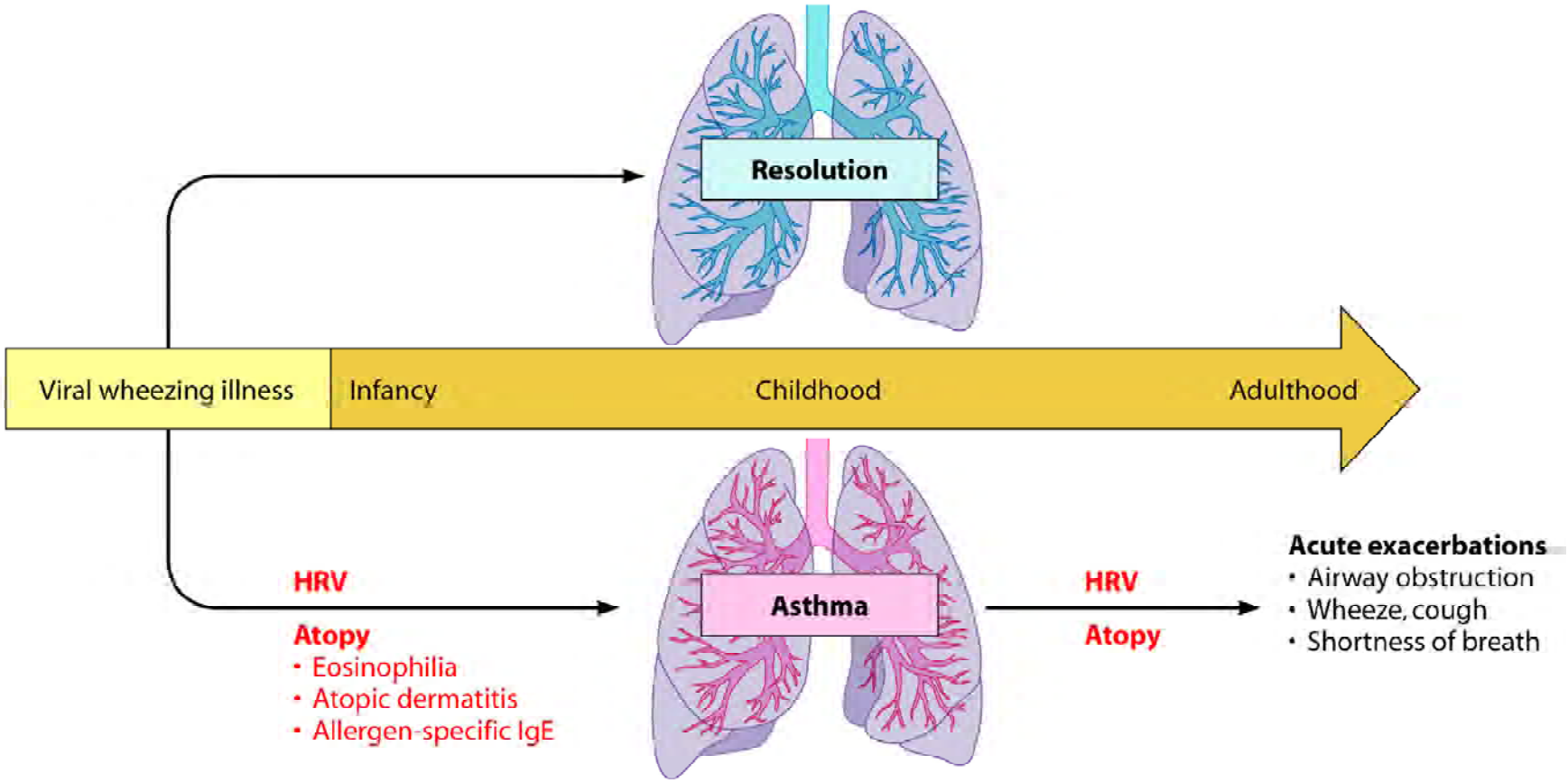
Adultos

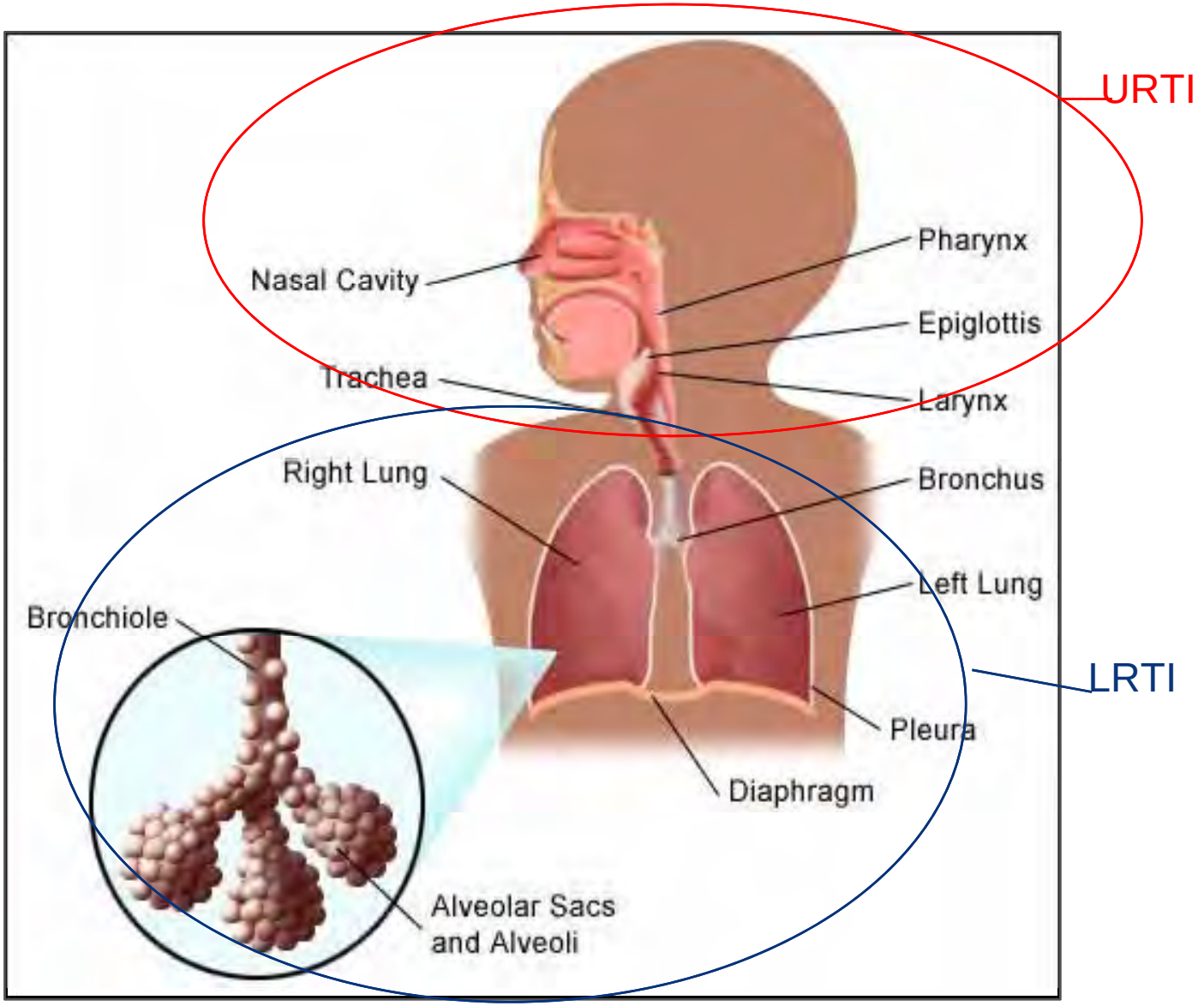


Detección viral positiva

No detección

Relación entre RVH y asma

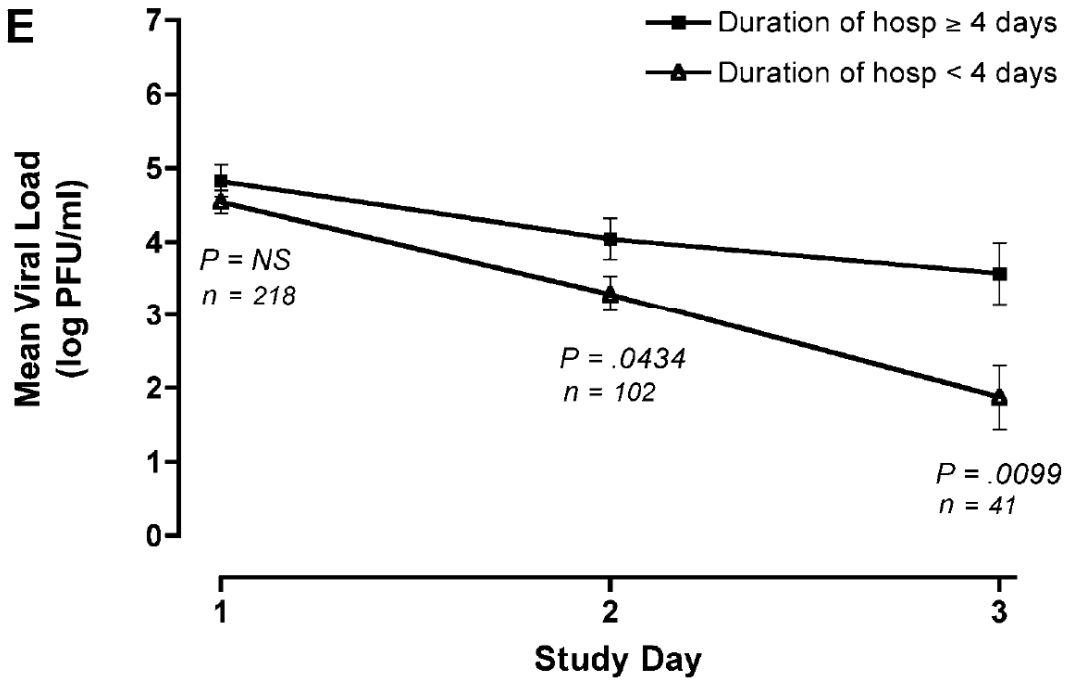




Source: http://www.pharmaceutical-networking.com/wp-content/uploads/2010/12/Young-Respiratory-System.bmp

Respiratory Syncytial Virus Load, Viral Dynamics, and Disease Severity in Previously Healthy Naturally Infected Children

Chadi M. El Saleeby,[1] Andy J. Bush,[2] Lisa M. Harrison,[3,4] Jody A. Aitken,[3,4] and John P. DeVincenzo[3,4,5,6]



The Journal of Infectious Diseases 2011;204:996–1002

La PCR ha aumentado la detección viral en sujetos asintomáticos

- Revisión de la literatura desde 1965 hasta el presente.
- 51 artículos; n ~ 15.000 muestras
- Prevalencia de virus respiratorios en muestras de secreciones de individuos asintomáticos

Virus	PCR +	Convencional +	p
HRV	15% (365/2416)	1.5% (255/14669)	0.0001
RSV	2,6% (51/1974)	0.7% (23/3175)	0.0001
AdV	5.3% (103/1958)	1.8% (40/2175)	0.0001

Jartti et al. Pediatr Infect Dis J 2008

THE ROLE OF RESPIRATORY VIRAL INFECTIONS AMONG CHILDREN HOSPITALIZED FOR COMMUNITY-ACQUIRED PNEUMONIA IN A DEVELOPING COUNTRY

*Cristiana M. Nascimento-Carvalho, MD, PhD,**

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