While we all plan for the upcoming holiday season, we must not forget to also prepare for the unforgiving reality of the viral respiratory season. Even before the decorations and lights go up here at TCH, we begin preparing for the arrival of the winter viruses that fill our clinics and our inpatient beds with sick children. Each year, a multidisciplinary group of clinicians meet to review virus epidemiology data from years past and also anticipate what viruses we will see circulating this year and to what extreme. Preventative strategies are also discussed to determine what will be implemented this year to minimize the spread of these infections here at TCH. Our influenza vaccination campaign has been in full swing for several weeks but that alone is not enough.

This edition will provide you with reminders about standard basic principles as well as new information on virus testing, visitation practices and prevention. Throughout the season, be sure to monitor “Bug Watch” so you can see what viruses we are detecting in our lab from TCH patient and community specimens.

Important information for this season:

- **New respiratory viral test** – Beginning mid-January 2009, our Rapid and Standard Respiratory Virus Culture will be discontinued and replaced by a “Comprehensive Respiratory Virus Test.” The new test will include Respiratory Virus PCR which is more rapid (results in 1-3 days), sensitive, and comprehensive than our prior culture for a greater impact on patient care. Viruses detected by PCR are RSV A, RSV B, influenza A and its subtypes H1 or H3, influenza B, parainfluenza virus 1, 2, and 3 (typing provided), enterovirus/rhinovirus (grouped together), human metapneumovirus (hMPV), and adenovirus. However PCR does not detect herpesviruses and can miss some adenoviruses. Therefore the Comprehensive Respiratory Virus Test will also include CMV, HSV and adenovirus culture (final result in 2 weeks). We will continue to provide our Respiratory Virus Direct Stain (or Influenza A/B Immunonassay, IA) as rapid screening tests. Three workups will again be available to accommodate differences in patient acuity and lengths of stay. See pages 3-4 for further information and recommended use. As always, order respiratory virus tests only if results will change patient care!

1) Direct Stain
2) Direct Stain with Backup Comprehensive Respiratory Virus Test
3) Direct Stain with Concurrent Comprehensive Respiratory Virus Test

- **Visitor screening and restrictions** – Once again we will have visitation restrictions on the inpatient units to prevent those visitors who come ill from visiting our patients. The program has 3 main components:

1) No ill visitors.
2) For children 12 years old and under, only well siblings will be allowed to visit. Siblings will be screened each day at the nurse’s station and those who are well will be given an “apple sticker” before visiting. Friends or relatives in this age group will not be allowed to visit.
3) Only 4 visitors (this number includes the parents) at a patient bedside at a given time. This is a change from last year when we only had 2. The fact that the new hospital has private rooms should accommodate this change. Some of our higher risk units have more stringent visitor restrictions that may affect the number allowed at the bedside or may include an approved visitor list for each patient. Decreasing the number of people visiting a single patient will decrease exposure risks and also provide an opportunity to educate a select group of visitors on the important steps to prevent transmitting infectious illnesses to our patients.

### Respiratory Infection Tips & Tools

#### Mode of Transmission of Most Respiratory Agents

Transmitted in large droplets by:
- Direct or close contact with secretions (e.g., close face to face contact), or
- Touching contaminated objects in the environment and inoculating self or others (e.g., hand-to-eye, hand-to-mouth).

Remember…

**RSV Persists:**
- Up to 30 minutes for secretions in facial tissues.
- 30 minutes or more on hands.
- Up to 6 hours on surfaces (some viruses can be even longer).

**Incubation Period** is 2 - 8 days (4 - 6 days most common).
The following policy is for patients with symptoms of a “suspected” or a “proven respiratory” infection from any cause and includes:

**Droplet Precautions**

1. Gown, glove and mask or face shield are needed whenever coming into contact with the patient or anything in the environment. ALSO, REMEMBER TO USE EYE PROTECTION WHEN SUCTIONING OR IF IN CLOSE CONTACT WITH A COUGHING PATIENT. If no such contact occurs, and you are not within a few feet of the patient, you are exempt as long as you are healthy and do not touch any items in the room!

2. Hospital personnel with even a mild respiratory illness SHOULD NOT CARE FOR HIGH-RISK, UNINFECTED PATIENTS, and should wear a mask / face shield and gloves during any patient contact. Employees with more involved respiratory illness should report to Employee Health Services.

3. Use good handwashing / hand hygiene after removing gloves prior to leaving the patient room.

4. Don’t forget to disinfect your stethoscope between patients.

5. Patients in isolation are not allowed to leave their room unless it is for the purposes of going to another department for a procedure that cannot be performed in their room. Precautions are to be used during transport and the receiving department is to be notified in advance of the need for isolation precautions for the patient. PLEASE do not tell patients in isolation that they can walk in halls or go to playroom, cafeteria, etc.

**DISCONTINUING ISOLATION FOR PATIENTS WITH VIRAL RESPIRATORY ILLNESS**

*This does not apply to patients with Pertussis.*

May discontinue isolation if ALL of the following conditions are met:

A. Patient is currently asymptomatic.
B. It has been at least 7 days from first positive specimen (exception: 2 weeks if patient has adenovirus)
C. Patient will be hospitalized at least 2 more weeks.
D. No underlying immunodeficiency or chronic respiratory condition.
E. If repeat Direct Stain and Comprehensive Virus Detection tests are negative. (IA may be used in place of Direct Stain for viruses which have this test available.)

1 Adenovirus may take up to 14 days to grow in viral culture.
2 If immunocompromised or with a chronic respiratory condition, then the individualized decision requires Epidemiology evaluation and consensus recommendation (at least 2 members of the Infection Control Executive Committee). Epidemiology will document recommendation in the patient record (progress notes).

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**Organism** | **Illnesses** | **Season**
--- | --- | ---
**Adenovirus** | Pharyngitis, Tonsillitis, Croup, Bronchiolitis, Pneumonia, Keratoconjunctivitis, Common cold | Late Winter through Summer. *(but we have seen it this Fall)*
**Coronavirus** | Common cold | Varies
**Human Metapneumovirus (hMPV)** | Bronchiolitis, Croup, Pneumonia | Year round, but mostly late Fall to late Spring.
**Influenza** | Flu, Bronchitis, Croup, Pneumonia, Secondary bacterial infections | December / January.
|  |  | Spring. *(Another strain could circulate.)*
**Parainfluenza** | Croup, Bronchiolitis, Bronchitis, Pneumonia, Common cold | Type 3 – Spring.
|  |  | Type 1 - Fall. *(Odd years – so we escaped seeing it this year!)*
**RSV** | Bronchiolitis, Pneumonia, Croup | December through April.
**Rhinovirus** | Common cold | Fall and Spring.

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**Isolation Basic Infection Control**

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**Sick Employees**

Many viruses exhibit themselves in adults as a slight cold; however, large amounts of virus can be shed and when transmitted can cause severe disease in our patients. If you have mild URI symptoms (minus fever), you may work if you wear a mask (changed frequently throughout the day), wear gloves with
Human Metapneumovirus

Human metapneumovirus (or hMPV) is a paramyxovirus first identified in 2001 in the Netherlands and is now known to cause acute respiratory disease worldwide, including Colorado. Genetically, hMPV is most closely-related to a turkey respiratory virus, but clinically it most closely-resembles RSV. Otherwise healthy children usually have mild or moderate symptoms with hMPV, but severe disease requiring hospitalization can occur, especially in very young children, premature infants, children with underlying cardiopulmonary disorders, immunocompromised individuals of any age, and the elderly. hMPV-associated infections in hospitalized children manifest primarily as bronchiolitis, with croup, pneumonia, and exacerbations of reactive airway disease also described. hMPV is a frequent co-pathogen with other respiratory viruses, although whether other viral illnesses are worsened by hMPV is controversial. At TCH, hMPV is recoverable from a significant proportion (5-15%) of respiratory specimens during the winter-spring. Serosurveys show that all children are infected at least once by 5 years of age. Recurrent infections occur throughout life and tend to be milder than the primary infection.

Visitation

From December 15, 2008 to April 15, 2009, TCH will be implementing VISITATION RESTRICTIONS.

Inpatient Visitation:

1. 4 visitors (including parents) per patient at any given time.

2. For children 12 years of age and younger: Only WELL siblings may visit patients or be on the inpatient units. “Apple sticker” screening for illnesses will be required each day before visiting and are obtained at the nurse’s station. NO relatives or friends in this age group are allowed to visit. Please advise your patient’s family of our visitation restrictions when referring them to TCH to prevent any confusion when they arrive at our facility. This really helps!

3. Visitors of patients are to check in at the nurse’s station before visiting and adhere to any isolation precautions on the door sign and are to wash hands before leaving the room. Exception: Parents and siblings may refrain from wearing isolation apparel, but need to wash hands each time upon entering and before leaving the room.

4. Ill visitors are discouraged from visiting. In the event the primary caretaker has a respiratory illness, he / she is requested to wear a mask when outside the room and to limit activity (and wear a mask) during the following:
   - Obtaining food in cafeteria (should return to patient room to eat, if possible).
   - Avoid crowded areas in hospital (e.g., gift shop).
   - Avoid high-risk patient visitation (if possible); if unavoidable (primary caregiver only), must wear a mask, gown and gloves. Discourage “close” patient contact.

5. Some units implement additional restrictions for the safety of their patient population.

Outpatient Visits & Surgery Procedure/Visits:

Due to an increase in respiratory illnesses in the community during these months, we discourage bringing siblings or friends who are 12 years of age or younger to your child’s scheduled visits to these areas.

Specimens:

Nasopharyngeal washes or tracheal aspirates are the best specimens for most patients. BALs can also be tested. Lower respiratory tract specimens may be required for maximum sensitivity in older patients. Specimens on swabs are not recommended. Cell-rich specimens yield the highest virus recovery. For best results follow our standardized Microbiology Nasopharyngeal Wash Procedure posted on the on-line Test Directory on the TCH Intranet and TCH public website. (See “Clinical Resources, Lab and Microbiology Test Directory”) The table below summarizes the tests available at TCH for wintertime respiratory pathogens. Call Microbiology (720-777-6703) if you have questions.

Ordering Tests:
Tests for respiratory viruses should be sent ONLY if the results will be used for patient management. Otherwise healthy children who are admitted during the peak of RSV season with typical symptoms may not need virus tests at all! See algorithm [page 5].

Testing May be Indicated for:

- Severely ill or immunocompromised patients who may need antiviral therapy or who may be started on multiple antibiotics, and a positive virus test might permit modification or discontinuation of antibiotics.
- An unusually-severe illness in an otherwise normal child.
- Monitoring efficacy of antiviral therapy in high-risk patients who cannot be assessed by symptoms alone.
## 2009 RESPIRATORY PATHOGEN TESTS

### Viruses:

<table>
<thead>
<tr>
<th>Tests</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu A + B IA</td>
<td>Available STAT for ED patients when only flu is suspected and patient to be treated if positive.</td>
<td>Detects and differentiates flu A vs. flu B. Flu A sensitivity 70 - 80%; flu B sensitivity lower. Direct Stain is more sensitive, detects other viruses causing influenza-like illness, and is preferred for inpatients.</td>
</tr>
<tr>
<td>Respiratory Virus Direct Stain</td>
<td>Twice daily M-F: In by 7 AM, out by 9 AM. In by 1 PM, out by 3 PM.</td>
<td>Detects RSV, influenza, parainfluenza, HMPV, and parainfluenza with sensitivity 80-90%. Less sensitive (50%) for adenovirus. Order alone or with backup or concurrent comprehensive virus detection. <em>See algorithm on page 5.</em></td>
</tr>
<tr>
<td>Respiratory Virus PCR:</td>
<td>2-3 day turnaround time during respiratory season</td>
<td>Permanently replaces rapid and standard respiratory virus culture in mid January 2009. Detects RSV A/B, influenza A (with H1, H2 sub-typing), influenza B, HMPV, parainfluenza 1-3, enterovirus, rhinovirus, and adenovirus. More sensitive and comprehensive than DFA. Identifies many co-infections. Does not detect CMV, HSV. May miss some species C and type 7a adenoviruses.</td>
</tr>
<tr>
<td>Rapid CMV/HSV culture:</td>
<td>2 weeks to final negative</td>
<td>Culture done regardless of PCR result.</td>
</tr>
</tbody>
</table>

### Comprehensive Virus Detection (New as of Jan, 09)

- **Respiratory Virus PCR:**  
  - 2-3 day turnaround time during respiratory season

### Other Pathogens:

<table>
<thead>
<tr>
<th>Tests</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>B. pertussis</em> PCR</td>
<td>2-3 days</td>
<td>Nasal wash.</td>
</tr>
<tr>
<td><em>Chlamydia trachomatis</em> culture</td>
<td>2-3 days</td>
<td>Nasal wash. Children less than 2 years of age</td>
</tr>
<tr>
<td><em>Chlamydia pneumoniae</em> culture</td>
<td>3-10 days</td>
<td>Throat swab in MT medium. Children older than 2 years.</td>
</tr>
<tr>
<td><em>Mycoplasma pneumoniae</em> PCR, IgM</td>
<td>PCR: 2-3 days. IgM: Daily</td>
<td>PCR: Throat swab in MT medium. IgM: Red top.</td>
</tr>
</tbody>
</table>

Please see the
Respiratory Virus Testing Algorithm
On the following page
RESPIRATORY VIRUS TESTING ALGORITHM

Febrile Illness with Respiratory and/or Flu Symptoms

Underlying High-Risk Condition
(e.g. Transplant, BPD, Severe Asthma)

Otherwise Normal or Low-Risk Child
(e.g. Previously-well, Mild Asthma)

Symptoms: Severe or Unusual
Symptoms: Mild / Moderate

Measurable Benefit of Positive or Negative Result

YES = Test
- Use Antivirals
- Decrease Antibiotics or Ancillary Testing
- Reduce Hospitalization, Decrease LOS
- Prognosis
- Document Nosocomial Infection

NO
- Isolation
- Parents Want to Know
- Physician Education

Multiple Viruses may be Relevant
(e.g. transplant, BALs)

Any Single Positive Result May Impact Care
(e.g. ICU, seriously III)

Only Rapid Result Impacts Care
(e.g. clinic, most ED)

No Test
(e.g. Bronchiolitis)

RAPID TEST & CONCURRENT COMP. VIRUS DETECTION
- DFA
- PCR
- Culture

RAPID TEST & BACKUP COMP. VIRUS DETECTION
- DFA. If Negative:
  - PCR (enhanced for common viruses plus flu H type, enterovirus)
  - Culture (CMV, HSV, adenovirus)

RAPID TEST ONLY
Resp Viral DFA
Common viruses (RSV, flu A & B, HMPV, parainfluenza, adenovirus)
or
Influenza Immunoassay*

Flu IA is available ONLY during flu “season” and is less sensitive than DFA. Consider DFA if IA is negative.
Figure 2 (see page 7 “Evaluating Clinical Status and Response to Treatment”.)

**Bronchiolitis Care Algorithm**

All Patients should receive upper airway suctioning prior to classification of disease severity. **Do not use treatment algorithm in the toxic appearing patient.**

**Mild Disease**
- Observe
- Supportive care (suctioning, & fluids)
- Teach supportive home care
- Discharge when criteria met
- Supplemental oxygen if RA sat consistently less than or equal to 88%

**Moderate Disease**
- Consider supportive care measures only
- If nebulizer treatment considered,
  - First Choice: Racemic epinephrine 0.25 ml (less than 5kg) or 0.5 ml (5kg+) via Nebulizer *
  - Alternate Choice: May consider Albuterol 2.5 mg †
  - If positive response‡ to neb suggest:
    - Observe
    - Supplemental oxygen
    - Supportive care (suctioning, & fluids)
    - Teach supportive home care
    - Discharge when criteria met
  - If no response to neb suggest:
    - Observation
    - Supplemental oxygen
    - Supportive care

**Severe Disease**
- First Choice: Racemic epinephrine 0.25 ml (less than 5kg) or 0.5 ml (5kg+) via Nebulizer *
  - Alternate Choice: May consider Albuterol 2.5 mg †
  - If positive response‡ to neb suggest:
    - Observe
    - Supplemental oxygen
    - Supportive care
  - If no response to neb suggest:
    - Blood gas
    - Supplemental oxygen
    - Consider CXR
    - Consider other etiologies- heart disease, sepsis, metabolic conditions
    - May require intubation and ICU care

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*data suggestive that may be helpful in outpatient setting (1 to 2 doses)
† data is not good for any benefit
‡15-30 minutes post neb- decrease in one level of severity classification
Supportive Therapy: Adequate hydration, upper airway suctioning, and oxygenation are the mainstays of treatment for most infants with viral pneumonia and bronchiolitis.


Evaluating Clinical Status and Response to Treatment:

1. On initial assessment, determine Severity Classification
2. Decide on intervention (based on Care Algorithm (Figure. 2))
3. Repeat severity classification to determine if intervention was helpful

Respiratory Severity Classification:

<table>
<thead>
<tr>
<th>Category</th>
<th>Patients</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Disease</td>
<td>Alert, active, feeding well</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None to minimal retractions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RR normal to mildly elevated (less than 50)</td>
<td></td>
</tr>
<tr>
<td>Moderate Disease</td>
<td>Alert, consoles, feeding decreased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimal to moderate retractions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RR is mildly to moderately elevated (50-70)</td>
<td></td>
</tr>
<tr>
<td>Severe Disease</td>
<td>Fussy, difficult to console, poor feeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate to severe retractions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RR is moderately to severely elevated (greater than 70)</td>
<td></td>
</tr>
</tbody>
</table>

Supportive Care - Routinely Indicated:
Oxygen is probably the most effective therapy in infants and children with bronchiolitis and/or viral pneumonia.
- Oxygen to achieve SaO2 at or above 90%
- P.O. / I.V. fluids as needed
- Suction upper airway (use saline PRN):
  - Prior to feeding
  - Prior to clinical assessment
  - PRN evidence of upper airway obstruction

Ribavirin

Ribavirin is a FDA approved synthetic nucleoside analogue for treatment of moderate to severe RSV disease. Ribavirin is a very expensive drug that may be irritating or toxic to healthcare workers exposed to the aerosol. Treatment protocols are initiated on an inpatient basis for the delivery of this intermittently aerosolized medication, but Ribavirin remains controversial because of conflicting results of efficacy trials.

2008 – 2009 TCH Guidelines for Ribavirin Use (Suspected or Proven RSV):

<table>
<thead>
<tr>
<th>Category</th>
<th>Patients</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>I High Risk</td>
<td>Complicated Congenital Heart Disease (including pulmonary hypertension).</td>
<td>Observe patients carefully. Ribavirin may be considered under critical care monitoring conditions if severely ill or rapidly deteriorating.*</td>
</tr>
<tr>
<td></td>
<td>Children on chronic oxygen therapy (i.e., CHD, BPD, CF and other chronic lung infections, etc.).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transplant or intensive chemotherapy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other conditions significantly affecting cardiopulmonary or immune system (useful guidelines include blood gas concentrations and response).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BMT with proven infection.</td>
<td></td>
</tr>
<tr>
<td>II Low Risk</td>
<td>Previously healthy kids, children with intermittent RAD, children with underlying disease not affecting cardiopulmonary or immune system.</td>
<td>Ribavirin is not indicated.</td>
</tr>
</tbody>
</table>

* See separate guidelines for BMT / severely immune suppressed Oncology patients available from BMT / Pharmacy.

RSV Prophylaxis

The Synagis (palivizumab) Clinic began in November for currently identified patients to ensure that first dose injections would be completed by Dec. 1st. However, we enroll children in the treatment regimen throughout the season.

Infants with hemodynamically insignificant heart disease are not at increased risk from RSV. Such patients are generally not qualified for treatment.

Any patient who is more than six months of age should have an influenza vaccination before or at the first visit at the Synagis clinic. Parents will be asked to bring proof of vaccination. Second influenza vaccinations (one month after the first one) are indicated for young children if they have not had an influenza vaccination the previous year. Influenza vaccination is best provided at the primary care physician's office (if available), but will also be available in the Synagis clinic.

For Synagis Clinic clinical questions or concerns, please contact Dr. Maya Bunik at 720-777-2740. All other questions, concerns or patient referrals should be forwarded to Liz Gonzales or Mary Navin at 720-777-6311 or by e-mail at navin.mary@tchden.org. Marsha Lehr/Special Care Clinic will provide palivizumab for their special needs patients; she can be reached at 720-777-2783.

Answers to frequently asked questions:
- Children and infants who are hospitalized, due for their next scheduled monthly administration of palivizumab and will not be discharging in a 48 hour “window” of
administration date should receive their palivizumab while in the inpatient setting.

- Children and infants who are hospitalized, ready for discharge, have outpatient authorization in place, have started the outpatient administrations prior to the current hospital admission and are scheduled for outpatient administration of palivizumab in the next 48 hours should NOT receive the palivizumab prior to discharge if at all possible.

- Inpatient infants who are determined to be at risk for severe RSV (e.g. preemies) should receive palivizumab 48-72 hours prior to discharging into the home environment during the respiratory virus season.

- Patients hospitalized on their scheduled day to receive Synagis may get it in the clinic on their discharge day before leaving the hospital. Be sure to contact the insurance provider.

- DISCONTINUATION: When the # of (+) RSV tests falls below 10% of the # run, TCH will stop giving palivizumab. Info/date will be posted in the comment section of “Bug Watch”.

The following indications are approved for Synagis (palivizumab) use at The Children’s Hospital:

- Any infant less than 2 years of age with chronic lung disease (defined as a history or persistent oxygen requirement during the first month of life) AND has required one of the following medical managements within the past 6 months:
  - Supplemental oxygen
  - Use of inhaled or oral bronchodilators
  - Corticosteroid therapy
  - Regular or intermittent use of diuretics to treat pulmonary disease

- Any infant born at 28 weeks or less with or without chronic lung disease who is less than 12 months of age

- Any infant born at 29-32 weeks gestational age with or without chronic lung disease who is less than 6 months of age

- Any infant born at 32 to 35 weeks gestational age who is less than 6 months of age AND meets at least 2 risk factors:
  - Attends day care
  - School-age siblings
  - Exposure to environmental air pollutants (excludes tobacco smoke, which is a controllable risk factor by the family or caregiver of the infant)
  - Congenital anomalies of the airways
  - Severe neuromuscular disease

- Any infant up to 2 years of age with hemodynamically significant heart disease defined as having one or more of the following:
  - Receiving medication to control congestive heart failure (antihypertensive, diuretics)
  - Diagnosed with moderate to severe pulmonary hypertension
  - Diagnosed with cyanotic heart disease
  (All the ‘risk factors’ can be checked on all patients - - these were added this year to accentuate the need for Synagis in worthy candidates)

### Some Final Thoughts

Finally, remember to adhere to infection control practices and isolation procedures. Avoid inappropriate use of antibiotics for viral illness, continue vaccination for influenza and now that you are knowledgeable about the management of patients with viral bronchiolitis etc., you can help to dispel the many widely prevalent myths regarding ineffective therapies and patient management.

### Bug Watch

Up-to-date information on currently circulating respiratory and enteric viruses detected by the TCH Laboratory and *B. pertussis* detected statewide provided to you weekly. Posted on the TCH Internet at:


and/or sent by broadcast FAX. Contact Carolyn Brock by e-mail brock.carolyn@tchden.org or phone (720-777-6412) to begin receiving your personal copy.

### VISITATION REMINDER!

**12/15/08 TO 4/15/09**

**Inpatient:**
- Check in at nurse’s station before visiting
- 4 visitors at bedside at one time (includes parents).
- For child visitors 12 years of age and younger: Only WELL siblings will be allowed. No relatives or friends in this age group will be allowed to visit.
- NO sick visitors, please!

**Outpatient:**
- Due to an increase in respiratory illnesses in the community during these months, we discourage bringing siblings or friends who are 12 years of age or younger to your child’s scheduled visits to these areas.

Thank You!
We are modifying our distribution process for Bug Watch and Contagious Comments. Below are the methods of distribution that we will be using. Please provide us with your preferred method of distribution.

Name: __________________________________________________

____  E-mail (please provide your Email address): ____________________________

_____ Fax (please provide us with your fax number and who the fax should be directed to):  (____)
________________________       ___________________________

Both of these publications are always posted on The Children's Hospital website at:

CONTAGIOUS COMMENTS
Department of Epidemiology

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**We Recycle!**

Please return your preference to: Carolyn Brock, The Children’s Hospital, Epidemiology – Box B276, 13123 E. 16th Avenue, Aurora, CO 80045 or E-mail address: brock.carolyn@tchden.org.

Thank you for your interest in our publication.