Nursing Alert

Refer children at risk for contracting these communicable diseases to the practitioner immediately in case of known exposure or outbreaks.

In the past decade, incidence of pertussis has increased, particularly in infants younger than 6 months old and in children 10 to 14 years old. Early clinical manifestations of pertussis in infants may include gagging, coughing, emesis, and apnea; the typical "whoop" associated with the disease is absent (Wood and McIntyre, 2008). In older children, the disease may manifest as a common cold, but a prolonged cough (6 to 10 weeks or longer) is common in adolescents (American Academy of Pediatrics, 2015) (see Table 6-1). There is now a recommendation that children 11 to 18 years old receive a booster pertussis vaccine (Tdap) to prevent the disease (see Pertussis earlier in chapter). Because pertussis is contagious, especially among close household members, identify pertussis early and initiate treatment for the child and those who have been exposed. Azithromycin (for infants <1 month) and erythromycin, clarithromycin, or azithromycin are administered to infants and children with pertussis (American Academy of Pediatrics, 2015).

Prevention of complications from diseases such as diphtheria, pertussis, and scarlet fever requires compliance with antibiotic therapy. With oral preparations, stress the need to complete the entire course of therapy (see Compliance in Chapter 20).

Evidence suggests that vitamin A supplementation reduces both morbidity and mortality in measles and that all children with severe measles should receive vitamin A supplements. A single oral dose of 200,000 international units for children at least 1 year old is recommended (use half that dose for children 6 to 12 months old) (see Table 6-1). The higher dose may be associated with vomiting and headache for a few hours. The dose should be repeated the next day and at 4 weeks for children with ophthalmologic evidence of vitamin A deficiency (American Academy of Pediatrics, 2015).

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