suppressed immune system. It was found in the Turkish studies that the 22-57% of pediatric hospitalized cases developed in children with suppressed immunity (4, 5). With a single dose in the USA, the disease prevalence dropped 57-90%, hospitalizations 75-88% and mortality 74% (6, 7); in other words, there may still be 10-43% disease, 12-25% hospitalization and <21% mortality risk in the USA. Ultimately, according to these data, although there occurs a great deal of decrease in the disease load through the single dose vaccine-related protection, the proposal of two doses of the vaccine was brought to the agenda in the USA, as Mr. Kurugöl stated, since there was a serious varicella-related disease load. Within this framework, we are of the opinion that single dose vaccine will significantly reduce disease cases and the nationwide varicella disease load; but, since it will not stop the virus circulation, some noticeable infections may develop especially in risky cases and adults in whom vaccine-related immunity drops. Even though high vaccination rates (85-90% and above) could reduce disease shift towards elder children and adults (3) a varicella infection that may develop in a vaccinated person or varicella-related hospitalization may seriously damage the confidence of the public in the vaccine and this negative psychology might impact other vaccines as well. The fact that varicella vaccine is a live viral one and more sensitive against other vaccines may be another factor contributing to this failure. Therefore, provided that logistic and economic support is supplied, we are of the opinion that recommendation of varicella vaccine as two doses just like MMR vaccine will be beneficial and necessary.

4. We agree with Mr. Kurugül's opinion that paracetamol should not be routinely given in order to reduce the side effects of the vaccine. In fact, given the antifebrile pathogenic mechanisms of paracetamol, it is clear that it is not in a path in which cellular immunity (B and T cell-related immunity) will be affected. Besides, there is no reliable evidence that paracetamol impacts the vaccine response or the responses of other immunities. In this framework, since the vaccines used in the routine vaccine calendar understate the side effects fever and pains to benefit from paracetamol, we share the opinion that there is no need to routinely use paracetamol.
5. As is commonly known, Advisory Committee on Immunization Practices (ACIP) in the USA does not recommend the diphtheria toxin conjugated MW4 vaccine since it may affect the protection level of the PW7 vaccine between 9-23 months in the presence of any risk group member (such as crescent-cell anemia or anatomic asplenia), the lack of data regarding its clinical significance and pneumococcal disease has greater risk than meningococcal disease among these risk groups (8). As is again commonly known, MW4 vaccine is still not recommended in the USA except the healthy adolescent non-risk group children (It should also be remembered that there may be different vaccine schemas in line with the rational and scientific assessment of all the epidemiologic data of the countries). With the recommendation of Mr. Kurugöl, it will be useful to clearly add the two risk groups in question into the specified segment.

Best regards,

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References

1. Arısoy ES, Çiftçi E, Hacımustafaoğlu M ve ark. Önceden sağlıklı çocuklarda ulusal aşı takvimi; ek aşılar konusunda uygulamaya yönelik öneriler. J Pediatr Inf 2014; 8: 1-6. [CrossRef]
2. Hacımustafaoğlu M. Aşı Kitabı. Badur S, Bakır M (ed). Yasal Açıdan Bağışıklama, İstanbul: Akademi Yayınevi, 2012.s.213-8.
3. Varicella vaccines. WHO position paper. Wkly Epidemiol Rec 1998; 73: 241-8.
4. Çandır O, Belet N, Tapısız A ve ark. Suçiçeği enfeksiyonunun komplikasyonları. J Pediatr Inf 2009; 3: 131-52.
5. Dinleyici EC, Kurugol Z, Turel O, et al. The epidemiology and economic impact of varicella-related hospitalizations in Turkey from 2008 to 2010: a nationwide survey during the pre-vaccine era (VARICOMP study). Eur J Pediatr 2012; 171: 817-25. [CrossRef]
6. Marin M, Meissner HC, Seward JF. Varicella prevention in the United States: a review of successes and challenges. Pediatrics 2008; 122: 744-51. [CrossRef]
7. Guris D, Jumaan AO, Mascola L, et al. Changing varicella epidemiology in active surveillance sites - United States, 1995-2005. J Infect Dis 2008; 197: 71-5. [CrossRef]
8. Apicella M. Meningococcal vaccines. Calderwood SB, Kaplan SL (ed). Uptodate.com, http://www.uptodate.com/contents/meningococcal-vaccines, Sürüm: 47.0 (Erişim: 09.06.2014).

RSV Pneumonia in the Pediatric Intensive Care Unit

Dear Editor,

I read the article titled "RSV Pneumonia in Pediatric Intensive Care Unit" written by Ganime Ayar et al. published in the first issue of 2014 with great interest (1). This was a well-prepared article examining and assessing the clinical processes of patients monitored with the diagno-

sis of RSV pneumonia at the 3rd Step Intensive Care Unit. 12 patients half of whom were under 2 years old and under were examined retrospectively during the months of November-March during which RSV infections were condense. However, as the authors themselves indicated, it is an undeniable reality that it will make a contribution to the national scientific literature if it is supported by new prospective studies with more subject cases. In our retrospective study in 2009 with a similar seasonal period, clinical and laboratory features of children under 2 diagnosed with lower respiratory tract infection and nasopharyngeal wipe sample analyzed for RSV antigen were investigated (2). Of 79 patients whose nasopharyngeal wipe samples were analyzed for RSV antigen, 6 were monitored with the diagnosis of pneumonia+bronchiolitis, 73 bronchiolitis, and it was found that 16 (20%) of these patients were RSV antigen positive. Four of the RSV positive patients (all under 3 months) were hospitalized in the intensive care unit since they needed ventilatory support. In their study in which Topçuoğlu et al. investigated viral factors in 77 rustling children aged under 5, it was found that RSV prevalence was 43% (3). In the study group, intensive care unit need or period of 40 hospitalized and monitored patients were no specified. RSV positivity in in respiratory tract infections in studies done in Turkey was reported to be 11-50% (4). Detection of antigen in nasopharyngeal secretion is a recommended diagnosis method. In serologic tests (ELISA IgM and IgG), it is the case that the rate of negativity of the quick antigen test performed with EIA is higher than the test performed by nasopharyngeal secretion. Viral culture is not practical since it requires more time and equipment (5). Since RSV infection prevails severely in infants and especially risky patients, early onset of early diagnosis and supportive therapy will greatly minimize inappropriate antibiotic use and intensive care transfer period.

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References

1. Ayar G, Şahin Ş, Yazıcı MU, Parlakay ÖA, Tezer H. Çocuk Yoğun Bakım Ünitesinde RSV Pnömonisi. J Pediatr Inf 2014; 8: 12-7. [CrossRef]
2. Kayıran SM, Paloğlu E, Gürakan B. Bronşiyolit tanısıyla izlenen küçük çocuklarda RSV sıklığı, klinik ve laboratuvar özellikleri. Turk Ped Arş 2010; 45 : 252-6. [CrossRef]
3. Topçuoğlu S, Arslanköylü AE, Kuyucu S, Kuyucu N. Hışıltılı Çocuklarda Respiratuvar Sinsisyal Virüs, Parainfluenza Virus, İnfluenza Virus ve İnsan Metapnömovirus Sıklığının Araştırılması. J Pediatr Inf 2009; 3: 153-60.
4. Yılmaz G, Uzel N, Işık N, Baysal SU, Aslan S, Badur S. Viral lower respiratory tract infections in children in İstanbul, Turkey. Ped Infect Dis J 1999; 18: 173. [CrossRef]
5. Hacımustafaoğlu M, Çelebi S, Aynacı E, Köksal N, Sınırtaş M, Göral G. Evaluation of RSV Frequency in Acute Bronchiolitis By Different Methods. J Pediatr Inf 2008; 2: 156-61.