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These guidelines are for use by BC health care professionals caring for internationally adopted children and their adopting families. More than half of internationally adopted children have medical conditions, mostly infectious. Screening leads to timely treatment and prevention of disease transmission. These guidelines were developed after a review of the literature and recommendations by health bodies. They cover the most common causes of infection in this population. Investigations done abroad may have to be repeated and additional investigations may be necessary depending on clinical presentation and country of origin.

1.0 HEPATITIS B

Hepatitis B screening is cost-effective and recommended for all internationally adopted children as many come from hepatitis B endemic countries.

- Order serology for HBsAg, anti-HBs and anti-HBc.
- Consider repeating the above hepatitis B tests six months later (the virus can have a long incubation period).
- Offer hepatitis B vaccination to family members prior to the arrival of the adopted child.

2.0 HEPATITIS C

Hepatitis C testing is recommended for children arriving from China, Russia, Eastern Europe, Egypt and Southeast Asia and for children from any country if they have received blood products or if there is a history of maternal illicit drug use.

- Order serology for anti-HCV.
- If anti-HCV is positive in children <18 months (may be due to circulating maternal antibodies), order hepatitis C PCR.

3.0 HUMAN IMMUNODEFICIENCY VIRUS

Adopted children may be from countries with a high incidence of HIV infection and/or from high risk segments of the population. The HIV positive child will benefit from early diagnosis and treatment.

- Order an anti-HIV antibody test.
- If anti-HIV is positive in children <18 months (may be due to circulating maternal antibodies), order HIV PCR.
- HIV positive children should be referred to a specialist for further care**.**

4.0 CONGENITAL SYPHILIS

International adoptees may have been born to women who received little prenatal care or who were at risk of sexually transmitted infections. A child affected by congenital syphilis may be asymptomatic (especially initially) or present with rash, osteochondritis, pseudoparalysis and hepatosplenomegaly. Late manifestations can involve the central nervous system.

- Order nontreponemal and treponemal antigen testing, including RPR (rapid plasma reagin) and FTA-Abs (fluorescent treponemal antibody absorbed) or their equivalent.

5.0 EOSINOPHILIA

Immigrant children from tropical countries can have systemic parasitic infections such as strongyloidiasis, schistosomiasis and filariasis leading to eosinophilia.

- Order a complete blood count and differential.

6.0 TUBERCULOSIS (TB)

Infected children are often asymptomatic but have a higher risk of presenting with extrapulmonary TB. TB screening by skin test is recommended for children under 15 years from countries where the TB rate is 15/100,000 or higher (see International Tuberculosis Incidence Rate by the Public Health Agency of Canada). Prior BCG vaccination is not a contraindication to skin testing.

- Perform a Mantoux (tuberculin) skin test upon arrival. A positive test is ≥10mm of induration.

- If negative, consider repeating the test 3 months post-arrival. Due to underlying conditions, the child may not initially mount an appropriate immune response. Also, he/she may have been exposed close to his/her departure date.
- Children with a positive skin test should be referred for follow-up investigations to a specialized TB clinic such as the Tuberculosis Control clinic at the BCCDC (604-660-6108).

7.0 INTESTINAL PATHOGENS

Children infected with intestinal parasites may be asymptomatic, have failure-to-thrive or be underweight with no obvious etiology. Unexplained eosinophilia may be the only indication of a parasitic infection. Bacterial enteric infections are usually associated with diarrhea.

- Order ova and parasite testing on two stool specimens for asymptomatic adoptees.
- If the stool is unformed, order culture and sensitivity on one stool specimen.

8.0 FEVER OF UNKNOWN ORIGIN

Fever in an otherwise asymptomatic child from a developing country may be caused by serious conditions such as malaria, typhoid fever or HIV. Blood cultures and a peripheral blood smear for malaria should be obtained early. Refer to an infectious disease specialist if the diagnosis or treatment is uncertain.

- Inquire about recent episodes of fever and investigate causes.

9.0 DERMATOLOGICAL CONDITIONS

Infections such as measles, rubella, leprosy and filariasis and infestations such as scabies which may be present in children from developing or tropical countries may present with dermatological signs.

- Perform a dermatological exam.

10.0 IMMUNIZATIONS

If a child lacks adequate written documentation of immunization, they should be started on a primary immunization schedule appropriate for their age. If the immunization record shows the child is not up to date, they should receive the appropriate immunizations. Most vaccines can be given even if they have been previously administered.

- Review the immunization history and records if available.
- Immunize or re-immunize according to Chapter 2, Section 2 of the Communicable Disease Manual - BC Immunization Schedule
- Minimum dose intervals can be used to accelerate the schedule.
- Contact your local health authority if you have immunization-related questions.