Age	Age Code	VAERS ID	VAERS ID Code	Adverse Event Description
6-11 months	1	259715-1	259715-1	Infant febrile morning of 5/18/2006 around 5:30 a.m. No other S/S per parent. Parent administered tylenol. Midday infant began seizing, mom called 911, infant transported and later pronounced dead at hospital. 7/19/06 Received death certificate which stated COD as pulmonary edema due to protracted febrile seizure. 7/28/06 Received tag-2 report from PCP. Family had moved to another state. Records accompanying report included vax records, Death Summary from ER & Autopsy Report. COD stated as non-cardiogenic pulmonary edema as the result of febrile seizures/ss
1-2 years	2-Jan	217129-1	217129-1	According to family, 3 hours after immunizations given, patient had vomiting and temperature of 103. Arrived in ER 2/26/04 at 21:15; temp was 106 rectally. C/C to ER; was crying, fever, vomiting. Died 2/26/04 at 23:58. The hospital discharge summary received on 3/23/04 states meningococcaemia/ sepsis and congenital heart dx. Nurse follow up on 09/21/04 states: ""septic shock, adrenal hemorrhage.""""
1-2 years	2-Jan	219786-1	219786-1	After vaccination, pt irritable and emesis 1-2 x. No fever. Acting better by morning. Mom gave pt bottle at ~4:30 am. Pt developed respiratory difficulty at ~5-5:30 am. Dad initiated CPR and ambulance called. Pt received CPR to local hospital. Coded there for 30-45 min (not at my facility). Pronounced dead at ~6:30 am. Nurse follow up on 05/14/04 states: Unresponsive, cyanosis, pupils fixed, apneic, asystold (stupor, cyanosis, mydriasis, apnea, heart arrest).

1-2 years	2-Jan	222269-1	222269-1	Information has been received from a physician via the VZV identification program concerning a 13 month old male with DiGeorge's syndrome status post central shunt (March 2003) and Rastelli repair for tetralogy of Fallot (26-Jan-2004) who on 31-Mar-2004 was vaccinated with a first dose of measles virus vaccine live (+) mumps virus vaccine live (+) rubella virus vaccine live (lot number 646705/0823N) and a first dose of varicella virus vaccine live (lot number 637710/1248N) in the left leg. The patient was concomitantly vaccinated on 31-Mar-2004 with a dose of diphtheria toxoid (+) hepatitis B virus vaccine rHBsAg (yeast) (+) pertussis acellular 3-component vaccine (+) poliovirus vaccine inactivated (+) tetanus toxoid) (lot 21924A2) in the right leg. It was reported that the patient did not developed a rash at the injection site post vaccination. On approximately 26-Apr-2004, the patient developed diffuse bilateral pneumonitis possibly due to heart failure. The patient was afebrile. On 03-May-2004, the patient was admitted to the hospital with severe amenia, congestive heart failure, and bloody emesis. Patient had decreased po intake lethargy, and retching for 1 week prior to admission. On 13-May-2004, the patient's pneumonitis worsened. The patient developed an increased requirement for pressor support, worsening respiratory distress requiring intubation and had diffuse pulmonary opacities on CXR. Therapy with caspofungin was stated on 13-May-2004. On 20-May-2004, therapy with ribavirin, vancomycin, and piperacillin was started. On 21-May-2004, the patient developed a papular rash with 5 lesions scattered on the trunk. On 21-May-2004, therapy with acyclovir was started. A culture/PCR from tracheal aspirate for varicella and measles was performed on 19-May-2004 and 21-May-2004, and a papule specimen was taken 21-May-2004. Preliminary reports from the CDC revealed that the culture from tracheal aspirate taken 21-May-2004 and 2 urines were PCR positive for measles virus (Strain ID to follow). The PCRs were being rep

1-2 years	2-Jan	230877-1	230877-1	Infant seemed fine except for cold (clear drainage) and was teething (2 teeth trying to come in). 4/23/04 PM, infant became more upset. Mother gave infant Tylenol Elixir with hydrocodone and infant spit it out on clothes. Infant was alive at 2 AM on 4/24/04 and was not breathing at 8 AM. Mother took her to ER. Autopsy report received which revealed COD to be SIDS & cosleeping.
1-2 years	2-Jan	233373-1	233373-1	Patient was found this afternoon cold and not breathing. His resuscitation was not successful. Autopsy report received stated COD was SIDS.
1-2 years	2-Jan	239690-1	239690-1	On the morning of 6/9/2005, patient was found in his crib apneic and without pulse. Resuscitation attempts were unsuccessful and the child was pronounced dead in the Emergency Room. Additional co start from Discharge summary rec'd 06/13/2005 -- cyanosis.
1-2 years	2-Jan	239904-1	239904-1	Information has been received from a RN concerning a 21 month old immunocompromised male who was vaccinated with a dose of varicella virus vaccine live. Concomitant vaccination included a dose of measles virus vaccine live (Enders-Edmonston) (+) mumps virus vaccine live (Jeryl Lynn) (+) rubella virus vaccine live (Wistar RA 27/3). Subsequently the pt was hospitalized and died two weeks later (not further specified). A product quality complaint was not involved. Additional information was received from the RN who reported that the pt had a lot of problems. The pt was hospitalized until he was 20 months old with a diagnosis of extreme prematurity among other problems. The nurse did not know the cause of death but did indicate that high temperatures were involved. Additional information was received from a health professional at a pediatricians office who reported that the pt's demise had nothing to do with the vaccinations. The pt's experience was considered to be immediately life threatening and disabling by the RN. Additional information has been requested. Received Autopsy Report which revealed COD as acute bronchopneumonia, bronchopulmonary dysplasia, dilated cardiomyopathy & prematurity.

1-2 years	2-Jan	239968-1	239968-1	Had been to MD week of 10/18 with normal well child exam. 10/19/2004 slight cough, chest clear temp 99.8 in our office. To MD office 10/21/04 - Dx beginning pneumonia. Antibiotic inj. given and sent home. 10/22/04 Rapid progression of pneumonia at ER. Blood sugar 700+ Dx: Diabetic Ketoacidosis. Life flight to Hosp. Brain stem swelling. Pt died 10/24. Added code of dehydration from Death Certificate rec'd 06/13/2005. From discharge Summary rec'd 06/21/2005, added terms are polyuris, lethargy, weight loss, tachycardia, dehydration, irritable, bradycardia, hypoventilation, pain, hyperventilation, pallow, and hyponatremia.
1-2 years	2-Jan	248538-1	248538-1	Patient became ill within 24 hours of vaccine administration with URI symptoms, He was then discovered by parents to have stopped breathing.
1-2 years	2-Jan	250504-1	250504-1	Child reportedly fussy, irritable and with mild fever during interval between vaccines and death. 2/27/06 Received autopsy report which reveals patient's COD was Sudden Unexpected Death in Childhood/ss No new information found in medical records from PCP.

1-2 years	2-Jan	252076-1	252076-1	Initial SAE report received on 13 May 2005. Additional information received on 06 June 2005. This subject is 16 month old male, who died from the congential anomaly static encephalopathy while enrolled in a study of DAPTACEL administered with other recommended vaccine according to the standard of care at 2, 4, and 6 months of age in infants and as a booster to toddlers. The subject received four dose of study vaccine. The last dose prior to the event was given on 03 November 2004. On that same date, the subject concomitantly received a dose of ActHib, lot number UE237AA (lot number 200672); a dose MMR/Measles, Mumps and Rubella Vaccine lot number 0181N and a dose of Prevenar lot number A74399C. The subject suffered from static encephalopathy and had a past medical history of central hypoventilation syndrome. The subject died on 28/Nov/2004, 25 days post-vaccination. Autopsy information is pending. The event of static encephalopathy was reported by the investigator as not related to the study vaccine. From additional information received on 06 June 2006 it was reported that pathological studies determined that the patient had Rett Syndrome. During internal review on 17 June 2005 it was noted that congenital anomaly was ticked in error for serious criteria. A corrective version was created to amend this. List of additional information available in source documents. Death certificate received which revealed COD: cardiopulmonary failure, arrhythmia-V-tach, encephalopathy and seizure disorder/ss

1-2 years	2-Jan	255329-1	255329-1	on 3/16/2006 was vaccinated with a dose of Varicella virus vaccine live. Concomitant vaccine administered on the same day included a doe of measles mumps rubella vaccine. Concomitant therapy included an inhaled corticosteroid unspecified. On 4/9/2006 the patient was diagnosed with adenosine deaminase deficiency and the mumps virus had been isolated from her bronchial tract. The patient was hospitalized, was being treated in the critical department, and was on a ventilator. At the time of the report the patient had not recovered. It was noted that there were numerous diagnostic studies, unspecified. Follow up information from a physician indicated that the patient was currently being treated, in April 2006, for disseminated Varicella. The patient was also being treated for lung disease attributed to Varicella, which had shown response to treatment. The patient was still being mechanically ventilated, which required 50% supplemental oxygen. A bronchioalveolar lavage sample was positive for mumps on day three. An immunofluorescence assay was negative for measles. The treatment of the patient has included acyclovir, foscarnet, ribavirin IV, amantadine, and pegylated adenosine deaminase. Current therapy included amantadine, ribavirin and acyclovir. The patients reaction was considered to be immediately life threatening, disabling, and an important medical event by the reporter (OMIC). Additional information has been requested. 6/1/06 Received t/c from reporter with unofficial COD of intracranial hemorrhage which was probably caused by the drug Ecmo. Had also used 2 IND drugs on this patient (ribavirin & VeriZIG) PMH: preexisting pulmonary fibrosis & intermittent thrush since birth. Patient had been hospitalized past fall with extensive pulmonary infection for approx 3 weeks. Patient was on less than 3% percentile mark in physicial development. 6/19/06 Received medical records from prior hospitalization 8/20/05-9/4/05 w/dx: pneumonia, hypoxia & dehydration. PMH: protracted history of colds & ear infections. Birth hx: pregnancy complicated by oligohydramnios, c-section, breech presentation, 6#, length 19 in & head circum 33.5. Blood cultures during hospitalization were neg. Final dx: viral pneumonia. 7/13/06

1-2 years	2-Jan	257684-1	257684-1	Received immunizations in this office on 5/31/06. She was noted to have an otitis media withoutfever. Mother called the office on 6/1/06 and talked to the nurse because she was running a fever and not acting quite right. She was given standard instruction for post immunization. During the night she became febrile and started having respiratory difficulties with her pulse ox dropping into the 80's. Mother drove her to the emergency room. In route the child became apneic. By the time she arrived she was asytolic. Rescussitation was unsuccessful. She had a temperature of 107 when she arrived in the ER.This patient had fever and cardiovascular colapse within 48 hours of immunization. I feel this was a major immunization reaction. 7/18/06 Received medical records from ER which reveal patient developed respiratory distress & failure. PMH: tracheomalacia, developmental delay, chronic respiratory deficitis & congenital heart defects. Had trach & PEG in place & was on home O2. Developed decreased LOC prior to hospitalization with cyanosis despite O2. Found to be febrile at 107, apneic & asystolic in ER & resuscitation was unsuccessful. 7/31/06 Received medical records from PCP which did not add new info. 8/9/06 Received Death Certificate which stated COD as pneumonia with dehydration with tracheomalacia as underlying cause./ss
1-2 years	2-Jan	266205-1	266205-1	Apparently healthy 13 montly old fraternal male twin received vaccines (see below) at approximately 9AM on 11/2/06. Approximately 12 hours later child experienced seizure at home. EMT came to home and gave Versed to patient at about 10:30PM and child was brought to ER. Temp at ER 101.8 (rectal). At about 11:15PM child experienced respiratory failure, attempte was made to intubate; child pronounced dead at approximately 12:02AM on 11/3/06. 2/22/07 Received autopsy report which reveals COD as complications of midazolam administration following a s/p vaccination benign febrile seizure.

				Information regarding Prevnar vaccine was received from a consumer, the mother of a 16-month-old female patient who on 21-Dec-2006, received a dose of Prevnar along with a dose of Hib (manufacturer unknown), a dose of Varivax (manufacturer unknown), and a dose of M-M-R II (Merck Sharp & Dome). On the same day, the patient experienced lethargy, possible seizure, irritability, was not acting normally, had jerky movements and clenched hands. On 22-Dec-2006, the child would not respond and on 24-Dec-2006, the child died. On 21-Dec-2006, the patient with a history of influenza like illness, pyrexia, virus (unspecified) and tremor of hands, was evaluated at the physician's office for those symptoms and was also administered Prevnar along with Hib, Varivax, and M-M-R II. Later that day, the child was lethargic and experienced a possible seizure, irritability, was not acting normally, had jerky movements and clenched hands. On 22-Dec-2006, child would not respond and was taken to the hospital and placed on life-support for two days. On 24-Dec-2006, the child died. The cause of death was not reported. The reporter stated she ""feels that her daughter had an adverse reaction to Prevnar."" No additional information was available at the time of this report.""
1-2 years	2-Jan	281033-1	281033-1	
1-2 years	2-Jan	290970-1	290970-1	Mother reported that child ran a fever following the immunizations.
1-2 years	2-Jan	291678-1	291678-1	Healthy 18 mo male with history of febrile seizure in 3/07 given MMR II, VZV, DTaP & Flu vaccine on 9/24/07. Child discovered by mother deceased in bed approx 9/25/07. 11/30/07 Reviewed autopsy report which states COD as undetermined & manner of death undetermined. Anatomic diagnoses: pulmonary congestion & edema, sudden of unknown etiology. Patient was found unresponsive face down on mattress in crib.
1-2 years	2-Jan	297178-1	297178-1	Child started with high fever, 48 C, post vaccination and died on 11/12/2007. 12/11/2007 Reviewed autopsy report which states COD as acute bronchopneumonia complicated by acute gastroenteritis. Blood c/s neg.

1-2 years	2-Jan	306817-1	306817-1	On 2/23/08 child received MMR and Varicella vaccinations during routine one year check up. No adverse events reported to physician prior to death on 2/27/08. 6/25/2008 Postmortem examination report received. COD-Acute Febrile Illness. DX based on exam: Pale doughy lungs. Bite marks on lower lip. Febrile illness by history. Acute inflammatory cells in walls of bronchi in peribronchial alveoli.
1-2 years	2-Jan	327331-1	327331-1	Pt found unresponsive & not breathing after nap. Resuscitated by EMS & in ER, never regained consciousness & later died in PICU at hospital. Intracranial bleed on head CT. 10/9/2008 Forensic Autopsy Summary Sheet received, COD pending further studies. Infant found unresponsive and transported to ER & dx with subdural hematoma. Transferred to higher level of care. Despite resuscitation efforts, infant pronounced dead. Autopsy findings of 2 small abraded contusions to L side of head, subdural hematoma overlying the L temporal lobe. Marked brain edema and pulmonary edema. Otherwise unremarkable
1-2 years	2-Jan	336785-1	336785-1	Patient seen on 12/18/08, received immunizations, had low grade fever next day and then was brought to ER lifeless. 2/17/09-records received COB bacterial sepsis. Other significant conditions contributing to death but not related to terminal conditions:sickle cell anemia trait. krk

1-2 years	2-Jan	337669-1	337669-1	Pt given HIB #4; PREVNAR #4; Hepatitis A #1; MMR #1; Varicella #1 and Influenza #1 on 11-17-08. Pt presented one week later ""barely breathing""; flacid and unresponsive to verbal-painful stimuli at 1755-transferred-died at local hospital a couple of hours later. 2/12/09 PCP and hospital records received from FDA. Pt with mild fever 11/24/08 put down to nap. Ptfound to be diaphoretic, limp, minimally breathing and non-interactive in crib. Upon arrival of EMS pt noted to be unresponsive to stim, satring with no blink response, pulse 160, RR 32 with rhonchi bilaterally R>L. Dx with severe croup at local hospital with transport planned to higher level of care. In ER unresponsive in severe respiratory distress, skin mottled, O2 sats 80s-90s on pale toes. Arrived to transfer hospital unresposive to pain, lethargic, initially flaccid then posturing, (+) cervical lymphadenopathy, resp distress with stridor and rhonchi- intubated. Impression- Respiratory Failure. Cardiac arrest. CPR unsuccesful. 3/25/09 Autopsy report received with COD: Community Acquired Pneumonia. Manner of Death: natural. Final DX: 1) Acute hemorrhage pneumonia, multifocal, community acquired- a) Diffusely firm, edematous and hemorrhagic lungs, bilaterally. b) Histologic exam confirms purulent multifocal pneumonia. 2) Moderate Cerebral Edema. 3) Serous Pleural and Peritoneal Effusions.""
1-2 years	2-Jan	338667-1	338667-1	Sudden death at home morning of 1/28/09. 6/1/09 Autopsy report states COD as sudden unexpected infant death & manner of death as natural. Report also states patient found dead in crib, tox screens & cultures all neg.

1-2 years	2-Jan	338821-1	338821-1	This case was reported by a healthcare professional and described the occurrence of death nos in a 12-month-old female subject who was vaccinated with HAVRIX (GlaxoSmithKline), MMR II (strain not specified), VARIVAX and PREVNAR. On 21 January 2009 at 07:43, the subject received unspecified dose of HAVRIX (.5 ml, unknown, right thigh), unspecified dose of MMR II (unknown), unspecified dose of VARIVAX (unknown), and unspecified dose of PREVNAR (unknown). On 22 January 2009, 1 day after vaccination with HAVRIX, after vaccination with MMR II, PREVNAR, and VARIVAX, the subject experienced death nos. The healthcare professional considered the event was disabling, life threatening and clinically significant (or requiring intervention). The subject died on 22 January 2009 from death nos. It was unknown whether an autopsy was performed. It was reported the subject had ""no history of illness or medical problems. Not on medications at time of death. Medical examiner stated undetermined cause of death on death certificate"". 3/5/09 Autopsy report received with COD: Undetermined. Manner of Death: Undetermined. Child had presented to PCP earlier on the DOD with fever and URI sx. 4 vax given taht day. Child remained cranky and put down to nap. Approx 1 hour later found face down without pulse or respirations. Resuscitation unsuccessful.""
1-2 years	2-Jan	341593-1	341593-1	Patient died 1-11-09. Had received vaccines in our office 1-5-09. Coroner determined cause of death as SIDS after autopsy completed. 3/16/09-autopsy report received-COS Sudden Infant Death Syndrome (SIDS). Manner of death natural. Moderate thymic and pleural petechiae. Pulmonary and visceral congestion.
1-2 years	2-Jan	347248-1	347248-1	None noted. Pt was not seen in our office after vaccine administration. Death was reported to our practice on Tuesday AM 5/26/09. 7/10/09 Autopsy report states COD as idiopathic epilepsy. Report also states pt had history of cardiac pacemaker & seizure disorder. Admitted to hospital on 5/23/09 for local reaction w/swelling at injection site, had seizure & cardiac arrest on 5/24/09.
1-2 years	2-Jan	360751-1	360751-1	Patient was seen on 10/1/09. Death reported on 10/4/09. Pt has seizure disorder along with encephalocele. / DANDY WALKER Syndrome. Had received vaccines on 10/1/09.

1-2 years	2-Jan	366004-1	366004-1	Patient given vaccine on 8/12/09. Hospitalized for respiratory illness/pneumonia 8/27-9/1, given steroids during hospitalization. Rash developed on 9/1/09, day of discharge. Saw patient on 9/2/09, started on oral acyclovir. DOH and hospital notified. 11/13/09 Death Certificate received DOD 11/2/09 Cause of Death: Multisystem Organ Failure, Acute Respiratory Distress Syndrome, Varicella Pneumonitis. 12/9/09 DC summary received for dates 8/27/09. DX: respiratory difficulty, bronchospasms, hypotonia. Chief c/o respiratory distress, URI x1day, fever, tachypnea, retractions. Caretaker reports pt having difficulty breathing, fever, irritable. Assessment, (+)fever, grunting, retractions, hypotonia, O2 sat 91% on 3LNC. Speech and swallow eval: oropharyngeal dysphagia. Pt improved over 3 days, stable at dc. ER/hospital 9/5/09 to 10/29/09. DX: muscular weakness disorder, viral pneumonitis, varicella. Resp distress, fever. Parent states varicella vax 8/12/09. Varicella skin rash formed 8/31/09.EMS presented pt. to ER. Assessment: stridor, rash, fever, mild distress. Pt admitted and following day resp distress increased, grunting, increase in fever 103F, pt found to be irritable, O2 sats 92% w/ O2 therapy. Tylenol given, within 30 min temp 104.5F. One hr later pt HR 220-240bpm. Pt later stabilized but prognosis guarded.
1-2 years	2-Jan	371206-1	371206-1	Unexpected death. Patient was asymptomatic except for skipping lunch. Took his usual afternoon nap but expired during sleep. Autopsy today did not reveal a cause. 01/07/2010. Autopsy received. DOD 1201/2009. Cause of Death: 1. Undetermined. Manner of Death: Undetermined. Additional Information Abstracted: I. [History of Febrile Seizures]: Cerebral Edema and Congestion. II. Pulmonary Edema and Congestion. II. Postmortem Toxicology Results: A. Blood: 1. Atropine = 870 NG/ML. B. Vitreous Humor: 1. Sodium = 137 MEQ/L. 2. Potassium = 17.8 MEQ/L. 3. Chloride = Creatinine = 0.8 MG/DL. 5. Urea Nitrogen = 7 MG/DL. 6. Glucose = <20 MG/DL.
1-2 years	2-Jan	382602-1	382602-1	Vomiting (up to 8 days later), lethargic, no appetite, dehydration, had to go back to the hospital for hydration. Stopped walking and talking and interacting with us. Stared into space, very droggy, wanted to sleep all the time; started losing weight and got a very distended abdomen, and loss of appetite. This has lasted for almost 3 full months, now.

				carried in from triage to shock room 2, lethargic and listless. HISTORY OF PRESENT ILLNESS: The patient, according to mother's history, was exposed to several family members who have had URI symptoms over the last 24 hours and this morning he slept more than usual, walking up around 10:30 this morning, and was found to be lethargic. The patient was carried into shock room 2. Further history was not available. PAST MEDICAL HISTORY AND SURGICAL HISTORY: Negative. ALLERGIES: Negative. MEDICATIONS: Currently negative. REVIEW OF SYSTEMS: As per HPI; otherwise, all negative. PHYSICAL EXAMINATION: General: The patient was lethargic, listless, and unremarkable. HEENT: His oropharynx was clear. He did not have any tongue lacerations or abrasions. He had moist mucous membranes. Neck: Supple. I did not appreciate any obvious lymphadenopathy or meningeal signs. Lungs: Clear on auscultation. He had moderate accessory muscle use with intercostal retractions. Abdomen: Soft. I did not appreciate any distention or signs of trauma. Extremities: The lower extremity exam was cold to touch. He had poor perfusion. He was mottled. Neurologic: The patient had positive nystagmus and almost exhibited tonic-clonic-like activity. EMERGENCY DEPARTMENT COURSE: Immediately, we decided to intubate this patient to maintain a definitive airway. Using a 4.5 endotracheal tube that was uncuffed, I proceeded with intubation. A peripheral IV was inserted immediately by our nurse. I used 15 mg of IV succinylcholine with a dosing determined using a weight based scale. We believed the patient was anywhere from 10 to 12 kg. Once the patient was adequately paralyzed, I was able to successfully intubate this patient. He had positive end-tidal CO2 and condensation in the tube. He had blood work including a CBC, a blood culture, and a BMET. I had the patient transferred immediately to head CT which showed evidence of chronic maxillary sinusitis with no evidence of mass effect. When the patient returned back to the emergency room into shock room 2, I proceeded with spinal tap. Given the emergency situation, we did not have a chance to
1-2 years	2-Jan	388098-1	388098-1	consent mother who was not immediately available. We went ahead and proceeded Pt. received vaccines on 1/7/10 and was found unresponsive in crib on 1/28/10.
1-2 years	2-Jan	388916-1	388916-1	Autopsy showed pt. died from Fibroelastosis of the heart.

1-2 years	2-Jan	404258-1	404258-1	Patient was found pulseless and apneic in her bed by mom in the morning (0500). CPR performed and pt taken to ED. Unable to resuscitate.
1-2 years	2-Jan	428370-1	428370-1	Fever & fussy 6/20/11. Fever 6/21/11. Found unresponsive after taking a nap.
1-2 years	2-Jan	429528-1	429528-1	Onset of fever on 8-6-11 up to 102 degrees. Playful when afebrile. Seen in doctor's office on 8/8. Presented later to ER where resp. arrest occurred during evaluation. CPR and defibrillation with aggressive IV inotropes unsuccessful. (intermittent fever present 8/6-8/8).
1-2 years	2-Jan	436743-1	436743-1	Parents found patient blue and not breathing at home. Code Blue to hospital.
1-2 years	2-Jan	440919-1	440919-1	Patient with likely osteodysplastic primary dwarfism began to have vomiting, diarrhea, rash, fever on 10/20, became progressively weaker. Seen in urgent care clinic 10/23, became very weak after home on BENADRYL, came to ER. Found to have hydrocephalus (more than previous MRI), decorticate posturing, intubated, ventriculostomy perform, no longer responsive, cerebral edema and herniation.
1-2 years	2-Jan	445693-1	445693-1	Patient traveled to another country on 12/1/11. Following day, began bleeding from his nose and coughing up blood. Found to have low platelets and profound coagulopathy. Subsequently has developed respiratory failure and acute renal failure requiring peritoneal dialysis. No infectious or other etiology identified to date.
1-2 years	2-Jan	450453-1	450453-1	Patient found unresponsive by babysitter. EMS called to scene. Patient transported to ER at Medical Center. Time of death noted to be 20:48 on 2/8/12 by ER.
1-2 years	2-Jan	451373-1	451373-1	Unexplained crib death 7d after MMR + VARIVAX.
1-2 years	2-Jan	453774-1	453774-1	Pt. received vaccines (MMR & Varicella) on 3/6/12. On 3/25/12 was found dead in crib (still waiting for autopsy results).
1-2 years	2-Jan	454298-1	454298-1	Child was found dead on the morning of 04/14/2012.
1-2 years	2-Jan	455358-1	455358-1	Pt. died of unknown causes. Autopsy. Toxicology testing in process.

1-2 years	2-Jan	460432-1	460432-1	The patient had a screening CBC done the same day as vaccinations (7/16/12) that showed leukocytosis with blasts, anemia and thrombocytopenia. She was admitted to the hospital on 7/17/12. On 7/19/12, she was diagnosed with AML by bone marrow aspirate. She also started having fever and was started on broad spectrum antibiotics. Had surgical placement of CVC on 7/20/12 and received intrathecal cytarabine. She had postoperative respiratory issues, which was treated with high flow nasal cannula oxygen and diuretics. On 7/21/12, she received dexamethasone, cytarabine, daunorubicin and etoposide. Bortezomib (a tyrosine kinase inhibitor) was given per experimental treatment protocol. Beginning 7/21/12, she developed vomiting, diarrhea, tachypnea and tachycardia with worsening desaturations. She progressed over the course of the day on 7/22/12 despite increasing respiratory support from high flow nasal cannula oxygen to bilevel positive airway pressure, to endotracheal intubation with mechanical ventilation. The team caring for her was unable to increase oxygenation, improve carbon dioxide retention or correct acidosis. The patient died on 7/22/12 at 2151. Cultures from blood and urine did not grow bacteria. An autopsy is being done.
1-2 years	2-Jan	494750-1	494750-1	This medically confirmed spontaneous report (initial receipt 18-Jun-2013) concerns a female patient approximately 2 years old. Some time in January or February of 2013, the patient developed sepsis and subsequently passed away. The patient had received a flu shot (influenza vaccine, batch and manufacturer unspecified) prior to developing sepsis. The patient had been hospitalised (hospital information and duration unspecified) and CPR (cardiopulmonary resuscitation) had been conducted. The event outcome was fatal. Reporter's comments: The reporter considered events serious due to hospitalisation, intervention to prevent serious criteria (CPR conducted), life threatening events (patient passed away) and death.

				Patient presented to urgent care on 8/1/13 with 2 day history of diarrhea, possible fever, decreased energy, and jaundice. She also developed a disseminated flesh colored papular rash which would rapidly scab over. She was found to be profoundly anemic to 5.4 and was admitted to hospital. She required nearly daily transfusions due to new onset warm Ab hemolytic anemia which only improved slightly with a burst of high dose steroids as well as two treatments with IVIG. She also developed three other rashes during this hospital course. She had a massive diagnostic workup at Hospital, and had a skin biopsy of a lesion that appeared to be consistent with a herpes virus infection but was negative for HSV1 or HSV2. She was treated with IV acyclovir at meningitic dosing for 14 days. She also developed worsening encephalopathy with decreased ability to clear her own secretions. It was determined that she was deteriorating clinically and required further diagnostic workup at a tertiary care center. She was transferred to another hospital on 9/4/13. She was admitted to the PICU due to worsening neurologic status and has required prolonged intubation due to concern for neuromuscular weakness. LP on admission and subsequent skin lesion sample was positive for VZV DNA by PCR, and MRI brain and neck has shown diffuse cerebral atrophy and hyperintensity of basal ganglia, medulla, and cervical spine. She was treated with a burst of high dose steroids and 3 back-to-back doses of IVIG with improvement in her transfusion requirements. She was also treated with acyclovir and subsequently foscarnet with improvement in symptoms. Of note, she has had multiple infections during her hospital courses including rhinovirus, adenovirus, Pseudomonas, Ambiotrophia, and Klebsiella.
1-2 years	2-Jan	503021-1	503021-1	
1-2 years	2-Jan	537090-1	537090-1	Child found dead the next morning by family member.
1-2 years	2-Jan	546331-1	546331-1	Was at daycare - had taken nap/aroused fussy - consoled/but then noted not breathing 911 - to ER/dx with cardiac arrest ELLD.

3-5 years	5-Mar	224262-1	224262-1	7/4/04: Puffy eyes/itchy eyes, diagnosed with OM. Prescribed but did not take amoxicillin (because of possible allergy). 7/6/04: Clinic. Temp 102.7. B posterior lymphadenopathy; alert, well appearing. 7/7/04 Seizure at home. ED; repeat seizure, apneic episodes 3 times. Flumazanil, Dilantin and transferred. Never regained consciousness. LP positive, WBC. Died 7/9/04. Labs. Nurse follow up on 08/02/04 states: ""Complete."" Autopsy report received stated patient experienced Epstein Barr infection and cerebral edema.""
3-5 years	5-Mar	339027-1	339027-1	Patient had fever within 24 hours of vaccine administration. Patient was found unresponsive the next morning. Patient had a history of febrile seizures. 2/17/09- records received-COD died from complications of a seizure disorder. Seizure disorder, clinical history of febrile seizures. Asthma Clinical history of mild asthma. histologic changes in large airways consistent with mild asthma.
3-5 years	5-Mar	416893-1	416893-1	apparently found dead in bed by parent
3-5 years	5-Mar	436253-1	436253-1	Patient was found dead in bathroom after no obvious reaction.
6-17 years	17-Jun	382746-1	382746-1	Unknown.

18-29 years	18-29	250332-1	250332-1	The Department of Health informed the HC in May 05 of the death of a medically discharged patient. The patient enlisted in Nov 04, medically discharged in Jan 05, and died on Feb 17th. The following HPI is an account of the events prior to his death as recalled by his mother during an interview in May 05. The service member a 20 year old male, who received his enlistment vaccines on 23 Nov 04. While speaking with his mom on 30 Nov he mentioned that he had a cough, and some chest pain. She state that she encourage him to seek medical attention. She state that a couple of days later, while he was running he 'passed out' and when he went to the doctor he was told it was asthma. Mom reported that while he was at home during Christmas, he reported to his family that he was experiencing some chest pain, and did have bumps on his face that cleared in Jan. Mom was unaware of which vaccines her son received but did remember that her son said that the needle was ""funny."" Mom does not recall if he had a scar on his arm. She state that he was discharged for stress related issues and complaints of chest pain. Mom is unaware of any other details regarding her son's illness during that time only that the chest pain persisted. When questioned about his past history of asthma, she mentioned that he had it a little in childhood but has not been bothered by it since that time. She did mention that her son felt that his pain was not related to asthma. Mom was also questioned about the waiver for a medical exam upon discharge. She state that he was told that if he requested a workup, it would delay his release and that they may not even discharge him. He received his enlistment vaccines of Hep A-Hep B, Influenza, Meningococcal, MRR, Polio, and Td on 23 Nov 04 and he received his second Hep A-Hep B on 5 Jan 05. Chest pain start 11/30/2004, dyspnea (shortness of breath) start 11/30/2004. 4/3/06 Received Autopsy Report which revealed COD as chronic myocarditis.""
40-49 years	40-49	261871-1	261871-1	Received MMR vaccine and Hepatitis B vaccine at 1:45 PM. Brought in to ER at 10:48 PM in full cardiac arrest. Apparently had witnessed seizure prior to arrest.

40-49 years	40-49	351934-1	351934-1	Per translator client died 2 to 3 hrs. after receiving vaccines on 7/2/09. Autopsy is pending to determine cause of death. Due to language barrier unable to get more information.7/21/09-Nancy with Med Exam office called with preliminary COD: Coronary Artery Disease with no other significant conditions contributing to death. 8/13/09 Cause of Death: Coronary artery disease. Manner of death: Natural. Autopsy report summary of findings: I. Atherosclerotic cardiovascular disease. A. Calcific coronary artery disease, marked, involving three major vessels and left main. B. Aortic atherosclerosis, mild to moderate. II. Nephrosclerosis. III. Right rib fractures consistent with resuscitation efforts.
40-49 years	40-49	432209-1	432209-1	Pt. wife reports pt. died.
40-49 years	40-49	451473-1	451473-1	Information has been received from a Doctor of microbiology and a licensed practical nurse (LPN) concerning a 45 year old female with end stage renal disease (ESRD), lupus, a history of renal transplant that was failing so patient was being considered for another one; who on an unspecified date, may have been vaccinated or exposed to someone who was vaccinated with a dose of VARIVAX (Merck) (manufacturer unknown) (lot number, dose and route not reported). The LPN reported that after much investigation it could not be determined if the patient had ever received a VARIVAX (Merck) (manufacturer unknown) or if she was exposed to chicken pox, and stated that the office would not have authorized or administered a live vaccine to a immunosuppressed patient. The Doctor of Microbiology reported that on 10-FEB-2012, the patient was admitted to the hospital with a diagnosis of cholecystitis. On 11-FEB-2012 a cholecystectomy was performed. On 15-FEB-2012, rash and skin lesions appeared. On an unspecified date, strain identification for samples was found to be varicella zoster virus (VZV) positive in the lab. The patient experienced respiratory failure on 19-FEB-2012 and died at 11:28 hours. The doctor of microbiology reported that there was ""disseminated varicella"" at time of death. The cause of death was respiratory failure secondary to herpes zoster viremia. It was unknown if an autopsy was performed (death certificate showed No for autopsy). Additional information has been requested.""

50-59 years	50-59	320862-1	320862-1	Brother states patient developed ""Transverse myelitis"" from the MMR vaccine then the patient ""Fell down and died"". Developed paralysis in legs one week after shot. 8/11/08-records received for DOS 12/12/07-1/6/08- DX: Paraparesis secondary to transverse myelitis. Death secondary to pulmonary embolism. Admitted for evaluation of lower extremity weakness for 2-3 weeks, with shooting pain in feet on 12/14/07- balance difficulties noted, tingling in left upper extremity prior to hospitalization Upgoing plantar reflex noted on right side, lower extremity reflex loss at ankles and left patella. Autopsy refused by family.""
Unknown	U	351421-1	351421-1	Information has been received from a case in litigation via a case report concerning a child patient who on 22-MAR-2006 was vaccinated with a dose of MMR II (Lot number not reported) and concomitantly on the same day with a dose of poliovirus vaccine inactivated (unspecified) and a dose of DTaP (unspecified). On an unknown date, the patient died. The family member alleged that as a result of the administration of the vaccines on 22-MAR-2006. No further information is available.