Safety of Medical Interventions in Children Versus Adults

WHAT'S KNOWN ON THIS SUBJECT: Drug use in pediatrics is often based on adult efficacy data. Clinically significant discrepancies between adults and children may exist. To our knowledge, there is no large-scale evaluation of evidence comparing rates of adverse events between adults and children.

WHAT THIS STUDY ADDS: Available evidence on the comparative safety of pharmacologic interventions in adults versus children is inconclusive. In a third of meta-analyses, twofold or greater differences were identified between adults and children, and some clinically important discrepancies were also found.

OBJECTIVE: Compare the risk of harm from pharmacologic interventions in pediatric versus adult randomized controlled trials (RCTs).

METHODS: We used systematic reviews from the Cochrane Database of Systematic Reviews. We considered separately 7 categories of harms/harm-related end points: severe harms, withdrawals due to harms, any harm, organ system–level harms, specific harms, withdrawals for any reason, and mortality. Systematic reviews with quantitative synthesis from at least 1 adult and 1 pediatric RCT for any of those end points were eligible. We calculated the summary odds ratio (experimental versus control intervention) in adult and pediatric trials/meta-analysis; the relative odds ratio (ROR) in adults versus children per meta-analysis; and the summary ROR (sROR) across all meta-analyses for each end point. ROR <1 means that the experimental intervention fared worse in children than adults.

RESULTS: We identified 176 meta-analyses for 52 types of harms/harm-related end points with 669 adult and 184 pediatric RCTs. Of those, 165 had sufficient data for ROR estimation. sRORs showed statistically significant discrepancy between adults and children only for headache (sROR 0.82; 95% confidence interval 0.70–0.96). Nominally significant discrepancies for specific harms were identified in 12 of 165 meta-analyses (RORs <1 in 7, ROR >1 in 5). In 36% of meta-analyses, the ROR estimates suggested twofold or greater differences between children and adults, and the 95% confidence intervals could exclude twofold differences only in 18% of meta-analyses.

CONCLUSIONS: Available evidence on harms/harm-related end points from pharmacologic interventions has large uncertainty. Extrapolation of evidence from adults to children may be tenuous. Some clinically important discrepancies were identified. Pediatrics 2014;133:e666–e673

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KEY WORDS comparative safety, harms, withdrawals, mortality, children, adults, pharmacologic interventions

ABBREVIATIONS CDSR—Cochrane Database of Systematic Reviews CI—confidence interval OR—odds ratio RCT—randomized controlled trial ROR—relative odds ratio sROR—summary relative odds ratio

Dr Lathyris contributed to the study design and generation of the methodologic plan for data extraction and analysis, performed data extraction, coordinated and supervised data collection, and reviewed and revised the manuscript; Dr Panagiotou contributed to the study design and generation of the methodologic plan for data analysis, performed statistical analyses, and reviewed and revised the manuscript; Dr Baltogianni contributed to the study design, performed data extraction, and reviewed and revised the manuscript; Dr Ioannidis contributed to the study design, generated the methodologic and statistical analysis plans, and reviewed and revised the manuscript; Dr Contopoulos-Ioannidis conceptualized and designed the study methodology, coordinated and supervised data collection, performed statistical analyses, and drafted the initial manuscript; and all authors approved the final manuscript as submitted.

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Adverse events from pharmacologic interventions are common among children and adult patients both in hospital and ambulatory settings.1–5 For most of these harms, it is unknown whether their frequency and profile differs between children and adults. Differences between these 2 age groups4,5 may be due to unique pharmacokinetic and pharmacodynamic properties of drugs in children.6 Children could be more resilient to drug adverse events due to better organ function or more vulnerable due to higher tissue sensitivity. There is also evidence that adverse drug reactions can lead more often to hospital admissions in children than in adults,7 and certain pediatric populations may be at even higher risk for hospitalization.8,9 Pediatric use of drugs often depends on adult efficacy data because of the limited amount of data from randomized controlled trials (RCTs) in children. However, clinically significant discrepancies between adults and children may occur.10 To our knowledge, there is no large-scale evaluation of the evidence on the comparative rates of adverse events between adults and children. Meta-analysis can be used as a tool to improve the power to detect clinically significant differences in harms.

We set out to perform a large-scale empirical evaluation, across diverse topics, of the relative risk of harms and related outcomes between adults and children by focusing on outcomes reported in meta-analyses of pediatric and adult RCTs. We wanted to study whether differences exist in the relative risks of harms and other harm-related outcomes (such as withdrawals and mortality) between adults and children.

METHODS

Eligible Systematic Reviews and Trials

We perused a sample of 106 systematic reviews previously identified in the Cochrane Database of Systematic Reviews (CDSR)10 as part of an empirical evaluation comparing primary effectiveness outcomes in pediatric versus adult RCTs. The eligibility criteria of these reviews have been described in detail elsewhere.10 We screened reviews in the 2011 (issue 1) of the CDSR (except for mortality, for which we used the CDSR 2013, issue 1 vol) to identify meta-analyses on pharmacologic interventions (drugs, biologics, vaccines, parenteral solutions) with a quantitative synthesis for binary harms and harm-related outcomes from ≥1 pediatric RCT and ≥1 RCT in adults. For the characterization of trials as adult or pediatric RCTs, we used the same rules as previously reported10 (Supplemental Appendix 1).

The types of end points considered were grouped in the following 7 categories: severe harm, withdrawals due to harm, any harm (without further specification), organ system–level harm (eg, gastrointestinal adverse events), specific harm (eg, headache, nausea), withdrawals for any reason, and mortality. The last 2 categories combine both effectiveness and harms. For the categorization of medical interventions into experimental and control interventions, we used the same criteria previously described.10 We excluded systematic reviews with no quantitative synthesis for any study end point and those without data available for both age groups. The screening was done in duplicate by 2 independent investigators (DL, MB) and disagreements were discussed with a third investigator (DCI) to reach consensus.

Data Extraction

From each eligible meta-analysis, we extracted the following information: title, experimental intervention, control intervention, outcome, and trials per age group (author, year, 2×2 table-data for outcomes per trial). Meta-analyses for different end points in the same systematic review were considered separately.

Primary and Secondary End Points

We considered the following 2 primary end points: severe harms and withdrawals due to harms. As secondary end points we considered any harm, organ system–level harms, specific harms, withdrawals due to any reason, and mortality.

Quantitative Data Synthesis

Odds ratio (OR) was used as the metric of relative risk for each harm or harm-related end point. All interventions and end points were coined so that the compared arms always referred to the experimental versus the control intervention and the calculated OR always referred to an adverse outcome (ie, OR <1.00 means that the experimental intervention fared better than the control). When >1 trial per age group was available in each meta-analysis, we estimated the OR for the experimental versus the control intervention separately for the adult and the pediatric trials combining the ORs within each age group by fixed and random effects models.11,12 Between-study heterogeneity was evaluated with the I² metric and the corresponding 95% confidence intervals (CI).13 Moreover, each end point was considered separately.

For each meta-analysis, we then calculated the relative odds ratio (ROR) and the corresponding 95% CI of adult versus pediatric trials per meta-analysis by dividing the OR in adults by the OR in children. A topic with ROR <1.00 means that the experimental intervention (versus the control intervention) fared worse in children compared with adults. Finally, when ≥4 meta-analyses were available for an end point, we calculated the summary ROR (sROR) in adults versus children, across all topics.
by combining the natural logarithms of all individual RORs per random effects meta-analysis.\textsuperscript{12} We calculated the between-topic heterogeneity for the sROR estimates by using $I^2$ and the 95% CIs thereof.\textsuperscript{13–15}

We identified the topics for which the results in children versus adults differed beyond chance; those where the point estimate of the ROR suggested differences $\geq$20% in the OR between children and adults; those where the point estimate of the ROR suggested differences twofold or greater in the OR between children and adults; and those in which the 95% CIs of the estimated ROR excluded twofold difference in the OR between children and adults. Calculations were performed in Stata 12 (Stata Corp, College Station, TX) using the metan module. The CIs for $I^2$ were obtained by using the heterogi module.\textsuperscript{13} P values are 2-tailed.

**RESULTS**

**Eligible Topics**

Of the previously identified systematic reviews,\textsuperscript{10} we considered as eligible 55 reviews (Supplemental Appendix 2) corresponding to 176 individual meta-analyses, pertaining to 113 comparisons of experimental versus control interventions and targeting 52 types of harm and harm-related end points. The total number of meta-analyses for each type of harms and harm-related end point is shown in Fig 1. After excluding 75 mixed age group and 69 unspecified age group studies, we included 669 adult RCTs and 184 pediatric RCTs across all 176 meta-analyses (Fig 1). RORs were calculated in 165 of 176 meta-analyses. In the remaining 11 meta-analyses, RORs could not be calculated because there were no harm or harm-related events in all adult or all pediatric trials or in both.

The topics for those systematic reviews are shown in Supplemental Table 3. We performed quantitative synthesis for sROR estimation for the following 12 unique harms and related end points with $\geq 4$ pertinent meta-analyses: severe harms, withdrawals due to harms, any harm, 7 specific harms (headache, drowsiness, nausea, fatigue, dizziness, tremor, and infections; from a total of 42 specific harms), withdrawals for any reason, and mortality. Additionally, there were 5 organ system–level harms and 35 specific harms for which only individual RORs were calculated because there were not $\geq 4$ pertinent meta-analyses for each.

**Frequency of Differences Between Children and Adults**

Nominally significant discrepancies for harm risks in children versus adults were identified in 12 of 165 (7%) meta-analyses (ROR < 1 in 7, ROR > 1 in 5).
In 38% (63 of 165) of the studied meta-analyses, the point estimates of the RORs were \( \leq 0.83 \) and in 19% (32 of 165), they were \( \leq 0.5 \). In another 36% (59 of 165) of the meta-analyses, the point estimates of the RORs were \( \geq 1.20 \), and in 16% (27 of 165) they were \( \geq 2.0 \). Thus, the point estimates suggested \( \geq 20\% \) differences in the OR between children and adults in 74% of the meta-analyses and twofold or greater differences in the OR in 36% of the meta-analyses.

The lower 95% CI of the estimated RORs were \( \leq 0.5 \) in 73% of the meta-analyses (120 of 165 for which RORs were calculated). The upper 95% CI of RORs were \( \geq 2.0 \) in 78% (124 of 165) of the meta-analyses. Only in 18% (30 of 165) of the meta-analyses could twofold differences in the OR between children and adults be excluded in both directions based on the 95% CIs. The characteristics of included meta-analyses for each harm and harm-related end point and the respective quantitative synthesis results are shown in Supplemental Tables 3 and 4.

**sRORs**

Across the 12 types of harms and harm-related end points for which quantitative synthesis was performed (Table 1), nominally statistically significant discrepancies between adults and children were identified for only 1, headache. The sROR for headache was 0.82 (95% CI 0.70–0.96), indicating that children fared worse than adults for this adverse event, although none of the individual meta-analyses on headache had nominally statistically significant RORs. For the other 11 categories of harm, the differences were not beyond chance, and sROR estimates were relatively close to 1.00 (range 0.88–1.15) for the end points that had the largest number of trials (192–406) and the largest number of meta-analyses (13–23); that is, mortality, withdrawals due to harms, withdrawals due to any reason, and any harm.

**Nominally Significant Differences in Children Versus Adults for Specific Topics**

There were 12 meta-analyses for which the RORs on specific harms or harm-related end points were nominally statistically significant (Supplemental Table 4). On the basis of random effects calculations of RORs, children fared worse than adults in 7 of those cases (ROR \(<1\)), whereas the opposite occurred in 5 cases. Results are summarized in Table 2, and we present these 12 topics in more detail next.

**RORs \( >1\)**

For 5 topics, children had less unfavorable outcomes than adults. Azithromycin caused fewer harms than amoxicillin/amoxicillin-clavulpanate in both adults and children with lower respiratory infections, but the decrease was even more prominent in children than in adults. Adults experienced a statistically significant increase in adverse events, mostly gastrointestinal, from antibiotics versus placebo when they were given for common cold and acute purulent rhinitis, whereas children did not show such a pattern; however, this difference should be interpreted with caution, because 5 additional pediatric trials had not reported results for adverse events.

For specific harms, topiramate caused increased drowsiness versus placebo in adults treated for partial seizure, but this was not documented in children. The RTS,S malaria vaccine caused injection-site pain in both adults and children; however, the increase in pain in children was relatively less.

Finally, in liver transplantation, tacrolimus was associated with fewer withdrawals due to harm than cyclosporine in both adults and children; however, the benefit was more prominent in children.

**DISCUSSION**

In this large-scale meta-epidemiologic evaluation of the relative risks of harms in adults versus children, we identified a number of topics in which...
TABLE 1 sRORs for Harms and Harms-Related Endpoints in Adult Versus Pediatric Studies

<table>
<thead>
<tr>
<th>Harms and Harm-Related Endpoints</th>
<th>N (MA)</th>
<th>RCTs (Adults/Peds)</th>
<th>sROR (95% CI)</th>
<th>$I^2$ (95% CI)</th>
<th>RCT per MA (Median Adults/Peds)</th>
<th>Sample Size per MA (Median Adults/Peds)</th>
<th>Sample Size per RCT (Median Adults/Peds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe harms</td>
<td>8</td>
<td>80/20</td>
<td>1.25 (0.73–2.15)</td>
<td>0 (0–79)</td>
<td>4/3</td>
<td>947/582</td>
<td>143/119</td>
</tr>
<tr>
<td>Withdrawals due to harms</td>
<td>15</td>
<td>154/58</td>
<td>1.11 (0.78–1.57)</td>
<td>0 (0–75)</td>
<td>10/1</td>
<td>1485/529</td>
<td>202/196</td>
</tr>
<tr>
<td>Any harm</td>
<td>18</td>
<td>162/65</td>
<td>1.03 (0.82–1.30)</td>
<td>57 (26–75)</td>
<td>4/2</td>
<td>1132/535</td>
<td>185/139</td>
</tr>
<tr>
<td>Specific harms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>15</td>
<td>164/41</td>
<td>0.82 (0.70–0.96)</td>
<td>0 (0–54)</td>
<td>4/1</td>
<td>1958/269</td>
<td>231/206</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>8</td>
<td>66/9</td>
<td>1.02 (0.58–1.70)</td>
<td>34 (0–71)</td>
<td>7/1</td>
<td>995/93</td>
<td>53/60</td>
</tr>
<tr>
<td>Nausea</td>
<td>8</td>
<td>33/9</td>
<td>0.69 (0.40–1.21)</td>
<td>0 (0–68)</td>
<td>2/1</td>
<td>769/223</td>
<td>272/199</td>
</tr>
<tr>
<td>Fatigue</td>
<td>6</td>
<td>24/6</td>
<td>0.81 (0.48–1.35)</td>
<td>0 (0–75)</td>
<td>3/1</td>
<td>854/224</td>
<td>127/224</td>
</tr>
<tr>
<td>Dizziness</td>
<td>5</td>
<td>21/5</td>
<td>0.60 (0.37–1.29)</td>
<td>0 (0–85)</td>
<td>4/1</td>
<td>735/199</td>
<td>105/199</td>
</tr>
<tr>
<td>Tremor</td>
<td>4</td>
<td>28/10</td>
<td>0.88 (0.68–1.13)</td>
<td>0 (0–85)</td>
<td>7/2</td>
<td>1503/338</td>
<td>195/131</td>
</tr>
<tr>
<td>Infections</td>
<td>4</td>
<td>42/7</td>
<td>0.62 (0.27–1.43)</td>
<td>0 (0–80)</td>
<td>10/2</td>
<td>1839/113</td>
<td>75/60</td>
</tr>
<tr>
<td>Withdrawals for any reason</td>
<td>15</td>
<td>190/46</td>
<td>1.15 (0.88–1.48)</td>
<td>38 (0–66)</td>
<td>9/1</td>
<td>1287/195</td>
<td>184/174</td>
</tr>
<tr>
<td>Mortality</td>
<td>23</td>
<td>321/85</td>
<td>0.86 (0.70–1.11)</td>
<td>32 (0–62)</td>
<td>7/2</td>
<td>1414/222</td>
<td>90/75</td>
</tr>
</tbody>
</table>

MA, meta-analyses; Peds, pediatrics.

harm differences nominally beyond chance in the 2 populations. In a third of the meta-analyses, the point estimates of the ROR suggested twofold or greater differences in the estimated OR for harms and harm-related outcomes between adults and children. In the majority of topics, evidence was limited, and thus twofold differences could be excluded only in 18% of cases.

We targeted for convenience a selected group of systematic reviews10 that had already included both adult and pediatric RCTs in their primary efficacy outcome analyses. Still, we were able to identify pertinent meta-analyses with some data on harm or harm-related end points from both adults and children in only half of those topics. Furthermore, there was a relative paucity of data on some clinically important types of adverse events, such as severe harm. Moreover, across the compiled database of 176 meta-analyses, the total number of identified pediatric trials reporting harms and harm-related end points was less than a third of the total number of adult trials. The dearth of pediatric evidence suggests that extrapolations from adults to children regarding the harm of drugs may be tenuous. Clinical investigators should systematically collect and report information on harms and harm-related end points in pediatric RCT. Pharmaceutical companies do not typically evaluate most new agents in children because children represent a small market, and most pediatric trials are not funded by industry.16 Pediatric trials often rely on governmental and nonprofit organization funding sources.16 Moreover, drugs tested in children under the Pediatric Exclusivity law often do not reflect true priorities in children, and pediatric trials are often performed for blockbusters in the adult market.17 Pediatric information on drug labeling is lacking in most drugs licensed in the United States,18 and many children, in both inpatient and outpatient settings worldwide, are prescribed off-label drugs.19–21 Even for conditions with high disease burden in children, only a small percentage of clinical trials have included children16; the problem is even larger for conditions with high disease burden in developing countries.

In the absence of pediatric RCTs for drugs widely used in routine pediatric clinical practice, safety information from postmarketing surveillance studies might fill this knowledge gap.22,23 Nevertheless, postmarketing surveillance studies have their own challenges23 and exhibit variable accuracy and completeness. Moreover, most postmarketing studies that pharmaceutical companies commit to are never completed.22 Rigorous prospective postmarketing safety surveillance studies should be systematically performed and reported.24 This would be particularly important for rare adverse events that can occur in children and that could not be detected in even large pediatric RCTs.25

Unfortunately, robust studies targeting harms in children are often never performed, and the documentation of true differences between adults and children will remain elusive. Availability of information on adverse events in RCTs remains suboptimal26–31 despite the existence of specific standards for reporting of harms.32,33 Problems include deficiencies in the study design phase to capture adverse events; neglected collection of adverse events during the trial conduct; lack of reporting or restricted reporting of adverse events; and occasionally even silencing of evidence on harms.26 Long-term adverse events might even not be detected within the time frame of the RCTs and safety data for vulnerable populations at risk for adverse events may be lacking because these populations are usually excluded. Furthermore, reporting of the severity of
<table>
<thead>
<tr>
<th>CD Number</th>
<th>Condition</th>
<th>Comparisons</th>
<th>Harms and Harm-Related Endpoints</th>
<th>N Adult Studies (Events/Total Sample Size)</th>
<th>N Pediatric Studies (Events/Total Sample Size)</th>
<th>ROR (95% CI)</th>
<th>OR Adults (95% CI)</th>
<th>OR Children (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD000247</td>
<td>Common cold and acute purulent rhinitis</td>
<td>Antibiotic versus placebo</td>
<td>Adverse events</td>
<td>4 (189/1267)/2 (45/228)</td>
<td>2.67 (1.19–5.99)</td>
<td>2.42 (1.68–3.48)</td>
<td>0.91 (0.44–1.86)</td>
<td></td>
</tr>
<tr>
<td>CD001954</td>
<td>Acute lower respiratory tract infections</td>
<td>Azithromycin versus amoxicillin or amoxicillin-clavulanate</td>
<td>Adverse events</td>
<td>10 (368/2071)/2 (43/228)</td>
<td>2.5 (1.45–4.38)</td>
<td>0.75 (0.59–0.95)</td>
<td>0.30 (0.18–0.49)</td>
<td></td>
</tr>
<tr>
<td>CD002109</td>
<td>Community acquired pneumonia</td>
<td>Clarithromycin versus erythromycin</td>
<td>Adverse events</td>
<td>2 (162/476)/1 (61/260)</td>
<td>0.28 (0.14–0.57)</td>
<td>0.30 (0.20–0.45)</td>
<td>1.07 (0.60–1.9)</td>
<td></td>
</tr>
<tr>
<td>CD000059</td>
<td>Schizophrenia</td>
<td>Clozapine versus typical antipsychotics</td>
<td>Drowsiness</td>
<td>14 (981/1415)/1 (12/21)</td>
<td>0.073 (0.006–0.87)</td>
<td>1.76 (1.33–2.31)</td>
<td>2.24 (2.05–2.79)</td>
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<tr>
<td>CD001417</td>
<td>Drug resistant partial epilepsy</td>
<td>Topiramate versus placebo</td>
<td>Drowsiness</td>
<td>9 (253/1282)/1 (25/86)</td>
<td>2.76 (1.03–7.53)</td>
<td>2.81 (1.92–4.11)</td>
<td>1.02 (0.40–2.58)</td>
<td></td>
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<tr>
<td>CD004125</td>
<td>Prevention of post-operative nausea and vomiting</td>
<td>Hyosine versus placebo</td>
<td>Dry mouth</td>
<td>9 (364/766)/1 (61/260)</td>
<td>0.08 (0.009–0.79)</td>
<td>1.97 (1.34–2.89)</td>
<td>23.2 (2.58–208.8)</td>
<td></td>
</tr>
<tr>
<td>CD006198</td>
<td>Malaria prevention</td>
<td>RTS,S vaccine versus control</td>
<td>Injection site pain</td>
<td>2 (644/1003)/3 (578/649)</td>
<td>3.23 (1.86–5.62)</td>
<td>5.31 (3.86–7.30)</td>
<td>1.64 (1.05–2.57)</td>
<td></td>
</tr>
<tr>
<td>CD006198</td>
<td>Malaria prevention</td>
<td>RTS,S vaccine versus control</td>
<td>Swelling</td>
<td>1 (1/865)/3 (327/6464)</td>
<td>0.32 (0.12–0.80)</td>
<td>0.33 (0.13–8.09)</td>
<td>10.38 (6.67–16.16)</td>
<td></td>
</tr>
<tr>
<td>CD002217</td>
<td>Partial onset seizures and generalized onset tonic-clonic seizures</td>
<td>Phenytoin versus phenobarbitone</td>
<td>Withdrawal</td>
<td>2 (186/438)/1 (25/53)</td>
<td>0.18 (0.33–0.99)</td>
<td>1.54 (1.04–2.26)</td>
<td>8.47 (1.62–44.25)</td>
<td></td>
</tr>
<tr>
<td>CD005161</td>
<td>Liver transplantation</td>
<td>Tacrolimus versus cyclosporine</td>
<td>Withdrawals</td>
<td>11 (385/2446)/1 (64/181)</td>
<td>2.16 (1.09–4.29)</td>
<td>0.71 (0.53–0.91)</td>
<td>0.33 (0.17–0.62)</td>
<td></td>
</tr>
<tr>
<td>CD000527</td>
<td>Severe malaria</td>
<td>Any artemisinin drug versus quinine</td>
<td>Mortality</td>
<td>11(236/1414)/8 (232/1492)</td>
<td>0.51 (0.34–0.78)</td>
<td>0.49 (0.36–0.65)</td>
<td>0.94 (0.71–1.26)</td>
<td></td>
</tr>
<tr>
<td>CD002152</td>
<td>Cerebral malaria</td>
<td>Phenobarbitone versus placebo or nothing</td>
<td>Death within 6 mo</td>
<td>1 (62/185)/1 (44/340)</td>
<td>0.25 (0.10–0.83)</td>
<td>0.60 (0.32–1.11)</td>
<td>2.39 (1.20–4.68)</td>
<td></td>
</tr>
</tbody>
</table>

CD, Cochrane Database; MA, meta-analysis.
There are some limitations that we should acknowledge in our study. First, in our analysis, we limited our search to topics previously identified as having comparative effectiveness results from both adults and children. It is possible that if we had screened the whole CDSR only for harms, we could have identified some additional pertinent meta-analyses. However, the scenario in which comparative safety data would be available without having any comparative efficacy data is likely to be uncommon. Second, by considering only meta-analyses that had included both pediatric and adult RCTs, it is possible that medical interventions for conditions that pertained exclusively to pediatric populations would not have been captured. Third, in our analyses we considered all pediatric RCTs together. Given the paucity of data, any age subgroup analyses (eg, infants, preschoolers) would be unable to detect any clinically significant differences. Fourth, for some subjective harms (eg, pain), it is possible that children might underreport them, and this may affect the frequency of estimated discrepancies between adults and children for such end points. Fifth, we also considered mortality among the eligible end points, although death is often considered an efficacy outcome. However, one cannot exclude that death could also be caused by treatment-related harms.

Acknowledging these limitations, we were able to document several cases in which significant discrepancies existed in harms between adults and children. However, in the majority of cases, our analysis suggests that evidence about the comparative harms of drugs in these 2 populations is inconclusive. Even large differences cannot be excluded. Pediatric drug therapy should certainly take into account the physiologic differences between children and adults, but making guesses about toxicity in the absence of evidence is not easy. In the absence of sufficient evidence, extrapolation to children of safety information for pharmacologic interventions from adults is likely to be tenuous.

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