National Institute for Health and Care Excellence

4-year surveillance (2017) – Fever in under 5s (2013) NICE guideline CG160

Appendix B: stakeholder consultation comments table

Consultation dates: 17 January to 30 January 2017

Do you agree with the proposal not to update the guideline?

Stakeholder	Overall response	Comments	NICE response
National Minor Illness Centre	No	You comment: "*We propose that a footnote should be added to recommendation 1.2.2.10 of the guideline, as well as the traffic light system for identifying risk of serious illness, to highlight that some vaccinations have been found to induce fever in children younger than 3 months.*" In our opinion this proposed change does not go far enough. The addition of Meningitis B to the first infant vaccination increases the percentage of babies with post-vaccination fever (of 38.5 degrees or above) to 77%. The use of paracetamol (as recommended) will reduce this figure to around 25%. But the NICE criterion for a "red traffic light" at this age is 38 degrees or above. Clearly it would not be logical to admit all of these babies to hospital, but any health professional who advises otherwise is currently working in contradiction to NICE guidance, and therefore highly susceptible to litigation. The less experienced and less highly	Thank you for your response. Vesikari et al. (2013) was highlighted by topic experts as evidence which shows that meningococcal B vaccines can induce fever in infants. The study is cited in the summary of new evidence document (Appendix A). The NICE surveillance team considered the comments from stakeholder consultation and evidence included in the surveillance review and guideline in detail. No evidence was identified including children post vaccine aiming to identify the likelihood of serious bacterial infection in the presence of a post vaccine fever. Therefore, adding a footnote to NICE guideline CG160 to notify clinicians that certain vaccinations can induce fever in children younger than 3 months was considered to be the most appropriate action. We will monitor this area at the next surveillance review.

		qualified the practitioner, the less likely they are to accept this risk. This is likely to lead to unnecessary hospital admissions. We would like to propose a clear exception to the guideline, stating that fever in the first 48 hours after the first infant vaccination is not an automatic “red light”. Ref: Vesikari T, et al. *Lancet*. 2013;381:825-835	
Meningitis Now	Yes	No comments	Thank you for your response.
The Royal College of Midwives (RCM)	Yes	We agree with the overall proposal not to update the guideline and to the following suggestions for amendment - *that a footnote should be added to recommendation 1.2.2.10 of the guideline, as well as the traffic light system for identifying risk of serious illness, to highlight that some vaccinations have been found to induce fever in children younger than 3 months.* - *that the guideline includes a recommendation that cross-refers to the NICE guideline on Sepsis (published in July 2016) so that clinicians can determine what considerations should be made, and what diagnostic tests should be performed if they suspect that a febrile child has sepsis.* - *that a recommendation is added to the non-paediatric section of the guideline highlighting that clinicians should not rely on a response to antipyretics to differentiate between serious and non-serious illness.*	Thank you for your response.
Royal College of Paediatrics and Child Health	No	Our commenters shared the following comments and observations: The use of the phrase “an ill looking child” makes the guidance less specific. The points already raised when assessing a seriously ill child are sufficient. The above phrase is ambiguous and should probably be taken out or be more specific.	Thank you for your response. The NICE surveillance team considered the comments from stakeholder consultation and evidence included in the surveillance review and guideline in detail. No evidence was identified including children post vaccine aiming to identify the likelihood of serious

		Our commenter agrees with the addition of a footnote to recommendation 1.2.2.10 and the traffic light system following the introduction of the Meningococcal B vaccine to highlight that some vaccinations have been found to induce fever in children younger than 3 months. It is vital that these guidelines cross refers to the new NICE guideline on Sepsis (published in July 2016). Post vaccination fever has resulted in several babies being over investigated and treated, therefor clearer guidance is welcomed. Our commenter stated that in their opinion, this guideline has limited value within paediatric services. It is very useful for the non-paediatric practitioner and for emergency department staff with minimal paediatric expertise. Once a child falls within paediatric care, this guideline is only useful if/when they have been assessed by a paediatrician, they still do not have a focus. At this point often further thought beyond what is mentioned in this guideline is needed. When audited this guideline locally 2 years ago, our commenter's team looked at 50 children with a fever but only 1 actually was a fever without focus and so only 1 really needed this guideline applied. From an audit point of view (audit done with compliance with NICE) it is very difficult and fairly pointless. The commenter thinks that paediatrics should be taken out of this guideline. Our commenter agrees that there is no new evidence which justifies updating the guideline at the present time. The need for clinical judgement is covered by the "looks ill" description combined with the clinical measurements and observations. The commenter points out that some children manage to smile even when they are very ill. The Coroner and GMC take a dim view if the observations are not recorded.	bacterial infection in the presence of a post vaccine fever. Therefore, adding a footnote to NICE guideline CG160 to notify clinicians that certain vaccinations can induce fever in children younger than 3 months was considered to be the most appropriate action. We will monitor this area at the next surveillance review. Regarding the cross-over between the fever (CG160) and sepsis (NG51) guidelines, we will proceed with adding a recommendation to NICE CG160 which cross-refers to NICE NG51. The comments about the phrase "ill looking child" will be logged for further consideration during subsequent surveillance reviews. The comments about the relevance of recommendations on paediatric care will also be logged for future consideration since no new evidence was identified through the surveillance review indicating that guideline recommendations for paediatric practitioners should be updated or removed.
RCGP	Yes	No comment	Thank you for your response.
Alder Hey Children's NHS Foundation Trust	No	Causes and incidence of serious bacterial infection 1.5.7.1 and 1.5.6.4 *For infants younger than 3 months, an antibiotic active against listeria (for example, ampicillin or amoxicillin) should be added.* [2007] New evidence suggests this is no longer correct. **Statement should be changed to;** **For infants younger than 1 month, an antibiotic active against listeria (for example, ampicillin or amoxicillin) should be added.**	Thank you for your response. In relation to your comment about empirical antibiotics: Okike et al. (2016) is a literature review which discusses the epidemiology of *Listeria monocytogenes* infections and suggests changes to how empirical antibiotics should be prescribed, citing some unpublished data. Literature reviews do not meet criteria for inclusion

		See; Empirical antibiotic cover for Listeria monocytogenes infection beyond the neonatal period: a time for change? Okike IO, Awofisayo A, Adak B, Heath PT. Arch Dis Child. 2015;100(5):423-5 Do we really need to worry about Listeria in newborn infants? Okike IO, Lamont RF, Heath PT. Pediatr Infect Dis J. 2013;32(4):405-6. .2.2.10 *Recognise that children younger than 3 months with a temperature of 38°C or higher are in a high-risk group for serious illness. [2013]* Introduction of the New MenB vaccine means that ~60% of infants aged 2-3 months will have a fever >38^{0}C after immunisation (A phase 2 randomized controlled trial of a multicomponent meningococcal serogroup B vaccine (I). Prymula R, Esposito S, Zuccotti GV, Xie F, Toneatto D, Kohl I, Dull PM. Hum Vaccin Immunother. 2014;10(7):1993-2004.) This means ~60% of infants have "red" features and if seen by a healthcare professional should be referred to hospital for assessment. Recent evidence supports an increased attendance at ED with post MenB fever in Scotland and N Ireland. Re-assessment of the risks of invasive bacterial infection at 0-1 months, 1-2 months and 2-3 months shows highest risk in 0-1 months, then 1-2 months, then lowest at 2-3 months (See Table 6 in Pantell et al. Management and outcomes of care of fever in early infancy. JAMA 2004;291(10):1203–12 And Variation in care of the febrile young infant <90 days in US pediatric emergency departments. Aronson et al. Pediatrics. 2014 Oct;134(4):667-77. To avoid this increasing number of unnecessary referrals to hospital for infants 2-3 months with post Men B fever statement could be changed to; **Recognise that children younger than 2 months with a temperature of 38°C or higher are in a high-risk group for serious illness.** Change the traffic light table accordingly 1.2.2.10 The footnote;	in NICE CG160 and would not be considered during the surveillance process. Okike et al. (2013) is a literature review which was published outside the search dates of the 4-year surveillance review (August 2014 – July 2016) and therefore cannot be considered during this surveillance process. No evidence was identified through the surveillance review to indicate a change to guidance on who should receive an antibiotic active against listeria. However, your comment relating to the causes of serious bacterial infection will be logged for further consideration during subsequent surveillance reviews. We considered your comment about induction of fever after vaccination, and the risk of serious illness in children less than 3 months. Thank you for highlighting the following studies: • Prymula et al. (2014) was highlighted by topic experts as evidence which shows that meningococcal B vaccines can induce fever in infants. The study is cited in the summary of new evidence document (Appendix A). • Pantell et al. (2004) was included in previous iterations of NICE guideline CG160 and therefore will not be considered in this surveillance review. • Aronson et al. (2014) was not identified in the 4-year surveillance literature searches. It has been added to the summary of new evidence document (Appendix A). The NICE surveillance team considered the comments from stakeholder consultation and evidence included in the surveillance review and guideline in detail. No evidence was identified including children post vaccine aiming to identify the likelihood of serious bacterial infection in the presence of a post vaccine fever. Therefore, adding a footnote to NICE guideline CG160 to notify clinicians that certain vaccinations can induce fever in children younger than 3 months was considered to be the most appropriate action.

		"*some vaccinations have been found to induce fever in children younger than 3 months*" is not sufficiently clear to help guideline users. Either specify Men B vaccine and the known risk or change the Traffic lights to make children younger than 2 months with a temperature of 38°C or higher a high-risk group for serious illness	
British Paediatric Allergy, Immunology and Infection Group	No	Causes and incidence of serious bacterial infection 1.5.7.1 and 1.5.6.4 *For infants younger than 3 months, an antibiotic active against listeria (for example, ampicillin or amoxicillin) should be added.* [2007] New evidence suggests this is no longer correct. **Statement should be changed to;** **For infants younger than 1 month, an antibiotic active against listeria (for example, ampicillin or amoxicillin) should be added.** See; Empirical antibiotic cover for Listeria monocytogenes infection beyond the neonatal period: a time for change? Okike IO, Awofisayo A, Adak B, Heath PT. Arch Dis Child. 2015;100(5):423-5 Do we really need to worry about Listeria in newborn infants? Okike IO, Lamont RF, Heath PT. Pediatr Infect Dis J. 2013;32(4):405-6. 1.2.2.10 *Recognise that children younger than 3 months with a temperature of 38°C or higher are in a high-risk group for serious illness. [2013]* Introduction of the New MenB vaccine means that ~60% of infants aged 2-3 months will have a fever >38^{0}C after immunisation (A phase 2 randomized controlled trial of a multicomponent meningococcal serogroup B vaccine (I). Prymula R, Esposito S, Zuccotti GV, Xie F, Toneatto D, Kohl I, Dull PM. Hum Vaccin Immunother. 2014;10(7):1993-2004.) This means ~60% of infants have "red" features and if seen by a healthcare professional should be referred to hospital for assessment. Recent evidence supports an increased attendance at ED with post MenB fever in Scotland and N Ireland. Re-assessment of the risks of invasive bacterial infection at 0-1 months, 1-2 months and 2-3 months shows highest risk in 0-1 months, then 1-2 months, then lowest at 2-3 months (See Table 6 in Pantell et al. Management and outcomes of care of fever in early infancy. JAMA 2004;291(10):1203–12	Thank you for your response. In relation to your comment about empirical antibiotics: Okike et al. (2016) is a literature review which discusses the epidemiology of *Listeria monocytogenes* infections and suggests changes to how empirical antibiotics should be prescribed, citing some unpublished data. Literature reviews do not meet criteria for inclusion in NICE CG160 and would not be considered during the surveillance process. Okike et al. (2013) is a literature review which was published outside the search dates of the 4-year surveillance review (August 2014 – July 2016) and therefore cannot be considered during this surveillance process. No evidence was identified through the surveillance review to indicate a change to guidance on who should receive an antibiotic active against listeria. However, your comment relating to the causes of serious bacterial infection will be logged for further consideration during subsequent surveillance reviews. We considered your comment about induction of fever after vaccination, and the risk of serious illness in children less than 3 months. Thank you for highlighting the following studies: • Prymula et al. (2014) was highlighted by topic experts as evidence which shows that meningococcal B vaccines can induce fever in infants. The study is cited in the summary of new evidence document (Appendix A). • Pantell et al. (2004) was included in previous iterations of NICE guideline CG160 and therefore will not be considered in this surveillance review.

		And Variation in care of the febrile young infant <90 days in US pediatric emergency departments. Aronson et al. Pediatrics. 2014 Oct;134(4):667-77. To avoid this increasing number of unnecessary referrals to hospital for infants 2-3 months with post Men B fever statement could be changed to; **Recognise that children younger than 2 months with a temperature of 38°C or higher are in a high-risk group for serious illness.** Change the traffic light table accordingly 1.2.2.10 The footnote; "*some vaccinations have been found to induce fever in children younger than 3 months*" is not sufficiently clear to help guideline users. Either specify Men B vaccine and the known risk or change the Traffic lights to make children younger than 2 months with a temperature of 38°C or higher a high-risk group for serious illness.	• Aronson et al. (2014) was not identified in the 4-year surveillance literature searches. It has been added to the summary of new evidence document (Appendix A). The NICE surveillance team considered the comments from stakeholder consultation and evidence included in the surveillance review and guideline in detail. No evidence was identified including children post vaccine aiming to identify the likelihood of serious bacterial infection in the presence of a post vaccine fever. Therefore, adding a footnote to NICE guideline CG160 to notify clinicians that certain vaccinations can induce fever in children younger than 3 months was considered to be the most appropriate action.
Johnson & Johnson Ltd	No	The current NICE guideline discusses the use of alternate dosing with paracetamol and ibuprofen in children with fever if their distress persists after initial dosing with paracetamol or ibuprofen, or recurs before the next dose is due[1]. Johnson & Johnson Ltd (J&J Ltd) commissioned a Market Research (MR) survey to explore and quantify the level of alternate dosing of paracetamol and ibuprofen for children aged 3 months to 12 years. A literature review was also conducted by J&J Ltd to identify the available literature on alternate dosing of paracetamol and ibuprofen in children. The MR survey, involving 1000 parents and 285 health care professionals (HCPs), highlighted that 100% of HCPs surveyed believe clear information/guidance is needed on alternate dosing. Therefore J&J Ltd requests that a review is undertaken of the current NICE guidelines to help HCPs recommend an alternate dosing regimen for children with fever. Further details are provided below. **Method** Market Research	Thank you for your response. Since the market research and literature review have not been published in a peer-reviewed journal, they do not meet the criteria for consideration in surveillance reviews. The NICE guideline CG160 review protocol (page 28) indicates that randomised controlled trials should be considered to answer the question on alternate dosing with paracetamol and ibuprofen. As a result, the market research (effectively a cross-sectional study) and the literature review do not meet the guideline inclusion criteria. In relation to the studies cited in the literature review: Sullivan et al. (2011) is a literature review which discusses the combination of acetaminophen and ibuprofen. Literature reviews do not meet the criteria for consideration in surveillance reviews and would not be included in a surveillance review. Nabulsi et al. (2006) is a randomised controlled trial which has already been identified and included in the clinical guideline.

		The MR activity took place in November 2016 and included 1,000 parents and 285 HCPs, who are all based in the United Kingdom. The parent sample included mothers (aged at least 18 years) who were either first time parents or those with multiple children aged between 3 months to 12 years. The HCP sample included GPs and paediatricians (N=91), pharmacists and pharmacy assistants (N=74), practice nurses / nurses who support NHS 111 (N=40), health visitors and midwives (N=40) and A&E / triage nurses and A&E doctors (N=40). The HCPs had been practicing for 3-35 years and provided advice to parents on alternate dosing of paracetamol and ibuprofen. Significance testing was also conducted on a number of sub-sets of the parent and HCP samples in order to explore attitudes and behaviours around alternate dosing in more detail. Literature The literature searches were performed using Ovid and PubMed databases. **Results** Market Research The MR survey showed: • Parents use alternate dosing with or without being advised by a HCP o 74% parents use alternate dosing for children aged 3 months to 12 years. Of these parents, 68% have been advised to do so by HCPs. o Parents also felt significantly more confident about alternate dosing following advice from a HCP. • Many HCPs recommend alternate dosing o 82% of HCPs actively recommend alternate dosing for children aged 3 months to 12 years o 18% of HCPs do not proactively recommend alternate dosing for children aged 3 months to 12 years. The primary reason for not proactively recommending alternate dosing was that there is no clear guidance on how to use alternate dosing effectively.	Paul et al. (2010) is a randomised controlled trial which has already been identified and included in the clinical guideline. Pashapour et al. (2009) is a randomised controlled trial which has already been identified and included in the clinical guideline. Colds in children. (2005) is an article which provides advice to parents about the epidemiology, diagnosis, treatment, and prevention of colds. The article would not meet criteria for consideration in the surveillance review.

		• There was a higher rate of recommendation of alternative dosing by HCPs for children aged above 1 year. A higher proportion of mothers used alternate dosing in children aged 3 – 11 months versus the proportion of HCPs who would recommend doing so. • There was inconsistency in the recommendations HCPs give to parents about time between alternate doses o A high proportion of HCPs would recommend between 2-4 hours whereas some HCPs recommend waiting 1 hour and some HCPs recommend waiting 7 hours or more. • HCPs typically recommend that mothers decide for themselves when to stop using alternate dosing, although they are more likely to be prescriptive for younger children. • HCPs, GPs, paediatricians, practice nurses and health visitors wanted clear guidance from NICE regarding alternate dosing Overall the MR survey revealed that although many parents and HCPs feel confident about alternate dosing, this is not universal; and both groups would like to see clearer guidance on the topic. 80% of mothers stated that they would like additional support around alternate dosing and 100% of HCPs surveyed believe additional information/guidance is needed. <u>Literature search</u> Few studies have investigated the efficacy of alternating paracetamol and ibuprofen in alleviating fever in children compared to either drug given alone. In studies comparing alternate therapy with paracetamol and ibuprofen versus either acetaminophen (paracetamol) or ibuprofen as single agents, differences in temperature reduction were only seen 4 or more hours after initiation of treatment.[2] In a randomized, double-blind and placebo-controlled clinical trial, Nabulsi et al showed that 6 to 8 hours after the initiation of the study, a greater percentage of children aged 6 months to 14 years was noted to be afebrile after receiving alternating treatment compared with those in the group that received ibuprofen alone. Seventy febrile children were randomly allocated to receive either a single oral dose of 10 mg/kg ibuprofen and 15 mg/kg oral acetaminophen after 4	

		hours, or a similar dose of ibuprofen and placebo at 4 hours. Rectal temperature was measured at baseline, 4, 5, 6, 7 and 8 hours later. A higher proportion of subjects in the intervention group (83.3%) became afebrile at 6 hours than in the control group (57.6%); P = 0.018. There were no significant differences between the two treatment groups for mean temperature taken at 4 hours.[3] No serious adverse reactions were observed in the subjects, and none of the subjects developed any symptom or sign suggestive of gastrointestinal, hepatic or renal toxicity. Paul et al studied febrile episodes from 46 children aged 6 to 84 months who were randomized into 3 treatment groups: a single dose of ibuprofen at the beginning of the observation period; a single dose of ibuprofen plus a single dose of acetaminophen at the beginning of the observation period; or ibuprofen followed by acetaminophen 3 hours later. Temperatures were measured hourly for 6 hours. Both combined and alternating regimens had statistically significantly greater antipyresis compared to ibuprofen alone at hours 4 to 6 (hour 4, P<0.005; hours 5 and 6, P<0.001) over a single 6-hour observation period.[4] Pashapour et al studied 70 hospitalised infants aged 9 to 24 months with fever of non-bacterial origin, where one randomized group received 10 mg/kg ibuprofen alternating with 15 mg/kg acetaminophen every 4 hours versus acetaminophen given alone. Results revealed a significant difference between the two groups in lowering fever at 4 (P=0.048), 5 (P=0.04), 7 (P=0.04), and 8 hours (P=0.02) after treatment was initiated; there was no significant difference at 2 hours after drug administration.[5] No studies in patients younger than 6 months of age have been found. **Conclusion** Given that there is no clear guidance available on how to dose paracetamol and ibuprofen alternately safely for fever in children, this could ultimately lead to a large amount of confusion and uncertainty with HCPs and parents. There is a degree of variability amongst HCPs as to whether or not they recommend alternate dosing for different age groups as well as a very high degree of variability in the time HCPs recommend to wait between alternate doses. Literature supports alternate dosing every 3-4 hours and some HCPs currently recommending alternate dosing	

		after 1-2 hours; this highlights the need for clearer guidance for HCPs on alternate dosing. Parents frequently use an alternate dosage regimen for fever in their children upon the advice of a HCP; however it has been highlighted that there are parents who do use an alternate dosage regimen without being advised to do so by a HCP. This appears to be more apparent for parents with children aged 3-11 months, which is the age range when children are most likely to develop a cold[6] which can result in a fever. The potential for overdosing in the paediatric population therefore exists especially if the parents or caregivers are not educated properly on a recommended dosing regimen. Based on these findings, J&J Ltd requests a review of the current guidelines on alternate dosing for fever in children under 5 years including consideration on information available for parents/caregivers (e.g. on NHS Choices website). **References** 1. Fever in under 5s: assessment and initial management (CG160). National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg160/chapter/1-Recommendations#antipyretic-interventions-2 (Accessed January 2017) 2. Sullivan JE, Farrar HC. Fever and antipyretic use in children. Pediatrics. 2011 Mar;127(3):580-587. 3. Nabulsi MM et al. Alternating ibuprofen and acetaminophen in the treatment of febrile children: a pilot study [ISRCTN30487061]. BMC Med. 2006;4:4. 4. Paul IM et al. Efficacy of standard doses of Ibuprofen alone, alternating, and combined with acetaminophen for the treatment of febrile children. Clin Ther. 2010;32(14):2433-40. 5. Pashapour N, Macooei A, Golmohammadlou S. Alternating ibuprofen and acetaminophen in the treatment of febrile hospitalized children aged 9-24 months. 2009;19(2):164-168. 6. Colds in children. Paediatr Child Health. 2005; 10(8): 493–495.	

Do you have any comments on areas excluded from the scope of the guideline?

Stakeholder	Overall response	Comments	NICE response
National Minor Illness Centre	No	No comment	Thank you for your response.
Meningitis Now	No	No comment	Thank you for your response.
The Royal College of Midwives (RCM)	No	No comment	Thank you for your response.
Royal College of Paediatrics and Child Health	Yes	Point 1.2.2.6 - this should be highlighted as good practice at every level of care; but beware of fever itself causing increase in heart rate. Point 1.6.3.3 - as there is little evidence about simultaneous admin of paracetamol and ibuprofen being a problem, should the statement do not give them simultaneously be amended? If the guideline has to remain then it should be made more clear that if a focus is found then management should be tailored appropriately (i.e. a child under 3 months with a fever and red flags may well have bronchiolitis and therefore may not need FBC, CRP, b/c if reviewed by a senior paediatrician.)	Thank you for your comments on recommendations 1.2.6 and 1.6.3.3 and tailoring treatment approaches, as appropriate. Although healthcare professionals are expected to take the guideline fully into account when exercising their clinical judgement, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient. In relation to medications, guideline users must check current indications and accuracy by consulting other pharmaceutical literature and following the guidelines laid down by the manufacturers of specific products and the relevant authorities in the country in which they are practising. Recommendation 1.6.3.3 states that paracetamol and ibuprofen should not be given simultaneously in children with fever. Through the surveillance process, one systematic review was identified which provided some evidence that both dual and alternating antipyretic therapy may be more effective than monotherapy for treating children with fever. However, few studies were included in the meta-analyses and the age range of children participating in these studies was not specified in the abstract. As a result, the surveillance concluded that there was insufficient evidence to deduce whether combined or alternating antipyretic therapy is more beneficial than monotherapy.

			This area will be monitored again at the next surveillance review of the guideline.
RCGP	No	No comment	Thank you for your response.
Alder Hey Children's NHS Foundation Trust	Not answered	No comment	Thank you for your response.
British Paediatric Allergy, Immunology and Infection Group	Not answered	No comment	Thank you for your response.
Johnson & Johnson Ltd	No	No comment	Thank you for your response.

Do you have any comments on equalities issues?

Stakeholder	Overall response	Comments	NICE response
National Minor Illness Centre	No	No comment	Thank you for your response.
Meningitis Now	No	No comment	Thank you for your response.
The Royal College of Midwives (RCM)	No	No comment	Thank you for your response.
Royal College of Paediatrics and Child Health	No	N/A	Thank you for your response.
RCGP	No	No comment	Thank you for your response.
Alder Hey Children's NHS Foundation Trust	No	No comment	Thank you for your response.

British Paediatric Allergy, Immunology and Infection Group	No	No comment	Thank you for your response.
Johnson & Johnson Ltd	No	No comment	Thank you for your response.