Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05156

Product Code: 1555.R3 16E1.20 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Recombinant Leukemia	298	25005	☒ Recombinant
2 FVRCP	298	04244005	☒ Viral
3 Rabdomun	189	A475509A	☒ Viral
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind leg		04/07/2005
2 1 ml	SQ	R hind leg		04/07/2005
3 1 ml	SQ	R hind leg		04/07/2005
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/07/2005
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Was given FELV, FVRCP and Rabies on 04/07/2005. The owner came in to clinic the cat had 104.3 and no appetite. The cat was given SQ fluids, DexSP 4 mg IM and Benedryl 15 mg IM and was monitored for the day until tem came down.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	12 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
We haven't seen this pet before the 8th of April. He had been vaccinated elsewhere.

Personal Information

Veterinarian		Owner	
*Name:	Christina Hutson	Name:	(b)(6)
Address:	820 Torrance Blvd.	Address:	
City:	Redondo Beach	City:	
State:	CA	State:	CA
Zip:	090277	Zip:	(b)(6)

*Phone:	310-540-9044(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	310-540-1667		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Christina
*Submitter's Last Name:	Hutson
*Submitter's Phone Number:	310-540-9044(XXX-XXX-XXXX)
*Today's Date:	04/26/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/08/2005
Verified:
Reviewed:
Date Entered:
CVB Reporter:
Acknowledgement:

Thank you for submitting the information in your Adverse Event Report. It is information such as this that enables the Center for Veterinary Biologics to monitor the performance of veterinary biologics used in field conditions.<p>CVB Home Page

Adverse Event Report

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United States Department of Agriculture
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510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05179

Product Code: 1555.R3 16E1.20 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Recombinant Leukemia	298	25005	☒ Recombinant
2 FVRCPC; Modified Live Virus & Chlamydia	286	04244005	☒ Combination
3 Defensor	189	A475509A	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2 1 ml	SQ			
3 1 ml	SQ			
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/07/05
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Cat was vaccinated at another clinic on 04/07/2005. The owner came to our clinic the next day, 04/08/2005. Cat had 104.3 temp, no appetite. Cat received the above vaccines the day before.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	6075	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:		Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yr		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Good health

Personal Information

Veterinarian		Owner	
*Name:	Christina Hutson	Name:	(b)(6)
Address:	Animal Hospital of Redondo Beach 820 Torrance Blvd	Address:	
City:	Redondo Beach	City:	(b)(6)
State:	CA	State:	

Zip:	90280	Zip:	(b)(6)
*Phone:	310-540-9044(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Christina
*Submitter's Last Name:	Hutson
*Submitter's Phone Number:	310-540-9044(XXX-XXX-XXXX)
*Today's Date:	04/08/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/09/2005
Verified:Yes
Reviewed:Yes
Date Entered: 05/13/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05197
Product Code: 1559.20 15A1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Vax Lv-K	112	223225A	☒ Combination
2 Primucell FIP	189	A365460C	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind leg	24	05/18/2005
2 1 ml	IN	nares	N/A	05/18/2005
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/18/05
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
4hrs post-vx kitten was lethargic, anorectic. Presented 5/19, 8am febrile (104.1), lethargic, crying. Tx with dexamethasone 0.36mg SQ, 70ml SQ NaCl, ICU observation. 2hrs post-tx febrile (105.5) and further tx with 35ml SQ NaCl, 0.36mg dexamethasone IM. 8hrs post presentation fever resolved to 102.2. Kitten doing well 5/20/05.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hours
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	2493	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Bengal	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	11 weeks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
acquired 1 wk prior from breeder in Denham Springs, LA. o reports previous vx by breeder, he will find brand-no hx of reaction at that time

Personal Information

Veterinarian		Owner	
*Name:	Jena Troxler, DVM	Name:	(b)(6)
Address:	1112 W. Airline Hwy	Address:	
City:	LaPlace	City:	
State:	LA	State:	LA

Zip:	70068	Zip	(b)(6)
*Phone:	985-652-6369(XXX-XXX-XXXX)	Phone	(XXX-XXX-XXXX)
FAX:	985-653-7522		
E-mail:	jenanow@excite.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Jena
*Submitter's Last Name:	Troxler
*Submitter's Phone Number:	985-652-6369(XXX-XXX-XXXX)
*Today's Date:	05/21/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/21/2005
Verified:Yes
Reviewed:Yes
Date Entered: 06/06/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

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United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05219

Product Code: 1901.R1 1555.21 16D1.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17079	☒ Recombinant
2 Leukocell 2	189	A474305	☒ Viral
3 Felocell 3	189	A476730A	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RRleg	25	06/14/2005
2 1 ml	SQ	LRleg	25	06/14/2005
3 1 ml	SQ	RFleg	25	06/14/2005
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/14/2005
Concurrent Drugs or Procedures:	annual exam

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Pet vomited shortly after vaccine & continued to vomit for several hours.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Owner has had since kitten, was vaccinated for all 3 previously but vaccine brand & type unknown (different clinic). Primarily indoor only but does go outside sometimes.

Personal Information

Veterinarian		Owner	
*Name:	Tonia Stephani	Name:	(b)(6)
Address:	4809 Chicago Ave. S.	Address:	
City:	Minneapolis	City:	
State:	MN	State:	
Zip:	55417	Zip:	
*Phone:	612-825-4427(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)

FAX:	612-825-9082		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Tonia
*Submitter's Last Name:	Stephani
*Submitter's Phone Number:	612-825-4427(XXX-XXX-XXXX)
*Today's Date:	06/16/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/17/2005
Verified:yes
Reviewed:yes
Date Entered: 07/07/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

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United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05224
Product Code: 1905.23 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Imrab 3 TF	298	18029B	☒ Viral
2 Felocell CVR-C	189	A471399C	☒ Combination
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/07/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
2 events two differnet cats. Seizure and Death. Severe Constipation in other cat. On 6-16-05 noticed butt was swollen on 6-17-05 rushed to emergency visit. Had colon cleaned out. On 6-24-05 other cat had a seizure and died. I listed other on the medication product because I'm not sure what to put.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10-17 days
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	1 died and 1 still recovering.

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	4
(Other Species):	1 male and 1 female	Number affected:	2
Breed :	DSH	Number vaccinated:	4
Sex:	☒ [Click arrow for selections]	Number dead:	1
Neutered:	☒ [Click arrow for selections]		
Age (i.e., 2 yrs or 2 mos):	15 yrs, 5 mos & 15 yrs, 4 mos.		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Bricktown Veterinary Hospital, P.A.	Name	(b)(6)
Address:	251 Chambers Bridge Road	Address	
City:	Brick	City	
State:	NJ	State:	NJ
Zip:	08723-2801	Zip:	(b)(6)

*Phone:	732-477-9440(XXX-XXX-XXXX)	Phone:	(b)(6) (XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	(XXX-XXX-XXXX)
*Today's Date:	06/28/2005(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/28/2005
Verified:yes
Reviewed:yes
Date Entered: 07/07/2005
CVB Reporter:
Acknowledgement:

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Adverse Event Report

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United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05240
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell CVR	189		☒ Viral
2 Felocell CVR	189		☒ Viral
3 Felocell CVR	189		☒ Viral
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Between Shoulders	22	01/03/2000
2 1 ml	SQ	Between Shoulders	22	11/14/2000
3 1 ml	SQ	Between Shoulders	22	05/22/2004
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/03/2000
Concurrent Drugs or Procedures:	N/A

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
When consulting with Dr. Davis, he explained to me that in most cases, the complere removal of the tumor is not very successful, as it is difficult to get all of the tumor. The only thing I did for Ben was to make his life a little more comfortable until he could not bare anymore of the pain. I refused to have any of my animals suffer.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	☒ Low
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:	Ben	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic Short Hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Ben was an inside cat that was well taken care of. When it was time for his vaccinations, I would contact Dr. Davis' office and scheldule a time to have Ben in and I took good care of him. Ben ate dry cat food, Purina most of the time; as he did not like canned food. I got Ben in early 2000, because I had just moved into a new home. Ben was given his FVRCP vaccine when it was due, and in the first section, there was not a listing for the FVRCP vaccine.

Personal Information

Veterinarian		Owner	
*Name:	Leonard A. Davis	Name:	(b)(6)
Address:	8526 Preston Highway	Address:	

City:	Louisville	City	(b)(6)
State:	KY	State:	KY
Zip:	40219	Zip	(b)(6)
*Phone:	502-968-9346(XXX-XXX-XXXX)	Phone	(b)(6) (XXX-XXX-XXXX)
FAX:	502-968-9666		
E-mail:	davisclinic@bellsouth.net	E-mail:	(b)(6)

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	(XXX-XXX-XXXX)
*Today's Date:	07/13/2005(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/13/2005
Verified:yes
Reviewed:yes
Date Entered: 07/19/2005
CVB Reporter:
Acknowledgement:

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United States Department of Agriculture
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510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05250
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A473310A	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/25/2005
Concurrent Drugs or Procedures:	Imrab 3 TF - different location

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
Cat developed large -3.5 cm x 4.0 cm- fluctuant, painful swelling at vaccine site. Developed fever 103.5. Cytology from fine needle aspirate showed epithelial cells and RBCs. Treated with Clavamox. Cat now has firm nodule, is not painful or febrile.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 wk
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Good health

Personal Information

Veterinarian		Owner	
*Name:	Christine A. Newman	Name:	(b)(6)
Address:	10 Sunset Road	Address:	
City:	Belle Mead	City:	
State:	NJ	State:	
Zip:	08502	Zip:	

*Phone:	908-359-2000(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name	
*Submitter's Last Name	
*Submitter's Phone Number:	908-359-2000(XXX-XXX-XXXX)
*Today's Date:	05/19/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/17/2005
Verified:yes
Reviewed:yes
Date Entered: 07/21/2005
CVB Reporter:
Acknowledgement:

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United States Department of Agriculture
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Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05272
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	A360999	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip/flank	22	11/01/2005
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/03/2004
Concurrent Drugs or Procedures:	FVRCP (scap.) FeLV (L flank) Depo-medrol IM gluteal

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
mass noted at presentation for annual physical, excisional biopsy performed 8/3/05, UGA histopath=fibrosarcoma in right flank

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 yr, poss. more
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	monitor for post-op recurrence, discussed oncology referral

Animal Information

Case Identification:	Felina Duncan	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
FVRCP, Rabies performed approx. every 1-2 yrs., no other health problems

Personal Information

Veterinarian		Owner	
*Name:	Anne MacFarlane	Name	(b)(6)
Address:	1441 Glenwood Avenue	Address	
City:	Atlanta	City	
State:	GA	State:	GA

Zip:	30316	Zip:	(b)(6)
*Phone:	404-873-1786(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:	404-873-1055		
E-mail:	annemacfarlane@comcast.net	E-mail:	N/A

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Anne
*Submitter's Last Name:	MacFarlane
*Submitter's Phone Number:	404-873-1786(XXX-XXX-XXXX)
*Today's Date:	08/17/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/17/2005
Verified:yes
Reviewed:yes
Date Entered: 08/23/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05277
Product Code: 1555.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189		☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/22/2003
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Lump development in mid R lumbar area. Diagnosed in January 2005 with sarcoma. Surgery July 9th has had 2 surgeries. Last vaccination in that area was 5/22/03 with Pfizer Leukocell 2.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx est 1 1-12 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Did not recover
Other:	on going w/surgery

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	10 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Bruce Bierhaum	Name	(b)(6)
Address:	1475 NE Jensen Beach Blvd.	Address	
City:	Jensen Beach	City	
State:	FL	State:	FL
Zip:	34957	Zip	(b)(6)
*Phone:	772-334-5901(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	08/15/2005(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/15/2005
Verified:yes
Reviewed:yes
Date Entered: 08/25/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06001
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189		☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear leg	22	
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/24/2001
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer
Explain the event and any treatment in a concise paragraph: haven't initiated treatment, wedge biopsy with part "for dog huge"??	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	observe in the past few days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	see oncologist next week

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	Erin Kilpatrick	Name	(b)(6)
Address:	4053 Commercial St. SE	Address:	
City:	Salem	City:	
State:	OR	State:	
Zip:	97302	Zip:	
*Phone:	503-581-1438(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Erin
*Submitter's Last Name:	Kilpatrick
*Submitter's Phone Number:	503-581-1438(XXX-XXX-XXXX)
*Today's Date:	09/30/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/30/2005
Verified:yes
Reviewed:yes
Date Entered: 10/25/2005
CVB Reporter: Murtle
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06029
Product Code: 16D1.20 1901.R1
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A477219B	☒ Viral
2 Purevax Feline Rabies	298	17094	☒ Recombinant
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	RShoulder	22	11/11/2005
2	SQ	RRear leg	22	11/11/2005
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/11/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Grand mal seizure 11/13/2005

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx 60 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:	Micha Rimer	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic Short Hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Had same vaccines administered in same manner 11/5/2004 without any known adverse events.

Personal Information

Veterinarian		Owner	
*Name:	Lynne Ricketts	Name	(b)(6)
Address:	409 Cabob Street	Address	
City:	Beverly	City	
State:	MA	State:	MA
Zip:	01915	Zip	(b)(6)
*Phone:	978-927-3622(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Lynne
*Submitter's Last Name:	Ricketts
*Submitter's Phone Number:	978-927-3622(XXX-XXX-XXXX)
*Today's Date:	11/21/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/21/2005
Verified:yes
Reviewed:yes
Date Entered: 12/08/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06039

Product Code: 1555.21 16E8.20 1901.R1

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A474305	☒ Viral
2 PureVax Feline 4	298	64148	☒ Combination
3 Purvax Feline Rabies	298	17093	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind		11/03/2005
2 1 ml	SQ	R front		11/03/2005
3 1 ml	SQ	R hind		
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/03/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Owner stated cat reclusive, anorexic, and painful since 3 hrs post-vaccination. Cat presented following morning w/rectal temp of 103.8 F, reclusive and painful to touch - vocalizes with any touch by human. Rest of phys WNL. Cat admitted to hosp. Admin 9 mg Diphenhydramine (50 mg/ml) IM, admin 0.45 mg Buprenex (0.3 mg/ml) sublingual. Rx for Metacam 1.5 mg/ml #0.88 ml sig 1.22 ml PO SID starting 6 pm 11/4/05. Cat was kept for observation and improved thru day. Released to owner at evening. Owner instructed to watch for and call if notice any abnormal behavior or if anorexia continues.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
acquired 8/18/05 found as stray. 8/20/05 FELV neg, FIV neg, dewormed, Vxn w/leukocall 2 & merials FRCPC. 11/3/05 Vxu w/leukocell 2, purevax & merials FRCPC.

Personal Information

Veterinarian		Owner	
*Name:	Niki Eld	Name	(b)(6)

Address:	3435 N. Cole Road	Address:	
City:	Boise	City	(b)(6)
State:	ID	State:	ID
Zip:	83704	Zip:	(b)(6)
*Phone:	208-375-0251(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	11/05/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/05/2005
Verified:yes
Reviewed:yes
Date Entered: 12/16/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06042
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A583521	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear leg	21	11/14/2005
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/14/2005
Concurrent Drugs or Procedures:	spayed/telozol

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
vestibular syndrome; has lateral nystagnus, trembling, wobbly, naeusues (?). treat SQ fluids, clavomox.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	not listed
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	still recovering

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	2
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
none

Personal Information

Veterinarian		Owner	
*Name:	Cynthia Nonovon	Name	(b)(6)
Address:	125 Mulberry Street	Address	
City:	Ellijay	City	
State:	GA	State:	GA
Zip:	30540	Zip	(b)(6)
*Phone:	706-635-7357(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Cynthia
*Submitter's Last Name:	Nonovon
*Submitter's Phone Number:	706-635-7357(XXX-XXX-XXXX)
*Today's Date:	11/15/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/15/2005
Verified:yes
Reviewed:yes
Date Entered: 12/16/2005
CVB Reporter: Doug Murtle
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06080
Product Code: 1901.R1 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 PureVax	298	17099	☒ Viral
2 Leukocell 2	189	A474305	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/27/2006
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
vomiting, defecation, and labored breathing shortly after vaccine was administered (on the way home); Oxygen, IV fluids, and Dexamethisone

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	20 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic, short-hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12.5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
asthmatic

Personal Information

Veterinarian		Owner	
*Name:	Laura Ryle	Name	(b)(6)
Address:	VCA Animal Hospital 815 Mission Street	Address	
City:	Santa Cruz	City	
State:	CA	State:	CA
Zip:	95060-3616	Zip	(b)(6)

*Phone:	831-427-3345(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Laura
*Submitter's Last Name:	Ryle
*Submitter's Phone Number:	831-427-3345(XXX-XXX-XXXX)
*Today's Date:	02/01/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	will report to manufacturer

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/01/2006
Verified:yes
Reviewed:yes
Date Entered: 02/13/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06109
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	A579781	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1		back of neck		02/25/2006
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/25/2006
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Severe Seizure

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Did not recover
Other:	Cat may still die

Animal Information

Case Identification:	Rabies Tag 061241	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Balinese	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Sasha is strictly indoor only and was in perfect health until 02/25/2006, I took her to ROCKWELL PET CLINIC and 10 hrs later she collapsed with a severe seizure and almost died! Since she has had a high fever and is not eating! I had to hospitalize her and she's still not better and may die! I have spent over $600.00 now trying to save her! I took her to my trusted vet whom I should of used instead but since we moved I didn't know who to go to and just picked a close vet... anyway... my vet ran extensive test including bloodwork,urinalysis. fel leuk and x-rays and all was normal! So it may be malpractice of the vet Leslie Wiewel giving the wrong shots or my cat had a severe reaction to vaccines!

Personal Information

Veterinarian		Owner	
*Name:	Leslie Wiewel	Name:	(b)(6)
Address:	9308 N. Rockwell	Address:	

City:	Oklahoma City	City	(b)(6)
State:	OK	State:	OK
Zip:	73132	Zip	(b)(6)
*Phone:	405-728-7387(XXX-XXX-XXXX)	Phone	(b)(6) (XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail	(b)(6)

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	
*Submitter's Last Name	
*Submitter's Phone Number	(XXX-XXX-XXXX)
*Today's Date:	03/20/2006(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/20/2006
Verified:yes
Reviewed:yes
Date Entered: 04/11/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06151
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A243624C	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind leg	25	07/28/2003
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/28/2006
Concurrent Drugs or Procedures:	Feline rhino-calici-panleuk in R front

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Saw cat again March 30, 2006 for small 5mm x 5mm in diam-firm nodule mass on R lateral mid thigh. Biopsied April 4 - giant cell sarcoma assoc. with vaccine. Diagnosed by a boarded pathologist. Owner thought mid march 2006 when first noticed nodule.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx. 3 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	cat asymtomatic will take cat to oncology dept at Cornell

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	7
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	7
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
cat vaccinated 4/21/00 also in approx. the same site. no other vaccinations in the affected leg.

Personal Information

Veterinarian		Owner	
*Name:	Cathy Wakefield	Name	(b)(6)
Address:	1672 Fairport 9 Mile Point Road	Address	
City:	Penfield	City	
State:	NY	State:	NY

Zip:	14526	Zip	(b)(6)
*Phone:	585-377-1160(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	385-377-0189		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Cathy
*Submitter's Last Name:	Wakefield
*Submitter's Phone Number:	585-377-1160(XXX-XXX-XXXX)
*Today's Date:	04/12/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/12/2006
Verified:yes
Reviewed:yes
Date Entered: 04/18/2006
CVB Reporter: Huls
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06153

Product Code: 16D1.20 16E8.20 16E8.20 16E8.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A475505A	☒ Viral
2 Purevax Feline 4	298	64123	☒ Viral
3 Purevax Feline 4	298	64088	☒ Viral
4 Purevax Feline 4	298	64075B	☒ Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	20	11/22/2005
2 1 ml	SQ	R shoulder	20	11/07/2002
3 1 ml	SQ	R shoulder	20	03/02/2000
4 1 ml	SQ	R shoulder	20	03/27/1999

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/07/2002
Concurrent Drugs or Procedures:	feline leukemia, rabies and/or FIP vaccines also given but at different sites

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
cat was consistently vaccinated for FVR-C-CP @right shoulder. a small cyst was noted 7/25/05 which later grew and developed a firm irregular mass @ anterior major mass was biopsied and confirmed as a fibrosarcoma.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 yrs & 8 mos to 4 yrs 1 mos.
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
uncertain medical history before 1999. single cat household; indoor only cat; commercial cat food diet; see records of other vaccines.

Personal Information

Veterinarian		Owner	
*Name:	Mary Sebzda	Name	(b)(6)
Address:	125 Mesa Drive	Address	
City:	Costa Mesa	City	
State:	CA	State:	CA

*Phone:	908-359-2000(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	908-359-2000(XXX-XXX-XXXX)
*Today's Date:	05/19/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/17/2005
Verified:yes
Reviewed:yes
Date Entered: 07/21/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05272
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	A360999	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip/flank	22	11/01/2005
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/03/2004
Concurrent Drugs or Procedures:	FVRCP (scap.) FeLV (L flank) Depo-medrol IM gluteal

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
mass noted at presentation for annual physical, excisional biopsy performed 8/3/05, UGA histopath=fibrosarcoma in right flank

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 yr, poss. more
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	monitor for post-op recurrence, discussed oncology referral

Animal Information

Case Identification:	Felina Duncan	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
FVRCP, Rabies performed approx. every 1-2 yrs., no other health problems

Personal Information

Veterinarian		Owner	
*Name:	Anne MacFarlane	Name:	(b)(6)
Address:	1441 Glenwood Avenue	Address:	
City:	Atlanta	City:	
State:	GA	State:	GA

Zip:	30316	Zip:	(b)(6)
*Phone:	404-873-1786(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:	404-873-1055		
E-mail:	annemacfarlane@comcast.net	E-mail:	N/A

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Anne
*Submitter's Last Name:	MacFarlane
*Submitter's Phone Number:	404-873-1786(XXX-XXX-XXXX)
*Today's Date:	08/17/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/17/2005
Verified:yes
Reviewed:yes
Date Entered: 08/23/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV05277
Product Code: 1555.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189		☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/22/2003
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Lump development in mid R lumbar area. Diagnosed in January 2005 with sarcoma. Surgery July 9th has had 2 surgeries. Last vaccination in that area was 5/22/03 with Pfizer Leukocell 2.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx est 1 1-12 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Did not recover
Other:	on going w/surgery

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	10 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Bruce Bierhaum	Name	(b)(6)
Address:	1475 NE Jensen Beach Blvd.	Address	
City:	Jensen Beach	City	
State:	FL	State:	FL
Zip:	34957	Zip	(b)(6)
*Phone:	772-334-5901(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	(XX-XXX-XXXX)
*Today's Date:	08/15/2005(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/15/2005
Verified:yes
Reviewed:yes
Date Entered: 08/25/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06001
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189		☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear leg	22	
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/24/2001
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer
Explain the event and any treatment in a concise paragraph: haven't initiated treatment, wedge biopsy with part "for dog huge"??	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	observe in the past few days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	see oncologist next week

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	7 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	Erin Kilpatrick	Name	(b)(6)
Address:	4053 Commercial St. SE	Address:	
City:	Salem	City:	
State:	OR	State:	
Zip:	97302	Zip:	
*Phone:	503-581-1438(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Erin
*Submitter's Last Name:	Kilpatrick
*Submitter's Phone Number:	503-581-1438(XXX-XXX-XXXX)
*Today's Date:	09/30/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/30/2005
Verified:yes
Reviewed:yes
Date Entered: 10/25/2005
CVB Reporter: Murtle
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06029
Product Code: 16D1.20 1901.R1
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A477219B	☒ Viral
2 Purevax Feline Rabies	298	17094	☒ Recombinant
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	RShoulder	22	11/11/2005
2	SQ	RRear leg	22	11/11/2005
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/11/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Grand mal seizure 11/13/2005

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx 60 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:	Micha Rimer	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic Short Hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Had same vaccines administered in same manner 11/5/2004 without any known adverse events.

Personal Information

Veterinarian		Owner	
*Name:	Lynne Ricketts	Name	(b)(6)
Address:	409 Cabob Street	Address	
City:	Beverly	City	
State:	MA	State:	MA
Zip:	01915	Zip	(b)(6)
*Phone:	978-927-3622(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Lynne
*Submitter's Last Name:	Ricketts
*Submitter's Phone Number:	978-927-3622(XXX-XXX-XXXX)
*Today's Date:	11/21/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/21/2005
Verified:yes
Reviewed:yes
Date Entered: 12/08/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06039

Product Code: 1555.21 16E8.20 1901.R1

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A474305	☒ Viral
2 PureVax Feline 4	298	64148	☒ Combination
3 Purvax Feline Rabies	298	17093	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind		11/03/2005
2 1 ml	SQ	R front		11/03/2005
3 1 ml	SQ	R hind		
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/03/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Owner stated cat reclusive, anorexic, and painful since 3 hrs post-vaccination. Cat presented following morning w/rectal temp of 103.8 F, reclusive and painful to touch - vocalizes with any touch by human. Rest of phys WNL. Cat admitted to hosp. Admin 9 mg Diphenhydramine (50 mg/ml) IM, admin 0.45 mg Buprenex (0.3 mg/ml) sublingual. Rx for Metacam 1.5 mg/ml #0.88 ml sig 1.22 ml PO SID starting 6 pm 11/4/05. Cat was kept for observation and improved thru day. Released to owner at evening. Owner instructed to watch for and call if notice any abnormal behavior or if anorexia continues.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
acquired 8/18/05 found as stray. 8/20/05 FELV neg, FIV neg, dewormed, Vxn w/leukocall 2 & merials FRCPC. 11/3/05 Vxu w/leukocell 2, purevax & merials FRCPC.

Personal Information

Veterinarian		Owner	
*Name:	Niki Eld	Name	(b)(6)

Address:	3435 N. Cole Road	Address:	
City:	Boise	City	(b)(6)
State:	ID	State:	ID
Zip:	83704	Zip:	(b)(6)
*Phone:	208-375-0251(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	11/05/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/05/2005
Verified:yes
Reviewed:yes
Date Entered: 12/16/2005
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06042
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A583521	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear leg	21	11/14/2005
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/14/2005
Concurrent Drugs or Procedures:	spayed/telozol

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
vestibular syndrome; has lateral nystagnus, trembling, wobbly, naeusues (?). treat SQ fluids, clavomox.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	not listed
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	still recovering

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	2
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
none

Personal Information

Veterinarian		Owner	
*Name:	Cynthia Nonovon	Name	(b)(6)
Address:	125 Mulberry Street	Address	
City:	Ellijay	City	
State:	GA	State:	GA
Zip:	30540	Zip	(b)(6)
*Phone:	706-635-7357(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Cynthia
*Submitter's Last Name:	Nonovon
*Submitter's Phone Number:	706-635-7357(XXX-XXX-XXXX)
*Today's Date:	11/15/2005(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/15/2005
Verified:yes
Reviewed:yes
Date Entered: 12/16/2005
CVB Reporter: Doug Murtle
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06080
Product Code: 1901.R1 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 PureVax	298	17099	☒ Viral
2 Leukocell 2	189	A474305	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/27/2006
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
vomiting, defecation, and labored breathing shortly after vaccine was administered (on the way home); Oxygen, IV fluids, and Dexamethisone

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	20 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic, short-hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12.5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
asthmatic

Personal Information

Veterinarian		Owner	
*Name:	Laura Ryle	Name	(b)(6)
Address:	VCA Animal Hospital 815 Mission Street	Address	
City:	Santa Cruz	City	
State:	CA	State:	CA
Zip:	95060-3616	Zip	(b)(6)

*Phone:	831-427-3345(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Laura
*Submitter's Last Name:	Ryle
*Submitter's Phone Number:	831-427-3345(XXX-XXX-XXXX)
*Today's Date:	02/01/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	will report to manufacturer

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/01/2006
Verified:yes
Reviewed:yes
Date Entered: 02/13/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06109
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	A579781	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1		back of neck		02/25/2006
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/25/2006
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Severe Seizure

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Did not recover
Other:	Cat may still die

Animal Information

Case Identification:	Rabies Tag 061241	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Balinese	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Sasha is strictly indoor only and was in perfect health until 02/25/2006, I took her to ROCKWELL PET CLINIC and 10 hrs later she collapsed with a severe seizure and almost died! Since she has had a high fever and is not eating! I had to hospitalize her and she's still not better and may die! I have spent over $600.00 now trying to save her! I took her to my trusted vet whom I should of used instead but since we moved I didn't know who to go to and just picked a close vet... anyway... my vet ran extensive test including bloodwork,urinalysis. fel leuk and x-rays and all was normal! So it may be malpractice of the vet Leslie Wiewel giving the wrong shots or my cat had a severe reaction to vaccines!

Personal Information

Veterinarian		Owner	
*Name:	Leslie Wiewel	Name	(b)(6)
Address:	9308 N. Rockwell	Address	

City:	Oklahoma City	City	(b)(6)
State:	OK	State:	OK
Zip:	73132	Zip	(b)(6)
*Phone:	405-728-7387(XXX-XXX-XXXX)	Phone	(b)(6) (XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail	(b)(6)

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	(b)(6) (XXX-XXX-XXXX)
*Today's Date:	03/20/2006(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/20/2006
Verified:yes
Reviewed:yes
Date Entered: 04/11/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06151
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A243624C	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind leg	25	07/28/2003
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/28/2006
Concurrent Drugs or Procedures:	Feline rhino-calici-panleuk in R front

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Saw cat again March 30, 2006 for small 5mm x 5mm in diam-firm nodule mass on R lateral mid thigh. Biopsied April 4 - giant cell sarcoma assoc. with vaccine. Diagnosed by a boarded pathologist. Owner thought mid march 2006 when first noticed nodule.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	approx. 3 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	cat asymtomatic will take cat to oncology dept at Cornell

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	7
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	7
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
cat vaccinated 4/21/00 also in approx. the same site. no other vaccinations in the affected leg.

Personal Information

Veterinarian		Owner	
*Name:	Cathy Wakefield	Name	(b)(6)
Address:	1672 Fairport 9 Mile Point Road	Address	
City:	Penfield	City	
State:	NY	State:	NY

Zip:	14526	Zip	(b)(6)
*Phone:	585-377-1160(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	385-377-0189		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Cathy
*Submitter's Last Name:	Wakefield
*Submitter's Phone Number:	585-377-1160(XXX-XXX-XXXX)
*Today's Date:	04/12/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/12/2006
Verified:yes
Reviewed:yes
Date Entered: 04/18/2006
CVB Reporter: Huls
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06153

Product Code: 16D1.20 16E8.20 16E8.20 16E8.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A475505A	☒ Viral
2 Purevax Feline 4	298	64123	☒ Viral
3 Purevax Feline 4	298	64088	☒ Viral
4 Purevax Feline 4	298	64075B	☒ Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	20	11/22/2005
2 1 ml	SQ	R shoulder	20	11/07/2002
3 1 ml	SQ	R shoulder	20	03/02/2000
4 1 ml	SQ	R shoulder	20	03/27/1999

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/07/2002
Concurrent Drugs or Procedures:	feline leukemia, rabies and/or FIP vaccines also given but at different sites

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
cat was consistently vaccinated for FVR-C-CP @right shoulder. a small cyst was noted 7/25/05 which later grew and developed a firm irregular mass @ anterior major mass was biopsied and confirmed as a fibrosarcoma.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 yrs & 8 mos to 4 yrs 1 mos.
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	12 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
uncertain medical history before 1999. single cat household; indoor only cat; commercial cat food diet; see records of other vaccines.

Personal Information

Veterinarian		Owner	
*Name:	Mary Sebzda	Name	(b)(6)
Address:	125 Mesa Drive	Address	
City:	Costa Mesa	City	
State:	CA	State:	CA

Zip:	92627	Zip	(b)(6)
*Phone:	949-631-1030(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	949-631-3354		
E-mail:	msebzda@newportharborvets.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Mary
*Submitter's Last Name:	Sebzda
*Submitter's Phone Number:	949-631-1030(XXX-XXX-XXXX)
*Today's Date:	03/30/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/30/2006
Verified:yes
Reviewed:yes
Date Entered: 04/18/2006
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06170
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	4584851	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 not listed	SQ	L flankfold		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/04/2006
Concurrent Drugs or Procedures:	dental cleaning with extractions

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
decreased appetite, vomiting. 3/22/06 2.5-3" long X 1-1.5" deep lesion left flank. skin red, dry/hard and area roughly diangular. Started on prednisone 2.5 mg BID x 7 wl decreasing dose. D/C'd clinamycin (rom post-dental). 3/31/06 returned to normal eating & attitude. Skin lesion more extensive - see hard copy for more details.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	still under treatment

Animal Information

Case Identification:	Baby	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs 3 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Yvonne Craiger	Name:	(b)(6)
Address:	VCA Woodland Animal Hospital 2200 South Main Street	Address:	
City:	Ann Arbor	City:	
State:	MI	State:	

Zip:	48103	Zip:	
*Phone:	734-761-1870(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	734-761-1925		
E-mail:	yvonne.craiger@vcamail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Yvonne
*Submitter's Last Name:	Craiger
*Submitter's Phone Number:	734-761-1870(XXX-XXX-XXXX)
*Today's Date:	04/21/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/21/2006
Verified:yes
Reviewed:yes
Date Entered: 05/23/2006
CVB Reporter: Pagala
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06171
Product Code: 1905.24 16E8.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A585594B	☒ Viral
2 Purevax Feline 4	298	64155	☒ Combination
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	22	11/01/2005
2 1 ml	SQ	R shoulder	22	04/25/2006
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/25/2006
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Approximately 30 min after receiving vaccines, patient began vomiting profusely - about 10 times in a 10-20 minute period.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30-45 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	4
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	4
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Unknown - owner reports no previous vaccine reactions

Personal Information

Veterinarian		Owner	
*Name:	Tanya Seckman	Name	(b)(6)
Address:	852 South Drive, Bldg. 856	Address	
City:	Scott AFB	City	
State:	IL	State:	IL
Zip:	62225	Zip	(b)(6)
*Phone:	618-746-2168(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:	618-256-1588		
E-mail:	tanya.seckman@scott.af.mil	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Tanya
*Submitter's Last Name:	Seckman
*Submitter's Phone Number:	618-746-2168(XXX-XXX-XXXX)
*Today's Date:	04/27/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/27/2006
Verified:yes
Reviewed:yes
Date Entered: 05/23/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06175

Product Code: 1905.24 16E1.20 1555.20 16E1.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun	189	A25001B	☒ Viral
2 Eclipse 4+FeLV	165A	207152	☒ Viral
3 Fevaxyn FeLV	165A	208147	☒ Viral
4 Eclipse 4+FeLV	165A	207186	☒ Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 standard	standard	R hind	unk	08/21/2003
2 standard	standard	R shoulder	unk	08/21/2003
3 standard	standard	L shoulder	unk	08/21/2003
4 standard	standard	R shoulder	unk	08/03/2004

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/21/2003
Concurrent Drugs or Procedures:	08/03/2004 also

Event Information

* Event description:	☒ Neoplasia/Cancer
Explain the event and any treatment in a concise paragraph: patient developed 3 vaccine associated tumors (1 at each inj site). Tumors diagnosed 4/06	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2.5 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Pepsibutler	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): all vaccines were given at this hopsital. I've filed separate reports for each vaccine visit.			

Personal Information

Veterinarian		Owner	
*Name:	Andrew Silverstone	Name	(b)(6)
Address:	3501 Holland Road #106	Address:	
City:	Virginia Beach	City:	
State:	VA	State:	
Zip:	23452	Zip:	
*Phone:	757-340-6996(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	757-340-7658		
E-mail:	dogtor@mac.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Andrew
*Submitter's Last Name:	Silverstone
*Submitter's Phone Number:	757-340-6996(XXX-XXX-XXXX)
*Today's Date:	04/29/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/29/2006
Verified:yes
Reviewed:yes
Date Entered: 05/23/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV06226
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	A580480A	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hind	25	
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/06/2006
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
was vaccinated and dog started to vomit at 9:30 the next morning owner brought dog to clinic and was treated with benadryl and dex sp.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	16 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Canine (Dog)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Shih Tzu	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	19 wks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Christina Hutson	Name:	
Address:	820 Torrance Blvd	Address:	
City:	Redondo Beach	City:	
State:	CA	State:	
Zip:	90277	Zip:	
*Phone:	310-540-9044(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:	info@ahorb.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Christina
*Submitter's Last Name:	Hutson
*Submitter's Phone Number:	310-540-9044(XXX-XXX-XXXX)
*Today's Date:	07/07/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/10/2006
Verified:yes
Reviewed:yes
Date Entered: 07/17/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07026
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	A588247	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			06/30/2006
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/30/2006
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Lack of Expected Efficacy

Explain the event and any treatment in a concise paragraph:
3 year old cat showed signs of neurologic illness, died on 9/20, diagnosed with rabies on DFA on 9/23/2006. Was vaccinated 6/17/05 and again on 6/30/06 by a veterinarian.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 mos, 20 days
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :		Number vaccinated:	1
Sex:	☒ Male	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Vaccinated for rabies and neutered 6/17/05. Revaccinated 6/30/06.

Personal Information

Veterinarian		Owner	
*Name:	Joy Wills	Name:	
Address:	Heritage Animal Hospital P.O. Box 470	Address:	
City:	Morgantown	City:	
State:	KY	State:	
Zip:	42261	Zip:	

*Phone:	270-526-3839(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	270-526-9296		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	09/25/2006(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	State Public Health Veterinarian

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/25/2006
Verified:yes
Reviewed:yes
Date Entered: 10/04/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07084
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor	189	S603744E	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	R hind	22	11/01/2006
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/17/2006
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
A <0.5cm lump was notice by the owner on 12/12/2006. Told owner to observe and recheck in 2 weeks if still there then aspirate and concider sx removal. If grows then biopsy.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 wks
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Other
Other:	Still observation.

Animal Information

Case Identification:	Bailey	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yr,10 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
In door cat post vaccinatation swelling noticed by owner 3 weeks post.

Personal Information

Veterinarian		Owner	
*Name:	Esteban Armendariz	Name	(b)(6)
Address:	1882 Plaza Del Sur Drive	Address	
City:	Santa Fe	City	
State:	NM	State:	NM
Zip:	87505	Zip	(b)(6)
*Phone:	505-471-2888(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:	505-438-3991		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Esteban
*Submitter's Last Name:	Armendariz
*Submitter's Phone Number:	505-471-2888(XXX-XXX-XXXX)
*Today's Date:	12/13/2006(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/13/2006
Verified:yes
Reviewed:yes
Date Entered: 12/26/2006
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07129

Product Code: 1905.24 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	A130617B	☒ Viral
2 Rabdomun 1	189	A352009B	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R hip	unknown	11/01/2007
2 1 ml	SQ	R hip	unknown	11/01/2007
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/12/2004
Concurrent Drugs or Procedures:	Rabies vax - Rrear; FVRCP - Lrear

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
patient noticed swelling on right hip 01/04/07. FNA - 01/06/07 revealed probable malignant fibrous histocytoma. growth removal - 01/10/07 - fibrosarcoma, high grade malignancy.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	unknown which vacine may have led to event
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	removed mass; 3-6 mos expected survival

Animal Information

Case Identification:	6714 - Buddy	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	2
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only; received routine vacines (rabies, FVRCP, FELV); patient has another cat, no masses seen.

Personal Information

Veterinarian		Owner	
*Name:	Chris Lewis	Name	(b)(6)
Address:	Blue Cross Animal Hospital 3470 S. Hualapai Way	Address	
City:	Las Vegas	City	
State:	NV	State:	NV
Zip:	89117	Zip:	(b)(6)

*Phone:	702-384-8737(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:	702-384-2881		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Chris
*Submitter's Last Name:	Lewis
*Submitter's Phone Number:	702-384-8737(XXX-XXX-XXXX)
*Today's Date:	01/18/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/18/2007
Verified:yes
Reviewed:yes
Date Entered: 02/21/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07135
Product Code: 16D1.20 1901.R1
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A604454	☒ Viral
2 Purevax Feline Rabies	298	17118	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/25/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
seizure - first time that owner is aware, lasted <1 min. blood work normal, toxoplasmosis is pending.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15-20 mins
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	in good health

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Andrea Ballou	Name	(b)(6)
Address:	1330 Old Chainbridge Road	Address:	
City:	McLean	City:	
State:	VA	State:	
Zip:	22101	Zip:	
*Phone:	703-356-5000(XXX-XXX-XXXX)	Phone:	(b)(6) XX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Andrea
*Submitter's Last Name:	Ballou
*Submitter's Phone Number:	703-356-5000(XXX-XXX-XXXX)
*Today's Date:	01/26/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/26/2007
Verified:yes
Reviewed:yes
Date Entered: 02/21/2007
CVB Reporter: Frana
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07157
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A604203	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	02/08/2007
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/08/2007
Concurrent Drugs or Procedures:	Rabies vaccine R thigh SQ

Event Information

* Event description:	☒ Autoimmune

Explain the event and any treatment in a concise paragraph:
3 days after vaccination cat was lethargic, anorexic, febrile, and had polyarthropathy and lingual ulcers. Treatment was supportive care (fluids, antibiotics, pain medication). Cat clinically improved 2 weeks after vaccination but liver enzymes are now elevated.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	2007 US 051 55	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	4 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
kitten was previously healthy & acquired from a private home. This was her second felocell 3 vaccine (1st one given on 1/4/07). Kept indoor only. Eats friskies.

Personal Information

Veterinarian		Owner	
*Name:	Laurence Sawyer	Name:	(b)(6)
Address:	15 Clews Street	Address:	
City:	Shrewsbury	City:	
State:	MA	State:	MA

Zip:	01545	Zip:	(b)(6)
*Phone:	508-753-7077(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:	508-753-2150		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Laurence
*Submitter's Last Name:	Sawyer
*Submitter's Phone Number:	508-753-7077(XXX-XXX-XXXX)
*Today's Date:	03/07/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/12/2007
Verified:yes
Reviewed:yes
Date Entered: 04/13/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07202
Product Code: 16C1.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell RESP-2	189	A590838	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	Between shoulder blades		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/14/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
2/15/07 vomiting; 2/15/07 p.m. & 2/16/07 a.m. hair loss. vomited on thursday owner noticing hair loss at injection site, 2/15/07 & 2/16/07. hair loss area size of half dollar. cannot reach area to lick or scratch. area is not painful, swollen, raised or red. otherwise after 2/15/07 eating/drinking fine acting normally, no more vomiting.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	within 24 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	not listed

Animal Information

Case Identification:	Buddy	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs 9 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Darlene M. Cook	Name:	(b)(6)
Address:	The Bluffs of Red Wing, A Clinic for Pets 2518 Old West Main Street	Address:	
City:	Red Wing	City:	
State:	MN	State:	WI

Zip:	55066	Zip:	(b)(6)
*Phone:	651-388-1103(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Darlene
*Submitter's Last Name:	Cook
*Submitter's Phone Number:	651-388-1103(XXX-XXX-XXXX)
*Today's Date:	02/17/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/28/2007
Verified:yes
Reviewed:yes
Date Entered: 05/02/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07264

Product Code: 1555.21 1555.20 1555.20 1555.R3

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A126132	☒ Viral
2 Protex FeLV	286	4232003A	☒ Viral
3 Fevaxyn FeLV	165A	208201	☒ Viral
4 Purevax Recombinant Leukemia	298	25010	☒ Recombinant

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind leg		11/03/2001
2 1 ml	SQ	L hind leg		12/28/2002
3 1 ml	SQ	L hind leg		12/11/2004
4 1 ml	SQ	L hind leg	22	03/25/2006

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/25/2006
Concurrent Drugs or Procedures:	other vaccines

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Patient developed a fibrosarcoma at the injection site. Histopathology supported vaccine induced neoplasia.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	Mass developed 2 mos after vaccine given 3/25/2006, then reduced in size then recurred at site approximately 10 mos later.
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	10 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor/outdoor. Multiple cat household, vaccinated consistently. Was originally a stray at least six months of age in 1998.

Personal Information

Veterinarian		Owner	
*Name:	Nya Gilmartin	Name	(b)(6)
Address:	Feline Medical Clinic 5801 NE 105th Ave	Address	
City:	Vancouver	City	
State:	WA	State:	WA
Zip:	98662	Zip	(b)(6)

*Phone:	360-892-0224(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	360-896-6206		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Nya
*Submitter's Last Name:	Gilmartin
*Submitter's Phone Number:	360-892-0224(XXX-XXX-XXXX)
*Today's Date:	05/18/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/18/2007
Verified:yes
Reviewed:yes
Date Entered: 06/05/2007
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07267
Product Code: 1905.20 16D1.20
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Imrab 3	298	12508B	☒ Viral
2 Felocell 3	189	A600693A	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ		25	04/02/2007
2 1 ml	SQ		25	04/02/2007
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/02/2007
Concurrent Drugs or Procedures:	none listed

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
4/7/07 vax at regular vet hospital. Overnight went to ER hospital for allergic reaction to vax. Gave diphenlyaramine 25 mg/IM. Sent home with owner to observe and call vet if any problems, no problems reported.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	hours
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Samsen	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs 3 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
vaccination

Personal Information

Veterinarian		Owner	
*Name:	Rheal J. Bouchard	Name	(b)(6)
Address:	MacDonald Veterinary Hospital, Inc. 267 Cottage Grove Road	Address	
City:	Bloomfield	City	
State:	CT	State:	CT
Zip:	06002	Zip	(b)(6)

*Phone:	860-242-5506(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)
FAX:	860-242-6656		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Rheal
*Submitter's Last Name:	Bouchard
*Submitter's Phone Number:	860-242-5506(XXX-XXX-XXXX)
*Today's Date:	05/21/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/21/2007
Verified:yes
Reviewed:yes
Date Entered: 06/05/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07287

Product Code: 1555.21 16E1.20 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Feline Leukemia	189		☒ Viral
2 Felocell 4	189		☒ Viral
3 Rabies	189		☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/27/2002
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Initial reaction developed within weeks - high fever over 105 degrees. cate developed stupor and could not walk. After treatment from other vets, cat recovered. Large fibersarcoma or injection site sarcoma vas/iss diagnosed on 3/17/05. Cate died on 4/26/06 after 1 yr of treatment. Prior to vas diagnosis cat would periodically vomit bile - improved after surgery.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	weeks to years
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:	Pookie	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Maine Coon	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs 8 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor cat, owner since cat was 3 weeks old. One companion cat, DSH, vaccinated same day - no reaction. Pet seen regularly as recommended by vet.

Personal Information

Veterinarian		Owner	
*Name:	Kelvin Kow	Name	(b)(6)
Address:	CSU Vet Teching Hospital 300 W. Drake Road	Address	

City:	Fort Collins	City	(b)(6)
State:	CO	State:	CO
Zip:	80523	Zip	(b)(6)
*Phone:	970-297-4175(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:	970-297-1254		
E-mail:	kkow@colostate.edu	E-mai	(b)(6)

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	04/22/2007(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/20/2007
Verified:yes
Reviewed:yes
Date Entered: 06/15/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07325
Product Code: 16D1.20 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A611807B	☒ Viral
2 Leukocell 2	189	A602401	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2	SQ			
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/31/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
within 30-40 mins of vaccination, vomiting then tremors, lethargy & mild hyperthermia; treated with benadryl.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Squeekers	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	not listed	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	9 wks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
no illness at time of vaccination, no pre-existing allergies, birth defects or medical conditions.

Personal Information

Veterinarian		Owner	
*Name:	Elizabeth Baird	Name:	(b)(6)
Address:	Country Oaks Animal Hospital 1412 Belcher Road	Address:	
City:	Palm Harbor	City:	
State:	FL	State:	FL
Zip:	34683	Zip:	(b)(6)
*Phone:	727-785-6524(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Elizabeth
*Submitter's Last Name:	Baird
*Submitter's Phone Number:	727-785-6524(XXX-XXX-XXXX)
*Today's Date:	06/23/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007
Verified:yes
Reviewed:yes
Date Entered: 07/11/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07326

Product Code: 16D1.20 1555.21 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A611807B	☒ Viral
2 Leukocell 2	189	A602401	☒ Viral
3 Defensor 1	189	S610805	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2	SQ			
3	SQ			
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/18/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
fever, anorexia, lethargy began after vacc & continued to 12 hours post vaccination. Hospitalized for fluid therapy & NSAID to reduce fever (104).

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Recovered with treatment
Other:	none

Animal Information

Case Identification:	Tigger	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	not listed	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	9 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
no illness at time of vaccination; no pre-existing allergies, birth defects or medical conditions.

Personal Information

Veterinarian		Owner	
*Name:	Elizabeth Baird	Name	(b)(6)
Address:	Country Oaks Animal Hospital 1412 Belcher Road	Address	(b)(6)
City:	Palm Harbor	City	(b)(6)
State:	FL	State:	FL
Zip:	34683	Zip	(b)(6)

*Phone:	727-785-6524(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Elizabeth
*Submitter's Last Name:	Baird
*Submitter's Phone Number:	727-785-6524(XXX-XXX-XXXX)
*Today's Date:	06/25/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007
Verified:yes
Reviewed:yes
Date Entered: 07/11/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07327

Product Code: 16D1.20 1555.21 1905.24

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fellocell 3	189	A611808B	☒ Viral
2 Leukocell 2	189	A602401	☒ Viral
3 Defensor 1	189	S610805	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ			
2	SQ			
3	SQ			
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/14/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
owner reported lethargy in the evening the same date as vaccination. presented the following a.m. with fever (104), lethargy, anorexia. treated with fluid therapy & NSAIDS

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	6 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Phoebe	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	not listed	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	3 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
no illness at time of vaccination & no pre-existing allergies, birth defects, or medical conditions.

Personal Information

Veterinarian		Owner	
*Name:	Elizabeth F. Baird	Name	(b)(6)
Address:	Country Oaks Animal Hospital 1412 Belcher Road	Address	
City:	Palm Harbor	City	
State:	FL	State:	FL
Zip:	34683	Zip:	(b)(6)

*Phone:	727-785-6524(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Elizabeth
*Submitter's Last Name:	Baird
*Submitter's Phone Number:	727-785-6524(XXX-XXX-XXXX)
*Today's Date:	06/25/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/26/2007
Verified:yes
Reviewed:yes
Date Entered: 07/11/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07340
Product Code: 1561.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fellocell FPV	189	A605873	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1	SQ	Scruff area		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/20/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: continous vomiting/diarrhea	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	immediately
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	not listed

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Sphynx	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	approx 3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): dexamethasone 2 mg/ml 0.25 ml IM; diphenhydramine 50 mg/ml .18 ml IM			

Personal Information

Veterinarian		Owner	
*Name:	Darlene Cook	Name:	(b)(6)
Address:	Bluffs Pet Clinic 2518 Old West Main St.	Address:	
City:	Red Wing	City:	
State:	MN	State:	MN
Zip:	55066	Zip:	(b)(6)
*Phone:	651-388-1103(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Darlene
*Submitter's Last Name:	Cook
*Submitter's Phone Number:	651-388-1103(XXX-XXX-XXXX)
*Today's Date:	07/20/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/20/2007
Verified:yes
Reviewed:yes
Date Entered: 08/28/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV07365
Product Code: 16D1.22 1905.24
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Guard Plus 3	112	117159A	☒ Viral
2 Defensor 3	189	S606113	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/17/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: death - anaphylaxis	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	minutes
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :		Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	Mary Ann Sheller	Name	(b)(6)
Address:	Vale Park Animal Hospital 2606 Valley Drive	Address	
City:	Valparaiso	City	
State:	IN	State:	IN
Zip:	46383	Zip	(b)(6)
*Phone:	219-462-5785(XXX-XXX-XXXX)	Phone	XX-XXX-XXXX)

FAX:	219-462-7180		
E-mail:		E-mail:	mse0730@hotmail.com

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	08/02/2007(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/02/2007
Verified:yes
Reviewed:yes
Date Entered: 08/28/2007
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08019
Product Code: 1555.21
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukovell 2	189	A612128B	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L lower femoral	22	09/05/2007
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/05/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
cat was seen for a laceration on tail. Tail was clipped. 0.2 ml diphenhydramine administered SQ in upper left femoral region, FeLV given at that time. Cat presented 24 hrs after vax with not eating, lethargic, temp of 103.6, dilated pupils. dexameth given & temp take every 2 hrs until reached 102.5 approx. 4 hrs later. Sent home & doing well. This same scenario occurred last year when she was given FeLV & FVRCP. RV given at separate visit & no reaction occurred. At that time, was determined to split vax & give benedryl prior but that has not resolved reaction so FELV vax will be OK'd. FVRCP not proven reactive at that time.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	within 24 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	11481-2	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs 9 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor/outdoor cat, uneventful ?. Been healthy, owner keeps cat current on vax & deworming, multiple cat (8) household. Eats Eukanuba adult, owner has had this cat since juvenile cat.

Personal Information

Veterinarian		Owner	
*Name:	Derine Winning	Name:	(b)(6)

Address:	Valley Veterinary Hospital 3210 Main Avenue	Address:	(b)(6)
City:	Fargo	City:	
State:	ND	State:	ND
Zip:	58103	Zip:	(b)(6)
*Phone:	701-232-3391(XXX-XXX-XXXX)	Phone:	XX-XXX-XXXX)
FAX:	701-293-6477		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	701-232-3391(XXX-XXX-XXXX)
*Today's Date:	09/07/2007(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Vet Tech

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/07/2007
Verified:yes
Reviewed:yes
Date Entered: 10/09/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08051

Product Code: 1901.R1 16D1.20 1555.R3

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17138	☒ Viral
2 Felocell 3	189	A715199C	☒ Viral
3 PureVax Recombinant Leukemia	298	25021	☒ Viral
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hip	26	10/12/2007
2 1 ml	SQ	L hip	26	10/12/2007
3 1 ml	intradermal	R hip	n/a	10/12/2007
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/12/2007
Concurrent Drugs or Procedures:	Physical exam, Drontal feline 1.5 tab PO

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Extreme lethargy & inappetance, febrile following day (104.1). Rest of PE unremarkable. Administered SQ fluids and 0.5 mg Dex IM. Recovered uneventfully.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	hrs per owner
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	"Jazz" Christensen	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	1.5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Has received other vaccines at different clinic (not sure product name but has received Rabies, FeLV, and FVRCP) without incident.

Personal Information

Veterinarian		Owner	
*Name:	Jacqueline Cyr	Name:	
Address:	Rhinebeck Animal Hospital 6450 Montgomery Street	Address:	
City:	Rhinebeck	City:	
State:	NY	State:	

Zip:	12572	Zip:	
*Phone:	845-876-6008(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	info@Rhinebeckanimalhospital.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Jacqueline
*Submitter's Last Name:	Cyr
*Submitter's Phone Number:	845-943-8949(XXX-XXX-XXXX)
*Today's Date:	10/15/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/15/2007
Verified:yes
Reviewed:yes
Date Entered: 11/09/2007
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

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United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08073
Product Code: 1901.R1 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline	298	17117	☒ Viral
2 Felocell 3 Rabies	189	A604203	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear	22	01/03/2007
2 1 ml	SQ	L rear	22	01/03/2007
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/03/2007
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
lump (3 cm diam) at site of rabies injection was noticed around 09/23/2007 and was diagnosed by biopsy as fibrosarcoma on 10/29/2007.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	9 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only cat owner has had since cat was a kitten no other problems with cat.

Personal Information

Veterinarian		Owner	
*Name:	Dustine Reppuhn	Name	(b)(6)
Address:	Parkway Veterinary Clinic 5743 Burke Centre Parkway	Address	
City:	Burke	City	
State:	VA	State:	VA
Zip:	22015	Zip	(b)(6)

*Phone:	703-323-9020(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	703--323-9023		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Dustine
*Submitter's Last Name:	Reppuhn
*Submitter's Phone Number:	703-323-9020(XXX-XXX-XXXX)
*Today's Date:	11/05/2007(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/05/2007
Verified:yes
Reviewed:yes
Date Entered: 11/30/2007
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08130

Product Code: 1905.24 1561.23 16C1.22

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A585925B	☒ Viral
2 Feline Ultranasal FPL Vaccine	213	4529	☒ Viral
3 Feline Ultranasal FVRC Vaccine	213	4438	☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	06/10/2006
2 0.2 ml	IN	nares	none	06/10/2006
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/10/2006
Concurrent Drugs or Procedures:	FeLV/FIV test, and microchip.

Event Information

* Event description:	☒ Systemic
Explain the event and any treatment in a concise paragraph: Vomiting, anorexia, lethargy. Gave 17.5mg Benadryl SQ, and 2.5mg famotidine PO.	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Bengal	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): Indoor only. No significant medical problems.			

Personal Information

Veterinarian		Owner	
*Name:	Cindy Houlihan	Name	(b)(6)
Address:	The Cat Pracrice 875 South Worth	Address	
City:	Birmingham	City	
State:	MI	State:	MI
Zip:	48009	Zip	(b)(6)

*Phone:	248-540-3390(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	248-540-3503		
E-mail:	meowmail@thecatpracticepc.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	248-540-3390(XXX-XXX-XXXX)
*Today's Date:	01/09/2008(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 01/09/2008
Verified:yes
Reviewed:yes
Date Entered: 01/23/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08178

Product Code: 1555.21 1905.24 15B5.20 15B5.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A602401	☒ Viral
2 Defensor 3	189	A470300B	☒ Viral
3 Fel-O-Vac Lv-K III	112	219128A	☒ Viral
4 Fel-O-Vac Lv-K III	112	219126A	☒ Viral

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L rear leg	22	03/30/2007
2 1 ml	SQ	R rear leg	22	04/30/2005
3 1 ml	SQ	L rear leg	22	04/30/2005
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/30/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Radiographs 12/27/07 for L rear leg lameness, radiographs revealed disuse atrophy of L rear leg. Metacam inj SQ, Buprenex sent home for oral use. 1/12/08 1lb wt loss since 12/27/07, not eating, lethargy, very painful L rear leg, much muscle atrophy of limb, cat hold foot in unnatural curled under position. Radiographs reveal increased density of soft tissue caudal totibia. Blood pressure 115. Fine needle aspirates done.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	9 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	Euthanized 1/30/08

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs 9 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Found as a stray 3/96. Linear foreign body 2/2000 surgically removed. Linear foreign body & sewing needle removed 11/2001. Routine annual exams 2002, 2003, 2004, 2005, 2007. vaccines given each year.

Personal Information

Veterinarian		Owner	
*Name:	Karen Vidos	Name	(b)(6)
Address:	Halsey East Animal Clinic PC 16057 NE Halsey Street	Address	

City:	Portland	City	(b)(6)
State:	OR	State:	OR
Zip:	97230	Zip	(b)(6)
*Phone:	503-255-0261(XXX-XXX-XXXX)	Phone	(b)(6) (XXX-XXX-XXXX)
FAX:	503-256-1373		
E-mail:	jnielsen1207@aol.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Karen
*Submitter's Last Name:	Vidos
*Submitter's Phone Number:	503-255-0261(XXX-XXX-XXXX)
*Today's Date:	02/05/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/12/2008
Verified:yes
Reviewed:yes
Date Entered: 02/22/2008
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08187
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A585925B	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	05/24/2006
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/24/2006
Concurrent Drugs or Procedures:	FeLV/FIV test and Bartonella test.

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Lethargy and tenderness. No treatment.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	24 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
History of struvite urinary crystals, eats Eukanuba Low pH-S canned food. No other medical history and no past vaccine reactions.

Personal Information

Veterinarian		Owner	
*Name:	Christie Budd	Name	(b)(6)
Address:	The Cat Practice 875 South Worth	Address	
City:	Birmingham	City	
State:	MI	State:	MI
Zip:	48009	Zip	(b)(6)

*Phone:	248-540-3390(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	248-540-3503		
E-mail:	meowmail@thecatpracticepc.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	248-540-3390(XXX-XXX-XXXX)
*Today's Date:	02/02/2008(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/02/2008
Verified:yes
Reviewed:yes
Date Entered: 02/22/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08191
Product Code: 1905.24 16D1.22
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	A246970	☒ Viral
2 Trivalent FVRCP	213	HF-188-051A	☒ Combination
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	06/02/2003
2 1 ml	IN/IO	nares/eyes	none	06/02/2003
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/02/2003
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Found pea-sized lump RR leg from rabies vaccine. ~20mm x 15mm x 10mm - firm nodule. Took FNA. Came back as localized inflammation probably from vaccine. Elect to monitor for changes. Lump resolved by next visit (1 year later).

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only. No significant medical history.

Personal Information

Veterinarian		Owner	
*Name:	Christie Budd	Name	(b)(6)
Address:	The Cat Practice 875 South Worth	Address	
City:	Birmingham	City	
State:	MI	State:	MI

Zip:	48009	Zip	(b)(6)
*Phone:	248-540-3390(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	248-540-3503		
E-mail:	meowmail@thecatpracticepc.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	248-540-3390(XXX-XXX-XXXX)
*Today's Date:	02/02/2008(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Licensed Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/02/2008
Verified:yes
Reviewed:yes
Date Entered: 02/22/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

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United States Department of Agriculture
Center for Veterinary Biologics
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Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08221
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	unknown	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind leg		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/30/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Presented 12/27/07 for lameness L hind leg, vocalizing, very painful. Radiographs revealed mild disuse muscle atrophy. Metacam 0.35 mg SQ inj, Buprenex p.o. sent home. 1/12/08 no improvement. Continued Buprenex p.o. & addd Synovi Feline granules 8 lb cat dose SID. 1/29/08 presented, very painful, 1 lb wt. loss, much muscle atrophy of limb, holds foot in unnatural curled under position. Radiographs reveal increased density of soft tissue caudal to tibia. Blood pressure 115. fine needle aspirates done. cytology - spindle cell tumor, consistant with fibrosarcoma. euthanized 1/30/08.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	9 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	euthanized

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs 9 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Karen Vidos	Name:	(b)(6)
Address:	Halsey East Animal Clinic	Address:	

	16057 NE Halsey Street		
City:	Portland	City:	
State:	OR	State:	
Zip:	97230	Zip:	
*Phone:	503-255-0261(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Karen
*Submitter's Last Name:	Vidos
*Submitter's Phone Number:	503-255-0261(XXX-XXX-XXXX)
*Today's Date:	03/03/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/03/2008
Verified:yes
Reviewed:yes
Date Entered: 04/01/2008
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08263
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189		☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hip	25	
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/04/1999
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
Owner noticed a growth on the point of the left hip on 1/10/08. Had surgery at the Animal Medical Center in NYC. Biopsy to follow.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Other
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	~10 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only cat. vaccinated 2 shots of feline leukemia in 1999 - none - since.

Personal Information

Veterinarian		Owner	
*Name:	Dawn D. Stelling	Name	(b)(6)
Address:	Olde Towne Animal Hospital 380 County Road 394	Address	
City:	Southhampton	City	
State:	NY	State:	NY
Zip:	11968	Zip	(b)(6)

*Phone:	631-283-0611(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:	631-283-5902		
E-mail:	ddstelling@aol.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Dawn
*Submitter's Last Name:	Stelling
*Submitter's Phone Number:	631-283-0611(XXX-XXX-XXXX)
*Today's Date:	04/10/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/10/2008
Verified:yes
Reviewed:yes
Date Entered: 04/23/2008
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08287
Product Code: 1901.R1 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17156	☒ Viral
2 Felocell 3	189	A722872A	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear	25	04/24/2008
2 1 ml	SQ	R shoulder	25	04/24/2008
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/24/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Lethargy, anorexia and fever (104.1) within a few hours of vaccination. Treated with sq fluids and NSAID (metacam)

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	7912 Cocoa Brannigan	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Owner found her as a stray 2 years ago. Current on vaccines since adoption, with no previous problems.

Personal Information

Veterinarian		Owner	
*Name:	Kara Malone	Name	(b)(6)
Address:	Timberlyne Animal Clinic Inc. 110 Banks Drive	Address:	
City:	Chapel Hill	City:	
State:	NC	State:	
Zip:	27514	Zip:	
*Phone:	919-968-3047(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	919-968-6230		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Kara
*Submitter's Last Name:	Malone
*Submitter's Phone Number:	919-968-3047(XXX-XXX-XXXX)
*Today's Date:	04/25/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/25/2008
Verified:yes
Reviewed:yes
Date Entered: 05/19/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08368
Product Code: 16D1.20 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A609138	☒ Viral
2 Felocell 3	189	A611170B	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/19/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Lack of Expected Efficacy

Explain the event and any treatment in a concise paragraph:
my 2 cats were immunized with felocell on following dates: 04-23-07,05-22-07,6-19-07. One caught panleukopenia and died, the other got calici virus and was very sick but lived. The vaccines did not do what they were supposed to do, protect against these diseases.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	11 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	2
Breed :		Number vaccinated:	2
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	10 -11 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
cats were brother and sister, vaccinated when kittens starting at 7-8 wks, perfectly healthy, indoor cats never outside, given dry and wet food, and no contact with other animals until they were brought to 9 lives animal rescue shelter.

Personal Information

Veterinarian		Owner	
*Name:	Jan Curtis	Name:	(b)(6)
Address:	Ft. Carson Vet Clinic 1535 Sheridan Avenue, Bldg. 6190	Address:	
City:	Ft. Carson	City:	

State:	CO	State:	CO
Zip:	80913	Zip	(b)(6)
*Phone:	719-526-3803(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:			
E-mail:		E-mai	(b)(6)

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Numbe	(b)(6) XXX-XXX-XXXX)
*Today's Date:	07/11/2008(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/11/2008
Verified:yes
Reviewed:yes
Date Entered: 08/07/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08388
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189		☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L pelvic limb	25	12/13/2005
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/13/2005
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Found mass on left hind leg couple weeks ago. Now encompasses most of quadriceps musculature. Wedge Bx confirms fibrosarcoma. Cat has not had leukemia vax since 2005, but had it yearly until then.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	at least 2.5 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Other
Other:	Owner still weighing options; may not treat

Animal Information

Case Identification:	Gizmo Sullivan	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	7 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only, suspended FeLV vax due to this housing.

Personal Information

Veterinarian		Owner	
*Name:	Jaclyn Martin	Name:	
Address:	Groton Ledyard Veterinary Hospital 5 Lorenz Industrial Parkway	Address:	
City:	Ledyard	City:	
State:	CT	State:	
Zip:	06339	Zip:	

*Phone:	860-464-1045(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	860-464-1563		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Jaclyn
*Submitter's Last Name:	Martin
*Submitter's Phone Number:	860-464-1045(XXX-XXX-XXXX)
*Today's Date:	07/21/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/21/2008
Verified:yes
Reviewed:yes
Date Entered: 08/28/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08389
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189		☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L pelvic limb	25	05/17/2007
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/17/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Bump developed on lateral left thigh, site of probable previous leukemia vaccinations. We have used same brand for several years, cannot tell which lot number may be associated/which particular dose caused reaction.
mass was removed 2 months ago; too soon to tell ultimate outcome

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	at least 1 year
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	mass was removed 2 months ago; too soon to tell ultimate outcome

Animal Information

Case Identification:	Heuschneider, Smokey	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
vaccinated yearly

Personal Information

Veterinarian		Owner	
*Name:	Jaclyn Martin	Name:	
Address:	Groton Ledyard Veterinary Hospital 5 Lorenz Industrial Parkway	Address:	
City:	Ledyard	City:	

State:	CT	State:	
Zip:	06339	Zip:	
*Phone:	860-464-1045(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	860-464-1563		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Jaclyn
*Submitter's Last Name:	Martin
*Submitter's Phone Number:	860-464-1045(XXX-XXX-XXXX)
*Today's Date:	07/21/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/21/2008
Verified:yes
Reviewed:yes
Date Entered: 08/28/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08397

Product Code: 1905.21 1905.24 1905.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabvac 3	112	1215280A	☒ Viral
2 Defensor 3	189	A473673	☒ Viral
3 Imrab 3	298	12467	☒ Viral
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				01/13/2007
2				10/08/2005
3				09/28/2004
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	01/13/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Sherman developed a mass caudal to the stifle in the right rear leg. The leg was removed with coxo-femoral disarticulation and the mass was biopsied. It was found to be a fibrosarcoma. (see attached report).

Note: the last rabies vaccine administered was Code 1905.21, Serial 1215280A, manufactured by 112.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 yrs 2 mos after the last vax in that leg
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	no evidence of metastasis or local spread at this time.

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):			

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
see attached records

Personal Information

Veterinarian		Owner	
*Name:	Hugh Davis	Name	(b)(6)
Address:	Veterinary Health Center/Spay Waggin 10 Chandler Street	Address	

City:	Boston	City:	(b)(6)
State:	MA	State:	MA
Zip:	02116	Zip	(b)(6)
*Phone:	617-226-5605(XXX-XXX-XXXX)	Phone	XX-XXX-XXXX)
FAX:	617-482-5113		
E-mail:	hdavis@arlboston.org	E-mail:	

This event has been reported to the manufacturer(s):	
*Submitter's First Name:	Hugh
*Submitter's Last Name:	Davis
*Submitter's Phone Number:	617-426-9170(XXX-XXX-XXXX)
*Today's Date:	05/05/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/06/2008
Verified:yes
Reviewed:yes
Date Entered: 08/28/2008
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08447
Product Code: 16D1.20 1901.R1
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A827030A	☒ Viral
2 Purevax Feline Rabies	298	17171A	☒ Recombinant
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF leg	22	08/27/2008
2 1 ml	SQ	RH leg	22	08/27/2008
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/27/2008
Concurrent Drugs or Procedures:	PE

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
On 9/3/2008 the cat presented with vomiting and diarrhea, lethargy, one day history of anorexia. Treated with SQ fluids Metronidazole and Metoclopramide.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	7 days
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	28070	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DLH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Only pet, indoor, had Merial Purevax 12/11/06 with no problems, last FVRCP vaccine was given in 2006 at another vet clinic, eats Fancy Feast wet and dry food.

Personal Information

Veterinarian		Owner	
*Name:	Christine Bohn Kirnos	Name:	(b)(6)
Address:	VCA Cat Hospital 226 S 20th Street	Address:	
City:	Philadelphia	City:	
State:	PA	State:	

Zip:	19103	Zip:	
*Phone:	215-567-6446(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	christine.bohn@vcamail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Christine
*Submitter's Last Name:	Bohn Kirnos
*Submitter's Phone Number:	215-567-6446(XXX-XXX-XXXX)
*Today's Date:	09/05/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/05/2008
Verified:yes
Reviewed:yes
Date Entered: 09/22/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV08456
Product Code: 16D1.20 1901.R1
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A827030A	☒ Viral
2 PureVax Feline Rabies	298	17172A	☒ Recombinant
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF leg	22	09/13/2008
2 1 ml	SQ	RH leg	22	09/13/2008
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/13/2008
Concurrent Drugs or Procedures:	Physical exam only

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Vaccines were administered following a thorough physical exam which was non-remarkable. Approximately 10 minutes later, cat became dyspneic and laterally recumbent. Cat was treated with diphenhydramine, dexamethasone, furosemide, epinephrine, and atropine and placed in an Oxygen cage. Cat regurgitated serosanguinous fluid and cardiac/respiratory arrest followed. Cat was intubated and CPR initiated. Attempts to resuscitate were unsuccessful. Owner declined necropsy.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10-15 mins
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:	30914	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	2
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	6 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
1 other cat in household, indoor but allowed outside w/supervision, last vaccines given at least 3 years ago, no known medical conditions

Personal Information

Veterinarian		Owner	
*Name:	Aimee Simpson	Name	(b)(6)
Address:	VCA Cat Hospital of Philadelphia	Address	

	226 South 20th Street		
City:	Philadelphia	City:	(b)(6)
State:	PA	State:	PA
Zip:	19103	Zip	(b)(6)
*Phone:	215-567-6446(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	215-567-7735		
E-mail:	aimee.simpson@vcamail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Aimee
*Submitter's Last Name:	Simpson
*Submitter's Phone Number:	215-567-6446(XXX-XXX-XXXX)
*Today's Date:	09/13/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	NB: Offices closed @ Pfizer and Merial on 9/13, message left with Merial for rep to call back 9/15

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/13/2008
Verified:yes
Reviewed:yes
Date Entered: 09/30/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09030
Product Code: 16E5.23 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Vax IV + CaliciVax	112	1841104A	☒ Combination
2 Defensor 3	189	S829084A	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L rear	22	10/13/2008
2 1 ml	SQ	R rear	22	10/13/2008
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/13/2008
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
patient became lethargic, febrile and anorexic with mild diarrhea within 12-24 hours post-vaccine.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	<24 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	Pending treatment

Animal Information

Case Identification:	Duncan Fournier	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DLH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only. One previous FvRCPC vaccine in 6/08.

Personal Information

Veterinarian		Owner	
*Name:	Jessica K. Nantz	Name	(b)(6)
Address:	Oak Forest Veterinary Clinic 2120 West 34th Street	Address	
City:	Houston	City	
State:	TX	State:	TX
Zip:	77018	Zip	(b)(6)
*Phone:	713-682-6351(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:			
E-mail:	jessnantz@yahoo.com	E-mail	(b)(6)

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Jessica
*Submitter's Last Name:	Nantz
*Submitter's Phone Number:	979-820-1597(XXX-XXX-XXXX)
*Today's Date:	10/14/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/14/2008
Verified:yes
Reviewed:yes
Date Entered: 11/18/2008
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09061
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S826915A	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF	22	10/24/2008
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/24/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
nystagmus circling

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 mins
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	18 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
hasn't been vaccinated for many years

Personal Information

Veterinarian		Owner	
*Name:	Leon Anderson	Name:	(b)(6)
Address:	Elizabeth Animal Hospital P.O. Box 1030	Address:	
City:	Elizabeth	City:	
State:	CO	State:	
Zip:	80107	Zip:	
*Phone:	303-646-2891(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	303-646-2891(XXX-XXX-XXXX)
*Today's Date:	11/10/2008(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Vet Tech

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/10/2008
Verified:yes
Reviewed:yes
Date Entered: 01/02/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09081
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	S608371	☒ Viral
2			☒ Combination
3			☒ Combination
4			☒ Combination

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/18/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
30 minutes after event my cat could not stand up no treatment given by vet on return visit.

ROC: I talked to owner and she said that Veternarian said that cat had diabetes & kidney failure prior to vaccination. Progressively got worse and died on 5/23/2008.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30 mins
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Died
Other:	Died 5/23/2008

Animal Information

Case Identification:	2008US35233	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese mix	Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	16 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Michael Reid	Name	(b)(6)
Address:	Animal Health Center 5341 North Glenstone Avenue	Address	
City:	Springfield	City	

State:	MO	State:	MO
Zip:	65803	Zip	(b)(6)
*Phone:	417-833-3122(XXX-XXX-XXXX)	Phone	XX-XXX-XXXX)
FAX:	417-833-5744		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	12/01/2008(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/01/2008
Verified:yes
Reviewed:yes
Date Entered: 01/02/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09088
Product Code: 16D1.20 16D1.20 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A827324C	☒ Viral
2 Felocell 3	189	A612496B	☒ Viral
3 Defensor 1	189	S714887C	☒ Viral
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LL scapula	22	10/22/2008
2 1 ml	SQ	LL scapula	22	10/12/2008
3 1 ml	SQ	LR scapula	22	10/12/2008
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/22/2008
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
The cat developed anorexia 5 days post vaccination. PE on 10/30/2008 revealed a severe ileus. Foreign body was suspected and an abdominal exploratory performed. Negative findings. Cat continued to decline despite agressive intensive care she continued to decline and was euthanized on 11/02/2008.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	about 5 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	

Animal Information

Case Identification:	Sidney	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2 yrs 4 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
owner got her as a kitten, history of fractured leg when kitten, healed and no other health problems. 3 other cats in house are fine/healthy and up to date on vaccines. Indoor 100%

Personal Information

Veterinarian		Owner	
*Name:	Michelle Thomas	Name:	(b)(6)
Address:	Mulnix Animal Clinic 1015 S. Taft Hill Road St. T	Address:	
City:	Ft. Collins	City:	(b)(6)

State:	CO	State:	CO
Zip:	80521	Zip	(b)(6)
*Phone:	970-484-1848(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	970-484-1251		
E-mail:	mthomasdvm@aol.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Michelle
*Submitter's Last Name:	Thomas
*Submitter's Phone Number:	970-204-9148(XXX-XXX-XXXX)
*Today's Date:	12/10/2008(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/10/2008
Verified:yes
Reviewed:yes
Date Entered: 02/20/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09102

Product Code: 1555.21 16D1.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A724420	☒ Viral
2 Felocell 3	189	A831848	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind	22	12/19/2008
2 1 ml	SQ	LF	22	12/19/2008
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	12/19/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Cat was lethargic and wouldn't eat. Gave diphenhydramine and dexamethasone injection and SQ fluids.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 day
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :	DLH	Number vaccinated:	2
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	2.5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
OWNER HAS HAD SINCE 2006 AND WE HAVE VACCINATED WITH SAME VACCINES IN PAST.

Personal Information

Veterinarian		Owner	
*Name:	Leon Anderson	Name	(b)(6)
Address:	Elizabeth Animal Hospital 330 West Kiowa Avenue	Address:	
City:	Elizabeth	City	(b)(6)
State:	CO	State:	CO
Zip:	80107	Zip	(b)(6)
*Phone:	303-646-2891(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	303-646-2487		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	303-646-2891(XXX-XXX-XXXX)
*Today's Date:	12/22/2008(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Vet Tech

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 12/22/2008
Verified:yes
Reviewed:yes
Date Entered: 02/20/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09159
Product Code: 1901.R1 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17178B	☒ Recombinant
2 Felocell 3	189	A828268	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH leg	22	02/20/2009
2 1 ml	SQ	RF leg	22	02/20/2009
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/20/2009
Concurrent Drugs or Procedures:	Cleaned ears with epi-otic advanced

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Extreme lethargy and multiple episodes of vomiting in the few hours following the appointment. Treated with SQ fluids, dexamethasone, diphenhydramine and cerenia.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	9050-3	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	
(Other Species):		Number affected:	
Breed :	DSH	Number vaccinated:	
Sex:	☒ Female	Number dead:	
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 10 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Adopted from foster agency 12/08. Indoor only. One other indoor cat in household. Otitis AS.

Personal Information

Veterinarian		Owner	
*Name:	Christine M. Echols	Name:	
Address:	Dog, Cat & Bird Clinic 324 Passaic Avenue	Address:	
City:	Nutley	City:	
State:	NJ	State:	
Zip:	07110	Zip:	

*Phone:	973-661-0441(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Christine
*Submitter's Last Name:	Echols
*Submitter's Phone Number:	973-661-0441(XXX-XXX-XXXX)
*Today's Date:	02/24/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/24/2009
Verified:yes
Reviewed:yes
Date Entered: 04/20/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09179
Product Code: 1905.24 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S608371	☒ Viral
2 Felocell 4	189	not given	☒ Combination
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			
2 1 ml	IM or SQ			
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	02/18/2008
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
My cats alleged 2 year rabies vaccination was due, which is all I wanted without my knowledge vet gave 4 other disease vaccines. I was not (at that time) a knowledgable pet owner. I did not realize my cat had diabetes. I did not realize that she was lucky to survive all the harmful vaccines I had put into her during her life. The vet who will ?? gave my cat all the vaccines waited until after the shots to tell me how seriously ill she appeared - even showed me a picture of a cat with diabetes who could not stand. This occured within 30-40 minutes after the shot. The vet did not offer any treatment - told me to get out before he charged me for another visit. He said she would die in 2 months and she did. He was very much aware of what he had done. Reid was aware of the adverse drug reaction before he even gave her the 2 shots.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	30-40 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:	Pooh	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese Mix	Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	16 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	

*Name:	R. Michael Reid	Name	(b)(6)
Address:	Animal Health Center 5341 North Glenstone Avenue	Address	
City:	Springfield	City	
State:	MO	State:	MO
Zip:	65803	Zip:	(b)(6)
*Phone:	417-833-3122(XXX-XXX-XXXX)	Phone:	XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	02/02/2009(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 02/02/2009
Verified:yes
Reviewed:yes
Date Entered: 05/12/2009
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09225
Product Code: 1905.24 16D5.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 1	189	S831727D	☒ Viral
2 Fel-O-Vax PCT	112	162325A	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R rear	25	04/11/2009
2 1 ml	SQ	R shoulder	25	04/11/2009
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/11/2009
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
vomiting and collapse. Poor perfusion of capillaries. No initial response to benedryl and dexamethasone sp. Iv catheter placed and shock fluids run(LRS). Vomiting continues, high heart rate, epi sq given. Vomiting slows but blood present. Metoclopramide given after blood tinged vomit. Vomiting stopped and color and perfusion improved. Cat went home after 5 hours.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5-10 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only. last vaccinated as young adult with eclipse 4(Sch/plough) and merial fvrcp- mod. live

Personal Information

Veterinarian		Owner	
*Name:	Tammy Schmitt	Name:	(b)(6)
Address:	Animal Ark 3235 North Kedzie	Address:	
City:	Chicago	City:	

State:	IL	State:	
Zip:	60618	Zip:	
*Phone:	773-442-6500(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	tammyschmitt@comcast.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Tammy
*Submitter's Last Name:	Schmitt
*Submitter's Phone Number:	773-442-6500(XXX-XXX-XXXX)
*Today's Date:	04/16/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/16/2009
Verified:yes
Reviewed:yes
Date Entered: 06/19/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09280
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A902401	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L thigh groin area		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/14/2007
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Oozing sore L dorsal lumbar area 2.5 cm X 2.5 cm serum mulit lobular mass identified firmly attached to underlying ??. Punch biopsy taken histopath - fibrosarcoma

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 yrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	no further treatment will be done

Animal Information

Case Identification:	Rennia - Josephina	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DLH - Himalyan	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	17 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	John Schutz	Name:	
Address:	Pawling Animal Clinic 550 Rte 22	Address:	
City:	Pawling	City:	
State:	NY	State:	
Zip:	12564	Zip:	

*Phone:	845-855-3316(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	John
*Submitter's Last Name:	Schutz
*Submitter's Phone Number:	845-855-3316(XXX-XXX-XXXX)
*Today's Date:	05/18/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/18/2009
Verified:yes
Reviewed:yes
Date Entered: 08/06/2009
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09281
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S720866A	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R lateral thigh		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/16/2008
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Quarter diameter X 1/2 cm firm, irregular, mass on right thigh - surgically removed 4/20/09; biopsy fibrosarcoma.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10-11 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	final outcome pending

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Fumuso-Simba	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	11 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	John Schutz	Name:	
Address:	Pawling Animal Clinic 550 Rte 22	Address:	
City:	Pawling	City:	
State:	NY	State:	
Zip:	12564	Zip:	
*Phone:	845-855-3316(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	845-855-3561		
E-mail:	pawlanclin@aol.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	John
*Submitter's Last Name:	Schutz
*Submitter's Phone Number:	845-855-3316(XXX-XXX-XXXX)
*Today's Date:	05/18/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/18/2009
Verified:yes
Reviewed:yes
Date Entered: 08/06/2009
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09290

Product Code: 1901.R1 1555.R3 16D1.20

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17185A	☒ Recombinant
2 PureVax Recombinant Leukeumia	298	25060	☒ Recombinant
3 Felocell 3	189	A836378A	☒ Viral
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 l ml	SQ	RR Leg, below knee	22	05/22/2009
2 1ml	SQ	RF, below elbow	22	05/22/2009
3 1 ml	Transdermal	L Hip	Vet Jet	05/22/2009
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/22/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Within 10 minutes cat became aggitated and open mouth breathing. Vomited by 25 mins. Gave epinephrine IM. Continued to vomit and gave Dexamethazone and Diphenhydramine along with Oxygen by mouth. Sent cat home after 1 hour. An hour later started breathing hard again and aggitated, went to EC for fluids and observation over night. Is normal now.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Feline	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	18 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Adopted from shelter 1 year ago. FVRCP, FELV and Rabies give last year.

Personal Information

Veterinarian		Owner	
*Name:	Marybeth Rymer	Name	(b)(6)
Address:	VCA Monte Vista Animal Hospital 1488 Washington Blvd.	Address	
City:	Concord	City	

State:	CA	State:	CA
Zip:	94521	Zip	(b)(6)
*Phone:	925-672-1100(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)
FAX:	925-672-4298		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Marybeth
*Submitter's Last Name:	Rymer
*Submitter's Phone Number:	925-672-1100(XXX-XXX-XXXX)
*Today's Date:	05/27/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/27/2009
Verified:yes
Reviewed:yes
Date Entered: 08/07/2009
CVB Reporter:
Acknowledgement:

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Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09301
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A8247742	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L hind leg	25	05/19/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	05/19/2009
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
The pet owner described lethargy and a decline in appetite. The cat was also walking very slowly with apparent joint stiffness as if painful. The owner declined another exam and treatment, but reported that the cat was back to normal 48 hours later.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	8 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :		Number vaccinated:	2
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Christine Farrar	Name:	
Address:	Countryside Animal Hospital 8701 South Rural Road	Address:	
City:	Tempe	City:	
State:	AZ	State:	

Zip:	85284	Zip:	
*Phone:	480-775-9966(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	480-831-8952		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Christine
*Submitter's Last Name:	Farrar
*Submitter's Phone Number:	480-775-9966(XXX-XXX-XXXX)
*Today's Date:	06/05/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/05/2009
Verified:yes
Reviewed:yes
Date Entered: 08/18/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09338
Product Code: 1901.R1 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17185B	☒ Recombinant
2 Felocell 3	189	A836846B	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Scruff	22	06/29/2009
2 1 ml	SQ	Scruff	22	06/29/2009
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/29/2009
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Excessive vomiting a couple hours post vaccination. Heart-WNL, CRT < 2sec, T102.7, BAR Treatment Dex/Na/P 4mg 1cc IV and Diphenhydramine 8mg IM

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2-3 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Zimmerman	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Himalayan	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Has had both Rabies and Feline vaccines before, however at another clinic so brands are unknown, is on Royal Canin Urinary S033 diet

Personal Information

Veterinarian		Owner	
*Name:	Paul Hintz	Name	(b)(6)
Address:	Heritage Pet Cremation Service 751 West Main	Address	
City:	Hortonville	City	
State:	WI	State:	WI

Zip:	54944	Zip	(b)(6)
*Phone:	920-779-4343(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	920-779-4303		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Nam	(b)(6)
*Submitter's Last Nam	(b)(6)
*Submitter's Phone Number:	920-757-0407(XXX-XXX-XXXX)
*Today's Date:	06/30/2009(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	CVT

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/30/2009
Verified:yes
Reviewed:yes
Date Entered: 09/17/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV09343
Product Code: 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 4	189	A836383A	☒ Combination
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	07/06/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/06/2009
Concurrent Drugs or Procedures:	Exam

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
death

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1 day
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:	Kitty (Black tabby)	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	1
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	8 wks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
stray, brought into house, previously treated for ocular discharge

Personal Information

Veterinarian		Owner	
*Name:	Perry Burros-Lemke	Name	(b)(6)
Address:	Eden Lake Veterinary Service 248 Park Avenue East	Address	
City:	Eden Valley	City	
State:	MN	State:	MN
Zip:	55329	Zip	(b)(6)
*Phone:	320-453-2293(XXX-XXX-XXXX)	Phone	XXX-XXX-XXXX)

FAX:	320-453-2287		
E-mail:	drperry@meltel.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Perry
*Submitter's Last Name:	Burros-Lemke
*Submitter's Phone Number:	320-453-2293(XXX-XXX-XXXX)
*Today's Date:	07/08/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 07/08/2009
Verified:yes
Reviewed:yes
Date Entered: 09/30/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10050
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A838581	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LF leg	22	07/14/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/14/2009
Concurrent Drugs or Procedures:	Rabies vx in right rear leg

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
Butler went home after appointment and was fine that night. The next morning the owner notices limping and that he was holding the left front lef up, and it was also sore when they touched it.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	18 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 yrs 5 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
No vx reaction before. Two other cats in the house.

Personal Information

Veterinarian		Owner	
*Name:	Melissa Caid	Name	(b)(6)
Address:	Valley Veterinary Hospital 3210 Main Avenue	Address	
City:	Fargo	City	
State:	ND	State:	ND
Zip:	58103	Zip	(b)(6)

*Phone:	701-232-3391(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Numbe	XXX-XXX-XXXX)
*Today's Date:	08/18/2009(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/18/2009
Verified:yes
Reviewed:yes
Date Entered: 12/14/2009
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10105
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A835664A	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	25	09/11/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/11/2009
Concurrent Drugs or Procedures:	Pyrantel Pamoate

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Approximately 60 hours after vaccine developed a fever of 104.4 degrees. Concurrently became accutely lame (non-weightbearing) on front left leg. Treated with Metacam. Within 8 hours was again weight bearing and fever had decreased to normal. Discharged with additional doses of Metacam and Amoxidrops. Fully recovered.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	60 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Siamese Cross	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	16 wks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
No vaccine history. Owner had recently adopted her from a friend.

Personal Information

Veterinarian		Owner	
*Name:	Kerrie Burns	Name	(b)(6)
Address:	All Paws Animal Hospital 5225 Excelsior Blvd	Address	
City:	St. Louis Park	City	
State:	MN	State:	MN

Zip:	55416	Zip	(b)(6)
*Phone:	952-848-0913(XXX-XXX-XXXX)	Phone	(XXX-XXX-XXXX)
FAX:	952-848-0896		
E-mail:	drkerrieb@allpawsvets.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Kerrie
*Submitter's Last Name:	Burns
*Submitter's Phone Number:	952-848-0913(XXX-XXX-XXXX)
*Today's Date:	10/05/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/05/2009
Verified:yes
Reviewed:yes
Date Entered: 01/19/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10114
Product Code: 16D1.22 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Guard 3	112	117182C	☒ Viral
2 Rabdomun	189	S833627	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LR	22	10/13/2009
2 1 ml	SQ	RR	22	10/13/2009
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/13/2009
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
immediately after vaccinations were administered Kobey began profusely vomiting, developed generalized erythema, angioedema, and swelling of his extremeties

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	immediately
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs 1 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Teri-Lee James	Name:	
Address:	Valley Veterinary Hospital 3210 Main Avenue	Address:	
City:	Fargo	City:	
State:	ND	State:	
Zip:	58103	Zip:	

*Phone:	701-232-3391(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	701-293-6477		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	701-232-3391(XXX-XXX-XXXX)
*Today's Date:	10/13/2009(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Veterinary Technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/13/2009
Verified:yes
Reviewed:yes
Date Entered: 02/01/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10119
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A942319	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LR leg	25	10/16/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/16/2009
Concurrent Drugs or Procedures:	examination

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Cat vomited and experience hypersalivation and open-mouth breathing/panting approximately 20 - 30 minutes post-vaccination. Temperature upon presentation for reaction was 102.8 F. Heartrate = 220 bpm. Treated with cerenia and diphenhydramine subcutaneously.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	20 - 30 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :		Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	9 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
indoor/outdoor; history of previous vaccination with same product 6 times with no adverse effects

Personal Information

Veterinarian		Owner	
*Name:	Rich Armstrong	Name:	
Address:	Animal Hospital of Hinesburg 220 Commerce Street	Address:	
City:	Williston	City:	
State:	VT	State:	

Zip:	05495	Zip:	
*Phone:	802-482-2955(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	ahh@gmavt.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Rich
*Submitter's Last Name:	Armstrong
*Submitter's Phone Number:	802-482-2955(XXX-XXX-XXXX)
*Today's Date:	10/16/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/16/2009
Verified:yes
Reviewed:yes
Date Entered: 02/01/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10138
Product Code: 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 4	189	A941583B	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	Dorsal/Scap	22	10/26/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/26/2009
Concurrent Drugs or Procedures:	Rabies (Merial)

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
3 kittens from same litter vaccinated 10/26/09; 3 days post vax, 1 kitten presented very lethargic, off feed, temp 107, PE=NSF else found. TX - SQ fluids, penicillin, dexamethasone. Owner reports died @ home 10/30/09. Other 2 kittens presented 11/2 weak, unresponsive, temps 106. Treated with Baytril, Pen, Dex. I kitten placed on IV cath. I kitten with sevre edema down both front limbs unable to bend limbs. On 11/4/09, both kittens looking brighter, however kitten with prior edema now has linear areas of necrotic skin ventral chest + limbs that sluff, likely due to vasculitis, secondary to vax reaction.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Other
Other:	1 dead, 2 likely to recover

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	3
(Other Species):		Number affected:	3
Breed :	DSM	Number vaccinated:	3
Sex:	☒ Not Listed	Number dead:	1
Neutered:	☒ Not Listed		
Age (i.e., 2 yrs or 2 mos):	17 wks		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
nothing out of ordinary, healthy when presented.

Personal Information

Veterinarian		Owner	
*Name:	Tanya Jackson	Name	(b)(6)
Address:	Eastview Veterinary Clinic	Address	

	1260 State Route 14A		
City:	Penn Yan	City	(b)(6)
State:	NY	State:	NY
Zip:	14527-9182	Zip	(b)(6)
*Phone:	315-536-9871(XXX-XXX-XXXX)	Phone	XX-XXX-XXXX)
FAX:	315-536-8297		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Tanya
*Submitter's Last Name:	Jackson
*Submitter's Phone Number:	315-536-9871(XXX-XXX-XXXX)
*Today's Date:	11/04/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/06/2009
Verified:yes
Reviewed:yes
Date Entered: 03/05/2010
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10140
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A835256B	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L lateral hip	25	10/05/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/05/2009
Concurrent Drugs or Procedures:	FVRCP vaccine

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
A firm, non-freely movable, 5 mm x 5 mm x 2 mm mass was discovered incidentally on physical exam on 11/03/2009 when the animal presented for rabies vaccine administration. The owner had noticed the lump and felt that it was geting smaller.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	unknown
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
also vaccinated with Leukocell on 09/08/2009 from same serial number with no known reaction

Personal Information

Veterinarian		Owner	
*Name:	Amanda Perkins	Name:	
Address:	The Cat Hospital of Metairie 1500 Veterans Blvd	Address:	
City:	Metairie	City:	
State:	LA	State:	

Zip:	70005	Zip:	
*Phone:	504-837-6137(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	alp42@cornell.edu	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Amanda
*Submitter's Last Name:	Perkins
*Submitter's Phone Number:	504-837-6137(XXX-XXX-XXXX)
*Today's Date:	11/04/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/04/2009
Verified:yes
Reviewed:yes
Date Entered: 03/05/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10141
Product Code: 1555.21
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A835256B	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	L lateral hip	25	09/15/2009
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/15/2009
Concurrent Drugs or Procedures:	FVRCP vaccine

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
A firm, non-freely movable, 5 mm x 5 mm x 2 mm mass was discovered incidentally on physical exam on 11/03/2009 when the animal presented to repeat vaccine administration.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	unknown
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Domestic Long Hair	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	5 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Amanda Perkins	Name:	
Address:	The Cat Hospital of Metairie 1500 Veterans Blvd	Address:	
City:	Metairie	City:	
State:	LA	State:	
Zip:	70005	Zip:	

*Phone:	504-837-6137(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	alp42@cornell.edu	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Amanda
*Submitter's Last Name:	Perkins
*Submitter's Phone Number:	504-837-6137(XXX-XXX-XXXX)
*Today's Date:	11/04/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/04/2009
Verified:yes
Reviewed:yes
Date Entered: 03/05/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10147
Product Code: 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 4	189	A941583C	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/08/2009
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
fever lethargic anorexic ataxia

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	10 days
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Did not recover
Other:	fever down, weak

Animal Information

Case Identification:	pfizer case no. 2009us36578	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	3
(Other Species):		Number affected:	2
Breed :	Mixed	Number vaccinated:	2
Sex:	☒ Not Listed	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	5-6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
one male one female

Personal Information

Veterinarian		Owner	
*Name:	Rusty Gailor	Name	(b)(6)
Address:	Gailor Animal Hospital 7422 3rd Street Road	Address:	
City:	Louisville	City:	
State:	KY	State:	
Zip:	40214-4362	Zip:	
*Phone:	502-367-6400(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	11/09/2009(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/09/2009
Verified:yes
Reviewed:yes
Date Entered: 03/05/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10150

Product Code: 1905.23 16D1.20 1555.R3

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Imrab 3 TF	298	18096C	☒ Viral
2 Felocell 3	189	A839308B	☒ Viral
3 PureVax Recombinant Leukemia	298	25064	☒ Recombinant
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RFront leg	25	10/22/2009
2 1 ml	SQ	RFront leg	25	10/22/2009
3	intradermal	LFront leg	vet jet	10/22/2009
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	10/22/2009
Concurrent Drugs or Procedures:	Revolution 5-15 lbs - applied following vaccination

Event Information

* Event description:	☒ Local

Explain the event and any treatment in a concise paragraph:
owner noted raised swollen not painful mass effect 10-14 day following vaccination of rabies vaccine on right pelvic limb (sets of rabies vaccine). mass had increased in size between 11/3 and 11/5 therefore owner brought patient in to be examined.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	12-14 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Did not recover
Other:	mass effect still present

Animal Information

Case Identification:	09114665	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Indoor only cat. one additional cat (also received vaccines on 10/22/09); no vomiting, diarrhea, cough or sneezing. no previous medical problems or concerns. commercial diet.

Personal Information

Veterinarian		Owner	
*Name:	Jeffrey Najarian	Name:	
Address:	VCA Santa Anita Animal Hospital 245 West Duarte Road	Address:	

City:	Monrovia	City:	
State:	CA	State:	
Zip:	91016	Zip:	
*Phone:	626-359-3281(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	626-305-0512		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Jeffrey
*Submitter's Last Name:	Najarian
*Submitter's Phone Number:	626-359-3281(XXX-XXX-XXXX)
*Today's Date:	11/11/2009(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	group case #09114665

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/13/2009
Verified:yes
Reviewed:yes
Date Entered: 03/05/2010
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10304
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun	189	S835928B	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR	22	11/01/2010
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/02/2010
Concurrent Drugs or Procedures:	Benadryl 0.2mls sq pre-vaccine

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
0.2mls Benadryl given sq prior to vaccination due to previous vaccine reactions. Rabies vaccine given sq. Approximately 3 hours later patient had numerous episodes of vomiting. Administered 0.15mls of Dexamethasone sq and 100mls LRS sq. Monitor rest of day.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	3 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	8 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Previous vaccination reaction (rabies and distemper given at same time)

Personal Information

Veterinarian		Owner	
*Name:	Derine Winning	Name:	(b)(6)
Address:	Valley Veterinary Hospital 3210 Main Avenue	Address:	
City:	Fargo	City:	
State:	ND	State:	ND

Zip:	58103	Zip	(b)(6)
*Phone:	701-232-3391(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:	tech@valleyveterinary.net	E-mail	(b)(6)

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	(b)(6)
*Submitter's Phone Number	(b)(6) XXX-XXX-XXXX)
*Today's Date:	03/05/2010(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	LVT and Patient Owner

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 03/05/2010
Verified:yes
Reviewed:yes
Date Entered: 08/27/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10344
Product Code: 1901.R1 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Purevax Feline Rabies	298	17210	☒ Recombinant
2 Felocell 3	189	A945514A	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1				
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/01/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Vomiting started 4 hours later and continued for hours. Eyrethyma of head with small red splotches.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:	Percy Perez	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	2
(Other Species):		Number affected:	1
Breed :		Number vaccinated:	2
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):			

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Martin Tohill	Name	(b)(6)
Address:	Chantilly Animal Hospital 13705 Lee Jackson Highway	Address:	
City:	Chantilly	City:	(b)(6)
State:	VA	State:	VA
Zip:	20151	Zip	(b)(6)
*Phone:	703-802-8387(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:	chantillyvet@gmail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Martin
*Submitter's Last Name:	Tohill
*Submitter's Phone Number:	703-802-8387(XXX-XXX-XXXX)
*Today's Date:	04/02/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 04/02/2010
Verified:yes
Reviewed:yes
Date Entered: 09/08/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10396

Product Code: 16D1.20 1901.R1 1555.R3

* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A942450	☒ Viral
2 PureVax Feline Rabies	298	17208	☒ Recombinant
3 PureVax Recombinant Leukemia	298	25067	☒ Recombinant
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R shoulder	22	04/14/2010
2 1 ml	SQ	RH leg	22	04/14/2010
3 0.25 ml	ID	LH leg	"vet jet" intradermal	04/14/2010
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	04/14/2010
Concurrent Drugs or Procedures:	none

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity
Explain the event and any treatment in a concise paragraph: Face red, especially noted on nose; vommited post vax, red wheal on one pinna	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	20 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	diphyenhydramine 2 mg/kg IM

Animal Information

Case Identification:	Willow	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.): no reaction noted to previous vax, done elsewhere, different manufacturer			

Personal Information

Veterinarian		Owner	
*Name:	Shiri Hoshen	Name	(b)(6)
Address:	VCA Arrighetti Animal Hospital 1882 Plaza del Sur Drive	Address	
City:	Santa Fe	City	
State:	NM	State:	NM
Zip:	87505	Zip:	(b)(6)
*Phone:	505-471-2888(XXX-XXX-XXXX)	Phone:	(b)(6) (XXX-XXX-XXXX)

FAX:	505-438-3991		
E-mail:	shoshen@earthlink.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name:	Shiri
*Submitter's Last Name:	Hoshen
*Submitter's Phone Number:	505-471-2888(XXX-XXX-XXXX)
*Today's Date:	05/10/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 05/10/2010
Verified:yes
Reviewed:yes
Date Entered: 09/23/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10427
Product Code: 1905.24 16D1.20
* Required Fields

Product Information

List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	S838776A	☒ Viral
2 Eclipse 3	165A	206209B	☒ Viral
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	03/25/2010
2 1 ml	SQ	RF leg	25	03/25/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/25/2010
Concurrent Drugs or Procedures:	none,exam

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
vomited and red, inflammed skin with welts; the patient experienced vomiting and red, inflammed skin with welts on its head about 1.5 hours after vax. given diphenhydramine (IM) and dexamethasone (IV) at clinic and then sent home.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	1.5 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 6 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
no previous vaccine reactions

Personal Information

Veterinarian		Owner	
*Name:	Dawn Keenan	Name:	
Address:	Avalon Veterinary Clinic 3520 Avalon Park Blvd., Ste 3	Address:	
City:	Orlando	City:	
State:	FL	State:	
Zip:	32828	Zip:	

*Phone:	407-275-3430(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	407-275-3431		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	407-275-3430(XXX-XXX-XXXX)
*Today's Date:	06/09/2010(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/10/2010
Verified:yes
Reviewed:yes
Date Entered: 09/30/2010
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10428
Product Code: 1905.24
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Rabdomun 1	189	S838776A	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	25	03/22/2010
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	03/22/2010
Concurrent Drugs or Procedures:	none, exam, heartworm, fecal flotation

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
swelling & redness/inflammation; the patient experienced facial swelling and red bumps after vaccination. owner was advised to give benadryl. patient recovered at home.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	later that evening
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DMH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	5 yrs 7 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
no previous vaccine reactions

Personal Information

Veterinarian		Owner	
*Name:	Dawn Keenan	Name:	
Address:	Avalon Veterinary Clinic 3520 Avalon Park Blvd., Ste 3	Address:	
City:	Orlando	City:	
State:	FL	State:	
Zip:	32828	Zip:	

*Phone:	407-273-3430(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	407-273-3431		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ No
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Numbe	XX-XXX-XXXX)
*Today's Date:	06/09/2010(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	technician

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/10/2010
Verified:yes
Reviewed:yes
Date Entered: 09/30/2010
CVB Reporter:
Acknowledgement: yes

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10432
Product Code: 1905.24 16D1.22
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S846249D	☒ Viral
2 Fel-O-Guard Plus 3	112	117182B	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RR leg	23	06/02/2010
2 1 ml	SQ	R shoulder	23	06/02/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/02/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Vomited several time in car on the way home

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15 mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered without treatment
Other:	

Animal Information

Case Identification:	8451	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Milton Crenshaw	Name:	
Address:	Animal Medical Clinic 234 Snelling Avenue South	Address:	
City:	St. Paul	City:	
State:	MN	State:	
Zip:	55105	Zip:	
*Phone:	651-690-1564(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	651-698-9595		
E-mail:	amc234@goldengate.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name:	Michelle
*Submitter's Last Name:	Thielen
*Submitter's Phone Number:	651-690-1564(XXX-XXX-XXXX)
*Today's Date:	06/10/2010(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	CVT

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/10/2010
Verified:yes
Reviewed:yes
Date Entered: 09/30/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV10436
Product Code: 16D8.21 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 PureVax Feline 3	298	66152	☒ Viral
2 Defensor 3	189	S947985C	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF leg	25	06/11/2010
2 1 ml	SQ	RH leg	25	11/01/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/11/2010
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
The client left the hospital the cat vomited and had diahrrea. The owner turned back and the hospital gave treatment for 5 hours. The client returned to the hospital for more treatment.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	15-20-mins
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	Maine Coon mix	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	1 yrs 2 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):

Personal Information

Veterinarian		Owner	
*Name:	Bradley Seaman	Name	(b)(6)
Address:	Greenpoint Veterinary Hospital 111 Nassau Avenue	Address	
City:	Brooklyn	City	
State:	NY	State:	NY
Zip:	11222	Zip	(b)(6)

*Phone:	347-529-4345(XXX-XXX-XXXX)	Phone	(b)(6) XX-XXX-XXXX)
FAX:	347-529-4394		
E-mail:	gpointvet@gmail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number	XXX-XXX-XXXX)
*Today's Date:	06/14/2010(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	Vet Staff

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/14/2010
Verified:yes
Reviewed:yes
Date Entered: 09/30/2010
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11022
Product Code: 16D1.22 1555.21
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Fel-O-Guard 3	112	1186B	☒ Viral
2 Leukocell 2	189	A950128	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LF	22	06/16/2010
2 1 ml	SQ	LH	22	06/16/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/16/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Systemic
Explain the event and any treatment in a concise paragraph: lethargic	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2-3 post vacc. continued through the night and next day
Attending veterinarian's level of suspicion that product caused event:	☒ Low
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs 5 mos		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	Derine Winning	Name:	
Address:	Valley Veterinary Hospital 3210 Main Avenue	Address:	
City:	Fargo	City:	
State:	ND	State:	
Zip:	58103	Zip:	
*Phone:	701-232-3391(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Number:	701-232-3391(XXX-XXX-XXXX)
*Today's Date:	06/17/2010(MM/DD/YYYY)
Relationship to animal:	☒ Not Listed
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 06/18/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11055
Product Code: 1905.24 16D1.22
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S846249D	☒ Viral
2 Fel-O-Guard Plus 3	112	117185C	☒ Viral
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RH	23	07/28/2010
2 1 ml	SQ	RS	23	07/28/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	07/28/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Systemic
Explain the event and any treatment in a concise paragraph: bloody diarrhea, vomiting, difficulty breathing	
If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.	
Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	571	**For animals handled in a group (herd, litter, etc.)**	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs		
History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):			

Personal Information

Veterinarian		Owner	
*Name:	Milton Crenshaw	Name:	
Address:	Animal Medical Clinic 234 Snelling Ave S	Address:	
City:	St. Paul	City:	
State:	MN	State:	
Zip:	55125	Zip:	
*Phone:	651-690-1564(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)

FAX:	651-698-9595		
E-mail:	amc234@goldengate.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ Not Listed
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Numbe	XXX-XXX-XXXX)
*Today's Date:	08/09/2010(MM/DD/YYYY)
Relationship to animal:	☒ Other
Other:	CVT

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 08/09/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11070
Product Code: 1905.24 16E1.20
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S950683B	☒ Viral
2 Felocell 4	189	A052459C	☒ Combination
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R femur	25	09/02/2010
2 1 ml	SQ	R humerus	25	09/02/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/02/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Vomiting, rapid respiratory rate, hyperthermia, erythema and violent licking/chewing of paws

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Ginny	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
No previous vaccine reactions, indoor only cat, no prior health problems, no current medications, lives with one other cat (littermate), a dog and a lovebird, eats Science Diet Indoor Cat food

Personal Information

Veterinarian		Owner	
*Name:	Scott Beeman	Name	(b)(6)
Address:	Adel Veterinary Clinic 619 Greene St.	Address	(b)(6)
City:	Adel	City	(b)(6)
State:	IA	State:	IA
Zip:	50003	Zip	(b)(6)

*Phone:	515-993-4707(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	515-993-4505		
E-mail:	scottbeeman@mediacombb.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	(b)(6)
*Submitter's Last Name:	
*Submitter's Phone Number:	X-XXX-XXXX)
*Today's Date:	D/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/03/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11071
Product Code: 1905.24 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S950683B	☒ Viral
2 Felocell 4	189	A052459C	☒ Combination
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	R femur	25	09/02/2010
2 1 ml	SQ	R humerus	25	09/02/2010
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	09/02/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
Profuse vomiting and vocalization

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	4 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Medium
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Jack	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	4 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
No previous vaccine reactions, indoor only cat, no prior health problems, no current medications, lives with one other cat (littermate), a dog and a lovebird, eats Science Diet Indoor Cat food

Personal Information

Veterinarian		Owner	
*Name:	Scott Beeman	Name:	(b)(6)
Address:	Adel Veterinary Clinic, PC 619 Greene St.	Address:	
City:	Adel	City:	
State:	IA	State:	IA
Zip:	50003	Zip:	(b)(6)

*Phone:	515-993-4707(XXX-XXX-XXXX)	Phone	(b)(6) XXX-XXX-XXXX)
FAX:	515-993-4505		
E-mail:	scottbeeman@mediacombb.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name	(b)(6)
*Submitter's Last Name	
*Submitter's Phone Numbe	XXX-XXX-XXXX)
*Today's Date:	09/03/2010(MM/DD/YYYY)
Relationship to animal:	☒ Owner
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/03/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11081
Product Code: 1905.24
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Defensor 3	189	S947581B	☒ Viral
2			
3			
4			

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	IM	Upper back/neck		
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/16/2010
Concurrent Drugs or Procedures:	

Event Information

* Event description:	☒ Anaphylaxis/Hypersensitivity

Explain the event and any treatment in a concise paragraph:
swollen face, severe itching, vomitating within 2.5 hours of vaccine injection. Indian River Vet office closed, pet taken to after hours clinic in Cheboygan, MI. Given injection & follow-up with predisone tabs for 6 days.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2.5 hrs
Attending veterinarian's level of suspicion that product caused event:	☒ Not Listed
*Outcome (select one):	☒ Died
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	1
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	15 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
single family home, no children, no other pets. on science diet

Personal Information

Veterinarian		Owner	
*Name:	Heidi Dirkse	Name:	(b)(6)
Address:	Indian River Veterinary Clinic 5668 South Straits Highway	Address:	
City:	Indian River	City:	
State:	MI	State:	MI
Zip:	49749	Zip:	(b)(6)

*Phone:	231-238-7022(XXX-XXX-XXXX)	Phone:	(b)(6) XXX-XXX-XXXX)
FAX:			
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Heidi
*Submitter's Last Name:	Dirkse
*Submitter's Phone Number:	231-238-7022(XXX-XXX-XXXX)
*Today's Date:	09/13/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/20/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11095
Product Code: 1555.21
* Required Fields

Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Leukocell 2	189	A948345	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	LL femoral area	25	06/28/2010
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	06/28/2010
Concurrent Drugs or Procedures:	Rabies, FVRCP vaccinations

Event Information

* Event description:	☒ Neoplasia/Cancer

Explain the event and any treatment in a concise paragraph:
Development of noticeable subcutaneous nodule over injection site 9/1/2010. 3 x 3 cm nodule excised 9/15/2010. Histopathology report described spindle cell tumor consistent with fibrosarcoma. Clean but narrow margins.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	2 mos
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	Lily Lutters	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Female	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	8 yrs		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
indoor/outdoor cat; no past pertinent medical history

Personal Information

Veterinarian		Owner	
*Name:	Rich Armstrong	Name:	
Address:	Animal Hospital of Hinesburg P.O. Box 356	Address:	
City:	Hinesburg	City:	
State:	VT	State:	
Zip:	05461	Zip:	

*Phone:	802-482-2955(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	802-482-4262		
E-mail:	ahh@gmavt.net	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Rich
*Submitter's Last Name:	Armstrong
*Submitter's Phone Number:	802-482-2955(XXX-XXX-XXXX)
*Today's Date:	09/22/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 09/22/2010
Verified:yes
Reviewed:yes
Date Entered: 02/15/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11136
Product Code: 16D1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 3	189	A052737A	☒ Viral
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ			08/27/2010
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	08/27/2010
Concurrent Drugs or Procedures:	Revolution

Event Information

* Event description:	☒ Some other event - Describe Below

Explain the event and any treatment in a concise paragraph:
Calicivirus induced polyarthritis. Lethargy, fever, joint pain. Treated with opioid pain medication. 2 of 3 littermates were reported to have been lethargic several days before this kitten was presented; one was lame and one was not. Both of those recovered without treatment within 2 days.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	5 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:	8482	For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	4
(Other Species):		Number affected:	3
Breed :		Number vaccinated:	4
Sex:	☒ Female	Number dead:	0
Neutered:	☒ No		
Age (i.e., 2 yrs or 2 mos):	2 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Litter of 4 acquired as strays, probably about 3 weeks old. Had fleas. All 4 vaccinated for the first time on the same day.

Personal Information

Veterinarian		Owner	
*Name:	Cheryl Yasuda	Name:	
Address:	Three Notch Veterinary Hospital 44215 Airport View Drive	Address:	
City:	Hollywood	City:	
State:	MD	State:	

Zip:	20636	Zip:	
*Phone:	301-373-8633(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:			
E-mail:	fuzzocat@gmail.com	E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	Cheryl
*Submitter's Last Name:	Yasuda
*Submitter's Phone Number:	301-373-8633(XXX-XXX-XXXX)
*Today's Date:	10/26/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 10/26/2010
Verified:yes
Reviewed:yes
Date Entered: 02/18/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page

Adverse Event Report

Pharmacovigilance
United States Department of Agriculture
Center for Veterinary Biologics
510 South 17th Street, Suite 104
Ames, IA 50010
Phone: (515) 232-5785
FAX: (515) 232-7120

Record Number: AIV11170
Product Code: 16E1.20
* Required Fields
Product Information
List ALL immunobiological products used.

*Brand Name or Generic Name	*U.S. Vet. License (Est. No.) or Manufacturer Name	Serial (lot) Number	Type of Product
1 Felocell 4	189	A055660A	☒ Combination
2			☒ [Click arrow for selections]
3			☒ [Click arrow for selections]
4			☒ [Click arrow for selections]

Administration of products.

Dose	Route	Site	Needle Size	Date Reconstituted
1 1 ml	SQ	RF	22	11/16/2010
2				
3				
4				

Administered by:	☒ Veterinarian (or veterinary staff)
*Date of Product Use:(MM/DD/YYYY)	11/16/2010
Concurrent Drugs or Procedures:	None

Event Information

* Event description:	☒ Systemic

Explain the event and any treatment in a concise paragraph:
Patient presented with Temp of 104.5 on 11/27/2010, was lethargic & anorexic at home. Other 7 cats in household were fine. No one else had received the vaccination. Bloodwork run was normal, urinalysis was unremarkable. Supportive care with Meloxicam SQ, Convenia inj, SQ and 150 ml SQ LRS were given. Fever resolved after 3 hrs. Pet went home. Fever returned in 24 hrs. Radiographs taken and unremarkable. Patient placed on IV Fluids, Baytril IV BID for 2 days, Meloxicam given SQ on 11/29/10. Fever again resolved. Patient then placed on Prednisolone and discharged with instructions to monitor temperature at home.

If this adverse event involves a possible lack of efficacy with a rabies product please contact the Center for Disease Control (CDC) at (404) 639-1050.

Onset (How long after product use did the event begin?): (Include Units:mins, hrs, days, wks, mos, yrs)	8 days
Attending veterinarian's level of suspicion that product caused event:	☒ High
*Outcome (select one):	☒ Recovered with treatment
Other:	

Animal Information

Case Identification:		For animals handled in a group (herd, litter, etc.)	
*Species:	☒ Feline (Cat)	Number in group:	1
(Other Species):		Number affected:	1
Breed :	DSH	Number vaccinated:	1
Sex:	☒ Male	Number dead:	0
Neutered:	☒ Yes		
Age (i.e., 2 yrs or 2 mos):	3 yrs 9 mos		

History and Environment (e.g., acquisition, vaccination, and medical histories; housing, diet, contacts, etc.):
Has been indoors since April 2007, no known issues. Housed with 7 other cats. Up to date on Rabies and Distemper

Personal Information

Veterinarian		Owner	
*Name:	John Ammeraal	Name:	
Address:	Whippany Veterinary Hospital	Address:	

	539 Route 10 East		
City:	Whippany	City:	
State:	NJ	State:	
Zip:	07981	Zip:	
*Phone:	973-386-1380(XXX-XXX-XXXX)	Phone:	(XXX-XXX-XXXX)
FAX:	973-386-1154		
E-mail:		E-mail:	

This event has been reported to the manufacturer(s):	☒ Yes
*Submitter's First Name:	John
*Submitter's Last Name:	Ammeraal
*Submitter's Phone Number:	973-386-1380(XXX-XXX-XXXX)
*Today's Date:	11/30/2010(MM/DD/YYYY)
Relationship to animal:	☒ Veterinarian
Other:	

Submit

Contact Scott Taylor if you have any questions regarding adverse events.

Date Received: 11/30/2010
Verified:yes
Reviewed:yes
Date Entered: 02/18/2011
CVB Reporter:
Acknowledgement:

This confirms that your Adverse Event Report has been received by the Center for Veterinary Biologics (CVB). Thank you for submitting this information in your Adverse Event Report. It is information such as this that enables the CVB to monitor the performance of veterinary biologics used in field conditions. If you have additional questions regarding Adverse Event Reporting for veterinary biological products, please visit the CVB. website.<p>CVB Home Page