Hib/MenC - adult use

Immunisation staff should be aware that monovalent Hib vaccine is no longer available and that Hib/MenC vaccine should now be used when protection against Hib and/or MenC is required. The Hib/MenC conjugate vaccine should be administered to all adults with asplenia or splenic dysfunction, 2 doses, 2 months apart. Post bone-marrow transplant patients should receive 1 dose at least 1 year post transplant.

Although the manufacturer’s specifications states that the vaccine is only licensed up to age 2 years, this is because there is insufficient efficacy data for individuals over the age of 2 years (it is not widely used over this age except for a small number of at-risk individuals).

The recommendations of the Joint Committee on Vaccination and Immunisation (JCVI) are built upon the most up-to-date scientific evidence and endorsed by the Department of Health and the Scottish Executive Health Department. The recommendation of the JCVI on this matter, expressed in the new Green Book, is that the Hib/MenC vaccine can be used, where indicated, in individuals of any age.

It is important to note that JCVI recommendations override the manufacturer’s specifications of vaccines, and staff who adhere to the guidance contained within the Green Book are legally covered.

Pertussis - ‘Green Book’ error

Please note that there is a typographical error on page 282 of the Pertussis chapter in the new Green Book. The section refers to the primary immunisation of children under 10 years of age who have completed a primary course (diphtheria, tetanus, polio) but have not received 3 doses of pertussis-containing vaccine.

At the bottom of page 281 it states that these children should be offered one dose of combined DtaP/IPV (Infanrix) or DtaP/IPV/Hib (Pedicel) vaccine to provide some priming against pertussis. At the top of page 282 the next sentence should read: ‘The DtaP/IPV vaccine, which contains a lower dose of pertussis antigen, should only be used as a booster in fully primed children’.

Hepatitis B vaccine - babies

Immunisation staff are reminded that they should not order hepatitis B vaccine for babies from Leverndale hospital pharmacy. The vaccine must be obtained on prescription through primary care.
Hib – management of contacts

Recently a case of invasive Haemophilus influenzae type b (Hib) disease was reported to the PHPU. Household contacts of a case of invasive Hib disease have an increased risk of contracting the disease. Unimmunised children under 4 years are at substantial risk. Older unimmunised, and even immunised children, may also be vulnerable. Depending on the composition of the household, some children may require chemoprophylaxis and vaccination.

Vaccination of household contacts

- Unimmunised/partially immunised children <10yrs - give required number of doses of DTap/IPV/Hib to complete immunisation (doses given 1 month apart)
- Children <1 yr with no history of Hib vaccination but history of 3 doses of DTaP/IPV - give 3 doses of Hib/MenC (1 month apart)
- Children over >1 yr and <10 yrs with no history of Hib vaccination but history of 3 doses of DTaP/IPV - give 1 dose of Hib/MenC

Chemoprophylaxis for household contacts

The following flowchart directs the clinician in establishing the need for chemoprophylaxis in the index case and contacts. The purpose of prophylaxis is to prevent transmission of Hib to at-risk contacts within a household.

Are there household contacts?

- Yes
- No

Are there *at-risk contacts in the household?*

- *Children < 4yrs*”
- *immunosupressed/asplenic individuals (of any age)* 
- *regardless of immunisation status*

- Yes
- No

Rifampicin prophylaxis for “all household contacts and” index case

- + within 30 days of onset in index case
- ** unless treated with Ceftriaxone

Dose

20mg/kg (max 600 mg) once daily for 4 days

The Health Protection Agency (HPA) has reported that cases of wound botulism continue to occur among injecting drug users (IDUs) in the UK. The Centre for Infections received reports of 22 suspected cases in 2006, fewer than in each of the previous two years, with 28 cases reported in 2005 and 40 in 2004. A total of 134 suspected cases have now been reported since the first cases were reported in 2000.

Of the 22 cases in 2006, 18 were in England, three in Scotland, and one in Wales. As with previous years, the majority of individuals were male (73%). The average age was 40 years, which is older than in previous years (demographic information has been systematically collected for cases since 2002).

Nine of the cases in 2006 were laboratory-confirmed either by detection of botulinum toxin in serum or wound tissue or by isolation of Clostridium botulinum from wound tissue. Of these, six cases were identified as type-A toxin, one as type-B and in two cases both type-A and type-B toxins were detected. However, laboratory procedures are insensitive and an unconfirmed laboratory result does not exclude a diagnosis of botulism. Botulinum antitoxin is effective at reducing symptoms if given early in the course of the infection. (In NHSGG&C botulinum antitoxin can be obtained from the pharmacy department at the Royal Infirmary, Glasgow). If clinical symptoms indicate botulism, the clinician should not wait for the results of microbiological testing before administering the antitoxin. C. botulinum is sensitive to benzylpenicillin and metronidazole. Surgical debridement is important to reduce the organism load and avoid relapse after antitoxin treatment.

All of the cases in 2006, where detailed patient information was provided, were admitted to hospital, the majority to intensive care. Only one individual reported that they did not have either a wound, boil or abscess present. Two individuals died, one of whom did not receive botulinum antitoxin. All of the other cases received antitoxin.

All thirteen cases for whom information about drug use was available reported injecting heroin. Wound botulism among injecting drug users has been associated with ‘skin popping’ (subcutaneous injection) and ‘muscle popping’ (intramuscular injection). Of the 12 cases who provided information about their injecting practices, only seven reported skin or muscle popping as their primary or secondary method of drug use. It is possible that the did not report skin popping injected muscle or skin whilst intending to inject intravenously.

If you would like to comment on any aspect of this newsletter please contact Marie Laurie on 201 4933 or at marie.laurie@gghb.scot.nhs.uk