GGNHSB PHPU NEWSLETTER

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New 5-in-1 vaccine

Immunisation staff should now be aware of the forthcoming changes to the vaccines provided for the routine childhood immunisation programme in Scotland. Similar changes are being made in other parts of the UK. These changes are being made following the recommendation of the Joint Committee on Vaccination and Immunisation (JCVI) and will be implemented from 27th September 2004 (see SEHD/CMO (2004) 17) .

There are two changes:

- **Live oral polio vaccine (OPV) will be changed to inactivated polio vaccine (IPV).** The risk of polio infection being brought into the UK is now very low. IPV does not carry any risk of causing vaccine associated paralytic polio that occurred very rarely with OPV.

- **Whole cell pertussis vaccine (wP) will be changed to acellular pertussis vaccine (aP). This** tends to cause fewer adverse reactions than whole cell pertussis vaccines, particularly at the injection site. This new vaccine offers at least the same level of protection as the whole cell pertussis vaccine currently used. Products containing a five-component acellular pertussis vaccine which meet the JCVI recommendation are now available.

In summary :

DTaP/IPV/Hib (diphtheria, tetanus, five-component acellular pertussis, inactivated polio and *haemophilius influenzae* type b vaccine (Pediacel)) will be supplied for primary immunisation. It replaces the DTwP-Hib and OPV vaccines that are currently given.

Please note that the new vaccines provide protection against the same diseases as the vaccines supplied previously. They are given to children at the same ages as the previous vaccines, and an immunisation course started with the previous vaccines can and should be completed with the new vaccine.

Detailed guidance on these new vaccines, including updated advice on contraindications and adverse events, can be found in the revised Green Book chapters which can be accessed on the Health Scotland website. **Immunisation staff are advised to read these revisions as a number of important changes have been made.**

www.healthscotland.com/immunisation.

HIV information leaflet

The information leaflet, 'HIV the Facts', produced by NHS Glasgow, has been translated into 9 languages. These are: Arabic - French - Kurdish - Punjabi - Somali - Swahili - Tamil - Turkish – Urdu.

A small print-run of each of the languages is planned, but in the meantime the information can be requested via PERL (Public Education Resource Library). A PDF file can be provided electronically or hard copies produced and mailed out. The English version of the leaflet has had minor revisions and is available from health promotion stores. PERL Enquiries: 0141 201 4914/4915

IPV for travel

Please note that oral polio vaccine (OPV) will no longer be available for routine use after October 2004. OPV contains live attenuated strains of poliomyelitis virus types 1, 2 and 3 grown in cultures of monkey kidney cells or in human diploid (MRC-5) cells. Td/IPV vaccine should be used where protection is required against tetanus, or diphtheria, or polio in order to provide comprehensive long-term protection against all three diseases. Tetanus/diphtheria (Td) vaccine may still be available but is not recommended because it does not give protection against poliomyelitis.

MRSA in a community setting

The PHPU receives many calls on the subject of MRSA, especially from staff in care homes (formerly nursing and residential homes). A common theme is the contradictory advice care-staff receive from various health-care professionals both within and without the residential facilities. There seems to be misunderstanding of the difference between colonisation and infection compounded by a failure to appreciate that management of MRSA colonisation in a hospital is different from that in a lower-risk community setting.

To avoid unnecessary isolation of residents, health-care professionals are encouraged to refer to the most recent guidelines in the Department of Health's advisory leaflet for management of MRSA in care homes. Unfortunately, this document is only available on line although the PHPU has some hard copies available. www.doh.gov.uk.

Pneumococcal policy 2004/05

The arrangements for 2004/05 build on last year's successful programme which saw a high up-take of the pneumococcal vaccine in the over-65-years group. Early estimates indicate an uptake of around 65% based on doses distributed and there is encouraging preliminary evidence that the campaign may have contributed to a reduction in the incidence of invasive pneumococcal disease in the over-65-yrs age group.

From 1st April this year, the new cohort of patients who are or will become 65 before 31st March 2005 and who have not previously been immunised, as well as eligible others who did not take up the opportunity last year, should be offered pneumococcal vaccine.

Pneumococcal vaccine continues to be recommended for certain "at risk" groups under 65 years of age. On the recommendation of JCVI, pneumococcal **conjugate** vaccine should now be recommended for "at risk" children **under 5 years of age** rather than under 2 years as previously recommended. The clinical risk groups recommended for pneumococcal immunisation have also been revised. The two new risk groups are :

- Individuals with CSF shunts
- Children under 5 years of age who have previously had invasive pneumococcal disease such as pneumococcal meningitis or bacteraemia. This is because these children may have an unrecognised condition such as congenital asplenia that may make them more susceptible to pneumococcal infection.

Tables 1 and 2 summarise the vaccine regimes for 'at risk' children presenting between birth and 5 years of age, with and without a history of previous polysaccharide vaccination. The minimum age for conjugate vaccination is 2 months.

Vaccine regime for under-5s 'at risk'

Table 1 No history of polysaccharide vaccine

Age of child at presentation		
2-6mnths	**7-11 mnths**	**12-60mnths**
Conjugate vaccine regime		
Dose 1	**Dose 1**	**Dose 1**
1 month gap	1 month gap	2 month gap
Dose 2	**Dose 2**	**Dose 2**
1 month gap	1 month (min)	-
Dose 3	**Dose 3** (after 1st birthday)	**not required**
1 month (min)	-	-
Dose 4 (after 1st birthday)	**not required**	**not required**
Followed by polysaccharide regime * at least two months after last dose of conjugate vaccine		
*** Single dose (at age 2)**	*** Single dose (at age 2)**	*** Single dose (at/over age 2)**

Please note that those with asplenia, splenic dysfunction or nephrotic syndrome require to be re-immunised every 5 years.

Table 2 Previous history of polysaccharide vaccine

Conjugate vaccine regime Children over *2 years and under 5 years	
Dose 1	✓ (at least 2 months after polysaccharide)
Dose 2	✓ (at least 2 months after dose 1)

* only children over 2 yrs. could have a previous history

A single pneumococcal vaccination offers long lasting protection against invasive pneumococcal disease and unlike flu vaccination does not need to be given annually.

Unlike influenza vaccination, pneumococcal vaccination can be given at any time of year.

Influenza policy 2004/05

Following advice from the Joint Committee on Vaccination and Immunisation (JCVI), the influenza immunisation policy for 2004/05 remains unchanged but there will be greater emphasis on the patients in the "at risk" groups from 6 months and under 65 years including the younger "at risk" groups and "at risk" children. The uptake target for those aged 65 years and over will remain at 70%

JCVI has recommended that uptake in risk groups under 65 years of age be brought up to this level. For this first year we are aiming at 60% uptake for "at risk" groups under 65 years. As in previous years, SCIEH will monitor vaccine uptake.

A national publicity campaign will be launched in late September.

Avian 'flu in Vietnam

Three fatal human cases of avian influenza have now been laboratory-confirmed in the recent outbreak in Vietnam. For two of these cases, further testing has identified the H5N1 strain as the causative agent. The most recent case died on 6 August and no new cases have been identified since then.

With support from the Ministry of Health in Vietnam, arrangements are under way to send specimens from these cases to a laboratory in the WHO Global Influenza Surveillance Network. The laboratory will perform gene sequencing and other analyses of the virus in order to yield information immediately relevant to assessment of the public health risk.

Studies will determine whether the virus responsible for these cases has mutated. It is particularly important to learn whether the H5N1 virus strain remains entirely of avian origin.

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