Incomplete and unscheduled immunisations

Q **A child has come from overseas/ was not brought for vaccines when younger, what vaccinations should I give now?**

A The principle behind which vaccines to give now, is to give a schedule which provides necessary protection, and brings the child in line with the UK routine schedule as quickly as possible with the minimum number of visits. If there is no reliable history of vaccination, the flow chart should be followed.
Children coming from developing countries will probably have received a measles-containing vaccine in their country of origin but may not have received mumps or rubella vaccines

The PHE incomplete/unscheduled immunisations flow chart provides the details of how to achieve this, depending on the age of the child.

Q **Do I need to repeat vaccine doses given previously?**

A If there is clear evidence that a vaccine dose has been given, there is no need to repeat that dose

Q **Do I need to restart a course if doses were delayed/not given?**

A No, generally there is no need to restart a course, just start from the point the previous course had been interrupted. There are a small number of exceptions to this, notably oral typhoid and cholera vaccines.

Q **Where do I find the routine immunisation schedules for other countries?**

A Routine schedules for most countries can be found on the WHO website

(To identify the routine vaccines in a specific **country** select it from the Drop down list, **select all vaccines** and press **ok).** However, just because a vaccine is listed on the schedule, it cannot be assumed that this was the schedule in force at the time an individual was vaccinated, nor that any individual received any particular vaccine without clear documentation of vaccination.

General contra-indications

Q **Are there any contraindications which apply to *all* vaccines?**

A There are only two absolute contraindications that apply to all vaccines

- Confirmed anaphylactic reaction to a previous dose of a vaccine containing the same antigens
- Confirmed anaphylactic reaction to another component of the vaccine.

There may be further contraindications for specific groups so the relevant Green Book Chapter/PGD should always be checked.

Q **What are the additional contraindications that apply to live vaccines?**

A Live vaccines may be contraindicated in those who are:

- Immunosuppressed
- Pregnant

Q There are many misconceptions around contraindications – what situations are NOT contraindications?

A The following are **not** considered contraindications:

- family history of any adverse reactions following immunisation
- previous history of the disease (with the exception of BCG for people who have evidence of past exposure to tuberculosis)
- contact with an infectious disease
- premature birth
- stable neurological conditions such as cerebral palsy and Down's syndrome
- asthma, eczema or hay fever
- mild self-limiting illness without fever, e.g. runny nose
- treatment with antibiotics or locally acting (e.g. topical or inhaled) steroids
- child's mother or someone in the household being pregnant
- currently breast-feeding or being breast-fed
- history of jaundice after birth
- under a certain weight
- being over the age recommended in the routine childhood immunisation schedule
- personal history of febrile convulsions or epilepsy
- close family history (parent or sibling) of febrile convulsions or epilepsy
- being a sibling or close contact of an immunosuppressed individual
- recent or imminent elective surgery
- imminent general anaesthesia
- unknown or inadequately documented immunisation history

(Whilst these are not contraindications, there may be precautions for specific vaccines. Check the appropriate Green Book chapter/PGD)

Q Some vaccines are contraindicated in specific groups – which vaccines and in which groups?

A Influenza and yellow fever vaccines are the only vaccines that are contraindicated for people who have a history of a severe (anaphylactic) allergy to eggs.

Individuals who have egg allergy may be at increased risk of reaction to some influenza vaccines.

Green Book Chapter 19 contains detailed information on administration of influenza vaccine in these patients.

Q Is there a risk of potential exposure during administration of the live influenza vaccine (LAIV) to children and health care workers?

A The PHE document, Information for head teachers and health care workers about the nasal flu vaccine and viral shedding (2015) outlines specific information on potential exposure during administration of the live flu vaccine and viral shedding post vaccination, to children with a weakened immune system and health care workers.

Excluding immunocompromised children from school during the period when LAIV is being offered is not necessary. The only exception to this would be a small number of children who are extremely immunocompromised (e.g. those who have just had a bone marrow transplant). These children are normally advised not to attend school anyway because of the higher risk of being in contact with other childhood infections that spread in schools.

Health care workers who are immunocompromised and those who are pregnant can safely administer the vaccine. As a precautionary measure, however, very severely immunocompromised healthcare workers should not administer LAIV.

Q Are there any considerations to be given to a person's religious beliefs when offering Fluenz® nasal spray vaccine?

A The nasal spray contains a highly processed form of gelatine derived from pigs. Although acceptable by some faith groups, there is considerable diversity in the Muslim community.
An information leaflet for the Muslim community regarding the flu vaccine for children, Fluenz® nasal vaccine, and pork gelatine, is available on the link.

Q How do I report an adverse reaction to a vaccine?

A All medicines can cause side effects. The Yellow Card Scheme is vital in helping the MHRA monitor the safety of all healthcare products in the UK including vaccines, blood factors and immunoglobulin. Suspected adverse reactions (ADRs) to vaccines should be reported via the Yellow Card Scheme

Chapter 9 of the Green Book gives detailed guidance on which ADRs to report and how to do so.

Additionally, Green Book Chapter 8 of the Green Book provides detailed advice on managing ADRs following vaccination.

Pregnancy and post-natal period

Q Which vaccines should be offered to pregnant women?

A All pregnant women should be offered the seasonal flu vaccine (any stage during pregnancy), and pertussis containing vaccine (ideally between weeks 16 and 32, but can be given up to two months after delivery if missed during pregnancy).

Q A woman had pertussis containing vaccine during her last pregnancy, does she require to have it in a subsequent pregnancy?

A Yes. The principle aim of the vaccination programme is to provide passive immunity to the unborn child, by inducing maternal antibodies which cross the placenta. The recommended vaccination period is chosen to maximise the amount of antibody that crosses the placenta.

From 1st April 2016, pertussis containing vaccine should be offered to pregnant women from 16 weeks gestation, ideally after their foetal anomaly scan (usually at around 20 weeks). It is
recommended that women should be offered the vaccine between gestational weeks 16 and 32 to maximise the likelihood that the baby will be protected from birth

Women may still be immunised after week 32 of pregnancy until delivery but this may not offer as high a level of passive protection to the baby however, if not vaccinated earlier in pregnancy, vaccinating the mother between 38 weeks and two months **after** delivery will provide some extra protection by reducing the risk of the mother contracting pertussis

Q Are there any vaccines which should not be given to pregnant women?

A There is a theoretical concern that vaccinating pregnant women with live vaccines may infect the foetus. There is no evidence that any live vaccine (including rubella and MMR) causes birth defects. However, since the theoretical possibility of foetal infection exists, live vaccines should generally be delayed until after delivery.

Since inactivated vaccines cannot replicate they cannot cause infection in either the mother or the foetus. However, inactivated vaccines should be administered to pregnant women only if protection is required without delay.

Q Ante-natal rubella testing shows the patient is rubella non-immune – what action needs to be taken?

A Since 2016, the routine antenatal testing of women for rubella susceptibility ceased. Pregnant women should have their vaccine status checked during or after pregnancy, for example at the post-natal check, and be offered any outstanding doses of MMR soon after delivery. Satisfactory evidence of protection would include documentation of having received two doses of rubella-containing vaccine.

Q The mother of a baby, presenting for their primary immunisations, was receiving immunosuppressive treatment while pregnant. Should rotavirus, a live vaccine, be administered?

A As a precaution, any infant who has been exposed to immunosuppressive treatment from the mother either in utero during pregnancy or via breastfeeding should have any live attenuated vaccination deferred for as long as a postnatal influence on the immune status of the infant remains possible. In the case of in utero exposure to TNFα antagonists and other biological medicines, this period should be until the infant is aged 6 months. The other routine vaccines should be given.