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.