County of San Diego

PHYSICIANS' BULLETIN

Health and Human Services Agency ◆ P.O. Box 85222, San Diego, CA ◆ 92186-5222 www.co.san-diego.ca.us/cnty/cntydepts/health

January 2002 *"Focusing on Families as Our Customers"* **No. 435**

National Health Survey To Begin Here In January

The national Health and Nutrition Examination Survey (NHANES) is a program of studies designed to assess the health and nutritional status of adults and children in the US. The survey will be conducted in San Diego County from January 23, 2002 through March 29, 2002. A sample of 539 people will be asked to participate.

Interviews are conducted in the home and standardized medical examinations will be done at a mobile site on the Del Mar Fair grounds.

Adolescent health, nutrition and fitness will be addressed. Specific tests and procedures will vary with age of participant. Participants will receive results of the examination and be advised to consult with their doctor if evaluation is merited.

This survey has been done in San Diego County several times in years past. Results are aggregated for each region of the country, but not by county. The county sample is too small to be generalizable locally. It is usually many months before results are published, although they may be used by federal programs to direct research, or to design or modify programs.

CBCBCBCBCB

Updated Immunization Information for 2002

Preteen Vaccine Informational Materials Available

January 20-26, 2002 is Preteen Vaccine Week. The purpose of this statewide observance is to alert families and health care providers that adolescents need immunizations to protect them against diseases like hepatitis B. Providers are encouraged to utilize vaccine-seeking behavior by preteens to promote the adolescent checkup and to screen for all needed vaccines (Hep A, Hep B, VAR, MMR #2 and Td) and to alert parents that vaccine coverage often disappears at age 18. To order informational materials in English and Spanish (illustrated on page 3) at no charge, call (619) 692-8663.

Updates on other vaccine shortages/ delays

Td Vaccine: The manufacturer indicates that the Td vaccine shortage (see Physicians' Bulletin #430, April 2001) will likely continue at least to the summer. School exemption notices should no longer be dated February 2, 2002, but rather no later than October 1, 2002.

DTaP Vaccine: Spot shortages of DTaP vaccine continue from the two U.S. manufacturers. Guidelines for use remain as recommended in Physicians' Bulletin #430.

MMR and VAR Vaccine: Due to manufacturer modifications last fall, shipping delays are occurring. Providers can expect a 3-4 week delay in January. This should improve over the coming months.

Updated Recommendations For Using Pneumococcal Conjugate Vaccine During a Shortage

(Note:this information was excerpted from an article in the Dec.21, 2001 issue of Morbidity and Mortality Weekly Report [MMWR]. For the full text, including references, please see that issue--the article is on pp. 1140-42.)

Because the duration of the pneumococcal conjugate vaccine shortage has been longer and more severe than anticipated, the Advisory Committee on Immunization Practices (ACIP) has revised its earlier recommendations to healthcare providers. New recommendations continue to advise providers to conserve vaccine by decreasing the number of doses administered to healthy infants rather than to leave some infants unvaccinated. All healthcare providers should reduce the number of vaccine doses used and ordered, regardless of their current supply, so that vaccine is more widely available until supplies are adequate.

Under a full vaccination schedule, approximately 1.5 million doses are needed per month. The manufacturer anticipates the distribution of approximately 1.2 million doses per month during November 2001–March 2002 (86%) and approximately 2.0 million doses per month during April 2002–mid-2002 (142%).

Until adequate supplies are available,

(continued on reverse)

ACIP recommends the following:

1. For high-risk infants and children <5 years of age, providers should follow the schedule as routinely recommended, with no change in number or timing of doses. High risk children include those with sickle cell disease and other hemoglobinopathies; anatomic asplenia; chronic diseases (e.g., chronic cardiac and pulmonary disease, and diabetes); cerebrospinal fluid leak; human immunodeficiency virus infection and other immunocompromising conditions; imunosuppressive chemotherapy or long-term systemic corticosteroid use, and children who have undergone solid organ transplantation.
2. Low to moderate risk children aged 24 to 59 months should have their doses deferred due to the vaccine shortage. Moderate risk 24-59-month children include *all* children 24-35 months of age without a high-risk condition plus the following special category children aged 36-59 months who: are African American, Native American/Alaskan Native, attend a childcare facility greater than four hours per week, live in crowded or substandard housing, or have history of severe or recurrent otitis media or prior or current tympanostomy tube(s).
3. Healthy infants and children aged <24 months should receive a decreased number of pneumococcal conjugate vaccine doses on the basis of the age at which vaccination is initiated and the estimated amount of vaccine available to the healthcare provider's practice (see table above right). On the basis of birth cohort size and recent experience with vaccine supply, if healthcare providers estimate a shortfall of <25% of the 4-dose infant schedule, a moderate shortage schedule is recommended. If estimates suggest a greater shortfall, the severe shortage schedule is recommended. If shortages are estimated to be more severe (>50%), healthcare providers should set infant vaccination priorities based on the assessment of risk, deferring infants at lowest risk. Demographic risk factors for invasive infections include being black or American Indian; exposure risk factors include not breastfeeding and attendance at out-of-home child care.Limited data support a 2-dose schedule among infants; this regimen is preferable to vaccinating some children with 3 doses and not vaccinating others.
4. Health-care providers should maintain a list of children for whom conjugate vaccine has been deferred so that it can be administered when the supply allows. The highest priority for vaccination among children who have been deferred is infants vaccinated with 2 doses. Infants who have received 3 doses and are eligible for a fourth dose would be a second priority group.

Because data are limited on the long-term efficacy of a 3-dose or 2-dose vaccine regimen for young infants, health-care providers are encouraged to report invasive pneumococcal disease following pneumococcal conjugate vaccine through usual disease reporting procedures (CMR fax reporting 619-515-6644 or phone 619-515-6620). If pneumococcal

(continued on next page)

Recommendations for pneumococcal conjugate vaccine use among healthy children during moderate and severe vaccine shortages (ACIP, 2001)

Age at first vaccination	No shortage*	Moderate shortage	Severe shortage
<6 months	2, 4, 6 and 12-15 months	2, 4 and 6th months (defer 4th dose)	2 doses at 2-month interval in 1st 6 months of life (defer 3rd and 4th doses)
7-11 months	2 doses at 2-month interval; 12-15 month dose	2 doses at 2-month interval; 12-15 month dose	2 doses at 2-month interval (defer 3rd dose)
12-23 months	2 doses at 2-month interval	2 doses at 2-month interval	1 dose (defer 2nd dose)
>24 months	1 dose should be considered	No vaccination	No vaccination
Reduction in vaccine doses used †		21%	46%

* The vaccine schedule for no shortage is included as a reference. Providers should not use the no shortage schedule regardless of their vaccine supply until the national shortage is resolved.

† Assumes that approximately 85% of vaccine is administered to healthy infants beginning at age <7 months; approximately 5% is administered to high-risk infants beginning at age <7 months; and approximately 10% is administered to healthy children beginning at age 7 to 24 months. Actual vaccine savings will depend on a provider's vaccine use.

The *Physicians' Bulletin* is published on an as-needed basis by the County of San Diego Health and Human Services Agency to provide updated information on health issues of concern to San Diego County's medical community.

Editor
Sandra Ross
(619) 692-8661
P.O. Box 85222, P-511B
San Diego, CA 92186-5222

isolates are available from vaccinated children, the San Diego County Public Health Laboratory can submit specimens to CDC to perform serotyping to determine whether it is a type included in the vaccine.

Immunization Q & A

(The following was excerpted from the Spring 2001 issue [Vol. 5, No. 1] of VACCINATE ADULTS!, a bulletin for adult medicine specialists from the Immunization Action Coalition [IAC]. IAC's website is www.immunize.org.)

By law, when vaccinating adults, must I give Vaccine Information Statements (VISs)?

The National Childhood Vaccine Injury Act requires that a VIS must be given to adult patients or to parents/guardians before administering a vaccine containing diphtheria, tetanus, pertussis, hepatitis B, measles, mumps, rubella, varicella, Hib, polio, or pneumococcal conjugate. A VIS must be provided prior to each dose, not just the first. Providers should be sure they are using the most current version of each VIS. Current VISs and their dates are available from the National Immunization Program website at www.cdc.gov/nip/publications/vis and from IAC's website at www.immunize.org/vis.

Which vaccines should be given before one becomes pregnant? Which vaccines may be given during pregnancy?

Women who intend to become pregnant should have documentation of immunity (either vaccination or serology) to tetanus, diphtheria, measles, mumps, rubella, and varicella. A history of chickenpox is considered adequate evidence of varicella immunity. Hepatitis B immunity is also recommended for women with occupational or behavioral risk factors for hepatitis B virus infection. Verification of rubella immunity is particularly important for women born outside the U.S.where rubella vaccine may not be part of routine childhood immunization. Live virus vaccines should not be given to a woman known to be pregnant or planning to become pregnant in the next 1–3 months, although yellow fever vaccine may be considered under some travel circumstances.Inactivated vaccines and toxoids may be administered to pregnant women for whom the vaccines are indicated. Influenza vaccine is recommended for women who will be in the second or third trimester of pregnancy during influenza season.

If a new employee in a health care setting cannot produce documentation of receiving any dose of MMR, what should be done?

Persons born in or after 1957 who work in health care facilities of any kind and cannot document prior vaccination should receive two doses of MMR separated by at least 4 weeks. Alternatively, serologic testing could determine if the person is immune to measles and rubella. Persons born before 1957 are generally considered immune to measles. However, ACIP recommends that at least one dose of MMR be considered for persons in this age group who do not have documentation of a measles-containing vaccination, history of physician-diagnosed measles, or laboratory evidence of measles and rubella immunity.

Should influenza vaccine be given on a separate visit from other vaccines?

No. Influenza vaccine can be given simultaneously with, or at any time before or after, any other vaccine.

How long does immunity from influenza vaccine last?

Protection from influenza vaccine is thought to persist for a year or less because of waning antibody and because of changes in the circulating influenza virus from year to year.

In which month is it too late to receive influenza vaccine?

Influenza vaccine can be administered whenever influenza is present in the community (generally through the end of March). For maximum protection, flu vaccine should be administered during October through November, prior to the onset of influenza season.

Preteen immunization materials

(see story on p.1)

Baby Shots Schedule
(Spanish on reverse side)

Are You 13-19 Years Old? Get Your Hepatitis B Shots!
(Spanish on reverse side)

Parents of 5th and 6th Graders: Your Pre-Teen Needs Some More Immunizations!
(Spanish on reverse side)