

GP MINI SCRIPT

Vaccine Issue
LATE NEWS: MONITOR MMR SUPPLY
Mumps

You will have received separate letters on the recent upsurge in mumps cases but in summary:

- * Most cases are aged 15-19 years.
- * The following should be offered MMR to complete 2 doses (unless there is a valid contraindication):
Any children or adults aged 5 to 23 years who have not received two MMR immunisations.
- * The Child Health Office

should be informed of all MMR vaccine given to school children up to 17 years inclusive.

- * The 2nd dose of MMR can be given 3 months after the first but it is never too late.
- * We are no longer requesting salivary samples for those born before 1989.

Please continue to notify all cases of mumps.

Thank you for all the work involved!

New Childhood Vaccines

Informal feedback to date suggests the new vaccines are well-accepted with a low incidence of adverse effects.

Infanrix IPV is now available as the pre-school booster and is equivalent to Repevax.

There is no suitable licensed vaccine for primary vaccination or pre-school booster which does not contain

pertussis. Adverse reaction rates are similar with use of vaccines with or without acellular pertussis component.

There is no indication for oral polio vaccine to be used (except in outbreaks of disease under the direction of Public Health).

New vaccine schedule attached.

Caution!

- * Repevax and Revaxis look similar. Check carefully! The packaging will be changed when current stocks are used.
- * Infanrix-IPV is not recommended for primary immunisation.

Tetanus, Diphtheria and Polio For Travel

Td/IPV is recommended if a booster of polio, diphtheria and/or tetanus is required for adult travel, even if this means a repeat antigen within a short time. The evidence is that this leads to a low rate of adverse effects. This problem will lessen with time.

Tetanus Prone Wounds

Existing stocks of Td could be used for administration at the time of a tetanus-prone wound, but will infrequently be the most appropriate choice. Adults who have not completed a 5-dose course of tetanus immunisations are unlikely to have completed a full course of polio either, and therefore it will usually be more appropriate to give Td/IPV.

All children/teenagers over 10, who require tetanus booster at the time of injury, should receive Td/IPV. Note that only those who are not up to date with the routine schedule of vaccines require a tetanus booster in any event. This avoids having to give a teenage (school-leaving) booster just to catch up on the polio component.

See attached information.

New Vaccines And Schools

Patient group directions used in the Trusts for childhood vaccines instruct nurses to refer patients to the doctor where there is a difference between manufacturer's Summary of Product Characteristics and national guidance. This includes patients who have had recent Td when they present for school-leaving booster, or who have had, for example, severe local reactions to a previous dose. These situations are not frequent and will decrease over time. The PGDs will be kept under review as more experience is gained.

Malaria in Dominican Republic and The Gambia

There have been a number of cases of serious and sometimes fatal, falciparum malaria in travellers to the Dominican Republic and the Gambia, from the UK, the rest of Europe and the US.

Malaria is common in these countries - both popular destinations for UK travellers, especially in the winter. Travellers to malarial-risk countries should always be advised of the need for insect-bite avoidance and prophylaxis.

MMR

There were 442 confirmed cases of measles in England and Wales, and 572 notifications in the Republic of Ireland, in 2003. There were no cases of confirmed measles in N Ireland in 2003, but clearly there is a real risk of importation of measles from these geographically close areas. Notifications continued in 2005 but numbers not yet confirmed.

MMR uptake across EHSSB was only 84.9% (at the age of 2) in the July-September 2004 period. This continues to be a concern particularly in those areas with extremely low uptake. Action Team work will continue in 2005. Late MMR vaccination leaves the younger, more vulnerable cohort susceptible for a longer than necessary period of time, and low MMR2 uptake leaves a sizeable susceptible cohort for life. MMR is a safe and effective vaccine. Risks from natural disease far outweigh any risks of MMR vaccine.

'Green Book' new chapters are being placed on the website – <http://www.dh.gov.uk/PolicyandGuidance/HealthandSocialCareTopics/GreenBook/fs/en>.

Patient Group Directions

Patient Group Directions can be a useful tool to allow nursing staff to administer vaccines without the need for an individual prescription from a doctor. They are designed to achieve safe administration of appropriate vaccines at the correct timing. Where patients cannot be immunised under a PGD because they do not fit all the criteria those patients should be referred to the doctor. Frequently immunisation can, and should, go ahead with the doctor's express written instruction.

A group in EHSSB is developing PGD templates for the new childhood vaccines which will be available on a website. We will let you know when they will be available. These are for use in practices for practice nurses where desired. PGDs for Trust employed staff are already available or should be shortly.

Flu Vaccination

Interim figures suggest that uptake of flu vaccine will reach targets this year again, thanks to an enormous effort in primary care. This success is despite the failure of one manufacturer's production of flu vaccine, leaving shortages at the beginning of the programme. Some 90% of orders from practices in N Ireland had been placed with this manufacturer and supplies had to be sourced by DHSSPS in the face of international shortage.

Reminder - Injection sites and needle lengths

For immunisations the anterolateral thigh or deltoid should be used for all intramuscular or deep subcutaneous injections. The anterolateral thigh is probably best used in infants and the deltoid in older children. **The buttock is not recommended.** A needle length of 5/8" is the minimum for all intramuscular or deep subcutaneous injections. There is insufficient evidence to recommend whether a larger (1") needle should be used in infants and young children, but it would seem sensible to do so in children of 5 years or older.

In younger children, a decision has to be made on an individual basis depending on the size of the child. Formal skin disinfection is not necessary before administering immunisations. **(From Royal College of Paediatrics and Child Health (RCPCH) Position Statement on Injection Technique March 2002)**