

NEEDLE TIPS

Visit www.immunize.org for up-to-date immunization information from the Immunization Action Coalition

What's Inside?

Ask the Experts	1
Are you Hooked on IAC's Video of the Week?	2
Vaccine Highlights: Recommendations, licensures ...	4
Influenza Ends Martin McGowan's Life	6
Make Sure Your Family Gets Influenza Vaccine	7
Materials for Your Healthcare Personnel Influenza Immunization Campaign	8
Influenza Materials for Patients and Staff	9
PPSV: CDC Answers Your Questions	10
Give the Birth Dose: Hep B at Birth Saves Lives ...	11
Summary of Child/Teen IZ Recommendations ...	12
Summary of Adult IZ Recommendations	15
IAC's Q&As on Diseases and Vaccines	18
All Healthcare Personnel Need Seasonal and H1N1 Vaccination	24



FEDERAL and
MILITARY
EMPLOYEES

Make the
Immunization Action Coalition

your charity of choice for the
Combined Federal Campaign.

Use agency code

#10612

The Immunization Action Coalition
is a 501(c)(3) charitable organization
and your contribution is tax-deductible
to the fullest extent of the law.

Vital Immunization News from IAC

Where to Get the Latest Updates on 2009 H1N1 Influenza

As was the case when we published the most recent issue of *Needle Tips* in July, the situation regarding H1N1 influenza continues to evolve quickly. The following links will provide the most up-to-date information:

CDC's main H1N1 webpage	www.cdc.gov/h1n1flu
Latest information from CDC	www.cdc.gov/h1n1flu/whatsnew.htm
Guidance for clinicians	www.cdc.gov/h1n1flu/guidance
H1N1 influenza vaccination resources	www.cdc.gov/h1n1flu/vaccination
General information for the public	www.cdc.gov/h1n1flu/general_info.htm
Subscribe to CDC's email updates	www.cdc.gov/emailupdates/index.html

We continue to update our H1N1 information page, www.immunize.org/h1n1, with highlights of officially released information, partner resources, and news and journal articles. New material is posted daily.

Don't Miss an Issue of *Needle Tips*!

If you found this issue of *Needle Tips* as a search result or while browsing www.immunize.org, consider signing up for free notifications of new issues. Each issue contains crucial, up-to-date resources for immunizers. When you sign up to be notified that an issue of *Needle Tips* has just been published, you will have the most current immunization information delivered to you the moment it becomes available.

Subscribe using the form on this page: www.immunize.org/subscribe

Subscribe to IAC Express for Weekly Updates

We also invite you to subscribe to *IAC Express*, our weekly email news and information bulletin. Like *Needle Tips*, this free publication covers developments in immunization science and policy—it is useful for everyone from clinic personnel to public health officials. New ACIP vaccine recommendations, new FDA vaccine licensures, new immunization resources, and other newsworthy items will be delivered directly to your email box. The link above will give you the option of subscribing to *IAC Express* in addition to *Needle Tips*.

Ask the Experts

IAC extends thanks to our experts, William L. Atkinson, MD, MPH, and Andrew T. Kroger, MD, MPH, medical epidemiologists at the National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention (CDC).

Immunization questions?

- Call the CDC-INFO Contact Center at (800) 232-4636 or (800) CDC-INFO
- Email nipinfo@cdc.gov
- Call your state health dept. (phone numbers at www.immunize.org/coordinators)

General vaccine questions

If a patient faints following vaccination, should we submit a report to the federal Vaccine Adverse Event Reporting System (VAERS)?

Yes. Any occurrence of medical significance warrants a VAERS report. You can obtain more information about VAERS at <http://vaers.hhs.gov> or by calling (800) 822-7967.

We understand that it is advisable to observe patients for 15 minutes after vaccination—can the patient sit in the waiting room for 15 minutes before leaving or do they have to be observed by a nurse?

Although syncope can occur in anyone, it is more common among adolescents and young adults. It can result in serious injury, and the 15-minute guideline is therefore advised. There are no specific

guidelines as to who should watch the patient. The main goal is to avoid a situation where the patient suffers injury from a fall.

What should we do if we give a dose of vaccine at less than the minimum interval since the previous dose?

If vaccines are given too close together (or to a child younger than the minimum recommended age), it can result in a less than optimal immune response. However, in most instances, a difference of a few days is unlikely to have a negative effect on immune response. With the exception of rabies vaccine, CDC recommends that vaccine doses given 4 or fewer days before the minimum interval or age be counted as valid, unless local or state requirements specify otherwise. If the dose needs to be repeated, the repeat dose should be

(continued on page 19)

IAC's
"Ask the
Experts"
team



William L. Atkinson,
MD, MPH



Andrew T. Kroger,
MD, MPH

(PCV7), wait at least 2 months following PCV before giving PPSV. Although *Haemophilus influenzae* type b (Hib) vaccine generally is not recommended for people age 5 years and older, studies suggest good immunogenicity in patients who have had a splenectomy. Giving 1 pediatric dose of Hib vaccine to these patients who have not previously received Hib vaccine is not contraindicated. Ideally, PPSV, meningococcal, and Hib vaccines should be administered

at least 2 weeks before a scheduled splenectomy, if possible. If vaccines are not administered before surgery, they should be administered as soon as the person's condition stabilizes post-operatively.

Seasonal & H1N1 influenza

In anticipation of H1N1 monovalent vaccine arriving later this fall, CDC recommends that we begin vaccinating with seasonal influenza vaccine now. Does protection from seasonal influenza vaccine decline or wane within 3 or 4 months of vaccination? Should I wait until October or November to vaccinate my elderly or medically frail patients?

CDC recommends that seasonal influenza vaccine be administered to all age groups as soon as it becomes available. Antibody to seasonal inactivated influenza vaccine declines in the months following vaccination. However, antibody level at a point several months after vaccination does not necessarily correlate with clinical vaccine effectiveness. There are no studies that compare vaccine effectiveness according to the month when the vaccination was given. The authors of a recent review on antibody declines among the elderly after vaccination reported, "In conclusion, we found no compelling evidence for more rapid decline of the influenza vaccine-induced antibody response in the elderly, compared with young adults, or evidence that seroprotection is lost at 4 months if it has been initially achieved after immunization." (See Skowronski, et al., *Rapid Decline of Influenza Vaccine-Induced Antibody in the Elderly: Is it Real, or Is It Relevant?* *Journal of Infectious Diseases* 2008;197:490-502). In addition, there is a lack of evidence for late-season outbreaks among vaccinated persons that can be attributed to waning immunity.

Will we be able to administer both the seasonal and H1N1 influenza vaccines at the same visit?

You can in most cases. See the points below.

- You can administer both the inactivated seasonal and the inactivated H1N1 influenza vaccines at the same visit (using separate syringes and sites) or at any time before or after each other.
- You can administer the inactivated seasonal and

live H1N1 influenza vaccines together or at any time before or after each other.

- You can administer the live seasonal and inactivated H1N1 influenza vaccines together or at any time before or after each other.
- Administering both the live attenuated seasonal and the live attenuated H1N1 influenza vaccines at the same visit is NOT recommended because of concerns about competition between the 2 vaccine viruses. If you have only live vaccines for both seasonal and H1N1 influenza available, you should separate the doses of the live vaccines by at least 4 weeks.

How long after someone is vaccinated with seasonal live attenuated influenza vaccine (LAIV) must they stay away from a severely immunosuppressed person (a person who is in protective [reverse] isolation)?

Persons vaccinated with LAIV should avoid contact with any person who is severely immunosuppressed for at least 7 days after receiving LAIV. There are no restrictions on being in contact with any other patients.

When will vaccine for the 2009 H1N1 influenza virus be available?

CDC estimates that approximately 45 million doses of H1N1 influenza vaccine will be available in mid-October. CDC anticipates that approximately 20 million additional doses will be released in each subsequent week. Keep in mind that vaccine availability is driven by a number of variables in the manufacturing process. Once vaccine is available, vaccination should begin immediately.

Is the 2009 H1N1 influenza vaccine experimental?

No. H1N1 influenza vaccine will be available in an inactivated, injectable formulation and a nasal-spray, live attenuated formulation. Neither is an experimental vaccine. The 2009 H1N1 influenza vaccines are made employing the same methods and facilities used annually to produce seasonal influenza vaccine. The vaccines are undergoing additional clinical trials at this time to determine the size of the dose and the number of doses that will be needed for protection.

(continued on page 20)

Needle Tips correction policy

The Immunization Action Coalition works tirelessly to ensure the accuracy of the information we make available. At times, however, mistakes occur. If you find an error, please notify us immediately by sending an email message to admin@immunize.org. We publish notification of significant errors in our email announcement service, *IAC Express*. Be sure you're signed up for this service. To subscribe, visit www.immunize.org/subscribe.

spaced after the invalid dose by the recommended minimum interval. You can look up minimum ages and intervals here: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/A/age-interval-table.pdf.

What vaccines are indicated for someone who has had a splenectomy, and is there concern that they may have a less than optimum response to vaccines?

Regarding which vaccines are indicated: People who do not have a functioning spleen or who have had a splenectomy do not handle encapsulated bacteria well and, therefore, are at increased risk for infection with encapsulated bacteria, especially *Neisseria meningitidis*, *Streptococcus pneumoniae*, and *Haemophilus influenzae* type b. They should be vaccinated with age-appropriate pneumococcal, meningococcal, and possibly Hib vaccines.

Regarding immune response to vaccines: Immunosuppression is not an issue unless the patient has other health issues or treatments that are suppressing the immune system. Their response to vaccination should not be affected by the lack of a functioning spleen.

In addition to receiving their routine vaccinations, children and adults without a functioning spleen who are age 2 years and older should receive 1 dose of pneumococcal polysaccharide vaccine (PPSV) and 1 dose of meningococcal conjugate vaccine (MCV4). However, if the person is age 56 years or older, give meningococcal polysaccharide vaccine (MPSV4). If the person is a child age 2 through 4 years who has recently been vaccinated with pneumococcal conjugate vaccine

How do you stay cool at a ball game?



Sit next to a fan!

Once a 2009 H1N1 influenza vaccine becomes available, who will be targeted to receive the vaccine?

On Aug. 28, 2009, CDC issued recommendations for the use of the 2009 H1N1 influenza vaccine. The recommendations identify 5 initial target groups for H1N1 influenza vaccination. They are (1) pregnant women; (2) people who live with or provide care for infants younger than age 6 months (e.g., parents, siblings, day care providers); (3) healthcare and emergency medical services personnel; (4) children and young adults ages 6 months through 24 years; and (5) people ages 25 through 64 years who have medical conditions that put them at higher risk for influenza-related complications. You can access the complete recommendations at www.cdc.gov/mmwr/pdf/rr/tr5810.pdf.

Why are pregnant women prioritized for vaccination?

Data from early 2009 H1N1 influenza cases in the United States show that pregnant women account for a disproportionate number of deaths, making them a high-priority group for vaccination (see [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)61304-0/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61304-0/abstract)). Also, guidance has been issued for clinicians to promptly treat pregnant women who become infected with the 2009 H1N1 virus with antiviral drugs (see www.cdc.gov/h1n1flu/clinician_pregnant.htm).

Why aren't adults age 65 years and older included as a priority group for the 2009 H1N1 vaccination as they are for seasonal influenza, where they are included as part of the age-50-and-older priority group?

Current studies indicate that the risk of infection, hospitalization, and death from the 2009 H1N1 influenza virus among persons age 65 years and older is less than is the risk for younger age groups. Studies suggest that there is some degree of preexisting immunity to the 2009 H1N1 strains, especially among adults older than age 60 years.

One possible explanation is that some adults in this age group have had previous exposure, either through infection or vaccination, to an influenza A (H1N1) virus. People age 65 years and older are included as a priority group if they live with or care for infants younger than age 6 months or are a healthcare or emergency services provider.

Will H1N1 influenza vaccine be available for healthy people age 25 years and older (who are not in targeted groups)?

Once public health authorities at the local level determine that the H1N1 influenza vaccine demand for the 5 target groups has been met, providers will be notified that they can administer the vaccine to healthy people ages 25 through 64 years. Once demand for H1N1 influenza vaccine among younger age groups is met, vaccination should be expanded to all people age 65 and older.

Once H1N1 influenza vaccine becomes available, should we stop administering seasonal influenza vaccine?

No. Providers should start administering seasonal influenza vaccine as soon as it is available and continue to administer it throughout influenza season, including during the winter and spring months.

If a patient has received the seasonal influenza vaccine, do they need to receive the H1N1 influenza vaccine?

If a patient is in a risk group to receive H1N1 influenza vaccine, they should be vaccinated. Studies suggest that vaccination with seasonal influenza vaccine will not provide protection against the 2009 H1N1 influenza virus.

Will there be a new Vaccine Information Statement (VIS) for the 2009 H1N1 influenza vaccine or can we use the same influenza VIS that have been issued from CDC for seasonal influenza vaccine?

A new VIS will be developed that pertains only to the 2009 H1N1 vaccine. You will find it posted at www.immunize.org/vis when it is available.

We have begun a more aggressive approach to vaccinating our high-risk patients against pneumococcal disease, especially in light of the pending 2009 H1N1 influenza virus pandemic. Do you have any suggestions on how we can improve our system?

Congratulations on your efforts to increase your clinic's vaccination rates against this serious and deadly disease. Health experts have found that influenza predisposes individuals to bacterial community-acquired pneumonia, and studies have shown that this is heightened during influenza pandemics. In June 2009, CDC issued interim guidance for use of 23-valent pneumococcal polysaccharide vaccine (PPSV) in preparation for the upcoming influenza season. Though the interim guidance does not change the groups indicated for PPSV vaccination, it does remind providers that many at-risk people younger than age 65 years and many people who are age 65 and older have not yet been vaccinated—and they need to be. You can find the interim guidance statement at www.cdc.gov/h1n1flu/guidance/ppsv_h1n1.htm.

For more information on PPSV vaccination, including a listing of the high-risk people recommended to be vaccinated, read IAC's professional education sheet "Pneumococcal polysaccharide vaccine (PPSV): CDC answers your questions" (see page 10 of this issue of *Needle Tips* or go to www.immunize.org/catg.d/p2015.pdf).

Other vaccine questions

I understand that the recommendation to give routine Hib boosters at 12–15 months has been reinstated. When did this happen, and how do we catch children up on their doses?

The Hib booster dose was reinstated on June 26, 2009. Here's some background: As you probably know, a shortage of Hib vaccine began in late 2007 when Merck voluntarily recalled certain lots of its PedvaxHIB (Hib) and Comvax (Hib-HepB) vaccines and temporarily suspended production. Healthcare providers were advised to conserve the limited supply of the other Hib-containing products (e.g., sanofi's ActHIB [Hib] and Pentacel [DTaP-Hib/IPV] vaccines) by temporarily deferring the routine Hib booster dose in healthy children. The booster is typically given to children ages 12–15 months. In July 2009, sanofi increased its production of these 2 Hib-containing vaccines such that the supply will be sufficient to reinstate the Hib vaccine booster dose for all children. CDC published "Updated Recommendations for Use of *Haemophilus influenzae* Type b (Hib) Vaccine: Reinstatement of the Booster Dose at Ages 12–15 Months" in the June 26 *MMWR* (www.cdc.gov/mmwr/preview/mmwrhtml/mm5824a5.htm).

About catching children up: CDC does not recommend a mass recall of all children who missed their booster dose. Rather, healthcare providers should administer Hib boosters to all children age 12–15 months who have completed the primary series of Hib vaccine (typically given at ages 2, 4,

To receive "Ask the Experts" by email, subscribe to the Immunization Action Coalition's news service, *IAC Express*. Special "Ask the Experts" issues are published five times per year. Subscribe at

www.immunize.org/subscribe

To find hundreds of "Ask the Experts" questions answered by CDC experts, go online to

www.immunize.org/askexperts

and 6 months). Children who have not yet reached their fifth birthday, and for whom the booster dose was deferred, should be vaccinated at their next routinely scheduled appointment or medical encounter. CDC has posted online guidance, “Hib Vaccine—Q&A for Providers about the Return to the Hib ‘Booster’ Dose,” on its website at www.cdc.gov/vaccines/vpd-vac/hib/faqs-return-to-booster-hcp.htm.

When we give the combination DTaP-IPV/Hib vaccine (Pentacel by sanofi) for the primary series to a child at ages 2, 4, 6, and 15–18 months, the child receives a total of 4 doses of IPV. Does the child still need a booster dose of IPV before entering kindergarten?

Yes. In summer 2009, ACIP updated its recommendations for use of inactivated poliovirus vaccines (IPV), partly in response to the availability of newer combination vaccines (e.g., Pentacel) that include an IPV component. ACIP now recommends that children receive at least 1 dose of IPV at age 4 through 6 years, even if they have previously received 4 doses. The interval between the next-to-last and last dose should be at least 6 months. This means that some children may receive a total of 5 doses, a practice ACIP considers acceptable. This is similar to the recommendation for the last dose in the DTaP series. To view the updated polio vaccine recommendations, go to www.cdc.gov/mmwr/preview/mmwrhtml/mm5830a3.htm.

This summer we saw a 4-year-old child who had a record of only 1 dose of polio vaccine (IPV). I understand that because of his age, he needs only 2 more doses of IPV. Can we give him those doses at 4-week intervals so he can be all caught up by the time he starts school in the fall?

No. In summer 2009, ACIP updated its recommendations for use of IPV to clarify that the interval between the last 2 doses must be at least 6 months. To view the recommendations, go to www.cdc.gov/mmwr/preview/mmwrhtml/mm5830a3.htm.

Can RotaTeq (RV5; Merck) and Rotarix (RV1; GlaxoSmithKline) vaccines be used interchangeably? If so, what schedule should we follow? Will giving 1 formulation alter the schedule for giving the other?

ACIP recommends that the rotavirus vaccine series be completed with the same product whenever possible. However, vaccination should not be deferred because the product used for a previous dose(s) is not available or is unknown. In these situations, the provider should continue or complete the series with the product available. If any dose in the series was RV5, or the vaccine product is unknown for any dose in the series, a total of 3 doses of rotavirus vaccine should be administered. The minimum interval between doses of rotavirus vaccine is 4 weeks. All doses should be administered by age 8 months and 0 days.

What can birthing hospitals do to prevent newborns from “falling through the cracks” (missing the birth dose) and becoming infected with hepatitis B?

The two most important things hospitals can do are (1) develop written policies and procedures for giving the birth dose that are based on the recommendations of CDC, AAP, and AAFP and (2) implement the policies and procedures they’ve developed. By putting this policy into place, hospitals ensure that every newborn will receive the birth dose prior to hospital discharge. You will find guidelines for implementing birth dose policies in CDC’s recommendations on hepatitis B prevention in children, which is available at www.cdc.gov/mmwr/pdf/rr/rr5416.pdf.

Effective hospital policies and procedures include establishing standardized admission orders for administration of hepatitis B vaccine as part of routine medical care of all medically stable infants weighing 2 kg (4.4 lb) or more. You can use IAC’s “Admission Orders for Labor & Delivery and Newborn Units to Prevent Hepatitis B Virus (HBV) Transmission” (www.immunize.org/catg.d/p2130.pdf) as a model in developing your hospital’s admission orders.

Note: According to the CDC recommendations, an order to delay the birth dose until after hospital discharge can be done on a case-by-case basis and only in rare circumstances. Further, it requires that a physician’s order to withhold the birth dose and a copy of the original laboratory report indicating that the mother was HBsAg negative during this pregnancy be placed in the infant’s medical record.

Delivery hospitals should also enroll in the federally funded Vaccines For Children (VFC) program to obtain free hepatitis B vaccine for administration of the birth dose to newborns who are eligible (i.e., Medicaid eligible, American Indian or Alaska Native, underinsured, or uninsured). The VFC information is available at www.cdc.gov/vaccines/programs/vfc/default.htm. In addition, many states have made free hepatitis B vaccine available to all infants at birth to help simplify the process. Call your state health department to find out if

free hepatitis B vaccine is available at birth for all newborns in your state. State health department phone numbers are available at www.immunize.org/coordinators.

We’ve heard there is a new recommendation for giving hepatitis A vaccine to people who will be in contact with recently adopted children. Would you give us the details?

Yes. ACIP voted in February 2009 to recommend vaccination against hepatitis A for all previously unvaccinated people who anticipate having close personal contact with an international adoptee from a country of high or intermediate endemicity during the first 60 days following the adoptee’s arrival in the U.S. In addition to the adoptee’s new parents and siblings, this group could include grandparents and other members of the extended family, caregivers, and healthcare providers. Ideally, the first dose of hepatitis A vaccine should be given to close contacts as soon as adoption is planned but no later than 2 weeks prior to the arrival of the adoptee. A second dose should be given no sooner than 6 months after the first dose.

Who is recommended to receive hepatitis A vaccine?

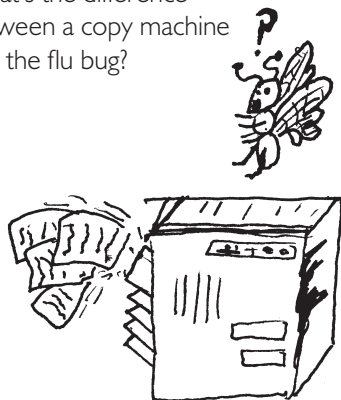
According to CDC, people recommended for vaccination include

- All children at age 1 year (12–23 months)
- People age 12 months or older who are traveling to or working in an area of the world except the United States, Canada, Western Europe, Japan, New Zealand, and Australia
- Men who have sex with men
- Users of illicit drugs, injectable or noninjectable
- Previously unvaccinated people who anticipate having close personal contact with an international adoptee from a country of high or intermediate endemicity during the first 60 days following the adoptee’s arrival in the U.S.
- People who have blood clotting disorders
- People who work with HAV-infected primates or with HAV in a research laboratory setting (no other groups have been shown to be at increased risk for HAV infection because of occupational exposure)
- People with chronic liver disease
- Any person who wishes to be immune to hepatitis A

Hepatitis A vaccine is not routinely recommended

(continued on page 22)

What’s the difference between a copy machine and the flu bug?



One makes facsimiles, the other makes sick families.

Visit IAC’s popular web sections!

Vaccine Information Statements
www.immunize.org/vis

Ready-to-print educational materials
www.immunize.org/printmaterials

IAC’s free periodicals & email news
www.immunize.org/subscribe

for healthcare workers, sewage workers, or day care providers. Children who are not vaccinated by age 2 years should be vaccinated as soon as feasible.

When we vaccinate children age 12–15 months or 4–6 years, should we use a separate MMR vaccine and a separate varicella vaccine, or should we use the combination MMRV vaccine? Does ACIP state a preference?

At its June 2009 meeting, ACIP voted to recommend (1) no preference for use of either the combination MMRV vaccine or the separate MMR and varicella vaccines when giving the first dose to a child age 12–15 months; (2) a general preference for MMRV vaccine (over separate MMR and varicella vaccines) when giving the first dose to a child age 4 years or older; and (3) a general preference for MMRV vaccine (over separate MMR and varicella vaccines) when giving the second dose to a child up through age 12 years. ACIP also voted to include a personal or family history of seizures as a precaution for administering MMRV vaccine. Data from post-licensure studies of administration of the combination MMRV vaccine versus separate MMR and varicella vaccines have suggested an increased risk for febrile seizures in the 1–2 week period after the first dose of MMRV when it is given to children at age 12–15 months.

Would you consider a person with 2 documented doses of MMR vaccine to be immune even if their serology for 1 or more of the antigens comes back negative?

There is no ACIP recommendation for this situation. A negative serology would more likely be the result of an insensitive test than of a true vaccine failure. No more doses are necessary.

When is it appropriate to give both pneumococcal conjugate vaccine (PCV7) and pneumococcal polysaccharide vaccine (PPSV)?

A child who has received pneumococcal conjugate vaccine AND who has a high-risk condition for which PPSV is recommended, should receive PPSV vaccine as long as they are at least 2 years old and it has been at least 2 months since their last dose of PCV7.

I understand a second dose of meningococcal conjugate vaccine (MCV4) is now

recommended for certain people. Please tell me more about this.

When meningococcal conjugate vaccine (Menactra; sanofi pasteur) was licensed in January 2005, data were lacking on long-term efficacy and the need for additional vaccination. Since that time, studies indicate that antibody level declines over time. ACIP voted on June 24, 2009, to recommend a routine second dose of MCV4 for people at highest risk for meningococcal infection. This group includes people (1) with persistent complement component deficiencies, (2) with anatomic or functional asplenia, (3) who are infected with HIV, or (4) who frequently travel to or live in areas with high rates of meningococcal disease (African meningitis belt). Children at continued high risk who received the first dose of MCV4 at ages 2 through 6 years should receive the second dose no sooner than 3 years after the first dose. People at continued high risk who received the first dose of meningococcal vaccine at age 7 years or older should receive the second dose no sooner than 5 years after the first dose. Because MCV4 is licensed only for people through age 55, adults 56 and older should instead receive meningococcal polysaccharide vaccine (MPSV4; Menomune; sanofi), as should people ages 2 through 55 years who have a precaution or contraindication to MCV4. Students living in on-campus housing are not included in the at-risk group to receive second doses of MCV4 vaccine.

Stay current! Subscribe to the Immunization Action Coalition's free weekly email immunization news service, IAC Express.
www.immunize.org/subscribe

Please review the recommended schedule for routine administration of human papillomavirus (HPV) vaccine. In what instances are shorter intervals acceptable?

The recommended dosing schedule is 0, 2, and 6 months. You should make every attempt to adhere to this schedule. However, you can count dose #2 as valid if you inadvertently give it sooner than 2 months after dose #1, as long as at least 4 weeks have passed since you gave dose #1. You must make sure that at least 24 weeks pass between giving dose #1 and dose #3. Similarly, you can count dose #3 as valid if you inadvertently give it sooner than 4 months after giving dose #2, as long as at least 12 weeks have passed since you gave dose #2, and that at least 24 weeks pass between giving dose #1 and dose #3. For detailed information on minimum ages and intervals, see table 1 as published in CDC's "General Recommendations on Immunization" at www.cdc.gov/mmwr/preview/mmwrhtml/rr5515a1.htm?s_cid=rr5515a1_e#tab1.

If an adult has had zoster with herpetic neuralgia ophthalmic complications, when can they receive the zoster vaccine?

Once they are no longer acutely ill, they can be vaccinated with zoster vaccine. There is no evidence that the vaccine will have therapeutic effect for a person with existing postherpetic neuralgia.

I understand that ACIP now recommends fewer doses of rabies vaccine be given in certain post-exposure situations. Can you tell me more?

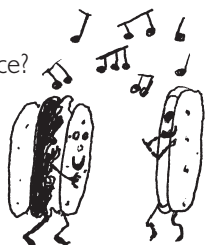
In June 2009, ACIP voted to eliminate the fifth dose of vaccine given as post-exposure prophylaxis to previously unvaccinated persons who are not immunosuppressed. This decision was based on evidence that the elimination of the fifth dose will not compromise immunity. The implications of this change are that it will conserve the supply of rabies vaccine, protect the patient, and reduce the number of office visits. To view the provisional recommendations, go to www.cdc.gov/vaccines/recs/provisional/downloads/rabies-July2009-508.pdf.

We provide vaccinations and health advice for international travelers. I understand that the recommendations for Japanese encephalitis virus (JEV) vaccines have recently changed. Can you explain?

You are probably aware that there had been a shortage of JEV vaccine because JE-Vax (Biken) is no longer being produced. The shortage of vaccine for adults has been alleviated somewhat since the licensure of a second vaccine (Ixiaro, Intercell Biomedical) in March 2009. Ixiaro is given as a 2-dose series to adults age 17 and older. JE-Vax is given as a 3-dose series to people ages 1 year and older. The remaining inventory of JE-Vax is now restricted for use in children ages 1 through 16 years. The revised JEV recommendations will include Ixiaro; the targeted populations (e.g., travelers who plan to spend a month or longer in endemic areas during the JEV transmission season) are the same for both JEV vaccines. CDC is revising the JEV Vaccine Information Statement to reflect the dosing information and age indications for both vaccines; in the meantime, providers can refer patients to the Ixiaro package insert (www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM142570.pdf) for more detailed information on the product.

To view ACIP's provisional recommendations for JEV vaccine, go to www.cdc.gov/vaccines/recs/provisional/downloads/je-july2009-508.pdf.

Where do the hamburger and hotdog like to dance?



At the meatball.

IAC Quicklinks You'll Value!

- www.immunize.org/vis
- www.immunize.org/printmaterials
- www.immunize.org/askexperts
- www.immunize.org/new
- www.immunize.org/concerns