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VACCINATE ADULTS!

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

What's Inside?

Where to Find Resources to Vaccinate Everyone Against Influenza

Starting with the 2010–11 influenza season, CDC is recommending annual influenza vaccination for everyone age 6 months and older. Public demand for vaccination is expected to be high, and manufacturers are planning to produce about 165 million doses of vaccine (see page 7 of this issue).

Following are some excellent resources that will help familiarize you with the new influenza recommendations and available vaccines so you can correctly and efficiently provide influenza vaccine to everyone for whom it is recommended.

Immunization Action Coalition (IAC)

This issue of *Vaccinate Adults* focuses on the materials needed for the 2010–11 influenza season. Click on titles in the table of contents to the left to access specific resources. Note: IAC's website has an enormous range of online influenza resources. See page 2 to learn about them.

Centers for Disease Control and Prevention (CDC)

Find a range of authoritative, continually updated influenza information at www.cdc.gov/flu. Access the 2010 ACIP influenza recommendations at www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.

California Department of Public Health (CDPH)

Just in time for influenza season, CDPH has released "Immunization Techniques: Best Practices with Infants, Children, and Adults," a new 25-minute DVD on how to administer vaccines (see page 5 for pricing and ordering information).

Influenza Vaccine Availability Tracking System (IVATS)

IVATS is an activity of the National Influenza Vaccine Summit, a coalition of organizations that works to resolve issues related to influenza disease and vaccine. IVATS allows providers to find out which vaccine distributors have vaccine available. To access IVATS, go to www.preventinfluenza.org/ivats.

Families Fighting Flu (FFF)

Composed of families and healthcare practitioners, FFF promotes influenza immunization. Healthcare providers may want to share FFF's video with vaccine-hesitant parents. It features two parents who lost their child to influenza and includes photos of other healthy children who died from influenza. To access the video, go to www.familiesfightingflu.org/media.

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).

Vaccine questions

When a vaccine vial is new and the cap has just been removed, is the rubber stopper sterile, or should it be cleansed with alcohol before inserting the needle?

The rubber stopper is not sterile. When you remove the protective cap from a vaccine or diluent vial, you should always clean the stopper with an alcohol wipe. This practice is covered in CDC's online vaccine storage and handling toolkit. To access the kit, go to www2a.cdc.gov/vaccines/ed/shtoolkit.

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)

We're glad that CDC has made a universal influenza vaccination recommendation to vaccinate everyone 6 months and older. Would you tell us how this came about?

Prior to the 2010–11 vaccination season, only children ages 6 months through 18 years and adults age 50 years and older were universally recommended for vaccination; recommendations for adults ages 19 through 49 years were targeted to people with specific risk factors, although other adults could be vaccinated if they wanted protection. Collectively, these targeted risk groups made up 85% of the U.S. population. During the 2009 H1N1 outbreak, additional risk groups were identified, such as obese individuals. The new universal vaccination recommendation simplifies previous recommendations, making it easier for healthcare providers to determine whom to vaccinate. The new recommendation also makes it easier for patients to remember to get vaccinated every year.

Will there be enough influenza vaccine to reach all people ages 6 months and older who want to be protected?

Supplies will be ample and there will likely be enough vaccine available to protect any person seeking vaccination. Vaccine manufacturers have projected supplies at around 165 million doses for the 2010–11 vaccination season. This is a significant increase in the number of doses of seasonal vaccine compared with any previous year. It should be noted that in the past, vaccine has consistently been left over at the end of each influenza season.

What is the appropriate month to begin vaccinating patients against influenza?

You can begin offering vaccine as soon as it becomes available, which is usually mid-to-late summer.

We have heard that ACIP advises waiting until October before vaccinating residents of long-term care facilities because of concern that vaccinating them before October will cause antibodies to wane, which could result in insufficient protection when the disease hits the community later in the influenza season. Is this correct?

ACIP no longer advises this. It made this recommendation in the past, but removed it from the influenza recommendations in 2007 because of lack of evidence. Therefore, you should begin vaccinating everyone, including residents of long-

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To receive "Ask the Experts" Q&As 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 more than a thousand "Ask the Experts" Q&As answered by CDC experts, go to www.immunize.org/askexperts

term care facilities as soon as vaccine becomes available. A literature review of 14 studies that examined this issue is available at www.immunize.org/journalarticles/skowronski_21508.pdf.

Please review which healthcare workers (HCWs) can be given the intranasal live attenuated influenza vaccine (LAIV) and which cannot.

LAIV can be administered to all HCWs for whom it is indicated based on age and health history—except to those who care for severely immunocompromised patients in a protective environment (typically defined as a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and frequent air changes). Despite the clarity of this strong recommendation, we have heard that some healthcare facilities erroneously take extreme measures to protect ALL patients from exposure to someone recently vaccinated with LAIV. Some even restrict visitors from seeing hospitalized patients, allowing only people vaccinated with injectable trivalent inactivated influenza vaccine (TIV) to visit. CDC addressed this issue in the recommendations for use of the 2010–11 influenza vaccine as follows: "Concerns about the theoretic risk posed by transmission of live attenuated vaccine viruses contained in LAIV to patients should not be used to justify preferential use of TIV in health-care settings other than inpatient units that house severely immunocompromised patients requiring protective environments. Some health-care facilities might choose to not restrict use of LAIV in close contacts of severely immunocompromised persons, based on the lack of evidence for transmission in health-care settings since [LAIV's] licensure in 2004." To read more on this topic, see pages 35–37 of "Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices [ACIP], 2010" *MMWR* 2010; 59(No. RR-8):35–37 at www.cdc.gov/mmwr/PDF/rr/rr5908.pdf.

Is it okay to draw up vaccine into syringes at the beginning of the day? If it isn't, how much in advance can this be done?

CDC discourages the practice of prefilling vaccine into syringes for several reasons, including

- the increased possibility of administration and dosing errors,
- the increased risk of inappropriate storage,
- the probability of bacterial contamination since the syringe will not contain a bacteriostatic agent, and
- the probability of reducing the vaccine's potency over time because of its interaction with the plastic syringe components.

Prefilling vaccine into syringes also violates basic medication administration guidelines, which state that an individual should administer only those medications he or she has prepared and drawn up.

Although pre-drawing vaccine is discouraged, a limited amount of vaccine may be pre-drawn in a mass-immunization clinic setting under the following conditions:

- only a single type of vaccine (e.g., influenza) is administered at the mass-immunization clinic setting,
- vaccine is not drawn up in advance of its arrival at the mass-vaccination clinic site,
- these pre-drawn syringes are stored at temperatures appropriate for the vaccine they hold,
- no more than 1 vial or 10 doses (whichever is greater) is drawn into syringes, and
- clinic staff monitor patient flow carefully and avoid drawing up unnecessary doses or delaying administration of pre-drawn doses.

At the end of the clinic day, any remaining vaccine in syringes prefilled by staff should be discarded.

Later on in influenza season, if a patient isn't sure if they received a dose of influenza vaccine and there is no way to check, should we assume they didn't receive it and give them a dose?

Yes.

If a healthcare worker (HCW) receives tetanus-diphtheria-acellular pertussis (Tdap) vaccine and is then exposed to someone with pertussis, do you treat the vaccinated HCW with prophylactic antibiotics or consider them immune to pertussis?

You should follow the post-exposure prophylaxis protocol for pertussis exposure recommended by CDC (www.cdc.gov/vaccines/pubs/pertussis-guide/guide.htm). Research is needed to evaluate the effectiveness of Tdap to prevent pertussis in healthcare settings. Until studies define the optimal management of exposed vaccinated healthcare personnel, or experts arrive at consensus, healthcare facilities should continue post-exposure prophylaxis protocol for vaccinated HCWs who are exposed to pertussis.

Tdap vaccine is licensed for use only in people ages 10–64 years. Are there exceptions for healthcare professionals or grandparents older than age 64 who are in contact with infants?

ACIP has not recommended off-label use of Tdap for adults age 65 years and older. However, there is no reason to believe that Tdap is any less safe for people age 65 years and older than it is for younger adults. Clinicians are always free to use their clinical judgment; they may decide that in this situation the benefit of administering Tdap off-label exceeds any hypothetical risk of giving the vaccine.

How would I follow up with a new healthcare worker (HCW) who has 2 documented doses of measles-mumps-rubella (MMR) vaccine but whose serologic testing doesn't show immunity to one of these diseases?

Two documented doses of MMR vaccine is considered proof of immunity according to ACIP. However, what ACIP recommends is not always what schools and institutions accept. Here are some basics about MMR vaccination and healthcare personnel.

1. ACIP considers receipt of 2 documented doses of MMR vaccine, given on or after the first birthday and separated by at least 28 days, to be proof of immunity to measles, mumps, and rubella. No serologic testing is required or recommended to confirm immunity in this instance.
2. If a HCW does not have any documented doses of MMR, he or she can (1) be tested for immunity or (2) just be given 2 doses of MMR at least 4 weeks apart. If the testing option is used, and the test indicates that the HCW is not immune to one or more of the vaccine components, the HCW should receive 2 doses of MMR at least 4 weeks apart. Note that a test finding of an "indeterminate" or "equivocal" level of immunity indicates that a HCW who lacks 2 documented doses of MMR vaccine be considered nonimmune. Also note, that ACIP does *not* recommend serologic testing *after* vaccination.
3. ACIP does not routinely recommend more than 2 doses of MMR vaccine. A negative serology after 2 documented doses probably represents a false negative (i.e., antibody titer is too low to detect with commercial tests). If a healthcare setting relies on post-vaccination testing to determine immunity, a negative serology can erroneously indicate that a HCW needs additional doses. Remember, ACIP does *not* recommend routine serologic testing after MMR vaccination.

For more information, see ACIP's recommendations on the use of MMR at www.cdc.gov/mmwr/PDF/rr/rr4708.pdf.