

VACCINATE ADULTS!

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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 *Vaccinate Adults* 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 *Vaccinate Adults*!

If you found this issue of *Vaccinate Adults* 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 *Vaccinate Adults* 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 *Vaccinate Adults*, 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 *Vaccinate Adults*.

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)

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.

(continued on page 2)

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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.

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

In late August, CDC announced that approximately 45 million doses of H1N1 influenza vaccine would be available in mid-October with approximately 20 million additional doses released in each subsequent week. On September 15, the FDA licensed three new injectable influenza A (H1N1) 2009 vaccines (CSL, Novartis, and sanofi pasteur) and one new intranasal influenza A (H1N1) vaccine (MedImmune). Package inserts are available at www.immunize.org/package-inserts/pi_h1n1.asp. Once H1N1 influenza vaccine is made available, vaccination efforts should begin immediately.

Is the 2009 H1N1 influenza vaccine experimental?

No. The 2009 H1N1 influenza vaccines are made employing the same methods and facilities used annually to produce seasonal influenza vaccine. H1N1 influenza vaccine will be available in an inactivated, injectable formulation and a nasal-spray, live attenuated formulation. These vaccines have been undergoing clinical trials to determine the size of the dose and the number of doses needed.

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/rr5810.pdf.

Are healthcare personnel among the initial target groups for monovalent H1N1 vaccine?

Emphatically yes. Healthcare personnel are among the highest priority groups for both monovalent H1N1 AND seasonal influenza vaccine. HCP of *all* ages should be vaccinated as soon as the vaccines become available.

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?

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. 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

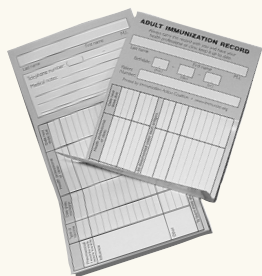
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Vaccinate Adults correction policy

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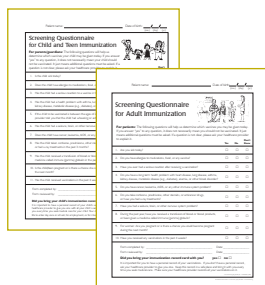
Now you can give any patient a permanent vaccination record card designed specifically for their age group: adult, child & teen, or lifetime. The three cards list all vaccines recommended for each age. The cards are printed on durable rip-, smudge-, and water-proof paper. Wallet-sized when folded, the cards are brightly colored to stand out. To view the cards or for more details, go to www.immunize.org/shop and click on the images.

Buy 1 box (250 cards) for \$37.50 (first order of a 250-card box comes with a 30-day, money-back guarantee). Discounts for larger orders:
2 boxes \$35 each; 3 boxes \$32.50 each; 4 boxes \$30 each

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To receive sample cards, contact us: admininfo@immunize.org

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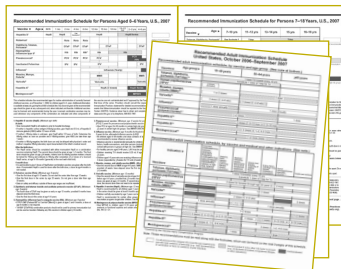
Save valuable staff time and make sure your patients are fully screened by using these simple 1-page questionnaires (one for adult immunization, another for children/teens). Patients respond to questions by checking off "yes" and "no" boxes while waiting to be seen. Staff reviews answers during the visit. These pads are priced at \$16 per 100-sheet pad. Prices drop to \$12 each for 2 pads, \$11 each for 3 pads, \$10 each for 4–9 pads. Keep pads at the receptionist's desk, the nurses' station, and in every exam room. To view the pads or for more details, visit IAC's website at www.immunize.org/shop.

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For 10 or more pads, contact us for discount pricing: admininfo@immunize.org

Laminated adult and child immunization schedules Order one of each for every exam room

Here are the ACIP/AAP/ACOG/ACP-approved immunization schedule for adults and the ACIP/AAP/AAPF-approved schedule for people ages 0 through 18 years. Both are laminated for heavy-duty use, complete with essential footnotes, and printed in color for easy reading. The cost is \$10 for each schedule and only \$6.50 each for five or more copies.



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Use these materials for your healthcare personnel influenza vaccination campaign

Free and CDC-reviewed, they're ready for you to download, copy, and distribute!

For a ready-to-copy
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catg.d/p2014.pdf](http://www.immunize.org/catg.d/p2014.pdf)

First do no harm

Protect patients by making sure all staff receive yearly influenza vaccine!

Healthcare employers are not only strongly encouraged to increase their employees' influenza immunization rates, in some instances, their organization's accreditation depends on it! The Centers for Disease Control and Prevention (CDC) published recommendations for healthcare settings, and the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) has established influenza infection control standards.

Big changes have taken place in influenza vaccination of healthcare personnel (HCP). The responsibility for increasing the rates of HCP influenza vaccination is rapidly shifting from the employee to the employer.

What's happened?

At CDC: In February 2006, CDC published "Influenza Vaccination of Health-Care Personnel." These recommendations "apply to HCP in acute care hospitals, nursing homes, skilled nursing facilities, physician offices, urgent care centers, and ambulatory surgical centers, as well as in long-term care, home healthcare, and emergency medical services." They were issued jointly by HICPAC (the Healthcare Infection Control Practices Advisory Committee) and ACP (the Advisory Committee on Immunization Practices). The summary box in the right column presents an overview, including the new CDC recommendation that all HCP be vaccinated at the work site at no cost. To obtain a copy of the complete recommendations, go to: www.cdc.gov/mmwr/PDF/nr5002.pdf.

At the Joint Commission: In January 2007, a new infection control standard of the Joint Commission for Disease Control and Prevention (CDC) was published. The new standard requires that all HCP be vaccinated at the work site at no cost. To obtain a copy of the complete recommendations, go to: www.cdc.gov/mmwr/PDF/nr5002.pdf.

Practical resources for vaccinating HCP against influenza

Immunization Action Coalition
Read "Influenza Vaccination of Health-Care Personnel" and "Influenza Vaccination of Health-Care Personnel" on the CDC's Influenza web page: www.cdc.gov/ncidod/diseases/influenza/vaccine-to-adults
Get these IAC print materials online:
• "Standing Orders for Administering Influenza Vaccine to Adults" www.immunize.org/catg.d/p2014.pdf
• "Screening Questionnaire for Injectable Influenza Vaccine" www.immunize.org/catg.d/p4066.pdf
• "Screening Questionnaire for Intranasal Influenza Vaccine" www.immunize.org/catg.d/p4067.pdf
• "Declination of Influenza Vaccination" form www.immunize.org/catg.d/p4068.pdf
National Influenza Vaccine Summit (NIVS)
The NIVS is a national summit for healthcare workers and CDC. See the NIVS Healthcare Workers home page: www.preventinfluenza.org/profs_workers.asp
The Joint Commission
"Strategies for Implementing Successful Influenza Immunization Programs for Health Care Personnel" at www.jointcommission.org/PatientSafety/InfectionControl/Influenza.asp
U.S. Dept. of Health & Human Services (HHS)
See the HHS "Health Care Personnel Initiative to Improve Influenza Vaccination Toolkit" at www.hhs.gov/opa/pressroom/04mar08/malware/vaccine0801

Technical content reviewed by the Centers for Disease Control and Prevention, September 2008.

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catg.d/p4068.pdf](http://www.immunize.org/catg.d/p4068.pdf)

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect our patients from influenza disease, its complications, and death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza disease to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including:
 - my patients and other patients in this healthcare setting
 - my coworkers
 - my family
 - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC: Prevention and Control of Seasonal Influenza with Vaccines—Recommendations of ACP at www.cdc.gov/ncidod/diseases/influenza/vaccine-to-adults

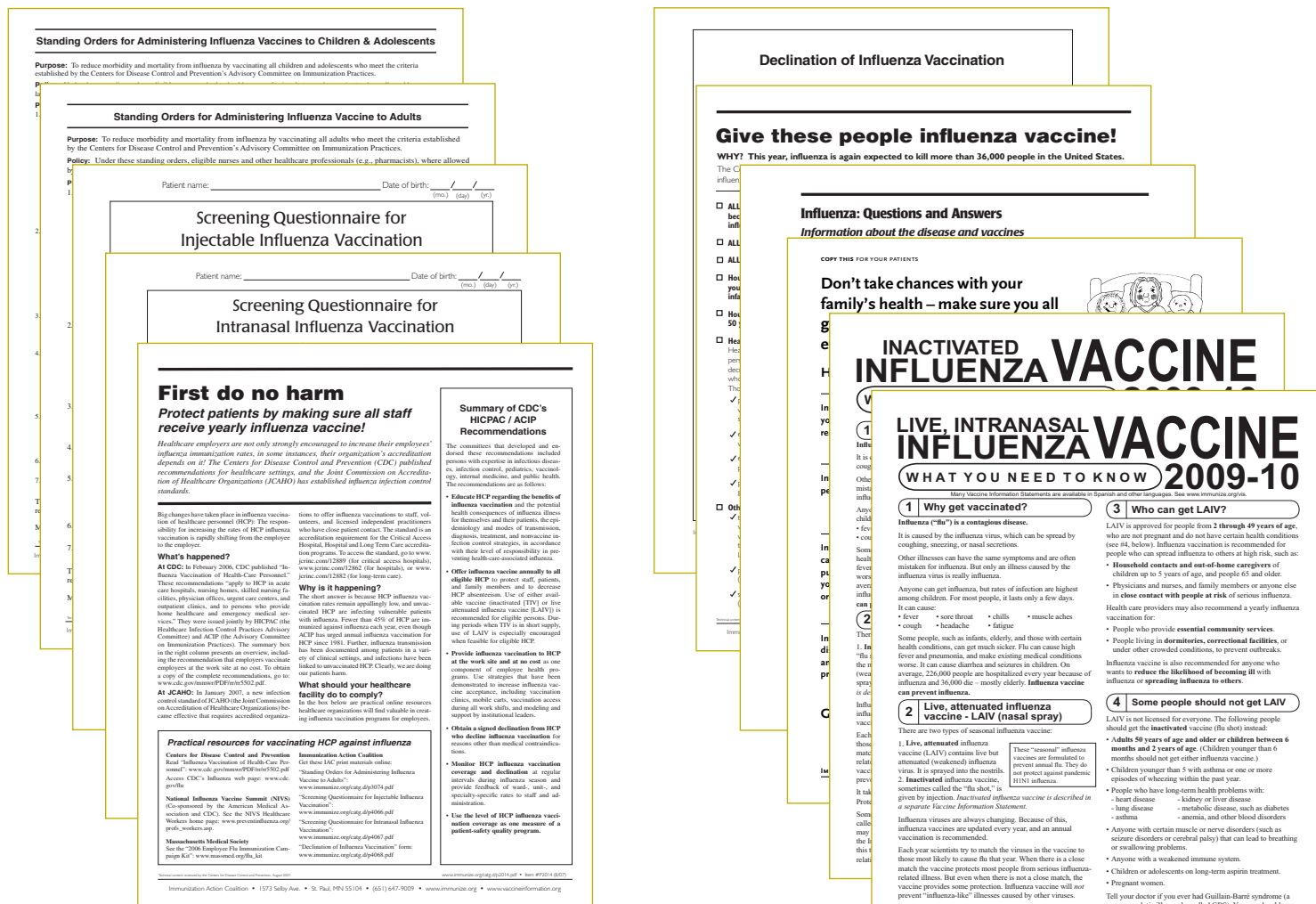
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www.immunize.org/catg.d/p4068.pdf • Item #P4068 (9/09)

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Influenza education materials for patients & staff

Free and CDC-reviewed, they're ready for you to download, copy, and distribute!



For 8-1/2" x 11" copies of the pieces above, visit IAC's website: www.immunize.org

1. Standing orders for administering seasonal influenza vaccines to children & adolescents: www.immunize.org/catg.d/p3074a.pdf
2. Standing orders for administering seasonal influenza vaccine to adults: www.immunize.org/catg.d/p3074.pdf
3. Screening questionnaire for injectable influenza vaccination: www.immunize.org/catg.d/p4066.pdf
4. Screening questionnaire for intranasal influenza vaccination: www.immunize.org/catg.d/p4067.pdf
5. First do no harm: Protect patients by making sure all staff receive yearly influenza vaccine! www.immunize.org/catg.d/p2014.pdf
6. Declination of influenza vaccination (for healthcare worker refusal): www.immunize.org/catg.d/p4068.pdf
7. Give these people seasonal influenza vaccine! www.immunize.org/catg.d/p2013.pdf
8. Influenza: Questions and Answers: www.immunize.org/catg.d/p4208.pdf
9. Don't take chances with your family's health—make sure you all get vaccinated against influenza! www.immunize.org/catg.d/p4069.pdf
10. Federally required Vaccine Information Statements in English and other languages: www.immunize.org/vis
 - Inactivated Influenza Vaccine: What you need to know: www.immunize.org/vis/2flu.pdf
 - Live, Intranasal Influenza Vaccine: What you need to know: www.immunize.org/vis/liveflu.pdf

Pneumococcal polysaccharide vaccine (PPSV)

CDC answers your questions

William L. Atkinson, MD, MPH, and Andrew T. Kroger, MD, MPH, medical epidemiologists with CDC's National Center for Immunization and Respiratory Diseases, answer your questions on pneumococcal polysaccharide vaccine (PPSV).

For complete information on CDC's recommendations for the use of pneumococcal vaccine, go to www.immunize.org/acip

How serious is pneumococcal disease?

An estimated 40,000 cases of invasive pneumococcal disease occur annually. Case-fatality rates are high, particularly when disease results in meningitis (~30%) or bacteremia (~20%). In addition, pneumococcal pneumonia, often a secondary complication of influenza, results in an estimated 175,000 hospitalizations annually.

My patient doesn't have a record of receiving pneumococcal polysaccharide vaccine (PPSV) and can't remember if she has had it in the past. What should I do?

Vaccinate her. People with unknown vaccination status should be vaccinated.

Should all nursing home patients be vaccinated against pneumococcal disease?

Yes. Standing orders for vaccination of persons admitted to long-term care facilities can help simplify the procedure (see suggested standing orders at www.immunize.org/standingorders).

Which additional groups did CDC target in 2008 for vaccination with PPSV?

In 2008, the CDC's Advisory Committee on Immunization Practices (ACIP) reviewed data that showed an increased risk of invasive pneumococcal disease among adults who smoked cigarettes or who had asthma. Consequently, these two groups were added to the categories of adults for whom vaccination is recommended.

My patient has had pneumococcal pneumonia. Is vaccination still necessary for him?

Yes, if he is in a group recommended for PPSV vaccination (see table). More than 90 known serotypes of pneumococcus exist; 23 serotypes are in the current vaccine. Infection with one serotype does not necessarily produce immunity to other serotypes.

Should HIV-positive patients receive PPSV?

Yes. Patients with HIV infection should be given PPSV as soon as possible after diagnosis and a one-time revaccination dose at the appropriate interval (see table). The risk of pneumococcal infection is up to 100 times greater in HIV-infected persons than in other adults of similar age. Although severely immunocompromised persons may not respond well to the vaccine, the risk of disease is great enough to warrant vaccination even though there is a chance that the vaccine may not produce an antibody response.

Can I give other vaccines at the same time I give PPSV to a patient?

Yes. PPSV is an inactivated vaccine, which means you can give all other recommended vaccines at the same visit (using separate syringes) or at any later time with no waiting period following PPSV.

When should I vaccinate patients who are planning to have either a cochlear implant or elective splenectomy?

If time permits, give PPSV to such patients at least 2 weeks before surgery.

What needle length is recommended for administering PPSV to adults?

Pneumococcal vaccine may be given either IM or SC. Use a 1–1½" needle for IM, depending on muscle mass. For SC, use a ⅝" needle.

Some physicians in our area order PPSV every 5 or 6 years for their patients. Is this correct?

CDC recommends 1 dose of PPSV for most people in a lifetime and 2 doses for certain people (see table below). PPSV is a polysaccharide vaccine that does not boost well, and data do not indicate that more than 2 doses are beneficial.

Who needs to be vaccinated with PPSV?	Who needs a second dose of PPSV?
<ol style="list-style-type: none"> 1. Vaccinate all previously unvaccinated adults age 65 years and older. 2. Vaccinate all adults who smoke cigarettes. 3. Vaccinate persons ages 2–64 years who <ul style="list-style-type: none"> • have chronic cardiovascular disease (e.g., congestive heart failure, cardiomyopathy), chronic pulmonary disease (e.g., COPD, emphysema, adults with asthma), or diabetes mellitus, or who are cochlear implant patients. • have chronic liver disease (including cirrhosis), are alcoholic, or have a cerebrospinal fluid leak. • live in special environments or social settings (e.g., adults ages 50–64 years who are Alaska Natives or certain American Indian populations if recommended by local health authorities). 4. Vaccinate persons ages 2–64 years with functional or anatomic asplenia (including persons with sickle cell disease or splenectomy patients). 5. Vaccinate immunocompromised persons age 2 years and older, including those with HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure (including dialysis patients), or nephrotic syndrome; those receiving immunosuppressive therapy (including long-term systemic corticosteroids); and those who have received an organ or bone marrow transplant. 	<p>A one-time revaccination is indicated for</p> <ul style="list-style-type: none"> • All adults age 65 years and older who were previously vaccinated with PPSV prior to age 65 years if 5 years (or more) have elapsed since the previous dose. • All children and adults who are at highest risk of serious pneumococcal disease or are likely to have a rapid decline in pneumococcal antibody levels (categories 4 and 5 to the left) if 5 years (or more) have elapsed since the previous dose.

Summary of Recommendations for Adult Immunization

(Page 1 of 3)

Vaccine name and route	For whom vaccination is recommended	Schedule for vaccine administration (any vaccine can be given with another)	Contraindications and precautions (mild illness is not a contraindication)
Seasonal Influenza Trivalent inactivated influenza vaccine (TIV) <i>Give IM</i> Live attenuated influenza vaccine (LAIV) <i>Give intranasally</i>	<ul style="list-style-type: none"> Vaccinate all persons who want to reduce the risk of becoming ill with influenza or spreading it to others. Special efforts should be made to vaccinate the following persons because they are at higher risk for influenza complications: those who are ages 50yrs and older; have pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, cognitive, neurologic/neuromuscular, hematologic, or metabolic (including diabetes) disorders; have immunosuppression (including that caused by medications or HIV); will be pregnant during influenza season; residing in long-term care facilities. Vaccinate adults, children, and teens who are household contacts, caregivers, or workplace contacts of the persons listed in bullet #2 above or of children age 0–59m. Vaccinate healthcare personnel. Travelers to the tropics, to areas with current influenza activity, or on trips with people from areas with current influenza activity (e.g., on organized tours) should consider vaccination. Vaccinate students or other persons in institutional settings (e.g., dormitories, correctional facilities). <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Note: LAIV may not be given to some of the persons listed to the left; see contraindications listed in far right column. </div>	<ul style="list-style-type: none"> Give 1 dose every year in the fall or winter. Begin vaccination services as soon as vaccine is available and continue until the supply is depleted. Continue to give vaccine to unvaccinated adults throughout the influenza season (including when influenza activity is present in the community) and at other times when the risk of influenza exists. If 2 or more of the following live virus vaccines are to be given—LAIV, MMR, Var, Zos, and/or yellow fever vaccine—they should be given on the same day. If they are not, space them by at least 28d. 	Contraindications <ul style="list-style-type: none"> Previous anaphylactic reaction to this vaccine, to any of its components, or to eggs. For LAIV only: age 50yrs and older; pregnancy; chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurological/neuromuscular, hematologic, or metabolic (including diabetes) disorders; immunosuppression (including that caused by medications or HIV). Precautions <ul style="list-style-type: none"> Moderate or severe acute illness. History of Guillain-Barré syndrome (GBS) within 6wks of previous influenza vaccination. For LAIV only: close contact with an immunosuppressed person when the person requires protective isolation.
Pneumococcal polysaccharide (PPSV) <i>Give IM or SC</i>	<ul style="list-style-type: none"> Persons age 65yrs and older. Persons who have chronic illness or other risk factors, including chronic cardiac or pulmonary disease (including asthma), chronic liver disease, alcoholism, diabetes, CSF leaks, cigarette smoking, as well as people living in special environments or social settings (including Alaska Natives and certain American Indian populations age 50 through 64yrs if recommended by local public health authorities). Those at highest risk of fatal pneumococcal infection, including persons who <ul style="list-style-type: none"> Have anatomic asplenia, functional asplenia, or sickle cell disease. Have an immunocompromising condition, including HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, or nephrotic syndrome. Are receiving immunosuppressive chemotherapy (including corticosteroids). Have received an organ or bone marrow transplant. Are candidates for or recipients of cochlear implants. 	<ul style="list-style-type: none"> Give 1 dose if unvaccinated or if previous vaccination history is unknown. Give a 1-time revaccination at least 5yrs after 1st dose to persons <ul style="list-style-type: none"> Age 65yrs and older if the 1st dose was given prior to age 65yrs At highest risk of fatal pneumococcal infection or rapid antibody loss (see the 3rd bullet in the box to left for listings of persons at highest risk). 	Contraindication Previous anaphylactic reaction to this vaccine or to any of its components. Precaution Moderate or severe acute illness.
Zoster (shingles) (Zos) <i>Give SC</i>	<ul style="list-style-type: none"> Persons age 60yrs and older. 	<ul style="list-style-type: none"> Give 1-time dose if unvaccinated, regardless of previous history of herpes zoster (shingles) or chickenpox. If 2 or more of the following live virus vaccines are to be given—MMR, Zos, and/or yellow fever vaccine—they should be given on the same day. If they are not, space them by at least 28d. 	Contraindications <ul style="list-style-type: none"> Previous anaphylactic reaction to any component of zoster vaccine (e.g., gelatin & neomycin). Primary cellular or acquired immunodeficiency. Pregnancy. Precaution Moderate or severe acute illness.

*This document was adapted from the recommendations of the Advisory Committee on Immunization Practices (ACIP). To obtain copies of these recommendations, call the CDC-INFO Contact Center at (800) 232-4636; visit CDC's website at www.cdc.gov/vaccines/pubs/ACIP-list.htm; or visit the Immunization Action Coalition (IAC) website at www.immunize.org/acip. This table is revised periodically. Visit IAC's website at www.immunize.org/adultrules to make sure you have the most current version.

Technical content reviewed by the Centers for Disease Control and Prevention, September 2009.

Summary of Recommendations for Adult Immunization (continued)

(Page 2 of 3)

Vaccine name and route	For whom vaccination is recommended	Schedule for vaccine administration (any vaccine can be given with another)	Contraindications and precautions (mild illness is not a contraindication)
Hepatitis B (HepB) <i>Give IM</i> Brands may be used interchangeably.	<ul style="list-style-type: none"> All persons through age 18yrs. All adults wishing to be protected from hepatitis B virus infection. High-risk persons, including household contacts and sex partners of HBsAg-positive persons; injecting drug users; sexually active persons not in a long-term, mutually monogamous relationship; men who have sex with men; persons with HIV; persons seeking evaluation or treatment for an STD; patients receiving hemodialysis and patients with renal disease that may result in dialysis; healthcare personnel and public safety workers who are exposed to blood; clients and staff of institutions for the developmentally disabled; inmates of long-term correctional facilities; and certain international travelers. Persons with chronic liver disease. <p>Note: Provide serologic screening for immigrants from endemic areas. If patient is chronically infected, assure appropriate disease management. Screen sex partners and household members; give HepB at the same visit if not already vaccinated.</p>	<ul style="list-style-type: none"> Give 3 doses on a 0, 1, 6m schedule. Alternative timing options for vaccination include 0, 2, 4m and 0, 1, 4m. There must be at least 4wks between doses #1 and #2, and at least 8wks between doses #2 and #3. Overall, there must be at least 16wks between doses #1 and #3. Schedule for those who have fallen behind: If the series is delayed between doses, DO NOT start the series over. Continue from where you left off. <div> For Twinrix (hepatitis A and B combination vaccine [GSK]) for patients age 18yrs and older only: give 3 doses on a 0, 1, 6m schedule. There must be at least 4wks between doses #1 and #2, and at least 5m between doses #2 and #3. An alternative schedule can also be used at 0, 7d, 21–30d, and a booster at 12m. </div>	<p>Contraindication Previous anaphylactic reaction to this vaccine or to any of its components.</p> <p>Precaution Moderate or severe acute illness.</p>
Hepatitis A (HepA) <i>Give IM</i> Brands may be used interchangeably.	<ul style="list-style-type: none"> All persons wishing to be protected from hepatitis A virus (HAV) infection. Persons who travel or work anywhere EXCEPT the U.S., Western Europe, New Zealand, Australia, Canada, and Japan. Persons with chronic liver disease; injecting and non-injecting drug users; men who have sex with men; people who receive clotting-factor concentrates; persons who work with HAV in experimental lab settings; food handlers when health authorities or private employers determine vaccination to be appropriate. Persons who anticipate 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. Adults age 40yrs or younger with recent (within 2 wks) exposure to HAV. For persons older than age 40yrs with recent (within 2 wks) exposure to HAV, immune globulin is preferred over HepA vaccine. 	<ul style="list-style-type: none"> Give 2 doses. The minimum interval between doses #1 and #2 is 6m. If dose #2 is delayed, do not repeat dose #1. Just give dose #2. 	<p>Contraindication Previous anaphylactic reaction to this vaccine or to any of its components.</p> <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. Safety during pregnancy has not been determined, so benefits must be weighed against potential risk.
Td, Tdap (Tetanus, diphtheria, pertussis) <i>Give IM</i>	<ul style="list-style-type: none"> All adults who lack written documentation of a primary series consisting of at least 3 doses of tetanus- and diphtheria-toxoid-containing vaccine. A booster dose of tetanus- and diphtheria-toxoid-containing vaccine may be needed for wound management as early as 5yrs after receiving a previous dose, so consult ACIP recommendations.* Using tetanus toxoid (TT) instead of Td or Tdap is <u>not</u> recommended. In pregnancy, when indicated, give Td or Tdap in 2nd or 3rd trimester. If not administered during pregnancy, give Tdap in immediate postpartum period. <p>For Tdap only:</p> <ul style="list-style-type: none"> All adults younger than age 65yrs who have not already received Tdap. Adults in contact with infants younger than age 12m (e.g., parents, grandparents younger than age 65yrs, childcare providers, healthcare personnel) who have not received a dose of Tdap should be prioritized for vaccination. Healthcare personnel who work in hospitals or ambulatory care settings and have direct patient contact and who have not received Tdap. 	<ul style="list-style-type: none"> For persons who are unvaccinated or behind, complete the primary series with Td (spaced at 0, 1–2m, 6–12m intervals). One-time dose of Tdap may be used for any dose if younger than age 65yrs. Give Td booster every 10yrs after the primary series has been completed. For adults younger than age 65yrs, a 1-time dose of Tdap is recommended to replace the next Td. Intervals of 2yrs or less between Td and Tdap may be used. <p>Note: The two Tdap products are licensed for different age groups: Adacel (sanofi) for use in persons age 11–64yrs and Boostrix (GSK) for use in persons age 10–64yrs.</p>	<p>Contraindications</p> <ul style="list-style-type: none"> Previous anaphylactic reaction to this vaccine or to any of its components. For Tdap only, history of encephalopathy within 7d following DTP/DTaP. <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. GBS within 6wks of receiving a previous dose of tetanus-toxoid-containing vaccine. Unstable neurologic condition. History of Arthus reaction following a previous dose of tetanus- and/or diphtheria-toxoid-containing vaccine, including MCV4. <p>Note: Tdap may be given to pregnant women at the provider's discretion.</p>
Polio (IPV) <i>Give IM or SC</i>	<ul style="list-style-type: none"> Not routinely recommended for U.S. residents age 18yrs and older. <p>Note: Adults living in the U.S. who never received or completed a primary series of polio vaccine need not be vaccinated unless they intend to travel to areas where exposure to wild-type virus is likely. Previously vaccinated adults can receive 1 booster dose if traveling to polio endemic areas or to areas where the risk of exposure is high.</p>	<ul style="list-style-type: none"> Refer to ACIP recommendations* regarding unique situations, schedules, and dosing information. 	<p>Contraindication Previous anaphylactic or neurologic reaction to this vaccine or to any of its components.</p> <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. Pregnancy.

Summary of Recommendations for Adult Immunization (continued)

(Page 3 of 3)

Vaccine name and route	For whom vaccination is recommended	Schedule for vaccine administration (any vaccine can be given with another)	Contraindications and precautions (mild illness is not a contraindication)
Varicella (Var) (Chickenpox) <i>Give SC</i>	<ul style="list-style-type: none"> All adults without evidence of immunity. <p>Note: Evidence of immunity is defined as written documentation of 2 doses of varicella vaccine; a history of varicella disease or herpes zoster (shingles) based on healthcare-provider diagnosis; laboratory evidence of immunity; and/or birth in the U.S. before 1980, with the exceptions that follow. Healthcare personnel (HCP) and pregnant women born in the U.S. before 1980 who do not meet any of the criteria above should be tested. If they are not immune, give the 1st dose of varicella vaccine immediately (HCP) or postpartum and before hospital discharge (pregnant women). Give the 2nd dose 4–8 wks later. Routine post-vaccination serologic testing is not recommended.</p>	<ul style="list-style-type: none"> Give 2 doses. Dose #2 is given 4–8wks after dose #1. If dose #2 is delayed, do not repeat dose #1. Just give dose #2. If 2 or more of the following live virus vaccines are to be given—LAIV, MMR, Var, Zos, and/or yellow fever vaccine—they should be given on the same day. If they are not, space them by at least 28d. May use as postexposure prophylaxis if given within 5d. 	<p>Contraindications</p> <ul style="list-style-type: none"> Previous anaphylactic reaction to this vaccine or to any of its components. Pregnancy or possibility of pregnancy within 4wks. Persons on high-dose immunosuppressive therapy or who are immunocompromised because of malignancy and primary or acquired cellular immunodeficiency, including HIV/AIDS (although vaccination may be considered if CD4+ T-lymphocyte counts are greater than or equal to 200 cells/μL. See MMWR 2007;56,RR-4). <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. If blood, plasma, and/or immune globulin (IG or VZIG) were given in past 11m, see ACIP statement General Recommendations on Immunization* regarding time to wait before vaccinating.
Meningococcal Conjugate vaccine (MCV4) <i>Give IM</i> Polysaccharide vaccine (MPSV4) <i>Give SC</i>	<ul style="list-style-type: none"> All persons age 11 through 18yrs. College freshmen living in a dormitory. Persons with anatomic or functional asplenia or with a persistent complement component deficiency. Persons who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of Sub-Saharan Africa). Microbiologists routinely exposed to isolates of <i>N. meningitidis</i>. 	<ul style="list-style-type: none"> Give 1 dose. If previous vaccine was MCV4 or MPSV4, revaccinate after 5yrs if risk continues. MCV4 is preferred over MPSV4 for persons age 55yrs and younger; use MPSV4 ONLY if there is a permanent contraindication/precaution to MCV4. If the only risk factor is living in a campus dormitory, there is no need to give a 2nd dose. 	<p>Contraindication</p> <p>Previous anaphylactic or neurologic reaction to this vaccine or to any of its components, including diphtheria toxoid (for MCV4).</p> <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. For MCV4 only, history of Guillain-Barré syndrome (GBS).
MMR (Measles, mumps, rubella) <i>Give SC</i>	<ul style="list-style-type: none"> Persons born in 1957 or later (especially those born outside the U.S.) should receive at least 1 dose of MMR if there is no laboratory evidence of immunity or documentation of a dose given on or after the first birthday. Persons in high-risk groups, such as healthcare personnel (paid, unpaid, or volunteer), students entering college and other post-high school educational institutions, and international travelers, should receive a total of 2 doses. Persons born before 1957 are usually considered immune, but evidence of immunity (serology or history of 2 doses of MMR) should be considered for healthcare personnel. Women of childbearing age who do not have acceptable evidence of rubella immunity or vaccination. <p>Note: Routine post-vaccination serologic testing is not recommended.</p>	<ul style="list-style-type: none"> Give 1 or 2 doses (see criteria in 1st and 2nd bullets in box to left). If dose #2 is recommended, give it no sooner than 4wks after dose #1. If a pregnant woman is found to be rubella susceptible, give 1 dose of MMR postpartum. If 2 or more of the following live virus vaccines are to be given—LAIV, MMR, Var, Zos, and/or yellow fever vaccine—they should be given on the same day. If they are not, space them by at least 28d. Within 72hrs of measles exposure, give 1 dose as postexposure prophylaxis to susceptible adults. 	<p>Contraindications</p> <ul style="list-style-type: none"> Previous anaphylactic reaction to this vaccine or to any of its components. Pregnancy or possibility of pregnancy within 4wks. Severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy; or severely symptomatic HIV.) Note: HIV infection is NOT a contraindication to MMR for those who are not severely immunocompromised (i.e., CD4+ T-lymphocyte counts are greater than or equal to 200 cells/μL). <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. If blood, plasma, and/or immune globulin were given in past 11m, see ACIP statement General Recommendations on Immunization* regarding time to wait before vaccinating. History of thrombocytopenia or thrombocytopenic purpura. <p>Note: If TST (tuberculosis skin test) and MMR are both needed but not given on same day, delay TST for 4–6wks after MMR.</p>
Human papillomavirus (HPV) <i>Give IM</i>	<ul style="list-style-type: none"> All previously unvaccinated women through age 26yrs. 	<ul style="list-style-type: none"> Give 3 doses on a 0, 2, 6m schedule. There must be at least 4wks between doses #1 and #2 and at least 12wks between doses #2 and #3. Overall, there must be at least 24wks between doses #1 and #3. 	<p>Contraindication</p> <p>Previous anaphylactic reaction to this vaccine or to any of its components.</p> <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. Data on vaccination in pregnancy are limited. Vaccination should be delayed until after completion of the pregnancy.

some adults in this age group have had previous exposure, either through infection or vaccination, to an influenza A (H1N1) virus.

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 and vice versa.

Will there be a new Vaccine Information Statement (VIS) for the 2009 H1N1 influenza vaccine or can we use the same influenza VISs 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 in light of the 2009

H1N1 influenza 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 6](#) of this issue of *Vaccinate Adults* or go to www.immunize.org/catg.d/p2015.pdf).

Other vaccine questions

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 grandpar-

ents 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); children who are not vaccinated by age 2 years should be vaccinated as soon as feasible
- 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 for healthcare workers, sewage workers, or day care providers.

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.

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All healthcare personnel need seasonal and H1N1 influenza vaccination

Dear Readers,

In August, the Centers for Disease Control and Prevention (CDC) published recommendations for the use of H1N1 influenza vaccine (www.cdc.gov/mmwr/PDF/rr/rr5810.pdf). In the recommendations, CDC identified healthcare workers as a high-priority group for immunization with H1N1 influenza vaccine. CDC did this for two reasons. Healthcare workers must be protected from the virus so they will be well enough to come to work and care for sick patients. Even more important, patients must not be placed at risk of getting H1N1 influenza from their caregivers.

As I discussed in the [July 2009 issue of *Vaccinate Adults*](#), the rate of healthcare worker influenza immunization has long been extremely low. This year more than ever before, it is important that every healthcare worker understand that influenza is a deadly disease and the vaccines that prevent it are safe.

Let's make this the season that healthcare professionals show their commitment to patient safety by getting vaccinated in record numbers against seasonal and H1N1 influenza.

Just as some healthcare workers and some patients may have inaccurate ideas about the seasonal influenza vaccine, some may have incorrect beliefs about this year's H1N1 vaccine. The box at the right will help you educate your co-workers and staff on the facts about H1N1 influenza vaccine. We encourage you to copy this letter and the facts at the right and distribute them widely.

Let's make this the season that healthcare professionals show their commitment to patient safety by getting vaccinated in record numbers against seasonal and H1N1 influenza. Make sure you are fully immunized yourself, and tell your co-workers and patients that no matter how serious the upcoming influenza season may be, you've done what you can to protect them from it. Your example may be all it takes for them to act—and to get vaccinated themselves.

Deborah L. Wexler, MD

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Key Facts About H1N1 Influenza Vaccine

1. Seasonal influenza vaccine won't protect against H1N1 influenza.

Every healthcare worker should be vaccinated against both H1N1 and seasonal influenza.

2. All healthcare personnel need 2009 H1N1 influenza vaccine, including those 65 and older.

The vaccine is recommended for every healthcare worker, regardless of age. Though preliminary data (which are all we have now) seem to show that older people are likely to have some immunity, don't assume this vaccine isn't necessary if you're a healthcare worker who is 65 or older.

3. H1N1 influenza is a dangerous virus.

It is easily passed from person to person, and it can cause serious complications among healthy people.

4. The vaccine against H1N1 is not experimental.

H1N1 influenza vaccine has been developed using the same safe methods that produce each year's seasonal influenza vaccine. There is every reason to expect that the H1N1 influenza vaccine will be as safe as seasonal influenza vaccine is.

5. Antiviral medicine is no substitute for vaccination.

If you are infected with influenza, you can pass it to others, including vulnerable patients, for 24 to 48 hours before you have any symptoms. And, though antiviral medicines are valuable for treating people with H1N1 influenza, the best way for you to protect your patients is by getting vaccinated.

It's convenient to contribute online at www.immunize.org/support

I want to **contribute** to the Immunization Action Coalition (IAC)

☐ \$25 ☐ \$50 ☐ \$75 ☐ \$100
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