

August 2002

UPDATE ON IMMUNISATION ISSUES:

- (i) Influenza immunisation programme 2002/2003
- (ii) Replacement of single antigen tetanus vaccine (T) by combined tetanus/diphtheria vaccine for adults and adolescents (Td)
- (iii) Pneumococcal conjugate vaccine for children under two years of age

Dear Colleague

This letter is important for everyone involved with immunisation. It contains details of this year's influenza immunisation programme, and also important information on other vaccines.

(i) The Influenza immunisation programme for 2002/03

Two years ago a major change in influenza immunisation policy was introduced, with immunisation being offered to everyone aged 65 years and over.

This major public health initiative achieved an overall national uptake of 65% in those aged 65 years and over in 2000/01, which was bettered last year with a national average uptake of 68%.

This year, the policy remains unchanged for the target groups. We are aiming to consolidate on what has already been done to achieve an overall national uptake of 70% among those aged 65 years and over.

In this first year of the new structure within the NHS and the formation of new Primary Care Trusts (PCTs), the target is not being applied to individual PCTs. However, uptake is being monitored, and we do expect each PCT to make every effort to maximise uptake among the target groups, both those aged 65 years and over, and the at risk groups (Annex 1).

From the Chief Medical Officer, the Chief Nursing Officer, and the Chief Pharmaceutical Officer

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PL/CMO/2002/4, PL/CNO/2002/4,
PL/CPHO/2002/2

For Action

- PCT Directors of Public Health
- Influenza Co-ordinators
- Consultants in Communicable Disease Control
- Medical Directors of NHS Trusts
- Chairs of Primary Care Trusts
- General Practitioners
- Directors of Nursing
- Lead Nurses at PCTs
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For circulation to all hospital A&E
Departments and Occupational Health
Departments

For information

- Regional Directors of Health & Social Care
 - Regional Directors of Public Health
 - Chairs Infection Control Committees
 - Accident and Emergency Departments
 - All Pharmacists
 - DHSC Nurse Directors
-

As last year, £5 million will be distributed to PCTs via Strategic Health Authorities to help achieve this.

There will again be a national publicity programme, to be launched in early October to allow time for practices to have their flu programme and early deliveries of vaccine in place. Posters, leaflets and materials for strategic health authorities and primary care trusts to adapt to their local programme will be supplied in advance, around mid-August. You may wish to take account of these dates in your planning; from early October patients should begin to be aware of the campaign.

The importance of the influenza immunisation programme is recognised by the General Practitioners' Committee (GPC) of the BMA. Negotiations are taking place between the GPC and DH on reimbursement for this year's programme.

Further information on the programme, and answers to commonly asked questions are available on the DH Influenza Website: www.doh.gov.uk/flu which will be kept up to date throughout the campaign.

We look forward to working together towards another successful campaign.

(ii) **Replacement of single antigen tetanus vaccine (T) by combined tetanus/low dose diphtheria vaccine for adults and adolescents (Td) and advice for tetanus immunisation following injuries**

Td vaccine replaced single antigen Tetanus vaccine for the routine booster immunisation given to school-leavers in 1994. CMO's Update 5, issued in March 1995, clarified that Td should now always be given rather than tetanus (T) alone.

The change was on the advice of the Joint Committee on Vaccination and Immunisation (JCVI), generated by concern at the low levels of immunity to diphtheria in older people in the UK. It brings us into line with recommendations from the World Health Organisation.

The following advice should replace that in the current 'Green Book', *Immunisation against Infectious Disease 1996*, until the new edition is published.

Routine Use

Single antigen tetanus vaccine (T) has been replaced by the combined tetanus/low dose diphtheria vaccine for adults and adolescents (Td) for all routine uses in these age groups. This advice was sent out from DH on 16 May 2002 by letter to all Immunisation Co-ordinators, Pharmacists and GP Practice Managers. Td should be used for primary immunisation of previously unimmunised adults and adolescents and where booster doses of tetanus are indicated to complete a full course of 5 doses of vaccine. Td vaccine for these purposes should be ordered direct from the manufacturer:

Aventis Pasteur MSD Ltd
Mallards Reach
Bridge Avenue
Maidenhead
Berkshire SL6 1QP

Tel: 01628 785291
Fax: 01628 671722

A limited amount of single antigen tetanus vaccine is available for use in individuals who require a tetanus booster but have recently received single antigen low dose diphtheria vaccine, for example for the purposes of travel. However, Td can still appropriately be used; no interval is required before a subsequent Td dose in these circumstances. A summary of the current recommendations is in Annex 2, Table 1.

Management of tetanus prone injuries

For both tetanus and diphtheria a total of 5 doses of vaccine at the appropriate intervals are considered to give lifelong immunity. Furthermore, tetanus vaccine given at the time of a tetanus prone injury may not boost immunity early enough to give additional protection within the incubation period of tetanus. This means that following a tetanus prone wound, where the individual has received a full 5 dose course of tetanus vaccine at the recommended intervals, no further doses of vaccine are recommended. If the risk of tetanus is especially high e.g. the wound is contaminated with stable manure, human tetanus immunoglobulin should be given to give immediate additional protection.

The same rationale applies to those individuals who have completed their primary immunisation course and who are up to date with their tetanus immunisation schedule.

For those people whose immunisation schedule is not up to date or whose status is unknown, a reinforcing dose of Td should be given at the time of treatment of an injury and further doses given as required to complete the recommended 5 dose schedule. In this situation immunoglobulin should be given for any injury defined as a tetanus prone wound (see Annex 2, Table 2).

For travellers to areas where medical attention may not be accessible should a tetanus prone injury occur and whose last dose of a tetanus containing vaccine was more than 10 years previously, a booster dose of Td **should** be given, even if the individual has received 5 doses of vaccine previously. This is a precautionary measure in case immunoglobulin is not available to the individual should a tetanus prone injury occur.

(iii) **Use of pneumococcal conjugate vaccine (Prevenar) in 'at risk' children under 2 years of age**

Advice on the use of the pneumococcal conjugate vaccine (Prevenar) in 'at-risk' children under 2 years of age was previously outlined in the CMO letter dated 4th Jan 2002 (PL/CMO/2002/01).

It has come to our attention that this advice differs from that recommended in the manufacturer's Summary of Product Characteristics (SPC) for Prevenar. The key differences are the recommended number of doses of pneumococcal conjugate vaccine that should be given to children under the age of twelve months; and the period between doses for children aged between 12 - 23 months.

Following discussion at the Joint Committee on Vaccination and Immunisation (JCVI) meeting in May, it was agreed that the Department of Health advice should be revised in line with the manufacturer's SPC as detailed in the box below:

Recommendations in Prevenar Summary of Product Characteristics (SPC):

4.2 *'Infants under the age of 6 months: three doses, each of 0.5ml, the first dose usually given at 2 months of age and with an interval of at least 1 month between doses. A fourth dose is recommended in the second year of life.*

Previously unvaccinated older infants and children:

Infants aged 7-11 months: two doses, each of 0.5ml, with an interval of at least one-month between doses. A third dose is recommended in the second year of life.

Children aged 12-23 months: two doses, each of 0.5ml, with an interval of at least 2 months between doses.'

The Department of Health's recommendation that a single dose of 23-valent pneumococcal **polysaccharide** vaccine should be given to all 'at-risk' children after their second birthday remains the same. This is to provide protection against a number of other serotypes of *S. pneumoniae* not covered by the conjugate vaccine. If the conjugate vaccine is given shortly before the child's second birthday, an interval of at least 1-month should be left between the conjugate vaccine and polysaccharide vaccine.

Liam Donaldson

Sir Liam Donaldson
Chief Medical Officer

Sarah Mullally

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Chief Nursing Officer

Dr Jim Smith

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Chief Pharmaceutical Officer

**UPDATE ON IMMUNISATION
ISSUES**

PL/CMO/2002/4, PL/CNO/2002/4,
PL/CPHO/2002/2

Date: August 2002

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Internet at:
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INFLUENZA IMMUNISATION POLICY and VACCINES FOR 2002/2003**National Policy**

National policy for 2002/2003 is that influenza immunisation should be offered to:

1. All aged 65 years and over
2. All aged over 6 months in the following risk groups:

<i>Clinical risk category</i>	<i>Some representative examples (GPs' clinical decision)</i>
<i>Chronic respiratory disease, including asthma</i>	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis, asthma requiring continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission.
<i>Chronic heart disease</i>	This includes chronic ischaemic heart disease, congenital heart disease and hypertensive heart disease requiring regular medication and follow-up (but excluding uncomplicated controlled hypertension), and chronic heart failure.
<i>Chronic renal disease</i>	Including nephrotic syndrome, chronic renal failure, renal transplantation.
<i>Diabetes</i>	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs.
<i>Immunosuppression</i>	Due to disease or treatment, including asplenia or splenic dysfunction, and also including systemic steroids equivalent to 20mg prednisolone daily for more than 2 weeks. <i>However, please note that some immunocompromised patients may have a suboptimal immunological response to vaccine</i>

3. Those living in long-stay residential and nursing homes or other long-stay facilities.

What has changed this year?

- There has been no change in the targeted risk groups from last year.
- Last year's target uptake among people aged 65 years and over was 70%, with the aim of reaching a minimum 65% uptake among this group. This year we want to see a steady improvement, with the overall target of 70% achieved.
- Last year, Health Authorities were charged with the responsibility of achieving this target. This year, Primary Care Trusts (PCTs) will be expected to make every effort to maximise uptake and are responsible for overall monitoring across their authority.
- The NHS in England will receive financial support for the flu programme this year, via resource limit adjustments, to a total of £5m. Strategic Health Authorities have discretion over which aspects of the programme they support with this money, but monies should be devolved as appropriate to PCTs.
- DH will still maintain direct contact with the Flu Co-ordinators, who will now be identified at PCT level. Ed Davis at DH remains programme co-ordinator. He can be contacted on 0207 972 1644, or by e-mail at: ed.davis@doh.gsi.gov.uk.

PHLS will be taking the lead in monitoring uptake on behalf of DH. Contact is Dr Carol Joseph, 0208 200 6868, or e-mail: cjoseph@phls.org.uk.

Influenza immunisation for health and social care staff

- As in previous years, NHS employers should offer influenza immunisation to employees directly involved in patient care.
- Social care employers should consider similar action.

Influenza immunisation is highly effective in preventing influenza in working age adults. In addition, influenza immunisation may reduce the transmission of influenza to vulnerable patients, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves.

Responsibility for occupational influenza immunisation rests with the employer and it should be provided through an occupational health service. It is up to individual Trusts/employers to determine their own programme and fund the immunisation of their staff.

- Occupational Health services should place orders for the vaccine they need as early as possible.
- Vaccine for staff should not be obtained at the expense of vaccine for the risk groups.
- Staff should not be asked to go to their GP for their immunisation unless they fall within one of the recommended high-risk groups, or GPs have been contracted specifically to provide this service.

Employers are recommended to keep records of staff immunised and monitor the effectiveness of their programme.

Influenza vaccine composition for 2002/03

Flu vaccine strains are recommended by the World Health Organisation following careful mapping of flu viruses as they travel the world. This monitoring is continuous and allows experts to make predictions of which strains are most likely to cause influenza outbreaks in the Northern Hemisphere in the coming winter.

The strains of influenza virus recommended by WHO to be included in the components for the 2002/03 vaccine are:

An A/New Caledonia/20/99 (H1N1)-like virus

An A/Moscow/10/99 (H3N2)-like virus (the widely used vaccine strain is A/Panama/2007/99)

A B/Hong Kong/330/2001-like virus

The H1N1 and H3N2 components are unchanged from the current vaccine and are considered to provide good protection against the new influenza A H1N2 subtype.

In recent years the strains in the vaccine have been a very good match with circulating strains and have offered good protection.

Vaccine suppliers

The following manufacturers have indicated they will be supplying the UK market during the coming season:

<i>Manufacturer</i>	<i>Name of Product</i>	<i>Vaccine Type</i>	<i>Contact details</i>
Aventis Pasteur MSD	Inactivated influenza (split virion) BP	Split virus	0800 085 5511
Evans Vaccines	Fluvirin	Surface antigen	08457 451 500
Glaxo SmithKline	Fluarix	Split virus	0808 100 2228
Solvay Healthcare	Influvac	Surface antigen	0800 358 7468
Wyeth Vaccines	Begrivac Agrippal	Split virus Surface antigen	01708 330225
MASTA (distributor)	Inflexal V	Surface antigen	0113 238 7555

TETANUS AND DIPHTHERIA IMMUNISATION SCHEDULES AND MANAGEMENT OF TETANUS PRONE WOUNDS

TABLE 1

ROUTINE TETANUS and DIPHTHERIA IMMUNISATION SCHEDULES

- Adults and adolescents requiring tetanus immunisation should now receive combined adsorbed tetanus/low dose diphtheria vaccine for adults and adolescents (Td).
- A full course of tetanus and diphtheria vaccines consists of 5 doses as follows:

SCHEDULE	CHILDREN	ADULTS
Primary Course	3 doses of vaccine (usually as DTP) at 2, 3 and 4 months of age	3 doses of vaccine (as Td) each one month apart
4 th dose	At least 3 years after the primary course, usually pre-school entry (as DTaP)	10 years after primary course (as Td)
5 th dose	Aged 13-18 years before leaving school (as Td)	10 years after 4 th dose (as Td)

- Older adults may be unimmunised and at particular risk. Opportunities should be taken to check their immunisation status when attending surgery, for example for their influenza immunisation, and complete the recommended 5 dose schedule. Td can be given at the same time as influenza vaccine in a different arm.
- For travellers to areas where medical attention may not be accessible should a tetanus prone injury occur and whose last dose of a tetanus containing vaccine was more than 10 years previously, a booster dose of Td should be given, even if the individual has received 5 doses of vaccine previously. This is a precautionary measure in case immunoglobulin is not available to the individual should a tetanus prone injury occur.

TABLE 2

TETANUS IMMUNISATION FOLLOWING INJURIES

Immunisation Status	Clean Wound	Tetanus Prone Wound (see definition at* below)	
	Vaccine	Vaccine	Human tetanus immunoglobulin#
Fully immunised i.e. has received a total of 5 doses of tetanus vaccine at appropriate intervals as single antigen or in a combined vaccine	None required	None required	Only if risk especially high (e.g. contaminated with stable manure)
Primary immunisation complete, boosters incomplete but up to date	None required (unless next dose due soon and convenient to give now)	None required (unless next dose due soon and convenient to give now)	Only if risk especially high (see above)
Primary immunisation incomplete or boosters <i>not</i> up to date	A reinforcing dose of combined tetanus/diphtheria vaccine and further doses as required to complete the recommended schedule (to ensure future immunity)	A reinforcing dose of combined tetanus/diphtheria vaccine and further doses as required to complete the recommended schedule (to ensure future immunity)	Yes: one dose of human tetanus immunoglobulin in a different site
Not immunised or immunisation status not known or uncertain	An immediate dose of vaccine followed, if records confirm this is needed, by completion of a full 3 dose course of combined tetanus/diphtheria vaccine to ensure future immunity	An immediate dose of vaccine followed, if records confirm this is needed, by completion of a full 3 dose course of combined tetanus/diphtheria vaccine to ensure future immunity	Yes: one dose of human tetanus immunoglobulin in a different site

* A tetanus prone wound is:

1. Any wound or burn sustained more than six hours before surgical treatment of the wound or burn.
2. Any wound or burn at any interval after injury that shows one or more of the following characteristics:
 - i. A significant degree of devitalised tissue
 - ii. Puncture-type wound
 - iii. Contact with soil or manure likely to harbour tetanus organisms
 - iv. Clinical evidence of sepsis

For prevention the dose of human tetanus immunoglobulin is:

- For most uses: 250iu by intramuscular injection
- If more than 24 hours have elapsed since injury or there is a risk of heavy contamination or following burns: 500iu by intramuscular injection.