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For further information on the Immunisation Program please contact:

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www.health.vic.gov.au/immunisation

Meningococcal C vaccine catch-up program to cease

The national meningococcal C conjugate vaccination catch-up program will cease on 30 June 2006. From 1 July 2006 eligibility for the meningococcal C conjugate vaccine (NeisVacC®) program will apply as follows:

 Scheduled at 12 months of age along with Priorix® and Comvax® vaccines

 Catch-up for children born on or after 1 January 2002

Up to the 30 June 2006 all people between the ages of one and 22 years who have not received a dose of meningococcal C conjugate vaccine are eligible to receive a single dose of the vaccine for free.

The national meningococcal C vaccination program commenced in January 2003 and targeted children between the ages of one and five years and 15 to 19 years from 1 January 2003 and children aged six to 14 years old from June 2003. The Australian government has funded the program and an ongoing catch up program for children and adolescence in the eligible age range has run for the last three years.

The number of children in Victoria born since 1 January 2002 is 211,270. The number of reported meningococcal C vaccines to ACIR as at 31 March 2006 for this group is 181,685. This represents 86% of the targeted population who should have received a meningococcal C vaccine scheduled at 12 months of age.

Vaccine orders - Fax number changed

For vaccine and resource orders to the Immunisation Program, please use the following number to ensure your order is received promptly:

FAX 1300 768 088

Or vaccine and resource orders may be emailed as an attachment to:

immunisation@dhs.vic.gov.au

Measles outbreak in school

In April this year, notification of a confirmed case of measles was made to the Communicable Diseases Control Unit. The case was a 10 year old male who had recently attended a camp in regional Victoria for a touring Spiritual Hindu leader known as Sri Mata Amritanandamayi Devi (AMMA) from India.

The child attended an independent school where parents are generally anti-immunisation. The child developed symptoms of vomiting and diarrhoea on 18 April followed the next day with a fever, rash on the face progressing to the chest, conjunctivitis and a cough. The case was confirmed as measles by serology.

The school was alerted and informed that under Schedule 6 of Regulations 13 and 14 of the Victorian Health (Infectious Diseases) Regulations 2001, unimmunised school contacts of a case of measles should be excluded until 14 days after the first day of appearance of the rash in the last case.

Unimmunised contacts in this context included all students and staff between the ages of four and 40 who did not have two documented doses of a measles containing vaccine. The school entry immunisation certificate played an important role in identifying children with documented evidence of receiving two doses of a measles containing vaccine. Measles, mumps and rubella (MMR) vaccine is scheduled at 12 months of age and the second dose is due at four years of age.

Children who had not provided a school entry immunisation certificate to the school on enrolment were considered unimmunised and were excluded unless they were able to provide documentation of having received two doses of a measles containing vaccine.

Two further cases of measles were notified to the Communicable Diseases Control Unit with onset dates of 1st and 2nd of May. The cases were an 11-year-old female sibling of the first male case and the other, a male aged 13 years who was in the same class as the first notified case. These cases were also considered confirmed due to their link to the first case and their symptoms of fever, red eyes, cough and rash on the face progressing to the body. All three cases of measles were unvaccinated.

Almost half of the children (250) enrolled in the school were excluded from the school for two weeks during the outbreak, as the children had no documentation of two measles containing vaccines. This created a major disruption to the educational program and for families. Many of the parents chose not to give their children MMR vaccine or immunoglobulin as they were conscientious objectors to immunisation. Homeopathic vaccines are not considered an alternative form of vaccination.

Measles is a highly infectious viral illness. A person can spread measles to other people from five days before the rash appears until four days after rash appearance. People generally develop symptoms of the infection after 10 days but may take up to 18 days after having been exposed to an infectious person.

The number of confirmed, notified cases of measles in Australia as at mid May 2006 is 76 compared to the year 2005 where there were 11 confirmed and notified cases in total.

Measles contact guideline: <http://www.health.vic.gov.au/ideas/bluebook/measles.htm>

Measles contact guideline: <http://www.health.vic.gov.au/ideas/bluebook/measles.htm>

Communicable Diseases Australia National Notifiable Diseases Section web link: http://www9.health.gov.au/cda/Source/Rpt_4.cfm



Health Care Workers influenza vaccination report 2005

The Immunisation Program in conjunction with the Victorian hospital acquired Infection Surveillance System (VICNISS) Coordinating Centre conducted a survey on the influenza vaccination amongst healthcare workers in the public hospital system.

As part of the annual DHS provision of influenza vaccine for health care workers in hospitals, staff administering the vaccine were requested to complete and return data forms regarding the staff category of recipients.

The objective of the survey was to measure the uptake rate of influenza vaccine at each public hospital, and review the breakdown of professions receiving the vaccine. The survey was sent to all Type 1 (>100 acute beds) and Type 2 (<100 acute beds) hospitals (total 117).

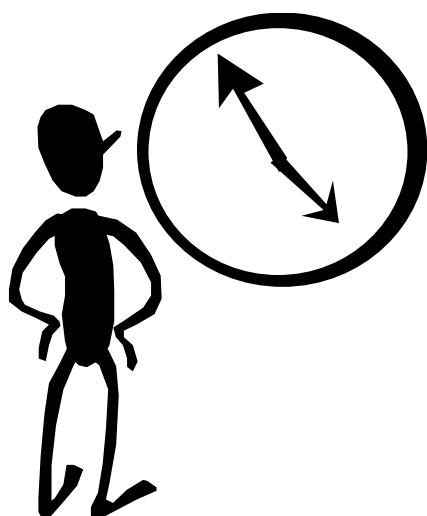
A total of 76 (65%) hospitals responded to the survey. Of these, 43 were able to provide data on the specific staff category of recipients. Results from these 43 sites are demonstrated in the table below.

Major Staff Category	Minor Staff Category	Total Staff	Proportion Vaccinated (%)
Clinical	Medical	5410	29.7
	Nursing	19412	35.7
	Allied Health	4529	46.0
	Other	7239	50.8
Non-clinical	Non-clinical	5529	37.4
Laboratory	Laboratory	740	41.6

NHMRC recommends that all healthcare workers involved in direct patient care should be vaccinated. As the results demonstrate, there is much room for improvement for the uptake of flu vaccine in the public hospital system.

Source: VICNISS Coordinating Centre staff

Observation after vaccination – why wait?



Vaccinees should remain under observation (in the vicinity of the place of vaccination) for **at least 15 minutes** to ensure that they do not experience an adverse event following immunisation. Most life-threatening adverse events begin within 10 minutes of vaccination.

The most serious reaction to vaccination is anaphylaxis. However, in adults and older children the most common immediate adverse event is a vasovagal episode (fainting), either immediately or soon after vaccination. Most fainting episodes following immunisation occur within 5 minutes, however a faint can occur within 30 minutes. Adults should therefore be warned of the risk of driving or operating machinery for at least 30 minutes after vaccination.

Source: *The Australian Immunisation Handbook, 8th Edition, page 29*

Are your asplenic (or functionally asplenic) patients' adequately immunised?

The Communicable Disease Control Unit of the Department of Human Services has been notified of two cases of invasive meningococcal disease in splenectomised patients in recent months. Sadly, one case died due to a vaccine-preventable strain of this disease. The second case was very ill but recovered. Both cases were not vaccinated against the disease.

According to The Australian Immunisation Handbook 8th Edition, all splenectomised individuals should be vaccinated first with a single dose of meningococcal C conjugate vaccine, followed 2 or more weeks later by a single dose of the tetravalent meningococcal polysaccharide vaccine. This should be followed up with a second dose of the tetravalent polysaccharide vaccine three to five years later.

It is also worth noting that individuals with an absent or dysfunctional spleen are at increased risk of fulminant bacteremia, most notably pneumococcal, for the rest of their lives. All splenectomised individuals should receive the pneumococcal polysaccharide vaccine. This should be followed up with a second dose of the polysaccharide pneumococcal vaccine five years later.

Haemophilus influenzae type b (Hib) vaccination is also recommended for splenectomised adults who have close contact with children less than 5 years of age.

These vaccines are not funded by DHS; patients with no spleen or poorly functioning spleen requiring these vaccines will need to purchase them privately.

Patients can also be referred to The Spleen Registry at The Alfred Hospital by their GPs. The Spleen Registry provides valuable information to patients on how to better manage their health, and useful educational material, vaccination reminders and regular newsletters on the subject.

For further information, contact the Spleen Registry Coordinator on (03) 9276 3828 or look up their website at www.alfred.org.au/departments/infectious_diseases_unit.html and scroll down to Spleen Registry Information Sheet.

Source: *The Australian Immunisation Handbook 8th Edition 2003, page 98.*

Successes in Immunisation Public Health Association of Australia 10th National Immunisation / 2nd Asia Pacific Vaccine Preventable Diseases Conference



30 July to 1 August 2006 Sydney

For further information on the immunisation conference please access the following web site at:

<http://www.phaa.net.au>

immunisation for life

What's new on the immunisation web site

The immunisation web site has been updated to include two new translated resources to assist the informed consent process.

- The Pre-immunisation checklist
- The Common reactions checklist.










They have been translated into 11 languages. Further languages will be available in the near future for your convenience.

The translated resources can be located and downloaded from the internet at the following web link:



<http://www.health.vic.gov.au/immunisation/>

When to give Infanrix IPV® and ADT® vaccine

Infanrix IPV® (DTPa IPV)	ADT®
Paediatric formulation diphtheria, tetanus, acellular pertussis and Inactivated polio	Adult formulation diphtheria and tetanus
<ul style="list-style-type: none">  Use up to the eighth birthday  For primary immunisation at two, four and six months  Booster dose at four years of age 	<ul style="list-style-type: none">  Use from eight years of age and over  For primary immunisation from eight years of age when either unimmunised or not completely immunised  Booster dose at age 50 years  Following a tetanus prone wound and more than 5 years since the last dose of tetanus vaccine
Funded on the National Immunisation Program schedule under eight years of age	Funded in the National Immunisation program schedule for the following: <ul style="list-style-type: none">  From eight years of age when either unimmunised or not completely immunised  Booster dose at age 50 years

Provision of free measles vaccine

The Immunisation Program provides free measles, mumps and rubella vaccine (MMR) for use in susceptible people. The MMR vaccine provided free of charge is Priorix[®].

People considered to be susceptible and who should receive MMR vaccine include:

- ✎ *Children, who should be vaccinated at one year old and four years old in accordance with the immunisation schedule; and*
- ✎ *Anyone born in or after 1966 (i.e. 40 years or younger) who has never had measles and has not had two doses of vaccine against measles, and does not have documented (i.e. serological) immunity to measles.*

Susceptible people planning overseas travel should always be reminded to include MMR as a pre-travel immunisation. Currently there are major outbreaks of measles in Germany and Fiji.

Measles infection in pregnancy is associated with increased foetal loss in early pregnancy and increased risk of maternal complications (such as pneumonia) in late pregnancy. Vaccination of susceptible women with MMR is recommended at least one month prior to a planned pregnancy.

Did you receive diluent?

Check your vaccine order when the delivery arrives and report promptly to **CSL Logistics on telephone (03) 9389 1408** if the diluent did not arrive with the vaccine order for Priorix[®].

