



July 30, 2009

ATTN: Medical Health Officers and Branch Offices
Public Health Nursing Administrators and Assistant Administrators
Holders of Communicable Disease Control Manuals

**Re: Revisions to Communicable Disease Control Manual:
Chapter II – Immunization Program**

Please note the following revisions to SECTION IA – “INTRODUCTION:”

Page 39, “Other:”

- Added information about the history of BCG use in BC.

Pages 41 and 42, “References:”

- Added reference for the above information. The last reference cited on page 41 moved to page 42.

Please note the following revisions to SECTION III – IMMUNIZATION OF SPECIAL POPULATIONS:”

Pages 4 AND 8, Section 1.0 “Immunocompromised Individuals:”

- Under the list of conditions that can affect the immune system of an individual, added “certain anti-rheumatic drugs” to the examples of immunosuppressive therapies.

Page 24, “1.5.6 Chronic kidney disease and dialysis clients:”

- Added rationale for immunization of this group with MMR vaccine.

Page 46, “3.1 Health and Childcare Workers: Recommended vaccines for health and childcare workers:”

- With regard to “all routine vaccines,” added “Meningococcal C conjugate for those born on or after January 1, 1988.” This is the age group that was eligible for MCC in Grade 12 from March 2005 to June 2007.

Please note the following revisions to SECTION IV – “ADMINISTRATION OF BIOLOGICAL PRODUCTS:”

Page 1, Subsection 2.1 “Product Preparation:”

- Under “Check the characteristics of the product to be administered,” added: “If an expired product is given inadvertently, the dose must be repeated. If it is a live vaccine, repeat 28 days later. If an inactivated product, give as soon as possible.”

Page 3, section “Considerations for the Scheduling and Administration of Multiple Injections:”

- Added a new bullet: “Give biological products that are known to cause more stinging and/or pain last (i.e., give Pediacel® first, followed by Prevnar™). Give MMRII™ vaccine last. Published pain-related data are not available for other vaccines.”

Pages 26 AND 27: “References:”

- Added references for above information.

Please note the following revisions to SECTION VII – “BIOLOGICAL PRODUCTS:”

Page 14, “Hepatitis B Vaccine Pre-exposure Indications:”

- Household contacts of internationally adopted children have now been included in the list of persons eligible for hepatitis B vaccine. This category of eligibility previously was stated as “household contacts of internationally adopted children who are chronic carriers or whose hepatitis B status is unknown.” Accordingly, household members can be immunized prior to the arrival of an internationally adopted child.

Page 15, “Hepatitis B Vaccine for Students of Health Care Professions:”

- Added the following note at the bottom of the table: “These students may have been immunized years earlier, without post- vaccination testing. Follow the protocol described in the [Communicable Disease Control Manual, Chapter 1, Hepatitis B, Section 9.0](#), for testing and vaccine administration.”

Pages 24 and 25, “Human Papillomavirus Vaccine (GARDASIL™):”

- Added a new footnote ❶: “Anyone in this grade 6 or 9 cohort remains eligible for the vaccine in the future. In subsequent years eligibility will be based on the birth year of 1997 for female grade 6 students and 1994 for female grade 9 students. At the discretion of Health Units, immunization may take place in health units, rather than the school setting.
- The other footnotes were consequently re-numbered.

Pages 35 and 36, “MMR vaccine:”

- The following footnote ❸ added to the indication of “**All individuals who require protection against measles, mumps, OR rubella:**” “See [Referral Form for MMR Vaccination](#) for list of individuals whose immune status may be suppressed and for whom the client’s medical specialist needs to provide a written referral.”

Page 37, “Meningococcal C Conjugate (MCC) Vaccine (Meningitec™)” AND page 39, “Meningococcal C Conjugate (MCC) Vaccine (Neis Vac-C):”

- Revised wording in the “Reinforcements” section: “In grade 6: one dose...” This is in line with the new recommendation made by the National Advisory Committee on Immunization (NACI) and published in the CCDR Volume 36 ACS-3 April 2009 “Update on the Invasive Meningococcal (IMD) Disease and Meningococcal Vaccine Conjugate Recommendations.” NACI is now recommending that an adolescent dose of meningococcal vaccine be incorporated into the routine schedule, even if the adolescent was previously vaccinated as part of a routine infant or 1-year old vaccination program. Due to the short incubation period of IMD (range 2 to 10 days, commonly 3 to 4 days) it is now generally accepted that the anamnestic response cannot be relied upon to prevent disease and that circulating antibodies are necessary for protection. NACI recommends the optimal age for the adolescent dose to be around age 12. The adolescent dose will help to ensure circulating antibody titres against serogroup C are present as adolescents enter the peak years for IMD beyond infancy (i.e., 15 and 24 years of age). As well, carriage of meningococci is highest during adolescence and preventing carriage in adolescents may have an impact on herd immunity in the community, indirectly protecting infants.

Page 41, “Meningococcal Quadrivalent Conjugate Vaccine (Menactra®):”

- Added primary antibody deficiencies to the examples of congenital immunodeficiency states.

Page 42, “Meningococcal Quadrivalent Conjugate Vaccine (Menactra®):”

- Added a hyperlink to footnote ❺ as to where to obtain further information regarding GBS and Menactra® vaccine.

Page 47, “Pneumococcal Polysaccharide Vaccine (Pneumo 23™)” AND page 49 “Pneumococcal Polysaccharide Vaccine (Pneumovax® 23):”

- Revised wording for the timing of revaccination. The timing relates to the age at the time of the initial vaccination, not as previously stated, the age at the time of revaccination. The wording is now consistent with that in the 2006 Canadian Immunization Guide.

Page 80 Varicella Vaccine (live attenuated) Varivax® and Varilrix®:

- Footnote ⑥ has been corrected to read “Varicella-susceptible women who receive Rhlg post-partum should be given the first dose of varicella vaccine 2 months after delivery.” Although theoretically possible, it is currently unknown whether administration of Rh immune globulin (Rhlg) to Rh-negative women in the post-partum period will interfere with the immune response to varicella vaccination. Until further data are available, varicella vaccination of susceptible post-partum women should be delayed for 2 months after they have received Rhlg. Also added to footnote ⑥: “... at 2 months after delivery, prior rubella-susceptible women should be tested for rubella immunity as they should have been immunized against rubella immediately post-partum.”

Please remove and destroy the following pages from the Communicable Disease Control Manual, Chapter 2 – Immunization Program:

Section IA - INTRODUCTION:

Pages 39, 41 & 42

Dated May 2009

Section III – IMMUNIZATION OF SPECIAL POPULATIONS:

Pages 4 & 46

Dated June 2009

Pages 8 & 24

Dated January 2009

Section IV – ADMINISTRATION OF BIOLOGICAL PRODUCTS:

Pages 1, 26 & 27

Dated October 2008

Pages 3

Dated June 2009

Section VII – BIOLOGICAL PRODUCTS:

Pages 14, 35, 36, 37, 39 & 80

Dated June 2009

Pages 15, 24, 25, 41, 42, 47 & 49

Dated January 2009

Please insert the following pages in the Communicable Disease Control Manual, Chapter 2 – Immunization Program:

Section IA - INTRODUCTION:

Pages 39, 41 & 42

Dated July 2009

Section III – IMMUNIZATION OF SPECIAL POPULATIONS:

Pages 4, 8, 24 & 46

Dated July 2009

Section IV – ADMINISTRATION OF BIOLOGICAL PRODUCTS:

Pages 1, 3, 26 & 27

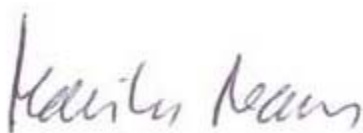
Dated July 2009

Section VII – BIOLOGICAL PRODUCTS:

Pages 14, 15, 24, 25, 35, 36, 37, 39, 41, 42, 47, 49 & 80 Dated July 2009

If you have any questions or concerns, please contact Karen Pielak, Nurse Epidemiologist or Cheryl McIntyre, Associate Nurse Epidemiologist at telephone (604) 660-6061, fax (604) 660-0197 or by email at karen.pielak@bccdc.ca or cheryl.mcintyre@bccdc.ca

Sincerely,



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