EPIC INSIDER

Educating Physicians in their Communities

Volume 4, Issue 12 **December 2014**

Mark Your Calendars:

Winter Symposium: Joint Meeting with Ga OBGYN Society
Atlanta Airport Marriott, Atlanta
February 21, 2015

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Parents Want Children in Day Care to Be Vaccinated: Poll

Three-quarters said they'd pull their kids out if others weren't up to date on shots

TUESDAY, Nov. 18, 2014 (HealthDay News) -- Three-quarters of American parents would consider removing their children from day care if other kids did not have all the recommended vaccinations, and many say that under-vaccinated children shouldn't be allowed to attend day care.

Those are among the findings from a national survey of parents of children up to 5 years old. The parents were asked how they would respond if 25 percent of children in their day care center were not up to date on vaccines, which mirrors the actual situation in the United States.

Seventy-four percent of parents said they would think about removing their children from the day care center. And 52 percent "strongly agreed" and 22 percent "agreed" that day care providers should review children's immunization status every year to ensure they have received all the recommended vaccinations.

Forty-one percent of parents said under-vaccinated children should not be allowed to attend day care, 28 percent supported a grace period to get those children vaccinated, and 21 percent would insist that parents of those children get a waiver from the child's doctor.

Only 10 percent of parents believed a child should be allowed to attend day care if he or she was not up-to-date on vaccines, according to the University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health.

Two-thirds of parents said they should be told the number of children in their day care center who are not up-to-date on vaccines, but only 25 percent said they should be given those children's names.

While all states require vaccines for children who attend day care, some don't require those children to have every vaccine recommended between birth to 5 years of age.

"Results of this poll indicate that most parents want strong policies around making sure children in day care are up-to-date on vaccines," Sarah Clark, associate director of the poll and associate research scientist in the university's pediatrics department, said in a university news release.

"Checking vaccination records every year is beyond the scope of many state requirements, and may represent a significant change in practice at many day cares," she said.

Clark added that "the bottom line is this poll shows that parents of young children have real concerns about whether vaccination standards are upheld in the day care setting. Parents should feel empowered to ask about day care vaccination policies, such as how the day care handles the situation of children who are not up-to-date, and whether they check children's vaccination status every year."

More information

The American Academy of Family Physicians has more about childhood vaccines.

SOURCE: University of Michigan, news release, Nov. 17, 2014 -- Robert Preidt

LAIV Not Effective Against Influenza A H1N1 Viruses in Children 2 through 8 Years During the 2013-'14 Influenza Season

Red Book Online Special Alerts—November 7, 2014

New observational data from the US Flu Vaccine Effectiveness Network and two additional studies conducted during the 2013-'14 influenza season unexpectedly showed that the live attenuated influenza vaccine (LAIV) was not effective against the influenza A H1N1 pandemic strain (H1N1 pdm09) virus when compared with inactivated influenza vaccine (IIV) in children 2 through 8 years of age. Specifically, children 2 through 8 years immunized with LAIV were not protected against H1N1 pdm09.

The Centers for Disease Control and Prevention (CDC) has not changed its recommendations for the preferential use of LAIV in healthy children 2 through 8 years of age for this season. The American Academy of Pediatrics (AAP), unlike the CDC, did not express a preference for LAIV for this influenza season. In light of the recent effectiveness estimates, the AAP is providing additional interim guidance:

- The goal continues to be to immunize as many children as possible to protect against influenza.
- All children 6 months and older who are eligible for influenza vaccination should continue to be immunized against influenza at the earliest opportunity.
- The LAIV vaccine produced for the 2014-'15 season is unlikely to provide protection against influenza A (H1N1 pdm09), since the same H1N1 vaccine virus was used for production of 2013-'14 vaccine.
- Based on previous study results, however, LAIV is predicted to provide protection against influenza A (H3N2) and influenza B viruses that are related to those contained in the vaccine and may offer better cross-protection against drifted strains of influenza viruses than IIV.
- Very limited and early US surveillance data for the 2014-'15 influenza season show a predominance of influenza A (H3N2) and influenza B viruses.
- Given the unpredictable nature of influenza each season, any licensed and age-appropriate influenza vaccine available should be used. Vaccination should not be delayed to obtain a specific product.
- Healthy children 2 through 8 years of age may be immunized with either IIV or LAIV (no preference).
- Children who require only one dose of influenza vaccine and who already have received LAIV this influenza season do not need to be re-immunized with IIV.
- Children who require two doses of influenza vaccine this season may get any combination of available licensed and age-appropriate influenza vaccine.
- Current AAP recommendations for the use of influenza antiviral treatment of influenza-like illness in children who have been immunized with influenza vaccine should be followed.

Serogroup B Meningococcal Vaccine: Who Should Get It?

Paul A. Offit, MD

November 19, 2014

Hi. My name is Paul Offit and I am speaking to you today from the Vaccine Education Center at the Children's Hospital of Philadelphia, in Pennsylvania.

Within the past few weeks, the US Food and Drug Administration licensed a serogroup B meningococcal vaccine (Trumenba®) for use in the United States. The vaccine consists of two factor H binding proteins and is now licensed as a three-dose vaccine for everyone between age 10 and 25 years.

Another vaccine, called Bexsero®, is also likely to be licensed soon. This vaccine consists of four different proteins: a *Neisseria meningitidis* adhesion molecule, one factor H binding protein, a heparin binding antigen, and a porin protein that is associated with an outer membrane vesicle. That will be a two-dose vaccine and also will likely be licensed for persons between age 10 and 25 years.

In the United States, only approximately 50 people will get serogroup B meningococcal disease in that age group. With such low numbers, to whom will we recommend this vaccine? I believe there are a few possibilities.

Who Should Be Vaccinated?

The vaccine could be recommended only for high-risk groups, which is to say those who have persistent complement deficiencies, comprising about 100,000 people in the United States. It could also be recommended for those who have functional or anatomic asplenia, especially sickle cell patients, which includes about 90,000 people in all, and for those microbiologists who work with *N meningitidis* serogroup B in both the research and the clinical setting, which would be thousands of people.

The vaccine could be recommended for those who are in the midst of an outbreak; for example, recent outbreaks of serogroup B meningococcal disease on the Princeton University campus necessitated vaccinating an additional 5000 people at the time. Similarly, an outbreak of serogroup B meningococcal disease at University of California, Santa Barbara, necessitated inoculating 20,000 people. In fact, virtually all of these outbreaks are now caused by serogroup B meningococcus, because we have a vaccine to prevent other, more common serotypes, namely serotypes C and Y in that age group.

Finally, we could recommend the vaccine for all college students, as is the case for the current meningococcal vaccine. Of interest, however, is that an 18- to 23-year-old who is *not* in college is more likely to get serogroup B meningococcal disease than one who *is* in college.

Thus, I believe that the ACIP, the Advisory Committee on Immunization Practices, which will meet in February, has a tough task ahead. At what level do you make a universal recommendation when, in this case, only about 50 people in the United States will get this infection every year? Remember that although it is low-risk, this is a very high-impact disease; roughly 10% of those who are infected will be killed by this bacterium, and a significant percentage will be permanently harmed by it.

We look forward to seeing what happens in February. Thank you.

Cite this article: Serogroup B Meningococcal Vaccine: Who Should Get It? *Medscape*. Nov 19, 2014.

Flublok Influenza Vaccine Now Approved for Adults Ages 18 and Older
PR Newswire (10/29/14)

Protein Sciences Corporation says the U.S. Food and Drug Administration has approved its Flublok influenza vaccine for all adults 18 and over. The vaccine--the only licensed flu vaccine developed with modern recombinant technology and 100 percent egg-free--was approved for people 50 and older under the accelerated approval of biological products regulations. Flublok, which earlier this year was granted a shelf-life extension to six months, has three times more active ingredients than traditional flu vaccines.

Federal Goal Is to Vaccinate 80 Percent of Boys and Girls Against HPV by 2020
Wall Street Journal (11/11/14) P. D4 McCabe, Caitlin

Growing evidence suggests that cancers linked to human papillomavirus (HPV) are affecting more men, prompting public-health officials to encourage higher HPV vaccination rates. The Department of Health and Human Services made it a goal to raise HPV-vaccination rates to 80 percent by 2020. Last year, the rate of completing the three-dose vaccine was 38 percent for girls and 14 percent for boys, according to data from the National Immunization Survey. HPV has long been considered a women's-only issue since it increases the risk of cervical cancer, but women's cervical-cancer rates have been falling as men's oral-cancer rates increase. A 2011 study by the Moffitt Cancer Center in Tampa found that less than 15 percent of physicians always recommended the HPV vaccine to boys and just over half always recommended it to girls. Healthcare providers may feel awkward talking to parents of young children about sexually transmitted infections, and parents may not believe their child needs the vaccine. "Discussing this vaccination is difficult because there's an implication of sexual activity," said Carrie Byington, chairwoman of the Committee on Infectious Diseases for the American Academy of Pediatrics. Resources on the Centers for Disease Control and Prevention website suggest that healthcare providers emphasize the vaccine as a protection against cancer and explain that it carries the most protection when administered around age 11. In addition, the CDC suggests that providers explain to parents that research shows that getting vaccinated against HPV does not make children more likely to become sexually active and highlight the minimal side effects from the vaccine.

PERTUSSIS

Evaluation of the Association of Maternal Pertussis Vaccination With Obstetric Events and Birth Outcomes
Journal of the American Medical Association (11/12/14) Vol. 312, No. 18, P. 1897 Kharbanda, Elyse O.; Vazquez-Benitez, Gabriela; Lipkind, Heather S.; et al.

Researchers studied more than 123,000 women with singleton pregnancies ending in a live birth between Jan. 1, 2010, and Nov. 15, 2012, to determine whether Tdap vaccination during pregnancy is associated with increased risks of adverse obstetric events or adverse birth outcomes. The Advisory Committee on Immunization Practices recommends that all pregnant women receive the Tdap vaccine, preferably between 27 and 36 weeks' gestation. Of the women in the study, 21 percent received the vaccine. Researchers concluded that the vaccine was not associated with increased risks of adverse birth outcomes. The study shows that 6.3 percent of vaccinated and 7.8 percent of unvaccinated women experienced preterm delivery, and 8.4 percent of vaccinated and 8.3 percent of unvaccinated women had a small-for-gestational-age birth. The vaccine also was not associated with increased risk of hypertensive disorders of pregnancy, and there was only a small increased risk of chorioamnionitis diagnosis, 6.1 percent of vaccinated women versus 5.5 percent of unvaccinated women.

Question of the Week
IAC Express Issue 1151: November 11, 2014
A 4-year-old patient came in with a rash and a low-grade fever. The first MMR dose was given 10 days ago. Her measles IgM was positive. Can the child have the disease or are the IgM results from the vaccination? After the rash resolves, how long is the patient contagious?

Answer: If there is no one else known to have measles in the community, or to have had contact with the child, the rash and positive IgM test are most likely related to the vaccination and the child is not contagious. We also recommend a viral specimen (nasopharyngeal swab) for PCR, to determine the genotype, which would be the only way to distinguish between wild-type virus and vaccine virus. If there is ANY possibility the child has been in contact with someone with measles, he/she should be isolated at home, and deemed possibly contagious until 4 days after the onset of the rash.

If you suspect measles disease for any reason, please also contact your local health department for assistance with contact tracing and disease control.

Question of the Week
IAC Express Issue 1152: November 18, 2014
What is the maximum number of hepatitis B vaccine doses a dialysis patient can receive?

Answer: There is no maximum number of booster doses a dialysis patient can receive. Serology should be performed once a year and a booster dose given if serology is negative (less than 10 mIU/mL). Serology is not recommended more frequently than once a year, so boosters wouldn't be given more than once a year. See www.cdc.gov/mmwr/PDF/rr/rr5516.pdf, pages 27-29.

Q: For hepatitis A vaccination, the recommended interval between the 2-dose series is at least 6 months. Is this the same as 24 weeks?
IAC Express - Special Edition - Ask the Experts Issue 1153: November 19, 2014

A: No. The recommended interval between dose #1 and #2 of hepatitis A vaccine is 6 calendar months, not 24 weeks. See CDC's The Pink Book (Epidemiology and Prevention of Vaccine Preventable Diseases) available at www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/A/age-interval-table.pdf,
footnote 5.