Hepatitis A Vaccine Recommended for All Children

ATLANTA — All children should receive hepatitis A vaccine beginning at age 12-23 months, and the vaccine should be integrated into the routine childhood immunization schedule, the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices voted at its fall meeting.

In voting for inclusion in the routine childhood immunization schedule, the committee specified that all children in a single age cohort should be given the vaccine, and that those who are not vaccinated at 1-2 years can be vaccinated at subsequent visits during the preschool years. ACIP’s recommendation for nationwide use of the hepatitis A vaccine—which does not yet have federal approval and published by the CDC—reflects both the success of the vaccine and the limitations of current practice.

When the vaccine was licensed in 1995, the vaccine initially was recommended for use in areas with high rates of hepatitis A. Currently, it is being routinely given to children in 17 states, according to Beth Bell, M.D., of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices.

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Target At-Risk Adults For Hepatitis B Vaccine

ATLANTA — A risk-targeted strategy will remain the recommended approach to adult hepatitis B vaccination, the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices voted at its fall meeting.

The committee has been considering revising this recommendation, which has been in place since 1982 because the burden of disease remains large. Last year there were 60,000 cases of hepatitis B in the United States, said Eric Mast, M.D., of the CDC’s division of viral hepatitis.

Tracy Lue, M.D., who chairs the ACIP working group on hepatitis, explained that consideration had been given to adding a recommendation for universal vaccination of 19- to 25-year-olds is more compelling,” Dr. Lue said.

“I think we’re all in agreement that the infrastructure for adult vaccination could use better development.” But for me and most of the working group members, the rationale against adding universal vaccination of 19- to 25-year-olds is more compelling,” she said.

Furthermore, the additional cost would be substantial, and would divert resources from the infrastructure that affected both children and adults in the communitywide outbreaks we don’t see in those populations anymore. There’s really no reason not to assume that we would see similar benefits by herd immunity in unvaccinated areas of the country.”

Two vaccines now are approved for use in children 1 year and older; Havrix (GlaxoSmithKline) and Vaqta (Merck). A minimum interval of 6 months between doses is recommended.

Panel: Use IVIG for Patients at Risk For Severe Varicella Complications

ATLANTA — Intravenous immune globulin (IVIG) for postexposure prophylaxis among persons at high risk of severe varicella complications if there is a shortage of varicella zoster immune globulin, according to a vote by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices.

This decision was made in the face of looming shortages of varicella zoster immune globulin (VZIG), which may begin as early as next month, when the sole U.S. manufacturer, Massachusetts Public Health Biological Laboratories, closes its plasma fractionation facility, said Dorothy Scott, M.D., of the Food and Drug Administration’s Center for Biologics Evaluation and Research.

Among the factors favoring the use of intravenous immune globulin (IVIG) for postexposure prophylaxis is the fact that it usually is in ample supply,” said Philip LaRuska, M.D., of the division of pediatric infectious diseases, Columbia Presbyterian Medical Center, New York City. Current IVIG has good antivaricella titers, with 3-8 mL/kg required. The use of IVIG also permits the window for prophylaxis to be extended, because the peak level is reached much more quickly than with VZIG, within 24 hours, Dr. LaRuska said.

An antiviral such as acyclovir also can be used for prophylaxis, in a dosage of 40-80 mg/kg per day for children and 800 mg five times a day for adults. The preferred time for administration is 7-10 days after exposure and for a total of 7 days of therapy, Dr. Marin said.

As with IVIG, in patients given acyclovir for prophylaxis, varicella vaccine should be administered at a later date if not contraindicated and if the patient did not develop varicella disease, Dr. Marin said.

The FDA continues its efforts to restore a supply of VZIG, which remains preferred for prophylaxis when available. One company has expressed an interest in manufacturing it, “and while we are not allowed to comment on a pending submission, we will do everything we can to make it available under [the Investigational New Drug protocol] as soon as possible,” FDA’s Dr. Scott said. “It’s conceivable that we will have a licensed product, but possibly not by January,” she said.

Premature infants born before 28 weeks or weighing 1,000 g or less who were exposed during the neonatal period and whose mothers do not have evidence of varicella immunity.

For pregnant women, ACIP’s measles-mumps-rubella-varicella working group recommended administration of IVIG or close monitoring and treatment with acyclovir if signs or symptoms of illness develop, said Mona Marin, M.D., of the working group.

The recommended dose of IVIG is 400 mg/kg, and it should be administered as soon as possible after exposure and as late as 96 hours after exposure.

Any patient to whom IVIG is administered should subsequently receive varicella vaccine provided it is not contraindicated, but vaccination should be delayed at least 8 months.

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Recent approval of the vaccine for use among 1- year-olds provides a further impetus for change.

Currently, 5,000-7,000 cases of symptomatic hepatitis A cases are reported each year, and an estimated 20,000-30,000 cases occur nationwide. Usage of the vaccine today prevents 81,000 cases annually. Nationwide use with vaccination at 1 year would prevent 180,000 cases of disease, according to Dr. Lieu. And while the $22 million annual direct costs of vaccination under the status quo would increase to $134 million, the cost-effectiveness ratio is still “very reasonable,” she said.

An additional question on epidemiologically was raised by Jonathan Temte, M.D., who is liaison to ACIP from the American Academy of Family Physicians. “How many of the adult cases are due to transmission from children,” said the CDC’s Dr. Bell.

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Where these areas of the country where children have been immunized have seen enormous declines in cases among adults as well, Dr. Bell said. And a large part of what I think of as a child-driven disease

that affected both children and adults in the communitywide outbreaks we don’t see in those populations anymore. There’s really no reason not to assume that we would see similar benefits by herd immunity in unvaccinated areas of the country.”

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