NOT FOR PUBLICATION

JCVI(00)25(a)

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

MINUTES OF THE MEETING HELD ON FRIDAY 21 JANUARY 2000

Agenda Item Number 5

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION
MINUTES OF THE MEETING HELD ON FRIDAY, 21 JANUARY 2000
Starting at 10.30am, Cathedral Room, Richmond House

ATTENDING:
Professor Michael Langman (acting chairman)
Dr Karl Nicholson
Dr Stephen Conway
Dr Barbara Bannister
Professor Keith Cartwright
Dr Marie Ogilvie
Professor Lewis Ritchie
Dr Robert Aston
Dr Colin Kennedy
Dr David Goldblatt
Dr Richard Smithson
Ex Officio:
Dr Chris Bartlett (PHLS)
Dr Ian Jones (SCIEH)
Dr Geoffrey Schild (NIBSC)
Professor George Griffin (CDVIP)

Observers:
Dr Elizabeth Miller (PHLS, CDSC)
Dr Mary Ramsay (PHLS, CDSC)
Dr Barbara MacFarlane (MRC)
Wg. CDR Andy Green (MoD)
Jo Yarwood (HEA)
Zoltan Bozoky (HEA)
Dr Mike Corbell (NIBSC)
Dr David Wood (NIBSC)
Dr Barbara Davis (Scottish Executive)
Dr Bill Smith (National Assembly for Wales)
Catherine Cody (National Assembly for Wales)
Dr Elizabeth Mitchell (DHSS, Northern Ireland)

DH
Dr David Salisbury, JCVI Medical Secretary
Nick Adkin, JCVI Administrative Secretary
Dr Jane Leese
Carole Fry
Helen Campbell
Dr Arlene Cook
Robert Freeman
Debby Webb
Josie St Juste
Emma Wilbraham
Monica Francis

Medicines Control Agency
Dr P Tsintis
Dr D Rogers
Dr P Arlett
Dr Anderson

1. ANNOUNCEMENTS AND WELCOME

1.1 The acting Chairman, Professor Michael Langman, welcomed members to the meeting, including Ms Catherine Cody from the National Assembly for Wales, who was attending her first meeting.

1.2 Apologies for absence were received from Professor Anderson, Ms Creighton, Dr Joynson and Dr Walford from the Committee; Dr Croft from the Ministry of Defence; Mr Oliver from the Scottish Executive; Mrs Godfrey from DHSS Northern Ireland; Dr Kiely from the Republic of Ireland; Dr Van Wijngaarden from The Netherlands; and, Mrs Gershon and Dr Smales from the Department of Health.

1.3 The Chairman reminded members that the proceedings of the Committee were confidential and were of great sensitivity. Professor Langman declared a current non-personal interest in MSD. This interest was not directly related to vaccines and it was agreed that this did not preclude Professor Langman from participating in the meeting.

1.4 Dr Salisbury thanked Professor Langman for undertaking to chair the Committee meeting on this occasion.

2. MINUTES OF LAST MEETING HELD ON FRIDAY 7 MAY 1999

JCVI(00)1

Members were advised that the minutes of the 7 May 1999 meeting had not yet been confirmed. Members were asked to provide the Secretariat with written comments on the draft as soon as possible.

3. MATTERS ARISING

The CSM report on ITP and MMR was available for members. The evidence supported the safety of a second dose of MMR vaccine when ITP had occurred after the first dose; there was a lack of evidence that ITP would occur after the second dose. There were no differences between the views of the CSM and the JCVI on the issue itself but a positional statement still needed to be agreed. The Secretariat would take this forward.

4. JCVI MEMBERSHIP

Oral Report by Mr Nick Adkin

The meeting was reminded that the terms of appointment of a number of members had finished at the end of May 1999. The Department of Health, in consultation with the other UK health departments, had sought nominations for membership, including for the post of Chairman. The Department was following the procedures laid down by the Office for the Commissioner for Public Appointments; these were based on the recommendations of the Nolan Committee. The process to recruit/ reappoint members to the Committee had been much delayed due to pressures of other work, but it was expected that appointments and re-appointments would be made before the next meeting. In the meantime, those members whose appointments had ended were being offered an extension of their appointment till the end of January 2000; a letter to this effect was to be sent by the Minister shortly.

5. COVERAGE AND OTHER REPORTS

5.1 Cover Report and Immunisation Statistics

Report by Dr Mary Ramsay and Joanne White. **JCVI(00)2**

The level of uptake of vaccines, including MMR, in England had not changed since the last meeting of the Committee. MMR vaccine coverage had been at its highest through 1995/96 and 1996/97. Update had since fallen; provisional figures for July-September 1999 showed that coverage had now stabilised at around 88%. Uptake in London remained worse than elsewhere. Uptake of MMR first dose by 5 years of age showed a 2 or 3% catch up on uptake at 2 years.

5.2 Immunisation Coverage - Northern Ireland

Report by Dr Elizabeth Mitchell. **JCVI(00)3**

MMR uptake had increased slightly in Northern Ireland and it was hoped that this good progress would be maintained. The uptake figures at age 5 years were pleasing.

5.3 Immunisation Coverage - Wales

Report by Dr Bill Smith **JCVI(00)4**

Wales was not so optimistic about MMR uptake. The South Wales Evening Post was strongly anti-MMR, calling for single doses to be made available. The situation was still delicate in places such as Llanelli and Neath. It was felt that uptake would need to increase soon or there would be a measles epidemic.

5.4 Immunisation Coverage - Scotland

Report by Dr Barbara Davis **JCVI(00)5**

MMR uptake was continuing to fall but Scotland was encouraged by recent returns. No data was available on pre-school uptake, but it was suggested as being 95.2% for MMR1 and 85.7% for MMR2 at 5 years of age.

6. THE MENINGOCOCCAL GROUP C IMMUNISATION PROGRAMME

6.1 Update on Immunisation Programme in England — JCVI(00)6

Report by Dr Arlene Cook

The papers before the Committee had been previously seen by Department of Health ministers and officials only. These weekly reports covered a number of operational aspects of the meningococcal Group C immunisation programme and included feedback from health care professionals. About ten Immunisation Co-ordinators were contacted weekly together with pharmacists and nurses to obtain feedback on implementation of the programme. A round-up of media and Parliamentary interest together with ADR information was also gathered. These reports had helped identify emerging issues and this exercise - the first of its sort for an immunisation programme - had provided a valuable lesson in effective information gathering.

6.2 Introduction of Immunisation against Group C Meningococcal Vaccine in the Trent Region — JCVI(00)7

Report by Dr Lindsey Davies

This paper was noted.

6.3 Vaccine Supply — JCVI(00)8

Report by Debby Webb

6.3.1 2.4 million doses of meningococcal Group C conjugate vaccine for 15-17 year olds had been provided by one manufacturer before Christmas 1999; another 1.6 million doses had been provided for babies. The under 2 programme had started on 10 January 2000 with 1.2 million doses being made available; this part of the catch-up programme would be concluded by the first week of March. A second source of supply was expected to become available from March 2000 onwards.

6.3.2 Implementation of the vaccine programme had, however, been substantially hindered by slowed vaccine delivery due to manufacturing problems. Despite these difficulties the initial timetable had been met. This reflected great credit on those responsible for implementation, and especially on NIBSC, who had very little time to test and release the vaccine.

6.3.3 At the last meeting of the Committee there had been a lot of difficult discussion on how we should use the vaccine as it became available and the value of waiting until we had at least two suppliers. The first manufacturer's vaccine had been licensed very close for comfort whilst the second was not licensed yet. But, if we had waited for the second supplier, we would still not have started the programme whilst storing 3 million unused doses of vaccine. Starting the programme with one supplier had proved a good decision. The meeting agreed the programme showed all the signs of meetings its objectives, and was likely to prove an outstanding success for the UK immunisation programme.

6.4 Meningococcal C Conjugate (MCC) Vaccine Evaluation Programme

JCVI(00)9

Report by Dr Elizabeth Miller

6.4.1 This report was based on research and on surveillance programmes. A clinical trial programme for the vaccine had been conducted (see the ICH/PHLS paper) and there were still a number of clinical trials in progress. The first cohort which had been immunised four years ago (with Wyeth vaccine) was now being investigated to see the levels of immune memory at school age. The evidence was that immune memory was good. NAVA, whose vaccine had been the most immunogenic in studies, was sponsoring a study to check the efficacy of a reduced dosage and the PHLS was recruiting for the studies in Gloucester, Fife and Sheffield. Recruitment for the studies in Scotland had been very high. The Department of Health was sponsoring antibody assays at Colindale, looking at the value of having only one dose. Information on T-cell priming and immune memory was also being obtained.

6.4.2 Dr Goldblatt reported that there was now enough data to follow up those children given the single dose at one year of age. These studies had been completed and the researchers would soon be in the position to answer the question of whether one dose of vaccine was sufficient. The Committee agreed that whether we required one dose or three was essential knowledge as the immunisation schedule was becoming crowded. The results of the study of the efficacy of one dose might be available for the next JCVI meeting.

6.4.3 For toddlers, additional tests had been conducted to check the antibody responses to the various types of vaccines. The results were very reassuring. The prior use of polysaccharide vaccine in young age groups did not inhibit the response to the later use of conjugate vaccine.

6.4.4 During safety studies conducted in eight schools in Liverpool and Hertfordshire there had been reports of headaches, nausea and dizziness and pyrexia. Comparison with similar studies of DT showed no clear differences indicating that findings with the new vaccine were not cause for concern. Nevertheless, headache, particularly if it was associated with muscle stiffness inevitably raised fears of actual meningitis, although the vaccine could not cause this. Allergic subjects did not seem to be at particular risk of adverse responses. Early results of the Phase 4 evaluation study gave some indication that there had been a reduction in the increase of the incidence of disease in the 15-18 year group. Only one vaccine failure had been reported.

6.4.5 During trials the frequency of headache in particular seemed to vary according to the vaccine in use. Headaches were commonly reported after vaccination of any kind. The contribution of the vaccine as opposed to the procedure and expectations of it were inevitably unclear. Initial experience also suggested to some, but not others, that local reactions might be somewhat more obvious to the meningococcal vaccine than to DTP. The general pattern had, however, been reassuring.

6.4.6 The Committee noted that this information would not have been available without the co-operation of the manufacturers. This had given everyone much more confidence in the vaccine programme and was a unique co-operation.

6.5 Impact on Disease **JCVI(00)10**

6.5.1 A paper was presented by Dr Arlene Cook. The main points of this paper were highlighted:

- the meningococcal season had now begun and meningococcal activity had risen sharply in the last couple of weeks with both meningococcal B and C activity at the highest levels on record.

- the recent introduction of meningococcal C immunisation did not appear to have altered the proportions of serological types of meningococcal disease to date.

- the number of cases in all ages (excluding 15-19 year olds) had increased sharply over the last two weeks and was now at a higher level than the previous two years.

- in contrast, the number of cases in the 15-19 year old age group which had already been fully immunised was lower than last year.

However, overall it was felt that it was too early to comment on what the full impact of the vaccine would be.

6.5.2 General discussion around the meningococcal C campaign took place. The Committee noted that, when the GPC of the BMA were consulted, the GPC had said that a four-person GP practice could expect to immunise 2 or 3 more children per week for the catch-up programme; at that rate the programme would not be finished before 2005. The arrangements now in place were that all the under 2s would be immunised within 2 or 3 months. It was also noted that, if the programme had started with babies, it would not have been possible to immunise so many children at once.

6.5.3 The Committee was asked to advise on the next steps for the programme. It was agreed that disease would remain in groups where people had not been immunised. Also, thought would need to be given to what to do about gap year students staring higher education in autumn 2000. This decision would depend on vaccine availability, whether it be polysaccharide or conjugate. JCVI would also have to consider the risks and benefits of the vaccine for other age groups.

6.5.4 The Committee would consider these issues further.

6.6 UK Reports of Suspected Adverse Reactions (Yellow Card Reports) **JCVI(00)11**
Report by Dr Peter Arlett

6.6.1 Data returned to the Medicines Control Agency had in the past, solely come from doctors, and latterly from pharmacists. The meningococcal vaccine campaign was

the first where reports collected by nurses were also submitted, this provided they were countersigned by doctors. As a consequence of this change, and the high profile of the campaign in general, it was not possible to make direct comparisons with adverse response reporting in the early phase of previous campaigns. Most reactions reported were not serious with headache, nausea and minor skin reactions being common. As always causality in these and other reactions reported was impossible to judge. More potentially significant were the few reports of anaphylaxis and convulsions. In no cases did there seem to be permanent sequelae. Where convulsions were reported it was difficult to distinguish some from complex faints of from simple febrile convulsions. Overall some 2,800 reactions had been reported in a total of 1,200 individuals, with an overall reporting rate of approximately one per thousand vaccinees. When, in due course, CSM examined the full set of reports it would consider whether the product information leaflet would require amending. At that time CSM would have both Dr Miller's paper and all other pertinent information.

6.6.2 It was noted that the speedy introduction of the programme in Northern Ireland might have been associated with a raised level of anxiety in recipients.

7 The Programmes in Scotland, Wales and Northern Ireland

Oral reports by Dr Barbara Davis, Dr Bill Smith, Dr Elizabeth Mitchell

6.7.1 Scotland reported that the immunisation programme had followed a similar pattern to that of England. Scotland could not start the programme till 1 November because of vaccine distribution problems. It had been possible to immunise babies only because they had 'borrowed' vaccine from the schools' programme supply. Most schools had finished the 15-17 year olds before Christmas. Out of school, 15-17 year olds were the most difficult to reach and the campaign was still being aimed at them. It was also felt that, as the summer term this year was short, there may be logistical problems with the groups to be immunised over that period. There had also been some problems with the student programme. Thanks were due to Professor Ritchie and Dr Jones and their teams for their work. Professor Ritchie – who had chaired Scotland's strategy group - said that we should not underestimate the positive impacts of the programme but that there had been some difficulties. Whilst it had had a great impact the difficulties should be assimilated so that we could avoid repeating the same mistakes in future.

6.7.2 Dr Smith said that there had been similar problems in Wales. In the schools they had immunised years 11, 12 and 13 and the FE Colleges. Groups of people that age not at school had not been actively targeted. The school vaccines supplemented the baby programme. When there had been one case of meningitis in a school the local people had demanded the new vaccine. Doctors and nurses in the field had done very well. Further Education 15 to 17 year olds had not proved difficult to reach.

6.7.3 Northern Ireland had had an implementation group chaired by Dr Smithson. There had been difficulties regarding vaccine supplies down to practice level, and there had been some discontent with people in the field saying that they did not know what was happening.

6.7.4 Dr Aston reported that people in the field in his authority did not have the same degree of discontent. There had been a lot of work but it had been a superb programme.

6.7.5 Dr Smith said that the Department of Health publications on the Internet in England had been read in Wales and this had caused local confusion. The Department of Health agreed to ensure its sites are clearly marked as England only.

6.8 Information for Health Care Professionals
JCVI(00)12
and
6.9 Information for the Public **JCVI(00)13**

6.9.1 Dr Jones raised two issues about the replacement meningococcal chapter for the Green Book: it had not been seen by the full JCVI; and it only included data from England and Wales. The epidemiology of meningococcal C disease in Scotland was very different from that of England and the way it was dealt with was different; he felt that it was essential to ensure a common approach. The Chair confirmed that the re-written chapter, which had to be prepared very rapidly, had been agreed by selected members of the Committee. It was noted that the use of England and Wales data only was common across all the existing Green Book chapters, reflecting problems of consistency. However, when the book was revised the contents would be amended to include full UK data.

6.9.2 The HEA had consulted with the other countries on common approaches to publicity for the new vaccine. There was some spill over the borders with the publicity, including the HEA website. Current activities for the HEA showed high demand for the parents' leaflet: 6.5 million copies had been printed and a change on the ADR, reflecting discussion at today's JCVI, would be available from mid-February. BFPO, the Channel Islands and Isle of Man also used HEA produced information.

7. SECOND MEETING OF JCVI SUB-GROUP ON VACCINE SUPPLY

Report by Helen Campbell **JCVI(00)14**

7.1 This was a complex issue and the information was presented to the Committee as Commercial in Confidence.

7.2 Over the past 18 months there had been difficulties with the supply of a number of vaccines. The reasons for the shortages were that Medeva and Pasteur Merieux had both experienced severe, but different, manufacturing problems at the same time. Medeva had been able to supply hardly any vaccine over the past 18 months and their contractual obligations were not being met. Pasteur Merieux had produced a very large bulk of DTP/Hib/IPV vaccine (not used in the UK) that had failed quality control testing and no supplies of that mixture had been available. The company had therefore put all its subsequent work into producing more DTP/Hib bulks but there was no back up should any of these new batches fail. Pasteur Merieux's problems had also affected supply of their DTP/Hib brand products in Europe and the Americas.

7.3 The manufacturers had failed to explain their problems to the Department of Health. The Secretary of State had met manufacturer's representatives twice. In the short term, the Department of Health had secured stocks of Infanrix-Hib (DTaP/Hib) from SmithKline Beecham to allow the primary immunisation of babies to continue. The UK therefore only had small quantities of DTP vaccine available.

7.4 Concerns had arisen in the US with regards to the thiomersal (used as a preservative) content of vaccines used in the childhood immunisation programme. In the US the amount of mercury a child of 6 months old could potentially be exposed to through childhood immunisations was shown to be higher than the recommended level of mercury intake and in some cases the recommended limit was being exceeded. The ACIP had announced that vaccines containing thiomersal should be replaced as soon as possible; ACIP had issued a statement on this in July 1999. It was noted that the US immunised children against hepatitis B (which does contain thiomersal) which is not presently included in the UK scheme. The number of thiomersal containing vaccines in the UK programme was somewhat lower, but the main problem was that it was used in the manufacturing process of most DTP vaccines (only DTP/IPV did not have it). The EU recommendations were similar to those of the US.

7.5 Finally, following the recognition of an increased risk of intussusception after rotavirus vaccine in the US, the suggestion that intussusception could be caused by oral polio vaccine had also arisen. This possibility followed the identification in the US of intussusception as a true adverse reaction after administration of the newly licensed and recommended rotavirus vaccine Rotashield. This had resulted in the suspension of the rotavirus vaccine. The possibility that oral polio vaccine might also be linked to intussusception was a very sensitive issue which was being investigated. OPV was necessary for the global eradication of polio, therefore this issue could cause international problems. The Committee would be kept informed of developments.

7.6 All these safety issues had occurred at the same time as the implementation of the meningococcal C immunisation programme. Two meetings of sub-groups of JCVI and other experts had met and had worked closely with MCA to consider these issues. The papers arising from those meetings were presented.

8. VACCINE SUPPLY ISSUES

8.1 Report from the Working Group on Pertussis — JCVI(00)15

Report by Dr David Salisbury

8.1.1 With the continuing manufacturing problems (see 7 above) the UK had reached the position where no wholecell pertussis (wP) vaccine (as used in DTP/Hib) matching UK requirements was available. The only vaccine which might meet these requirements was acellular pertussis (aP) vaccine. The Committee was asked to consider what should be done to try and ensure the childhood immunisation programme was least adversely affected by the various problems this issue threw up.

8.1.2 The epidemiology of pertussis and the effect of the aP vaccines had been looked at. This work had included looking at the PHLS's enhanced surveillance of hospital admissions over a number of years. Pertussis disease was at an all time low but data on morbidity in Paediatric Intensive Care Units in young infants showed that there was a significant amount of disease in this group. It was noted that the sensitivity of PCR testing was not optimal and clinical diagnosis was insensitive and that this may be why the disease was under detected. One third of patients got the infection from older siblings and one-third from parents. Only preliminary data was available, but more information on school aged children was being gathered. It was noted that France, with similar concerns, had now introduced a booster dose of acellular pertussis vaccine at 5 years.

8.1.3 The shortened immunisation schedule appeared to have had no adverse effects on the incidence of the disease. However, there had been changes in the strain reported in The Netherlands which had been associated with an upsurge in disease. The Netherlands authorities had decided that the vaccine being used was sub-potent: the vaccine had been changed and the disease had declined (France and Italy had had similar problems). It was not known what the implications for the UK were at present. The epidemiology of the disease was changing and resurgence may happen. Enhanced surveillance should be maintained. It was noted that the efficacy of the vaccine to protect against clinical disease would be lower and would decline with age.

8.1.4 The Committee agreed that the choice of vaccine was a very complex issue. Studies were to be conducted into 5 component aP vaccine (with IPV) but only limited supplies of this vaccine, the most effective, were available.

8.1.5 It was likely that more information on the efficacy and use of aP vaccine would become available for a JCVI sub-group to consider. It was extremely unlikely that wP vaccine would become available during 2000 to allow routine wP use for all children.

8.1.6 It was agreed that this issue was urgent, but it was felt that there was not enough evidence on which to make proper decisions. The Committee agreed to the use of the currently available aP vaccines for the short term. However, members felt that this decision had been rather forced onto the Committee by circumstance (failure to supply currently recommended wP vaccine).

8.2 Update on Supplies of Hib/DTP, DT, BCG and PPD **JCVI(00)16**
Paper by Debby Webb

8.2.1 When the Department of Health had been made aware of the serious supply problems, they had 3 weeks in which to find a replacement Hib/DTP vaccine for primary immunisations. Stock of SmithKline Beecham's DTaP/Hib 'Infanrix Hib' had been secured and had been issued since 1 January 2000. The Department had obtained some Behring vaccine which would be available from February. This should alleviate the recent shortages of the vaccine for pre-school boosting.

8.2.2 Medeva was the only licensed source for BCG in the UK. However, the company only had a 50% production capacity at present and was continuing to experience problems. The decision had been taken that, with such limited supply, vaccine should be

issued only for higher risk groups and that the schools programme should be suspended. One possible alternative supply (from Denmark) was being actively pursued.

8.2.3 The Committee noted the supply problems, the problems this created for the childhood immunisation programme and the actions being taken to reinstate satisfactory supply. It was noted that, in Scotland, for example, two whole school years had missed their BCG.

9. THIOMERSAL

9.1 Thiomersal and Childhood Vaccine **JCVI(00)17**
Report by Dr Arlene Cook

9.2 Thiomersal in Vaccines: **JCVI(00)18**
A Joint Statement of the American Academy Of Pediatrics and the Public Health Service
MMWR Vol. 48 No. 26

9.2.1 A paper comparing the potential levels of thiomersal exposure at 6 months of age through the UK and the US childhood immunisation programme was presented. The estimated potential thiomersal exposure through the UK programme was calculated to range between 0.15 and 0.30mg (equivalent to 75-150 ug of mercury). In the US, the level of potential thiomersal exposure was calculated as 0.05 to 0.375 mg (equivalent to 2.5-187.5ug of mercury). (It was noted that the US table showing which vaccines contained thiomersal was helpful).

9.2.2 The main problem for the UK was that DTwP vaccine contained thiomersal. DTwP/IPV did not contain thiomersal neither did DTaP vaccine. The effect of taking thiomersal out of vaccines on immunogenicity was not known and more studies were needed. The manufacturers were concerned that should the topic of thiomersal in vaccines lead to an unfounded safety scare, then they would have difficulties providing alternatives.

10. POLIOMYELITIS

<u>Safety of OPV</u>

10.1(a) OPV and Intussusception **JCVI(00)19A**
Report by Dr David Salisbury

10.1(b) Recent analysis of OPV and Intussusception by CDSC **JCVI(00)19B**
Report by Dr Elizabeth Miller

10.1.1 Preliminary analysis using linked data sets had been used to look at adverse events associated with OPV and the suggestion that there may be an association between OPV and intussusception had been investigated. The risk period had been suggested as

being during the third week after vaccination and information on this putative risk period had been obtained from the US. The document dated 15.10.1999 from PHLS suggested a significant increased risk of intussusception after OPV but there were many caveats. It had been felt that no decision was possible on the information available and more data had been sought to test the hypothesis. This extra data had now been checked and the statistical analysis confirmed that there was not a significantly increased risk of intussusception. A third data set was being sought (available by the end of January 2000) to try and establish some certainty and SCIEH was getting a 4th data set. .

10.1.2 The Committee felt that this suggested association was unsupported by the evidence. The Committee agreed to wait for further information to see whether this is a significant problem.

10.2(a) Vaccine Associated Paralytic Polio **JCVI(00)20A**
Articles for Discussion

10.2(b) Surveillance of Polio **JCVI(00)20B**
Report by Dr Mary Ramsay

There had been 39 cases of polio in the UK between 1985 and 1999 of which at least 28 were vaccine associated. Use of OPV, although overall highly protective, appeared associated with the occasional occurrence of polio. The specific risk was mainly at the first dose and vaccine associated polio was extremely rare after subsequent doses.

Eradication of Poliomyelitis

10.3 Overview of Global Eradication of Poliomyelitis **JCVI(00)21**
Report by the World Health Organisation

10.3.1 The WHO papers were presented. Much progress had been made in India during 1998/99 and surveillance of polio in India was improving rapidly. Gigantic quantities of OPV had been used in four national immunisation days, where 130 million children were immunised in one day. The risk of the importation of polio to the UK was, therefore, declining but still existed.

10.3.2 The Committee had to address the issue of the future use of OPV. Questions raised included: would the immune response be acceptable enough with IPV and what was the risk of importing polio from the Indian sub continent/ Africa? It was believed that, by the end of 2001, global eradication of polio would be achieved. The Committee would then have to consider a policy change in the post-eradication era. The risk of continuing OPV use and when/if we should move to IPV before ceasing immunisation completely needed thought. The Committee asked for short papers supporting the use of IPV for discussion at the next meeting and on what to do when polio transmission was stopped. Once polio transmission had been interrupted elsewhere it was felt that there was no justification for continuing use of OPV. The latest WHO estimate was that the last cases were likely to be seen in 2002. There would be 3 years of intense surveillance after that and only then would it be possible to consider about stopping immunisation.

10.4 Laboratory Containment of Polio Viruses **JCVI(00)22**
Report by Helen Campbell

10.4.1 Laboratory containment was an important issue. It was of particular significance in the UK as the very last cases of smallpox in the world occurred after laboratory infection in the UK. A lengthy lead-in time was needed to make the necessary arrangements for the containment of the virus. A subgroup of the JCVI and the Advisory Committee on Dangerous Pathogens had been set up to develop a database of all laboratories that handled polioviruses and an UK-wide initiative was in place.

10.4.2 Any Committee member with an interest who wished to join the subgroup was asked to contact Helen Campbell.

11. INFLUENZA

11.1 Influenza Update
Oral Report by Dr Jane Leese

11.2 Weekly Updates for Information **JCVI(00)23**
Reports by Dr Arlene Cook

The Committee was aware of media and public concerns about influenza, real or otherwise, during the current influenza season. The influenza vaccine in use matched this years' strains well, but vaccine uptake figures and a full assessment of the influence of influenza on pressures on the NHS were still awaited. It was noted that RSV co-circulated with influenza and that this undoubtedly contributed to the very high levels of acute bronchitis in the elderly. The Respiratory Panel would meet again soon to continue its work on extending the age groups recommended for vaccine. A report would be provided for the next meeting of JCVI.

12. IMMUNISATION AND THE IMMUNO-COMPROMISED **JCVI(00)24**
Report by Dr Rachel Hardie

12.1 An increasing number of enquiries were being received regarding immunisation of the immuno-compromised and the Green Book did not cover this issue fully. A literature review had been undertaken and the Committee was asked: whether there were any sources of information which had been overlooked? Whether this was the right approach? Should there be any other disease categories? And, should this rather lengthy document be condensed for the Green Book?

12.2 It was agreed that a condensed version of the guidance should be included in the Green Book. This should omit very rare diseases (such as those with an incidence of 1 in 1 million) which would be too much detail for the Green Book. However, information for, for example, bone marrow patients, should be made available in a bigger version of the guidance which should be made available for specialist groups. Clinicians, such as transplant surgeons, might not think about the need for vaccines in adults. It was felt that

a small group should be established to look at this further, including input from such as the RCPCH which was doing similar work. It was acknowledged that there was no real evidence base for much of this work and much would be based on expert opinion. Some diseases were so rare that sound evidence may not exist at all and decisions would have to be based on ad hoc information. The MCA indicated its wish to support this work.

13 . REVISED RABIES MEMORANDUM

Oral Report by Dr Jane Leese

A team in the Department of Health (not the Immunisation Team) was revising the Rabies Memorandum in the light of the imminent introduction of the Pet's Passport Scheme. Immunisation was just one small part of that work. The scheme was now being taken forward as a pilot and the Memorandum would then be reassessed. It was noted that the new scheme was being introduced on the basis that it introduced no significantly increased risk of importation of the disease. The current immunisation advice was therefore unchanged.

14. MEASLES

14.1 Outbreak of Measles in the Netherlands — JCVI(00)25

Report by Dr van Wijngaarden

There had been a measles outbreak in The Netherlands with 2,300 cases, 3 deaths and many hospitalisations. It was suggested that this information should be made widely known to the public but it was acknowledged that this was a double edged sword as some might ask why they could not have single dose vaccines (see the CSM report on MMR and autism).

14.2 Prospective Study of UK Measles Outbreak — JCVI(00)26

Report by Dr Mary Ramsay

This was a study of the outbreak in the Steiner communities where there had been 300 cases with no deaths. No one outside the communities was affected showing good immunity elsewhere.

14.3 Measles Immunisation for travellers under the age of 12 months — JCVI(00)27

Report by Dr Jane Leese (tabled)

The Committee had asked for further information before it could advise on this issue. Giving the vaccine to children under 12 months of age was outside the current licence recommendation. The concern was that it gave less immunity if given at too young an age and that this might impair the effectiveness of the later dose. The Committee felt that the vaccine was reasonably immunogenic at 6 months of age but that a booster should be given as soon as possible after age 1 and a further booster given at 4 years.

15. FUTURE PROGRAMMES OF WORK — JCVI(00)28

Report by Dr David Salisbury and Dr Jane Leese

A list of new work items and work priorities for JCVI had been prepared and was presented for consideration; the Committee was asked for its view of the priorities. The Committee agreed that the issues of OPV, IPV and vaccine supply were appropriate. Hepatitis B vaccines should be included as well, especially as universal screening was to commence shortly. It was confirmed that cancer vaccines were not appropriate to JCVI at this stage in their development. Allergy vaccines were also coming along quickly and RSV vaccine would be a useful addition, although information on the burden of disease was necessary.

16. TETANUS IMMUNISATION BROADSHEET — JCVI(00)29

Correspondence from Dr Michael McCabe

The issues raised in Dr McCabe's letter were difficult as few people had research experience in tetanus vaccines. Professor Sir Joe Smith would be asked for his views.

17. ARTICLES FOR INFORMATION — JCVI(00)30

The meeting was asked to especially note the article in GUT from Dr Minor.

The following papers were tabled were:

Measles Immunisation for Travellers Under 12 Months of Age (JCVI(00)27);

Health Education Authority Immunisation Programme: Meningitis C Communication Campaign

Committee on safety of Medicine: Report of the Working Party on MMR Vaccine

18. ANY OTHER BUSINESS

There was none.