JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the Meeting held on Friday 1 November 1991, in room 63/64 Hannibal House at 10 30 am

PRESENT:

MEMBERS:

Professor A G M Campbell (Chairman)
Professor J E Banatvala
Dr M F H Bush
Professor A Geddes
Professor P Grob
Dr I Jones
Professor H P Lambert
Professor C Peckham
Dr G Schild
Dr J B Selkon
Sir Joseph Smith

SECRETARIAT:

Dr D M Salisbury, Med MCD
Mr L T Wilson, CMP3B

INVITED TO ATTEND:

Dr N T Begg, CDSC
Dr K N Citron, BCG Sub-Committee Chairman
Ms H McGuire, HEA

OGD REPRESENTATIVES, ETC.

Dr C Bartlett, CDSC
Dr N Cumberland, MoD
Dr A Greer, DHSS (NI)
Dr J Ludlow, WO
Dr D Reid, CD(S)U
Dr S Tamblyn (Canada)
Dr O A Thores, SOHHD

DEPARTMENT OF HEALTH:

Mrs S Ely (for Mrs Philogene), NUR
Mr R M Freeman, CMP3B
Dr J Hilton, Med MCD
Dr J Leese, Med MCD
Mr K O'Leary, CMP3B

The Chairman began the meeting by congratulating Sir Joseph Smith on his knighthood, and by welcoming Dr Tamblyn of Canada to her first meeting, in succession to Professor Dixon.

Apologies were received from Professor Breckenridge, Professor Collee, Professor Crompton, Professor Levinsky, Dr MacFarlane, Professor Miller and Mrs Roden; and, from Dr Cooke (HEA), Dr O'Dwyer (Republic of Ireland), Dr Rotblat (MCA) and Mr Hale, Mr Sharpe, Dr Rubery, Dr Lewis and Mrs Philogene from the Department of Health.

1. Minutes of the Last Meeting held on 3 May 1991

These were agreed with the following amendment: in paragraph 15.1, "7p" should read "70p".

2. Matters Arising

Dr Selkon asked whether the Department had been able to make any progress with vaccine manufacturers with regard to obtaining reductions in the cost of Hepatitis B vaccine. Dr Salisbury said that an endorsement of a recommendation for central contact by the JCVI would assist officials. This endorsement was given.

Dr Schild told the meeting that a first meeting of all 12 involved European countries would be held in March 1992 to discuss a Community-wide agreement on a policy for Influenza vaccine (JCVI/91/25).

3. Hepatitis B

The minutes of the last Advisory Group on Hepatitis were tabled by Professor Banatvala. On the immunisation of health care workers, Professor Banatvala said that the paper was ready for distribution and consultation and would be available for comment shortly. A questionnaire for health authorities on their policies for immunisation of health care workers had been agreed and was being piloted in East Anglia. Following a

policy statement on Hepatitis B immunisation for industrialised countries by the WHO European Region a small working party under the chairmanship of Professor Zuckerman had been established to consider future UK immunisation policy for Hepatitis B.

Dr Bush expressed the hope that any decisions on the HBV immunisation programme would be based on good data on disease prevalence and also asked about the position with regard to immunisation of those Health Care Workers who were engaged in community care work. Professor Banatvala said that it should be remembered that for every one patient with clinical Hepatitis B, five had a sub-clinical infection. He also said that full updated data was being sought on all aspects of the illness.

3.1 Ante-natal Screening (JCVI(91)31)

Dr Hilton spoke on this paper. Existing selective screening programmes missed some pregnant women who belonged to risk groups and also missed women who were carriers of Hepatitis B despite not belonging to an identified risk group. A study at St Thomas' Hospital had shown that, under selective screening, almost as many carrier mothers were being missed as were being picked up; other research at the Whittington and the Royal Free hospitals had confirmed these findings. The costings which Dr Hilton's papers gave were only rough estimates as it was not known how many hospitals already practised universal screening; the additional costs for hospitals outside major cities were likely to be high. The whole programme was likely to cost more than it saved but the Advisory Group on Hepatitis considered the policy change desirable on public health grounds.

Dr Selkon requested that caution be exercised. He felt that the paper was too heavily influenced by the situation as experienced in the major cities and that the evidence was not objective enough to provide any firm conclusions.

Professor Peckham agreed with this view and said that more information was required on matters such as yield as well as on screening.

Professor Banatvala agreed that these were valid points, but said that the vast majority of people lived in cities and that changes in life style were being seen which could lead to increases in the incidence of the disease. Some babies were being missed and this could be described as negligent. He believed that any extra data which could be provided would only confirm what had already been seen. Dr Tamblyn said that, in Canada, incidence of HBV was increasing and that their universal screening policy was identifying many carrier mothers who would have otherwise been missed. Dr Greer said that Northern Ireland had universal screening, although, because of the differences between the population in the province and other parts of the UK, few babies with HBV were found. Dr Jones said that he agreed that there was sufficient information available now to support the proposed policy change but felt that the change should be monitored so as to gauge its benefits. Dr Salisbury asked what information would convince JCVI that universal screening should not be introduced; he said that this was a major public health problem which needed to be addressed. Professor Peckham felt that making new policies without sufficient information was not scientifically sound. This point was taken. However, the meeting agreed in general that, on public health grounds, it was right to introduce this new policy. The Chairman confirmed the Committee's decision, requesting that the effects of the new policy be monitored carefully.

3.2 Amendments to Chapters 12 and 13 of "Immunisation Against Infectious Disease" (the Green Book) (JCVI(91)32)

Dr Hilton said that these proposed amendments were a first draft. On Hepatitis A she reported that a vaccine was likely to be available in the near future but that it was unlikely to be licensed before the introduction of the new Green Book. It was, however, proposed that the Green Book should recommend vaccination as an alternative to the use of immunoglobulin

for, eg regular travellers and sewage workers. On Hepatitis B, amendments on ante-natal screening had been included in anticipation of agreement from the Joint Committee to proposals in the preceding paper JCVI(91)31 and proposals were included to broaden the immunisation of contacts of Hepatitis B carriers to include non-sexual household contacts. Evidence for this was not as good as might be wished, but professionals in the field believed that such contacts were at risk.

Dr Bush again mentioned the position of health care workers working outside the hospital and Dr Jones asked about the situation with regard to the protection of patients from infected health care workers. On the first point, Dr Hilton said that there was little evidence to suggest that there was increased risk in, eg non-residential special schools. On the second point, she said that she did not believe the Green Book was the appropriate place to give such guidance. This would be covered in a document "Occupational Guidance on Health Care Workers Infected with the Hepatitis B Virus" which was being issued for consultation in the near future. Members had seen an early draft of the document.

The Chairman requested that any comments on these proposed amendments be sent to Dr Hilton as soon as possible.

3.3 Minutes of Advisory Group on Hepatitis held on 19 September 1991

The only amendment to this was in paragraph 6.2, where Professor Banatvala's name should be included in the Working Party membership.

4. Uptake Reports

4.1 COVER (JCVI(91)33)

Dr Begg said that these figures now showed changes as a result of the accelerated childhood immunisation schedule. The statistics showed that, with the acceleration of the schedule,

immunisation was now completed six months earlier. Generally, coverage continues to improve. The Chairman hoped that the increase in the uptake of Pertussis vaccine, would be reflected in notifications of the illness by the time of the next JCVI meeting.

4.2 Scotland (tabled papers)

Dr Thores reported that half the health boards in Scotland showed over 95% take-up of immunisation, although Pertussis uptake remained disappointing. The Chairman said that there was still a great variation in take-up between the health boards in Scotland and he queried whether the data was accurate. Dr Jones said that some Scotland figures were difficult to believe, eg Lothian and the Western Isles. He said that the denominator was consistently wrong. He felt that if the data provided directly by the health boards was used they would be more accurate.

4.3 Wales (JCVI(91)34)

Dr Ludlow reported that the figures showed continuing increase in uptake. Uptake for MMR was 90%, but Pertussis still lagged behind. There had been a Measles outbreak in a secondary school in Gwynedd. The children with Measles had not been immunised properly.

4.4 Northern Ireland (JCVI(91)35)

Dr Greer reported that uptake levels had been encouraging. MMR had reached 88%. "Immunisation Action Teams" had been set up to encourage the public (eg through displays in shopping centres).

Dr Salisbury said that these improvements had resulted in great interest being shown from abroad. Officials from the US Government were coming to meet Dr Salisbury and the PHLS to discuss the UK system.

5. Accelerated Schedule

5.1 Preliminary report of a study of reactions to an accelerated schedule JCVI(91)36)

Dr Begg spoke on this paper. The study had been undertaken in Colchester, the control being based on an earlier Hertfordshire study. Tables 1-3 showed significant reductions in reactions under the new schedule compared to the old, except for injection site swelling after the first dose with the new schedule. The conclusions to be drawn from this study were that, as far as adverse reactions were concerned, the accelerated schedule is not inferior to, and may be better than, the longer schedule.

Dr Salisbury had searched the CSM database for yellow card reports showing adverse events following DTP for the one year period before May 1990 (ie under the old schedule) and for one year after May 1990 (ie under the new schedule). He said that during the second period one million more doses had been given because more children had been brought into the schedule, 2.8m doses for May 89/90 and 3.8m doses for May 1990/91. The same number of convulsions had been recorded indicating that the accelerated schedule had actually reduced the incidence; there were fewer cases of fever reported but more injection site reactions, although this might be linked to reactions to injection in the thigh. He said that the analysis would be re-run in six months' time for May 1991/92.

6. Introduction of Hiv vaccines

6.1 Minutes of previous meetings

These were taken as read.

6.2 PHLS Regional Survey (JCVI(91)37)

Dr Begg reported that a working party had been established and extended surveillance had been set up in five English Regions and in Wales. The first report showed the data collected for the first nine months. There were few infections of Hib after the age of five years, the only exception being in Oxford where there were some adult cases. The peak period for infection is age 7-11 months; it is most common in the winter. He reported that half of the deaths following infection by Hib were in infants, whilst there were five deaths in elderly people which were being investigated by Oxford PHL. The death rate in the elderly who acquired Hib was 30%. One infant had died from Hib Meningitis. Professor Lambert said that drug resistance was increasing and that present treatment was sometimes ineffective.

6.3 Report of Gloucester Study.

This oral report was presented by Dr Begg. He said that 240 immunisations had been given and reports on the post-immunisation antibodies would be available by March 1992. Of 81 children, 79 had achieved protective levels of antibodies (there had been one failure with Merieux and one with Praxis vaccines), and 57 children had antibody levels associated with long-term immunity. The study showed that Merieux was the most immunogenic while MSD was the least. Blood samples would also be taken at 12 months to measure the maintenance of antibodies. As far as reactions were concerned, Dr Begg reported that the most immunogenic vaccine also appeared to be the most reactogenic with local swelling being observed, especially after the first and second doses, although this disappeared within 24 hours. The Chairman emphasised that the swelling was much less than that accepted as a Green Book

contra-indication; only one reaction fulfilled the Green Book criteria for severe local reaction.

Dr Tamblyn reported that Canada was ahead of the UK. Immunisation against Hib had started in 1986 using non-conjugated vaccines and a 50% decline in the disease had been seen. Two vaccines (Praxis and Merieux) were licensed. Which of these vaccines could be mixed with DTP had yet to be discovered.

Professor Peckham asked Dr Begg about studies in ethnic minorities. He reported that studies were being undertaken in Brixton and Harrow but the results would not be available until October 1992. Professor Geddes said that an epidemiological study on Meningitis in the West Midlands had shown that Hib seemed commoner amongst Asians.

6.4 Report from HEA (JCVI(91)38)

Ms Maguire reported that two market research studies had been undertaken. The first was on the information needs of parents; the results of this research should be due in late November 1991. The second proposal was to look at professional attitudes, eg explaining the vaccine and its limitations. Reports on this would be due at the end of November and finished by January 1992. Decisions on how to proceed once these results were known would then need to be taken. Ms Maguire said that the MORI software proposal was not being taken forward. The Chairman expressed the satisfaction of the Committee with the HEA work.

6.5 Vaccine Supply and Schedule (JCVI(91)39)

Dr Salisbury spoke on this paper. The studies undertaken at NIBSC had shown that the various vaccines could not be interchanged, ie that once a child had started one vaccine it must continue the course with that same vaccine. He concluded that as far as the need for a booster dose was concerned, both the Hib Implementation Group and the MRC had concluded that there was no evidence to persuade them that it was necessary;

if, in practice, it was demonstrated that there was need for a booster then it could be added at a later date.

Dr Salisbury explained the schedule, including the plans for "catch-up". The aim had been to protect as many children as quickly as possible bearing in mind the logistics of such a demanding timetable. Younger children were at a higher risk and therefore had to be done first but older children must not get lost. He had achieved the aim of having no more than four extra cohorts per month attending the clinics; all children under 13 months would be immunised by May 1993 and all older ones would be immunised by December 1993.

Dr Salisbury proposed that in September 1992 the computer services should send letters to parents telling them the date of their child's appointment; Dr Begg would meet all software suppliers in December 1991 to tell them of the requirements. The Department had already met the vaccine manufacturers to advise them of requirements and they had agreed that the demands of the schedule were acceptable. Vaccine licensing had yet to be resolved. Some manufacturers were more enthusiastic than others; problems were anticipated with regard to mixing with DTP.

Dr Bush said that immunisers must be prepared for the fact that many parents would not be prepared to wait to have their children immunised. This was agreed but it was felt some sort of order should be set. Dr Selkon reported that Oxford was studying the issue of vaccine failure; Dr Begg said that evidence from the USA reported that there was a good response to a single dose. Dr Salisbury reported that all financial matters, eg GP payments, were being pursued with Treasury.

The Committee endorsed the work of the Hib Implementation Group thus far and acknowledged that this exercise would provide valuable experience for the introduction of any new vaccine in the future.

7. MMR

7.1 Report on MMR (JCVI(91)40)

Dr Salisbury spoke on this paper. He reported that the specially earmarked funds were now being reduced because the catch-up had been completed. £1m had been recouped because of efficient ordering of vaccine; this had been refunded to the health authorities. The present notifications of Measles were the lowest ever. GPs hardly ever saw Measles today, although there were indications that they were having problems distinguishing between Measles and Rubella. Routine reporting was no longer sufficiently sensitive. Congenital Rubella was continuing to decrease.

On adverse reactions to the vaccine, the most worrying reports had been studies which showed problems with Urabe vaccine, particularly Mumps Meningitis. Reports had also come from overseas countries, Canada being the most helpful. Surveillance had been introduced through BPSU. All sources of information were collated and the Oxford based Research Fellow was investigating all reports, then reviewing the children's development 12 months later. A CDR had shown that, of 67 reported cases between October 1988 and August 1990, 38 children had definite or probable Aseptic Meningitis and one Encephalitis. Ten of these were definitely caused by the vaccine, and a further 29 were probably caused by the vaccine. Of these 39 children, 37 were followed up at 12 months. 33 (or 89%) were neuro-developmentally normal. Of the remaining four, two had neuro-developmental problems before being given MMR, one had behaviour problems and one had a cerebral astrocytoma. There had been eight reports of nerve deafness although one was pre-MMR; six needed further investigation. The over-all picture was that there were 3.7 cases per 100,000 doses of Urabe vaccine and no cases reported with the Jeryl Lynn vaccine. However, the MSD vaccine was generally not well accepted because of pain at the injection site. Urabe is the most reactogenic vaccine but some data suggested that it may also be the most immunogenic. It was impossible to make a

firm decision about this until all information had been collected.

Dr Salisbury said that the question of boosters for 12-year-old girls coming up for their Rubella vaccine needed to be addressed. It was generally felt by Members that a booster might be required but that the Hib implementation programme should not be complicated by adding another immediate demand on the service.

7.2 Discussions with Manufacturers

Dr Salisbury reported on his recent meetings with Merieux, MSD and SKB. Information was shared and details of adverse events discussed. The manufacturers felt that the Department's line - that is, surveying adverse events and checking immunogenicity - was correct. Problems regarding fridge time and "stinging" were discussed and the manufacturers would look into those.

8. Acute Flaccid Paralysis Surveillance (JCVI(91)41)

The study described was required in order to confirm the UK as polio-free. The UK was the first industrialised country to do this and WHO saw this as a model.

9. Pneumococcal Vaccine

9.1 Vaccine Policy (JCVI(91)42)

Dr Leese presented this paper; the recommendations had been pared to their simplest. Professor Lambert suggested that there would be an advantage in seeing to what extent the recommendations for giving Pneumococcal vaccine could be linked up with the recommendations for giving Influenza vaccine. Sir Joseph Smith suggested that this might then be discussed at the next Influenza meeting and that the two might then be married up as much as possible. It would be valuable to get these recommendations into the Green Book as soon as possible.

Dr Selkon said that no mention had been made of the earlier paper by Professor Fedson which suggested making Pneumococcal vaccination routine for all those discharged from hospital irrespective of health or age. Sir Joseph Smith said that Fedson omitted checks on the efficacy of the vaccine and he felt that Dr Leese's paper went as far as it was possible to go at the moment; Dr Schild reported that efficacy research was at a very early stage. Dr Reid asked about the apparent missing five years between the waning of immunity and the suggested timing of booster injections. Dr Bush suggested that the use of this vaccine should be promulgated much more widely than through the Green Book - which is not often referred to for general patient management. The Chairman felt that the reference to "over 55" in paragraph 2 of the Recommendations should be deleted; members of the Committee were invited to write to Dr Leese with comments.

10. Tuberculosis and BCG

Dr Citron spoke on the minutes of the 3 July 1991 BCG meeting. Important points to note were:

i The question of BCG immunisation of infants who were immunodeficient was to be considered by a working group.

ii Nothing worthwhile would be gained by changing the immunisation programme for schoolchildren aged 10-13 and this should be kept, bearing in mind the review due in 1993;

iii More evidence was required before HIV family groups should be immunised;

iv In paragraph 11 of the minutes, the introduction of the disposable head Heaf Gun was acknowledged as a big step forward;

v The results of the 1993 survey of notifications of Tuberculosis were a prerequisite for making any decisions

on the future of the schools BCG programme; he requested that JCVI confirm the need for funding of this. He reported that it was proposed to test more subjects with the disposable head Heaf gun, although the doctors who had carried out the study on 32 subjects felt the results documented its efficiency adequately. There were some teething problems still with regard to the pressure at which the head fires. It had therefore been decided to delay notification of the availability of the Gun until this point had been assured. Dr Leese reported that a video was being made for the Spring showing how to properly use the Gun.

The Chairman indicated that JCVI supported the request for funding for the 1993 Survey.

11. Influenza

The 1991 CMO Letter to Doctors and (for the first time) explanatory leaflet were noted, as was the table showing comparative vaccine distribution in several countries.

Dr Leese reported on the death of a 26 year old asthmatic in Chesterfield about 12 hours after he had been given influenza vaccine. There appeared to be no obvious cause of death, and the coroner had not implicated the vaccine. Two other contemporaneous deaths were in elderly persons, one of whom had ischaemic heart disease and the other a fractured hip.

12. Rabies

Dr Leese presented her paper on proposed changes in the recommendations for antibody testing after immunisation. The suggestion to stop testing after immunisation and bring forward a third dose to six or three months would affect mainly quarantine workers, as laboratories did their own checks. Travellers usually received two doses and were very rarely checked. Dr Selkon offered to contact Dr Mary Warrell on the available evidence in favour of a 12 month reinforcing dose; but the Committee agreed to a short course of three

doses, subject to confirmation of satisfactory immunity, and to abandoning routine post-immunisation antibody testing.

13. Cholera and Typhoid (JCVI(91)47)

13.1 CMO letter on Cholera and Typhoid Immunisation for Foreign Travel

This letter had been issued following JCVI recommendations and was provided for information.

14. Japanese B Encephalitis

14.1 Adverse reactions to vaccine (JCVI (91)48)

Dr Leese said that the vaccine against Japanese B Encephalitis was not licensed in the UK but was used on a "named patient" basis because of increased travel to Asia. No major problems had been reported in the UK although, as the "yellow card" scheme was reserved for licensed vaccines, some adverse reactions may be being missed.

14.2 Allergic Reactions Study Protocol (JCVI(91)4)9

Dr Begg presented this paper. He said that this was a retrospective study following up 1,000 recipients of the vaccine. The aim was to get a rough estimate; if any major problems were identified then another study would be required. Dr Schild said that the vaccine was very crude and could not be licensed in the UK using normal criteria; one case of Japanese B Encephalitis had been reported in the UK over the past 20 years.

15 Correspondence

15.1 Dr Furminger re: Plain vaccine (JCVI(91)50)

The Committee agreed that Adsorbed vaccine was much safer than unabsorbed vaccine. The Chairman agreed that there was no

place for the routine supply of Plain vaccine and Dr Furminger could be advised accordingly.

15.2 Dr Thores re: Diphtheria (JCVI(91)51)

The Committee agreed with Dr Fallon's suggestion. Dr Begg said that the Green Book had previously had an appendix on policy for vaccination of NHS staff and he suggested that this should be reintroduced.

16. Articles for Information

These were taken as read.

17. Any Other Business

There was no other business.

18. Future Meetings

The Chairman requested that members note the dates of the next meetings, 1 May and 6 November 1992. [Date subsequently amended to 30 October.]

6 November 1992
30 April 1993
29 October 1993
} book