JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the meeting held on Friday 4 May 1990 in Room 63/4 Hannibal House at 10.30.

Present.

Members:	Professor A G M Campbell (Chairman)	
	Professor J E Banatvala	
	Dr M F H Bush	
	Professor J G Collee	
	Professor G Crompton	
	Professor A M Geddes	
	Professor P Grob	
	Professor D Hull	
	Dr I Jones	
	Professor E P Lambert	
	Dr J Noble	
	Professor C Peckham	
	Dr D Reid	
	Dr J B Selkon	
	Dr J W G Smith	
	Professor R W Smithells	
Secretariat:	Dr D M Salisbury	
	Mr L T Wilson	
Invited to attend:	Professor A Breckenridge	Chairman of ARVI
	Dr N T Begg	CDSC
	Dr J Watson	CDSC
	Dr M Ramsay	CDSC
	Mr J Huntington	HEA
Observers:	Dr S N Donaldson	DHSSNI
	Dr K Richmond	WO
	Dr O A Thores	SHHD
	Dr N Cumberland	MOD
	Dr A Mills	HEA
Department of Health:	Dr E Rubery	
	Dr F Rotblat	
	Dr J Hilton	
	Dr D Milner	
	Mrs S Philogene	
	Mr R Anderson	
	Mr M Neterman	
	Miss J Adaoui	
	Mr K O'Leary	
	Ms J Copeland	
	Miss V Wood	

1. Apologies were received from Professor Levinsky, Dr Macfarlane, Professor Miller, Mrs Roden and Dr Schild; from Mr Hale and Mr Cunningham; and from Dr Chambers, Dr Lewis and Dr McIntyre. Dr A Mills attended in Dr Chambers's place, and Dr Thores in place of Dr McIntyre.

2. Announcements:

i. The Chairman gave the Committee's thanks to Dr Fenton Lewis and Dr Penn who had both recently retired from the Department and welcomed Dr Hilton and Dr Milner in their place. Welcome was also given to Mrs Philogene, Nursing Officer.

ii. The Chairman said that Professor Smithells was retiring from JCVI, and thanked him for the many years of service he had given to the Committee.

iii. The Chairman explained that other members may have suspected that their membership of the committee had expired, but the Department was still giving the full membership its consideration and would be in touch with members as soon as possible.

iv. The Chairman said that Departmental officials had recently met vaccine manufacturers who were keen to be informed, in confidence, of the outcome of JCVI discussions which might affect their own plans. Agreement was sought from the committee on the appropriateness of a summary of such discussions, cleared by the Chairman, being provided to manufacturers. The committee agreed to this. In connection with this Professor Hull brought to the Committee's attention a recent letter he had received from a GP, the contents of which indicated, and the Chairman and committee agreed, a continuing communication problem on the relationship between JCVI advice and manufacturers data sheets. Dr Salisbury said he was aware of this particular correspondence.

v. The Chairman also said that manufacturers would be told that they could submit papers for the JCVI to consider.

3. Minutes of the last meeting.

The minutes of the meeting held on 3 November 1989 were agreed with the following amendments:

Page 1. add Col. Robson to those attending.

Page 8. at 11.4 add after "Dr Begg pointed out that coverage" - "at two years of age".

Page 8. at 12.1 delete the sentence beginning "The Judge's conclusions ...".

Page 10. at 20 second paragraph delete "treatment" insert "prophylaxis".

Matters arising.

i. Page 2, paragraph 4, sub-paragraph 4 (legal position on prescriptions) - Mr Wilson reported that the Department continues to pursue this matter.

ii. Page 3, paragraph 5, fifth sub-paragraph - Mr Wilson said that officials had met colleagues from the NHS Management Executive, who offered to brief the Director of Information about the Committee's concern on the compatibility and accuracy of statistics being brought to the attention of all RHAs.

iii. Page 4, paragraph 5, fifth sub-paragraph - Mr Wilson confirmed that the duties of District Immunisation Co-ordinators include a responsibility to ensure the accuracy of statistical returns.

5. Vaccination and Immunisation Statistics 1988/89.

5.1 England.

a. Dr Salisbury presented paper JCVI/90/1 together with a tabled graph of Immunisation Uptake in England. The papers showed the continued improvement in uptake, especially as the numerator in calculations is now children immunised by their second birthday (a tighter definition than before).

b. The regional graphs showed an especially good performance in increasing uptake in the Mersey Region.

c. Professors Hull and Smithells made various comments about the presentation of these statistics, which the Secretariat noted.

5.2 Scotland.

a. Dr Thores presented tabled paper JCVI/90/2 which gave Scottish uptake rates up to December 1989. The rates were showing a steady improvement.

b. There were no measles uptake figures presented because the introduction of MMR had led to the possibility of double counting. Some areas had reached 90 per cent for measles before MMR commenced.

c. No figure was given for Rubella in Lothian as in this Health Board, alone of all Scotland, immunity is checked before the vaccine is given. The figures for immunity ultimately achieved are high in Lothian.

d. Dr Thores said that there were some methodological problems with the Scottish data which were being dealt with. Just over half the Scottish Boards were fully computerised and the number was increasing.

e. Dr Jones and Professor Collee expressed concern about the problems in Scotland and hoped for early improvement.

5.3 Wales.

a. Dr Richmond presented tabled paper JCVI/90/3, a graph of uptake of pertussis, diphtheria and measles in Wales.

b. There were no district breakdowns of the figures as yet. Dr Richmond explained that Wales were now moving to the Korner data to help resolve some of their current collection problems.

[Dr Donaldson DHSSNI presented a revision of the Northern Ireland uptake figures tabled at the last meeting.]

5.4 Harmonisation of National Statistics.

a. Mr Wilson presented this paper which gave an overview of the current systems of uptake statistics calculations in the UK.

b. Northern Ireland, Wales and England were all now using the standard Korner returns to calculate uptake. Scotland had not adopted Korner. Dr Thores said that SHHD were considering with their statistical branch how best to collect and present uptake data for Scotland. Dr Jones regretted the delay in Scotland and asked that the Committee request SHHD to hasten harmonisation.

c. Dr Salisbury agreed that a decision was needed as to which of Diphtheria, Tetanus or Polio should be quoted in presentations of statistics as indicative of these three immunisations.

6. BMRB Report.

a. The British Market Research Bureau Report "The Uptake Of Pre-School Immunisation In England", JCVI/90/5, had been circulated to members in advance of the meeting.

b. Professor Peckham agreed that the report was complementary to the "Peckham" Report, but regretted its lack of cross referencing or references to other published literature.

c. Professors Peckham and Smithells were disappointed by the level of response from Health Visitors, especially as the "Peckham " Report had shown that the knowledge of Health Visitors had more effect on uptake levels than that of GPs.

d. Dr Jones said that a large scale national campaign was contrary to the Report's evidence and that it is Co-ordinators, Health Visitors and other health professionals who influence uptake levels. Mr Huntington explained that the campaign is aimed at parents, to get them to the clinics and surgeries, and to managers and professionals , to ensure they use their influence once the parents arrive with the children.

e. The Chairman noted that Health Visitors not being permitted to provide immunisations in some areas was causing problems. This was compounded, said Dr Noble, by the new GP's contract, with Health Visitors and Nurses indicating that the targets are for the Doctors to achieve and it is not their duty.

7. District Immunisation Co-ordinators Meeting 22.2.90.

a. Professor Campbell in reporting on the latest District Immunisation Co-ordinators meeting said that he had chaired an enthusiastic and enjoyable meeting.

b. Dr Salisbury indicated that the Co-ordinators, as shown by the meeting's programme JCVI/90/6, had taken on a large part of the meeting and that the next meeting (planned for 12 December) would continue this practice.

c. Dr Thores said that the Scottish Co-ordinators held meetings every few months and that they would be pleased to consider possible exchanges with other co-ordinators.

8. New Memorandum and Schedule.

8.1 a. The Chairman regretted that copies of the new memorandum were not yet available, but information in the form of CMO and EL letters (JCVI/90/7) had already been issued to GPs, Health Authorities and others.

b. Consideration was given by the Committee about how to get copies to medical students and nurses. Officials would ensure that as in previous years all those involved in vaccination and immunisation were made aware of the new edition and sent a free copy.

8.2 a. Dr Ramsay presented her paper, JCVI/90/8. The two studies in Plymouth and Colchester showed that the accelerated schedules had provided satisfactory levels of immunogenicity; there had been little cause for concern from reactogenicity.

b. Dr Smith emphasised that in Table 2 the two children with antibodies below 0.05 iu/ml could still be protected, as a level above 0.01 iu/ml would provide protection. Dr Ramsay said that all children had levels in excess of 0.01 iu/ml.

9. Adverse Reactions Committee (ARVI).

9.1. a. Professor Breckenridge presented the minutes of the last ARVI meeting, which he explained was largely concerned with consideration of MMR adverse reactions.

b. Of especial concern to ARVI were the reports from Japan of a high level of meningoencephalitis associated with the administration of MMR. However ARVI concluded that the Japanese experience may be due to different reporting/investigating criteria or other local factors.

c. They also felt that the methods of surveillance in the UK would detect problems were they occurring on that scale and welcomed the BPSU protocol.

9.2. a. Dr Salisbury introduced paper JCVI/90/9 which summarised the latest MMR adverse reactions reported to the CSM.

b. Professor Lambert queried how much Urabe vaccine had been distributed and how much Jeryl Lynn. Dr Salisbury estimated 2,500,000 doses of Urabe strain MMR vaccine compared to 500,000 doses of Jeryl Lynn. This differential was due to the reputation acquired by the Jeryl Lynn vaccine of pain at the injection site and the manufacturer's recommendation for a brief "out of the fridge" time for this vaccine.

c. Dr Smith asked if there were any reports of different sequelae from the use of amniotic fluid or chick fibroblast culture media in the production of the different vaccines. Dr Salisbury had no direct information but said that Merieux use amniotic fluid and have reported no such problems.

d. Dr Smith asked if the estimate of 2 cases per year reported in the conclusion to JCVI/90/9 took into account the increase in reporting derived from the BPSU surveillance. Dr Salisbury said that of the seven cases mentioned, four were known through yellow cards, the other three would not have satisfied the ARVI criteria but would have been noted by the BPSU.

e. Professor Hull urged the Committee to obtain more information about all cases of definite, probable and possible adverse reactions. He also asked that any differences between the ARVI and BPSU definitions of cases should be established, and that more information should be gathered on other adverse reactions such as parotitis. Dr Salisbury said that from Dr Christine Miller's and others' work the incidence of parotitis was around 1%.

f. The Chairman emphasised the merit of the BPSU having a broad definition of adverse reactions. Dr Begg agreed and said that all cases detected by the BPSU would be encouraged to be reported on Yellow Cards.

g. Professor Banatvala was concerned about the possibility of the Japanese experience being published widely in the UK, and urged the gathering of information on the various episodes from all the MMR manufacturers. Professor Breckenridge said that the Japanese had withdrawn a letter sent to the Lancet, however the withdrawal may indicate the later submission of a fuller article.

9.3. a. Dr Thores spoke to the letter, JCVI/90/10, from Dr McIntyre. He highlighted SHHD concern about the Canadian decision not to use Urabe strain vaccine, the cases of neurological complications in Japan, the seeming bias of UK adverse reactions towards Scotland, and the continued use of vaccine distribution figures as the denominator when calculating adverse reaction rates.

b. Dr Salisbury reminded the Committee that the use of distribution figures as the denominator had been debated many times before with the conclusion that there is no other sensitive figure available.

c. Professor Peckham told the Committee that she was aware of three districts changing from use of Urabe to Jeryl Lynn vaccine, and therefore the Committee needed to reassure authorities of the safety of all MMR vaccines.

d. Dr Smith, with reference to (a) in Dr McIntyre's letter, said that the Committee could not disregard the Japanese findings but because of the differences in vaccine dose and population one could not extrapolate from Japan to the UK. Professors Geddes and Breckenridge also emphasised the differences in adverse reaction reporting between countries.

e. The Chairman asked the Committee if it thought it necessary to draw up a statement about MMR.

f. Dr Smith said if a statement were made one of the facts the Committee needed to be secure of was whether or not Jeryl Lynn gives rise to fewer adverse reactions than Urabe.

g. Professor Hull suggested a simple sheet with ARVI's evaluation of the vaccines. This would let doctors know that an expert committee had looked at the situation and perhaps reassure them. It would be a clear statement to any enquirers and an aid to Co-ordinators who also may face questions.

h. Dr Salisbury said that in any statement it would be difficult to group together the two Urabe strain vaccines in use in the UK because the vaccines were grown differently and as yet, there had been relatively little experience with Merieux vaccine.

i. Professor Breckenridge suggested that a statement could be included in a copy of "Current Problems" issued by the MCA. The Committee agreed with this suggestion.

10. MRC Committee on Development of Vaccines and Immunisation.

10.1 a. Dr Smith presented the minutes of the last CDVIP meeting and drew the Committee's particular attention to:

- **i.** the Varicella vaccine soon to be licensed in the USA,
- **ii.** the phase 2 whooping cough trial of reactogenicity and immunogenicity, being repeated with a second group of children,
- **iii.** the phase 3 whooping cough trial for which the MRC had yet to obtain funds,
- **iv.** an AIDS vaccine which gives some promise by evidence of protection in simians,
- **v.** the continued work on polio vaccine.

b. Professor Smithells said that the NCRSP would have to run for twenty years or more and that funding for this length of time was not approved. Professor Banatvala said that the process of review associated with renewed funding applications was good for the health of the research, and asked that the Department should help fund the programme.

10.2

Professor Peckham introduced her paper, JCVI/90/11. She explained that the reason for its production was to demonstrate that CMV research is in hand, including that funded by the MRC at the Royal Free. Professor Banatvala emphasised that CMV was still the commonest microbial cause of mental retardation.

11. Measles, Mumps and Rubella (MMR).

11.1 Dr Salisbury spoke to paper JCVI/90/12 and to the tabled graph of measles notifications. Although there was no need for complacency as there are still many susceptible individuals, measles notifications are now running at the lowest ever recorded levels.

11.2 a. Paper JCVI/90/13 was noted with the Chairman asking how the UK is to avoid the USA experience of a resurgence of measles.

b. Dr Salisbury noted that in the US most of the recent upsurge had been in large cities and that the rate of notifications in California was four times that of the UK. He reminded the Committee that although the US had compulsory school entry vaccinations this had not prevented the upsurge as the majority of cases occur in the under fives.

c. The Chairman asked that the MMR Sub-Committee should meet to review the US experience and evidence, and to prepare a way forward for the UK. In this context Dr Salisbury would consult Dr Orenstein of CDC, Atlanta on waning immunity in the U.S.

12. Whooping Cough.

12.1 Dr Salisbury spoke to paper JCVI/90/15, and said that this information would be conveyed shortly to Immunisation Co-ordinators.

12.2,3,4. Papers JCVI/90/16 & 17 & 18 were noted for information by the Committee.

13. Influenza.

13.1 a. Dr Smith reported to the Committee the proceedings of the previous week's Influenza Sub-Group Meeting. In particular the meeting had agreed with the WHO composition of this year's vaccine, and had discussed the Departmental policy on high risk groups receiving vaccine.

b. The Committee agreed with the Sub-Group's proposal to give more positive advice in the annual CMO letter about high risk groups susceptible to influenza.

13.2 a. Dr Watson presented paper JCVI/90/19.

b. Dr Rubery stressed two details with regard to influenza. Firstly that in the light of last year's experience of vaccine shortage, in 1990/91 there was unlikely to be enough vaccine to cover health care workers outside the high risk groups. Secondly the Pandemic Plan for Influenza was being looked at again in the light of the 1989/90 epidemic experience.

14. Pneumococcal Vaccines.

14.1 a. Dr Reid presented paper JCVI/90/20.

b. The Committee agreed that the next edition of the memorandum should contain information about Pneumococcal Immunisation. In the meantime the Department should publicise the vaccine's availability, possibly as part of the CMO letter on influenza.

14.2 Paper JCVI/90/21 was noted for information by the Committee.

15. Poliomyelitis.

a. The paper, JCVI/90/22, was noted.

b. Dr Smith said that the Committee required more time to discuss this subject, and Dr Begg noted that trials were currently being carried with a combined OPV and IPV schedule.

16. BCG and tuberculosis.

16.1 The Committee noted from JCVI/90/23 that the supply of BCG vaccine was now restored.

16.2 a. Dr Bush, on behalf the BCG Sub-Committee, introduced the minutes of its last meeting. He said that the Sub-Committee had considered the cessation of routine schools BCG vaccination. However in the light of the incidence of tuberculosis amongst people with HIV and AIDS the Sub-Committee had decided to recommend that the programme should continue.

b. The Sub-Committee recommended that a further survey of the incidence of tuberculosis should be carried out in 1993, and that the routine vaccination programme should be reviewed again in 1995/6. The Committee agreed with these recommendations.

16.3 Professor Geddes presented the EAGA papers. These confirmed the BCG Sub-Committee's views that the occurrence of tuberculosis amongst HIV/AIDS sufferers indicated the need for continuation of routine BCG vaccination.

16.4 Dr Watson presented the paper prepared by Dr Gill and himself. The problem of incomplete notification of cases of TB occurring in HIV positive people was drawn to the Committee's attention. Dr Smith said that proposed changes in the law may make laboratories responsible for reporting all cases.

17. Haemophilus Influenzae.

17.1 Dr Begg introduced this paper. He explained that further research into the immune response achieved when Hib vaccine is given at 2, 3 and 4 months (the new schedule) was needed. An application had been made for funding, to include a sum for training staff to take venous blood samples, for this research. Also the proposed research has been submitted to a local ethics committee for approval. The Committee strongly supported this planned research.

17.2 Mr Anderson presented his paper which concluded that any savings from use of Hib vaccine would depend on its cost and on long term sequelae. Professor Peckham emphasised that no assessment was made of the cost caused by parents taking time off work.

17.3 The Committee noted the correspondence.

18. HEA Report.

18.1 a. Mr Huntington presented his paper, saying that this year's campaign would be aimed at the medical and nursing professions and the public, as there was still a good deal of confusion and misunderstanding amongst both groups.

b. A campaign pack and training guide would be issued in June; copies would be sent to all members of the Committee. The campaign will be launched in September. There had been close co-operation between the Department and the HEA.

19. HIV and Immunisation.

19.1 Dr Salisbury's paper on HIV and Immunisation was noted.

20. BPA/JCVI Liaison.

20.1 Professor Hull said that the BPA/JCVI Liaison Group meeting on 24 April had covered three main issues:

a. the use of paracetamol for fever following vaccination: as the new schedule now extended to infants under 3 months the group decided to recommend the appropriate use of paracetamol in such cases;

b. premature babies still in neonatal units should receive the first DTP at 2 months, but OPV should be delayed until they were discharged;

c. every effort should be made to progress towards introduction of Hib vaccine.

20.2 Professor Breckenridge said that the committee could be reassuring about the use of paracetamol and that such recommendation should be drawn to the attention of manufacturers and the BNF.

21. WHO expanded programme.

21.1 The Committee noted the paper, and that no case of indigenous polio had been reported in the whole of the Region of the Americas since the introduction in September 1989 of the $100 reward.

22. Cold Chain Storage.

22.1 The paper, which will be copied to all Co-ordinators, was noted for information.

23. Hepatitis B.

23.1 The paper was noted. The Committee asked that the Department discover which authorities are carrying out selective and which universal screening for Hepatitis B infection.

23.2 The letter was noted with a view to revising the Memorandum at the next edition.

24. Any other business.

Dr Noble expressed his regrets on leaving the Committee after twenty years, and the Chairman thanked him on behalf of the Committee.

25. The next meetings are:

2 November 1990
3 May 1991
1 November 1991